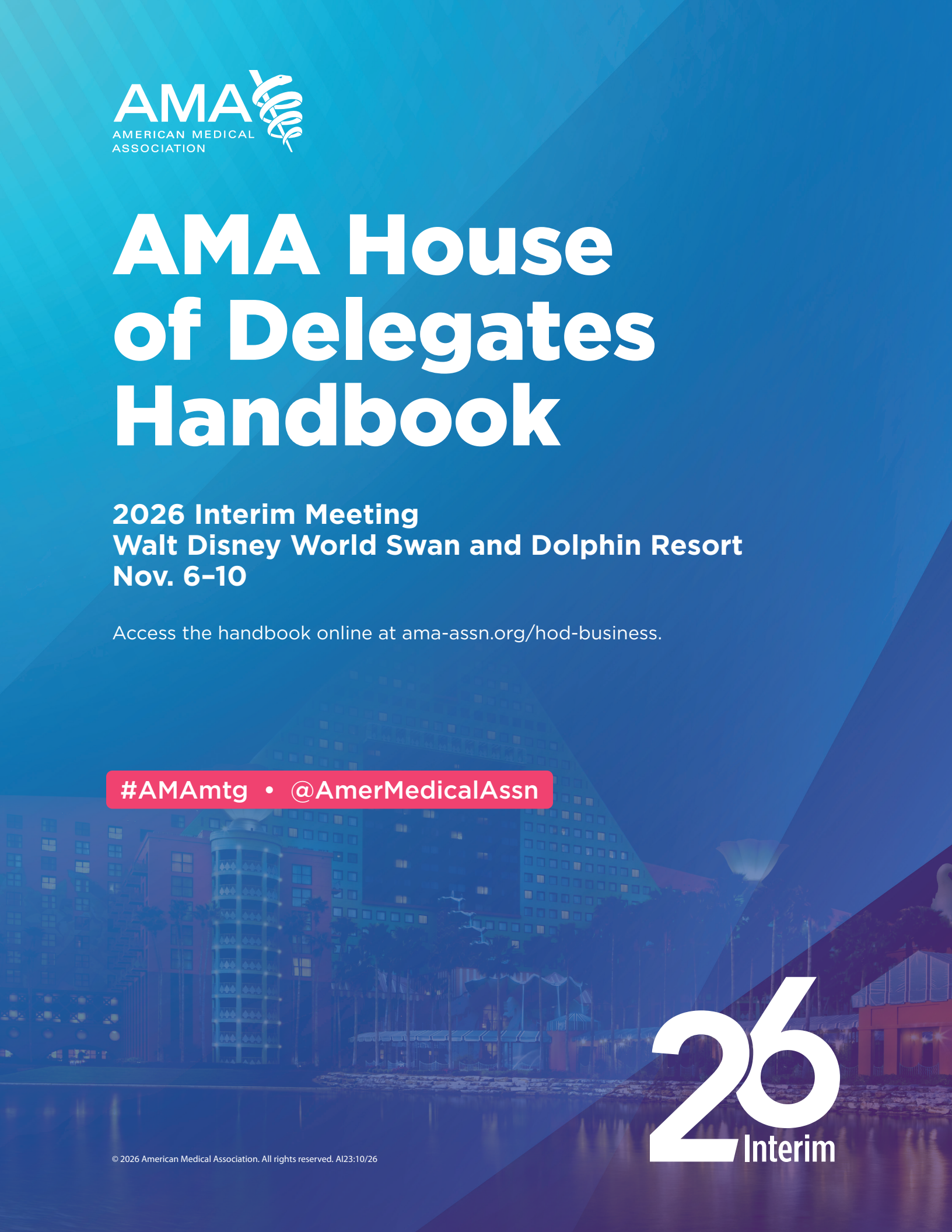
AMA
AMERICAN MEDICAL ASSOCIATION

AMA House of Delegates Handbook

2026 Interim Meeting
Walt Disney World Swan and Dolphin Resort
Nov. 6–10

Access the handbook online at ama-assn.org/hod-business.

#AMAmtg • @AmerMedicalAssn



26 Interim

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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

- **The Interim Meeting is focused on advocacy issues. A resolution committee (see AMA Bylaw 2.13.3) considers each resolution and recommends that the item be considered or not considered at the Interim Meeting. Items that meet the following definition of advocacy or that are considered urgent are recommended for acceptance:**

  Active use of communication and influence with public and private sector entities responsible for making decisions that directly affect physician practice, payment for physician services, funding and regulation of education and research, and access to and delivery of medical care.

  Resolutions pertaining to ethics should also be included in the agenda. Remaining items are recommended against consideration, but any delegate may request consideration when resolutions are presented for consideration (during Saturday's "Second Opening" Session). A simple majority of those present and voting is required for consideration.

- **REMINDER***: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions are informational and explanatory only.*

AMA
AMERICAN MEDICAL ASSOCIATION

UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with "abortion" and running to "women"; the former topic was assigned the number 5, and "women" was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will *generally* have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- "H" – for statements that one would consider positional or philosophical on an issue
- "D" – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- "G" – for statements related to AMA governance
- "E" – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at https://policysearch.ama-assn.org/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the *Proceedings*, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

BOT – Board of Trustees
CCB – Council on Constitution and Bylaws
CEJA – Council on Ethical and Judicial Affairs
CLRPD – Council on Long Range Planning and Development
CME – Council on Medical Education
CMS – Council on Medical Service
CSAPH – Council on Science and Public Health

If a resolution was involved, "Res" is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

5.000 Abortion	10.000 Accident Prevention/Unintentional Injuries
15.000 Accident Prevention: Motor Vehicles	20.000 Acquired Immunodeficiency Syndrome
25.000 Aging	30.000 Alcohol and Alcoholism
35.000 Allied Health Professions	40.000 Armed Forces
45.000 Aviation Medicine	50.000 Blood
55.000 Cancer	60.000 Children and Youth
65.000 Civil and Human Rights	70.000 Coding and Nomenclature
75.000 Contraception	80.000 Crime
85.000 Death and Vital Records	90.000 Disabled
95.000 Drug Abuse	100.000 Drugs
105.000 Drugs: Advertising	110.000 Drugs: Cost
115.000 Drugs: Labeling and Packaging	120.000 Drugs: Prescribing and Dispensing
125.000 Drugs: Substitution	130.000 Emergency Medical Services
135.000 Environmental Health	140.000 Ethics
145.000 Firearms: Safety and Regulation	150.000 Foods and Nutrition

155.000 Health Care Costs	160.000 Health Care Delivery
165.000 Health Care/System Reform	170.000 Health Education
175.000 Health Fraud	180.000 Health Insurance
185.000 Health Insurance: Benefits and Coverage	190.000 Health Insurance: Claim Forms and Claims Processing
195.000 Health Maintenance Organizations	200.000 Health Workforce
205.000 Health Planning	210.000 Home Health Services
215.000 Hospitals	220.000 Hospitals: Accreditation Standards
225.000 Hospitals: Medical Staff	230.000 Hospitals: Medical Staff - Credentialing and Privileges
235.000 Hospitals: Medical Staff - Organization	240.000 Hospitals: Reimbursement
245.000 Infant Health	250.000 International Health
255.000 International Medical Graduates	260.000 Laboratories
265.000 Legal Medicine	270.000 Legislation and Regulation
275.000 Licensure and Discipline	280.000 Long-Term Care
285.000 Managed Care	290.000 Medicaid and State Children's Health Insurance Programs
295.000 Medical Education	300.000 Medical Education: Continuing
305.000 Medical Education: Financing and Support	310.000 Medical Education: Graduate
315.000 Medical Records and Patient Privacy	320.000 Medical Review
330.000 Medicare	335.000 Medicare: Carrier Review
340.000 Medicare: PRO	345.000 Mental Health
350.000 Minorities	355.000 National Practitioner Data Bank
360.000 Nurses and Nursing	365.000 Occupational Health
370.000 Organ Donation and Transplantation	373.000 Patients
375.000 Peer Review	380.000 Physician Fees
383.000 Physician Negotiation	385.000 Physician Payment
390.000 Physician Payment: Medicare	400.000 Physician Payment: Medicare - RBRVS
405.000 Physicians	406.000 Physician-Specific Health Care Data
410.000 Practice Parameters	415.000 Preferred Provider Arrangements
420.000 Pregnancy and Childbirth	425.000 Preventive Medicine
430.000 Prisons	435.000 Professional Liability
440.000 Public Health	445.000 Public Relations
450.000 Quality of Care	455.000 Radiation and Radiology
460.000 Research	465.000 Rural Health
470.000 Sports and Physical Fitness	475.000 Surgery
478.000 Technology - Computer	480.000 Technology - Medical
485.000 Television	490.000 Tobacco Use, Prevention and Cessation
495.000 Tobacco Products	500.000 Tobacco: AMA Corporate Policies and Activities
505.000 Tobacco: Federal and International Policies	510.000 Veterans Medical Care
515.000 Violence and Abuse	520.000 War
525.000 Women	600.000 Governance: AMA House of Delegates
605.000 Governance: AMA Board of Trustees and Officers	610.000 Governance: Nominations, Elections, and Appointments
615.000 Governance: AMA Councils, Sections, and Committees	620.000 Governance: Federation of Medicine
625.000 Governance: Strategic Planning	630.000 Governance: AMA Administration and Programs
635.000 Governance: Membership	640.000 Governance: Advocacy and Political Action

LIST OF MATERIALS INCLUDED IN THIS HANDBOOK (I-26)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Ethics and Bylaws begin with 001, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Saturday, November 7, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. **Memorandum from the Speaker**

2. **Understanding the Recording of American Medical Association Policy**

3. **Declaration of Professional Responsibility - Medicine's Social Contract with Humanity**

4. **Delegate / Alternate Delegate Job Description, Roles, and Responsibilities**

5. **Seating Allocation and Seating Chart for the House of Delegates**

6. **Hotel Maps**

7. **Official Call to the Officers and Members of the AMA**
   - **Officials of the Association and AMA Councils**
   - **Ex Officio Members of the HOD**
   - **SSS Representatives**
   - **Listing of Delegates and Alternate Delegates**

8. **Reference Committee Schedule and Room Assignments**

9. **Note on Order of Business**

10. **Summary of Fiscal Notes**

11. **List of Resolutions by Sponsor**

FOLLOWING COLLATED BY REFERRAL

12. **Report(s) of the Board of Trustees - Toluwalasé Ajayi, MD, Chair**

01	Study of Grading Systems in AMA Board Reports	F
02	American Medical Association Optimal Health Outcomes Annual Report	Info. Report
03	Reduce Environmental Impact of Medical Journals	K
04	Informed Consent for Genetic Testing	K
05	Increasing Access through Federated Healthcare Data Architecture	K
06	Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care	B
07	Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians	B

08	Access to, and Retention of, Electronic Medical Records	B
09	Medicare Should Not Unfairly Penalize Physicians	B
10	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	F
11	Opposing Unilateral Downcoding of Physician Services by Insurance Companies	J
12	Rethink the Medicare Annual Wellness Visit	K
13	Enhancing the Work of the Center for Digital Health and AI	Info. Report
14	Patient Options to Restrict Secondary Use of Their Healthcare Data	E&B
15	Gender-Based Pay Equity in Medicine	E&B
16	Ensuring Medical Liability Insurance Transparency and Continuity	B
17	Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform	B
18	Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients	E&B
19	2026 AMA Advocacy Efforts	Info. Report
20	AMA Efforts on Medicare Payment Reform	Info. Report
21	Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care	B
22	Clarifying Conscientious Objection	E&B

13. Report(s) of the Council on Constitution and Bylaws - Mary Ann Contogiannis, MD, Chair

01	Clarifications Regarding Establishment and Nominations to AMA Committees	E&B
02	Amendments to Bylaws Governing the AMA Sections	E&B
03	Autonomy of House of Delegate Member Entities: Bylaw Clarification	E&B

14. Report(s) of the Council on Ethical and Judicial Affairs - Larry E. Reaves, MD, Chair

01	Preserving Autonomy in the Patient-Physician Relationship	E&B
02	Clarifying Conscientious Objection	E&B
03	Guidelines on Chaperones for Sensitive Exams	E&B
04	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	E&B
05	Care of Patients in Legal Custody	E&B
06	Recording Clinical Encounters	E&B
07	Physicians Are Not Providers	E&B

15. Report(s) of the Council on Long Range Planning and Development – G. Sealy Massingill, MD, Chair

01	Evaluation of the Size and Structure of the AMA House of Delegates	F
02	Underrepresented in Medicine Advocacy Section Five-Year Review	F
03	Integrated Physician Practice Section Five-Year Review	F

16. Report(s) of the Council on Medical Education - Shannon M. Kilgore, MD, Chair

01	Medical Education Program and Content	C
02	Medical Education Systems	C
03	Professional Regulation of Physicians	C
04	Physician as Medical Professional	C
05	Entry into and transition through the medical education continuum	C
06	Obligations to Students and Trainees	C
07	Mission of Medical Education	C
08	Hardship for International Medical Graduates in Humanitarian Crisis or Conflict	C

17. Report(s) of the Council on Medical Service - A. Patrice Burgess, MD, Chair

01	Transparency with the Term "Emergency Department"	J
02	The Impact of the Inflation Reduction Act on Physician Practices	J
03	Non-Medical Switching of Prescription Drugs	J
04	Determining Fair Market Value when Contracting with Physician Practices	J
05	Improving Marketplace Affordability through Premium Tax Credits	J
06	Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries	J

18. Report(s) of the Council on Science and Public Health - Tamaan Osbourne-Roberts, MD, MBA, Chair

01	Drug Shortages: 2026 Update	K
02	Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup	K
03	Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing	K
04	Deprescribing in Clinical Practice	K
05	Battlefield Acupuncture	K

19. Report(s) of the HOD Committee on Compensation of the Officers - Hilary Fairbrother, MD, MPH, FACEP, Chair

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

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

01	Election Rule Updates	F
02	Recommended Policy Reconciliations	Info. Report

21. Resolutions

001	Recognition of Intersex Individuals and their Human Rights	EB
002	Surgical Consent	EB
005	Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials	EB
006	Ethics of Medical Usury	EB
007	Opposing the Required Creation of "Detransition Clinics"	EB
008	Recognition of Moral Injury in the Physician Workforce	EB
009	Ensuring the Appropriate Placement of Children After Parental Deportation	EB
010	Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring	EB
201	Artificial Intelligence Having Prescriptive Authority	B
202	Rapid Response Framework for Unsupported Medical Claims by Public Officials	B

203	Set-Aside Federal Funding for Tribal Health Programs	B
204	Federal Framework for Social Media Access by Minors Under Age 16	B
205	Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs	B
206	Third-Party Litigation Funding in Medical Liability Claims	B
207	Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety	B
208	Facilitating Short-Term Supervised Clinical Training for International Physicians	B
209	Protecting GME Subject to Funding Uncertainty	B
210	Requiring Physician Oversight for Artificial Intelligence Tools	B
211	Fair and Clinically Appropriate EMTALA Investigations	B
212	Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract	B
213	Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings	B
214	Prohibiting Health Care Sale-Leaseback Transactions	B
215	Establishing Product Liability for Clinical Augmented Intelligence Failures	B
216	Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process	B
217	Strengthening the Patients First Act and Medicare Physician Payment Reform	B
218	Firearm Manufacturer Accountability for the Cost of Gun Violence	B
219	Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material	B
220	Advocating for the Older Americans Act and Community-Based Services for Older Adults	B
221	Preserving Duration of Status for J-1 Physicians in Graduate Medical Education	B
222	Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)	B
223	Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine	B
224	Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents	B
225	Supporting a Common Legal Framework for Medical Capacity Holds	B
226	Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review	B
227	Increasing Access to Long-Acting Injectable Medications for SUD	B
228	Hospital-Based Substance Use Disorder Care	B
229	Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation	B
230	Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities	B
231	Medicare and Medicaid Payment Equity for Puerto Rico	B
232	Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care	B
233	Medicaid Protections & Continuous Coverage for Active Cancer Care	B
234	Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers	B
235	Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions	B
302	Augmented Intelligence Use in Assessment Development During Medical Education	C
304	Transparency in AI-Assisted Admissions	C

305	Certification for Hospice Medical Directors	C
306	Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States	C
601	Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy	F
602	Enhancing Equity in House of Delegates Resolution Processes by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus	F
603	Ensuring Relevance and Mission Alignment in House of Delegates Business	F
604	Increasing Time Between Handbook Release and Opening of Online Reference Committees	F
801	Improving the External Appeals Process for Denied Claims	J
802	Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs	J
803	Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit	J
804	Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes	J
805	Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine	J
806	Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked	J
807	Continuing Care Retirement Communities (CCRC's)	J
808	Increasing Payment for Patient Portal Messages	J
809	Joint Commission Standards for Medical Staff Self-Governance	J
810	Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence	J
811	Government Support of Adaptive Sports Programming	J
812	Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions	J
813	Small Medical Practice Website and other Digital Service Compliance with ADA Regulation	J
814	Coverage of SMART Therapy for Asthma	J
815	Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies	J
816	Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services	J
817	Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care	J
818	Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment	J
819	Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers	J
820	Strengthening Emergency Interfacility Transfer Infrastructure	J
901	The Establishment of Mandatory National Reporting of Naegleria Fowleri and Other Amebic Encephalitides	K
902	Illegal Electronic Health Record Sharing and Patient Trust	K
903	Improving Health Outcomes in Native Hawaiian Populations	K
904	Regulation of Organ Transplant Open Offers	K
905	Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care	K
906	Establishing Menstrual Products as a Standard of Inpatient Care	K

907	Affirming Support for the National Institutes of Health Advisory Councils	K
908	Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients	K
909	Public Emergency Alert Reporting Requirements on Private Platforms	K
910	Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation	K
912	Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products	K
913	Withdrawn	
914	National Strategy to Close the Women's Health Gap	K
915	Ensuring Expert and Lived Experience Input in Federal National Health Plans	K
916	Opposition to Recreational Nicotine Products in Federal Correctional Facilities	K
917	Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health	K
918	Strengthening the Radiation Protection Standard	K
919	Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions	K
920	Improving Protection for Patient Medical Records and Health Care	K
921	Transgender and Gender Diverse Cancer Research	K
922	Eliminating Tax Barriers to Equitable Clinical Trial Participation	K
923	Research the Community Health Impacts of Data Centers	K
924	Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice	K
925	Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers	K
926	Support for One Health Approaches to Protect Human, Animal, and Environmental Health	K
927	Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement	K
928	Electric Bike and Scooter Safety, Regulation, and Enforcement	K
929	Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis	K
930	Supporting the Use of Firearm Suppressors to Prevent Hearing Loss	K
931	Allocation, Liability Protections, & Generic Drug Shortages	K
932	Recognizing the Challenge of Tobacco use in the Era of Commercial E-Cigarettes and Nicotine Products	K
933	Preventing Silicosis Associated with Engineered Stone Countertops	K

22. Not for Consideration

003	Support for Completion of Medical Directives Before Elective Surgeries	EB
004	Use of Live Animals in Medical Training	EB
301	Missing Indigenous People Crisis in Medical Education	C
303	Transparent Visiting Rotation Fee Disclosure	C
307	Promoting Transparency on Fertility Healthcare Policies for Trainees	C
308	Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems	C
309	Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners	C
310	Disparities in Preliminary and Transitional Year GME Funding	C
911	Annual Alcohol Report and Comprehensive Review of AMA Alcohol Policy	K

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1. Respect human life and the dignity of every individual.

2. Refrain from supporting or committing crimes against humanity and condemn all such acts.

3. Treat the sick and injured with competence and compassion and without prejudice.

4. Apply our knowledge and skills when needed, though doing so may put us at risk.

5. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

6. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

7. Educate the public and polity about present and future threats to the health of humanity.

8. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

9. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association
in San Francisco, California on December 4, 2001

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were last modified at the 2024 Interim Meeting by Speakers' Report 02. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
- Active member of the AMA.
- Elected or selected by the principal governing body or the membership of the sponsoring organization.
- The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
- Regularly communicate AMA policy, information, activities, and programs to constituents so they will be recognized as the representative of the AMA.
- Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
- Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
- Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
- Serve as an advocate for patients to improve the health of the public and the health care system.
- Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
- Actively recruit new AMA members and help retain current members.

SEATING ALLOCATION – 2026 INTERIM MEETING

ADDICTION MEDICINE - 3
American Society of Addiction Medicine (ASAM) – 3
Trustee (Dr. Levin) – 1
Delegates - 2

AMGA - 1
American Medical Group Association (AMGA) - 1

ANESTHESIOLOGY - 12
American Society of Anesthesiologists (ASA) - 10
Trustee (Dr. Kataria) – 1
Former President (Dr. Ehrenfeld) - 1
Delegates – 8
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

ARS – 1
American Rhinologic Society (ARS) - 1

CARDIOLOGY - 21
American College of Cardiology (ACC) - 9
American Society of Echocardiography (ASE) - 2
American Society of Nuclear Cardiology (ASNC) - 2
Heart Rhythm Society (HRS) - 3
Society for Cardiovascular Angiography and Interventions (SCAI) - 2
Society for Cardiovascular Magnetic Resonance (SCMR) - 1
Society of Cardiovascular Computed Tomography (SCCT) - 2

CHEST PHYSICIANS - 3
American College of Chest Physicians (CHEST) (ACCP) - 3

CRITICAL CARE MEDICINE- 2
Society of Critical Care Medicine (SCCM) - 2

DERMATOLOGY - 16
American Academy of Dermatology Association (AAD) – 7
Trustee (Dr. Van Beek) - 1
Former President (Dr. Resneck) - 1
Delegates - 5
American College of Mohs Surgery (ACMS) - 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery Association (ASDSA) - 3
American Society for Laser Medicine and Surgery, Inc. (ASLMS) - 1
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1
Society for Pediatric Dermatology (SPD) - 1

EMERGENCY MEDICINE - 15
American Academy of Emergency Medicine (AAEM) - 3
American College of Emergency Physicians (ACEP) - 12
Former President (Dr. Stack) - 1
Delegates - 9
Resident and Fellow Section Delegates - 2

ENDOCRINOLOGY - 4
American Assn of Clinical Endocrinology (AACE) - 2
Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 28
American Academy of Family Physicians (AAFP) - 28
Former Board Chair (Dr. Langston) - 1
Delegates - 26
Resident and Fellow Section Delegate – 1

GASTROENTEROLOGY - 10
American College of Gastroenterology (ACG) - 4
American Gastroenterological Association (AGA) - 3
American Society for Gastrointestinal Endoscopy (ASGE) - 3

GERIATRIC MEDICINE - 2
American Geriatrics Society (AGS) – 2

GREAT LAKES - 67
Illinois - 17
Delegates - 13
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 8
Trustee (Dr. Welsh) - 1
Delegates – 6
Medical Student Regional Delegate - 1
Michigan - 16
Delegates - 14
Resident and Fellow Section Delegate - 1
American Osteopathic Association (AOA) – 1
Ohio - 18
Delegates (minus Speaker @ dais) - 11
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
American College of Legal Medicine (ACLM) - 2
Delegate - 1
Resident and Fellow Section Delegate - 1
American Institute of Ultrasound in Medicine (AIUM) - 2
Wisconsin - 8
Trustee (Ms. Ruprecht) - 1
Delegates - 5
Resident and Fellow Section Delegate - 1
Undersea & Hyperbaric Medical Society (UHMS) - 1

HEART OF AMERICA - 16
Kansas - 6
Delegates - 4
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
Missouri – 10
Former President (Dr. Barbe) - 1
Delegates - 7
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1

HEMATOLOGY - 2
American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 3
Society of Hospital Medicine (SHM) - 3

INFECTIOUS DISEASE - 2
Infectious Diseases Society of America (IDSA) - 2

INTERNAL MEDICINE - 32
American College of Lifestyle Medicine (ACLsM) - 2
American College of Physicians (ACP) – 30
Trustee (Dr. Kelkar) - 1
Former President (Dr. Wilson) - 1
Delegates - 26
Renal Physicians Association (RPA) - 2

MOBILITY CAUCUS - 16
American Acad of Orthopaedic Surgeons (AAOS) – 6
Trustee (Dr. Suk) - 1
Delegates - 5
Former President (Dr. Gurman)
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOrA) - 1
American Orthopaedic Foot and Ankle Society (AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 2
American Society of Interventional Pain Physicians (ASIPP) - 2
International Soc for the Advancement of Spine Surgery (ISASS) -1
North American Spine Society (NASS) - 2

NEUROSCIENCES - 42
Academy of Consultation-Liaison Psychiatry (ACLP) - 1
American Academy of Addiction Psychiatry (AAAP) - 1
American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 2
American Academy of Neurology (AAN) - 7
Delegates - 4
Resident and Fellow Section Delegates - 3
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 3
Former President (Dr. Carmel) - 1
Delegates – 2
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM)- 2
American Epilepsy Society (AES) - 1
American Psychiatric Association (APA) - 12
Former President (Dr. Harris) - 1
Delegates - 9
Resident and Fellow Section Delegates – 2
American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 2
GLMA: Health Professionals Advancing LGBTQ+ Equality – 1
International Pain and Spine Intervention Society (IPSIS) - 2
North American Neuromodulation Society (NANS) - 2
Delegate - 1
Resident and Fellow Section Delegate – 1

NEW ENGLAND - 31
Connecticut - 6
Trustee (Ms. Breig) - 1
Delegates - 4
Medical Student Regional Delegate- 1
Maine - 3
Delegates - 2
Medical Student Regional Delegate- 1
Massachusetts - 17
Delegates - 14
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1
New Hampshire - 2
Rhode Island - 2
Vermont – 1

NEW YORK - 35
Former President (Dr. Nielsen) - 1
Delegates - 28
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate – 1
American Society of Neuroradiology (ASNR) - 2
American Medical Women's Association (AMWA) - 2
Delegate - 1
Resident and Fellow Section Delegate - 1

NORTH CENTRAL - 20
Iowa - 6
Delegates - 4
Medical Student Regional Delegate - 1
Outpatient Endovascular and Interventional Society (OEIS) - 1
Minnesota – 6
Delegates - 5
Resident and Fellow Section Delegate – 1
Nebraska – 4
Delegates - 3
Resident and Fellow Section Delegate – 1
North Dakota - 2
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 22
American Association of Gynecologic Laparoscopists (AAGL) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1
American College of Medical Genetics and Genomics (ACMGG) -1
American College of Obstetricians and Gynecologists (ACOG) - 16
Trustee (Dr. Smith) - 1
Delegates - 14
Former President (Dr. Wah)
Resident and Fellow Section Delegate - 1
American Society for Reproductive Medicine (ASRM) - 2

ONCOLOGY - 6
Association for Clinical Oncology (ASCO) – 6
Delegates - 5
Former President (Dr. McAneny)
Resident and Fellow Section Delegate - 1

PACWEST CONFERENCE - 100
Alaska - 1
Arizona - 6
Delegates - 5
American College of Radiation Oncology (ACRO) - 1
California - 56
Trustee (Dr. Aizuss) - 1
Delegates - 45
Medical Student Regional Delegates - 3
Resident and Fellow Section Delegates - 2
American Clinical Neurophysiology Soc (ACNS) – 1
American Soc for Radiation Oncology (ASRO) – 2
International Society of Hair Restoration Surgery (ISHRS) – 1
North American Neuro-Ophthalmology Society (NANOS) - 1
Colorado -10
Former President (Dr. Lazarus) - 1
Delegates - 6
Resident and Fellow Section Delegates - 2
Obesity Medicine Association (OMA) - 1
Hawaii - 2
Idaho - 1
Montana - 1

PACWEST CONFERENCE cont'd
Nevada – 3
New Mexico - 2
Oregon - 4
Utah - 4
Delegates - 3
Medical Student Regional Delegate - 1
Washington – 9
Trustee (Dr. Rege) - 1
Delegates - 7
Medical Student Regional Delegate - 1
Wyoming – 1

PALTmed –2
Post-Acute and Long-Term Care Medical Association (PALTmed) – 2

PATHOLOGY - 9
American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1

PEDIATRICS - 7
American Academy of Pediatrics (AAP) - 7
Trustee (Dr. Garretson) - 1
Delegates - 5
Resident and Fellow Section Delegate - 1

PENNSYLVANIA - 17
Delegates - 15
Medical Student Regional Delegate- 1
American Hernia Society (AHS) - 1

PHYSICAL MEDICINE AND REHABILITATION - 4
American Acad of Physical Med & Rehabilitation (AAPMR) - 3
Association of Academic Physiatrists (AACP) - 1

PREVENTIVE MEDICINE - 7
Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 1
American College of Medical Quality (ACMQ) - 1
American College of Occup & Environmental Med (ACOEM) -2
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 18
American College of Radiology (ACR) – 9
Delegates – 8
Former President (Dr. Johnson)
Resident and Fellow Section Delegate – 1
American Roentgen Ray Society (ARRS) – 3
Association of Academic Radiology (AAR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 2

RHEUMATOLOGY - 2
American College of Rheumatology (ACRh) - 2

SECTIONS - 12
Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
LGBTQ+ Section - 1
Medical Student Section (MSS) - 1
Underrepresented in Medicine Advocacy Section (UMAS) - 1
Organized Medical Staff Section (OMSS) - 1
Private Practice Physicians Section (PPPS) - 1
Resident and Fellow Section (RFS) – 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

SERVICES - 7
Air Force - 1
Army - 1
AMSUS - Society of Federal Health Professionals - 2
Navy - 1
Public Health Service - 1
Veterans Affairs - 1

SLEEP MEDICINE – 2
American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 121
Alabama - 5
Delegates - 4
Resident and Fellow Section Delegate - 1
Arkansas -4
Delegates - 3
Medical Student Regional Delegate - 1
Delaware - 2
Former Board Chair (Dr. Permut) – 1
Delegate - 1
District of Columbia - 3
Former Board Chair (Dr. Scalettar) – 1
Delegates - 2
Florida - 23
Delegates - 19
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
National Medical Association (NMA) - 1
The Triological Society (TS) - 1
Georgia - 8
Delegates - 7
Medical Student Regional Delegate- 1
Kentucky - 7
Former Presidents (Drs. Hoven, Scott) - 2
Delegates - 5
Louisiana - 7
Maryland - 7
Delegates - 6
Acad of Physicians in Clinical Research (APCR) - 1
Mississippi - 4
Former President (Dr. Hill) - 1
Delegates - 3
New Jersey - 12
Delegates - 10
Medical Student Regional Delegate- 1
American Assn of Physicians of Indian Origin (AAPIO) - 1
North Carolina - 6
Oklahoma - 6
Delegates - 4
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
Puerto Rico - 2
South Carolina – 7
Former Presidents (Drs. Harmon, Smoak) - 2
Delegates - 4
Medical Student Regional Delegate - 1

SOUTHEASTERN cont'd
Tennessee - 7
Delegates - 6
Medical Student Regional Delegate - 1
Virginia - 8
Delegates - 7
Medical Student Regional Delegate- 1
West Virginia – 3
Delegates - 2
Medical Student Regional Delegate- 1

SURGEONS - 60
American Academy of Cosmetic Surgery (AACS) - 1
American Acad of Facial Plastic and Reconstructive Surg (AAFPRS) -1
American Academy of Ophthalmology (AAO) – 5
Delegates - 4
Resident and Fellow Section Delegate – 1
American Acad of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Oto-Head & Neck Surgery (AAOHNS) -4
American Association for Thoracic Surgery (AATS) - 1
American Association of Hip and Knee Surgeons (AAHKS) - 2
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) - 14
Delegates (minus Vice Speaker @ dais) - 13
Resident and Fellow Section Delegate – 1
American Society for Aesthetic Plastic Surgery (ASAPS) - 1
American Soc for Metabolic and Bariatric Surgery (ASMBS) - 1
American Soc for Reconstructive Microsurgery (ASRMS) - 1
American Soc of Cataract and Refractive Surgery (ASCTRS) - 2
American Soc of Colon and Rectal Surgeons (ASCRS) - 2
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) -1
American Soc of Plastic Surgeons (ASPS) - 5
Trustee (Dr. Jeffers) - 1
Delegates - 3
Resident and Fellow Section Delegate – 1
American Soc of Retina Specialists (ASRS) - 2
American Soc of Transplant Surgeons (ASTS) - 1
American Venous Forum (AVF) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 3
Delegates - 2
Resident and Fellow Section Delegate – 1
Soc of Amer Gastrointestinal Endo Surgeons (SAGES) -2
The American Soc of Breast Surgeons (ASBS) - 2
The Soc of Laparoscopic and Robotic Surgeons (SLRS) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2
Guam - 1
Virgin Islands - 1

TEXAS - 34
Former Presidents (Drs. Bailey, Dickey, Rohack) - 3
Former Board Chair (Dr. Kridel) – 1
Delegates - 25
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegates - 2
American College of Allergy, Ashtma & Immunology (ACAAI) - 2

THORACIC MEDICINE - 2
American Thoracic Society (ATS) - 2

UROLOGY - 6
American Assoc of Clinical Urologists (AACU) - 2
American Urological Association (AUA) – 4
Delegates - 2
Resident and Fellow Section Delegates - 2

OFFICIAL OBSERVERS - 18
Accreditation Council for Continuing Medical Education (ACCME)
Ambulatory Surgery Center Association
American Academy of Physician Associates
American Association of Medical Assistants
American Board of Medical Specialties
American Dental Association
American Podiatric Medical Association
Association of periOperative Registered Nurses
Association of State and Territorial Health Officials
Council of Medical Specialty Societies
Federation of State Medical Boards
Federation of State Physician Health Programs
Intealth (ECFMG)
Medical Professional Liability Association
Project IMG
Society for Academic Continuing Medical Education
United States Professional Association for Transgender Health
World Medical Association

TELLERS - 3

HOUSE OF DELEGATES · WALT DISNEY WORLD SWAN AND DOLPHIN RESORT, ORLANDO, FLORIDA (I-26)

Audience Left | STAGE | **Audience Right**

SPEAKER | VICE SPEAKER

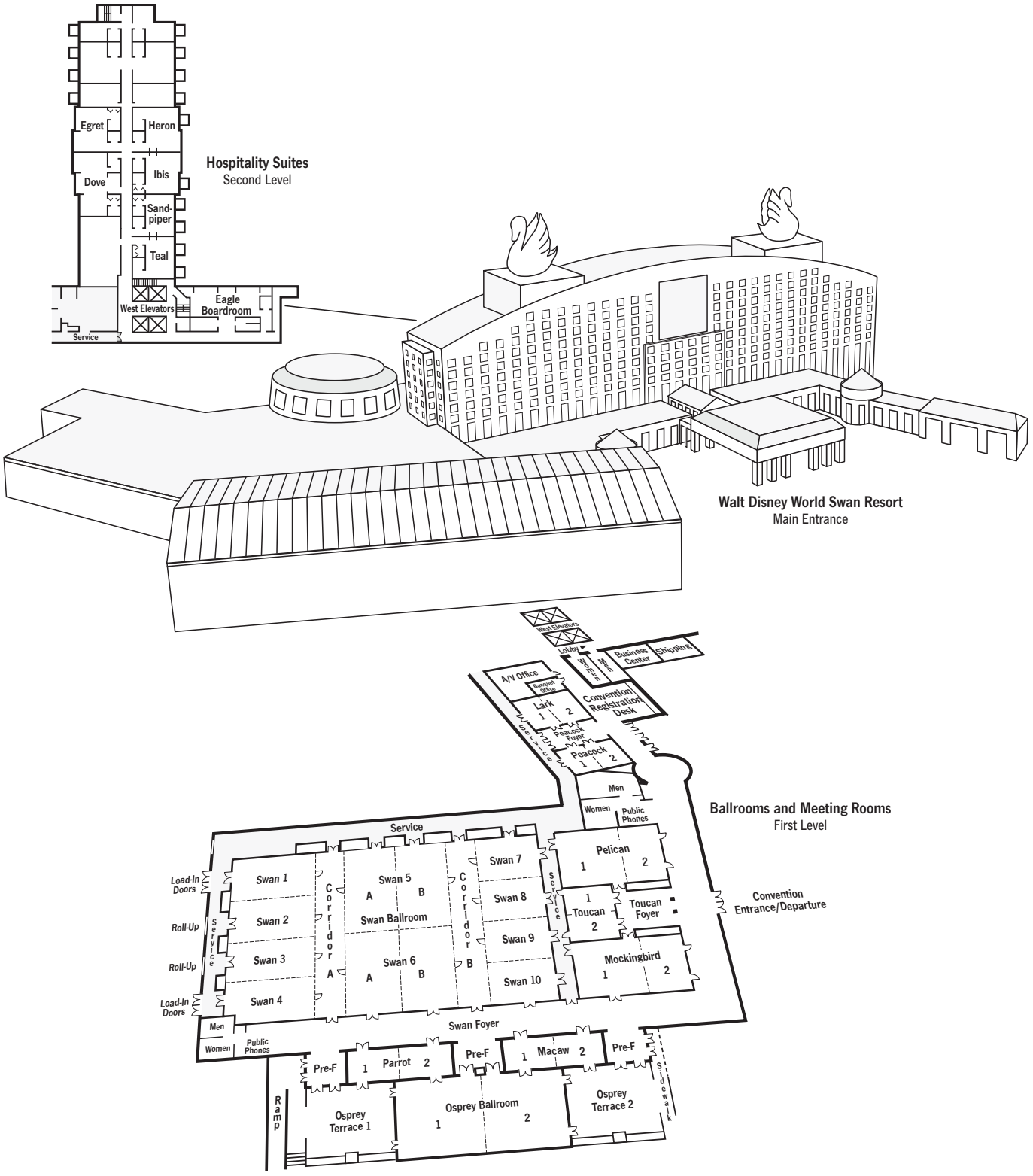
SEAT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
ROW																				
1	TEXAS - 34				TX/ MSS	ACAAI	ACAAI	MINNESOTA - 6					MN/ RFS	NEUROSCIENCES - 42						
2	TEXAS						TX/ RFS	IOWA - 6		IA/ MSS				NEUROSCIENCES						
3	TEXAS						TX/ RFS	NEBRASKA - 4			NORTH DAKOTA-2			NEUROSCIENCES						
4	TEXAS							SOUTH DAKOTA-2			SECTIONS - 12			NEUROSCIENCES						
5	TEXAS						KRIDEL			RFS	SPS	WPS	YPS	AAN/ RFS	AAN/ RFS	AAN/ RFS	AAN	AAN	APA	APA
6	NEW MEXICO - 2		OREGON - 4				PALTMED-2			SECTIONS				NEUROSCIENCES						
7	COLORADO - 10							WASHINGTON - 9			SECTIONS			NEUROSCIENCES						
8	COLORADO					NEVADA - 3			WY - 1	AK - 1	OBSTETRICIANS AND GYNECOLOGISTS - 22									
9	ARIZONA - 6						HAWAII - 2		ID -1	MT -1	OB-GYN			RADIOLOGY - 18						
10	UTAH - 4					CALIFORNIA - 56					RADIOLOGY									
11	CALIFORNIA										CHEST PHYSICIANS - 3			ADDICTION MEDICINE - 3			GASTROENTEROLOGY - 10			
12	CALIFORNIA										SERVICES - 7			GASTROENTEROLOGY						
13	CALIFORNIA										SERVICES			MICHIGAN - 16						
14	CALIFORNIA										MICHIGAN									WI
15	CALIFORNIA										INDIANA - 8			WISCONSIN - 8						
16	DERMATOLOGY - 16							TERRITORIES - 2			INDIANA					ILLINOIS - 17				
17	DERMATOLOGY							GERIATRIC MED -2			ILLINOIS									
18	ENDOCRINOLOGY - 4			HOSPITAL MEDICINE - 3			AMGA-1	CRITICAL CARE - 2			ILLINOIS			OHIO - 18						
19	EMERGENCY MEDICINE - 15							THORACIC MED - 2			OHIO									
20	EMERGENCY MEDICINE							ANESTHESIOLOGY - 12						ONCOLOGY - 6						
21	PREVENTIVE MEDICINE - 7							ANESTHESIOLOGY					SLEEP MED - 2	RHEUMATOLOGY -2		INFECTIOUS DIS - 2		HEMATOLOGY - 2		

ROW	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	SEAT
1	T	T	T	PHYSICAL MEDICINE & REHAB - 4				PENNSYLVANIA - 17					AHS	PEDIATRICS - 7							1
2	KENTUCKY - 7							PENNSYLVANIA						FAMILY PHYSICIANS - 28							2
3	DISTRICT OF COLUMBIA - 3			DELAWARE - 2		PENNSYLVANIA								FAMILY PHYSICIANS							3
4	MARYLAND - 7							INTERNAL MEDICINE - 32						FAMILY PHYSICIANS							4
5	OKLAHOMA - 6							INTERNAL MEDICINE											FAMILY PHYSICIANS		5
6	TENNESSEE - 7							INTERNAL MEDICINE													6
7	ALABAMA - 5				WEST VIRGINIA - 3			INTERNAL MEDICINE						MOBILITY CAUCUS - 16							7
8	VIRGINIA - 8							SURGEONS - 60						MOBILITY CAUCUS							8
9	NORTH CAROLINA - 6							SURGEONS						UROLOGY - 6							9
10	SOUTH CAROLINA - 7							SURGEONS						CARDIOLOGY - 21							10
11	FLORIDA - 23							SURGEONS						CARDIOLOGY							11
12	FLORIDA							SURGEONS						CARDIOLOGY							12
13	FLORIDA						ARS-1	SURGEONS						CARDIOLOGY			PATHOLOGY - 9				13
14	GEORGIA - 8							SURGEONS						PATHOLOGY							14
15	NEW JERSEY - 12							SURGEONS						KANSAS - 6			MISSOURI - 10				15
16	MISSISSIPPI - 4			NEW JERSEY				SURGEONS						KANSAS			MISSOURI				16
17	LOUISIANA - 7							SURGEONS			NEW HAMPSHIRE - 2		RHODE ISLAND-2	VT-1	MISSOURI						17
18	ARKANSAS - 4			PUERTO RICO - 2				NEW YORK - 35						MASSACHUSETTS - 17					CONNECTICUT - 6		18
19	NEW YORK													MASSACHUSETTS					CONNECTICUT		19
20	NEW YORK													MASSACHUSETTS					MAINE - 3		20
21	NEW YORK																				21

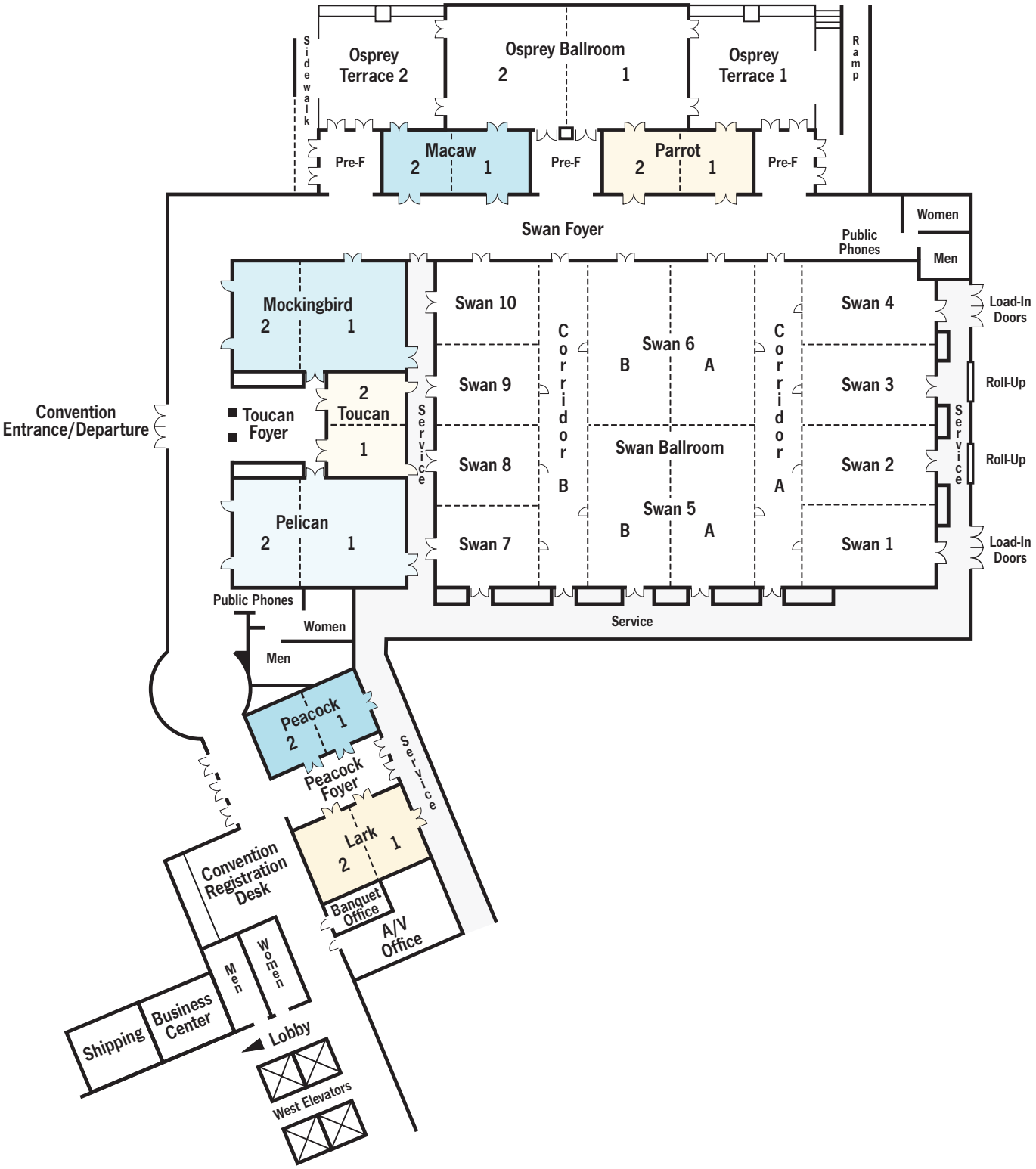
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1				AAPMR	AAPMR	AAMPR	AACP							GARRETSON	AAP/ RFS						1
2			SCOTT	HOVEN																	2
3			SCALETTAR		PERMUT					PA/ MSS	AAFP/ RFS										3
4					APCR			ACLsM	ACLsM	ACP	ACP	ACP									4
5				OK/ RFS	OK/ MSS		ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	LANGSTON			5
6				TN/ MSS				WILSON	ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	ACP	6
7				AL/ RFS			WV/ MSS		RPA	RPA	KELKAR	NASS	NASS	ISASS	ASIPP	ASIPP	ASSH	ASSH	AAHS	AOFAS	7
8				VA/ MSS					AAOA	AAOHNS	AAOHNS	AAOHNS	AAOHNS	SUK	GURMAN	AAOS	AAOS	AAOS	AAOS	AOrA	8
9							JEFFERS	ASPS/ RFS	ASPS	ASPS	ASPS	AACS	ASAPS	AAPS	AACU	AACU	AUA/ RFS	AUA/ RFS	AUA	AUA	9
10			HARMON	SC/ MSS	SMOAK			STS	STS	AATS	ASMBS	ASRMS	AAHKS	AAHKS	ASNC	ASNC	SCAI	SCAI	SCCT	SCCT	10
11									ASTS	SVS/ RFS	SVS	SVS	SAGES	SAGES	ACC	ACC	ACC	ASE	ASE	SCMR	11
12			FL/ RFS	FL/ MSS					ASBS	ASBS	SLRS	SLRS	ASCRS	ASCRS	ACC	ACC	ACC	ACC	ACC	ACC	12
13			NMA	TS				ARS-1	AVF	AAFPRS	ASCTRS	ASCTRS	ASMS	ICSUS	HRS	HRS	HRS	ASCP	ASCP	ASCP	13
14			GA/ MSS						AAO/ RFS	AAO	AAO	AAO	AAO	ASOPRS	NAME	CAP	CAP	CAP	CAP	ASC	14
15				NJ/ MSS	AAPIO				ASRS	ASRS	ACS/ RFS	ACS	ACS	ACS	KS/ MSS			MO/ RFS			15
16			HILL						ACS	ACS	ACS	ACS	ACS	ACS	KS/ RFS			MO/ MSS			16
17								ACS	ACS	ACS	ACS						BARBE				17
18				AR/ MSS						AMWA	AMWA/ RFS	MA/ MSS						CT/ MSS			18
19											NY/ MSS	MA/ RFS						BREIG			19
20												NY/ RFS	AAAAI					ME/ MSS			20
21					NIELSEN	ASNR	ASNR														21

WALT DISNEY WORLD SWAN RESORT

Meeting Space Aerial View



First Level

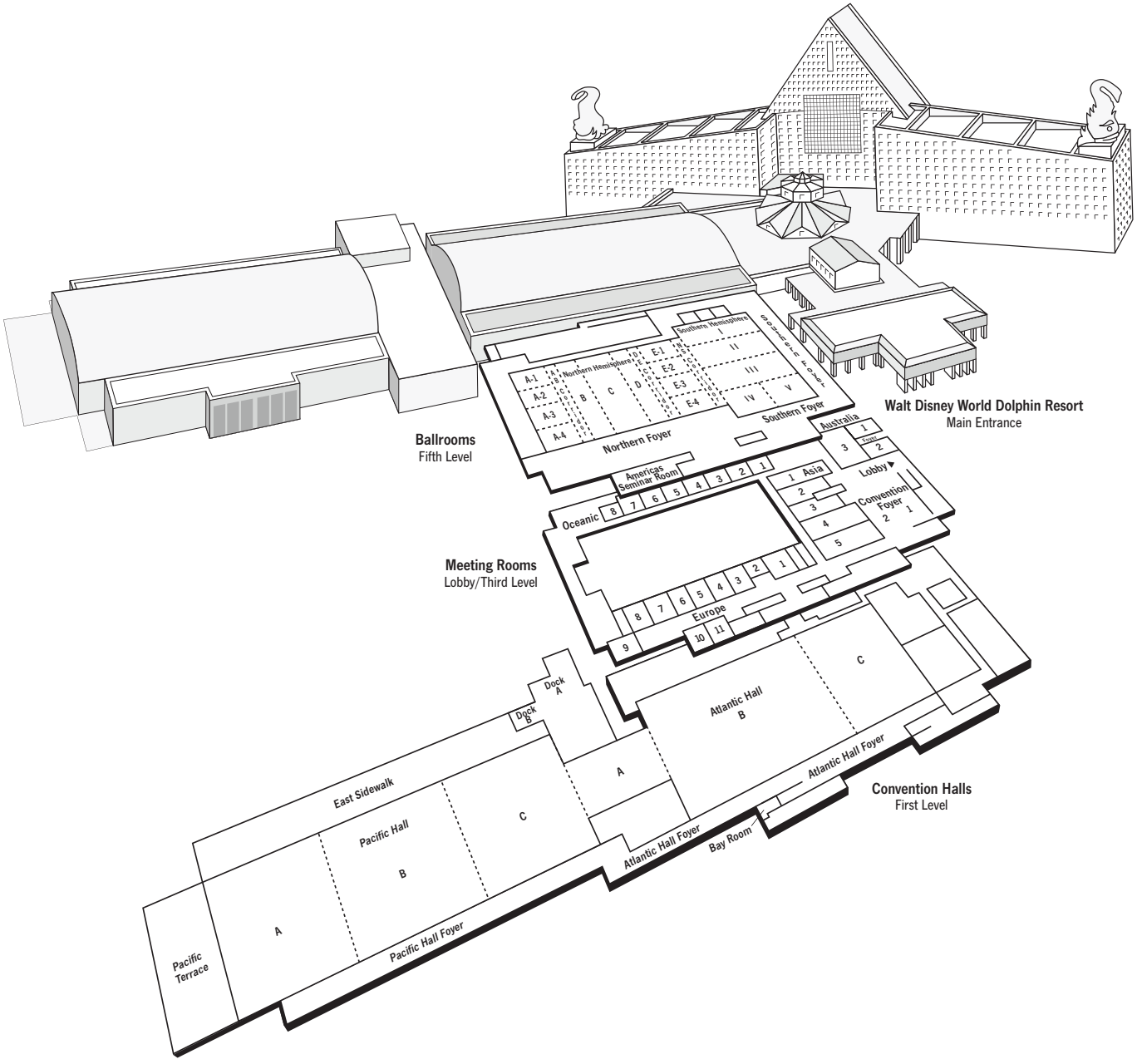

Sidewalk
Osprey Terrace 2
Osprey Ballroom
2
1
Osprey Terrace 1
Ramp
Pre-F
Macaw
2
1
Pre-F
Parrot
2
1
Pre-F
Swan Foyer
Women
Public Phones
Men
Mockingbird
2
1
Swan 10
Swan 6
B
A
Swan 4
Load-In Doors
Swan 9
Swan 3
Roll-Up
Convention Entrance/Departure
Toucan Foyer
2
Toucan
1
Service
Corridor B
Corridor A
Swan 8
Swan Ballroom
Swan 2
Roll-Up
Pelican
2
1
Swan 5
B
A
Swan 7
Swan 1
Load-In Doors
Public Phones
Service
Women
Men
Peacock
2
1
Peacock Foyer
Service
Lark
2
1
Convention Registration Desk
Banquet Office
A/V Office
Men
Women
Shipping
Business Center
Lobby
West Elevators

Second Level

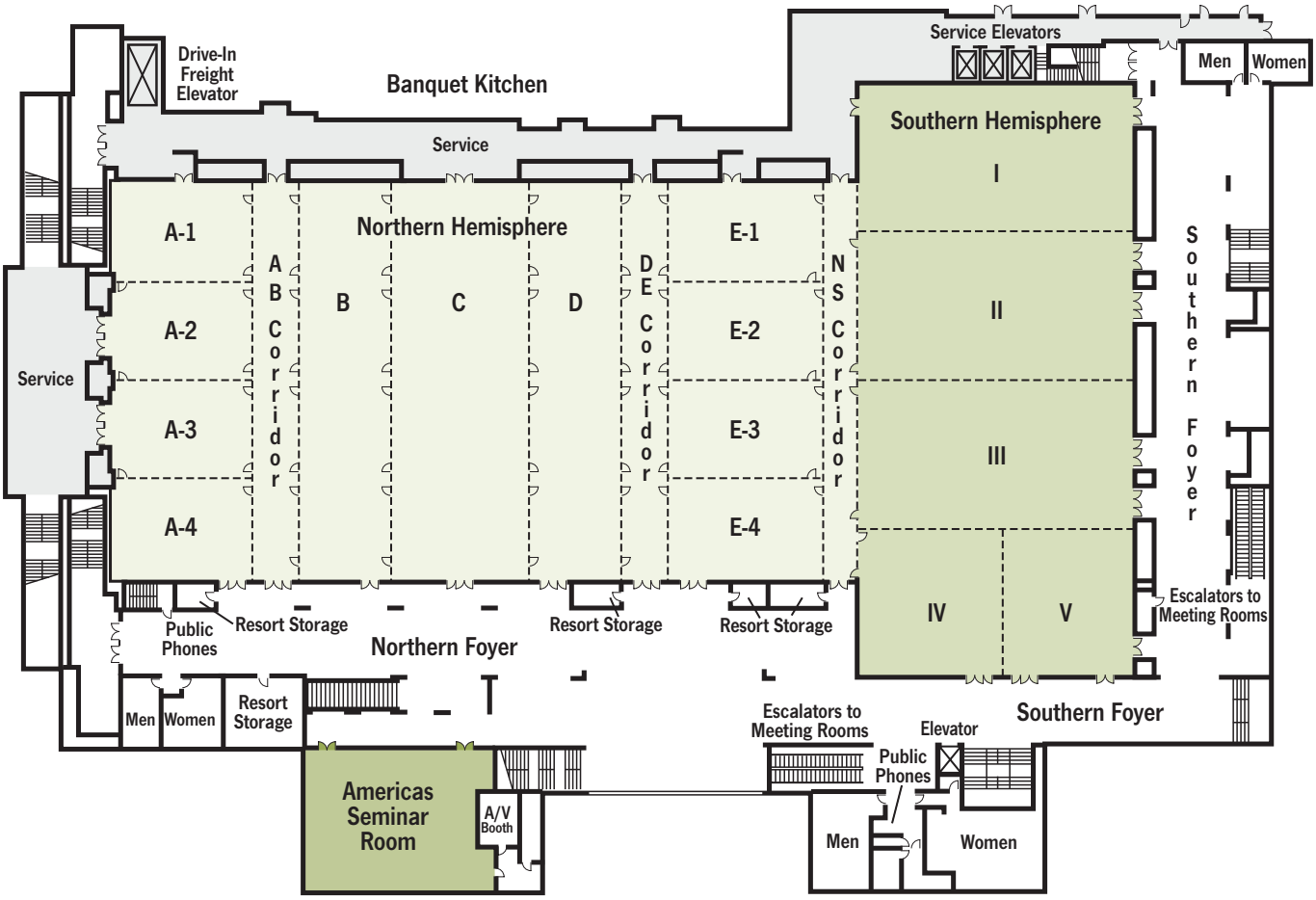


WALT DISNEY WORLD DOLPHIN RESORT

Meeting Space Aerial View



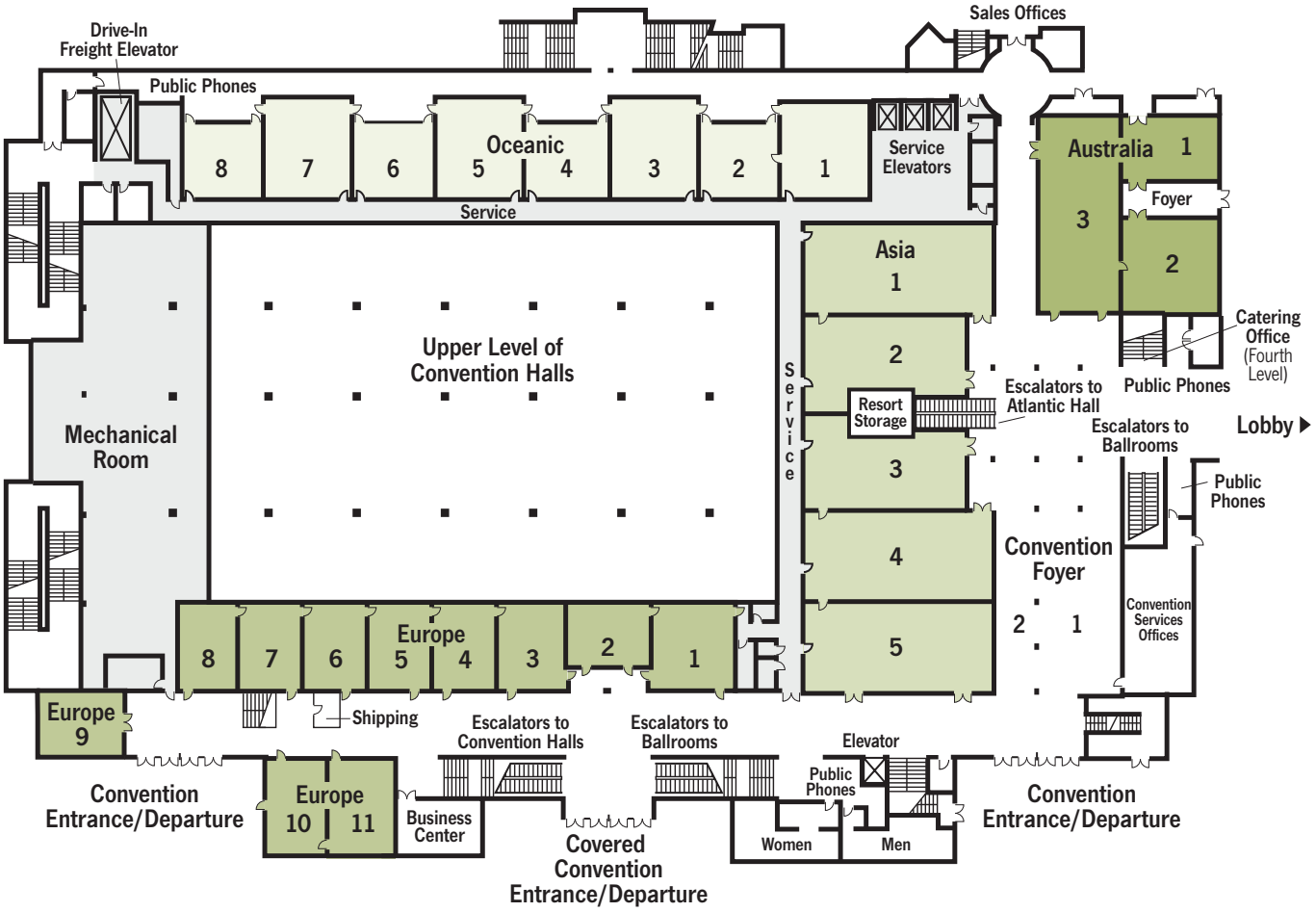
Fifth Level



FEATURES:

- 10,000 square foot sound booth running along the side of both ballrooms
- Programmable lighting and hang points in ceiling
- Extensive ventilation system permitting indoor pyrotechnics
- Drive-in freight elevator: 23'L x 10'W x 12'H; load limit: 12,000 lbs.
- Fully scalable DS-3 class Internet service, delivered via our fiber-optic and Ethernet backbone, available in the ballrooms and foyers
- Wireless access available throughout the ballrooms and foyers
- Salon B and Salon D in the Hemispheres Ballroom cannot stand alone
- Built-in A/V booth in Americas Seminar Room
- Complimentary house phone in Americas Seminar Room
- Convention network infrastructure managed by on-site technicians
- On-site audio/visual services department

Lobby/Third Level



FEATURES:

- Both fluorescent and incandescent adjustable lighting
- Simultaneous recording of presentation through a central audio mixer
- Each room includes four solid walls with bulletin board wall to maximize sound proofing, built-in A/V screen, and patches for microphone and video
- Drive-in freight elevator: 23'L x 10'W x 12'H; load limit: 12,000 lbs.
- Fully scalable DS-3 class Internet service, delivered via our fiber-optic and Ethernet backbone, available in all meeting rooms and foyers
- Wireless access available throughout all meeting rooms and foyers
- Complimentary house phone in meeting rooms
- Australia Boardroom
  - Projection display system and upgraded A/V system with touchpad control
  - Warm, modern décor with luxurious blonde wood paneling
  - Executive board table for 16 with over-sized ergonomic leather chairs
  - Private entry area
  - Connected his/hers lavatories

2026 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the November 2026 Interim Meeting of the House of Delegates in Orlando, Florida, November 6-10, 2026.

The House of Delegates will convene at 6:00 p.m., on November 6 at the Walt Disney World Swan and Dolphin Resort.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4	Florida 19	Kentucky 5	Montana 1	Ohio 12	Texas 25
Alaska 1	Georgia 7	Louisiana 7	Nebraska 3	Oklahoma 4	Utah 3
Arizona 5	Guam 1	Maine 2	Nevada 3	Oregon 4	Vermont 1
Arkansas 3	Hawaii 2	Maryland 6	New Hampshire 2	Pennsylvania 15	Virgin Islands 1
California 45	Idaho 1	Massachusetts 14	New Jersey 10	Puerto Rico 2	Virginia 7
Colorado 6	Illinois 13	Michigan 14	New Mexico 2	Rhode Island 2	Washington 7
Connecticut 4	Indiana 6	Minnesota 5	New York 28	South Carolina 4	West Virginia 2
Delaware 1	Iowa 4	Mississippi 3	North Carolina 6	South Dakota 2	Wisconsin 5
District of Columbia 2	Kansas 4	Missouri 7	North Dakota 2	Tennessee 6	Wyoming 1

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

AMDA-The Society for Post-Acute and Long-Term Care Medicine 2
AMSUS- The Society of Federal Health Professionals 2
American Academy of Child and Adolescent Psychiatry 2
American Academy of Dermatology Association 5
American Academy of Emergency Medicine 3
American Academy of Family Physicians 26
American Academy of Hospice and Palliative Medicine 2
American Academy of Neurology 4
American Academy of Ophthalmology 4
American Academy of Orthopaedic Surgeons 5
American Academy of Otolaryngology-Head and Neck Surgery 4
American Academy of Pediatrics 5
American Academy of Physical Medicine and Rehabilitation 3
American Academy of Sleep Medicine 2
American Association of Clinical Endocrinology 2
American Association of Clinical Urologists, Inc. 2
American Association of Gynecologic Laparoscopists 2
American Association of Hip and Knee Surgeons 2
American Association of Neurological Surgeons 2
American Association of Neuromuscular & Electrodiagnostic Medicine 2
American College of Allergy, Asthma and Immunology 2
American College of Cardiology 9
American College of Chest Physicians (CHEST) 3
American College of Emergency Physicians 9
American College of Gastroenterology 4
American College of Lifestyle Medicine – 2
American College of Obstetricians and Gynecologists 14
American College of Physicians 26
American College of Radiology 8
American College of Rheumatology 2
American College of Surgeons 14
American Gastroenterological Association 3
American Geriatrics Society 2
American Institute of Ultrasound in Medicine 2
American Psychiatric Association 9
American Roentgen Ray Society 3
American Society for Clinical Pathology 3
American Society for Dermatologic Surgery 3
American Society for Gastrointestinal Endoscopy 2
American Society for Radiation Oncology 2
American Society for Reproductive Medicine 2
American Society for Surgery of the Hand 2
American Society of Addiction Medicine 2
American Society of Anesthesiologists 8
American Society of Cataract and Refractive Surgery 2
American Society of Colon and Rectal Surgeons 2
American Society of Echocardiography 2
American Society of Hematology 2
American Society of Interventional Pain Physicians 2
American Society of Neuroradiology 2
American Society of Nuclear Cardiology 2
American Society of Plastic Surgeons 3
American Society of Regional Anesthesia and Pain Medicine 2
American Society of Retina Specialists 2
American Thoracic Society 2
American Urological Association 2
Association for Clinical Oncology 5
College of American Pathologists 4
Congress of Neurological Surgeons 2
Heart Rhythm Society 3
Infectious Diseases Society of America 2
International Pain and Spine Intervention Society 2
North American Spine Society 2
Radiological Society of North America 3
Renal Physicians Association 2
Society for Cardiovascular Angiography and Interventions 2
Society for Vascular Surgery 2
Society of American Gastrointestinal Endoscopic Surgeons 2
Society of Cardiovascular Computed Tomography 2
Society of Critical Care Medicine 2
Society of Hospital Medicine 3
Society of Interventional Radiology 2
Society of Thoracic Surgeons 2
The American Society of Breast Surgeons 2
The Endocrine Society 2
The Society of Laparoscopic and Robotic Surgeons 2

Remaining eligible national medical specialty societies (57) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, LGBTQ+ Section, Medical Student Section, Underrepresented in Medicine Advocacy Section, Organized Medical Staff Section, Private Practice Physicians Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

State Medical Associations	351
National Medical Specialty Societies	350
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	26
Resident and Fellow Delegate Representatives	42
Sections	12
Services	5
Total Delegates	**792**

Registration facilities will be maintained at the Walt Disney World Swan and Dolphin Resort Atlanta B Foyer.

Willie Underwood, III, MD, MSc, MPH
President

Lisa Bohman Egbert, MD
Speaker, House of Delegates

Pauline P. Huynh, MD
Secretary

2026 - 2027

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President – Willie Underwood, III ..... Buffalo, New York
President-Elect - Sandra Adamson Fryhofer ..... Atlanta, Georgia
Immediate Past President – Bobby Mukkamala ..... Flint, Michigan
Secretary – Pauline P. Huynh ..... Oakland, California
Speaker, House of Delegates - Lisa Bohman Egbert ..... Dayton, Ohio
Vice Speaker, House of Delegates - John H. Armstrong ..... Ocala, Florida

Toluwalase A. Ajayi (2030), *Chair* ..... San Diego, California
Marilyn J. Heine (2030), *Chair-Elect* ..... Dresher, Pennsylvania
David H. Aizuss (2028) ..... Encino, California
Geralyn R. Breig (2028) ..... West Port, Connecticut
Melissa Garretson (2028) ..... Fort Worth, Texas
Lynne Jeffers (2028) ..... Oxnard, California
Tripti C. Kataria (2030) ..... Chicago, Illinois
Amar H. Kelkar (2030) ..... West Roxbury, Massachusetts
Ilse R. Levin (2028) ..... Silver Spring, Maryland
Sheila D. Rege (2029) ..... TriCities, Washington
Kylie K. Ruprecht (2027) ..... Madison, Wisconsin
Heather A. Smith (2030) ..... Newport, Rhode Island
Michael Suk (2027) ..... Danville, Pennsylvania
Marta J. Van Beek (2029) ..... Iowa City, Iowa
David Welsh (2028) ..... Batesville Indiana

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Mary Ann Contogiannis, Greensboro, North Carolina, Chair, (2029); Steven C. Thornquist, Vice Chair, Bethany, Connecticut (2030); Jerry P. Abraham, Los Angeles, California, (2029); John H. Armstrong, Ocala, Florida, Vice Speaker: Ex Officio (2027); Mark N. Bair, Highland, Utah (2027); Lisa Bohman Egbert, Dayton, Ohio, Speaker: Ex Officio (2027); Stuart J. Glassman, Bedford, NH (2030); Christopher E. Gribbin, Princeton, New Jersey (2028); Helene Nepomuceno, Las Vegas, Nevada (Resident) (2027); Natasha L. Topolski, Houston, Texas (Student) (2027).
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Larry E. Reaves, Fort Worth, Texas, Chair (2027); Daniel P. Sulmasy, Washington, District of Columbia, Vice Chair (2028); Arthur R. Derse, Shorewood, Wisconsin (2030); Charles J. Hickey, Mechanicsburg, Ohio (2031); Michael G. Knight, Washington, District of Columbia (2029); Michael J. Redinger, Vicksburg, Michigan (2032); Ishaan Rischie, Alpharetta, Georgia (Student) (2027); Natalia Solenkova, Sunny Isles Beach, Florida (2033); Christopher K. Wong, (Resident) (2028).
Secretary: Jake Young, Chicago, Illinois.

COUNCIL ON LEGISLATION
Maryanne C. Bombaugh, Falmouth, Massachusetts, Chair (2027); Ann Rosemarie Stroink, Heyworth, Illinois, Vice Chair (2027); Claude D. Brunson, Ridgeland, Mississippi (2027); Michael D. Chafty, Kalamazoo, Michigan (2027); Hilary E. Fairbrother, Houston, TX (2027); Merrilee Aynes Gober, Atlanta, Georgia (Alliance Rep) (2027); Ross F. Goldberg, Miami, Florida (2027); Loralie Ma, Fulton, Maryland (2027); Jon "Klint" Pebbles, Washinton, District of Columbia (2027); Danielle Rivera, Albuquerque, New Mexico (Resident) (2027); Jayesh B. Shah, San Antonio, Texas (2027); J. Elizabeth Struble, North Manchester, Indiana (2027); Katherine M. Yu, Iowa City, Iowa (Student) (2027).
Secretary: Bryan Hull, Washington, District of Columbia.

COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
G. Sealy Massingill, Fort Worth, Texas, Chair (2027); Gary R. Katz, Dublin, OH, Vice Chair (2027); Erin K. Harnish, Longview, Washington (2028); Moudi K. Hubeishy, Tucson, Arizona (Resident) (2028); Jan M. Kief, Merritt Island, Florida (2027): Samuel Lin, Issaquah, Washington (2029); Andrew Norton, Madison, Wisconsin (Student) (2027); Bhushan H. Pandya, Danville, Virginia (2029); Shilpen A. Patel, San Francisco, California (2028); Brigitta J. Robinson, Centennial, Colorado (2030).
Secretary: Adrianne Dues, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Shannon M. Kilgore, Los Altos, California Chair (2027); Louito C. Edje, Cincinnati, Ohio, Chair-elect (2029); Sherri S. Baker, Edmond, Oklahoma (2029); Kelly J. Caverzagie, Portland, Oregon (2027); Ricardo R. Correa, Phoenix, Arizona (2027); Mark Milstein, New York, New York (2030); Scott H. Pasichow, Maplewood, New Jersey (2029); Jordan Samuel, Clive, Iowa (Student) (2027); David J. Savage, Albuquerque, New Mexico (2029); Seema Sidhu, Morgan Hill California (2028); Joseph T. Whelihan, Philadelphia, Pennsylvania (Resident) (2027); Daniel M. Young, Vestal, New York (2027).
Secretary: Tanya Lopez, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
A. Patrice Burgess, Boise, Idaho, Chair (2027); Erick A. Eiting, New York, New York, Chair-Elect (2028); Alain A. Chaoui, Boxford, Massachusetts (2029); Steven L. Chen, San Diego, California (2028); Alice Coombs, Richmond, Virginia (2027); Laura Faye Gephart, Temple, Texas (2029); Ravi Goel, Cherry Hill, New Jersey (2030); Michael A. Hanak, La Grange, Illinois (2030); Russell B. Hawes, Charlottesville, Virginia (Student) (2027); Hari S. Iyer Detroit, Michigan (Resident) (2027); Ezequiel Silva, III, San Antonio, Texas (2028); Steven Wang, Bakersfield, California (2030).
Secretary: Linda Walsh, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Tamaan K. Osbourne-Roberts, Denver, Colorado, Chair (2027); Joshua M. Cohen, New York, New York, Chair-Elect (2030); Kavita Shah Arora, Philadelphia, Pennsylvania (2029); Ankush K. Bansal, Westlake, Florida (2027); Jennifer J. Bryan, Brandon, Mississippi (2029); David R. Cundiff, Ilwaco, Washington (2030); Abhishek J. Dharan, Redlands, California (Resident) (2028); Laura E. Halpin, Los Angeles, California (2030); Akhil Mahant, Rochester, New York (Student) (2027); Marc Mendelsohn, St. Louis, MO (2027); Cynthia Romeo, Virginia Beach, Virginia (2029); Raymond K. Tu, Washington, DC (2028).
Secretary: Andrea Garcia, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
John W. Poole, Ridgewood, New Jersey (Chair); Jordan M. Warchol, Omaha, Nebraska (Secretary); Hans C. Arora, Chapel Hill, North Carolina; Michael H. Brisman, Old Westbury, New York; Seemal R. Desai, Dallas, Texas; Victoria Gordon, Houston, Texas (Resident); Mary G. Lawrence, Minneapolis, Minnesota; George “Trey” R. Lee, Nashville, Tennessee; Likhit Agrawal, Flower Mound, Texas (Student); Ryan J. Ribeira, Los Gatos, California; Janice E. Tildon-Burton, Wilmington, Delaware.
Executive Director and Treasurer: Rob Jordan, Washington, District of Columbia.

EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

Susan R. Bailey	2020-2021	Gerald E. Harmon	2021-2022	Nancy H. Nielsen	2008-2009
David O. Barbe	2017-2018	Patrice A. Harris	2019-2020	Jack Resneck, Jr	2022-2023
Lonnie R. Bristow	1995-1996	J. Edward Hill	2005-2006	J. James Rohack	2009-2010
Peter W. Carmel	2011-2012	Ardis D. Hoven	2013-2014	Bruce Scott	2024-2025
Yank D. Coble, Jr.	2002-2003	Daniel H. Johnson, Jr.	1996-1997	Randolph D. Smoak, Jr.	2000-2001
Richard F. Corlin	2001-2002	Jeremy A. Lazarus	2012-2013	Steven J. Stack	2015-2016
Nancy W. Dickey	1998-1999	Barbara L. McAneny	2018-2019	Robert M. Wah	2014-2015
Jesse Ehrenfeld	2023-2024	Alan R. Nelson	1989-1990	Cecil B. Wilson	2010-2011
Andrew W. Gurman	2016-2017	John C. Nelson	2004-2005	Percy Wootton	1997-1998

FORMER TRUSTEES

Herman I. Abromowitz	1997-2005	Andrew W. Gurman	2007-2015	Nancy H. Nielsen	2005-2007
Susan Hershberg Adelman	1998-2002	Patrice A. Harris	2011-2018	Albert J. Osbahr, III	2011-2019
Kendall S. Allred	2008-2009	Alan C. Hartford	1989-1990	Harris Pastides	2020-2024
Raj S. Ambay	2009-2011	Drayton Charles Harvey	2020-2023	Rebecca J. Patchin	1988-1989
Joseph P. Annis	2006-2014	William A. Hazel, Jr	2004-2009	Rebecca J. Patchin	2003-2011
Grayson W. Armstrong	2019-2021	Cyril M. Hetsko	2003-2011	Stephen R. Permut	2010-2018
John H. Armstrong	2002-2006	J. Edward Hill	1996-2004	Pamela Petersen-Crair	1996-1998
Maya A. Babu	2013-2017	Ardis D. Hoven	2005-2012	Dina Marie Pitta	2015-2016
Susan R. Bailey	2011-2018	William E. Jacott	1989-1998	Stephen Pool	1995-1996
Timothy E. Baldwin	1987-1989	Hillary D. Johnson	2001-2002	Liana Puscas	1999-2001
David O. Barbe	2009-2016	Matthew D. Kagan	1999-2000	Kevin C. Reilly	2003-2005
Regina M. Benjamin	1995-1998	Christopher K. Kay	2008-2012	Ryan J. Ribeira	2013-2014
Scott L. Bernstein	1991-1992	William E. Kobler	2012-2020	J. James Rohack	2001-2008
Stefano M. Bertozzi	1986-1988	Russell W.H. Kridel	2014-2022	David A. Rosman	2002-2004
David J. Brailer	1985-1986	Pratistha Koirala	2021-2025	Samantha L. Rosman	2005-2009
Lonnie R. Bristow	1985-1994	Edward L. Langston	2003-2011	Raymond Scalettar	1985-1994
Madelyn E. Butler	2021-2025	Matthew C. Lawyer	2004-2005	Bruce A. Scott	1998-2002
Peter Carmel	2002-2010	Jeremy A. Lazarus	2005-2011	Aliya Siddiqui	2024-2025
Alice A. Chenault	1984-1985	W. J. Lewis	1979-1984	Carl A. Sirio	2010-2018
Yank D. Coble	1994-2001	Audrey J. Ludwig	1990-1991	Sarah Mae Smith	2019-2020
David S. Cockrum	1993-1994	Thomas J. Madejski	2020-2024	Randolph D. Smoak, Jr.	1992-1999
MaryAnn Contogiannis	1989-1993	Justin W. Magrath	2025-2026	Steven J. Stack	2006-2014
Malini Daniel	2012-2013	Justin B. Mahida	2009-2010	Michael Suk	1994-1995
Christopher M. DeRienzo	2006-2008	Omar Z. Maniya	2016-2017	Andrew M. Thomas	1997-1999
Nancy W. Dickey	1989-1997	Barbara L. McAneny	2010-2017	Jeffrey A. Towson	1998-1999
Alexander Ding	2011-2013	William A. McDade	2016-2020	Georgia A. Tuttle	2011-2019
Alexander Ding	2022-2026	Mary Anne McCaffree	2008-2016	Jordan M. VanLare	2011-2012
William A. Dolan	2007-2011	Joe T. McDonald	2005-2006	Robert M. Wah	2005-2013
Jesse Ehrenfeld	2014-2022	Samuel J. Mackenzie	2014-2015	Peter Y. Watson	2001-2003
Willarda Edwards	2016-2024	Sandeep “Sunny” Mistry	2000-2001	Monica C. Wehby	2011-2013
E. Scott Ferguson	2018-2026	Mario Motta	2018-2022	Kevin W. Williams	2016-2020
Melissa J. Garretson	1992-1993	Elizabeth Blake Murphy	2020-2021	Meredith C. Williams	2010-2011
Michael S. Goldrich	1993-1997	Alan R. Nelson	1980-1988	Cecil B. Wilson	2002-2009
Julie K. Goonewardene	2012-2016	John C. Nelson	1994-2003	Percy Wootton	1991-1996

SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES
2026 Interim Meeting of the AMA House of Delegates

(The following are representatives of the following societies which are represented in the SSS but are not members of the House of Delegates.)

American Association of Endocrine Surgeons	Dina Elaraj, MD
American College of Correctional Physicians	Johnny Wu, MD
American College of Medical Toxicology	Jacob Altholz, MD
American Dermatological Association	Murad Alam, MD
American Foregut Society	Jonathan Levy, MD
American Shoulder and Elbow Surgeons	Kathleen Leinweber, MD
American Society of Nephrology	Jeffrey S. Berns, MD
American Society of Pain and Neuroscience	Hemant Kalia, MD
American Urogynecologic Society	Jennifer Wu, MD
American Vein and Lymphatic Society	Satish Vayuvegula, MD
AO North America	Augustine Saiz, MD
Association of Physicians of Pakistani Descent of North America	Raffia Qutab, MD
Association of Professors of Dermatology	Christopher R. Shea, MD
International Academy of Independent Medical Evaluators	Mark Melhorn, MD
Korean American Medical Association	Jennifer Inhae Lee, MD
Orthopaedic Trauma Association	Milan K. Sen, MD
Skin of Color Society	Elizabeth Kiracofe, MD
Society for Maternal-Fetal Medicine	Andrea L. Greiner, MD
The OrthoForum	Jeffrey Racca, MD
Urgent Care College of Physicians	Patrick Dolan, MD

MEMBERS OF THE HOUSE OF DELEGATES - NOVEMBER 2026
The following is a list of credentialed delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

Medical Association of the State of Alabama
Delegates
B Jerry Harrison, MD, Haleyville, AL
John Meigs Jr., MD, Brent, AL
William Schneider, MD, Huntsville, AL
George C. Smith Jr., MD, Lineville, AL
Alternate Delegates
Alexis Mason, MD, Tuscaloosa, AL
Charles Jeremy Thompson, MD, Sheffield, AL
Jane Weida, MD, Tuscaloosa, AL
Tom Weida, MD, Tuscaloosa, AL

Alaska State Medical Association
Delegate
Alex Malter, MD, MPH, Juneau, AK
Alternate Delegate
Rhene Merkouris, MD, Anchorage, AK

Arizona Medical Association
Delegates
Veronica K. Dowling, MD, Lakeside, AZ
Gary R. Figge, MD, Tucson, MD
M Zuhdi Jasser, MD, Phoenix, AZ
Marc Leib, MD, Phoenix, AZ
Alternate Delegates
Ilana Addis, MD, Phoenix, AZ
Nadeem Kazi, MD, Casa Grande, AZ
Laura Mercer, MD, Phoenix, AZ
Sarah Patel, MD, Glendale, AZ
Marla Rejbi, DO, Pehonix, AZ

Arkansas Medical Society
Delegates
Omar Atiq, MD, Little Rock, AR
Scott Ferguson, MD, West Memphis, AR
Stephen Magie, MD, Conway, AR
Alternate Delegates
Danny Wilkerson, MD, Little Rock, AR
Alan Wilson, MD, Monticello, AR

California Medical Association
Delegates
Jerry P. Abraham, MD, MPH, CMQ, Los Angeles, CA
Barbara J. Arnold, MD, Sacramento, CA
Patricia L. Austin, MD, Alamo, CA
Dirk Stephen Baumann, MD, Burlingame, CA
Peter N. Bretan Jr., MD, Novato, CA
Resa Caivano, MD, Inglewood, CA
J Brennan Cassidy, MD, Newport Beach, CA
Jack Chou, MD, Baldwin Park, CA
Jason Cord, MD, Anaheim, CA
Maisha Draves, MD, Fairfield, CA
Suparna Dutta, MD, Oakland, CA
Kyle P. Edmonds, MD, San Diego, CA
Sergio Flores, MD, San Diego, CA
George Fouras, MD, Los Angeles, CA
Dev A. GnanaDev, MD, Upland, CA
Brian Grady, MD, San Francisco, CA
Donaldo Hernandez, MD, Santa Cruz, CA
Robert Hertzka, MD, Rancho Santa Fe, CA
Jennifer Hone, MD, Santa Barbara, CA
Samuel Huang, MD, Los Angeles, CA
Jeff Klingman, MD, Orinda, CA
Mehzabin Lala, Pomona, CA
John Lam, MD, Woodland Hills, CA
Man Kit Leung, MD, San Francisco, CA
Terence Lin, MD, Palo Alto, CA
John Maa, MD, San Francisco, CA
Ramin Manshadi, MD, Stockton, CA
Theodore Mazer, MD, Fort Myers, FL
Kelly McCue, MD, Davis, CA
Mihir Parikh, MD, La Jolla, CA
Stephen Parodi, MD, Oakland, CA
Eric Rafla-Yuan, MD, San Diego, CA
Albert Ray, MD, San Diego, CA
Ryan J. Ribeira, MD, Mountain View, CA
Katrina Saba, MD, Oakland, CA
Shireen Saxena, MD, Los Angeles, CA
Ilan Shapiro Strygler, MD, Commerce, CA
Diana Shiba, MD, Pasadena, CA
Seema Sidhu, MD, Fremont, CA
Tatiana W. Spirtos, MD, Redwood City, CA
James J. Strebig, MD, Irvine, CA
Shannon Udovic-Constant, MD, San Francisco, CA
Steven Wang, MD, Bakersfield, CA
Holly Yang, MD, San Diego, CA
Anna Yap, MD, Carmichael, CA
Alternate Delegates
Ameena Ahmed, Oakland, CA
Mary Alice Ambrose, MD, Santa Clara, CA
Alpesh Amin, MD, Anaheim, CA
Timothy Auran, MD, Atascadero, CA
Raul Ayala, MD, Fresno, CA
Duc Chung, MD, Fresno, CA
Lisa Firestone, MD, Los Angeles, CA
David Friscia, MD, San Diego, CA
Liliane Gibbs, MD, Anaheim, CA
Douglas Gibson, MD, Folsom, CA
Raminder Gill, MD, Sacramento, CA
Catherine Gutfreund, MD, Santa Rosa, CA
Bonnie Hamilton, MD, Fairfield, CA
Eric Hansen, DO, Oak Hills, CA
Sharon Jakus-Waldman, MD, Downey, CA
Kavon Javaherian, MD, San Francisco, CA
Scott Richard Karlan, MD, West Hollywood, CA
Mark H. Kogan, MD, San Pablo, CA
Sudeep Kukreja, MD, Orange, CA
Mary Le, MD, Riverside, CA
Quinn Lippman, MD, San Diego, CA
Debbie Lupeika, MD, Redding, CA

Lindsay Mazotti, MD, Oakland, CA
Linda Mirdamadi, MD, Los Angeles, CA
Timothy Murphy, MD, Fallbrook, CA
Chang Na, MD, Bakersfield, CA
Richard Pan, MD, Sacramento, CA
Daniel Resnick, MD, Loma Linda, CA
Smita Rouillard, MD, Fresno, CA
Sion Roy, MD, Malibu, CA
Shivani Ruben, MD, Sacramento, CA
Javier Sanchez, MD, Redlands, CA
Samuel Santoro, DO, Fairfield, CA
Misbah Shafi, El Dorado Hills, CA
Ryan Shanahan, MD, Ventura, CA
Piyush Srivastava, MD, Walnut Creek, CA
Raymond Tsai, MD, Lost Hills, CA
William Tseng, MD, San Diego, CA
Kurt Vandevort, MD, Saratoga, CA
Valencia Walker, MD, Los Angeles, CA
Christina K. Wang, MD, San Francisco, CA
Barbara Weissman, MD, Pacifica, CA
Doug Wilson, MD, Napa, CA
Richard Wong, MD, Panorama City, CA
Roxana Yoonessi, MD, Pasadena, CA

Colorado Medical Society
Delegates
Jan Kief, MD, Merritt Island, FL
Rachelle M. Klammer, MD, Denver, CO
A. "Lee" Morgan, MD, Denver, CO
Tamaan Osbourne-Roberts, MD, FAAFP, Denver, CO
Lynn Parry, MD, Littleton, CO
Brigitta J. Robinson, MD, Centennial, CO
Alternate Delegates
David Downs, MD, Denver, CO
Amy Duckro, DO, Lafayette, CO
Carolynn Francavilla, MD, Dillon, CO
Mark Johnson, MD, Louisville, CO
Michael Volz, MD, Englewood, CO
Patricia Weber, MD, Grand Jct, CO

Connecticut State Medical Society
Delegates
M. Natalie Achong, MD, Unionville, CT
Katherine L. Harvey, MD, Canton, CT
Kathleen A. LaVorgna, MD, Norwalk, CT
Steven C. Thornquist, MD, Bethany, CT
Alternate Delegates
Krishna Channa, MD, New Haven, CT
Raymond Lorenzoni, MD, Woodbridge, CT
Stacy Taylor, MD, New Hartford, CT
Michael Virata, MD, Woodbridge, CT

Medical Society of Delaware
Delegate
Janice Tildon-Burton, MD, Newark, DE
Alternate Delegate
Matthew Burday, DO, Wilmington, DE

Medical Society of the District of Columbia
Delegates
Peter E. Lavine, MD, Washington, DC
Raymond K. Tu, MD, Washington, DC
Alternate Delegates
Neal D. Barnard, MD, Washington, DC
Susanne Bathgate, MD, Arlington, VA

Florida Medical Association
Delegates
Ankush Bansal, MD, Westlake, FL
Rose Berkun, MD, Williamsville, NY
Rebekah Bernard, MD, Fort Myers, FL
Charles J. Chase, DO, Winter Park, FL
Andrew Cooke, MD, Mount Dora, FL
Eva Crooke, MD, Tampa, FL
Mark Dobbertien, DO, Orange Park, FL
Michelle Falcone, MD, Miami, FL
Shelley C. Glover, MD, Clermont, FL
Ryan Hall, MD, Lake Mary, FL
Tra'Chella Johnson Foy, MD, Jacksonville, FL
John Montgomery, MD, MPH, Fleming Island, FL
Vicki Norton, MD, Boca Raton, FL
Michael L. Patete, MD, JD, MS, Venice, FL
Sanjay Pattani, MD, Windermere, FL
Thomas G. Peters, MD, Jacksonville, FL
Mark Rubenstein, MD, Jupiter, FL
Stacie Wenk, DO, Evansville, IN
Michael Andrew Zimmer, MD, St. Petersburg, FL
Alternate Delegates
Shawn Baca, MD, Boca Raton, FL
Lisa Cosgrove, MD, JD, MS, Jacksonville, FL
Michael Cromer, MD, Tampa, FL
Aaron Elkin, MD, Hollywood, FL
Michael Gimness, MD, Plant City, FL
Raphael C. Haciski, MD, Naples, FL
Lawrence S. Halperin, MD, Altamonte Spg, FL
Karen Harris, MD, Gainesville, FL
Nariman Heshmati, MD, Fort Myers, FL
Ali Kasraeian, MD, Jacksonville, FL
Deborah Mulligan, MD, Coral Springs, FL
Ralph Jacinto Nobo Jr., MD, Bartow, FL
Arthur E. Palamara, MD, Hollywood, FL
Alan B. Pillersdorf, MD, Lake Worth, FL
Sergio B. Seoane, MD, Lakeland, FL

Medical Association of Georgia
Delegates
John S. Antalis, MD, Dalton, GA
S William Clark III, MD, Waycross, GA
Shamie Das, MD, Atlanta, GA
Billie Luke Jackson, MD, Macon, GA
Zachary Lopater, MD, Macon, GA
Ali R. Rahimi, MD, MPH, FACC, Atlanta, GA
Charles Wilmer, MD, Atlanta, GA
Alternate Delegates

Lethenia Baker, MD, Lagrange, GA
Keisha Callins, MD, Macon, GA
Samuel Church, MD, Hiawassee, GA
Phillip Coule, MD, Augusta, GA
Jin Lee, MD, Lawrenceville, GA
Fonda A. Mitchell, MD, Atlanta, GA
Vini Patel, DO, Atlanta, GA

Hawaii Medical Association
Delegates
Elizabeth A. Ignacio, MD, Kahului, HI
Angela M. Pratt, MD, Honolulu, HI

Idaho Medical Association
Delegate
A. Patrice Burgess, MD, Boise, ID
Alternate Delegate
Zachary Warnock, MD, Pocatello, ID

Illinois State Medical Society
Delegates
Rodney Alford, MD, Watseka
Howard Axe, MD, Grayslake, IL
Christine Bishof, MD, Elmhurst, IL
Howard Chodash, MD, Springfield, IL
Scott A. Cooper, MD, Chicago, IL
Alissa Haas, MD, Springfield, IL
Niva Lubin-Johnson, MD, Chicago, IL
James L. Milam, MD, Grayslake, FL
Vikram B. Patel, MD, South Barrington, IL
Judith G. Savage, MD, Tinley Park, IL
Shastri Swaminathan, MD, Westmont, IL
Piyush Vyas, MD, Lake Forest, IL
Steven D. Williams, MD, Bourbonnais, IL
Alternate Delegates
Thomas M. Anderson, MD, Chicago, IL
Smitha Arekapudi, MD, Chicago, IL
Nancy Church, MD, Chicago, IL
Richard A. Geline, MD, Glenview, IL
Maha Khan, Chicago, IL
Anne Langguth, MD, Hinsdale, IL
Martha Menchaca, MD, Brookfield, IL
Holly Rosencranz, MD, Champaign, IL

Indiana State Medical Association
Delegates
Heidi Dunniway, MD, Evansville, IN
Lisa Hatcher, MD, Columbia City, IN
Vidya S. Kora, MD, Michigan City, IN
Tashera Perry, MD, Bloomington, IN
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Rajadhar Reddy, MD, MSc, Fairhope, AL (Endorsed by Medical Association of the State of Alabama)
Kylee Borger, MD, MPH, New York, NY (Endorsed by Medical Society of the State of New York)
Hari S. Iyer, MD, Detroit, MI (Endorsed by Michigan State Medical Society)
Michael Rigby, MD, PhD, Rochester, MN (Endorsed by Minnesota Medical Association)
Jay Devineni, MD, MPH, MSJ, Saint Louis, MO (Endorsed by Missouri State Medical Association)
Mollie Dreicer, MD, Omaha, NE (Endorsed by Nebraska Medical Association)
James Mossner, MD, MS, Chicago, IL (Endorsed by North American Neuromodulation Society)
Megan Chiu, MD, Cleveland, OH (Endorsed by Ohio State Medical Association)
Shaminy Manoranjithan, MD, Grand Rapids, MI (Endorsed by Society for Vascular Surgery)
Victoria Gordon, DO, Houston, TX (Endorsed by Texas Medical Association)
Christopher Wong, MD, MSc, Houston, TX (Endorsed by Texas Medical Association)
Abby Willgruber, MD, Madison, WI (Endorsed by Wisconsin Medical Society)

Alternate Delegates

Ethan Stephens, DO, MS, Houston, TX (Endorsed by Aerospace Medical Association)
Rishab Chawla, MD, Houston, TX (Endorsed by American Academy of Child and Adolescent Psyciatry)
Robert Dunn, MD, Baltimore, MD (Endorsed by American Academy of Emergency Medicine)
Katy Wyszynski, DO, MS, Fort Worth, TX (Endorsed by American Academy of Emergency Medicine)
Ida Vaziri, MD, Washington, DC (Endorsed by American Academy of Neurology)
Tristan Mackey, MD, Peoria, IL (Endorsed by American Academy of Pediatrics)
Mona Amin, MD, Washington, DC (Endorsed by American Academy of Physical Medicine and Rehabilitation)
Rebecca Peoples, MD, New York, NY (Endorsed by American Association of Public Health Physicians)
Allison Young, MD, Chicago, IL (Endorsed by American College of Emergency Physicians)
Bianca Radut, DO, Shreveport, LA (Endorsed by American College of Nuclear Medicine)
Allie Conry, MD, Memphis, TN (Endorsed by American College of Obstetrician Gynecologists)
Katie Claycomb, MD, Washington, DC (Endorsed by American College of Obstetricians and Gynecologists)
Rachel Ekaireb, MD, Sacramento, CA (Endorsed by American College of Surgeons)
Ekwevugbe Ogbon, MD, Chicago, IL (Endorsed by American Society of Regional Anesthesia and Pain Medicine)
Lauren Edgar, MD, Chicago, IL (Endorsed by American Society of Transplant Surgery)
Helene Nepomuceno, MD, Union City, CA (Endorsed by California Medical Association)
Daniel Kerekes, MD, MHS, New Hyde Park, NY (Endorsed by Connecticut State Medical Society)
Jean-Luc Germany, MD, Chicago, IL (Endorsed by Illinois State Medical Society)
Andrew Ray, MD, MBA, MSc, Louisville, KY (Endorsed by Kentucky Medical Association)
Pooja Patel, MD, Boston, MA (Endorsed by Massachusetts Medical Society)
Katherine Russell, DO, MSPH, Atlanta, GA (Endorsed by Medical Association of Georgia)
Katherine Holder, MD, Rochester, MN (Endorsed by Minnesota Medical Association)
Kira Dubester, MD, Charlottesville, VA (Endorsed by Medical Society of Virginia)
Varnica Bajaj, MD, Omaha, NE (Endorsed by Nebraska Medical Association)
Samantha M. Thomas, MD, Cleveland, OH (Endorsed by Ohio State Medical Association)
Dalton Delaney, DO, PhD, MHA, Oklahoma City, OK (Endorsed by Oklahoma State Medical Association)

Ashton Glover Gatewood, DO, MPH, Bixby, OK (Endorsed by Oklahoma State Medical Association)
Holley See, DO, Tulsa, OK (Endorsed by Oklahoma State Medical Association)
Amanda Kahn, MD, Pennsylvania, PA (Endorsed by Pennsylvania Medical Society)
Nidhi K. Reddy, MD, Chicago, IL (Endorsed by Society for Vascular Surgery)

Regional Medical Students with Endorsing Society

Delegates

Elizabeth Dawson, Little Rock, AR (Endorsed by Arkansas Medical Society)
Preston Dang, Mission Viejo, CA (Endorsed by California Medical Association)
Isabel Nguyen, Pomona, CA (Endorsed by California Medical Association)
Karina Patel, Irvine, CA (Endorsed by Connecticut State Medical Society)
Ami Dave, Suwanee, GA (Endorsed by Florida Medical Association)
Sami Muslmani, Chicago, IL (Endorsed by Illinois State Medical Society)
Layla Ahmadi, Haute, IN (Endorsed by Indiana State Medical Association)
Katherine M. Yu, Iowa City, IA (Endorsed by Iowa Medical Society)
Ella Wright, Overland Park, KS (Endorsed by Kansas Medical Society)
Varun Kota, Saco, ME (Endorsed by Maine Medical Association)
Isabel Ball, Somerville, MA (Endorsed by Massachusetts Medical Society)
Kyle Smith, Port Orange, FL (Endorsed by Medical Association of Georgia)
Chelsea Chen, Short Hills, NJ (Endorsed by Medical Society of New Jersey)
Akhil Mahant, Rochester, NY (Endorsed by Medical Society of the State of New York)
Yumna Rahman, Richmond, VA (Endorsed by Medical Society of Virginia)
Mason Tuttle, Kansas City, MO (Endorsed by Missouri State Medical Association)
Jessy Silfer, Cleveland, OH (Endorsed by Ohio State Medical Association)
Lily Robistow, Owasso, OK (Endorsed by Oklahoma State Medical Association)
Denise Ocampo, Hummelstown, PA (Endorsed by Pennsylvania Medical Society)
Kayla Jernigan, Greenville, SC (Endorsed by South Carolina Medical Association)
Paneeta Mohapatra, Memphis, TN (Endorsed by Tennessee Medical Association)
Mary Conley, Fort Worth, TX (Endorsed by Texas Medical Association)
Laura Hult, Salt Lake Cty, UT (Endorsed by Utah Medical Association)
Patrick Hewes, Spokane, WA (Endorsed by Washington State Medical Association)
Mitchell Nelson, Charleston, WV (Endorsed by West Virginia State Medical Association)

Alternate Delegates

Allison Kelley, Aurora, CO (Endorsed by Colorado Medical Society)
Daniel Brocke, Hartford, CT (Endorsed by Connecticut State Medical Society)
Zhuochen Yuan, Miami, FL (Endorsed by Florida Medical Association)
Isaac Meng, Indianapolis, IN (Endorsed by Indiana State Medical Association)
Sara Armstrong, Overland Park, KS (Endorsed by Kansas Medical Society)
Lillian Cain, Worcester, MA (Endorsed by Massachusetts Medical Society)
Grace Johnson, Boston, MA (Endorsed by Massachusetts Medical Society)
Kareena Dash, Alpharetta, GA (Endorsed by Medical Association of Georgia)
Krisha Darji, Deptford, NJ (Endorsed by Medical Society of New Jersey)
Myra Moghal, New York, NY (Endorsed by Medical Society of the State of New York)
Saad Ramsha, Leesburg, VA (Endorsed by Mississippi State Medical Association)
Druv Bhagavan, St Louis, MO (Endorsed by Missouri State Medical Association)
Joel Dumonsau, Omaha, NE (Endorsed by Nebraska Medical Association)
Austin Osborn, Omaha, NE (Endorsed by Nebraska Medical Association)
Micah Char, Las Vegas, NV (Endorsed by Nevada State Medical Association)
Jordon Ma, Chino Hills, CA (Endorsed by Nevada State Medical Association)
Rehet Chugh, Fresno, CA (Endorsed by New Mexico Medical Society)
Shalmali Bhadkamkar, Toledo, OH (Endorsed by Ohio State Medical Association)
Kelly Delano, Crescent Spgs, KY (Endorsed by Ohio State Medical Association)
Sarah Boliek, Corvallis, OR (Endorsed by Oregon Medical Association)
Camryn Briggs, Bluffton, SC (Endorsed by South Dakota State Medical Association)
Nate Tamez, Harrogate, TN (Endorsed by Tennessee Medical Association)
Camille Bourgeois, Houston, TX (Endorsed by Texas Medical Association)
Sanjay Neerukonda, Houston, TX (Endorsed by Texas Medical Association)

Reference Committee Hearing Room Assignments
Saturday, November 7

15 minutes after HOD second session close	**Room**
Ethics & Bylaws	Southern Hemisphere Salon IV-V
B Legislative advocacy	Northern Hemisphere B
C Advocacy on medical education	Northern Hemisphere C
F AMA governance and finance	Northern Hemisphere A
J Advocacy on medical service, practice, and insurance	Northern Hemisphere D
K Advocacy on science and public health	Northern Hemisphere E

AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES

2026 Interim Meeting
Notes on Orders of Business

Swan and Dolphin Resort, Orlando, FL
Pacific A-B Ballroom

FIRST SESSION, Friday, November 6, 6:00pm

SECOND SESSION, Saturday, November 7, 12:00pm

THIRD SESSION, Monday, November 9, 9:00am

FOURTH SESSION, Tuesday, November 10, 8:30am

Summary of Fiscal Notes I-26

Report(s) of the Board of Trustees

01	Study of Grading Systems in AMA Board Reports	Minimal
02	American Medical Association Optimal Health Outcomes Annual Report	
03	Reduce Environmental Impact of Medical Journals	Minimal
04	Informed Consent for Genetic Testing	Minimal
05	Increasing Access through Federated Healthcare Data Architecture	Minimal
06	Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care	Minimal
07	Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians	Minimal
08	Access to, and Retention of, Electronic Medical Records	Minimal
09	Medicare Should Not Unfairly Penalize Physicians	Minimal
10	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	Minimal
11	Opposing Unilateral Downcoding of Physician Services by Insurance Companies	Minimal
12	Rethink the Medicare Annual Wellness Visit	Minimal
13	Enhancing the Work of the Center for Digital Health and AI	
14	Patient Options to Restrict Secondary Use of Their Healthcare Data	Minimal
15	Gender-Based Pay Equity in Medicine	Minimal
16	Ensuring Medical Liability Insurance Transparency and Continuity	Minimal
17	Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform	Minimal
18	Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients	Minimal
19	2026 AMA Advocacy Efforts	
20	AMA Efforts on Medicare Payment Reform	
21	Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care	
22	Clarifying Conscientious Objection	

Report(s) of the Council on Constitution and Bylaws

01	Clarifications Regarding Establishment and Nominations to AMA Committees	
02	Amendments to Bylaws Governing the AMA Sections	
03	Autonomy of House of Delegate Member Entities: Bylaw Clarification	

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

01	Preserving Autonomy in the Patient-Physician Relationship	Minimal
02	Clarifying Conscientious Objection	Minimal
03	Guidelines on Chaperones for Sensitive Exams	Minimal
04	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization	Minimal
05	Care of Patients in Legal Custody	Minimal
06	Recording Clinical Encounters	Minimal
07	Physicians Are Not Providers	Minimal

Summary of Fiscal Notes I-26

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

01	Evaluation of the Size and Structure of the AMA House of Delegates	Modest
02	Underrepresented in Medicine Advocacy Section Five-Year Review	Minimal
03	Integrated Physician Practice Section Five-Year Review	Minimal

Report(s) of the Council on Medical Education

01	Medical Education Program and Content	Minimal
02	Medical Education Systems	Minimal
03	Professional Regulation of Physicians	Minimal
04	Physician as Medical Professional	Minimal
05	Entry into and transition through the medical education continuum	Minimal
06	Obligations to Students and Trainees	Minimal
07	Mission of Medical Education	Minimal
08	Hardship for International Medical Graduates in Humanitarian Crisis or Conflict	Minimal

Report(s) of the Council on Medical Service

01	Transparency with the Term “Emergency Department”	Minimal
02	The Impact of the Inflation Reduction Act on Physician Practices	Minimal
03	Non-Medical Switching of Prescription Drugs	Minimal
04	Determining Fair Market Value when Contracting with Physician Practices	Minimal
05	Improving Marketplace Affordability through Premium Tax Credits	Minimal
06	Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries	Minimal

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

01	Drug Shortages: 2026 Update	Minimal
02	Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup	Minimal
03	Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing	Minimal
04	Deprescribing in Clinical Practice	Minimal
05	Battlefield Acupuncture	Minimal

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

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

Report(s) of the Speakers

01	Election Rule Updates
02	Recommended Policy Reconciliations

Summary of Fiscal Notes I-26

Resolutions

001	Recognition of Intersex Individuals and their Human Rights	Minimal
002	Surgical Consent	Modest
005	Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials	Modest
006	Ethics of Medical Usury	Modest
007	Opposing the Required Creation of "Detransition Clinics"	Minimal
008	Recognition of Moral Injury in the Physician Workforce	Modest
009	Ensuring the Appropriate Placement of Children After Parental Deportation	Modest
010	Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring	Minimal
201	Artificial Intelligence Having Prescriptive Authority	Modest
202	Rapid Response Framework for Unsupported Medical Claims by Public Officials	Modest
203	Set-Aside Federal Funding for Tribal Health Programs	Minimal
204	Federal Framework for Social Media Access by Minors Under Age 16	Moderate
205	Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs	Moderate
206	Third-Party Litigation Funding in Medical Liability Claims	Modest
207	Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety	Moderate
208	Facilitating Short-Term Supervised Clinical Training for International Physicians	Moderate
209	Protecting GME Subject to Funding Uncertainty	Moderate
210	Requiring Physician Oversight for Artificial Intelligence Tools	Minimal
211	Fair and Clinically Appropriate EMTALA Investigations	Modest
212	Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract	Moderate
213	Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings	Minimal
214	Prohibiting Health Care Sale-Leaseback Transactions	Moderate
215	Establishing Product Liability for Clinical Augmented Intelligence Failures	Moderate
216	Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process	Moderate
217	Strengthening the Patients First Act and Medicare Physician Payment Reform	Moderate
218	Firearm Manufacturer Accountability for the Cost of Gun Violence	Modest
219	Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material	Modest
220	Advocating for the Older Americans Act and Community-Based Services for Older Adults	Moderate
221	Preserving Duration of Status for J-1 Physicians in Graduate Medical Education	Moderate
222	Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)	Moderate
223	Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine	Minimal
224	Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents	Modest
225	Supporting a Common Legal Framework for Medical Capacity Holds	Moderate
226	Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review	Moderate
227	Increasing Access to Long-Acting Injectable Medications for SUD	Modest

228	Hospital-Based Substance Use Disorder Care	Modest
229	Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation	Modest
230	Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities	Modest
231	Medicare and Medicaid Payment Equity for Puerto Rico	Moderate
232	Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care	Moderate
233	Medicaid Protections & Continuous Coverage for Active Cancer Care	Modest
234	Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers	Modest
235	Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions	Moderate
302	Augmented Intelligence Use in Assessment Development During Medical Education	Minimal
304	Transparency in AI-Assisted Admissions	Minimal
305	Certification for Hospice Medical Directors	Minimal
306	Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States	Minimal
601	Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy	Minimal
602	Enhancing Equity in House of Delegates Resolution Processes by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus	Minimal
603	Ensuring Relevance and Mission Alignment in House of Delegates Business	Minimal
604	Increasing Time Between Handbook Release and Opening of Online Reference Committees	Minimal
801	Improving the External Appeals Process for Denied Claims	Minimal
802	Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs	Modest
803	Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit	Modest
804	Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes	Minimal
805	Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine	Minimal
806	Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked	Moderate
807	Continuing Care Retirement Communities (CCRC's)	Modest
808	Increasing Payment for Patient Portal Messages	Minimal
809	Joint Commission Standards for Medical Staff Self-Governance	Modest
810	Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence	Moderate
811	Government Support of Adaptive Sports Programming	Modest
812	Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions	Modest
813	Small Medical Practice Website and other Digital Service Compliance with ADA Regulation	Moderate
814	Coverage of SMART Therapy for Asthma	Modest
815	Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies	Moderate

816	Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services	Moderate
817	Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care	Minimal
818	Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment	Modest
819	Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers	Minimal
820	Strengthening Emergency Interfacility Transfer Infrastructure	Modest
901	The Establishment of Mandatory National Reporting of Naegleria Fowleri and Other Amebic Encephalitides	Modest
902	Illegal Electronic Health Record Sharing and Patient Trust	Modest
903	Improving Health Outcomes in Native Hawaiian Populations	Minimal
904	Regulation of Organ Transplant Open Offers	Minimal
905	Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care	Modest
906	Establishing Menstrual Products as a Standard of Inpatient Care	Modest
907	Affirming Support for the National Institutes of Health Advisory Councils	Minimal
908	Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients	Minimal
909	Public Emergency Alert Reporting Requirements on Private Platforms	Minimal
910	Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation	Modest
912	Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products	Moderate
913	Withdrawn	
914	National Strategy to Close the Women's Health Gap	Moderate
915	Ensuring Expert and Lived Experience Input in Federal National Health Plans	Minimal
916	Opposition to Recreational Nicotine Products in Federal Correctional Facilities	Modest
917	Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health	Modest
918	Strengthening the Radiation Protection Standard	Modest
919	Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions	Modest
920	Improving Protection for Patient Medical Records and Health Care	Modest
921	Transgender and Gender Diverse Cancer Research	Minimal
922	Eliminating Tax Barriers to Equitable Clinical Trial Participation	Minimal
923	Research the Community Health Impacts of Data Centers	Modest
924	Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice	Modest
925	Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers	Modest
926	Support for One Health Approaches to Protect Human, Animal, and Environmental Health	Modest
927	Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement	Moderate
928	Electric Bike and Scooter Safety, Regulation, and Enforcement	Moderate
929	Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis	Minimal
930	Supporting the Use of Firearm Suppressors to Prevent Hearing Loss	Minimal

Summary of Fiscal Notes I-26

931	Allocation, Liability Protections, & Generic Drug Shortages	Modest
932	Recognizing the Challenge of Tobacco use in the Era of Commercial E-Cigarettes and Nicotine Products	Minimal
933	Preventing Silicosis Associated with Engineered Stone Countertops	Minimal

I-26 RESOLUTIONS BY SPONSOR

SPONSOR	RES#	TITLE
American Academy of Child and Adolescent Psychiatry	219	Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material
	919	Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions
American Academy of Dermatology	917	Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health
American Academy of Emergency Medicine	212	Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract
	213	Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings
	214	Prohibiting Health Care Sale-Leaseback Transactions
	820	Strengthening Emergency Interfacility Transfer Infrastructure
American Academy of Hospice and Palliative Medicine	305	Certification for Hospice Medical Directors
American Academy of Ophthalmology	912	Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products
American Academy of Physical Medicine & Rehabilitation	811	Government Support of Adaptive Sports Programming
American Association of Clinical Urologists	201	Artificial Intelligence Having Prescriptive Authority
American Association of Neurological Surgeons	603	Ensuring Relevance and Mission Alignment in House of Delegates Business
American Association of Public Health Physicians	901	The Establishment of Mandatory National Reporting of Naegleria Fowleri and Other Amebic Encephalitides
	929	Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis
American College of Emergency Physicians	211	Fair and Clinically Appropriate EMTALA Investigations
	805	Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine
	817	Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care
	818	Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment
American College of Lifestyle Medicine	802	Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs

I-26 RESOLUTIONS BY SPONSOR

SPONSOR	RES#	TITLE
American College of Preventive Medicine	209	Protecting GME Subject to Funding Uncertainty
American College of Surgeons	208	Facilitating Short-Term Supervised Clinical Training for International Physicians
American Epilepsy Society	915	Ensuring Expert and Lived Experience Input in Federal National Health Plans
American Psychiatric Association	916	Opposition to Recreational Nicotine Products in Federal Correctional Facilities
American Society for Reproductive Medicine	803	Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit
American Society of Addiction Medicine	227	Increasing Access to Long-Acting Injectable Medications for SUD
	228	Hospital-Based Substance Use Disorder Care
American Society of Interventional Pain Physicians	232	Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care
American Society of Plastic Surgeons	216	Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process
	217	Strengthening the Patients First Act and Medicare Physician Payment Reform
	601	Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy
American Thoracic Society	235	Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions
	814	Coverage of SMART Therapy for Asthma
	932	Recognizing the Challenge of Tobacco use in the Era of Commercial E-Cigarettes and Nicotine Products
	933	Preventing Silicosis Associated with Engineered Stone Countertops
Association for Clinical Oncology	233	Medicaid Protections & Continuous Coverage for Active Cancer Care
	234	Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers
	931	Allocation, Liability Protections, & Generic Drug Shortages
California	928	Electric Bike and Scooter Safety, Regulation, and Enforcement
Colorado	229	Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation
Endocrine Society	914	National Strategy to Close the Women’s Health Gap

I-26 RESOLUTIONS BY SPONSOR

SPONSOR	RES#	TITLE
Florida	815	Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies
	816	Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services
Illinois	902	Illegal Electronic Health Record Sharing and Patient Trust
Indiana	210	Requiring Physician Oversight for Artificial Intelligence Tools
International Medical Graduates Section	221	Preserving Duration of Status for J-1 Physicians in Graduate Medical Education
	222	Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)
	306	Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States
Kansas Medical Society	206	Third-Party Litigation Funding in Medical Liability Claims
Kentucky	207	Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety
	804	Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes
LGBTQ+ Section	007	Opposing the Required Creation of “Detransition Clinics”
	920	Improving Protection for Patient Medical Records and Health Care
	921	Transgender and Gender Diverse Cancer Research

I-26 RESOLUTIONS BY SPONSOR

SPONSOR	RES#	TITLE
Medical Student Section	001	Recognition of Intersex Individuals and their Human Rights
	202	Rapid Response Framework for Unsupported Medical Claims by Public Officials
	203	Set-Aside Federal Funding for Tribal Health Programs
	302	Augmented Intelligence Use in Assessment Development During Medical Education
	304	Transparency in AI-Assisted Admissions
	801	Improving the External Appeals Process for Denied Claims
	903	Improving Health Outcomes in Native Hawaiian Populations
	904	Regulation of Organ Transplant Open Offers
	905	Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care
	906	Establishing Menstrual Products as a Standard of Inpatient Care
	907	Affirming Support for the National Institutes of Health Advisory Councils
	908	Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients
	909	Public Emergency Alert Reporting Requirements on Private Platforms
Minnesota	819	Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers
New England	005	Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials
	218	Firearm Manufacturer Accountability for the Cost of Gun Violence
	918	Strengthening the Radiation Protection Standard
New Jersey	010	Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring
	926	Support for One Health Approaches to Protect Human, Animal, and Environmental Health
	927	Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement

I-26 RESOLUTIONS BY SPONSOR

SPONSOR	RES#	TITLE
New York	812	Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions
	813	Small Medical Practice Website and other Digital Service Compliance with ADA Regulation
	930	Supporting the Use of Firearm Suppressors to Prevent Hearing Loss
Ohio	002	Surgical Consent
Organized Medical Staff Section	204	Federal Framework for Social Media Access by Minors Under Age 16
	205	Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs
	226	Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review
	809	Joint Commission Standards for Medical Staff Self-Governance
	810	Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence
	925	Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers
Private Practice Physicians Section	230	Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities
Puerto Rico	231	Medicare and Medicaid Payment Equity for Puerto Rico
Resident and Fellow Section	008	Recognition of Moral Injury in the Physician Workforce
	223	Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine
	224	Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents
	225	Supporting a Common Legal Framework for Medical Capacity Holds
	602	Enhancing Equity in House of Delegates Resolution Processes by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus
	922	Eliminating Tax Barriers to Equitable Clinical Trial Participation
	923	Research the Community Health Impacts of Data Centers
	924	Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice

I-26 RESOLUTIONS BY SPONSOR

SPONSOR	RES#	TITLE
Senior Physicians Section	006	Ethics of Medical Usury
	220	Advocating for the Older Americans Act and Community-Based Services for Older Adults
	806	Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked
	807	Continuing Care Retirement Communities (CCRC's)
Texas	604	Increasing Time Between Handbook Release and Opening of Online Reference Committees
Underrepresented in Medicine Advocacy Section	009	Ensuring the Appropriate Placement of Children After Parental Deportation
	910	Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation
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REPORT 14 OF THE (I-26)
Patient Options to Restrict Secondary Use of Their Healthcare Data

EXECUTIVE SUMMARY

At the American Medical Association's (AMA's) 2025 Interim Meeting, Resolution 004-I-25 was introduced, "Patient Options to Restrict Secondary Use of Their Healthcare Data," which focused on AMA's support for healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, and retroactively withdraw their data from de-identified data sets. The resolution was referred.

The "Health Insurance Portability and Accountability Act (HIPAA) of 1996" provides patients with limited ability to restrict secondary uses of their healthcare data, but the extent of control depends on the type of data, who holds it, and the purpose of the use. HIPAA generally prohibits covered entities (CEs) and business associates (BAs) from using or disclosing protected health information (PHI) unless authorized by the patient, except for certain specific instances and scenarios.

For any use or disclosure of PHI that falls outside treatment, payment, and healthcare operations (TPO) and outside of the required or permitted scenarios, HIPAA requires a written, specific, patient authorization. Many legal scholars regard disclosure for purposes of TPO as the main channel through which secondary use of patient data occurs without any additional patient consent. An additional broad catalyst of secondary use is what is referred to as de-identification of health data. Once PHI is deemed de-identified, the restrictions of the HIPAA Privacy Rule no longer apply, as HIPAA does not consider de-identified data to be PHI. De-identified data can be used, sold, published, or transferred to non-HIPAA-covered recipients without patient authorization, including for AI model training.

The AMA has longstanding policy supporting the supremacy of patient privacy rights and the importance of AI model development that prioritizes data privacy as well as disclosures about how individuals' data is used or reused. AMA policy also includes a flat prohibition on re-identifying data for secondary AI use. It sets a hard line against exactly the kind of "de-identify, then re-identify" pattern that makes secondary use of health data risky, and the AMA also calls out de-identification itself as an unreliable basis for permitting secondary AI use.

The Board of Trustees recognizes the challenges posed by unauthorized secondary uses of patient data. There is real tension between patients' privacy rights and the growing secondary use of health data, particularly in the context of AI development, deployment, and use. Stakeholders in the healthcare community continue to seek larger datasets to develop and train AI models. AMA's advocacy efforts are ongoing and will continue to emphasize the importance of strengthening patient privacy protections and modernizing regulatory frameworks to address AI-driven data use. This includes continuing to advocate for stronger privacy safeguards, greater transparency, and regulatory mechanisms that provide patients with more meaningful control over the secondary uses of their health information.

The Board of Trustees recommends that the AMA continue to support healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, including retroactive withdrawal of their data from de-identified data sets.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 14-I-26

Subject: Patient Options to Restrict Secondary Use of Their Healthcare Data

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 004-I-25, "Patient Options to Restrict Secondary Use of Their Healthcare Data," was referred. It asked the following:

> 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 to retroactively withdraw their data from de-identified data sets.

Testimony was limited, with the majority of online testimony in favor of referral for study. Delegates offered mixed views during in-person testimony, with the majority favoring non-adoption.

BACKGROUND

HIPAA Provisions for Patients to Restrict Secondary Use of Their Healthcare Data

Secondary use of healthcare data generally means using patients' health data for purposes other than direct patient care. These purposes include clinical research, public health activities, marketing, augmented intelligence (AI) model development, and insurance operations. The "Health Insurance Portability and Accountability Act (HIPAA) of 1996"[1] provides patients with limited ability to restrict secondary uses of their healthcare data, but the extent of control depends on the type of data, who holds it, and the purpose of the use.

HIPAA applies to covered entities (CEs), which consist of medical providers, health plans, and healthcare clearinghouses. Patient information is generally collected by a medical provider or health plan, at which point that information is deemed protected health information (PHI) under HIPAA and subject to its privacy and security protections. These provider and health plan CEs, in order to facilitate the processing of their PHI for claims payment, business analytics, and other purposes, generally will contract with one or more entities that perform these services; HIPAA terms these entities "business associates" (BAs). The disclosure of PHI from the CE to the BA is strictly regulated and may only be done according to the terms of a BA agreement.

HIPAA generally prohibits a CE or BA from using or disclosing PHI unless authorized by the patient, except for two instances where disclosure is required[2] and six scenarios where disclosure is permitted,[3] but not required. For any use or disclosure of PHI that falls outside treatment, payment, and healthcare operations (TPO) and outside of the required/permitted scenarios,[4] HIPAA requires a written, specific, patient authorization. Most marketing communications and instances of sale of

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PHI receive heightened patient authorization requirements as exemplars of secondary uses of data, as the patient likely did not anticipate at the time of disclosing their information and did not meaningfully provide consent.

The principal carve-out from the general prohibition on use and disclosure of PHI is when that is done for purposes of TPO, which many legal scholars see as the main channel through which secondary use of patient data occurs without any additional patient consent. Because the definition of healthcare operations is broadly interpreted, and not confined to a specific clinical encounter, the "operations" purpose can be used as a basis to authorize a wide range of secondary uses that do not require a fresh authorization for each use.

Physicians and other providers must allow patients to request restrictions on additional sharing of their data,[5] although providers are not always required to agree to patients' wishes.[6] One important exception[7] is that providers generally must honor a request not to disclose information to a health plan when the patient paid out of pocket in full for that service and no law requires the disclosure.

Fundamental to TPO use and disclosures of PHI, is the "minimum necessary" standard,[8] which states that CEs must make reasonable efforts to limit use, disclosure, and requests for PHI to the minimum data necessary to accomplish the intended purpose. Minimum necessary requirements regulate how much data is disclosed by a CE for a given purpose. There are several significant built-in exceptions exempt from minimum necessary requirements, such as disclosures for treatment purposes, to the individual, or to the Department of Health and Human Services (HHS) Office for Civil Rights (OCR).

42 Code of Federal Regulations (CFR) Part 2 (42 CFR Part 2)

It is also important to note that 42 CFR Part 2 was revised in 2024,[9] altering privacy protections for patients seeking substance use disorder (SUD) treatment by aligning them more closely with HIPAA rules. The updated regulations expand certain patient rights and enforcement by adopting HIPAA's penalty structure, requiring healthcare providers to follow standard breach notification rules, and granting a patient the right to request an accounting of disclosures. However, the changes have elements that can weaken confidentiality through easier record sharing after a single, general patient consent and put patients at risk of discrimination and stigma in healthcare or employment without providing strong enough parallel anti-discrimination protections. Written patient consent is generally required before a provider can use or disclose SUD treatment records. Under 42 CFR Part 2, patients can provide a single, general consent for all future uses and disclosures for treatment, payment, and healthcare operations. Another safeguard is the prohibition on the use of SUD records or testimony in any criminal, civil, administrative, or legislative proceedings against the patient without their consent or a specific court order.

Information Blocking Rule Provisions for Patients to Restrict Secondary Use of Their Healthcare Data

Uses and disclosures of PHI were further regulated at the federal level with development of Information Blocking Rule (IBR) regulations, promulgated in 2020 pursuant to the "21st Century Cures Act." The IBR regulations govern electronic health information (EHI) and align with HIPAA, but require that under the six scenarios[10] where disclosure is permitted, such disclosures are now required, unless they fit into one of the exceptions stated in the IBR regulations: "[I]f an actor is permitted to provide access, exchange, or use of EHI under the HIPAA Privacy Rule (or any other law), then the information blocking provision would require that the actor provide that

access, exchange, or use of EHI so long as the actor is not prohibited by law from doing so (assuming that no exception is available to the actor)."[11]

How does this IBR provision affect a patient's right to restrict secondary use of their data?

The IBR's Privacy Exception[12] allows actors to protect patient privacy by respecting preconditions under federal or state laws or formal, documented individual consent choices. Because HIPAA gives individuals the right to request privacy protection for PHI[13] the IBR regulations do not disturb those protections. The specific IBR exception that applies and, as referenced in the above-quoted excerpt from the "21st Century Cures Act," is an individual's request not to share EHI, which is governed by 45 CFR §171.202[14] specifically, sub-exception (e).

The broadest catalyst of secondary use is de-identification of health data. Once PHI is deemed de-identified, the restrictions of the HIPAA Privacy Rule no longer apply, as HIPAA does not consider de-identified data to be PHI. De-identified data can be used, sold, published, or transferred to non-HIPAA-covered recipients without patient authorization. OCR guidance states that removing personal identifiers from health information mitigates any privacy risks to individuals and supports the secondary use of data for many additional purposes, including for AI model training, which was not envisioned when the HIPAA regulations were finalized nearly 25 years ago.

HIPAA BAs can also play a role in secondary uses of data. Like CEs, BAs are required to maintain the HIPAA Security Rule's administrative, physical, and technical safeguards, and can only use or disclose PHI as necessary to perform the contracted services for the CE, or as required by law. The Security Rule requires that BAs and CEs protect against any reasonably anticipated uses or disclosures of PHI that are not permitted or required under the Privacy Rule, and BAs must provide CEs with written assurances that they will safeguard HIPAA-covered information and handle PHI appropriately.

The HIPAA Privacy Rule provides specifics on whether the secondary use of data is permissible while the HIPAA Security Rule stipulates the infrastructure potency needed to protect the data and allows secondary data uses to occur in a safe and limited fashion.

AMA POLICY

The AMA has longstanding policy supporting the supremacy of patient privacy rights and the importance of AI model development that prioritizes data privacy as well as disclosures about how individuals' data is used or reused. The Board notes the following policy excerpts are particularly relevant to this discussion:

Policy H-315.983, "Patient Privacy and Confidentiality"

1. Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
    a. that there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
    b. that patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of

confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;

c. that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;

d. that any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and

e. that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received

. . .

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use . . .

Policy H-480.931, "Assessing the Intersection Between AI and Health Care"

1. General Governance
    a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration . . .

…

6. Data Privacy and Augmented Intelligence
    a. Entity Responsibility:
        i. Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
        ii. Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
        iii. Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy . . .

Policy H-315.958, "Ensuring Privacy in Retail Health Care Settings"

…

6. Our AMA supports the requirement that retail health care companies clearly indicate how patients can withdraw consent and request deletion of data retained by the non-health care providing units, which should be by a means no more onerous than providing the initial consent . . .

AMA policy is explicit that a patient's right to control secondary use extends to the training set itself, not just to the disclosure of a single record. Under the "Entity Responsibility" provisions, entities developing generative AI must make clear what the intended use of an individual's data is, and "these rights should encompass AI training data and disclosure to other users of the tool." The policy is explicit that the rights to opt-out, update, or delete one's data grant patients the ability to reach back into the model's training structures, not just to a single disclosure event. This distinction is critical and more granular than the original HIPAA considerations since HIPAA's access and accounting-of-disclosures rights were not written with model training in mind.

AMA policy also includes a flat prohibition on re-identifying data for secondary AI use. It sets a hard line against exactly the kind of "de-identify, then re-identify" pattern that makes secondary use of health data risky: generative AI tools should not reverse-engineer, reconstruct, or re-identify an individual's originally identifiable data, nor use identifiable data for purposes beyond what was permitted. The policy also directs that this be enforced through both legal agreements and technical controls, including by naming specific architecture-level safeguards that should back up the legal restriction, rather than relying solely on contractual promises alone.

AMA policy also calls out de-identification itself as an unreliable basis for permitting secondary AI use. The policy posits that many tools marketed as "HIPAA-compliant" rely on outdated notions of de-identification by simply stripping personal identifiers, and warns that with today's computing power, such data can easily be re-identified. HIPAA's own framework logic (if you "de-identify data, it is no longer PHI") has served as an entry point for unrestricted secondary use of health data. The AMA's position is that historical "de-identification" with the current reality of "re-identification" as it currently stands for AI training purposes, creates tremendous risk for patient privacy. Consequently, privacy needs to be designed into technology products from their inception rather than retrofitted through identifier removal after development concludes.

In addition, AMA policy emphasizes the importance of the data minimization requirements and how entities should only collect the minimum data needed for a stated purpose. Ultimately, this functions as an upstream restriction on secondary use, since data that was never collected in the first place cannot later be repurposed into a training set.

These policies provide the basis for AMA's ongoing regulatory and legislative advocacy efforts on patient privacy, including reforms and updates to HIPAA regulations, and development of robust AI governance policies.

DISCUSSION

The Board of Trustees understands the concerns that prompted Resolution 004-I-25 and recognizes the challenges posed by unauthorized secondary uses of patient data. A 2022 AMA survey[15] found that while 92 percent of people believe that privacy of their health data is a right, most are unclear about the rules relevant to their privacy. The AMA is concerned that health data are increasingly vulnerable and has called for regulations for an individual's right to control, access, and delete personal data collected about them. As discussed above, patients have historical ways to restrict

secondary uses. Under HIPAA, patients may request restrictions on how providers and health plans use or disclose their PHI. Although providers must allow patients to make such requests, they are not always required to agree.[16] The minimum necessary standard provides that CEs must make reasonable efforts to limit use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.

However, once PHI is deemed de-identified, the restrictions of the HIPAA Privacy Rule no longer apply, as HIPAA does not consider de-identified data to be PHI. Typical (and innumerable) de-identified data use cases are using data to train AI models. Specifically, discrete data fields of structured patient data and unstructured data from clinical notes and discharge summaries are "de-identified" by EHRs and healthcare institutions and used to train AI, which can, in turn, use the data to "re-identify" the patient. Furthermore, there is concern that that the original unstructured clinical narratives can never feasibly be "de-identified" because the descriptors can sufficiently describe a singular patient without the name, date of birth, gender or other historically considered identifiable variables. De-identification is a misnomer, since de-identified data is not equivalent to anonymous data.

Moreover, AMA Privacy Principles[17] underscore rights that an individual should possess. Our principles highlight that individuals have the right to know exactly what personal data an entity is accessing, using, disclosing, and processing—and for what purpose—at or before the point of collection. Individuals also have the right to control how entities access, use, process, and disclose their data, including secondary (and beyond) uses.

AMA has regulatory and legislative advocacy outreach on these topics and continues to look for opportunities to address the use and possible misuse of de-identified data as well as retroactively withdraw that data from AI training and other data sets. The Administration has thus far focused on and prioritized fostering AI innovation and adoption across sectors, rather than developing a robust AI governance model that preserves patient privacy and security. Accordingly, current governance does not include set provisions for retroactively removing de-identified data from training sets. As policymakers continue to navigate the rapidly evolving AI landscape, the AMA's advocacy has centered on educating them about both the potential and limitations of AI, while promoting its responsible development, deployment, and use in healthcare through the lens of AMA policy.

Legislative Action

Discussions on updating HIPAA privacy and security laws are continuing in Congress. One of the most prominent bills is Senator Bill Cassidy's, MD (R-LA) "Health Information Privacy Reform Act" (HIPRA, S. 3097). This bill was introduced in November 2025 and addresses secondary use of patient data primarily by closing gaps in HIPAA's existing framework rather than creating an entirely new secondary-use framework. The bill was considered by the Senate Health, Education, Labor, and Pensions (HELP) Committee and was voted out unanimously. AMA advocacy staff has been working with the HELP Committee to provide technical assistance and insights regarding these issues, and have seen positive changes in the legislation.

HIPRA extends HIPAA-style limits to non-HIPAA entities by defining a new category of "regulated entity" that covers essentially any organization that determines the purpose and means of processing "applicable health information." This definition would be broader than existing protections, and HHS would be directed to extend HIPAA Privacy, Security Rule-style protections to this data, closing the gap for wearables, wellness apps, and direct-to-consumer health platforms which currently face no federal use restrictions once they acquire health data (although individuals may have some privacy protections from the Federal Trade Commission (FTC) Act,[18] the FTC

Health Breach Notification Rule,[19] and an increasing number of state health privacy laws). The bill also restricts secondary use through HIPAA's right of access. Currently, once a patient directs their PHI to a third party via HIPAA's right of access, HIPAA no longer governs that data. HIPRA would require the patient to state the purpose of the disclosure before it happens, and would let the disclosing entity bind the third-party recipient to the patient's stated use restrictions, essentially making the patient's designated purpose(s) for the disclosure of the data part of the data exchange.

HIPRA also targets AI training specifically, by directing HHS to issue guidance on applying the "minimum necessary" standard to AI/Machine Learning development, address when "limited data sets" are appropriate for that purpose and establish new national de-identification standards. These new standards are a direct response to AI training, being a secondary data use that strips personal identifiers from individuals' data. This scenario currently surpasses the legal landscape and thus needs to be considered and folded into regulation as this area continues to rapidly expand.

In addition, HIPRA requires entities to tell patients once their data exits HIPAA protections, when their data is accessed by a third party and is no longer HIPAA-protected, and that their data may be redisclosed

State Action

Many states have used changes to their privacy laws to address de-identified data issues and restrictions on its use.

The California "Consumer Privacy Act" (CCPA) and the California "Privacy Rights Act" (CPRA) provide the most developed state framework and give consumers a right to delete their personal information, but exempts de-identified information from that right entirely if it meets a three-part test. The test requires that an entity: (1) implement reasonable technical and business-process safeguards to prevent re-identification of the data; (2) publicly commit to maintaining the data in a de-identified form and refrain from attempting to re-identify it; and (3) contractually require any downstream recipients to uphold the same commitments. If the entity meets those thresholds, an individual's deletion request simply does not reach that dataset because the data has been deemed sufficiently de-identified. CCPA/CPRA also has a research-specific exception, allowing an entity to retain data despite a deletion request where deleting it would seriously impair research and the consumer has already provided informed consent, which does not allow an individual to retroactively change their mind about sharing their data.

CONCLUSION

There is real tension between patients' privacy rights and the growing secondary use of health data, particularly in the context of AI development, deployment, and use. AMA advocates for patients who seek to safeguard their privacy, while recognizing the imbalance of influence between patients and health systems who encourage patients to enter PHI into their portals with the potential to monetize that individual's data. Under HIPAA, health data generally may not be used or disclosed without patient authorization, except for TPO, and a set of well-defined purposes. While HIPAA provides certain mechanisms for patients to restrict data sharing, its broad interpretation of "health care operations" has enabled substantial secondary uses of patient information to proliferate without additional consent mechanisms.

Stakeholders in the healthcare community continue to seek larger datasets to develop and train AI models. Although HIPAA's de-identification standards were designed to mitigate privacy risks, technology advances in computing power and data analytics have raised new concerns about re-

identification and the adequacy of decades-old regulatory assumptions and standards. The AMA's policy positions reflect these concerns by emphasizing that patients should understand how their data are used, reused, and incorporated into AI training datasets, and by asserting rights to opt out, update, or request deletion of their data, including within AI training models.

The AMA views de-identification alone as an insufficient safeguard for modern AI applications. AMA policy calls for both legal and technical protections against re-identification, including privacy-preserving approaches such as secure enclaves, federated learning, and differential privacy. It also emphasizes data minimization, transparency, and privacy-by-design principles that limit secondary uses before data are collected rather than attempting to mitigate risks afterward.

AMA's advocacy efforts are ongoing and will continue to emphasize the importance of strengthening patient privacy protections and modernizing regulatory frameworks to address AI-driven data use. This includes educating policymakers about both the opportunities and limitations of AI and promoting governance structures that balance innovation with patient trust and autonomy. There are significant gaps in the rights that individuals possess to limit secondary uses of their data. Moreover, considerable discrepancies remain once health information is de-identified, and what de-identification really means in the setting of natural language processing of unstructured narratives. As AI development increasingly relies on large-scale health datasets, the AMA will continue to advocate for stronger privacy safeguards, greater transparency, and regulatory mechanisms that provide patients with more meaningful control over the secondary uses of their health information.

RECOMMENDATION

The Board of Trustees recommends that Resolution 004-I-25 be adopted as amended by addition and deletion and the remainder of the report be filed.

> That our American Medical Association continue to support healthcare data privacy practices that provide patients with options to withdraw or restrict secondary uses of their data, including ~~to~~ retroactive~~ly~~ withdrawal of their data from de-identified data sets. (New HOD Policy)

Fiscal Note: Minimal.

REFERENCES

[1] See https://www.hhs.gov/hipaa/for-professionals/index.html.
[2] A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action.). 45 C.F.R. §164.502(a)(2).
[3] A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations.18 Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make. 45 C.F.R. §164.502(a)(1), *supra* at note 1.
[4] See 45 C.F.R. §164.502(a) *supra* at notes 2, and 3.
[5] See 45 C.F.R. §164.502(a)(2) *supra* at note 2.
[6] See 45 C.F.R. §164.522(a)(2) *supra* at note 3.
[7] See 45 CFR 164.522(a)(1)(B)(vi), and 45 C.F.R. §164.502(a)(1), *supra* at note 3.
[8] The minimum necessary standard is defined under the HIPAA Privacy Rule in federal regulations 45 CFR §164.502(b), which sets the core standard requiring reasonable limits on any use, disclosure, or request for PHI to accomplish its intended purpose, and 45 CFR §164.514(d), which details the operational requirements, policies, procedures, and criteria for determining what constitutes the minimum necessary for routine and non-routine disclosures. These rules require covered entities and business associates to make reasonable efforts to limit disclosure of PHI to the specific amount needed.
[9] See https://www.federalregister.gov/documents/2024/02/16/2024-02544/confidentiality-of-substance-use-disorder-sud-patient-records.
[10] See 45 C.F.R. §164.502(a)(2) *supra* at note 2.
[11] See 84 FR 25642, 25812, May, 2020.
[12] See 45 CFR §171.202 Privacy exception—When will an actor's practice of not fulfilling a request to access, exchange, or use electronic health information in order to protect an individual's privacy not be considered information blocking?
[13] See 45 C.F.R. §164.522(a)(2), *supra* at note 3.
[14] *Ibid., see* sub-exception (e).
[15] See https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf.
[16] See 45 C.F.R. §164.522(a)(1)(ii), *supra* at note 3.
[17] See https://www.ama-assn.org/system/files/2020-05/privacy-principles.pdf.
[18] See https://www.ftc.gov/legal-library/browse/statutes/federal-trade-commission-act.
[19] See https://www.ftc.gov/legal-library/browse/rules/health-breach-notification-rule.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 15-I-26

Subject: Gender-Based Pay Equity in Medicine

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 American Medical Association (AMA) Interim Meeting, the House of Delegates (HOD) adopted Policy D-385.939 "Report on Gender-Based Pay Equity in Medicine." The policy directs the AMA "to study and report at I-26 the current pay structures and existing gender-based disparities in physician pay." The policy further calls on the AMA to "propose data-driven guidance to end gender-based pay disparities and create strategies to achieve transparency and equitable compensation across medical practice settings."

This report describes current physician compensation structures, reviews evidence on existing gender-based compensation disparities, identifies factors that may contribute to those disparities, and summarizes relevant AMA policy. The report also outlines evidence-informed approaches to addressing persistent inequities in physician compensation.

BACKGROUND

Current compensation structures

Physician compensation in the United States generally consists of three primary components: base salary, productivity-based compensation, and incentive bonuses.[1] While compensation models vary across practice settings and specialties, organizations use a combination of these elements to reward clinical work, support organizational goals, and incentivize high-quality patient care.[2]

The AMA Physician Practice Benchmark Survey provides a comprehensive snapshot of physician practice arrangements, characteristics, and trends across the United States. A recent AMA analysis of Benchmark Survey data found that 70.5 percent of physicians receive a salary, making it the most common mode of compensation. The analysis also found that 55 percent of physicians receive some form of productivity-based compensation, and 39 percent receive some form of bonus compensation.[1] Bonus compensation may be tied to quality performance measures, patient satisfaction scores, research productivity, teaching responsibilities, or leadership contributions.[3] Blended compensation models are also becoming more common: in 2024, 60.8 percent of physicians received compensation from more than one of these three categories, up from 51 percent in 2014.[1]

On average, compensation structures also differ between male and female physicians, with male physicians receiving a larger share of their income from productivity-based compensation and a smaller share from salary than female physicians. This pattern suggests that male physicians may have greater earning potential under current compensation models because more of their income is tied to variable, productivity-based pay.[1]

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Existing gender-based compensation disparities

Gender-based compensation disparities are well documented across medical specialties and practice settings, with female physicians earning less than their male counterparts.[4] The Doximity 2025 Physician Compensation Report found a 26 percent physician gender pay gap in 2024. Even after adjusting for specialty, geographic location, and years of experience, female physicians earned an average of $120,917 less annually than their male counterparts.[5] Over a 40-year career, a disparity of this magnitude could translate into approximately $2 million less in gross income for a female physician.[6]

These disparities are driven in part by both the unequal distribution of male and female physicians across specialties and differences in earnings between specialties. Female physicians are disproportionately represented in lower-compensated specialties, including pediatrics, family medicine, endocrinology, and obstetrics and gynecology. By contrast, male physicians remain overrepresented in higher-paying, often procedural specialties such as orthopedic surgery, diagnostic radiology, critical care medicine, and interventional cardiology.[7]

Differences in physician productivity may also contribute to gender-based pay gaps, particularly in payment models that tie compensation to patient volume and other quantifiable outputs. One study found that female primary care physicians spend about six percent more time with patients per visit than male primary care physicians.[8] Proposed explanations for this finding include that female physicians may provide more detailed explanations to patients, take more thorough patient histories, or offer more counseling during visits. Evidence also suggests that female physicians spend approximately 20 percent more time managing electronic health record portal messages than male physicians, in part because they receive 24 percent more staff messages and 26 percent more patient messages.[9] Taken together, these differences may affect compensation in systems that reward visit volume more heavily than time-intensive patient care.

Although measurable factors may explain a substantial portion of the physician gender pay gap, compensation disparities persist even after adjusting for specialty, practice setting, productivity, and other observable variables. This persistence suggests that less easily measured factors also contribute to inequitable compensation.

One such factor is the disproportionate share of childcare and other caregiving responsibilities assumed by female physicians. In one study, marriage and children were associated with an earnings penalty for female physicians, who worked seven percent fewer hours when married without children and 18 percent fewer hours with children than male physicians.[10] This difference may reflect greater caregiving demands and household responsibilities.

Differences in salary negotiation may also contribute to compensation disparities. Male physicians are more likely to negotiate for higher salaries.[11] By contrast, female physicians may be less likely to negotiate pay because they may face negative consequences for doing so and may be less likely to receive raises than their male counterparts when they do.[12]

Existing AMA Policy

These findings underscore the need for structural and policy interventions to promote equitable physician compensation. The AMA has established a robust policy framework addressing gender-based pay equity. Your Board identifies three policies as particularly relevant to persistent gender-based compensation inequities and to the AMA's commitment to advancing pay equity.

Policy H-65.961, "Principles for Advancing Gender Equity in Medicine," affirms the AMA's commitment to gender equity in medicine and identifies a variety of evidence-based approaches to addressing gender-based pay disparities, including salary transparency and compensation audits, among many others.

Policy D-65.989, "Advancing Gender Equity in Medicine," supports advocacy for practice policies that promote compensation transparency, objective pay structures, training to increase awareness of potential gender bias in compensation systems, and the development of equitable compensation models. The policy also emphasizes collaboration with interested parties in advancing this work.

Policy D-65.983, "Gender Equity and Female Physician Work Patterns During the Pandemic," supports research on data related to female physicians' work patterns and employment outcomes, including potential inequities related to terminations, furloughs, and other gender-based differences observed during the pandemic.

DISCUSSION

Addressing physician gender-based pay disparities requires multifaceted, evidence-based interventions that target the structural drivers of compensation inequity. Although outcomes data remain limited, one of the most consistently recommended approaches is the implementation of transparent compensation systems that clearly delineate salary ranges, productivity benchmarks, bonus criteria, and additional compensation for leadership, administrative, and academic responsibilities.[13-15] By reducing reliance on discretionary decision-making, transparent compensation structures can help limit unwarranted variation and facilitate the identification of unexplained salary differences. For example, an academic medical system reported that applying a structured compensation model incorporating multiple relevant factors resulted in gender pay equity.[16,17]

Routine salary audits, or pay equity audits, are similarly important.[13,18] These audits assess physician compensation using standardized methods that adjust for relevant factors, including specialty, clinical full-time equivalent status, years of experience, academic rank, productivity, leadership responsibilities, and geographic location. When conducted regularly, salary audits enable organizations to identify unexplained disparities, implement timely salary adjustments, and monitor the impact of compensation policies over time. One salary audit intervention among academic physicians resulted in salary adjustments that raised female salary as a percent of male salary from 89.4% pre-intervention to 93.5% post-intervention.[19]

Further, if female physicians are disadvantaged by productivity-based payment models, as discussed above, reforming physician compensation models so that they better account for value-based care, rather than primarily rewarding clinical volume, may promote greater equity. Traditional productivity-based models largely reward procedural intensity and patient volume, while undervaluing activities that are central to high-quality care, such as patient education, shared decision-making, interdisciplinary collaboration, teaching, and mentorship. Broadening compensation frameworks to recognize these contributions may reduce unintended biases associated with volume-driven reimbursement and support a more comprehensive evaluation of physician performance. Supporting this strategy, one study found that female physicians achieved similar or better quality outcomes and earned more than their male counterparts under a value-based payment model.[20]

Overall, these approaches highlight that reducing gender-based pay disparities requires coordinated structural reform. As the AMA policies outlined above demonstrate, the AMA has already established a strong policy basis for evidence-informed strategies to improve compensation transparency, promote objective and gender-neutral pay structures, support regular review of compensation practices, and address bias through training, pay audits, and other corrective mechanisms. Existing AMA policy therefore not only reflects the AMA's commitment to pay equity but also provides a strong foundation for the reforms needed to address persistent gender-based compensation inequities.

Additional AMA resources on this topic are available on the AMA's Advancing Gender Equity in Medicine: Resources for Physicians webpage, which serves as a central repository of relevant policy and supporting materials.

RECOMMENDATIONS

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

1. That our American Medical Association encourage continued study of evidence-based interventions to promote gender pay equity for physicians. (New HOD Policy)

2. That AMA Policy D-65.989, "Advancing Gender Equity in Medicine," and AMA Policy H-65.961, "Principles for Advancing Gender Equity in Medicine," be reaffirmed. (Reaffirm HOD Policy)

3. That AMA Policy D-385.939, "Report on Gender-Based Pay Equity in Medicine," be rescinded as having been accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal

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RELEVANT AMA POLICY

H-65.961 Principles for Advancing Gender Equity in Medicine

Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

D-65.989 Advancing Gender Equity in Medicine

1. Our American Medical Association will:
    a. advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation.
    b. advocate for pay structures based on objective, gender-neutral criteria.
    c. encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians.
    d. advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

2. Our AMA will recommend as immediate actions to reduce gender bias:
    a. Elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice.
    b. Create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act.
    c. Establish educational programs to help empower all genders to negotiate equitable compensation.
    d. Work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings.
    e. Create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

5. Our AMA will:
    a. require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA.
    b. work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.

Gender Equity and Female Physician Work Patterns During the Pandemic D-65.983

1. Our American Medical Association will advocate for research on physician-specific data analyzing changes in work patterns and employment outcomes among female physicians during the pandemic including, but not limited to, understanding potential gaps in equity, indications for terminations and/or furloughs, gender differences in those who had unpaid additional work hours, and issues related to intersectionality.

2. Our AMA will collaborate with relevant organizations to evaluate obstacles affecting female physicians and medical students during the pandemic.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 18-I-26

Subject:	Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients
Presented by:	Toluwalaṣé A. Ajayi, MD, Chair
Referred to:	Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting of the American Medical Association (AMA), the House of Delegates (HOD), adopted Policy D-65.968, "Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients," which directs the AMA as follows:

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

Online testimony was in near unanimous support. The minimal in-person testimony was in unanimous support of the report as amended.

BACKGROUND

The usability of Electronic Health Records (EHRs) for transgender and gender diverse patients has taken on a new importance in the current political landscape given concerns about protecting individuals' privacy and maintaining patient agency over one's own data. Several initiatives are underway across the healthcare community to provide greater support for sharing sensitive health information and to ensure that data is protected from nefarious use. The AMA is collaborating across the sector to ensure that physicians and other providers can build trust, respect patient preferences when sharing data, and implement privacy protections for that data.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996[1] is the cornerstone of patient privacy. HIPAA generally prohibits a covered entity and their business associates from using or disclosing protected health information (PHI) unless authorized by the patient, except for two instances where disclosure is required[2] and six scenarios where disclosure is permitted,[3] but not required. For any use or disclosure of PHI that falls outside treatment, payment, and healthcare operations (TPO) and outside of the required/permitted scenarios listed above, HIPAA requires a written, specific, patient authorization.

Under HIPAA, patients also have the right to request restrictions on sharing their PHI. For example, a patient can ask a covered entity not to disclose certain PHI to a health plan for a service the patient paid for out of pocket, in full. In principle, this means a patient can keep a self-pay gender-affirming care visit out of their health records that are shared with an insurer. Patients also have the right to request confidential communications to protect their privacy—a patient can ask

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that communications from a provider or plan be sent to an alternate address or by an alternate method. Patients have to affirmatively invoke these rights, and a covered entity must accommodate reasonable requests.

The issue of subpoenas and release of information for transgender and gender diverse patients under HIPAA is one of the more consequential issues impacting patient privacy. HIPAA does not compel disclosure even when PHI is subpoenaed; it permits it only after specific conditions are met. Physicians and other providers who receive a subpoena (rather than a court order) must obtain either satisfactory written assurance that the patient was given notice and an opportunity to object, or there is a "qualified protective order" limiting the scope of disclosure and requiring return or destruction of the records afterward, before disclosure is permitted. Without proof that the patient was notified of the subpoena and given a real chance to object or obtain a qualified protective order, HIPAA requires that the provider not disclose the records. Most of the current, highest-profile clashes over transgender patients' medical record subpoenas concern subpoenas without a judge's signature, which is a substantial step-down from a judge-issued subpoena, and holds less weight.

It is crucial to emphasize that HIPAA sets a minimum level of privacy protections, and states remain free to add stricter protections than the HIPAA privacy rules. Eighteen states and DC currently have shield laws offering protections for those providing and receiving gender-affirming care. This overlay has produced real legal friction where a provider is simultaneously subject to a federal subpoena and resides in a state with a stricter state confidentiality statute. Such a scenario creates a compliance dilemma over conflicting state and federal rules.

The Department of Health and Human Services (HHS) Office of the National Coordinator for Health IT's (ONC's)[4] work on EHRs and data sharing intersects with patient privacy concerns. ONC has finalized rules that require EHR technology to be capable of tagging and restricting sensitive data, and rules that protect physicians and other providers who choose to honor a patient's request to withhold part of their record. However, ONC has not finalized any rule that requires the actual segmentation of sensitive health data. Such a step would allow patients and providers to maintain granular privacy controls over sensitive health data within their health records. It would compartmentalize specific parts of an individual's medical record—such as gender status/identity, mental health diagnoses, substance abuse treatment, or genetic information—so that they require higher authorization to view or share. This would allow patients to control who can see their private medical data while complying with strict privacy laws such as HIPAA.

Our work on data segmentation issues led to the AMA co-founding and serving on the Governing Board of the not-for-profit Shift Collaborative[5] to help address the gap between what patients want and what technology can offer. Shift is an independent health care task force of over 300 expert stakeholders that seeks to advance a health care ecosystem in which better technology for clinical data sharing increases trust among patients, physicians, providers, and caregivers, improving health quality and outcomes, as today's health data systems often force patients to choose between care and privacy. Shift believes that patients should be able to share the information they want safely, securely, and on their own terms. Ensuring that individuals' data sharing preferences are respected is a critical component of advancing safe, effective, and patient-centered value-based care and chronic disease management.

The feedback Shift has received is that patients want, and physicians and other providers need, more features that support granular segmentation. In the absence of reliable, standards-based segmentation capabilities and with the complexities of Institutional Review Board (IRB) practices still unresolved, physicians and other providers may over-share to avoid information-blocking

liability, under-share to mitigate privacy risk, or under-document information in patients' charts, thereby making the chart less reliable.

Shift takes the view that data segmentation and computable consent can only be achieved at scale through Fast Healthcare Interoperability Resources (FHIR), which is why Shift is focusing its efforts on updating FHIR standards and collaborating with key partners across the community. In recognition of the need for granular segmentation, Shift created an open, standards-based sandbox tool that includes a redacted record viewer that simulates what a patient record with redacted information might look like, based on dynamic patient consent preferences. It also supports workflow demonstrations using synthetic data in a mock EHR environment and will soon allow vendors to connect their products via FHIR application programming interfaces (APIs) to test and validate these workflows within their systems using Shift's synthetic data, use cases, and implementation guidance. To this end, Shift is drafting an implementation guide to assist technology partners with implementation.

With the creation of its sandbox, Shift's work is supporting the community's transition to FHIR. The future of data segmentation and computable consent is in FHIR, and Shift's sandbox is our community's best shot at quickly scaling these functionalities.

AMA POLICY

The AMA has longstanding policy supporting patient privacy and promoting the use of EHRs and other health technologies to support patients in their health journeys. The Board notes the following policies as particularly relevant to this discussion:

Policy H-315.983, "Patient Privacy and Confidentiality"

1. Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
    a. that there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
    b. that patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
    c. that patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
    d. that any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and
    e. that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received . . .

Policy D-478.972, "EHR Interoperability"

1. Our American Medical Association will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive-Based Payment System . . .

Policy D-478.976, "Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians"

1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status . . .

AMA policy provides clear advocacy priorities to protect patient information, improve health data exchange, and advance EHR innovation and usability.

DISCUSSION

The Board understands the growing concerns among patients, physicians, providers, and other interested parties that the indiscriminate sharing of health data may be used against them or lead to other irreversible, deleterious consequences. While improved transparency regarding data exchange and audit trails may be helpful, these interventions do not mitigate apprehension regarding data that have already been shared.

Concerns about indiscriminate access to and use of personal health data are higher among marginalized populations, including racial and sexual minorities, as well as individuals with housing insecurity and immigrant populations. In addition, concerns are higher among patients with reported lower trust in the health system and those who have experienced either lower quality or discriminatory care. Patients with such privacy concerns may withhold information from physicians or fail to seek appropriate treatment, which perpetuates disparities in care. These privacy concerns can permeate the healthcare delivery system and affect substantial parts of it. For example, the inability to control sharing of one's data has been shown to further reinforce mistrust in the health ecosystem, which is associated with decreased likelihood to follow medical advice, receive recommended preventive care, fill prescriptions and keep follow-up appointments, as well as higher Emergency Department use, reduced continuity of care, and more advanced conditions when care is sought, resulting in poorer outcomes and overall higher costs of care. Addressing greater protections around personal health information and strengthening sharing policies is paramount.

The health IT vendor community has historically pushed back against granular data redaction since they have not been required to enable this functionality, and it could result in unintended downstream safety implications for patients. For these reasons, ONC's efforts in this space to emphasize the necessity of data segmentation to vendors and the entire community are vital.

Back in 2011, ONC launched the Data Segmentation for Privacy (DS4P) Initiative[6] as a pilot program, with a goal to demonstrate, through small pilot projects, that it is technically possible to share part of a medical record while withholding sensitive information, rather than the "share

everything or share nothing" default that most EHR systems used. This was proof-of-concept work that was later incorporated into actual Health IT Certification rules, resulting in the 2015 Edition Health IT certification criterion. The requirement was that software must be able to mark a portion of a health record as "restricted" using a specific technical labeling standard (Health Level Seven's DS4P standard). This standard essentially labeled an individual's health information as "sensitive," and flagged it for stricter disclosure requirements before it could be shared.

With the 2015 Edition Health IT certification criterion, ONC simply finalized requirements that health IT software have the capability, without ever finalizing a rule requiring providers to actually use that capability in any particular way. Further work from ONC on API Consent Management capabilities was helpful in requiring certified software to support tools that let patients (or systems acting on their behalf) manage granular consent preferences when data moves through modern API-based data-sharing channels that power patient portals and other health apps.

ONC's Information Blocking Rules also impact a physician or other regulated actor's ability to share or withhold sharing of an individual's granularly segmented health data. The exceptions that ONC has defined support physicians' efforts to abide by patients' wishes about sharing or restricting the sharing of sensitive data, although the community is still waiting for HHS enforcement of Information Blocking rules to fully materialize; therefore, many questions remain.

In December 2024 rulemaking, ONC's Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability" (HTI-2 Rule)[7] was finalized without a previously proposed provision to require data segmentation capabilities in certified health IT.

Without these ONC requirements in place, the work of the Shift Collaborative is indispensable in supporting our community's efforts to make progress toward enabling greater data segmentation capabilities. The Shift Sandbox is a live, open source, publicly accessible test environment where health IT developers can see data segmentation actually functioning, where sensitive data is being tagged at the source, patients are able to set sharing preferences, those preferences are automatically enforced, and redaction of data and revocation of privileges work seamlessly with data sharing processes. The sandbox will be showcasing real-world use cases using FHIR and standards-based data segmentation, security labeling, and consent enforcement, meant to help clinicians, policymakers, developers, and implementers understand, test, and advance the vision of granular, patient-centered data sharing.

There are three clinical scenarios currently being tested—an older adult who wants his primary care team, but not third-party apps, to see his history of depression and opioid use disorder; or to adolescents who want to keep reproductive health and gender-identity information private from certain viewers of a shared patient portal. Once the segmentation and consent logic is proven, it can be applied to other use cases and directly support transgender and gender diverse patients and their needs related to privacy and sharing preferences.

CONCLUSION

The protection of sensitive health information for transgender and gender diverse patients represents both an urgent privacy imperative and a broader test of the healthcare system's ability to maintain patient trust in an increasingly interconnected digital environment. While HIPAA establishes an essential baseline for safeguarding PHI, evolving legal, technological, and social challenges underscore the need for more robust and patient-centered approaches to data governance.

Current limitations of EHR systems, particularly the lack of widespread implementation of granular data segmentation capabilities, continue to constrain patients' ability to exercise meaningful control over how their information is shared and used. The evidence suggests that stronger privacy protections are not only important for safeguarding individual autonomy but are also fundamental to promoting access to care, fostering trust, and improving health outcomes.

The AMA's leadership role in initiatives such as the Shift Collaborative demonstrates a strong commitment to advancing solutions that support both patient privacy and effective clinical care. By providing practical tools, implementation guidance, and real-world testing environments, these efforts are helping to accelerate the development of health IT systems capable of honoring patient consent at a granular level. Continued collaboration among policymakers, physicians, other providers, standards development organizations, vendors, and patient advocates will be essential to achieving this vision.

Ultimately, the future of patient-centered data sharing depends on creating health information systems that are both interoperable and trustworthy. Ensuring that individuals can safely share health information on their own terms will strengthen confidence in the health care system, improve continuity of care, and support better health outcomes for transgender and gender diverse patients and other populations with heightened privacy concerns. The advancement of scalable data segmentation and consent-management capabilities should remain a priority for the AMA and the entire community as work continues to align technological innovation with fundamental principles of privacy, autonomy, and equity.

RECOMMENDATIONS

The Board of Trustees recommends that Policy D-65.968 be amended by deletion as accomplished by this report, and that the remainder of the report be filed:

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

Fiscal Note: Minimal.

REFERENCES

[1] https://www.hhs.gov/hipaa/for-professionals/index.html.
[2] A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action.). 45 C.F.R. §164.502(a)(2).
[3] A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations. Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make. 45 C.F.R. §164.502(a)(1), viewable at the link in Note ii, *supra*.
[4] https://healthit.gov/.
[5] https://www.shiftinterop.org/.
[6] https://healthit.gov/wp-content/uploads/2017/07/2015editionehrcertificationcriteriads4p_10615.pdf.
[7] https://healthit.gov/regulations/hti-rules/hti-2-final-rule/.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 22-I-26

Subject: Clarifying Conscientious Objection

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting, the House of Delegates (HOD) adopted Policy D-140.945, "Clarifying Conscientious Objection," the first directive states:

> Our American Medical Association will 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.

This report is submitted to the HOD in fulfillment of the above directive and provides background discussion and policy recommendations regarding physician exercise of conscience while protecting patients from harmful discrimination.

BACKGROUND

Increased legal and professional attention to physician exercise of conscientious objection, such as refraining from providing specific forms of care including but not limited to abortion services, gender affirming care, and family-planning methods, has generated concern that conscientious objection is being used by some physicians to target and discriminate against specific groups of patients.[1] While those critical of conscientious objection worry about discrimination and unequal access to care, proponents insist that it is necessary to uphold physician autonomy and protect physicians' professional judgment at a time of increasing pressure on clinical decision-making from governmental and administrative forces.[2]

DISCUSSION

Concerns regarding conscientious objection as cover for discriminatory behavior are valid, though assessing and quantifying the prevalence of such instances remains difficult, especially regarding cases of refusal to provide care that do not meet legal standards of discrimination. Proving discrimination in a court of law can also be difficult because direct evidence is often rare. Additionally, without meeting a legal standard for discrimination, alleged instances where intent remains uncertain means that two parties can have vastly diverging views on whether or not an action was discriminatory.

Healthcare and social service providers must adhere to several federal civil rights laws and regulations enforced by the Office for Civil Rights. These include but are not limited to: Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, Section 1557 of the Patient Protection and Affordable Care Act, Title II of the Americans with Disabilities Act, and Section

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1908 and Section 1947 of the Public Health Service Act.[3] Under federal law, it is illegal to treat certain protected classes of people differently or less favorably. The groups protected from discrimination include those based on race, religion, national origin, age, sex, sexual orientation, gender identity, pregnancy, family status, disability, veteran status, and genetic information.[4] Alleged instances of physician conscientious objection as discriminatory can be particularly challenging because both the patient and the physician may claim that an action forcing them to not follow their beliefs or wishes is discriminatory if they belong to separate protected classes with opposing values, as is sometimes the case, for example, between some religious groups and sexual or gender minorities.

The AMA *Code of Medical Ethics* is clear that physicians have a right to exercise their conscience and act, or refrain from acting, in accordance with their beliefs but that such freedom is not without limits. Opinion 1.1.7, "Physician Exercise of Conscience," states that physicians must provide care in cases of emergency, that their actions should not discriminate against or unduly burden individual patients or patient population, and they should provide a referral (or at minimum, information regarding access) for another physician or institution to provide any treatment refused the patient.[5]

While it has long been the ethical standard that "[p]hysicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive [or other] services that patients request"[5,6], this is not always the case. One national survey found that 11% of physicians believe that a physician does not have an obligation to refer a patient to another physician for a treatment they object to providing,[7] while another national survey found that 19% of physicians strongly disagree and 25% moderately disagree that "[p]hysicians have a professional obligation to refer patients for all legal medical services for which the patients are candidates, even if the physician believes that such a referral is immoral."[8] These statistics validate concerns that physician conscientious objection to refuse care may lead to discrimination and unequal access to care for certain patient populations, such as those seeking gender affirming care or abortion services.[9,10]

RELEVANT AMA POLICY

There exist several AMA policy provisions relevant to the issue of physician conscientious objection and related concerns regarding discrimination. H-405.958 "Physician Right to Conscience" recognizes that physicians have differing beliefs and a right to exercise their conscience, and supports physicians conducting themselves in a civil and respectful manner. H-65.951 "Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions" outlines several guidelines for organizations to establish anti-discrimination policies and an inclusive organizational culture. And D-5.998 "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era" further supports provisions protecting physician exercise of conscience of care "in accordance with accepted standards of medical care and medical ethics", outlined in the *Code of Medical Ethics*. For a detailed analysis of relevant *Code* opinions, please refer to the corresponding CEJA report on Clarifying Conscientious Objection.

CONCLUSION

Physicians have a right to exercise their conscience. However, this right is not without limits and must be exercised in a manner that avoids harming patients and patient populations. Physicians have ethical obligations to respect patients as persons, to not impede timely care, and to uphold the primacy of patient welfare. While physicians may choose to refrain from providing care in

accordance with their conscience in certain circumstances, they must always do so in a professional and respectful manner. The conscientious refusal of care must never be done out of discrimination against a patient or patient population, nor should it give the appearance of such impropriety, as even the appearance of discrimination can be harmful to the trust that is foundational to the patient-physician relationship and the practice of medicine. Therefore, great care must be taken when physicians exercise conscience to ensure that patients are not negatively affected. This is especially true if a physician not only chooses to exercise conscience refusal but also to refuse to refer their patient to another qualified physician. While physicians may exercise their conscience, they should generally refer their patient to another physician or institution in accordance with *Code* Opinion 1.1.7; however, a physician may instead offer impartial guidance to the patient on how to inform themselves about access to a desired service in cases of "a deeply held, well-considered personal belief."[5] In such cases, though, the physician must still uphold their ethical obligations, including to the provision of timely care, as outlined in Opinion 1.1.6, "Quality Care," and Opinion 1.1.3, "Patient Rights."

RECOMMENDATIONS

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

1. Our AMA supports physicians' right to exercise their conscience in the provision of care, but any conscientious refusal to provide care should be done in keeping with their ethical obligations to not invidiously discriminate against individual patients or patient populations. (New HOD Policy)

2. Our AMA encourages physicians to provide referral to patients in cases where the physician exercises their right to conscientious refusal, in order to reduce potential delays in care.

3. The first directive of D-140.945 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal.

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-26

Subject:	Clarifications regarding Establishment and Nominations to AMA Committees
Presented by:	Mary Ann Contogiannis, MD, Chair
Referred to:	Reference Committee on Bylaws and Ethics

The House of Delegates (HOD) referred back the recommendations of CCB Report 2-I-25 which attempted to clarify the authority of the Board of Trustees (BOT) and the HOD with respect to the establishment of advisory committees as referenced in Bylaw 5.3, Board of Trustees Duties and Privileges. This was in response to an issue that arose at A-25 around a resolution calling for an Advisory Committee on Tribal Affairs, subsequently adopted as Policy D-615.976. To implement this directive, the BOT established the Advisory Committee on American Indian and Alaska Native (AI/AN) Affairs. While the outcome on this matter was positive, the root issue that generated referral of CCB's language related to whether it was the HOD or the BOT that had the authority to establish an advisory committee – not the merits of the advisory committee. The debate in both the reference committee and on the floor of the HOD centered on the ability of the HOD to establish an advisory committee, as the BOT had previously denied a similar request advanced in writing by the Medical Student Section (MSS).

Under our AMA Constitution and Bylaws, CCB issues bylaw language for HOD action, and CEJA interprets the Bylaws. At A-25, the resolution authors and supporting delegations approached CEJA for a bylaw interpretation, and CEJA opined that based on existing bylaw language and historical precedence that only the BOT can **establish** and **appoint** members of advisory committees. While both CEJA and CCB have confirmed that the HOD may request the Board to consider establishing an advisory committee via a letter or resolution, the BOT holds final authority over the creation and governance of advisory committees (see Bylaws 5.3, Duties and Privileges, and 2.13.6, Special Committees of the House of Delegates).

In doing its due diligence, CEJA identified some other Bylaw terminology associated with appointments and nominations that it believed were inconsistent and which it believed CCB should clarify for accuracy.

ADDITIONAL FACT-FINDING/BACKGROUND

CCB also reviewed past CLRPD documents related to AMA governance and the roles of the BOT and HOD. These confirmed the BOT as ultimately having fiduciary and management responsibility. The Office of the General Counsel has also confirmed the Board's exclusive authority over advisory committees.

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The Council also reviewed Policy G-615.003, AMA Member Component Groups, which includes the following definitions:

- An "advisory committee" is an entity whose activities relate to education and advocacy. An advisory committee will have a governing council and a direct reporting relationship to the BOT. Advisory committees, however, will not have representation in the HOD. Advisory committees will operate under a charter that will be subject to review and renewal by the BOT at least every four years.

- An "ad hoc committee" is a special committee, workgroup, or taskforce appointed by the BOT, the Speaker of the House, or the House of Delegates. These committees will operate for a specific purpose and for a prescribed period of time.

Overlapping Committee Terminology

The Bylaws currently use “special committee” in two distinct contexts:

1. Bylaw 2.13.6 allows the HOD to “establish special committees for specified terms of one to 3 years,’ with reports to the HOD through the Board.
2. Bylaw 5.3.10.2 states that a BOT ad hoc committee will be constituted as a special committee, workgroup or taskforce.

This shared label makes it unclear, when someone references a “special committee,” whether it was created by the HOD or by the BOT, and which reporting and accountability rules apply.

Meanwhile, the advisory committee provisions in Bylaw 5.3.10.1 lack detail on how the Board actually establishes an advisory committee.

Under the proposed amendments, both the HOD and the Board retain their respective authority to create committees and time-limited bodies, but the originating authority determines the governance track:

- Committees and other bodies established by the HOD under Bylaw 2.13.6, regardless of their designated form, operate under the direction of the House, report to the House through the Board pursuant to Bylaw 2.13.6.1, and are subject to the terms established by the authorizing motion.

- Advisory committees and ad hoc bodies established by the Board under Bylaw 5.3.10 operate under the direction of and report directly to the Board, subject to the charter and term requirements set forth in Bylaws 5.3.10.1 and 5.3.10.2.

This approach eliminates the need to police labels across the two governance tracks and ensures that the authority, reporting structure, and accountability for any committee can be determined by reference to its authorizing provision rather than its name.

The Council presents the following proposed amended language to clarify existing bylaw language, provide consistent terminology and avoid future misunderstandings.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following Bylaw amendments and deletions (shown in red and amended by insertion or ~~deletion~~) be adopted and that the remainder of

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the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2—House of Delegates

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2.13.6 Special Committees of the House of Delegates. The House may establish special committees for specified terms of one to ~~3~~ three years. The number of members, the manner of their appointment and the functions of these committees shall be in accordance with motions authorizing their appointment. Any active member of the AMA is eligible to serve on a special committee of the House of Delegates. Members of special committees of the House of Delegates who are not members of the House of Delegates may present their reports in person to the House of Delegates and may participate in debate thereon, but are not entitled to vote in the House of Delegates. Special committees established under Bylaw 2.13.6 are distinct from committees appointed by the Board of Trustees under Section 5.3.10, and the term "special committee" as used in this Bylaw 2.13.6 refers exclusively to committees established by the House of Delegates.

2.13.6.1 Method of Reporting. Special Committees of the House of Delegates established under Bylaw 2.13.6 shall submit their reports to the House of Delegates through the Board of Trustees. The Board of Trustees may make such non-binding recommendations regarding the reports to the Special Committees as it deems appropriate, prior to transmitting the reports to the House of Delegates without delay or modifications by the Board. The Board may also submit written recommendations regarding the reports to the House of Delegates.

2.13.6.2 Special committees of the House of Delegates, regardless of their designated form, shall operate under the direction of the House and report to the Board of Trustees pursuant to Bylaw 2.13.6.1.

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2.13.7 Other Committees. The Speaker may establish ~~appoint~~ such other committees as may be desirable for the efficient transaction of business of the House of Delegates.

2.13.7.1 Appointment. The Speaker shall appoint the Chair and other members of the committees. Membership on these committees is restricted to delegates and alternate delegates.

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5—Board of Trustees

5.1.1 Officers and Committees. Immediately following the conclusion of the Annual Meeting, the Board shall organize by electing a Chair-elect~~,~~ and a Secretary, and by establishing committees necessary for its functions. The Chair shall appoint committee members.

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5.3.10 Establishment and Appointment of Advisory and Ad Hoc Committees. ~~Appoint~~ Establish such advisory and ad hoc committees as necessary to carry out the purposes of the AMA and appoint their members. Committees appointed by the Board under Bylaw 5.3.10 are distinct from special committees established by the House of Delegates under Bylaw 2.13.6.

5.3.10.1 An advisory committee will be ~~constituted~~ established by a majority vote of the Board for purposes of education and advocacy.

5.3.10.1.1 ~~It~~ An advisory committee will have a governing council and a direct reporting relationship to the Board.

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

5.3.10.1.3 An advisory committee will operate under a charter approved by the Board. The charter shall specify the committee's purpose, composition, membership criteria, terms of service for governing council members, and reporting obligations. The charter ~~that~~ will be subject to review and renewal by the Board at least every four years.

5.3.10.2 An ad hoc committee will be ~~constituted~~ established by the Board as a ~~special committee,~~ workgroup or taskforce.

5.3.10.2.1 An ad hoc committee will operate under a charter approved by the Board. The charter shall specify the committee's purpose, composition, membership criteria, terms of service for members, and reporting obligations.

5.3.10.2.2 An ad hoc committee will not have representation in the House of Delegates.

~~**5.3.10.2.1**~~

5.3.10.2.3 ~~It~~ An ad hoc committee will operate for a specific purpose and for a prescribed period of time.

(Modify Bylaws)

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CLEAN BYLAW LANGUAGE IF RECOMMENDATIONS ARE ADOPTED

2—House of Delegates

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2.13.6 Special Committees of the House of Delegates. The House may establish special committees for specified terms of one to three years. The number of members, the manner of their appointment and the functions of these committees shall be in accordance with motions authorizing their appointment. Any active member of the AMA is eligible to serve on a special committee of the House of Delegates. Members of special committees of the House of Delegates who are not members of the House of Delegates may present their reports in person to the House of Delegates and may participate in debate thereon, but are not entitled to vote in the House of Delegates. Special committees established under Bylaw 2.13.6 are distinct from committees appointed by the Board of Trustees under Section 5.3.10, and the term "special committee" as used in this Bylaw 2.13.6 refers exclusively to committees established by the House of Delegates.

2.13.6.1 Method of Reporting. Special Committees of the House of Delegates established under Bylaw 2.13.6 shall submit their reports to the House of Delegates through the Board of Trustees. The Board of Trustees may make such non-binding recommendations regarding the reports to the Special Committees as it deems appropriate, prior to transmitting the reports to the House of Delegates without delay or modifications by the Board. The Board may also submit written recommendations regarding the reports to the House of Delegates.

2.13.6.2 Special committees of the House of Delegates, regardless of their designated form, shall operate under the direction of the House and report to the Board of Trustees pursuant to Bylaw 2.13.6.1.

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2.13.7 Other Committees. The Speaker may establish such other committees as may be desirable for the efficient transaction of business of the House of Delegates.

2.13.7.1 Appointment. The Speaker shall appoint the Chair and other members of the committees. Membership on these committees is restricted to delegates and alternate delegates.

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5—Board of Trustees

5.1.1 Officers and Committees. Immediately following the conclusion of the Annual Meeting, the Board shall organize by electing a Chair-elect and a Secretary, and by establishing committees necessary for its functions. The Chair shall appoint committee members.

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5.3.10 Establishment and Appointment of Advisory and Ad Hoc Committees. Establish such advisory and ad hoc committees as necessary to carry out the purposes of the AMA and appoint their members. Committees appointed by the Board under Bylaw 5.3.10 are distinct from special committees established by the House of Delegates under Bylaw 2.13.6.

5.3.10.1 An advisory committee will be established by a majority vote of the Board for purposes of education and advocacy.

5.3.10.1.1 An advisory committee will have a governing council and a direct reporting relationship to the Board.

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

5.3.10.1.3 An advisory committee will operate under a charter approved by the Board. The charter shall specify the committee's purpose, composition, membership criteria, terms of service for governing council members, and reporting obligations. The charter will be subject to review and renewal by the Board at least every four years.

5.3.10.2 An ad hoc committee will be established by the Board as a workgroup or taskforce.

5.3.10.2.1 An ad hoc committee will operate under a charter approved by the Board. The charter shall specify the committee's purpose, composition, membership criteria, terms of service for members, and reporting obligations.

5.3.10.2.2 An ad hoc committee will not have representation in the House of Delegates.

5.3.10.2.3 An ad hoc committee will operate for a specific purpose and for a prescribed period of time.

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-I-26

Subject: Amendments to Bylaws governing the AMA Sections

Presented by: Mary Ann Contogiannis, MD, Chair

Referred to: Reference Committee on Ethics & Bylaws

Over the last year, the Board of Trustees (BOT), the AMA Sections and the Council on Constitution and Bylaws (CCB) have been discussing the intertwined relationship between the AMA Bylaws and the Sections' Rules, often referred to as Internal Operating Procedures (IOPs). Per Bylaw 7.0.7, "All rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees."

By way of background, the IOPs initially came into being nearly 20 years ago to supplement details not included in the Bylaws. In 2006, as part of a major Bylaw revision, the House of Delegates (HOD) voted to remove details regarding section operations (governing council composition, duties and responsibilities of governing council members, election procedures, meeting procedures and deadlines, to IOPs rather than include them in the Bylaws. All sections were given a template of elements that should be included in their IOPs; however, the individual section IOPs have been modified frequently and significantly over the years. CCB, per Bylaw 6.1.1.4, has served as advisory to the BOT in reviewing the rules, regulations, and procedures of the AMA Sections.

Recently, it became apparent that there is some duplication, some perceived conflicts between the Bylaws and IOPs, and some inconsistent terminology, nomenclature and procedures. Over the last year, the BOT, CCB and Section management and leadership have been collaborating to reach consensus on what belongs in Bylaws rather than IOPs, with additional some decisions yet to be finalized. The ultimate goal is to make both the Bylaws and IOPs transparent to all, minimize redundancy and be consistent across sections where possible. Future amendments likely will incorporate provisions to address any section or governing council activity that impacts the HOD.

As a starting point, CCB Report 8-A-26, Business Meetings of the Sections, provided flexibility as to when and how Sections may convene their business meetings. The adopted amended language allows a Section to convene business meetings prior to each HOD meeting without the prior restriction that a meeting must occur "a day prior" to each HOD meeting. This change allows Sections to convene virtual reference committees, finalize resolutions for submission to the HOD and hold elections as necessary, with all these functions being components of a business meeting. Other CCB reports adopted at A-26 provided additional details associated with section delegates to the HOD.

To comport with guidance from the BOT, CCB has examined the other 'overarching' rules that apply to the sections and has proposed changes in terminology for accuracy (namely disallowing reference to officers) and proposed changes to provide clarity as to the BOT's authority over sections and their IOPs. Unlike other groups with HOD delegate seats, the sections are funded and staffed by AMA and do not function autonomously as do other HOD delegations. Explanatory details regarding the Council's proposed changes are summarized below.

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Summary of Proposed Changes

Officers – The AMA Constitution defines the officers of the AMA as "the President, President-Elect, Immediate Past President, Secretary, Speaker of the House of Delegates, Vice Speaker of the House of Delegates and the other members of the Board of Trustees." Some individual section bylaws have also used the term officers to define the section leadership (chair, chair-elect, or vice chair). Within the section IOPs, there is no consistency: some consider all governing council members to be officers; some consider the chair, chair-elect (or vice chair) and immediate past chair to be the officers; and others do not use the term at all. Admittedly, current and long-standing bylaws reference section officers; however, as sections are HOD-established member component groups and funded by AMA with BOT oversight of their rules, CCB proposes to eliminate the term officers within both the section Bylaws and individual section IOPs to minimize confusion between the AMA Officers and section leaders.

Governing Council Member Qualifications – Some sections provide for a grace period to allow those who "age out" or "time out" of a section to continue service. CCB has proposed an amendment to acknowledge the existence of such provisions in the general bylaws that govern all sections.

Board Authority over IOPs – The AMA Constitution Article VI state that "The Board of Trustees shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations and such duties as prescribed in the Bylaws." Bylaws 5.3 and its subprovisions expand on the BOT's duties and privileges, with Bylaw 6.1.1.4 specifying CCB's role of serving as advisory to the BOT in reviewing the rules, regulations and procedures of the AMA Councils and Sections. CCB Report 3-I-12 which informed the House of Delegates about the differences between the AMA Bylaws and Section IOPs, noted "The Board of Trustees then reviews the updated IOP and decides whether or not to approve the proposed change." CCB offers clarifying language to reflect the BOT's authority over all governance decisions adopted by the Sections.

Updated Nomenclature re: Resident/Fellow Sectional Delegates – CCB's proposed bylaw changes to 7.1.6 reflect updated bylaw nomenclature to reference the resident and fellow sectional delegates.

Provisions to Fill Vacant Governing Council Positions – Some existing bylaw language provides more specificity regarding governing council vacancies, with most such language stating that the position remains vacant, the implication being that the vacancy will be filled at the next business meeting at which elections take place. In practice, however, while many sections fill a vacant position by election at the next election cycle, other section-specific rules allow for temporary appointments until such time at there can be an election. The proposed bylaw changes are for the sake of consistency across sections. Additionally, existing AMA Bylaws include provisions for filling section delegate and alternate delegate vacancies.

Use of the term "this bylaw" – As this appears to be a generic phrase, CCB has added more specificity for clarity.

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RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the Bylaws (shown in red and amended by insertion or ~~deletion~~) be adopted and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

7.0.1 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

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7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section. Each Section shall adopt rules governing the composition, election, terms and tenure of its Governing Council members. Each Section's ~~The~~ programs and activities, as well as its rules governing the composition, election, term and tenure of Governing Council members, shall be subject to the approval of the Board of Trustees ~~or the House of Delegates~~.

7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section, unless otherwise provided in a section-specific bylaw. A Section Governing Council member may not serve concurrently as a voting member of more than one Section Governing Council or on an AMA Council while a voting member of a Section Governing Council.

7.0.3.2 Voting. Members of each Section Governing Council, including a chair and vice chair or chair-elect, shall be elected by the voting members of the Section present at the business meeting of the Section, unless otherwise provided in ~~this Bylaw~~ a section-specific bylaw.

~~**7.0.3.3 Additional Requirements.** Each Section shall adopt rules governing the composition, election, term, and tenure of its Governing Council.~~

~~**7.0.4 Officers.** Each Section shall select a Chair and Vice Chair or Chair-Elect and other necessary and appropriate officers.~~

~~**7.0.4.1 Qualifications.** Officers of each Section must be members of the AMA and of the Section.~~

~~**7.0.4.2 Voting.** Officers of each Section shall be elected by the voting members of the Section, unless otherwise provided in this Bylaw.~~

~~**7.0.4.3 Additional Requirements.** Each Section shall adopt rules governing the titles, duties, election, term, and tenure of its officers.~~

7.0.4
~~**7.0.5**~~ **Delegate and Alternate Delegate.** Each Section shall elect a Delegate and Alternate Delegate to represent the Section in the House of Delegates, consistent with Bylaw 2.6.

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7.0.5
~~7.0.6~~ **Business Meetings.** There shall be a Business Meeting of members of each Section prior to each meeting of the House of Delegates.

7.0.5.1
~~7.0.6.1~~ **Purpose.** The purposes of the Business Meeting shall be:

7.0.5.1.1
~~7.0.6.1.1~~ To hear such reports and resolutions as may be appropriate.

7.0.5.1.2
~~7.0.6.1.3~~ To adopt resolutions for submission by the Section to the House of Delegates.

7.0.5.1.3
~~7.0.6.1.2~~ To consider other business and vote upon such matters as may properly come before the meeting.

7.0.5.1.4 To develop a section position on pending House of Delegates business items.

7.0.5.1.5
~~7.0.6.1.4~~ To hold elections for Governing Council members, unless otherwise specified in a section-specific bylaw.

7.0.6
~~7.0.7~~ **Rules.** All rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees. The Board of Trustees may approve, not approve, or approve with required modifications.

7.1 Resident and Fellow Section. ***

7.1.2 Cessation of Eligibility. If a~~ny officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant. If ~~the officer or~~ a member completes residency or fellowship within 90 days prior to an Annual Meeting, the ~~officer or~~ member shall be permitted to continue to serve in office until the completion of the Annual Meeting. An immediate past chair who completes residency or fellowship during their term as immediate past chair shall be permitted to serve as a nonvoting ex officio member of the Governing Council for the remainder of their immediate past chair term.

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7.1.6 Additional Purposes of the Meeting. In addition to the purposes of the Business Meeting set forth in Bylaw ~~7.0.6.1~~ 7.0.5.1, the purposes of the meeting shall include:

7.1.6.1 To adopt procedures for election of the resident and fellow sectional delegates and alternate delegates ~~for the Resident and Fellow Section~~ established in Bylaw 2.4, subject to the approval of the Board of Trustees.

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7.1.6.2 To elect, at the business meeting prior to the Interim Meeting of the House of Delegates ~~AMA~~, resident and fellow sectional delegates and alternate delegates ~~for the Resident and Fellow Section~~. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

7.2 Academic Physicians Section. ***

7.2.2 Elections. Membership on the Governing Council shall be determined through election by members of the Academic Physicians Section. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.2.2.1 Cessation of Eligibility. If a~~ny~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.2.1 prior to the expiration of the term for which elected, the term of such Governing Council member shall terminate and the position shall be declared vacant.

7.3 Medical Student Section. ***

7.3.2 Cessation of Eligibility. If a~~ny officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant. If the ~~officer or~~ member graduates from an educational program during their term, the ~~officer or~~ member shall be permitted to continue to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

***

7.3.4 Additional Purposes of the Meeting. In addition to the purposes of the Business Meeting set forth in Bylaw ~~7.0.6.1~~ 7.0.5.1, the purposes of the meeting shall include:

7.3.4.1 To elect the medical student trustee at the Business Meeting prior to the Interim Meeting of the House of Delegates ~~AMA~~., as provided in Bylaw 3.5.6.1.

7.3.4.2 To adopt procedures for election of ~~Medical Student Regional~~ medical student regional delegates and alternate delegates to the House of Delegates as established in Bylaw 2.3.3, subject to the approval of the Board of Trustees.

7.3.4.3 To elect ~~Medical Student Regional~~ medical student regional delegates and alternate delegates at the business meeting prior to the Interim Meeting of the House of Delegates ~~AMA~~. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

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7.4 Organized Medical Staff Section. ***

7.4.3 Cessation of Eligibility. If a~~ny officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.4.1 or ceases to be credentialed as a representative consistent with Bylaw 7.4.2 prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant.

7.5 Young Physicians Section. ***

***

7.6 International Medical Graduates Section. ***

7.6.2
~~7.6.3~~ Elections. Membership on the Governing Council shall be determined through election by members of the IMG Section. Designation of specific offices of the Governing Council members shall be determined through election by members of the IMG Section present at the Section's Business Meeting at which the election is held.

7.6.2.1
~~7.6.3.1~~ Election of Governing Council Members. All members of the IMG Section shall be entitled to vote in elections of membership of the Governing Council. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.6.2.2
~~7.6.3.2~~ ~~Designation of Specific Offices~~. Election of the Chair-elect. All members of the IMG Section present at the Section's Business Meeting shall be entitled to elect the Chair-elect from among those Governing Council members elected by the Section. ~~Only~~ R~~r~~esident/fellow physicians shall be eligible to be elected only to the resident/fellow physician member ~~office~~ position.

7.6.3
~~7.6.2~~ Cessation of ~~Membership~~ Eligibility. If a~~ny~~ ~~officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.6.1 prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant.

7.7 Underrepresented in Medicine Advocacy Section. ***

7.7.2 Elections. Membership on the Governing Council shall be determined through election by members of the Underrepresented in Medicine Advocacy Section. All members of the Underrepresented in Medicine Advocacy Section, except provisional members, shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

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7.7.2.1 Election of ~~Officers~~ the Chair and Vice Chair. The Governing Council shall elect ~~its~~ a Chair and Vice Chair from among ~~the~~ those Governing Council members elected by the Section.

7.7.2.2 Election of Alternate Delegate. The Governing Council shall elect an Alternate Delegate from among those Governing Council members elected by the Section.

7.7.3 Cessation of ~~Membership~~ Eligibility. If a~~ny officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.7.1 prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant.

7.7.3.1 Designated Section ~~Representatives~~ Member on the Governing Council. If ~~a representative~~ the designated member of the Resident and Fellow Section or Young Physicians Section who has been elected to the Governing Council ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If ~~a representative~~ the designated member of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

7.7.3.2 Designated Section ~~Representative~~ Member as Immediate Past Chair. A designated Section ~~representative~~ member who has been elected as C~~e~~hair of the Governing Council, but who ceases to meet the criteria for membership in the section from which elected during their term as Immediate Past Chair, shall be permitted to complete the term of office, as long as ~~the officer~~ they remain~~s~~ an active physician member of the AMA.

7.8 Integrated Physician Practice Section. ***

7.8.2 Governing Council ~~and Officers~~. Only Associate Members of the Section are eligible to ~~hold office or~~ serve on the Governing Council and vote in elections and on items of business.

7.8.3 Cessation of ~~Membership~~ Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.8.1.1 prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant~~ and a successor will be elected~~.

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7.9 Senior Physicians Section. ***

7.9.2 Elections. Membership on the Governing Council shall be determined through election by members of the Senior Physicians Section. All members of the Senior Physicians Section shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.9.2.1 Election of Chair-Elect. ~~Officers.~~ The Governing Council shall elect ~~the Section~~ its Chair-Elect from among ~~the~~ those Governing Council members elected by the Section.

7.9.3 Cessation of ~~Membership~~ Eligibility. If a~~n officer or~~ Governing Council member ceases to be an active member of the AMA prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant.

7.10 Women Physicians Section. ***

7.10.2 Elections. Membership on the Governing Council shall be determined through election by members of the Women Physicians Section. All members of the Women Physicians Section shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.10.2.1 Election of ~~Officers~~ Governing Council Leadership. The Governing Council shall elect its Chair and Vice Chair from among the Governing Council members.

7.10.3 Cessation of ~~Membership~~ Eligibility. If a~~n officer or~~ Governing Council member ceases to be an active member of the AMA prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant.

7.11 Private Practice Physicians Section. The Private Practice Physicians Section is a delineated Section.

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7.11.3 Cessation of ~~Membership~~ Eligibility. If a~~n officer or~~ Governing Council member ceases to meet the membership requirements of Bylaw 7.11.1 prior to the expiration of the term for which elected, the term of such officer or member shall immediately terminate and the position promptly shall be declared vacant.

7.12 LGBTQ+ Section. The LGBTQ+ Section is a delineated Section.

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7.12.2 Elections. Any Section member is eligible to ~~hold office or~~ serve on the Governing Council. All members of the Section shall be entitled to vote in elections. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Section and approved by the Board of Trustees.

7.12.2.1 The Governing Council shall ~~annually~~ elect its Chair and Vice Chair from among the Governing Council members elected by Section members.

7.12.3
~~**7.12.2.2**~~**Cessation of Eligibility.** If a Governing Council member ceases to meet the membership requirements of Bylaw 7.12.1 prior to the expiration of the term for which elected, the term of such ~~officer or~~ member shall terminate and the position shall be declared vacant ~~and a successor will be elected~~.

7.12.3.1
~~**7.12.2.3**~~ **Cessation of Eligibility of Designated Section Members.** If ~~any~~ the designated member of the Resident and Fellow Section ~~resident/fellow~~ or ~~young physician member~~ Young Physicians Section who has been elected to ~~of~~ the governing council ceases to meet the criteria for membership in their respective section ~~they represent~~ within 90 days prior to the Annual Meeting they will be permitted to continue to serve in their position until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of their section. If the designated member of the Medical Student Section ~~any medical student member~~ graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

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CLEAN BYLAW LANGUAGE IF RECOMMENDATIONS ARE ADOPTED

7.0.1 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

***

7.0.3 Governing Council. There shall be a Governing Council for each Section to direct the programs and the activities of the Section. Each Section shall adopt rules governing the composition, election, terms and tenure of its Governing Council members. Each Section's programs and activities, as well as its rules governing the composition, election, term and tenure of Governing Council members, shall be subject to the approval of the Board of Trustees.

7.0.3.1 Qualifications. Members of each Section Governing Council must be members of the AMA and of the Section, unless otherwise provided in a section-specific bylaw. A Section Governing Council member may not serve concurrently as a voting member of more than one Section Governing Council or on an AMA Council while a voting member of a Section Governing Council.

7.0.3.2 Voting. Members of each Section Governing Council, including a chair and vice chair or chair-elect, shall be elected by the voting members of the Section present at the business meeting of the Section, unless otherwise provided in a section-specific bylaw.

7.0.4 Delegate and Alternate Delegate. Each Section shall elect a Delegate and Alternate Delegate to represent the Section in the House of Delegates, consistent with Bylaw 2.6.

7.0.5 Business Meetings. There shall be a Business Meeting of members of each Section prior to each meeting of the House of Delegates.

7.0.5.1 Purpose. The purposes of the Business Meeting shall be:

7.0.5.1.1 To hear such reports and resolutions as may be appropriate.

7.0.5.1.2 To adopt resolutions for submission by the Section to the House of Delegates.

7.0.5.1.3 To consider other business and vote upon such matters as may properly come before the meeting.

7.0.5.1.4 To develop a section position on pending House of Delegates business items.

7.0.5.1.5 To hold elections for Governing Council members, unless otherwise specified in a section-specific bylaw.

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7.0.6 Rules. All rules, regulations, and procedures adopted by each Section shall be subject to the approval of the Board of Trustees. The Board of Trustees may approve, not approve, or approve with required modifications.

7.1 Resident and Fellow Section. ***

7.1.2 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If a member completes residency or fellowship within 90 days prior to an Annual Meeting, the member shall be permitted to continue to serve in office until the completion of the Annual Meeting. An immediate past chair who completes residency or fellowship during their term as immediate past chair shall be permitted to serve as a nonvoting ex officio member of the Governing Council for the remainder of their immediate past chair term.

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7.1.6 Additional Purposes of the Meeting. In addition to the purposes of the Business Meeting set forth in Bylaw 7.0.5.1, the purposes of the meeting shall include:

7.1.6.1 To adopt procedures for election of the resident and fellow sectional delegates and alternate delegates established in Bylaw 2.4, subject to the approval of the Board of Trustees.

7.1.6.2 To elect, at the business meeting prior to the Interim Meeting of the House of Delegates, resident and fellow sectional delegates and alternate delegates. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

7.2 Academic Physicians Section. ***

7.2.2 Elections. Membership on the Governing Council shall be determined through election by members of the Academic Physicians Section. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.2.2.1 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.2.1 prior to the expiration of the term for which elected, the term of such Governing Council member shall terminate and the position shall be declared vacant.

7.3 Medical Student Section. ***

7.3.2 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant. If the member graduates from an educational program during their term, the member shall be permitted to continue to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

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7.3.4 Additional Purposes of the Meeting. In addition to the purposes of the Business Meeting set forth in Bylaw 7.0.5.1, the purposes of the meeting shall include:

7.3.4.1 To elect the medical student trustee at the Business Meeting prior to the Interim Meeting of the House of Delegates, as provided in Bylaw 3.5.6.1.

7.3.4.2 To adopt procedures for election of medical student regional delegates and alternate delegates to the House of Delegates as established in Bylaw 2.3.3, subject to the approval of the Board of Trustees.

7.3.4.3 To elect medical student regional delegates and alternate delegates at the business meeting prior to the Interim Meeting of the House of Delegates. Elected delegates and alternate delegates shall be seated at the Annual Meeting of the House of Delegates.

7.4 Organized Medical Staff Section. ***

7.4.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.4.1 or ceases to be credentialed as a representative consistent with Bylaw 7.4.2 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.5 Young Physicians Section. ***

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7.6 International Medical Graduates Section. ***

7.6.2 Elections. Membership on the Governing Council shall be determined through election by members of the IMG Section. Designation of specific offices of the Governing Council members shall be determined through election by members of the IMG Section present at the Section's Business Meeting at which the election is held.

7.6.2.1 Election of Governing Council Members. All members of the IMG Section shall be entitled to vote in elections of membership of the Governing Council. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.6.2.2 Election of the Chair-elect. All members of the IMG Section present at the Section’s Business Meeting shall be entitled to elect the Chair-elect from among those Governing Council members elected by the Section. Resident/fellow physicians shall be eligible to be elected only to the resident/fellow physician member position.

7.6.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.6.1 prior to the expiration of the term for

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which elected, the term of such member shall terminate and the position shall be declared vacant.

7.7 Underrepresented in Medicine Advocacy Section. ***

7.7.2 Elections. Membership on the Governing Council shall be determined through election by members of the Underrepresented in Medicine Advocacy Section. All members of the Underrepresented in Medicine Advocacy Section, except provisional members, shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.7.2.1 Election of the Chair and Vice Chair. The Governing Council shall elect a Chair and Vice Chair from among those Governing Council members elected by the Section.

7.7.2.2 Election of Alternate Delegate. The Governing Council shall elect an Alternate Delegate from among those Governing Council members elected by the Section.

7.7.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.7.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.7.3.1 Section Member on the Governing Council. If a member of the Resident and Fellow Section or Young Physicians Section who has been elected to the Governing Council ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of the respective section. If a member of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

7.7.3.2 Section Member as Immediate Past Chair. A Section member who has been elected as Chair of the Governing Council, but who ceases to meet the criteria for membership in the section from which elected during their term as Immediate Past Chair, shall be permitted to complete the term of office, as long as they remain an active physician member of the AMA.

7.8 Integrated Physician Practice Section. ***

7.8.2 Governing Council. Only Associate Members of the Section are eligible to serve on the Governing Council and vote in elections and on items of business.

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7.8.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.8.1.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.9.2.1 Election of Chair-Elect. The Governing Council shall elect a Chair-Elect from among those Governing Council members elected by the Section.

7.9 Senior Physicians Section. ***

7.9.2 Elections. Membership on the Governing Council shall be determined through election by members of the Senior Physicians Section. All members of the Senior Physicians Section shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.9.2.1 Election of Chair-Elect. The Governing Council shall elect its Chair-Elect from among those Governing Council members elected by the Section.

7.9.3 Cessation of Eligibility. If a Governing Council member ceases to be an active member of the AMA prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.10 Women Physicians Section. ***

7.10.2 Elections. Membership on the Governing Council shall be determined through election by members of the Women Physicians Section. All members of the Women Physicians Section shall be entitled to vote in elections of Governing Council members. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Governing Council and approved by the Board of Trustees.

7.10.2.1 Election of Governing Council Leadership. The Governing Council shall elect its Chair and Vice Chair from among the Governing Council members.

7.10.3 Cessation of Eligibility. If a Governing Council member ceases to be an active member of the AMA prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.11 Private Practice Physicians Section. ***

7.11.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.11.1 prior to the expiration of the term for which elected, the term of such member shall immediately terminate and the position promptly shall be declared vacant.

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7.12 LGBTQ+ Section. The LGBTQ+ Section is a delineated Section.

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7.12.2 Elections. Any Section member is eligible to serve on the Governing Council. All members of the Section shall be entitled to vote in elections. Ballot distribution and the voting process shall be conducted pursuant to election procedures adopted by the Section and approved by the Board of Trustees.

7.12.2.1 The Governing Council shall elect its Chair and Vice Chair from among the Governing Council members elected by Section members.

7.12.3 Cessation of Eligibility. If a Governing Council member ceases to meet the membership requirements of Bylaw 7.12.1 prior to the expiration of the term for which elected, the term of such member shall terminate and the position shall be declared vacant.

7.12.3.1 Cessation of Eligibility of Designated Section Members. If the designated member of the Resident and Fellow Section or Young Physicians Section who has been elected to the governing council ceases to meet the criteria for membership in their respective section within 90 days prior to the Annual Meeting they will be permitted to continue to serve in their position until the conclusion of the Annual Meeting in the calendar year in which they cease to meet the membership requirement of their section. If the designated member of the Medical Student Section graduates from an educational program during their governing council term, such medical student member shall be permitted to serve in office for up to 200 days after graduation but not extending past the completion of the Annual Meeting following graduation.

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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 3-I-26

Subject: Autonomy of House of Delegate Member Entities: Bylaw Clarification

Presented by: Mary Ann Contogiannis, MD, Chair

Referred to: Reference Committee on Ethics & Bylaws

Following the adoption of several reports of the Council on Constitution and Bylaws (CCB) at the last House of Delegates meeting (HOD), some questions have arisen from AMA leadership, Federation members and individual members of the AMA Sections regarding the accuracy of AMA Bylaw language that discusses the autonomy of the various entities represented in the HOD.

The HOD comprises delegates and alternate delegates from the following types of independent legally constituted entities: constituent associations (US geographical medical societies), national medical specialty societies (scientific specialties and subspecialty organizations, with admittance and continued representation governed by the AMA Specialty and Service Society), professional interest medical associations (physician organizations who represent their members' ethnic, cultural, demographic, minority or other interests, with admittance and continued representation governed by the SSS), the federal services (Army, Navy, Air Force, US Public Health Service and the Chief Medical Director of the Department of Veterans Affairs), the National Medical Association, the American Medical Women's Association, and the American Osteopathic Association. The HOD also includes delegates from the AMA Sections (Medical Student Section, Resident and Fellow Section, Young Physicians Section, Senior Physicians Section, International Medical Graduates Section, Underrepresented in Medicine Advocacy Section, LGBTQ+ Section, Academic Physicians Section, Integrated Physicians Practice Section, Organized Medical Staff Section, Women Physicians Section, and Private Practice Physicians Section). The AMA Sections are member component groups and are funded and staffed by AMA. The Sections were formed to give voice to a distinct group of AMA members who were underrepresented in the HOD. Additionally, the HOD includes the medical student regional delegates and the resident and fellow sectional delegates. These individuals are elected either by the MSS or the RFS, have a requisite endorsement from a constituent association, a national medical specialty society or professional interest medical association, with their funding derived from various sources (self-funding, constituent society, specialty society, or educational program).

To be accurate and minimize further confusion, CCB has proposed some bylaw amendments to clarify the autonomy of these various represented entities.

RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the Bylaws (shown in red and amended by insertion or ~~deletion~~) be adopted and that the remainder of the report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting following a one-day layover.

2—House of Delegates

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2.0.1 Composition and Representation. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw. A delegate may introduce resolutions into the House of Delegates, speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, vote on items of business and vote in elections.

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2.0.1.6 Autonomy. The participation of any independent organization in the House of Delegates that is not an AMA Member Component Group is voluntary. Policy actions of the AMA do not in themselves bind an independent organization or subject it to any obligation that it does not voluntarily assume.

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7—Sections

7.0.1 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

7.0.1.1 Involvement. To provide a direct means for membership segments represented in the Sections to participate in the activities, including policy-making, of the AMA.

7.0.1.2 Outreach. To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections.

7.0.1.3 Communication. To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section.

7.0.1.4 Membership. To promote AMA membership growth.

7.0.1.5 Representation. To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates.

7.0.1.6 Education. To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.

7.0.1.7 Support. Sections are established by the House of Delegates as Member Component Groups of the AMA, function under Rules approved by the Board of Trustees, and do not function autonomously. While the Sections may generate internal section positions to guide their advocacy within the House of Delegates, they may only create policy through the House of Delegates and are bound by AMA policy outside of the HOD. Section governing council members are not officers of the AMA and are not permitted to speak on behalf of the AMA, unless explicitly designated to do so by the Board of Trustees.

(Modify Bylaws)

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RELEVANT AMA POLICY

G-615.002, AMA Member Component Groups. A "Section" is a formal group of physicians or medical students directly involved in policymaking through a delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Each Section will continue to have representation in the House of Delegates. There will be two types of Sections, fixed and delineated.
"Fixed Sections" will represent the natural cycles related to a physician's career span. Since members of these groups would have limited opportunities for representation through their state/specialties societies, the need for focused representation will be enduring.
"Delineated Sections" will allow a voice in the house of medicine for large groups of physicians, who are connected through a unique perspective, but may be underrepresented. These Sections will often be based on demographics or mode of practice. Delineated Sections will have a single delegate and alternate delegate in the HOD, and will operate under Internal Operating Procedures approved by the Board of Trustees. Delineated Sections will be reviewed every 5 years by the Council on Long Range Planning, which will make recommendations through the Board of Trustees to the House of Delegates, for renewal of the Section, based on criteria adopted by the House. The review provision allows for fluidity in the Association's structure as the activities and impact of the member groups are routinely evaluated.

G-615.001, Establishment and Function of Sections

1. Our American Medical Association adopts the following criteria in consideration of requests for establishing new **sections** or changing the status of member component groups:
    a. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.
    b. Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.
    c. Appropriateness - The structure of the group will be consistent with its objectives and activities.
    d. Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members. It is important to note this threshold will not be used to determine representation as each new group will be allocated only one delegate and one alternate delegate.
    e. Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.
    f. Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD.
2. Our AMA will consider requests for establishing new **sections** by letter of application to the CLRPD, which will make recommendations to the BOT and HOD for further action or by submission of a resolution.

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CLEAN BYLAW LANGUAGE IF RECOMMENDATIONS ARE ADOPTED

2—House of Delegates

2.0.1 Composition and Representation. The House of Delegates is composed of delegates selected by recognized constituent associations and specialty societies, and other delegates as provided in this bylaw. A delegate may introduce resolutions into the House of Delegates, speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, vote on items of business and vote in elections.
***

2.0.1.6 Autonomy. The participation of any independent organization in the House of Delegates that is not an AMA Member Component Group is voluntary. Policy actions of the AMA do not in themselves bind an independent organization or subject it to any obligation that it does not voluntarily assume.

***

7—Sections

7.0.1 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

7.0.1.1 Involvement. To provide a direct means for membership segments represented in the Sections to participate in the activities, including policy-making, of the AMA.

7.0.1.2 Outreach. To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections.

7.0.1.3 Communication. To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section.

7.0.1.4 Membership. To promote AMA membership growth.

7.0.1.5 Representation. To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates.

7.0.1.6 Education. To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.

7.0.1.7 Support. Sections are established by the House of Delegates as Member Component Groups of the AMA, function under Rules approved by the Board of Trustees, and do not function autonomously. While the Sections may generate internal section positions to guide their advocacy within the House of Delegates, they may only create policy through the House of Delegates and are bound by AMA policy outside of the HOD. Section governing council members are not officers of the AMA and are not permitted to speak on behalf of the AMA, unless explicitly designated to do so by the Board of Trustees.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 01-I-26

Subject: Preserving Autonomy in the Patient-Physician Relationship

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting, the AMA House of Delegates adopted Policy D-140.944, "Preserving Autonomy in the Patient-Physician Relationship," which states:

> Our American Medical Association will 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.

This report is submitted for the information of the House of Delegates in fulfillment of the above directive and outlines relevant opinions in the *Code of Medical Ethics* that address outside political and administrative impact on the patient-physician relationship and shared decision-making.

BACKGROUND

There is a general sense among physicians that as medicine continues down a path of market consolidation and deprofessionalization, physicians are losing autonomy to the detriment of patient care and wellbeing, and that they are facing increasing pressure and overreach by political actors and administrators.[1] A 2025 survey by The Physicians Foundation found that 91 percent of physicians believe that loss of autonomy is a major threat that will exacerbate the physician shortage, with potentially grave impacts for patients.[2] In today's heightened political climate, certain physician specialties have raised warnings about governmental incursion into their medical practices, negatively impacting the patient-physician relationship and shared decision-making. Research on physicians who provide family planning care,[3] obstetrician-gynecologists,[4] neonatology and pediatrics,[5] and physicians who provide gender-affirming care[6] all suggest that bans and other forms of political influence undermine evidence-based practices, negatively impact the patient-physician relationship and shared decision-making, and ultimately harm patients.

ETHICS ISSUE

Society has an obligation to support, or at minimum not to impede, the practice of medicine. However, many people today feel that this social obligation is being infringed upon or even overtly ignored. Physicians are frustrated by what many see as increasing outside political and administrative influences on the patient-physician relationship and their impact on shared decision-making in the clinical setting. There are valid concerns that these influences constrain physicians from practicing medicine in an ethically or professionally appropriate manner. At question is

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whether the AMA's *Code of Medical Ethics* adequately addresses outside political and administrative influence. It is important to bear in mind that the *Code* is only upheld by physicians, it is an ethics document without legal force in most cases (though some states have enshrined the *Code* in their state's laws), and any such changes are unlikely to reduce the influences of outside political and administrative forces.

RELEVANT AMA POLICY PROVISIONS

Substantial policy exists to uphold and protect the patient-physician relationship and shared medical decision-making. Multiple policies specifically outline our AMA's opposition to political interference with clinical care. Policy H-140.835, "Political Interference in the Patient-Physician Relationship," states that our AMA opposes any policies that interfere with the patient-physician relationship or that impose legislative barriers to medical decision-making. Policy H-373.995, "Government Interference in Patient Counseling," upholds the sanctity of the physician-patient-family relationship and opposes state and/or federal interference that may compromise a physician's ability to deliver quality care or effective communication without a compelling evidence-base. And Policy H-270.959, "AMA Stance on the Interference of the Government in the Practice of Medicine," is explicit: "[o]ur American Medical Association opposes the interference of government in the practice of medicine".

With respect to administrative influence, Policy H-160.887, "Corporate Practice of Medicine," acknowledges the potential risk to the patient-physician relationship posed by the corporatization of medicine and, indirectly, any associated administrative overreach. Policy H-165.837, "Protecting the Patient-Physician Relationship," outlines that physicians have an obligation to advocate for patients as a means to protect and support the patient-physician relationship, which can be understood to include advocacy in light of either negative political or administrative influences. And Policy D-140.948, "The Preservation of the Primary Care Relationship," directs our AMA to "uphold the sanctity of the patient-physician relationship, irrespective of healthcare system pressures or economic incentives."

Importantly, our AMA has established a task force charged with preserving the patient-physician relationship, as directed by Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted." This task force is obligated to present annual reports on their work with recommendations for future actions, as outlined in by Policy D-5.998, "Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era," and Policy D-605.982, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance."

RELEVANT *CODE* OPINIONS

The *Code of Medical Ethics* is quite clear on the sanctity of the patient-physician relationship and the importance of shared decision-making, and repeatedly outlines physicians' ethical obligations to support and uphold them. Nowhere is this more clearly defined than in the opening opinion to the *Code*, Opinion 1.1.1, "Patient Physician Relationships," which was recently revised and adopted at the 2025 Interim Meeting, and which added language specifically addressing outside influences. The body of that newly adopted report directly addressed financial, political, and administrative influences, and new language in the opinion states, "[w]hen external influences negatively impact this trust, or the patient-physician relationship directly, physicians individually and collectively should advocate for changes to ameliorate the situation and promote a more hospitable environment in which patient-physician relationships may flourish."

Additionally, Opinion 11.1.4 , "Financial Barriers to Health Care Access," states that all stakeholders, including policymakers and administrators, must work together to ensure access to appropriate care. Opinion 11.2.1, "Professionalism in Health Care Systems," outlines that physicians have an ethical responsibility to hold leadership accountable and to advocate for change if policies create barriers to equal access to high-quality care. Opinion 11.2.3, "Contracts to Deliver Health Care Services," states that all physicians "who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession." Opinion 11.2.4, "Transparency in Health Care," stipulates that physicians have an obligation to inform patients of any information that may influence treatment recommendations or care, which could include political or administrative constraints. And Opinion 11.2.7, "Responsibilities to Promote Equitable Care," states that hospitals and other healthcare institutions share a duty with physicians to ensure that patient care is "safe, effective, patient centered, timely, efficient, and equitable."

ETHICS ANALYSIS & CONCLUSION

The issue of political, outside, and systems-level influence on the provision of health care and on the patient-physician relationship, specifically, has recently been addressed by CEJA reports on revised Opinion 1.1.1 "Patient-Physician Relationships" and the new report on "Health Care Systems." Several additional *Code* opinions emphasize the importance and ethical obligation of physician advocacy and physicians' duty to be transparent with patients, which could be interpreted to include disclosure of outside political or administrative influences that impact the provision of care. There is also significant relevant AMA policy on the issue. The matter of protecting the patient-physician relationship and shared medical decision-making is of vital importance. CEJA would like to acknowledge the work of the AMA Task Force to Preserve the Patient-Physician Relationship and acknowledge the substantive ethics policy outlined in the *Code* that supports their work.

The *Code of Medical Ethics* and related AMA policies are clear that the patient-physician relationship and the process of shared medical decision-making that occurs within that relationship must be upheld and protected from any negative outside influence.

RECOMMENDATIONS

The Council on Ethical and Judicial affairs recommends that Policy D-140.944 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-I-26

Subject: Clarifying Conscientious Objection

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting, the AMA House of Delegates adopted Policy D-140.945, "Clarifying Conscientious Objection," which states:

1. Our American Medical Association will 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.
2. Our AMA will 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.

This report is submitted for the information of the House of Delegates in fulfillment of the second directive and outlines relevant opinions in the *Code of Medical Ethics* that address ethical issues related to physician conscientious objection, discrimination, and equitable access to care. Board of Trustees Report 22-I-26, "Clarifying Conscientious Objection," addresses the first directive separately.

BACKGROUND

Over the past decade, there has been a growing focus on physician exercise of conscientious objection and the tension between upholding physician autonomy while also protecting patients and patient populations from discrimination.[1-6] Proponents of conscientious objection believe that it is essential to ensuring physicians maintain independent professional judgments and acts as a check against external influence by the state and administrative pressures.[1] Critics of conscientious objection point to a legal history of conscientious objection clauses as stemming from religious anti-abortion beliefs and argue that the practice is harmful and derogatory.[2] As legal protections for physicians to exercise conscientious objection of care continue to grow, moving well beyond issues of abortion to include the provision of contraception, sterilization, gender-affirming care, and other services, there is valid concern that the practice is being used to target specific groups of patients, placing physician choice above patient's rights.[3,7,8]

ETHICS ISSUE

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Physicians maintain the right to exercise their conscious to practice medicine in alignment with "well-considered, deeply held beliefs that are central to their self-identities" (Opinion 1.1.7). Therefore, physicians may conscientiously object to initiating a patient-physician relationship or treating a patient in keeping with their beliefs as outlined in the *Code of Medical Ethics*. An ethical issue emerges, however, when a physician exercises their conscience in such a way that it rises to the level of discrimination against an individual patient or patient population. The primary concern raised by the second directive of Policy D-140.945, "Clarifying Conscientious Objection," is whether the *Code* sufficiently protects patients and the profession against such instances of discrimination.

RELEVANT *CODE* OPINIONS

Several opinions in the AMA *Code of Medical Ethics* pertain to the issues surrounding physicians exercising conscientious refusal of care. Opinion 1.1.7, "Physician Exercise of Conscience," clearly states that physicians may ethically act or refrain from acting in accordance with their conscience but that their actions may not discriminate or unduly burden individual patients or patient populations and must not violate their professional obligations. This includes exercising their conscience while simultaneously upholding their obligations to patient rights (Opinion 1.1.2) and providing equitable care (Opinion 11.2.7). Opinion 1.1.2 "Prospective Patients," similarly states that physicians must not discriminate against prospective patients on the basis of non-clinically relevant characteristics. The aforementioned *Code* opinions, as well Opinion 1.1.3 "Patient Rights," clearly oppose invidious discrimination.

The Principles laid out in the *Code of Medical Ethics,* taken as a whole, likewise support physicians' right to exercise conscience within legal, professional, and ethical constraints that protect patients and uphold their rights to respect and human dignity. Importantly, Principle IX is explicit that physicians have an ethical and professional responsibility to "support access to medical care for *all* people" (emphasis added).

ETHICS ANALYSIS & CONCLUSION

The growing focus, both legal and professional, on physician exercise of conscience to refuse care to patients should continue to be monitored. While physicians must be allowed the freedom to exercise their independent professional judgment and uphold their autonomy, such rights should not come at the cost of harming individual patients or patient populations. As outlined in the *Code of Medical Ethics*, physicians have a right to exercise their conscience so long as doing so does not constitute discrimination (Opinions 1.1.2, 1.1.7). Physicians have an ethical and professional obligation to uphold the patient-physician relationship through a commitment to act in the patient's best interest, respect patients as persons, provide clear communication, and maintain professional competence (Opinion 1.1.1). For physician conscience, this entails an obligation to communicate clearly and respectfully with patients about any decision to refuse to provide care and to also provide a referral to ensure the rights of patients are respected. The *Code of Medical Ethics* and its corresponding Principles are clear that a physician's right to choose their patients is appropriately limited by their duty to provide equitable access to care.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the second directive of Policy D-140.945 be rescinded as having been accomplished by this report.

Fiscal Note: Minimal

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REPORT 03 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-26)
Guidelines on Chaperones for Sensitive Exams

EXECUTIVE SUMMARY

In this report, the Council on Ethical and Judicial Affairs considers the appropriate use of chaperones for sensitive exams and, in general, how to create safe environments for all patients while maintaining professional boundaries. The report recommends revising Opinion 1.2.4, "Use of Chaperones," to reflect current best practices for sensitive exams. New recommendations include: (1) adoption of an "opt-out" approach for sensitive exams in routine circumstances, (2) guidance for when a physician may require a chaperone even if the patient declines, and (3) guidance for sensitive examinations and persons who cannot give informed consent, including children and adolescents.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 03-I-26

Subject: Guidelines on Chaperones for Sensitive Exams

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy D-140.950, "Guidelines on Chaperones for Sensitive Exams," was adopted at the 2022 Interim Meeting and reads as follows:

> Our American Medical Association will ask the Council on Ethical and Judicial Affairs to consider amending E-1.2.4, "Use of Chaperones in the *Code of Medical Ethics*," to ensure that it is most in line with the current best practices for adult and pediatric populations and potentially considers the following topics:
>
> a. Opt-out chaperones for breast, genital, and rectal exams.
> b. Documentation surrounding the use or not-use of chaperones.
> c. Use of chaperones for patients without capacity.
> d. Asking patients' consent regarding the gender of the chaperones and attempting to accommodate that preference as able.
> e. Use of chaperone at physician request when physician deems necessary.

To fulfil this directive, the Council on Ethical and Judicial Affairs (CEJA) submitted Report 7, "Guidelines on Chaperones for Sensitive Exams," for consideration at the 2025 Annual Meeting. The report was referred with concerns expressed that the report did not adequately address certain issues such as physician safety, the economic hurdles of training and staffing chaperones, and challenges related to varying clinical scenarios, such as those posed by rural hospitals. This report includes recommendations that address these concerns.

BACKGROUND

Conducting sensitive examinations in an ethically and clinically sound manner requires physicians to be responsive to both the distinctive characteristics of the individual patient and the boundaries appropriate to the patient-physician relationship. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region or the rectum, physicians should be aware that a patient's personal history, including their cultural background and beliefs or identity, may broaden their definition of what constitutes a sensitive examination or procedure.[1] Efforts to provide a comfortable and considerate atmosphere for the patient during sensitive exams are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clear

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explanations of various components of the physical examination. They also include the use of chaperones regardless of the gender of the physician or patient.[2]

A chaperone is a trained professional who serves as a support and witness for a patient during an exam or procedure.[1] If the chaperone is trained to do so, they may also assist the clinician with equipment and specimen handling. The use of chaperones is appropriate in a variety of specialties and clinical settings.[3] Several states have implemented legal mandates ranging in stringency from requiring that physicians offer a chaperone for sensitive examinations to constituting any exam without a chaperone of a patient's genitals or breasts by a physician of the opposite gender as professional misconduct.[4] Physicians should therefore make themselves aware of local regulations when they consider their chaperone policy.

Having chaperones present can help prevent misunderstandings between the patient and physician and can protect the integrity of the patient-physician relationship. A fair and effective policy on the use of chaperones must balance: (1) concern for both physician and patient safety, dignity, and vulnerability; (2) respect for patient preferences; and (3) the ethical responsibility to maintain clear professional boundaries.

In most instances, only an authorized member of the healthcare team should serve as a chaperone and understand the responsibilities of the role. Broadly speaking, chaperones should be provided with information regarding[5]:

- Expected components of the procedures they will be observing;
- Ways to ensure patient comfort during the examination or procedure;
- Appropriate gowning or draping for privacy;
- Suitable positioning in the room such that they can assess the nature of the contact between physician and patient;
- How to intervene or stop an examination or procedure if they are concerned that the patient is distressed or that inappropriate contact has occurred; and
- Reporting mechanisms for concerns about and noncompliance with established chaperone policy.

Expert consensus is that individuals for whom patient care is not a routine part of their ordinary duties (such as front desk or office support staff) should not function as chaperones.[1,6] It may be appropriate for medical students, residents, and fellows to perform the duties of a chaperone, provided that special attention is paid to how these duties may be impacted by the power imbalance inherent in the trainee-supervisor relationship. Trainees should be provided with information about their role serving as a chaperone, sufficient knowledge about the procedure or interaction they will be observing, and how to report any concerns without repercussions, fear of retaliation, or other professional disadvantages.

The standard approach is to have healthcare staff (such as nurses, medical assistants, or physician assistants) act as chaperones, provided they are fully trained in the responsibilities of the role. Occupying a dual role as chaperone and member of the care team is acceptable when the two sets of responsibilities do not conflict and are well understood by everyone involved. "Parents and other untrained individuals" should not act as chaperones, except in the case of young children.[3,6]

Chaperones may feel uncertain or hesitant about intervening during an examination or procedure or about reporting misconduct. To establish expectations for the role of chaperones, institutions and practices should set policies for both physicians and chaperones in advance. They should also agree

on methods of communication to signal patient distress or chaperone concerns while examinations or procedures are in progress.[3]

Concerns may arise regarding the additional resources needed to implement current best practices for the use of chaperones. In particular, physicians may be concerned that these resources will be diverted away from patient care. Despite these valid concerns, it has been established that "most patients regard the offer of a chaperone as a sign of respect" and, further, that chaperones can help minimize physician misconduct, which has significant detrimental effects on patient well-being, the patient-physician relationship, and the integrity of the profession as a whole.[1,7] In light of these considerations, limited resources or additional costs do not ethically justify the failure to regularly employ chaperones for sensitive examinations and procedures and/or to make them available in other situations at the patient's or physician's request.

ETHICS ISSUES

The ethical concerns related to the use of chaperones for sensitive examinations center around the trust and trustworthiness of the patient-physician relationship. The use of a chaperone is meant to uphold respect for patients as persons and is intended as a means to recognize and protect patients' dignity, vulnerability, and autonomy. Chaperones are also important for minimizing risks to physicians, such as verbal or physical harassment. In addition to concerns for patient and physician safety, the need for chaperones raises other ethical concerns, such as how to appropriately train, fund, and staff chaperones. These concerns can be particularly challenging in limited resource settings, such as rural hospitals, highlighting that ethical necessities may at times conflict with practical realities and that the need for a chaperone is always contextually situated, making it difficult to establish clinical guidance that is able to cover all possible scenarios.

DISCUSSION

Medical examinations and procedures often require the patient to put aside their norms regarding modesty and give consent to being heard, seen, and touched in ways they would not usually allow. Therefore, it is critical to show respect to patients and foster trustworthiness. The presence of a chaperone reinforces the professional nature of the clinical interaction, with the goal of providing reassurance that the patient's experiences and concerns and the boundaries of the clinical encounter are being respected.[1] Having chaperones present can also help prevent misunderstandings between patients and physicians by clarifying expectations and facilitating communication about the examination. Chaperones should be familiar with the elements of sensitive examinations and procedures, know how to properly observe them, and know when to intervene if they have concerns. When used in this manner, chaperones may augment a patient's sense of safety by assuring the patient that the interventions are appropriate. Additionally, having a third-party present who can attest to what occurred during the encounter may protect physicians from false allegations of misconduct.[1]

Mandatory, Opt-in, and Opt-Out Chaperone Policies

There are three types of chaperone policies: opt-in, opt-out, and mandatory.

- An opt-in policy is one in which patients are *automatically offered* a chaperone for sensitive examinations and procedures (the patient is informed that they can request a chaperone).

- An opt-out policy is one in which a chaperone *is automatically provided* for all sensitive examinations and procedures (the patient is provided a chaperone, although the patient is given the option to decline, so long as the physician agrees a chaperone is not needed).
- A mandatory policy is one in which a chaperone must be present during all sensitive examinations or procedures, or else the examination or procedure will not be performed.

Currently, the AMA *Code of Medical Ethics* recommends an opt-in policy, which states that physicians should "adopt a policy that patients are free to request a chaperone" and communicate that policy to patients and that a patient's request should always be honored (Opinion 1.2.4). Under the opt-in model, the default is to proceed with the examination or procedure without a chaperone unless an explicit request for one is made by the patient. This opt-in approach provides less protection for both the patient and the physician than a mandatory or opt-out approach, since the responsibility to ask for the chaperone belongs to the patient. The difficulty with this type of policy is that it assumes the patient feels empowered to ask for a chaperone without fear of damaging the patient-physician relationship or causing inconvenience or annoyance.[3] Additionally, evidence suggests that patients may not request a chaperone because they think it may insinuate that their physician is untrustworthy,[7,8] and only a small percentage of patients feel comfortable asking for a chaperone when none was explicitly offered.[9]

By contrast, under an opt-out policy, patients do not need to make a specific request because the policy makes it standard practice to have chaperones present for sensitive examinations. Specifically, chaperones are made available and routinely present during sensitive exams, unless the patient refuses. Opt-out policies are effective at protecting both the physician and the patient since, by default, they make it the norm to have a third-party present as a witness to sensitive exams or procedures.

Although the opt-out approach offers patients more protection, in some cases, this approach may introduce problems with obtaining informed consent. For instance, once a chaperone is brought into the examination room, a patient may be reluctant to object since this is presented as the usual way things are done. Some patients also may not realize they have a choice regarding the presence of a chaperone.[10] Under ordinary circumstances, remaining silent should not be understood as valid consent.

Both opt-in and opt-out policies can create challenges in part because patients' requests and/or consent for use of a chaperone take place directly in the treatment room. For this reason, it has been suggested that patients' preferences regarding chaperones should be solicited by front desk staff or other intake staff as a routine part of the check-in procedure.[4,8]. This approach is an opportunity to provide materials explaining the purpose of the chaperone and to inform patients of the standard policy while allowing patients to express their preferences in a low-pressure environment. However, regardless of where and how consent for the use of a chaperone is solicited and obtained, physicians should keep in mind that what is most important during "the process of obtaining consent is equalizing the patient's ability to say *yes* or to say *no*."[11]

Documentation of Chaperone Use

Regardless of the chaperone policy implemented in a particular setting, the medical record should document the presence or absence of a chaperone for each sensitive examination.[1,3,8] For all examinations or procedures in which a chaperone is present, the medical record should reflect whether the patient requested a chaperone explicitly or whether one was present as a matter of policy. Additionally, the name of the chaperone present and any patient preferences regarding the use of a chaperone should also be documented. Note that there is a range of acceptable practices for

recording chaperone information, and therefore the extent of documentation, including what precise data to include, varies among medical specialties.

Patients with Diminished or Lacking Decisional Capacity

It is widely agreed that patients who are unable to give informed consent should always have a chaperone present for sensitive examinations and procedures. These patients might be unconscious, sedated, have cognitive impairments, or have severe mental illness.[2,3,12] When treating adult patients who have diminished capacity or lack capacity to consent, it is imperative to have a trusted companion, social worker, caregiver, or group home escort present alongside the chaperone to ease any potential patient distress.[3] It should be made clear that chaperones are mandatory in these circumstances.

Patient Preferences Regarding Chaperones

With regard to patient preference for specific characteristics of a chaperone (such as gender or religious affiliation), physicians should be respectful of the patient's values and preferences while also being mindful not to accede to discriminatory or disruptive patient demands. Disrespectful, derogatory, or prejudiced language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either patients or physicians, can undermine trust and compromise the integrity of the patient-physician relationship while also creating an "environment that strains relationships among patients, physicians, and the health care team" (Opinion 1.2.2). Discriminatory requests should not typically be accommodated, and accommodation should only occur after careful weighing of the circumstances. Patients' preferences, if nondiscriminatory, should be respected, documented, and upheld within reason and feasibility.

The Use of a Chaperone at Physician Request

There may be times when the physician deems the use of a chaperone necessary. In such cases, if the patient declines, the American College of Obstetricians and Gynecologists (ACOG) suggests that the physician should explain that "the chaperone is an integral part of the clinical team whose role includes assisting with the examination and protecting the patient and the physician. Any concerns the patient has regarding the presence of a chaperone should be elicited and addressed if feasible."[1] Ideally, these conversations will be a process of joint decision-making between the patient and the physician. If the patient declines a chaperone when the physician determines having a chaperone present is clinically indicated, every effort should be made to accommodate the preferences of the patient, consistent with the requirements of patient safety, physician safety, and the maintenance of professional boundaries. Physicians should inquire about specific concerns the patient may have and suggest ways these might be addressed in a mutually acceptable manner. Physicians should engage the patient in a detailed discussion of how care might be provided in a way that maintains a comfortable and respectful environment before deciding that they cannot perform the exam or procedure. If the examination is ultimately performed without the use of a chaperone, the rationale should be documented.[1] As a last resort, if the patient and physician cannot come to an agreement, then the physician may defer the examination or procedure and refer the patient to another clinician. In this situation, patients should be provided with "reasonable assistance in making alternative arrangements" so they can receive care in a timely fashion (Opinion 1.1.3).

The Use of a Chaperone without Patient Consent in Exceptional Circumstances

In some situations, insisting on a chaperone when the patient declines may violate the patient's autonomy and therefore be impermissible. However, physicians may proceed with the use of a chaperone without the expressed consent of the patient in the following circumstances:

- When it is an emergency and failure to proceed rapidly would result in an immediate risk to the patient's life or long-term health; or
- In cases where the integrity of the patient-physician relationship is at risk, such as when a patient's behavior compromises (or has previously threatened or crossed) professional boundaries or the physician has reason to believe such a boundary violation or other unsafe situation is likely to occur.[13]

Pediatric & Adolescent Patients

Appropriate use of chaperones for pediatric and adolescent patient populations is distinct from that of adult patients because they have different needs and sensitivities. Normally, a parent or guardian may act as the chaperone for young pediatric patients (from newborns to children aged 11 years).[14] In cases where a parent or guardian is unavailable or their presence would interfere with the examination (such as in cases of suspected abuse), another chaperone should be present.[14] Should a parent or guardian decline the physician's request that a chaperone be present in such situations, it may nevertheless be appropriate for the physician to insist that a chaperone be present for the sake of patient safety.

Addressing the needs of adolescent patients (aged 12-17 years) is more complex. Since many adolescents are "preoccupied with their changing bodies, self-conscious about their appearance, and longing for increased privacy," any examination that requires them to remove their clothes could be distressing.[9] Physicians should not assume that their own definitions of a sensitive examination reflect the understanding of the individual teenage patient.[15] Research shows that 60 percent to 70 percent of female adolescents would like the option of a chaperone for both standard and sensitive examinations. Only 21 percent indicated that they would ask for a chaperone if one was not offered, and substantially more female adolescents wanted a chaperone for sensitive examinations if they had a chaperone in the past.[9]

Many adolescents want a parent to act as chaperone instead of a healthcare professional, although in general as their age increases their preference for a non-parent chaperone also increases.[15] Some adolescents do not wish to have chaperones, indicating that it would be more embarrassing, awkward, or uncomfortable to have an additional person in the room.[8]

As such, in the treatment of adolescents, the best policy is to explain the role of chaperone in detail and then solicit their preferences. It is also important to ask whether they wish to have their family member or guardian in the room, either in addition to, or instead of, the healthcare professional acting as chaperone. Since adolescents may not have prior experience with chaperones, it is probably not sufficient to have them fill out a form at intake. Instead, their options should be presented during a conversation (and, if they wish, with a parent or guardian present) so a decision can be made together. Their preferences are also likely to change over time, so this conversation will need to be revisited.

As noted in Opinion 2.2.1, "Pediatric Decision Making," the "more mature a minor patient is […] the stronger the ethical obligation to seek minor patients' assent." This obligation extends to their assent for the presence of a chaperone, as well as their preferences for who the chaperone will be

and the gender of the chaperone. In general, physicians and parents/guardians should respect a minor's refusal to assent to a chaperone (except under the exceptions outlined above when a physician may either insist on a chaperone or may decline to proceed with the examination for emergency or safety reasons).

Policies around the use of chaperones for adolescents are separate from issues of parental consent for treatment. Physicians should be aware that, "[in] some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services" or to prevent, diagnose, or treat sexually transmitted disease without parental consent and/or notification (Opinion 2.2.2). Once the legally required consent has been obtained, the minor patient's preferences concerning use of chaperones can be discussed.[6]

ETHICS ANALYSIS

There is a power imbalance embedded in the patient-physician relationship. Patients make themselves vulnerable to the physician both by permitting procedures and examinations to be conducted on their bodies and by disclosing private information to the physician during the course of the clinical encounter. The physician guides the care that the patient receives and should adopt practices within the clinical encounter to foster trustworthiness. The presence of a trained chaperone during sensitive examinations contributes to establishing trust between physician and patient, as knowing that the encounter has been witnessed provides everyone involved with reassurance that the encounter was professional and safe.

Appropriate use of chaperones during sensitive examinations and procedures is meant to protect both the physician and the patient. Having a chaperone present can increase trust between the physician and patient, contribute to the comfort and safety of the patient, and help maintain the patient's dignity. The use of chaperones can also help protect the physician against accusations of misconduct that arise from misunderstandings or that are intentionally false.

Chaperones are responsible for upholding the patient's privacy and confidentiality; however, because physicians are obligated to "seek to protect privacy in all settings to the greatest extent possible" (Opinion 3.1.1), opportunities should be provided for private conversation with the patient without the chaperone present. In addition, physicians should minimize inquiries or taking a patient's history during a chaperoned examination or procedure. If a patient shares information with the chaperone that is relevant to patient care but requests that this not be disclosed to the physician, the chaperone should make it clear that they cannot maintain confidentiality when doing so would endanger the health of the patient. The chaperone may also encourage the patient to either raise the issue with the physician themselves or obtain permission from the patient to communicate the information to the physician separately.

What is considered a sensitive examination or procedure can vary widely among patients. In order to foster trust between the patient and physician and to set appropriate professional boundaries for sensitive examinations and procedures, various factors affecting the particular patient should be considered, including history of trauma, sexual orientation, gender identity, personal beliefs, and cultural norms and expectations.

Since patients may not disclose their history of sexual assault or previous negative healthcare experiences, trauma-informed care (sometimes alternatively described as "healing-centered engagement"[16]) should be employed for all examinations, including those not usually understood as sensitive. A trauma-informed framework "assumes that all people have experienced trauma, may

be currently experiencing it, or will experience it in the future."[11] This approach is focused on creating "safety, empowerment, and trustworthiness" in the clinical encounter.[17]

For sexual and gender minority patients, their lived experiences, perspectives, and current health needs should guide physicians in jointly identifying which examinations and procedures should be treated as sensitive.[17] Likewise, some patients may have personal or religious beliefs or may adhere to cultural norms that they wish to have respected in the clinical encounter. This may necessitate tailoring the conditions and understanding of what are defined as sensitive exams to the patient's level of comfort and concepts of appropriateness. One way for physicians to provide a consistently safe and respectful environment for all patients is to be open to broadening the range of circumstances in which a chaperone is used.

The presence of a chaperone also promotes patient safety by acting as a deterrent to inappropriate behavior.[1] Patients may be more comfortable with someone of a particular gender being present because that person can better understand the kinds of embarrassment or discomfort associated with their sensitive exam and so may be better equipped to provide support.[18]

While opt-in chaperone policies have historically been regarded as adequate, this is no longer the case for some specialties. There is evidence that a shift to opt-out policies will better protect both patients and physicians in many settings. ACOG argues that given "the profoundly negative effect of sexual misconduct on patients and the medical profession and the association between misconduct and the absence of a chaperone," regular use of chaperones is necessary to assure patients and the public that significant "efforts [are being made] to create a safe environment for all patients."[1] Because physician misconduct undermines the integrity of the profession as a whole, there is strong reason to adopt policies that reduce it. Similarly, the American College Health Association supports the adoption of opt-out chaperone policies and recommends that every medical institution have a policy regarding sensitive examinations "to protect patients' safety and minimize risk associated with the performance of these exams" that should include the presence of a chaperone for such exams.[5]

Physicians deserve to work in an environment where false allegations of misconduct or misunderstandings between physicians and patients do not compromise either their professional reputation or the relationships of trust that they have established with their patients. Likewise, patients deserve to be treated in an environment that supports their agency and improves the quality of their experience, without being expected to make a special request. These goals are best promoted through the implementation of an opt-out policy for the use of chaperones during sensitive exams. Therefore, the presence of chaperones should be standard during sensitive exams and procedures. In other situations, it is recommended that a chaperone be made available if the patient requests one. While chaperones are not mandatory for every clinical encounter, patients should be made aware that they have a right to request a chaperone for any examination. Finally, physicians should honor patients' preferences for a chaperone even when a trusted companion is present.

CONCLUSION

Policies surrounding the appropriate use of chaperones for sensitive examinations and procedures have evolved in recent years. New standards specify that the use of chaperones should be standard for all sensitive exams and procedures and that chaperones should be made available in all situations when the patient requests one. Use of chaperones should not be influenced by the gender of the physician or patient. Chaperones should receive information regarding the responsibilities of their role, and patient preferences concerning chaperones should be documented. Chaperones must

be made aware of appropriate mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Reporting mechanisms that do not expose chaperones to retaliation must also be established in order for the new standards to serve the purpose of protecting both the physician and the patient. As far as possible, lines of authority in the reporting process should be removed from the immediate employment and clinical supervisory hierarchy of the reporter.[3] Multiple pathways for patient reporting should be established, including an anonymous option, and this information should be communicated clearly to patients. When a patient reports a concern about misconduct, this must not adversely affect their care. While there are valid concerns related to funding, training, and staffing chaperones, these challenges do not supersede the ethical obligation to provide a chaperone to patients during sensitive examinations and procedures. If physicians cannot uphold this ethical obligation, they should work with their administrators and specialty associations to seek guidance for remediating the situation.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends the following be adopted and the remainder of the report be filed:

1. Opinion 1.2.4, "Use of Chaperones," be amended by deletion and addition as follows:

> Chaperones should be authorized members of the healthcare team. All chaperones should understand the responsibilities of the role and be aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality.
>
> Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive examinations and procedures while also empowering patients. ~~Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, clear~~ly explaining~~ explanations of various components of the physical examination, and the use of ~~having~~ a chaperone ~~available~~. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region, or the rectum, physicians should be aware that a patient's personal history, beliefs, or identity may broaden their definition of what constitutes a sensitive examination or procedure.
>
> Having a chaperone~~s~~ present ~~also~~ during a sensitive exam helps protect the integrity of the patient-physician relationship ~~prevent misunderstandings between patient and physician~~. Physicians should, as always, be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. Additionally, ~~P~~physicians should:
>
> (a) Make every reasonable effort to provide a chaperone for all sensitive exams, regardless of patient capacity, unless a delay in obtaining a chaperone would result in significant harm to the patient.
>
> (b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam:

i. if the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician;

ii. in emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale.

~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.~~

~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~

~~(e)~~(c) Minimize inquiries or history taking ~~of a sensitive nature~~ while a chaperone is present.

(d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries.

(e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or if their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision-making between patient and physician.

All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk.

For nonsensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request.

(Modify HOD/CEJA Policy)

2. Policy D-140.950 be rescinded, as it has been accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal.

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REPORT 04 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-26)
Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization

EXECUTIVE SUMMARY

In adopting Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," the House of Delegates requested that the Council on Ethical and Judicial Affairs (CEJA) "review the advisory restricting collective action in section 1.2.10 of its *Code of Medical Ethics* to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform."

Although not all collective actions by physicians may impact clinical practice, the practical issue for consideration is whether disruptive collective actions by physicians, such as but not limited to strikes, may be permissible. The ethical dilemma is whether physicians can prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit. To respond to these issues, CEJA recommends amending Opinion 1.2.10, "Political Action by Physicians," to more clearly articulate that disruptive collective actions that would likely harm patients are to be avoided; however, this does not mean that all forms of disruptive collective action must be avoided. Disruptive actions may be considered if non-disruptive actions fail, though such actions should not directly compromise patient care and the aim of such actions should be to improve patient care and not primarily for physician self-interest.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 04-I-26

Subject:	Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization
Presented by:	Larry Reaves, MD, Chair
Referred to:	Reference Committee on Ethics and Bylaws

Council on Ethical and Judicial Affairs (CEJA) Report 8, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," was introduced by CEJA at the 2025 Annual Meeting and was referred. CEJA Report 08-A-25 responded to Policy H-405.946, "Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization," which was adopted at the 2023 Annual Meeting and asks the following:

1. Our American Medical Association will reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally.

2. Our AMA will request CEJA to review the advisory restricting collective action in section 1.2.10 of its *Code of Medical Ethics* to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform.

In response to testimony at the 2026 Annual Meeting, CEJA has changed "could" to "would predictably" in subsection (iii) of recommendation (b). CEJA also wishes to highlight that, contrary to the current version of the *Code,* which probits physicians from striking, the proposed use of "should avoid" is not a prohibition and does not mean physicians must never engage in such actions. The recommendations presented in this report do not prohibit physicians from striking but rather lay out the ethical obligations under which such disruptive collective actions may take place.

BACKGROUND

The consolidation of hospitals and physician practices in recent years has led to a shift in the practice of medicine away from the independent practice model to one in which physicians increasingly find themselves working as employees. In 2012, only 5.6 percent of physicians were directly employed by hospitals, with 23.4 percent of physician-owned practices having some hospital ownership; however, by 2022, a total of 74 percent of practicing physicians were employed, including 52.1 percent of physicians employed by hospitals or health systems and 21.8 percent employed by other corporate entities.[1] Paralleling this increase in corporate intrusion into medicine has been the rise of unionization within the profession. While the number of physicians who are members of a union is relatively small, and mostly among house officers, their ranks saw an approximately 26 percent increase in just five years from 2014–2019.[2] As of 2021, an estimated 5.9 percent of practicing physicians were union members, with union contracts covering 8.1

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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percent of practicing physicians.[1] Currently, two of the main physician unions are the Federation of Physicians and Dentists and the Union of American Physicians and Dentists.

As the financing, organization, and leadership of the healthcare system change, the practice environment increasingly makes it challenging for physicians to provide the kind of care patients want and deserve. Physicians are now increasingly held to strict performance metrics that many feel are more about meeting corporate financial goals than they are about providing quality patient care. As a recent *New York Times* article puts it, "longer-term consolidation of healthcare companies has left workers feeling powerless in big bureaucracies. They say the trend has left them with little room to exercise their professional judgment."[3] There is a growing sense among physicians that current working conditions are increasingly compromising the patient–physician relationship, physicians' health, and medical professionalism, driving burnout, moral injury, and retirement from medicine.

Unions are seen by some as a mechanism for physicians to exert influence on corporate health systems where physicians have less autonomy than in private practices.[4] Unions' power for collective bargaining comes from their ability to organize members to take collective action. Unionization, however, is not the only means by which physicians can organize and take collective action. Hospitals' organized medical staff has been a means by which physicians have exercised authority over decision making and culture, but the authority and scope of responsibility of the organized medical staff has been limited.[5] While employed physicians in large systems have not typically explored reinvigorating the organized medial staff, this remains an alternative means by which physicians can reclaim lost authority and exercise collective action.[5]

Physicians may undertake many forms of collective action, both in the public arena and within healthcare institutions. Public actions include, but are not limited to, public advocacy, media campaigns, lobbying, negotiation, and litigation. Collective actions in the clinical setting increasingly are being considered as additional forms of collective action, particularly to effect change in specific clinical environments. Some of these are not disruptive, such as negotiation with administrators. Disruptive actions are also being considered, such as picketing, refusal to comply with corporate directives deemed unethical, withholding billing, work slowdowns, or striking. A primary concern surrounding the use of these disruptive collective actions by physicians in the clinical setting is that some of these actions may impact patient care and thus be in direct conflict with physicians' professional and ethical duties to not abandon patients and to prioritize patient care above self-interest.[6]

Relevant Laws

In 1935, Congress passed the National Labor Relations Act (NLRA), amended in 1947 through the Taft-Hartley Act, which guarantees private sector employees the right to unionize, engage in collective bargaining, and take collective actions such as strikes.[1] The NLRA covers most private sector employees but does not cover independent contractors, supervisors, or managers. Part-time physicians working as independent contractors, physicians in private practice, and physicians considered to serve a supervisory role, such as medical directors or tenured medical faculty, are currently excluded.[2]

When Congress passed the 1974 amendments to the NLRA, which extended coverage to nonprofit hospitals, it added Section 8(g), requiring healthcare employee unions to give at least a ten-day notice before engaging in any strike or picketing to ensure that hospitals have sufficient time to make appropriate arrangements for the continuity of patient care in the event of a work stoppage.[2]

Laws prohibiting the corporate practice of medicine are an underappreciated mechanism for physicians to use in reclaiming clinical authority. Most states have had laws dating to the 1880s that prohibit the corporate practice of medicine, but little attention has been paid to the potential use of such laws to prevent healthcare institutions from infringing upon the clinical decision-making authority that properly belongs to physicians.[7]

Relevant AMA Policy Provisions

In 2019, the AMA modified two relevant policies: H-385.973, "Collective Negotiations," and H-385.976, "Physician Collective Bargaining."[8,9] Both support the right of physicians to engage in collective bargaining and express the AMA's commitment to work for the expansion of which physicians are eligible for that right under federal law. This includes supporting efforts to narrow the definition of supervisors such that more physicians are protected under the NLRA. Though not policy, the AMA's Advocacy Resource Center has also issued a recent Issue Brief: "Collective bargaining for physicians and physicians-in-training" that outlines AMA policy on physician unions and collective bargaining, including the interpretation that the AMA's position is that "physicians should refrain from the use of the strike as a bargaining tactic, although in rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care."[2]

Relevant Code Provisions

The AMA *Code of Medical Ethics* Opinion 1.1.1, "Patient-Physician Relationships," states that the core tenets of the clinical encounter for the physician are "to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare." This foundational opinion emphasizes the primary ethical duties of physicians to prioritize patient care and regard their responsibility to the patient as paramount. The Principles enumerated in the *Code* also indicate that such duties extend beyond the bedside and that physicians have a responsibility to seek changes to laws that are contrary to the best interests of the patient.

Opinion 1.2.10, "Political Action by Physicians," currently states that not only *can* physicians seek to change policies or laws that they find contrary to the best interest of patients but they in fact *have* an ethical duty to do so, though they also "have a responsibility to do so in ways that are not disruptive to patient care."[10] While the opinion states that "[s]trikes and other collective actions […] should not be used as a bargaining tactic," it also adds that "[i]n rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care."[10] However, this permissibility must be balanced by the opinion's first directive that physicians participating in advocacy activities should "[e]nsure that the health of patients is not jeopardized and that patient care is not compromised."[10]

This is in line with Opinion 1.1.6, "Quality," which states that "[a]s professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable."[11] Taken together, by stating that "physicians have an ethical responsibility to seek change" at times (Opinion 1.2.10) and that they also have an "obligation to ensure" quality care (Opinion 1.1.6), these opinions highlight the fact that certain conditions may arise that actually demand action be taken by physicians to improve patient care.

Opinion 9.3.1, "Physician Health & Wellness," similarly outlines that physicians have a responsibility to take action when their own health or wellness is compromised.[12] The opinion

stipulates that physicians have a responsibility both individually and collectively to ensure and promote health and wellness among physicians and that when their health or wellness is compromised, individual physicians should fulfill this responsibility by "taking measures to mitigate the problem."[12] Physician health and wellness is necessary for effective healing and the provision of quality care, and collective action may be an appropriate means of securing institutional conditions that are conducive to both physician and patient health and well-being.

Additional Relevant Policy

The World Medical Association recommends that physicians adopt the following guidelines regarding collective action:

1. Physicians who take part in collective action are not exempt from their ethical or professional obligations to patients.
2. Even when the action taken is not organized by or associated with the Constituent Member, the Constituent Member should ensure that the individual physician is aware of and abides by their ethical obligations.
3. Whenever possible, physicians should press for reforms through non-violent public demonstrations, lobbying and publicity or informational campaigns, and/or through negotiation or mediation.
4. If involved in collective action, Constituent Members should act to minimize the harm to the public and ensure that essential and emergency health services, and the continuity of care, are provided throughout a strike. Further, Constituent Members should advocate for measures to review exceptional cases. If involved in collective action, Constituent Members should provide continuous and up-to-date information to their patients and the general public with regard to the demands of the conflict and the actions being undertaken. The general public must be kept informed in a timely manner about any strike actions and the restrictions they may have on healthcare.[13]

ETHICS ISSUE

What are the ethical considerations regarding participation in collective labor action by physicians? Since certain collective actions can be disruptive, they present a potential risk to patient care and thus create a dilemma for physicians, particularly when collective actions may create immediate risks to patients, even if intended as a means to improve patient care in the long term. What collective actions by physicians are ethically permissible must be examined to ensure that the primacy and quality of patient care are protected. The core ethical issue is whether physicians who embrace tactics used by organized labor will also still be able to embrace their role as professionals.

REVIEW OF RELEVANT LITERATURE

While not all collective actions by physicians may impact clinical practice, disruptive actions such as strikes result in practical challenges to clinical care. This report defines a disruptive collective action by physicians as any collective action that disrupts the day-to-day workflow of physicians within the healthcare systems in which they practice. Some of these actions may have the potential to decrease quality of care and cause patient harm.

The normative ethics literature on the use of collective actions by physicians is generally cautious about collective actions that present a risk to patients, such as striking. A common stance is that, provided adequate precautions are taken to minimize the risk to patients, the primary goal of the

collective action is to improve patient care, and the disruptive action is considered only as a last resort after all other means have been exhausted, physician strikes may be ethically justifiable.[6,13,14,15,16] However, strikes and other disruptive collective actions become ethically problematic when they are done for any reason other than for improving patient care, such as for increasing physicians' income.[6,14]

One line of argument in favor of permitting disruptive collective actions that might harm patients, such as strikes, is to suggest that physicians are, and have always been, workers like any other set of workers, and that claims of professionalism that would place physicians in a special position of privilege in recognition of a higher set of ethical standards have always been a mere pretense. On this view, there is nothing intrinsically "special" about medicine as opposed to any other form of work. There are some limits on what forms of collective action may be undertaken that are due to the critical nature of the service physicians provide, but there is no reason to maintain the fiction that they cannot engage in strikes or job actions because they are professionals called to put patient interest ahead of self-interest. The ethical question thus becomes how to draw limits on the scope of permissible collective action that recognize physicians as laborers with all the rights of laborers, while protecting the public from harm.

A second line of argument is a variation on this first line of argument—asserting that while medicine is ideally construed as a profession with intrinsically special rights and obligations, one must now, however reluctantly, accept the deprofessionalization of physicians as a socioeconomic and historical fact. On this view, physicians have been forced out of their professional status by changes in the financing and organization of healthcare, and the only available means of asserting power now is through unionization and the means of negotiation that have been used for the last two centuries by other workers in resolving disputes with their employers. Again, the operative ethical question becomes one of setting limits on these actions in accord with the vital nature of the service physicians provide.

A third line of argument attempts to reconcile a conception of physicians as professionals, obligated to place patient interest above self-interest, with an understanding that, under certain circumstances (such as those experienced by house officers and, increasingly, physicians employed in large healthcare systems), there is a *de facto* imbalance in power between the administrators and the employed physicians. They argue on consequentialist grounds that if impediments to good patient care are sufficiently serious and the goal of a disruptive collective action (such as a strike) is to improve patient care in the long run, then if potential harm to patients in the short run is minimized, the action is undertaken only as a last resort, and the goal of improving patient care through the action is foreseeably achievable, such an action could be justified.[6,15] These commentators reject the idea that a disruptive collective action with the potential to harm patients could be ethically and justifiably undertaken solely to advance the welfare of physicians. However, they generally recognize that the motives for such actions will often be mixed and admit that the argument that physician welfare could be sought as the primary (or even secondary) goal of a strike but justified as a necessary means for achieving patient welfare in the long run might either be self-deceived or, at least, difficult for the public to believe.[6,15,17]

Others have held that strikes by physicians are almost never justifiable.[18-20] Strikes by physicians raise serious questions at the heart of what it means to be a physician. As Pellegrino has written:

> Whatever justification they may have, the use of such means as strikes or slowdowns by segments of the profession have seriously damaged the image of medicine as a profession dedicated to service above its own interests. One of the distinguishing features of the profession of medicine has thus been compromised by physicians themselves. Those who

> choose to pursue their self-interest, as union members might, cannot at the same time demand a superior moral position in society.[18]

Contrary to the arguments favoring physicians strikes, opponents have appealed to the principle that the duty to promote the good of the patient is always paramount and that strikes will always harm patients, at least to a modest degree. In fact, they argue, this is the point of the strike—to disrupt care and inconvenience or possibly harm patients, even if minimally, in order to pressure administrators into acceding to the demands of the striking physicians. Even granting that the ultimate aim of the strike is to improve patient care in the long run, patients will be harmed in the short run, and this conflicts with the profession's ancient duty to protect patients from harm.

Moreover, opponents take issue with the consequentialist argument that some patients could justifiably be exposed to potential harms now for the sure benefit of others in the future. They argue that a primary principle of ethics is that persons should always be treated as ends in themselves and never as means only. Physician strikes, by their nature, instrumentalize some patients, using their potential harm as means of achieving physicians' ends, even if those ends are justifiable and good.

Additionally, the effect of strikes on public trust in the profession must be considered. Trust is the glue that holds the patient-physician relationship together. The sense that one's own health as a patient could in any way be jeopardized or used as a bargaining tool might lead to public distrust in the profession.

While there is not a substantive body of empirical research on the effects of physician strikes on patient outcomes, there are some data. Although the majority of available empirical evidence shows that strikes have minimal impact on patient care,[21-24] much of the data are of relatively poor quality, are at risk of bias, and suffer from a lack of generalizability.[22,23] Furthermore, most studies examine patient mortality as the primary outcome of interest, which has limitations as an indicator of deleterious change in patient health outcomes.[21] Importantly, a 2019 study found a slight increase in 30-day readmission rates for Black patients on strike days in the U.K., suggesting that the ways in which strikes impact staffing are unlikely to affect all patient groups equally, with minority groups more likely to experience worse care when hospital systems are under strain.[24] This observation has critical importance in determining care for vulnerable populations when considering collective actions. Additionally, there is a lack of crucial research on how collective actions by physicians impact patient perceptions of and trust in both the medical profession and healthcare institutions. Reports of strongly negative public perceptions during a recent physicians' strike in South Korea, while not systematic, suggest a note of caution.[25]

ETHICS ANALYSIS

In its review of Opinion 1.2.10, "Political Action by Physicians," CEJA has examined the ethics of collective actions by physicians. While the practical issue for consideration is whether disruptive collection actions by physicians, such as but not limited to strikes, may be permissible, the ethical dilemma is whether physicians can, in fact, fully understand themselves as professionals called to prioritize patient welfare over their own self-interest while engaging in tactics that have the potential to harm patients in the short term, even if the ultimate goal of the action is proposed to be long-term patient benefit.

Historically, physicians retained strong independence in clinical practice, and self-regulation permitted this professionalism to flourish. However, the growth of the healthcare sector has seen an increase in the complexity of healthcare systems, the transition to a majority physician employment

structure, and, as a result, a loss of physician independence and control in clinical practice. This bureaucratization has led physicians to seek other nonphysicians to run the administrative aspects of their practices, and decreasing margins has led physicians to seek capital infusions and buyouts from private equity firms and venture capitalists, further driving the financialization of medicine and the employment of physicians.

The result is a general loss of control over practice conditions that has driven dissatisfaction, burnout, and early retirement from the profession. However, the issue is not necessarily employment itself, but the associated loss of independence of clinical practice and control over the clinical environment, which many today see as the deprofessionalization of medicine.

For those seeking to maintain and restore physician authority and independence, the primary avenue has been to pursue legal and political actions, such as lobbying (either independently or through medical associations). However, with the shift towards physician employment, physicians are now considering the use of tools that laborers have historically relied on for negotiating, such as legally permissible collective actions, in their attempts to improve patient care. This acceptance of the tools of organized labor, however, is in tension with medicine's self-understanding and public representation of itself as a profession with distinct privileges granted by society in recognition of its commitment to a distinctive set of ethical duties. Certainly, some forms of collective action are not likely to violate the norms of medical professionalism.[26] Disruptive collective actions, however, which have the potential to disrupt the day-to-day workflow of physicians, decrease quality of care, and cause harm to patients, seem prima facie to violate the medical profession's fundamental duty to do no harm and care for patients. Any disruptive collective action that causes harm to patients is inherently inconsistent with the responsibilities and duties of physicians.

Disruptive collective actions that create the potential for harm to patients, even minimally, and even if undertaken for the purpose of improving the care of other patients in the future, are therefore to be avoided. This does not mean, however, that all forms of disruptive collective action must be avoided. Certain forms of disruptive action, such as collective refusal to comply with administrative directives that are understood as antithetical to good patient care or otherwise incompatible with the norms of professional ethics, may be ethically justified. Other forms of disruptive action that are aimed at disrupting administrative processes such as billing but do not disrupt service to patients might also be justified. Disruptive actions should only be undertaken, however, as a last resort when good faith negotiations have broken down and the aim of the action is to improve patient care.

CONCLUSION

Physicians must uphold their central ethical and professional responsibilities to patients when considering collective actions. When considering disruptive collective actions, physicians should take into account that the care of current patients must be continued and not compromised; urgent, emergent, and otherwise needed medical care must still be provided; and all other non-disruptive actions that do not negatively impact patients must first be exhausted. Additionally, the primary goal of the action must be to improve patient care and not solely physician self-interest. To protect the integrity of the profession, patients and the public should also be informed well in advance and be continuously updated with respect to the demands being made and the actions being undertaken, with the terms for resolving disruptive actions made public and open to scrutiny and discussion. Whether all these conditions can ever be met in a physician strike or work slowdown remains an open question.

Physicians thinking about participating in disruptive collective actions therefore must first consider their professional responsibilities and obligations.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:

1. That Opinion 1.2.10 be amended by addition and deletion with a change in title to read as follows:

Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the well-being of patients in jeopardy.

Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician well-being, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician well-being.

When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions:

(a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and well-being.

(b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work

conditions, health and well-being, and/or institutional culture that negatively affect patient care:

(i) physicians should refrain from collective action that would likely jeopardize the health of patients or compromise patient care;

(ii) physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of collective action that do not compromise patient care, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture; and

(iii) physicians should avoid disruptive collective actions that would predictably and directly compromise patient care, including strikes, due to their potential to undermine physicians' primary duty to patient welfare, and should not use such actions primarily for physician self-interest.

(c) Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients.

(d) Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities. (Modify AMA Policy)

2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)

Fiscal Note: Minimal

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REPORT 05 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-26)
Care of Patients in Legal Custody

EXECUTIVE SUMMARY

Policy D-345.970, "Carceral Systems and Practices in Behavioral Health Emergency Care," was adopted at the 2025 Annual Meeting. Its third directive asks the Council on Ethical and Judicial Affairs: "to study this topic to provide clearer guidance for healthcare professionals regarding interacting with law enforcement while caring for patients and the shackling of youth and adults in carceral custody, with particular attention to the removal of shackles."

This report examines the ethical challenges involved in caring for patients in legal custody, with attention to the practical constraints faced by both patients and their physicians. The Council identifies ethics issues beyond the scope of shackling and offers recommendations on a wide range of concerns, including conflicts of interest and dual loyalties, decisional autonomy, informed consent, surrogate decision-making, privacy, confidentiality, shackling, continuity of care, reporting abuse, improving policies, and working alongside custodial staff. The report emphasizes that patients in legal custody retain the same ethical rights as all other patients regardless of custodial status.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 05-I-26

Subject: Care of Patients in Legal Custody

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

Policy D-345.970, "Carceral Systems and Practices in Behavioral Health Emergency Care," was adopted at the 2025 Annual Meeting. The third directive asks the following:

> 3. Our AMA asks the Council on Ethical and Judicial Affairs to study this topic to provide clearer guidance for healthcare professionals regarding interacting with law enforcement while caring for patients and the shackling of youth and adults in carceral custody, with particular attention to the removal of shackles.

This report provides ethics analysis and ethics policy recommendations regarding the treatment of patients in legal custody, including but not limited to the use of shackles.

BACKGROUND

The United States has approximately 2.3 million incarcerated people,[1] a population that also faces healthcare disparities.[2] The U.S. prison population has rapidly increased over the last 50 years, rising from 300,000 people in the early 1970s to well over 2 million people today.[3] In 2016, the United States possessed 21percent of the world's prisoners while only accounting for about 4 percent of the world's population,[1] making the U.S. a world leader in incarceration, both per capita and in total.[4] Additionally, there was a record high of individuals in immigration detention in January 2026, numbering over 70,000 people, 74 percent of whom have no criminal convictions.[5] In this report, people in legal custody are considered broadly and include anyone in prison (state or federal), jail, immigration detention centers, or held as prisoners of war. All people in legal custody should be considered patients in custody, because, as wards of the state, their health is overseen by the state as are all medical issues—whether preventive, acute, or emergent.[6]

In the U.S. context, prisons have played a role in an unjust legacy of slavery and racial discrimination. After the Civil War, the criminal justice system became "central to new strategies of racial control."[3] Any analysis of the U.S. carceral system should reflect and consider this historic and political reality. The legacy of racial discrimination and institutional control not only amplifies disparities in healthcare for people in legal custody, but also informs specific practices such as shackling, where security and safety measures often overshadow professional assessment and ethical patient care. Although shackling is intended for safety and may not be used as a method of punishing an inmate,[7] the common use of shackles reflects a broader history rooted in control and punishment. Ongoing work by the American Medical Association (AMA) addresses the ethical

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implications of practices such as shackling and highlights the need for comprehensive guidance on physicians' responsibilities to all patients in custody.

The AMA's Council on Science and Public Health (CSAPH) presented a report at Annual 2025 covering current protocols for shackling patients in legal custody, the arguments made in support of shackling, and current reforms to ban or limit universal shackling of patients in legal custody.[8] The report found that while incarcerated individuals experience significantly worse physical and mental health than the general population, correctional systems generally lack adequate health infrastructure, often requiring that patients be transferred to external healthcare institutions.[8] Patients in legal custody are often shackled through the entirety of their stay at these external healthcare institutions without consideration of individualized risk assessments, and hospital staff rarely intervene to request the removal of shackles. The CSAPH report calls for shackling policies to mirror restraint standards, clear procedures for clinicians on how to communicate with correctional officers, and defined circumstances regarding when shackling is not necessary or should be prohibited.[8] While the CSAPH report addresses issues specific to shackling, there remains a need for comprehensive guidance on the broader ethical responsibilities of physicians caring for patients in legal custody.

ETHICS ISSUES

Patients in legal custody face a loss of physical liberty and other systemic constraints, which often make upholding physicians' ethical obligations challenging and reduce trust in the patient-physician relationship.[8] Physicians treating patients in legal custody also may face conflicts of dual loyalties and inconsistent or absent institutional practical guidelines and may feel unsure about how to best support safety and security. Such situations can also create barriers to privacy and confidentiality, autonomy in medical decision-making, access to care (including choosing a health care professional or receiving timely and/or quality care), and informed consent and create greater risk of physical and mental harm. While patients in legal custody do face inequities, patients in legal custody retain the ethical right to high-quality healthcare as do all other patients, and the comprehensive ethics guidelines outlined in the AMA *Code of Medical Ethics* still apply to this patient population.

REVIEW OF RELEVANT LAWS & POLICY

Relevant Laws

An overview of the legal landscape reflects the minimum standards society has codified for patients in legal custody. The constitutional foundation for the healthcare of patients in legal custody derives from the Eighth Amendment,[9] which prohibits cruel and unusual punishment. In *Estelle v. Gamble* (1976), the Supreme Court held that deliberate indifference to the serious medical needs of incarcerated individuals is unconstitutional, establishing a state duty to provide medical care.[10] In *Brown v. Plata* (2011), the Court confirmed that institutional conditions, such as overcrowding leading to inadequate care, are equally impermissible.[11]

Pretrial detainees are protected under the Fourteenth Amendment's Due Process Clause,[12] as established in *Kingsley v. Hendrickson* (2015),[13] while individuals in immigration detention are covered under the Fifth Amendment's Due Process Clause,[14] as established in *Zadvydas v. Davis* (2001).[15] Regardless of the relevant constitutional provision, the underlying obligation is consistent: the state must provide adequate medical care to those in its custody.

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Patients in legal custody also retain fundamental rights to bodily autonomy, informed consent, and decision-making, including the refusal of life-sustaining interventions.[16] *Washington v. Harper* (1990) affirmed the right to refuse treatment; however, at the discretion of a prison's internal review board, patients in custody can be medicated against their will if they have a mental disorder and are deemed dangerous to themselves or others.[17] *Cruzan v. Director, Missouri Department of Health* (1990) established that incarceration does not eliminate informed consent requirements.[18] *Riggins v. Nevada* (1992) and *Sell v. United States* (2003) established that forced psychiatric medication must be medically appropriate, necessary, and the least restrictive option available.[19,20]

For patients in legal custody who lose the capacity to make medical decisions, a legally authorized healthcare representative should serve as a surrogate decision-maker in accordance with state law. Few states explicitly address custodial status in surrogate decision-making statutes, and correctional staff rarely have legal authority to make medical decisions on behalf of incapacitated patients.[16] As of 2022, 12 jurisdictions explicitly prohibit correctional officials from serving as surrogates for incarcerated patients who lack decisional capacity.[21,22] Four states explicitly authorize correctional staff to make medical-decisions for unrepresented incarcerated patients.[23]

The Emergency Medical Treatment & Labor Act (EMTALA) protects any individual presenting to a Medicare-participating emergency department, and law enforcement cannot remove a patient before they are medically stable.[24] The Americans with Disabilities Act (ADA) and Rehabilitation Act require equal access to care and reasonable accommodations across all facility types.[25] The Health Insurance Portability and Accountability Act (HIPAA) legally protects patient privacy in custodial settings, permitting only minimum necessary disclosures related to safety and custody coordination.[26]

Federal law provides additional protection for certain populations. The First Step Act (2018) prohibits, with limited exceptions, the use of physical restraints on pregnant individuals in federal custody during labor, delivery, and postpartum recovery.[27] Forty-two states and Washington D.C. have enacted similar restrictions as of 2025.[28] For youth, the Juvenile Justice and Delinquency Prevention Act establishes baseline care standards,[29] and, while not illegal, courts have increasingly condemned routine shackling of minors in any setting as unconstitutional.

Taken together, these standards establish that patients in legal custody have the legal right to healthcare as well as other protected rights equal to any other patient. The law does not create a separate standard of care for this population; instead, it reaffirms the same principles of adequate care, informed consent, bodily autonomy, and non-discrimination that govern the broader practice of medicine.

Relevant AMA Policy

The *Code of Medical Ethics* Opinion 1.1.3, "Patient Rights," and Principles I and IX make it clear that patients in all clinical scenarios, including those in legal custody, should be treated equitably and with respect for their human dignity. When patients or populations are discriminated against, treated unjustly, or receive less than adequate healthcare, physicians are ethically obligated to advocate for change, address barriers to equitable care, and protect the most vulnerable patients and populations as outlined in Opinion 1.1.2, "Prospective Patients"; Opinion 11.1.1, "Defining Basic Health Care"; Opinion 11.1.4, "Financial Barriers to Health Care Access"; Opinion 11.2.1, "Professionalism in Health Care Systems"; and Opinion 11.2.7, "Responsibilities to Promote Equitable Care."

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House Policy H-430.986, "Health Care While Incarcerated," advocates for healthcare rights and support of patients before, during, and after incarceration. The AMA supports patients in custody and advocates for quality healthcare, adequate physician financial compensation, security of health insurance, reduced co-pay, health literacy training, staff training, and institutional oversight. Additionally, the AMA is represented on the Board of Representatives for and supports the standards outlined by the National Commission on Correctional Health Care.[30]

Opinion 1.2.7, "Use of Restraints," is also clear that all individuals have a right to be free from unreasonable bodily restraint. It provides guidelines that restraints should be used only when necessary to prevent harm, applied in the least restrictive manner, and removed promptly when no longer needed. However, shackles used in custodial situations differ from clinical restraints in that shackles are used for security purposes and controlled by correctional authorities, while clinical restraints are used to protect the patient and staff from harm and are only clinical in their purpose. The AMA has one policy explicit to the practice of shackling. House Policy H-420.957, "Shackling of Pregnant Patients in Labor," supports only using the least restrictive restraints when they are necessary for patients in the 2nd or 3rd trimester of pregnancy and holds a high bar for necessitating restraints on an inmate in labor, in delivery, or recuperating postdelivery.

Overall, the use of shackles lacks medical ethical oversight; however, physicians are still ethically obligated to protect patient dignity and safety, including by advocating against the use of shackles when they cause harm or interfere with medical care while respecting their potential necessity to maintain safety. Physicians have an ethical obligation to respect patient rights as outlined in Opinion 8.5, "Disparities in Health Care," and Opinion 1.2.7, "Use of Restraints," including by providing respectful, dignifying care and avoiding discrimination in the care they provide.

In addition to issues that arise due to loss of physical liberty, physicians caring for patients in legal custody often face dual loyalties resulting in ethical dilemmas, conflicts of interest, and potential harm to patients. Upon entering a contract to deliver healthcare, physicians maintain the obligation to put the welfare of patients ahead of other considerations and ensure their contract does not restrict care or prevent them from upholding their ethical and professional obligations as addressed in Opinion 11.2.2, "Conflicts of Interest in Patient Care"; Opinion 11.2.3, "Contracts to Deliver Health Care Services"; Opinion 1.2.6, "Work-Related & Independent Medical Examinations"; and Opinion 11.2.1, "Professionalism in Health Care Systems." Regardless of dual loyalties, physicians should put the care of their patients first (Opinion 11.1.1).

Dual loyalties to the state may also arise through court-initiated medical treatments in which physicians are ordered to provide specific treatments to patients in legal custody. Opinion 9.7.2, "Court-Initiated Medical Treatment in Criminal Cases," outlines a framework for using professional judgment to determine the efficacy and ethicality of a mandated treatment and reinforces the necessity of obtaining voluntary informed consent before initiating treatment. Opinion 2.1.1, "Informed Consent," outlines the ethical and legal process of informed consent, which is essential for upholding trust and independent, voluntary decisions within the patient-physician relationship. Physicians have the ethical obligation to uphold informed consent for all patients or their surrogate if the patient lacks decision-making capacity, including those in legal custody.

Beyond individual physicians' ethical responsibilities to vulnerable populations, including those in legal custody, healthcare and custodial institutions and systems have ethical obligations to uphold the health and safety of people in legal custody as well. Healthcare organizations and physician employers must recognize patients as the primary obligation of physicians by enabling them to respond to the unique needs of individual patients and providing avenues for meaningful appeal

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and advocacy on behalf of patients (Opinion 11.2.1). Additionally, Opinion 11.2.7, "Responsibilities to Promote Equitable Care," states that healthcare organizations should "change institutional policies and practices that may perpetuate or create barriers to equitable care," and work "to minimize conditions of living that contribute to adverse health status" within the community. This includes advocating for changes to custodial systems that negatively impact patients' health.

ETHICS ANALYSIS

Physicians have an ethical obligation to provide quality care and uphold patients' ethical rights, including informed consent; timely, high-quality, and responsive care; dignity; privacy; confidentiality; and autonomy in making healthcare decisions. Patients in legal custody, however, face a distinct set of circumstances that creates conditions whereby established ethical standards are regularly compromised, including, but not limited to, loss of autonomy, loss of physical liberty, and inadequate institutional protections. The following analysis examines these challenges through the lens of the AMA *Code of Medical Ethics.*

Loss of Physical Liberty

Patients in legal custody face a loss of autonomy and agency from their confinement, surveillance, and custody under the state. Custody status impacts not just one's access to care, but the quality and timing of that care. Patients in custody report a lack of available services, including specialty care and mental health services, as well as care that is compassionate and trauma informed.[31] They also face poor quality care due to bias and discrimination.[31,32,33] For example, the condition of solitary confinement, which has been recognized as cruel, inhumane, and a form of torture by the United Nations Human Rights Committee,[34] not only exacerbates existing health conditions, but also increases the likelihood of receiving no or delayed care.[35] Those specifically held in immigration detention, such as Immigration and Customs Enforcement (ICE), Customs and Border Patrol (CBP), and the Office of Refugee Resettlement (ORR), often face conditions that fail to uphold the health and dignity of migrants or even provide basic services at all.[36] While many barriers to accessing adequate healthcare may stem from institutional policies, the *Code* outlines physicians' and organizations' responsibilities to promote change as well as physicians' ethical obligations to provide timely and quality care in Opinion 11.2.7, Responsibilities to Promote Equitable Care"; Opinion 11.2.1, Professionalism in Health Care Systems"; Opinion 1.1.6, "Quality"; and Opinion 1.1.3, "Patient Rights."

For patients in legal custody who are able to access and receive care, the physical design of healthcare facilities can directly affect their autonomy, privacy, and dignity. Buildings designed to accommodate necessary security needs—for example, with secure treatment areas, separate entrances or units, or doors and windows that allow custody staff to maintain line of sight from outside the room—may reduce reliance on more disruptive or harmful measures, such as shackling or the presence of custody staff during private clinical encounters.[37] This raises an important justice concern, because not all healthcare settings are built to balance security needs with patients' rights. Within those environmental limitations, physicians should still work with custody staff to protect each patient's dignity, privacy, confidentiality, and access to appropriate care.

A common safety procedure for patients in legal custody that can impact autonomy and the provision of care is the practice of shackling during transport and throughout medical encounters. The use of shackles can contribute to poor quality care and illicit harm, create a coercive environment, and ultimately reduce patient autonomy, privacy, confidentiality, and trust. Shackling may interfere with medical care, including diagnostic evaluation, physical examination, or mobility

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for rehabilitation.[38] It is also associated with exacerbation of trauma, stigmatization, and decreased trust in health systems and the patient-physician relationship.[39] Moreover, the presence of shackles, compounded by discrimination, may impact how physicians perceive incarcerated patients, thus reducing empathy, increasing diagnostic skepticism, and heightening fear of personal harm.[40,41] Beyond physical and psychological consequences, shackling may also compromise informed consent, as shackling can contribute to negative physician bias and patients may be unable or unwilling to ask questions, express concerns, or refuse care when physically restrained or in the presence of custodial staff.[42]

Not all hospitals have policies and communication protocols regarding shackling despite the known risks of its use, and there is a common misconception among physicians that they cannot influence custodial staff's routine use of shackles. However, Opinion 1.1.1, "Patient-Physician Relationships," states that physicians have an ethical obligation to advocate for their patients' welfare. Recognizing the influence physicians have is a critical step toward advocating for the safety and dignity of patients. Importantly, advocacy does not always equate to requesting the removal of shackles; rather, it involves carefully assessing each situation and collaborating with custodial staff to balance patient safety, dignity, and clinical needs. This collaboration can help make safety practices such as routine shackling more individualized and reduce harm.[37] While literature remains limited, one study from 2022 found that only 37 percent of physicians and 33 percent of nurses requested the removal of their patients' shackles during their clinical encounter.[41] Established ethics review committees, outlined in Opinion 10.7, "Ethics Committees in Health Care Institutions, and Opinion 10.7.1, "Ethics Consultations," offer a structured option for physicians to advocate for their patients when disagreements arise and are frequently suggested as a practical tool for working alongside custodial staff.[43,44]

One model demonstrating how ethical shackling can be operationalized in practice comes from Boston Medical Center (BMC). BMC has pioneered its "Recurring Shackle Assessment" process, which utilizes the electronic health record (EHR) and physician communication with the correctional health team.[39] The model parallels standard hospital evaluations of patients restrained for medical or behavioral reasons, making shackling review a part of routine clinical care.[39] If criteria for removing shackles are met, the medical team escalates the request through structured communication with the correctional health team.[39] By formalizing documentation, creating a shared-decision framework, and building accountability through the EHR, BMC's model reduces the unnecessary use and harm of shackles. Ethically, this procedural innovation demonstrates how a clinical workflow can operationalize principles of beneficence and nonmaleficence while respecting patient dignity. Although designed as an institutional protocol, such an approach could be adopted more broadly by health systems or mandated by professional ethics bodies, illustrating how procedural safeguards can serve as enforceable solutions to ethical violations in custodial healthcare.

Other key ethical concerns that often arise in caring for this patient population involve privacy, confidentiality, and informed concent.[45] Legal and physical limits on the right to privacy can interfere with medical ethics obligations to uphold patient privacy and confidentiality, often with ramifications for the patient-physician relationship and the provision of quality care. Opinion 3.1.1, "Privacy in Health Care," addresses privacy as fundamental for respecting patient autonomy and upholding trust. While the *Code* provides ethical guidance on maintaining trust with the presence of outside observers, the presence of custodial staff poses unique challenges (Opinion 3.1.2). Unlike typical outside observers, custodial staff are present to enforce security measures, and their presence may not be optional. Therefore, physicians should use discretion and balance obligations to patient privacy and confidentiality with legally mandated security protocols when advocating for patients in legal custody.

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Informed consent is crucial to shared decision-making and to upholding patients' right to receive information, ask questions about treatments, and make informed, voluntary decisions about their healthcare (Opinion 2.1.1). Additionally, the American College of Correctional Physicians lists "Justified treatment & informed consent" and "The right to refuse care" as key principles for caring for incarcerated patients,[46] requiring that physicians respect patients' right to make their own medical treatment decisions and optimize the ability of patients to provide informed consent, including for treatments at the end of life.

Physician Dual Loyalty Conflicts

Physicians caring for patients in legal custody, especially those working within custodial settings, may face a conflict of dual loyalty, such that their primary obligation to the patient's welfare is challenged by pressures from an employer, institution, or state, which often arise from the necessity to balance patient care with safety and security. Physicians working outside of custodial settings may be challenged by similar pressures and may fail to mitigate perceptions of dual loyalty. While physicians should respect the obligations of custodial staff to prevent patient elopement and ensure a safe environment, collaboration with custodial staff should not compromise the physician's independent clinical judgment.

Many physicians work in custodial settings under contract with government agencies, private companies, or correctional institutions. This contractual employment structure can exacerbate dual loyalty conflicts by tying physicians to institutional priorities over patient care. Contracts may pressure physicians directly or implicitly to compromise patient care in favor of reducing costs, limiting advocacy, or avoiding reporting institutional abuses. Resource limitations, including restricted staffing, short appointment times, or limited access to specialty care, can reduce both physician and patient autonomy.[47] Additionally, physicians may be asked to perform evaluations for parole, fitness for duty, or legal compliance, creating further tension between the patient's best interests and institutional or legal requirements, potentially leading to moral distress for physicians.[47]

The *Code* directly addresses the ethical implications of such arrangements. Opinion 11.2.3, "Contracts to Deliver Health Care Services," emphasizes that contracts with institutions or employers should not interfere with physicians' independent medical judgment, nor should they restrict their ability to provide clinically appropriate care or to advocate for the needs of their patients. Despite clear ethics guidelines, pressure to stay loyal to employers and to not risk facing blowback or negative consequences from reporting abuse remains prevalent. While medical professionals have a duty to report abuse in the best interests of patients, such as any potentially inappropriate use of shackles during labor and delivery, such violations continue to occur even in states with legislative bans.[47-49] An expose in New York prisons demonstrated how, between 2010 and 2024, researchers identified 61 allegations of prison medical staff "concealing evidence of guards' abuse, usually by forgoing examinations or not documenting injuries."[51]

A common example of a conflict of interest that may lead to improper care is the involvement of custodial staff in medical decision-making, even when patients retain medical decision-making capacity.[52] Patients in legal custody maintain the right to make their own healthcare decisions and appoint a surrogate decision-maker in the event of future incapacity; however, physicians often lack awareness of this legal and ethical right.[16] It is not uncommon in clinical settings for physicians to mistakenly default to custodial staff instead of the patient for medical decision-making.[53] When a patient in custody lacks decisional capacity and has not previously designated a surrogate, or the patient in legal custody is a minor and their parent or legal guardian is not accessible, the legal standard for surrogate decision-making that applies to other patients in that

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jurisdiction should be followed. In the case a surrogate cannot be identified, it is ethically necessary to obtain a court-appointed surrogate rather than defaulting to custodial staff in order to ensure that the patient's best interests are protected and decision-making is made by someone free from conflicting loyalties to custodial authorities and who is not inappropriately influenced by the patient's custodial status.

Additional Impacts of Institutional Oversight

Patients who are in legal custody are afforded the right to basic healthcare by federal law; however, governmental guidance and practical policies are incomplete or inconsistently implemented, contributing to ethical pitfalls in the care of patients in legal custody. The *Code,* however, holds physicians, healthcare organizations, and physician employers accountable for advocating for changes to promote high-quality care for all patients (Opinion 11.2.1, Opinion 11.2.7). Federal and state policies should be developed to support physicians in their ethical and professional obligation to prioritize patient care as well as recognize the unique challenges and potential areas of confusion physicians face when caring for patients in legal custody. Institutions should also develop policies and guidelines that recognize barriers that lead to differences in care and health outcomes for people in legal custody, including restrictions on autonomy and dual loyalty conflicts, and provide physicians with actionable steps to overcome those barriers rather than ignore or accept them.[54]

In 2025, the U.S. Secretary of Homeland Security rescinded guidelines limiting ICE enforcement in hospitals,[55] thus increasing the interactions of hospital employees with immigration officers. While hospitals are directed to train staff, guidelines are fragmented, often provide conflicting advice, and perpetuate ethical violations relating to patient care, including failures to provide continuity of care or proper discharging of patients, the ethical obligations outlined in Opinion 1.1.5, "Terminating a Patient-Physician Relationship.[56] This lack of institutional organization perpetuates confusion among physicians despite the *Code*'s existing ethics guidance. The BMC Recurring Shackle Assessment embedded in the EHR is one example of a policy supporting physicians' advocacy for patients and demonstrates that effective policies can reduce ethical violations.

Financial factors also arise as a barrier to care.[48] While more recent studies are lacking, as of 2016, the rate of patients who were incarcerated that received medical care for an existing health problem was significantly less within facilities charging co-payments for medical visits.[57] The National Commission on Correctional Health Care (NCCHC) is opposed to fees or co-pays that may restrict people's access to healthcare,[58] and the AMA encourages physicians to be mindful when "arrangements have the potential to put patients' interests at risk" (Opinion 11.2.3) and guides physicians and organizations to advocate for policy changes when patient access to care is restricted (Opinion 11.2.7).

Additionally, visitation policies vary wildly and often act as an impediment to surrogate decision-making, despite patients in custody's legal right to an advance directive and a surrogate if they lack decisional capacity.[59] When patients in legal custody lack decisional capacity, physicians often express uncertainty regarding who the appropriate decision-maker should be and often give deference to prison authority.[60] However, custodial staff acting as a surrogate has natural liabilities, as the staff have conflicts of interests in pursuit of the state's interest, may not know patient preferences, or do not have the best interest of the patient at heart.[21,61] Therefore, custodial staff should be treated as outside observers to medical treatment and should not be defaulted to as surrogate decision-makers. When patient health information must be disclosed to custodial staff, disclosure should be limited to the minimum amount necessary. Compromises to patient privacy

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should be limited only to when there is an unmitigable threat to patients, physicians, or public safety that outweighs the harms of denying privacy and confidentiality.

CONCLUSION

Patients in legal custody face threats to their ethical rights due to external factors such as a loss of autonomy and the consequences of inherent dual loyalty conflicts faced by their physicians. Lacking or inconsistent institutional policies and guidelines often lead to undue harm from these external factors, such as impacts to respect, dignity, timely care, alternative care options, decisional autonomy, privacy, confidentiality, informed consent, and continuity of care. While the *Code* does not explicitly address the care of patients in legal custody, its opinions pertain to the care of all patients, including those in legal custody. Furthermore, the *Code* is clear that physicians and healthcare organizations, including custodial institutions, have ethical obligations to advocate for vulnerable populations and make policy changes to promote equitable care for all patients.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

1. Patients in legal custody possess the same inherent human dignity and right to healthcare as all other patients. Regardless of custodial status, the formation of a patient-physician relationship obligates the physician to work to advance the good of the patient and to uphold respect for patients as persons. Physicians must approach patients in legal custody with a nonjudgmental regard and not allow invidious discrimination or assumptions about criminality to undermine their clinical judgment or the quality of care provided.

   Patients in legal custody face unique circumstances that render them especially susceptible to harm and healthcare inequities. Understanding the historical, structural, institutional, and legal factors that contribute to their vulnerability provides essential insights that can assist physicians in upholding their ethical responsibilities and optimizing patient care. Confinement, surveillance, dependence on custodial officials, and loss of legal rights can disrupt access to healthcare services and challenge physicians' ability to uphold their ethical obligations to privacy, confidentiality, and the provision of safe, equitable care. Physicians must ensure the primacy of patient welfare and professional independence despite real or perceived conflicting loyalties to custodial authorities.

   When caring for patients in legal custody, physicians should:

   (a) Provide care according to the same professional standards that apply to all patients, and work to identify and eliminate individual and systemic biases that threaten their care.

   (b) Mitigate real or perceived conflicts of interest and divided loyalties that may interfere with the delivery of equitable, high-quality care.

   (c) Respect their right to make their own medical treatment decisions and optimize the ability of patients to provide informed consent, including for treatments at the end of life. For patients lacking medical decision-making capacity, utilize a legally authorized surrogate decision-maker who is free from conflicting loyalties to custodial authorities and who will make medical treatment decisions based on ethically appropriate standards unless otherwise legally compelled.

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(d) Uphold patient privacy and confidentiality to the greatest extent possible. Limit disclosures of patient health information to custodial staff to the minimum amount necessary and obtain patient consent to disclose when possible.

(e) Attempt to mitigate the harms of shackling or other custodial restraints when imposed by custodial staff, and advocate for the least restrictive use of custodial restraints safely possible, especially when they interfere with care delivery, with special attention to those most vulnerable to harm.

(f) Strive to ensure safe disposition and continuity of care when patients are discharged or return to custody.

(g) Support efforts within healthcare institutions to identify and improve policies and procedures that create barriers to optimal care, establish mechanisms for documenting and reporting abuse and neglect, and mitigate conflicts of interest and conflicting loyalties that may threaten the physician's obligation to the primacy of patient welfare.

(h) Advocate with custodial staff and legal authorities to optimize patient access to high-quality, equitable medical care, and advocate for change when patient care or the ethical obligations of physicians are compromised by institutional policies and practices or custodial staff actions that are beyond the physician's control.

(New HOD/CEJA Policy)

2. That the third directive of Policy D-345.970 be rescinded as it has been accomplished by this report (Rescind AMA Policy)

Fiscal Note: Minimal

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REPORT 06 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (I-26)
Recording Clinical Encounters

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, Resolution 002, "Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters," was referred. The Council on Ethical and Judicial Affairs has deemed it necessary to expand the scope of this report beyond just wearable recording devices and analyze issues relating to the use of multiple recording technologies during clinical encounters by both patients and physicians, with recommendations for new ethics policy as well as revisions to existing policy.

The use of recording technologies has the potential to benefit physicians and patients, but these benefits must be weighed against the associated risks. Recordings of clinical encounters should be made in a respectful and open manner that upholds the rights of all parties involved. Covert recordings (by either physician or patient) may endanger trust and hurt the patient-physician relationship if the situation is not carefully managed. Recording a clinical encounter by either patients or physicians necessitates that great care be taken not to cause harm to any party, which requires trust and transparency. Recording technologies also create the potential for unintended outside observers to be brought into clinical encounters. In order to support patients and uphold all parties' ethical obligations, physicians should only use recording technologies for clinical purposes, and, while the *Code* does not speak to patients, patients should generally only use such technologies during clinical encounters for the purpose of improving their own well-being.

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 06-I-26

Subject: Recording Clinical Encounters

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2025 Interim Meeting, Resolution 002, "Ensuring Ethical Use of Wearable Recording Devices in Clinical Encounters," was referred. The resolution asks:

> 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. (Directive to Take Action); and be it further
>
> 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. (Directive to Take Action)

Resolution 002 specifically cites AMA *Code of Medical Ethics* opinions 3.1.3, "Audio or Visual Recording Patients for Education in Health Care," and 3.1.4, "Audio or Visual Recording of Patients for Public Education." This report provides analysis of issues relating to the use of recording technologies during clinical encounters by both patients and physicians and offers recommendations for ethics policy.

BACKGROUND

Technological advances have made it increasingly easy to record information and to do so discreetly. The development of personal and wearable recording devices, from smartphones to glasses with recording capabilities, is driving societal and ethical controversy over their covert ability to record audio and video,[1] along with integrated AI technologies, such as facial recognition.[2]

In contrast to these technologies, there are also personal smart health devices that collect and track a wide variety of health data, such as movement trackers or data recorders of sleep, heart rate, blood pressure, or other types of physiological information.[3,4] While these type of wearable devices track and record health data (and sometimes also use video to track data[5]), they are categorically

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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different from audio-visual recording devices. In somewhat of a middle ground are ambient transcription tools, which can create written and audio records of conversations and which are becoming increasingly common tools for physicians to use during clinical encounters for note-taking purposes. Although there is some overlap of issues associated with audio-visual recording devices and wearable devices for tracking health data, such as concerns regarding privacy and data security,[6] the key issues with health tracking devices are generally distinct from those associated with audio-visual recording devices. A primary area of concern for audio-visual recording centers on consent and disclosure.[7]

This report focuses primarily on personal audio-visual recording devices, especially those that can covertly record conversations or interactions between physicians and patients. In recent years, covert recordings with the use of wearable devices during clinical encounters have raised concerns and questions, both among patients and physicians. Incidents of recordings, given the ubiquitousness of the technology, are rising, performed by both patients and physicians,[8] and are taking place both with and without permission.[9,10] Covert recordings may endanger or negatively impact the patient-physician relationship, especially if a lack of dialogue leads to mistrust or fears of misuse.

Importantly, recording technologies can help improve the clinical experience by "recording care in the moment"[11] and offer useful applications in research, training, audits, quality improvement (QI) initiatives, streamlining consultations, and safety surveillance. However, these benefits are coupled with risks to patient privacy and data security, as rapid technological innovation raises questions about proper security protocols to protect patients, physicians, and data.[11]

Relevant Legal Provisions

A notable legal concern associated with the use of wearable recordable devices in clinical encounters is the fact that the federal government and states may have different rules regarding consent to record conversations. The Electronic Communications Privacy Act[12] is a federal wiretapping law that "prohibits the interception and disclosure of wire, oral, or electronic communications without specific consent of at least 1 party."[13] Some states follow the federal "one-party" rule, while other states like California and Florida have adopted an "all-party" consent rule.[13]

Additionally, with regards to Health Insurance Portability and Accountability Act (HIPAA) compliance, whether the video is subject to HIPAA standards will depend on if it is created or received by a covered entity, like a physician. Notably, any recording made by a patient (and then not given to a physician) is not subject to HIPAA.[9] This reflects an imbalance of protections and responsibilities between physician and patient, and presents an asymmetric legal risk that may engender distrust between them.[10]

Relevant AMA Policy Provisions

There are no House policies that directly address personal or wearable recording devices. However, there are a few related policies, which broadly support principles of patient privacy and confidentiality. Policy H-315.983, "Patient Privacy and Confidentiality," affirms our AMA's commitment to upholding privacy and confidentiality, a stance reaffirmed in Policy H-315.990, "Confidentiality of Computerized Patient Records." Policy H-480.943, "Integration of Mobile Health Applications and Devices into Practice," outlines our AMA's support of patient privacy specifically within the context of mobile health apps and associated devices, trackers, and sensors. Lastly, Policy 315.990 reaffirms the importance of confidentiality of patient records "regardless of

the form in which they are stored" and highlights the importance of "regulating third parties' use of computerized patient records."

Relevant Code *Provisions*

The *AMA Code of Medical Ethics* speaks broadly to the relevant issues of patient respect and autonomy, informed consent, safety, privacy, and confidentiality in multiple opinions, including: Opinion 1.1.1, "Patient-Physician Relationships"; Opinion 1.1.3, "Patient Rights"; Opinion 1.1.6, "Quality"; Opinion 2.1.1, "Informed Consent"; Opinion 3.1.1, "Privacy in Health Care"; Opinion 3.1.2, Patient Privacy & Outside Observers to the Clinical Encounter"; and Opinion 3.2.1, "Confidentiality." Taken together, these opinions highlight the importance of upholding patients' rights and ensuring that these rights are not violated if audio-visual recordings are made during clinical encounters.

Conversely, Opinion 1.1.4, "Patient Responsibilities," highlights patients' ethical obligations and is a reminder that any recording done by patients should not interfere with their responsibilities to be truthful and forthcoming, be aware of and refrain from behavior that could jeopardize the health of others, and refrain from disruptive behavior. This includes refraining from making recordings with vindictive or malicious intent.

Additionally, there are two *Code* opinions that directly relate to audio and visual recordings of patients; however, these opinions only speak to the context of recording patients for educational purposes. Opinion 3.1.3, "Audio or Visual Recording Patients for Education in Health Care," speaks to audio and visual recordings as valuable tools for healthcare professionals but notes that physicians must balance educational goals with upholding patient privacy and confidentiality. Similarly, Opinion 3.1.4, "Audio or Visual Recording of Patients for Public Education," addresses how audio and visual recordings of patient care for public broadcast can help educate the public about healthcare, but states physicians also have an obligation to protect patient interests and ensure that professional standards are upheld. While the context for these opinions is not clinical care, both highlight the need to secure patient consent.

Despite the abundance of relevant ethics policy, there is no current opinion in the *Code* that directly addresses the use of personal recording devices by patients or physicians during clinical encounters.

ETHICS ISSUES

There exist several ethical issues associated with the use of recording technologies in clinical encounters, including patient autonomy, confidentiality, privacy, informed consent, safety, trust, and data security. Any type of recording (audio, visual, ambient, or transcription) may provide some record of a patient's intimate details, which, if not properly stored or safeguarded, could substantially violate a patient's privacy and could constitute a breach of confidentiality. However, such recordings can be valuable if they enhance clinical encounters, allow the physician to perform QI initiatives, or streamline medical recordkeeping. The recording of a clinical encounter by either patients or physicians necessitates that great care be taken not to cause harm to any party, which requires trust and transparency.[14]

Covert recordings (by either physician or patient) may endanger trust and hurt the patient-physician relationship if the situation is not carefully managed. Data on physician attitudes and responses to patient-initiated recordings are mixed, with some supportive but others finding that recordings may

inhibit discussion between the physician and patient.[15] Experts now advise that physicians should "strive to treat every interaction with a patient as if it were being recorded and to carefully consider the complex ethical considerations at play" and approach recordings "with a more amicable orientation."[16]

ETHICS ANALYSIS

It is important to emphasize that, ethically, video and audio recordings, including ambient transcriptions, produced by physicians or patients should only occur for clinical use, training (either for AI tools or other clinical staff), QI initiatives, research, education, or similar clinical purposes.[17] If a recording is produced by a physician and it is not for clinically relevant purposes, such as for a physician's personal use that is not medically related, then there exists no ethical basis for such recordings, even if patient consent is obtained. This is largely due to the inherent asymmetry of power in the patient-physician relationship and the potential for coercion, even if unintended. A potential exemption may be considered in cases of recordings for marketing purposes, though such instances must meet a high ethical barrier that includes far more than just obtaining informed consent and which must also adhere to the standards set out in *Code* Opinion 9.6.1, "Advertising & Publicity." Conversely, patients should not record clinical encounters without disclosing their intent to do so, obtaining consent where legally required, and acting in compliance with all institutional patient policies, and should generally only record medical encounters with the intention of supporting their own well-being specifically in relation to their medical visit.

Recordings by Physicians

From the medical perspective, recordings during clinical encounters are ethically appropriate only if their potential benefits have first been fully weighed against potential disadvantages.[18] While recording technologies offer clinical benefits, including for patient care, medical education, and QI initiatives, their adoption also presents complex ethical concerns regarding patient privacy, consent, data management and security, and resource allocation.[19] To ameliorate these concerns, all recorded patient data must be HIPAA compliant and must be recorded only for clinical purposes. Patients should be reasonably informed about what will be recorded and the purposes of the recording. The use of any recording technology, including ambient listening tools, should be disclosed to patients, and informed consent should be obtained when necessary, such as when imaging sensitive areas.[20] Patients should be given the opportunity to decline the use of recording technology, and physicians should meaningfully engage with patients to answer any questions or concerns they may have regarding the use of such technology.[20]

While it may be ethically permissible to use recordings of clinical encounters for advertising or publicity in certain circumstances, such instances should generally be discouraged. The use of recordings of clinical encounters for marketing creates risks to patient privacy and confidentiality, places undo pressure on informed consent due to the power differential in the relationship, creates the potential for an implied improper *quid pro quo* agreement, and in today's social media environment creates the risk that such advertising becomes infotainment that diminishes the professional nature of the practice of medicine—all of which would not have otherwise occurred.[21,22] In fact, prior to the Federal Trade Commission suing the AMA in 1975 over perceived restraint of trade, which forced the AMA to change its stance in the *Code*, the AMA had been unambiguous in its position since 1847 that advertising is the antithesis of professionalism and should be forbidden by physicians.[23,24]

Recordings by Patients

While physicians are bound by professional ethics, patients are not held by the same professional obligations. Patients should generally only record clinical encounters in order to expressly support their well-being, such as to enable their review of verbal instructions and discussions related to their care or to assist with language barriers or learning difficulties, and not for retaliatory or other non-medically related purposes. Patients may wish to record a clinical encounter to help uphold accountability and protect against wrongdoing in support of their well-being but should not use such recordings in a coercive manner. Unfortunately, some patients may intend to surreptitiously record clinical encounters for malicious purposes; such actions violate patients' own responsibilities to refrain from disruptive behavior and be truthful and forthcoming with their physicians, which can severely damage trust and the patient-physician relationship.

If being recorded makes a physician uncomfortable, they should discuss this with the patient. If some form of understanding cannot be reached, the physician has the right to terminate the relationship consistent with *Code* Opinion 1.1.5, "Terminating a Patient-Physician Relationship." In such an instance, the physician must not immediately cease the provision of care and must facilitate the transfer of care and ensure that the patient has sufficient time to secure another physician before terminating the relationship.

In some circumstances, patients may wish to record their own clinical encounter as a means to share their experience and educate other patients. Similarly, some patents may wish to record their clinical experiences as a form of memento or a record of a personal journey, such as may occur during chemotherapy or during the birth of a child. Such instances generally constitute an appropriate and ethical use of recording technologies and may be broadly construed as part of patient well-being, though ethical procedures for recordings should still be upheld, such as ensuring other patients are not inadvertently recorded without their consent.

Before recording, patients should notify the physician of their intent to record, explain their reasoning for doing so, and ideally obtain consent from the physician to record the interaction in order to support clear communication and trust. However, patients do not always adhere to such practices, sometimes on purpose but also often out of ignorance. To support and protect physicians and facilitate trust and clear communication that underlie the patient-physician relationship, institutions can establish policies for the use of recording devices by patients and families, educate staff and volunteers about such policies, make information regarding such policies highly visible to patients, and provide written information regarding such policies to patients.[25]

Responsibilities of Healthcare Institutions

In addition to establishing policies and procedures for the use of recording devices and educating patients and physicians about them, healthcare institutions also should ensure proper safeguards are in place related to data governance, stewardship, and security for recordings made by physicians in clinical settings. This can be particularly challenging when it comes to ambient scribe tools, as significant privacy risks are introduced by passively recording clinical encounters. These risks include the introduction of third-party vendors with potential access to audio and text data from encounters as well as increased targets for cyberattacks due to multi-vendor chains of data handling introduced by cloud-based data processing. In addition to local data, cybersecurity, and cross-border governance, healthcare institutions also face challenges due to uncertain and evolving regulatory frameworks for ambient transcription tools. Of note, the "ambient" terminology may also be misleading, obscuring the fact that data are not entirely passive, as they are often stored outside the institution's electronic health record. Ambient scribe technologies can also generate

multiple data artifacts far beyond finalized clinical notes, including raw audio recordings, conversation transcripts, draft outputs, prompts entered by users, and provenance logs, with governance of these data streams often unspecified or unclear to physicians.[26]

The data collected from recording devices, especially those that collect a large volume of data such as ambient transcription tools, have been proposed as potentially useful for research; however, such practices would create ethical challenges. While there may be valuable research information that could be mined from such data, obtaining informed consent for unspecified purposes poses an ethical dilemma, as such broad or blanket consent policies fall short of true informed consent requirements for research. The involvement of third-party vendors also raises questions regarding who has access to and ownership of the data and for what purposes the data could be used. Though it may be possible to de-identify such data for QI initiatives or for health research that could fall under the ethically approved purpose of recordings used "for clinical care," this would only be ethically permissible if patients are properly informed and consented in compliance with existing ethical standards. At present, such research practices likely infringe upon patients' rights to autonomy, confidentiality, privacy, and informed consent and thus should be avoided.

CONCLUSION

The use of recording technology has the potential to benefit physicians and patients, but these benefits must be weighed against the associated risks. Recordings of clinical encounters should be made in a respectful and open manner that upholds the rights of all parties involved. Institutions have an ethical obligation to inform patients of their rights and responsibilities regarding the recording of clinical encounters, as well as to train physicians how and when to appropriately use such technologies themselves.

Recording technologies also create the potential for unintended outside observers to be brought into clinical encounters. Patients or physicians might post videos to online social media platforms, while device manufacturers might capture user data that potentially infringe upon patient privacy, especially as new technology makes de-identified data easier to re-identify, blurring traditional lines of who can be or should be considered an outside observer. In order to support patients and uphold all parties' ethical obligations, physicians should only use recording technologies for clinical purposes, and patients should typically only use such technologies during clinical encounters for the purpose of improving their own well-being.

In general, physicians should remember to maintain professionalism in all patient interactions and that all conversations have the potential to be recorded. If a patient asks to record a clinical encounter, physicians should consider it a sign of patient engagement, ascertain the rationale for the recording to determine if it is ethically appropriate, and, if necessary, help to ensure that recordings do not capture other patients or staff without their express consent to uphold privacy and confidentiality. Institutions should develop policies and procedures for recordings by patients and should train physicians and other medical staff on how to respond to patients recording or making requests to record.[27]

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

1. Recording technologies can help improve the clinical experience but also present risks to privacy, safety, security, and trust. Any type of recording (audio, visual, or transcription) of the

clinical encounter may provide some record of a patient's intimate details and, if made by or provided to a physician, constitutes a part of the medical record. The recording of a clinical encounter by either patient or physician necessitates that great care be taken not to cause undue harm to any party and requires transparency, communication, and trust. Covert recordings (by either physician or patient) endanger trust and harm the patient-physician relationship. Physicians should not record patients for non-medically relevant purposes, such as for a physician's personal use that is not medically related, even if patient consent might be obtained.

Conversely, physicians should help patients understand that they should not record clinical encounters without disclosing their intent to do so, obtaining consent where legally required, and acting in compliance with all legal and clinical regulations and should generally only record medical encounters with the intention of supporting their own well-being. If a patient asks to record a clinical encounter, physicians may inquire about the patient's intent and, if appropriate, help to ensure that recordings do not capture other patients or staff without their express consent to uphold privacy and confidentiality. If the physician suspects that a patient wishes to record a clinical encounter due to distrust, the physician should strive to find ways to build trust in the patient-physician relationship. In general, physicians should remember to maintain professionalism in all patient interactions and that all interactions have the potential to be recorded.

When recording clinical encounters, physicians should:

(a) Inform the patient (or authorized decision maker) of the intent to record and:

  (i) the purpose of the recording;

  (ii) that any uses of the recording will be limited to those related to healthcare;

  (iii) that they may withdraw consent to being recorded at any time, including during recording, and, if so, what will be done with the recording;

  (iv) their right to access and request that information recorded be amended for accuracy as part of their medical record;

  (v) assure the patient that their information will be treated as confidential health information and stored securely but acknowledge that no information can be perfectly secured.

(b) Ensure that the patient has the opportunity to discuss any concerns about recording before, during, and after recording.

(c) Obtain consent from the patient (or the authorized decision maker) prior to recording whenever possible.

(d) In the case of minors, seek assent from the patient in addition to consent from the patient's parent or guardian.

(e) Ensure recordings are securely stored and, when necessary, properly destroyed, in keeping with ethics guidance for managing medical records.

(f) Engage openly with patients who wish to record their own clinical encounter. If the physician believes a patient recording compromises the patient-physician relationship, the physician may choose to terminate the relationship in keeping with ethics guidance.

To support patients and physicians, physician leaders in healthcare institutions should:

(g) Create clear policies and procedures for the use of recording devices within their institutions by physicians.

(h) Create clear policies and procedures for the use of recording devices within their institutions by patients and families.

(i) Make information regarding such policies and procedures highly visible to patients and families, including by providing written information regarding such policies to patients.

(j) Educate and train staff and volunteers about such policies and procedures.

(k) Train physicians and other medical staff on how to respond to patients recording or making requests to record.

(l) Advocate that patients only record clinical encounters in order to expressly support their well-being and not for retaliatory or other non-medically related purposes.

(m) Advocate that before recording, patients notify the physician of their intent to do so, explain their reasoning for doing so, and obtain consent from the physician to record the interaction.

(n) Minimize third-party exposure to patient care, including recordings and associated data. (New HOD/CEJA Policy)

2. That Opinion 3.1.2, "Patient Privacy & Outside Observers to the Clinical Encounter," be amended by addition and deletion as follows:

Individuals legitimately present during patient-physician encounters include those directly involved in the patient's care, and can include other members of the healthcare team or employees of pharmaceutical or medical device companies when they are present to provide technical assistance, in keeping with ethics guidance. However, recording technologies expand the notion of who counts as an outside observer by enabling third parties to access aspects of clinical encounters (including associated patient data) without being physically present at the time of a clinical encounter.

When individuals or entities who are not involved in providing care seek to observe patient-physician encounters, e.g., for educational, commercial, or governmental purposes, physicians should safeguard patient privacy by permitting such outside observers ~~to be present during~~ access to a clinical encounter only when:

(a) The patient has explicitly agreed to ~~the presence of~~ grant the observer(s) access. Outside observers or recordings should not be permitted when the patient lacks

decision-making capacity, except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.

(b) ~~The presence of~~Granting access to the observer, including access to recorded data, will not compromise care.

(c) The observer understands and has agreed to adhere to standards of medical privacy and confidentiality.

Under no circumstances should physicians accept payment from outside observers, including vendors, to allow ~~those observers~~ them to ~~be present during~~ observe a clinical encounter.

To support patients and physicians, healthcare institutions should:

(d) Ensure that granting access to third-party observers to clinical encounters, including access to patient data, does not cause harm to patients or patient populations.

(e) Minimize third-party exposure to patient care, including recordings or any associated patient data. (Modify HOD/CEJA Policy)

3. That Opinion 3.1.3, "Audio or Visual Recording Patients for Education in Health Care," be amended by deletion as follows:

Audio or visual recording of patients can be a valuable tool for educating healthcare professionals, but physicians must balance educational goals with patient privacy and confidentiality. The intended audience is bound by professional standards of respect for patient autonomy, privacy, and confidentiality, but physicians also have an obligation to ensure that content is accurate and complete and that the process and product of recording uphold standards of professional conduct.

To safeguard patient interests in the context of recording for purposes of educating healthcare professionals, physicians should:

(a) Ensure that all nonclinical personnel present during recording understand and agree to adhere to medical standards of privacy and confidentiality.

(b) Restrict participation to patients who have decision-making capacity. Recording should not be permitted when the patient lacks decision-making capacity except in rare circumstances and with the consent of the parent, legal guardian, or authorized decision maker.

(c) Inform the patient (or authorized decision maker, in the rare circumstances when recording is authorized for minors or patients who lack decision-making capacity).
   (i) about the purpose of recording, the intended audience(s), and the expected distribution;

(ii) about the potential benefits and harms (such as breach of privacy or confidentiality) of participating;

(iii) that participation is voluntary and that a decision not to participate (or to withdraw) will not affect the patient's care;

(iv) that the patient may withdraw consent at any time and, if so, what will be done with the recording;

(v) that use of the recording will be limited to those involved in healthcare education~~, unless the patient specifically permits use by others~~.

(d) Ensure that the patient has had opportunity to discuss concerns before and after recording.

(e) Obtain consent from a patient (or the authorized decision maker):

(i) prior to recording whenever possible;

(ii) before use for educational purposes when consent could not be obtained prior to recording.

(f) Respect the decision of a patient to withdraw consent.

(g) Seek assent from the patient for participation in addition to consent by the patient's parent or guardian when participation by a minor patient is unavoidable.

(h) Be aware that the act of recording may affect patient behavior during a clinical encounter and thereby affect the film's educational content and value.

(i) Be aware that the information contained in educational recordings should be held to the same protections as any other record of patient information. Recordings should be securely stored and properly destroyed, in keeping with ethics guidance for managing medical records.

(j) Be aware that recording creates a permanent record of personal patient information and may be considered part of the medical record and subject to laws governing medical records. (Modify HOD/CEJA Policy)

Fiscal Note: Minimal

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REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 07-I-26

Subject: Physicians Are Not Providers

Presented by: Larry E. Reaves, MD, Chair

Referred to: Reference Committee on Ethics and Bylaws

At the 2026 Annual Meeting, the House of Delegates (HOD) adopted H-405.942, "Physicians are not Providers." The fourth item of this policy states:

> 4. Our AMA refers the issue of "Physicians are not Providers" for possible consideration by the American Medical Association's Council on Ethical and Judicial Affairs (CEJA).

This report is submitted to the HOD in fulfillment of the above directive and outlines relevant opinions in the *Code of Medical Ethics* that address ethical issues related to physician practice terminology.

BACKGROUND & ETHICS ISSUES

It is widely recognized that medicine is a learned profession, that the practice of medicine is a calling, not a trade. To describe medicine as such is to recognize the trust placed upon the profession, the corresponding rights granted by the public, and the associated ethical duties that physicians are accountable for and must uphold. Yet medicine as a profession has increasingly come under threat from commercial forces in recent decades that have driven trends in deprofessionalization. One such example is the use of the term *provider* to describe physicians and other healthcare professionals. The effect of this inaccurate terminology is not only harmful to medicine as a profession but also carries detrimental ethical consequences, as outlined in the July 2025 American College of Physicians position paper, "Physicians Are Not Providers: The Ethical Significance of Names in Health Care: A Policy Paper from the American College of Physicians."[1]

The use of the term *provider* is ethically problematic largely because it undermines professionalism and the corresponding ethical obligations. Its use creates confusion and misconceptions, as the term *provider* is often applied to a wide range of entities, including institutions, insurers, physicians, nurses, physician assistants, and other clinicians, thereby obscuring differences in clinical training, expertise, and obligations to patients. Of great concern is that the term creates the appearance of a transactional relationship, but patient-physician relationships are relational and built on trust; the patient is not merely a consumer but an autonomous individual who enters the relationship seeking care from a trained physician who is bound by ethical duties to help and who must act first and foremost in the patient's best interest. Importantly, not only does the use of the term *provider* negatively impact patients' and the public's view of physicians and other healthcare professionals,

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Ethics and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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but it can also negatively alter physicians' own sense of self, perceived professional value, and behavior.[1]

RELEVANT POLICY & *CODE* OPINIONS

AMA Policy H-405.968, "Clarification of the Term 'Provider' in Advertising, Contracts and Other Communications," states: "Our AMA […] considers the generic terms 'health care providers' or 'providers' as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches." This policy is in alignment with the Principles outlined in the *AMA Code of Medical Ethics,* which clearly refers to the practice of medicine as a profession. This position is also outlined in the very first opinion in the *Code*, Opinion 1.1.1, "Patient-Physician Relationships," which states: "The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship that emerges between a patient and a physician must be based on trust." This trust is fundamentally undermined by the use of the term *provider*.

ETHICS ANALYSIS & CONCLUSION

In ethics, words matter. The use of the term provider to refer to physicians and other healthcare professionals is not only inaccurate; it is ethically misleading and potentially dangerous. Existing House policy and ethics policy in the *Code* is clear: physicians are not providers and should not be referred to as such. In accordance with Policy H-405.968, the term *provider* should not be used in lieu of *physician*.

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the fourth item of Policy H-405.942, "Physicians are not Providers," be rescinded as having been accomplished by this report.

Fiscal Note: Minimal

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-26)

Introduced by: Medical Student Section

Subject: Recognition of Intersex Individuals and their Human Rights

Referred to: Reference Committee on Ethics and Bylaws

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

Whereas, intersex is not synonymous with gender identities outside the male-female binary, such as "non-binary" or "undesignated," and individuals who are intersex may identify with any gender, including man, woman, cisgender, or transgender[2]; and

Whereas, while intersex individuals may choose to self-determine their gender identity, they should also have the right to identify as intersex as a distinct legal sex category, consistent with precedent of intersex individuals seeking recognition of their intersex identities in legal sex documentation outside of nonbinary gender markers[3-5]; and

Whereas, in January 2025, the President of the United States issued an executive order, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, which erased the recognition of intersex individuals by asserting a sexual binary defined by medically inaccurate terms[6]; and

Whereas, this legal and administrative oversight for intersex individuals reduces recognition of their legitimate identity outside of the gender binary and increases the disparities experienced by intersex people in all aspects of life, including healthcare, and violates their human rights[7,8]; and

Whereas, the United Nations Committee against Torture recommends that legislative and administrative procedures are in place to protect the recognition of intersex individuals and their capacity to make decisions regarding their individual personal integrity and bodily autonomy[9]; and

Whereas, the requirements and necessary documentation needed to obtain accurate identification are inconsistent across different regions of the United States, often placing an undue burden on intersex individuals seeking accurate identification[10]; and

Whereas, a study evaluating 1.5 million patient profiles from the Mass General Brigham Epic EHR system revealed three sex and gender demographic fields comprising "Legal Sex", "Sex Assigned at Birth", and "Gender Identity", where the classification of "X" was restricted solely to the "Legal Sex" field[11]; and

Whereas, the use of multiple demographic and clinical data fields in electronic health records, including legal sex, sex assigned at birth, and gender identity, has been shown to support more

accurate, patient-centered care than reliance on a single designation, thereby enabling inclusive identifiers such as “X” to coexist with safe and individualized medical decision-making[12]; and

Whereas, given the patchwork, bad-faith legislative landscape, as evidenced by the Kansas Senate Bill 244 and Louisiana House Bill 578, a binary definition of sex may compel the removal of “X” and other non-binary classifications in EHR databases[13,14]; and

Whereas, the absence of an "Intersex”, “X”, or "DSD" designation in medical records may leave clinicians without critical and necessary "safety flags” or clinical decision support tools to bypass standard binary screening and care algorithms in favor of individualized care; therefore be it

RESOLVED, that the American Medical Association support the right of intersex individuals, including individuals with Differences of Sex Development (DSD) and variations in sexual characteristics (VSC), to have “intersex” or other inclusive alternatives, such as “X,” beyond the sex binary available as a sex designation at birth or selected later in medical and legal documentation at both the federal and state levels. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-26)

Introduced by: Ohio

Subject: Surgical Consent

Referred to: Reference Committee on Ethics and Bylaws

Whereas, Ohio Rule 4731-25-08 section A calls for the surgeon to personally examine a patient for elective surgery and personally obtain informed consent; and

Whereas, several physicians are relegating the initial determination of need for surgery to their PA or NPs without examining the patient themselves. The first time that the physician personally meets the patient, performs a physical exam, and obtains informed consent is in preoperative area, immediately prior to the patient's scheduled procedure. This means that the initial decision for surgery was initially made by a non-physician and not the surgeon; and

Whereas, the surgeon potentially disagreeing with the relegated decision for surgery at the last moment may disrupt the ethical integrity of the patient-physician relationship and informed consent process; and

Whereas, AMA Code of Medical Ethics does not address the delegation of initial determination of need for surgery and surgical informed consent to a non-physician under CEJA Opinion 2.1.1 Informed Consent; and

Whereas, this mechanism seems to be skirting the ethical guidelines of informed consent; and

Whereas, AMA ethical guidelines are not clearly defining this practice arrangement; therefore be it

RESOLVED, that our American Medical Association re-evaluate its CEJA guidelines regarding initial decision for surgery and informed consent - as practice patterns have changed and more team-based care is being utilized - in order to prioritize and strengthen the physician-patient relationship prior to all medical procedures and interventions (Directive to Take Action); and be it further

RESOLVED, that our AMA facilitate the creation of specialty-specific guidelines, inclusive of the entire house of medicine, defining meaningful supervision and informed consent processes for physician-led care. (Directive to Take Action)

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

Received: 9/1/26

REFERENCES:

AMA Code of Medical Ethics CEJA Opinion 2.1.1 Informed Consent.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials

Referred to: Reference Committee on Ethics and Bylaws

Whereas, online prediction market platforms, including Kalshi and Polymarket, have begun offering trades on the outcomes of clinical trials and on whether the U.S. Food and Drug Administration will approve new medications, with billions of dollars traded weekly on these lightly regulated platforms[1]; and

Whereas, investigators, research coordinators, pharmacists, and other trial personnel can directly influence the outcomes being traded, creating financial incentives to alter dosing, data collection, or trial conduct for a betting payout, thereby compromising scientific objectivity, trial integrity, and patient safety[1,2]; and

Whereas, trading by individuals with inside knowledge of confidential, unpublished trial data constitutes insider betting that platform surveillance safeguards cannot reliably prevent given the large number of personnel involved in the conduct of clinical trials[1]; and

Whereas, markets that reward bets on trial failure allow speculators to profit from the suffering of seriously ill patients and erode public trust in biomedical research and the physicians and scientists who conduct it[1]; and

Whereas, the AMA Code of Medical Ethics obligates physicians engaged in research to safeguard scientific integrity and to avoid financial conflicts of interest that could compromise the objectivity of research or the welfare of participants, yet does not currently address trading on research outcomes[3]; therefore be it

RESOLVED, that our American Medical Association strongly oppose the inclusion of biomedical research, including clinical trial outcomes and regulatory approval decisions, as subjects of trading on online betting platforms or prediction markets (New HOD Policy); and be it further

RESOLVED, that our AMA asks the Council on Ethical and Judicial Affairs to review and update the Code of Medical Ethics to address participation by physicians, medical trainees and other research personnel in trading on the outcomes of biomedical research and clinical trials (Directive to Take Action).

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

Received: 9/16/26

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RELEVANT AMA POLICY

H-275.939 Internet Gambling

1. Our American Medical Association informs physicians and patients of the dangers of addiction associated with Internet gambling and supports prohibiting the availability of Internet gambling to children.
2. Our AMA supports efforts to establish federal and state consumer protections for online gambling, including sports betting, prediction markets, and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors.
3. Our AMA supports epidemiological research to characterize the health impacts of online gambling, including sports betting, prediction markets, and daily fantasy sports, with particular attention to adolescents, young adults, older adults, people with cognitive impairment, and other vulnerable populations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-26)

Introduced by: Senior Physicians Section

Subject: Ethics of Medical Usury

Referred to: Reference Committee on Ethics and Bylaws

Whereas, the fragmented system of healthcare in the U.S. has led to a crisis of both the uninsured and underinsured, with four out of ten patients unable to afford a medical debt of even $400, and that medical debt is the leading cause of bankruptcy[1,2]; and

Whereas, due to recent federal legislative actions the population of those losing both private and public insurance will be significantly higher; and

Whereas, the current administration has proposed administrative rules that would allow insurance companies to offer interest bearing loans to patients unable to afford their medical bills[3]; and

Whereas, the ethics of insurance companies potentially trapping patients in long term debt has not been previously addressed; therefore be it

RESOLVED, that our American Medical Association recommends to CEJA that it develop statements and policy regarding the ethics of private insurance companies offering interest bearing loans to patients otherwise unable to afford medical debt. (Directive to Take Action)

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

Received: 9/16/26

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RELEVANT AMA POLICY

D-180.979 Health Plan Payment of Patient Cost-Sharing

Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.
[CMS Rep. 09, A-19]

H-155.954 Nonprofit Hospital Policies

1. Our American Medical Association advocates that all nonprofit hospitals be required to screen patients for charity care eligibility and other financial assistance program eligibility prior to billing.
2. Our AMA advocates to encourage debt collectors to ensure a patient has been screened for financial assistance eligibility before pursuing that patient for outstanding debt, provide an appeals process for those patients not screened previously or deemed ineligible, and require the hospital to reassume the debt account if an appeal is successful.
3. Our AMA advocates for the development on minimum standards for nonprofit hospital financial assistance eligibility programs which are publicly accessible.
4. Our AMA advocates for a standardized definition of what is considered a "community benefit" that includes addressing social drivers of health and population health when evaluating community health improvement activities and eligibility for nonprofit status.
5. Our AMA advocates for the development of transparent, publicly available, standardized data sets and/or reports on nonprofit hospital community benefit spending, including consideration of charity care-to-expense ratios.
6. Our AMA advocates for transparency and consistency regarding governmental oversight of nonprofit hospitals, enforcement of federal and/or state guidelines, and standards for community benefit requirements and reporting, including the ability to enact penalties and/or loss of tax-exempt status.
7. Our AMA encourages nonprofit hospitals to publicly share the results from assessments, such as the Community Health Needs Assessment (CHNA), including progress that has been made since the previous assessment, as well as areas where there is room for improvement.

[CMS Rep. 01, I-24; Modified: CMS Rep. 09, A-26]

H-373.990 Patient Medical Debt

1. Our American Medical Association encourages health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions.
2. Our AMA supports innovative efforts to address medical debt for patients, including sliding-scale, interest-free payment plans before collection or litigation activities and public and private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation.
3. Our AMA supports amending the Fair Debt Collection Practices Act to include hospitals and strengthen standards within the Act to provide clarity to patients about whether their insurance has been or will be billed, which would require itemized debt statements to be provided to patients, thereby increasing transparency, and prohibiting misleading representation in connection with debt collection.
4. Our AMA opposes wage garnishments and property liens being placed on low-wage patients due to outstanding medical debt at levels that would preclude payments for essential food and housing.
5. Our AMA supports patient education on medical debt that addresses dimensions such as:
    a. patient financing programs that may be offered by hospitals, physicians offices, and other non-physician provider offices;
    b. the ramifications of high interest rates associated with financing programs that may be offered by a hospital, physician's office, or other non-physician provider's office;
    c. potential financial aid available from a patient's hospital and/or physician's office; and
    d. methods to reduce high deductibles and cost-sharing.

[CMS Rep. 05, A-24]

H-373.996 Exclusion of Medical Debt That Has Been Fully Paid or Settled

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.
[Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-26)

Introduced by: LGBTQ+ Section

Subject: Opposing the Required Creation of “Detransition Clinics

Referred to: Reference Committee on Ethics and Bylaws

Whereas, there gender-affirming care for youth is multifaceted, medically necessary, and evidence-based[1-3]; and

Whereas, recent federal actions, including executive orders, agency directives, regulatory proposals, or funding conditions, have sought to criminalize or restrict access to gender-affirming care through a variety of mechanisms including funding[4,5]; and

Whereas, recent governmental actions and lawsuits seeking to limit access to gender-affirming care have mandated institutions open “Detransition Clinics”[6,7]; and

Whereas, there are no clinical guidelines or expert consensus to outline “detransition” care[8]; and

Whereas, “detransition” care is contained within the spectrum of gender-affirming care, not a separate entity, as it is still care that helps a patient align with their gender identity; and

Whereas, the percentage of those who “detransition” or those who have regret of obtaining gender affirming care, both with medication and surgery is low and lower than many other standard of care therapies[9,10]; and

Whereas, of those who detransition, most report external factors such as pressure from others and societal stigma as primary reasons for their detransition[11]; and

Whereas, mandating detransition clinics fuels harmful ideology labeling gender affirming care as abuse, attempting to criminalize physicians and parents[7,12]; and

Whereas, these settlements have been costly for hospitals, resulted in the firing of doctors and financial impact covering services, shifting resources away from all other avenues of care[6,7,13]; and

Whereas, “detransition” is a rare yet real experience for some patients and the receipt of medical care to assist in a patient’s choice to detransition is encompassed within the spectrum of gender-affirming care decisions that should be kept contained within the patient-physician relationship rather than extended to legal or regulatory enforcement methods for patients and providers; therefore be it

RESOLVED, that our American Medical Association opposes creation of “Detransition Clinics” through mechanisms including but not limited to, legal settlements, executive orders, agency directives or funding conditions. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 09/16/26

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RELEVANT AMA POLICY

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers. [Res. 05, A-16Modified: Res. 015, A-21Modified: Res. 223, A-23Appended: Res. 304, A-23Reaffirmed: CSAPH Rep. 08, A-24Reaffirmed: BOT Rep. 23, I-24]

Gender Affirming Healthcare and Research D-460.957
1. Our American Medical Association affirms that gender affirming healthcare (GAHC) includes social, medical and surgical GAHC with a shared decision-making process involving the physician, patient and legal guardians, when applicable.
2. Our AMA advocates and supports new and restored funding, as well as opportunities for GAHC research across modalities and age ranges, ensuring that such research and guideline development meaningfully involve clinicians who provide this care, researchers who study affected populations, and members of the impacted communities to strengthen the evidence base and uphold scientific integrity.
3. Our AMA will collaborate with relevant specialty societies and multidisciplinary experts to support education and promote educational resources for physicians and trainees on evidence-based, patient-centered, shared decision-making GAHC.
[Res. 509, A-26]

Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824
1. Our American Medical Association supports shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers.
2. Our AMA supports treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process. [Res. 014, A-22Reaffirmed: CSAPH Rep. 08, A-24Reaffirmed: BOT Rep. 23, I-24]

Advocating for the Informed Consent for Access to Transgender Health H-185.905
Our American Medical Association unambiguously supports access to and insurance coverage of medically necessary gender-affirming care but does not identify a preferred model of care for determining medical necessity. The AMA vigorously advocates for equitable payment policies, relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria. [BOT Rep. 23, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(I-26)

Introduced by: Resident and Fellow Section

Subject: Recognition of Moral Injury in the Physician Workforce

Referred to: Reference Committee on Ethics and Bylaws

Whereas, moral injury describes the psychological wounds sustained by physicians when systemic constraints force them to provide care they know to be inadequate, inequitable, or harmful[1,2]; and

Whereas, moral injury is distinct from burnout; burnout comprises emotional exhaustion, depersonalization, and diminished personal accomplishment attributed to demand-resource mismatches, while moral injury reflects systemic and institutional failures that produce guilt, shame, loss of meaning, and erosion of professional identity when physicians cannot deliver care aligned with their ethical and medical obligations[2–4]; and

Whereas, distinguishing moral injury from burnout is valuable because individual-level burnout interventions such as resilience training, mindfulness, and wellness initiatives have been ineffective at meaningfully addressing physician distress, as moral injury requires systemic solutions that address the organizational and policy conditions generating moral conflicts[5,6]; and

Whereas, the 2026 Physicians for a National Health Program (PNHP) survey found that nearly 50% of practicing physicians often or always felt unable to provide optimal care due to inadequate time or insurance barriers[7]; and

Whereas, the PNHP report further identified that systemic contributors to moral injury include prior authorization requirements, coverage denials, productivity quotas, excessive documentation, and the financialization of healthcare, which obstruct timely, evidence-based, patient-centered care[7]; and

Whereas, moral injury contributes to physician workforce attrition, with 25% of PNHP surveyed physicians currently considering leaving a position due to moral distress and 27% having already left a position for this reason, and a 2021 AMA survey found that one-in-five physicians were planning to retire within two years[7,9]; and

Whereas, moral injury also impacts medical students and residents, with 25% of medical students in the United States considering quitting their studies, and structural sources of moral injury may differ across medical students, residents, fellows, and practicing physicians, such as medical students having ample time to learn about their patients social determinants of health but realizing resources are not available to address these needs, residents studying the most evidence based intervention but finding it inaccessible based on payor status, or attendings spending more time handling authorizations than with their patients; warranting further investigation across all career stages[7,10]; and

Whereas, the 2024 AMA Prior Authorization Physician Survey found that nearly all physicians encountered adverse effects from prior authorization, with 29% reporting that prior authorization has led to a serious adverse event[11]; therefore be it

RESOLVED, that our American Medical Association defines moral injury as the harm that occurs when healthcare professionals are compelled by systemic constraints to act in ways that transgress their moral beliefs and professional obligations, including the inability to deliver evidence-based, equitable, and patient-centered care due to institutional, financial, or administrative barriers (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes moral injury as a distinct and significant threat to the wellbeing of medical students, residents, and physicians (New HOD Policy); and be it further

RESOLVED, that our AMA study the prevalence, drivers, and impact of moral injury across the continuum of medical training and practice, including medical students, residents, and practicing physicians, and report back with recommendations for systemic interventions. (Directive to Take Action)

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

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RELEVANT AMA POLICY

Physician and Medical Student Burnout D-310.968

1. Our American Medical Association recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical

Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.\
9. Our AMA will continue to:
   a. address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient workflows and regulatory oversight.
   b. develop and promote mechanisms by which physicians in all practice settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
10. Our AMA supports physicians who are caregivers to alleviate physician burnout.

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Peer Support Groups for Second Victims D-405.980

Our AMA: (1) encourages institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the “second victim phenomenon”; and (2) will work with other interested organizations to encourage that any future surveys of physician **burnout** should incorporate questions about the prevalence and potential impact of the “second victim phenomenon” on our physician workforce.

Physician Burnout D-405.972
1. Our American Medical Association will work with Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians.
2. Our AMA will work with hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Curricular Structure Reform to Support Physician and Trainee Well-Being H-295.838
1. Our AMA promotes a systems approach to student well-being and support research into the impact (beneficial or deleterious) of various educational structures and processes, including but not limited to, the use of third-party resources and distance learning, upon learner well-being, self-efficacy, and the skills needed to become a practicing physician.
2. Our AMA discourages burnout prevention programs that impose inflexible requirements, additional time burdens on physicians, residents, fellows, and medical students, mandatory assignments, or punitive measures, except where required by law.

3. Our AMA supports evidence-based burnout prevention programs that allow for voluntary participation, options to complete any expectations or activities flexibly, and recognize the importance of personal time for burnout prevention and wellbeing while maintaining the core pedagogy of medical training.
4. Our AMA encourages funding entities and training programs to support the implementation of evidence-based evaluation strategies for the ongoing assessment and improvement of burnout prevention programs.

Factors Causing Burnout H-405.948

Our American Medical Association recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to **burnout** during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-26)

Introduced by:	Underrepresented in Medicine Advocacy Section, Resident and Fellow Section
Subject:	Ensuring the Appropriate Placement of Children After Parental Deportation
Referred to:	Reference Committee on Ethics and Bylaws

Whereas, 5.8 million U.S. households are home to at least one undocumented resident, 5.5 million children in these households were born in the U.S., and 1.8 million children live in a household with two undocumented parents[1]; and

Whereas, there is an estimated 145,000 U.S. citizen children with one parent in immigration detention, and more than 22,000 of these children have two parents in custody[2,3]; and

Whereas, approximately 36.5% of these children are <6 years old, 36.1% aged 6-12, and 27.4% aged 13-17[2]; and

Whereas, parental detention and deportation can disrupt established family caregiving arrangements and impose substantial economic and societal costs associated with providing continued care for affected U.S.-born children[1]; and

Whereas, separation from a primary caregiver during critical developmental periods removes the child's primary stress buffer, inducing toxic stress that impairs emotional co-regulation and physiologic functioning[4]; and

Whereas, U.S.-born Latino children ages 6-12 whose parents were detained or deported exhibited significantly greater post-traumatic stress symptoms, internalizing problems, suicidal ideation, and poorer overall functioning than peers without such exposure[5,6]; and

Whereas, U.S.-citizen adolescents who recently experienced parental deportation had significantly worse health status and more behavioral problems than adolescents in comparable families[7]; and

Whereas, among 190 children affected by parental arrest, detention, or deportation, over half cried frequently and one-third had concurrent sleep, eating, and crying disturbances persisting beyond nine months, worsening with longer separation[8]; and

Whereas, judicial precedent, federal child welfare law, and Immigration and Customs Enforcement (ICE) Directive 11064.4 recognize parental rights in determining the placement of their children, but do not mandate safety screening of designated caregivers before placement [9-11]; and

Whereas, ICE does not always follow Directive 11064.4, particularly in cases where a final order of removal was issued, and the individual is deported rapidly[12,13]; and

Whereas, federal oversight has found that ICE does not consistently document detained

parents' custody preferences or track whether children were placed with a designated caregiver, leaving no auditable record of placement decisions prior to removal[14,15]; and

Whereas, immigration enforcement-related parental separation is associated with increased foster care entry, and the absence of a standardized federal process has left families reliant on informal arrangements outside child welfare systems and states with fragmented caregiver designation mechanisms[13,16]; and

Whereas, such informal arrangements culminated in the murder of a child after his mother was deported[17]; and

Whereas, children held in ICE or contracted detention facilities have faced unsanitary conditions and inadequate access to medical care, food, and water, with a congressional investigation citing credible reports of human rights abuses[18]; and

Whereas, ICE data fields implemented in September 2025 on detained parents and their minor children do not capture the physical, developmental, behavioral, or mental-health outcomes of affected children[19]; and

Whereas, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and American Psychiatric Association have policies that recommend trauma evaluation and care coordination, and support expeditious reunification of children separated from their parents[20-22]; and

Whereas, current AMA policy address the health and wellbeing of children during deportation proceedings, but not after, or the parent’s autonomy in deciding where their child is placed; and

Whereas, the scale and severity of harm to U.S.-citizen children of deported parents stands in contrast to the absence of any federal process for honoring parental placement decisions, screening substitute caregivers, reporting these children's health outcomes, or connecting them to timely health and social services; therefore be it

RESOLVED, that our American Medical Association support policies that preserve the ability of parents or primary caregivers who are detained or deported to participate in decisions regarding their child’s health and wellbeing, including designation of an appropriate caregiver, consistent with the child’s safety and applicable law (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for safe, timely, culturally and linguistically appropriate, and trauma-informed processes to ensure continuity of health care for children experiencing immigration enforcement-related separation from a parent or primary caregiver (New HOD Policy); and be it further

RESOLVED, that our AMA support privacy-protective mechanisms for secure communication between detained or deported parents and designated caregivers to facilitate continuity of care and health care decision-making. (New HOD Policy)

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

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RELEVANT AMA POLICY

Care of Women and Children in Family Immigration Detention H-350.955

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.

5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.
6. Our AMA advocates for the implementation of evidence-based, child-centered, and trauma-informed policies across all detention centers, ensuring detained minors have access to developmentally appropriate socioemotional care, including physical contact, and for all detained people, free, unfettered communication access including regular in-person communication, phone calls, and letters.
7. Our AMA supports efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers.

Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents D-60.966
Our AMA: (1) supports that the mental health, physical well-being, and welfare of U.S. citizen minors should be taken into consideration in determining whether undocumented parents of U.S. citizen minors may be detained or deported; and (2) will work with local and state medical societies and other relevant stakeholders to address the importance of considering the health and welfare of U.S. citizen minors in cases where the parents of those minors are in danger of detention or deportation.

Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children H-60.905
1. Our AMA objects to policies separating undocumented, immigrant parents or guardians from children.
2. Our AMA only supports the practice of administering psychotropic drugs to immigrant children when there has been evaluation by appropriate medical personnel, and with parental or guardian consent or court order except in the case of imminent danger to self or others.
3. Our AMA (a) supports education for immigration officials regarding increased risk of sexual assault and sexual trauma amongst unaccompanied minor immigrant children, as well as the emotional decompensation in this immigrant population due to these abuses and other traumas, and (b) encourages policies designed to decrease incidence of sexual assault, increase reporting and timely access to treatment services, and decrease stress and emotional trauma.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(I-26)

Introduced by: New Jersey

Subject: Preserving Human Dignity and Safety by Limiting Unnecessary Restraints and Monitoring

Referred to: Reference Committee on Ethics and Bylaws

Whereas, American Medical Association ethics affirm human dignity and the right to be free from unreasonable bodily restraint, directing use of the least restrictive means necessary;[1,2] and

Whereas, safety measures must not themselves cause preventable harm[14-17,] and unnecessary shackles, ankle monitors, or other restrictive or stigmatizing devices can cause physical and psychological harm, humiliation, stigma, and loss of dignity;[5–13, 18–24] and

Whereas, existing AMA policy opposes universal shackling of incarcerated patients in medical settings, supporting individualized assessment and restraint only when a demonstrated need exists;[3,4] and

Whereas, existing AMA policy does not expressly extend these safeguards to the use of restraints or monitoring outside health care settings;[3,4] therefore be it

RESOLVED, that our American Medical Association advocate against the routine use of shackles, ankle monitors, or other restrictive or stigmatizing devices unless an individualized assessment by a qualified professional establishes a substantial safety need that cannot be addressed by less restrictive means (Directive to Take Action); and be it further

RESOLVED**,** that our AMA support policies requiring such measures to be the least restrictive necessary, regularly reassessed, and promptly discontinued when no longer needed, consistent with Code of Medical Ethics Opinion 1.2.7. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

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RELEVANT AMA POLICY

Use of Restraints E-1.2.7

All individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient.

Except in emergencies, patients should be restrained only on a physician's explicit order. Patients should never be restrained punitively, for convenience, or as an alternate to reasonable staffing.

Physicians who order chemical or physical restraints should:

(a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient.

(b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity. Physicians should explain to the patient or surrogate: (i) why restraint is recommended; (ii) what type of restraint will be used; and (iii) the length of time for which restraint is intended to be used.

(c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record.

In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed. *[Issued: 2016]*

Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals H-430.974
1. Our AMA opposes the universal shackling of patients in medical settings who are incarcerated as a means of punishment, control, and oppression and believes shackling should only be used when there is an immediate and serious threat of self-harm, harm to others, or risk of elopement, that cannot be reasonably mitigated by other least restrictive means necessary.
2. Our AMA encourages health care facilities, in collaboration with carceral facility leadership and hospital security, to develop and implement policies that eliminate or reduce universal shackling of patients who are incarcerated while receiving health care. Such policies should include: (a) individualized assessments that allow patients who are incarcerated to be unshackled when appropriate, particularly when incapacitating medical conditions are present such as weakness due to age or clinical condition, sedation, paralysis, dependence on life support, or while receiving end of life care; (b) clearly delineated procedures for shackle removal and/or replacement of shackles with the least restrictive means necessary; and (c) expeditious procedures for health care professionals to communicate to and collaborate with the decision-making authority of carceral facilities and hospital security to allow timely shackle removal when medically necessary to provide the standard of care.
3. Our AMA urges, through its representation on the National Commission on Correctional Health Care, development and implementation of policies that eliminate or reduce universal shackling of patients who are incarcerated while receiving health care.
[CSAPH Report 04-A-25; adopted as amended, A-25]

Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections D-430.993
1. Our American Medical Association supports the development of:
1. Best practices for acute care of patients in the custody of law enforcement or corrections.
2. Clearly defined and consistently implemented processes between health care professionals and law enforcement that:
a. can best protect patient confidentiality, privacy, and dignity while meeting the needs of patients, health professionals, and law enforcement and
b. ensures security measures do not interfere with the capacity to provide medical, mental health, pregnancy, end of life care, palliative care, and substance use care, especially in emergency situations, and
3. If conflict arises during an incarcerated individual's hospitalization that the hospital's bioethics committee should convene to address the issue and not a law enforcement liaison.
2. Our AMA affirms that:
1. the adoption of best practices in the acute care of patients in the custody of law enforcement or corrections is an important effort in achieving overall health equity for the U.S. as a whole.
2. it is the responsibility of the medical staff to ensure quality and safe delivery of care for incarcerated patients.
3. Our AMA supports universal coverage of essential health benefits for all individuals in the custody of law enforcement or corrections and who are incarcerated.
4. Our AMA will work with interested parties, including but not limited to, the American College of Emergency Physicians and the American College of Correctional Physicians, to develop model federal legislation requiring health care facilities to inform patients in custody about their rights as a patient under applicable federal and state law.
[Res. 407, A-22; Modified: CSAPH Rep. 06, A-23; Reaffirmed: CSAPH Rep. 4, I-23]

Shackling of Pregnant Women in Labor H-420.957
1. Our AMA supports language adopted by the New Mexico legislature that 'an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used.'
2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. *[Res. 203, A-10; reaffirmed 2025]*

CMS Interim Final Rule on the Use of Seclusion and Restraints H-280.952
Our AMA uses the following principles in establishing policy regarding restraints and seclusion:
(1) the patient has the right to be free of restraints and seclusion unless medically necessary.
(2) the least restrictive means be considered first.
(3) the use of restraints and seclusion is a medical decision and should not be dictated by government agencies.
(4) when a physician is not physically present a properly trained and authorized health care professional may institute seclusion and restraints when this is clinically appropriate. In such cases the physician shall be contacted immediately. The patient must be examined by a physician within a period of time that meets an acceptable clinical standard.
[Sub. Res. 101, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Reference Committee B

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212 Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract
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215 Establishing Product Liability for Clinical Augmented Intelligence Failures
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218 Firearm Manufacturer Accountability for the Cost of Gun Violence
219 Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material
220 Advocating for the Older Americans Act and Community-Based Services for Older Adults
221 Preserving Duration of Status for J-1 Physicians in Graduate Medical Education
222 Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)
223 Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine

Reference Committee B

224 Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents
225 Supporting a Common Legal Framework for Medical Capacity Holds
226 Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review
227 Increasing Access to Long-Acting Injectable Medications for SUD
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231 Medicare and Medicaid Payment Equity for Puerto Rico
232 Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care
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235 Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions

REPORT 06 OF THE BOARD OF TRUSTEES (I-26)
Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care

EXECUTIVE SUMMARY

Resolution 205-I-25, referred at the 2025 Interim Meeting, asks that our American Medical Association (AMA) prioritize advocacy to restore private physicians' ability to balance bill for non-emergency outpatient services regardless of network status, oppose caps on balance billing amounts, support the continuation of balance billing protections for emergency care and vulnerable populations, and advocate for reform of the rules governing physician waiver of patient cost-sharing. This report responds to that referral.

The environment in which balance billing operates has changed substantially since our AMA's foundational policies in this area were adopted. The "No Surprises Act," effective in 2022, now establishes a comprehensive federal framework that governs when balance billing is permitted, what commercially insured patients owe, and how physicians contest inadequate payment. In the settings the statute reaches, and for a broad category of hospital-based and ancillary services, balance billing is unavailable by statute rather than regulation, and restoring it would require Congress to amend a bipartisan framework our AMA helped shape and continues to support.

The Board of Trustees shares the House of Delegates concern for the financial stability of independent practices, but concludes that the constraint physicians most acutely experience is not a ceiling on what they may charge. Where balance billing remains permissible, no federal cap applies. What governs physician revenue is the qualifying payment amount and the accessibility and integrity of the dispute resolution process. Our AMA has directed sustained advocacy at exactly those mechanisms, in comments on the qualifying payment amount methodology and the federal independent dispute resolution process, and existing policy provides ample authority for that work, and our AMA remains committed to defending physicians' billing autonomy and to securing fair payment through sustained advocacy on QPA methodology, dispute resolution accessibility, network adequacy, and plan accountability.

Two matters warrant new policy. Our AMA lacks an explicit position supporting the continuation of balance billing protections for patients who cannot exercise meaningful choice over the network status of their treating physician, and adopting one clarifies that our AMA's objection is to inadequate plan payment rather than to patient protection. Our AMA also lacks any policy addressing physician discretion to waive cost-sharing for patients in financial hardship, an area where the practical obstacle is regulatory uncertainty and administrative burden rather than outright prohibition, since federal law already permits waiver based on an individualized, good-faith determination of financial need.

The Board therefore recommends reaffirmation of six existing policies, adoption of the third resolve, and adoption as amended of the fourth resolve.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 06-I-26

Subject:	Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care
Presented by:	Toluwalaṣé A. Ajayi, MD, Chair
Referred to:	Reference Committee B

At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 205, "Restoring Balance Billing and Allowing Copay Forgiveness to Preserve Independent Practice and Improve Access to Care," was referred. It asked the following:

> 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 (Directive to Take Action); and be it further
>
> 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 (New HOD Policy); and be it further
>
> 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 (New HOD Policy); and be it further
>
> 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. (Directive to Take Action)

Testimony before the Reference Committee was mixed. Some testimony supported the Resolution in its entirety, noting the importance of the financial stability of small physician practices. Other testimony supported only certain resolves, noting in particular that the final resolve introduced topics, such as federal anti-kickback rules, that did not align with the balance billing focus of the remaining resolves and warranted separate consideration. Testimony was divided on the first and second resolves, with some expressing concern that advocacy for balance billing by in-network physicians is in tension with the premise of network contracting and could disturb patient protections enacted in the No Surprises Act. Testimony was broadly supportive of the third resolve and of the objective underlying the fourth. Additional testimony opposed the Resolution in its entirety or offered amendments, and further testimony stated that referral was appropriate because our AMA already has policy on this topic. Given the lack of consensus, the existence of relevant AMA policy, and the need to ensure consistency within the Resolution, the Reference Committee recommended that Resolution 205 be referred, and the House concurred.

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BACKGROUND

Balance billing is the practice of billing a patient for the difference between a physician's charge and the amount allowed by the patient's health plan. It has been the subject of federal and state regulation for decades. In the Medicare program, the "Omnibus Budget Reconciliation Act of 1989" established limiting charges that cap the amount a nonparticipating physician may bill a Medicare beneficiary above the Medicare-approved amount. Many states subsequently enacted statutes restricting balance billing in the commercial market, particularly for emergency services and for care delivered by out-of-network physicians at in-network facilities.

The most consequential recent development is the federal "No Surprises Act" (NSA), enacted as part of the "Consolidated Appropriations Act, 2021," with its principal provisions effective January 1, 2022. The NSA prohibits out-of-network physicians, other providers, and facilities from balance billing commercially insured patients in defined circumstances, and establishes methodologies for determining both patient cost-sharing and the out-of-network payment owed by the health plan.

The NSA's balance billing prohibition applies in two principal settings: out-of-network emergency services furnished at a hospital emergency department, an independent freestanding emergency department, or by air ambulance; and non-emergency care rendered by out-of-network physicians at an in-network hospital, hospital outpatient department, critical access hospital, or ambulatory surgical center, unless the physician has furnished advance written notice and obtained the patient's written consent to be balance billed.

The notice-and-consent exception is unavailable for a substantial category of services. Under 45 C.F.R. § 149.420(b), a physician may not seek patient consent to balance bill for items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; items and services provided by a nonparticipating provider where no participating provider is available to furnish the service at the facility; and items or services furnished as a result of unforeseen, urgent medical needs arising at the time of service. For these services, an out-of-network physician practicing at an in-network facility is limited to collecting in-network cost-sharing and may not balance bill under any circumstance.

Where the NSA applies and the parties cannot agree on payment, the statute establishes a federal independent dispute resolution (IDR) process. A health plan must issue an initial payment or notice of denial within 30 days of receiving a clean claim, after which a dissatisfied physician may initiate a 30-day open negotiation period and, failing agreement, IDR. The certified IDR entity selects between the parties' final offers, considering the qualifying payment amount (QPA), generally the median of the plan's contracted rates as of January 31, 2019, indexed for inflation, along with additional permitted factors including physician training and experience, patient acuity and case complexity, market share, and prior contracting history. The IDR entity may not consider usual and customary charges, billed charges, or public payer rates. The federal IDR process does not apply where a specified state law establishes the out-of-network payment methodology.

Arising from a separate body of law, federal fraud and abuse authorities govern the waiver of patient cost-sharing. The federal anti-kickback statute and the civil monetary penalty provisions addressing beneficiary inducement restrict the routine forgiveness of copayments and deductibles for federal health care program beneficiaries. These authorities are subject to well-established exceptions, including for individualized, documented determinations of financial hardship made in good faith and not advertised or offered routinely.

AMA POLICY

The AMA has extensive, longstanding policy on physician balance billing, opposition to inadequate reimbursement, private contracting, and freedom of choice. The Board of Trustees notes six policies that are particularly relevant to the discussion:

Policy H-385.991, "Balance Billing"

> Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.

Policy D-380.996, "Balance Billing for All Physicians"

> 1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.
>
> 2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.
>
> 3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.

Policy D-390.985, "Medicare Balance Billing"

> Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.

Policy D-390.986, "Medicare Balance Billing"

> Our American Medical Association advocates that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; our AMA seeks introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and our AMA further advocates that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Policy H-390.854, "Freedom of Choice"

> (1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.

Policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement"

> Our American Medical Association continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients… Our AMA aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services. If the reimbursement is not improved, our AMA declares the Medicare reimbursement unworkable and intolerable, and seeks immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee.

Additional policy reinforces this framework. Policy D-390.969, "Parity in Medicare Reimbursement," expressly includes balance billing among the mechanisms our AMA supports to ensure adequate physician payment. Policy D-330.924, "Reform the Medicare System," centers AMA Medicare reform efforts on pluralism, freedom of choice, and balance billing. Policy H-400.991, "Guidelines for the Resource-Based Relative Value Scale," reaffirms physicians' right to decide on a claim-by-claim basis whether to accept Medicare assignment and opposes the elimination of balance billing. Policy H-465.989, "Rural Health," directs our AMA to monitor the impact of balance billing restrictions on reimbursement and access in rural areas.

Together, these policies establish a comprehensive advocacy foundation centered on physician autonomy in billing, opposition to artificial limits on reimbursement, preservation of private contracting and freedom of choice, and attention to the access consequences of balance billing restrictions. They provide the basis for our AMA's ongoing regulatory and legislative efforts to secure fair payment for physician services in both the Medicare and commercial markets.

DISCUSSION

The Board of Trustees understands the concerns that prompted Resolution 205 and recognizes the financial pressures confronting independent physician practices. Decades of reimbursement erosion, combined with consolidation among health plans and the growth of narrow networks, have placed small and independent practices under sustained strain, and the Board agrees that our AMA should pursue a range of strategies to strengthen practice viability.

The environment in which balance billing operates has also changed substantially since our AMA's foundational policies in this area were adopted. Those policies were developed principally in response to Medicare limiting charges and state laws restricting balance billing in the commercial market. The NSA introduced a comprehensive federal framework that now governs when balance billing is permitted, what patients owe, and how physicians contest inadequate payment. How our AMA's existing policy operates within that framework is central to determining what additional policy, if any, is needed.

The Current Federal Framework and Its Limits

The NSA materially narrowed the circumstances in which a physician may balance bill a commercially insured patient. In the two settings the statute reaches, out-of-network emergency care and out-of-network care delivered at an in-network facility, balance billing is prohibited unless the physician satisfies notice and consent requirements, and for a substantial category of hospital-based and ancillary services the consent pathway is unavailable altogether. As a practical matter, this means that for many physicians in anesthesiology, pathology, radiology, emergency medicine, neonatology, and related fields, balance billing is not available at in-network facilities under any circumstance.

This is a matter of statute, not regulation. Changing it would require Congress to amend the "Consolidated Appropriations Act, 2021," a framework enacted with bipartisan support following extended negotiation in which physician organizations, including our AMA, participated directly. Advocacy to restore balance billing authority in the settings the NSA reaches would therefore be a legislative undertaking of substantial scope, and one that would place our AMA in the position of seeking to reopen patient protections it helped to shape and continues to support.

The Board also observes that the constraint physicians most acutely experience in the commercial market is not a cap on what they may charge. Where balance billing remains permissible, no federal ceiling limits the amount. What determines physician revenue is the qualifying payment amount, the benchmark the health plan uses to calculate its payment obligation and one of the factors an IDR entity weighs, together with the accessibility and integrity of the dispute resolution process itself. A policy directed at billing caps would not reach the mechanism that actually governs payment. A policy directed at QPA methodology and IDR function would.

AMA Advocacy on Out-of-Network Payment

Our AMA has long opposed artificial limits on physician payment, and that opposition is reflected in its sustained work on the mechanisms that set out-of-network reimbursement. In the commercial market, the practical successor to the payment ceilings our AMA has historically resisted is not a statutory cap but the qualifying payment amount, which functions as the benchmark against which plans calculate what they owe. Our AMA's advocacy has therefore been directed at preventing the QPA from operating as a de facto cap.

Consistent with that assessment, our AMA has directed sustained advocacy at the methodologies and processes that determine out-of-network payment. In comments on the interim final rule implementing the NSA, our AMA raised detailed objections to the calculation of the QPA, including the breadth of the definitions of "market" and "geographic region," the reliance on small data sets, and the exclusion of risk-sharing, bonus, penalty, and other incentive-based payments from the median contracted rate. Our AMA also emphasized the importance of transparency in how the QPA is derived and disclosed to physicians, and cautioned that the rule expanded certain administrative requirements in ways that burden practices without benefiting patients.

Our AMA also challenged, in coordination with other physician and hospital organizations, the federal rules that would have required arbitrators to presume the QPA as the appropriate payment amount, and the courts vacated those provisions. That outcome preserved the independent dispute resolution process as a genuine alternative to plan-set payment rather than a mechanism for ratifying it.

In comments on the Federal Independent Dispute Resolution Operations proposed rule (CMS-9897-P), our AMA advocated for changes designed to make the dispute resolution process accessible to independent practices. Among other positions, our AMA:

- Supported mandated use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes so that physicians can determine at the outset whether a claim is subject to the federal process or to a specified state law;
- Supported establishment of a centralized health plan registry accessible through the federal IDR portal, so that practices can identify the correct plan contact and determine whether a plan is fully or self-insured;
- Urged that health plans, rather than physicians, bear responsibility for submitting the QPA and the methodology used to calculate it;

- Supported expanded batching of claims and urged that the proposed line-item limitation be increased so that batching produces meaningful efficiency;
- Encouraged the Departments to exercise waiver authority to shorten the 90-calendar-day cooling off period, which can otherwise stack across successive disputes; and
- Supported reduced administrative fees for low-dollar disputes while urging further reductions, so that the dispute resolution process remains financially accessible to smaller, rural, and independent practices.

Our AMA has separately pressed the Departments on the administrative burdens associated with good faith estimate and advanced explanation of benefits requirements, urging phased implementation and cautioning against technology mandates that would fall disproportionately on small, rural, and under-resourced practices.

The Board recognizes the concern that our AMA has maintained balance billing policy without corresponding visibility in its advocacy. The record above reflects active and continuing engagement with the frameworks that most directly determine physician payment. The Board is satisfied that existing policy provides ample authority for this work, and that additional policy directed at balance billing authority and billing caps would duplicate positions our AMA already holds, and our AMA remains committed to defending physicians' billing autonomy and to securing fair payment through sustained advocacy on QPA methodology, dispute resolution accessibility, network adequacy, and plan accountability.

Patient Protections and Physician Payment

Protecting patients from balance billing in circumstances beyond their control and securing fair payment for physicians are complementary objectives, not competing ones. A patient who arrives at an emergency department does not select the treating physician, and a patient admitted through that department does not negotiate the network status of the hospitalist, the intensivist, or the pathologist who reads the specimen. In these circumstances the patient is not a party to the contracting failure that produced the out-of-network encounter. Our AMA has consistently maintained that the resulting payment dispute belongs between the physician and the health plan, and that our advocacy should be directed at making that dispute resolvable on fair terms rather than at transferring liability to patients.

Our AMA does not currently have freestanding policy supporting the continuation of these protections. Given the durability of the NSA framework and the likelihood that its patient protection provisions will be revisited in future legislative debate, the Board believes our AMA would benefit from an explicit position. Such a position would strengthen our AMA’s standing when it presses the Departments and Congress on QPA methodology, dispute resolution reform, insurer accountability, and network adequacy, because it makes clear that our objection is to inadequate plan payment rather than to patient protection.

Such a position would not disturb our AMA’s Medicare balance billing policy. Policies D-390.985 and D-390.986 address the Medicare limiting charge; the protections at issue here concern emergency care, Medicaid beneficiaries, and other vulnerable populations under existing state and federal law. The two operate in different contexts: our AMA supports patient protection where patients cannot exercise choice, and physician latitude in payment arrangements where they can.

Physician Discretion to Waive Patient Cost-Sharing

The Board turns finally to a subject on which our AMA has no policy at all: the ability of physicians to forgive copayments and deductibles for patients experiencing financial hardship. The Board regards this as a genuine gap warranting the House's attention.

Physicians in independent practice have historically exercised discretion to adjust or forgive patient obligations based on individual circumstances, a longstanding professional norm that serves patients directly. The growth of high-deductible health plans has increased the frequency with which patients face obligations they cannot meet, and practices in safety-net and high-volume settings encounter these circumstances routinely. Physicians should be able to respond without exposure to regulatory jeopardy.

It is important, however, to be precise about what current law provides, because the framing of an advocacy position determines whether it can succeed. Federal fraud and abuse authorities do not categorically prohibit waiver of cost-sharing for patients experiencing financial hardship. The anti-kickback statute and the beneficiary inducement civil monetary penalty provisions restrict the routine, advertised, or indiscriminate waiver of copayments and deductibles for federal health care program beneficiaries. Longstanding guidance permits waiver based on an individualized, good-faith determination of financial need.

The difficulty is therefore not prohibition but uncertainty and burden. The standards governing an adequate hardship determination are not clearly specified, documentation expectations are ill-defined, and the expectation that a practice demonstrate reasonable collection efforts before forgiving an obligation imposes administrative cost that can exceed the amount at issue. Because the consequences of a financial hardship determination that is later deemed to be insufficient are severe, many physicians decline to exercise discretion that federal law in fact, permits. Advocacy premised on removing a prohibition that does not exist would be unlikely to produce results. Advocacy directed at clarifying and simplifying the standards, while reducing the associated burdens, addresses the problem that physicians actually face and is something the responsible agencies could act upon through updated guidance, without statutory change.

Further, this subject involves two separable concerns. Federal fraud and abuse authorities are one. Private payer contracting provisions that restrict physician discretion over the collection of cost-sharing are another, requiring an advocacy approach directed at contracting practice rather than federal guidance. Policy addressing this subject should distinguish between those concerns.

CONCLUSION

The financial pressures confronting independent physician practices are significant and persistent, and the Board of Trustees shares the House's commitment to addressing them. Our AMA has longstanding and comprehensive policy supporting physicians' right to balance bill, opposing artificial limits on reimbursement, and defending private contracting and freedom of choice. That policy, when combined with sustained advocacy before the Departments on qualifying payment amount methodology, dispute resolution accessibility, plan accountability, and administrative burden, provides ample authority for our AMA's continuing work in this area, and reaffirmation renews that commitment without creating duplicative policy.

Two matters warrant new policy. First, our AMA lacks an explicit position supporting the continuation of balance billing protections for patients who cannot exercise meaningful choice over the network status of their treating physician; adopting one clarifies that our AMA's objection is to

inadequate plan payment rather than to patient protection. Second, our AMA lacks any policy addressing physician discretion to waive cost-sharing for patients experiencing financial hardship, an area where the practical obstacle is regulatory uncertainty and administrative burden rather than outright prohibition. The Board will continue to pursue a coordinated legislative and regulatory strategy consistent with Policies H-385.991, D-380.996, D-390.985, D-390.986, H-390.854, and H-330.932.

RECOMMENDATIONS

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

1. That our American Medical Association reaffirm: Policy H-385.991, "Balance Billing;" Policy D-380.996, "Balance Billing for All Physicians;" Policy D-390.985, "Medicare Balance Billing;" Policy D-390.986, "Medicare Balance Billing;" Policy H-390.854, "Freedom of Choice;" and Policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement." (Reaffirm HOD Policy)

2. 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. (New HOD Policy)

3. That our AMA advocate at the federal level for clarification of standards governing physician waiver of patient cost-sharing obligations for patients experiencing documented financial hardship, including reduction of the administrative, documentation, and collection-effort burdens associated with existing hardship exceptions under federal fraud and abuse authorities; and that our AMA oppose payer contracting provisions that restrict physicians from exercising discretion permitted under those authorities. (New HOD Policy)

Fiscal Note: Minimal.

REPORT07 OF THE BOARD OF TRUSTEES (I-26)
Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians
(Reference Committee B)

EXECUTIVE SUMMARY

Resolution 209-I-25, referred at the 2025 Interim Meeting, asks that our American Medical Association (AMA) advocate for federal legislation or regulatory changes that would allow physicians to opt out of Medicare in one employment setting while maintaining the ability to bill Medicare for services provided in other settings. This report responds to that referral.

Opt-out is presently structured as a complete and sustained exit from the program. Section 1802(b) of the "Social Security Act" permits a physician to contract privately with a Medicare beneficiary only on the condition that the physician file an affidavit forgoing all Medicare payment for all beneficiaries, in all settings, for at least two years. That status attaches to the physician's National Provider Identifier and overrides the participation status of every entity through which the physician bills. The uniformity is not an artifact of drafting. Congress adopted it to prevent confusion among patients about whether a given visit would be covered and what they could expect to pay, and to give beneficiaries a stable basis on which to select their physicians.

The Board of Trustees shares the House of Delegates concern for physicians whose practices span multiple settings, but concludes that our AMA should not advocate for the mechanism the resolution proposes. The decisive consideration is that a setting-specific framework would transfer risk to beneficiaries in a form they cannot manage. Under current law, a beneficiary facing an opted-out physician confronts a large but knowable liability, disclosed in a written contract executed in advance and verifiable through a public file. Under the proposed framework, that same liability would arise contingently, in settings the beneficiary may not have chosen and on the basis of a distinction the beneficiary has no practical means of anticipating. Much of the flexibility the resolution seeks is moreover available today through membership and hybrid arrangements requiring no change in law, and the narrower restriction that remains follows from the mandatory claims submission requirement rather than from any rule about practice setting.

Our AMA has long supported private contracting that does not cost the patient their Medicare benefits, but the substantive principle underlying that position was rescinded from the text of current policy in 2020 when it was folded into our AMA's advocacy for the Medicare Patient Empowerment Act. Restating it gives the House an explicit position rather than one carried by reference. Separately, physicians who practice through genuinely separate entities in geographically distinct locations present a circumstance in which the risk of beneficiary confusion is substantially reduced, and that circumstance warrants examination rather than a categorical answer.

Underlying all of this is inadequate Medicare physician payment, which has declined approximately 33 percent since 2001 when adjusted for practice cost inflation and remains the pressure that leads physicians to reconsider participation at all. Our AMA's advocacy is directed at that cause.

The Board therefore recommends reaffirmation of five existing policies, explore options for physicians practicing in geographically distinct settings, and adoption of new policy supporting an additional payment option in Medicare fee-for-service, in lieu of Resolution 209-I-25.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 07-I-26

Subject:	Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians
Presented by:	Toluwalaṣé A. Ajayi, MD, Chair
Referred to:	Reference Committee B

At the 2025 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 209-I-25, "Support for Legislative Changes Allowing Partial Medicare Opt-Out for Physicians," was referred which asked the following:

> RESOLVED, That our American Medical Association advocate for federal legislation or regulatory changes that would allow physicians to opt out of Medicare in one employment setting while maintaining the ability to bill Medicare for services provided in other settings, such as private practices, hospices, or hospitals. (Directive to Take Action)

Mixed testimony was received for Resolution 209. Some testimony advocated for adoption, noting that the current system of all-in or all-out for Medicare is antiquated and needs to be remedied. Other testimony opposed the resolution, stating that the approach suggested in the resolution would fragment care and lead to patient confusion. Additional testimony recommended referral, highlighting the need to allow our AMA time to examine key questions related to feasibility, administrative impact, and policy alignment before determining whether new policy is necessary. Given the mixed testimony and the existence of AMA policy on this topic, the Reference Committee recommended that Resolution 209 be referred, and the HOD concurred.

BACKGROUND

Section 1802(b) of the "Social Security Act," codified at 42 U.S.C. 1395a(b) and added by section 4507 of the "Balanced Budget Act of 1997," permits a physician to enter into a private contract with a Medicare beneficiary for items or services that would otherwise be covered by Medicare. To do so, the physician must file an affidavit with the Secretary of Health and Human Services affirming that the physician will not submit any claim to Medicare, and will not receive any Medicare reimbursement, for any item or service furnished to any Medicare beneficiary during the applicable opt-out period. Emergency and urgent care services are excepted. The opt-out period runs for two years and, following amendments enacted in the "Medicare Access and CHIP Reauthorization Act of 2015," renews automatically unless the physician cancels it.

The universal scope of opt-out was not incidental to the 1997 compromise. Congress authorized private contracting in response to concerns about physician participation, but conditioned that authority on a complete and sustained exit from the program. A physician may leave Medicare but may not hold both positions at once.

That principle is carried through the implementing framework. Opt-out is available only to individual practitioners; groups, clinics, and other organizations cannot opt out. Because the affidavit binds the practitioner, the resulting status applies to all items and services furnished to Medicare beneficiaries regardless of service location, and it applies across all of the physician's employment arrangements. Where a group employs a physician who has opted out, the group cannot bill Medicare for that physician's services even though the group itself is enrolled in Medicare. Opt-out status likewise extends across Medicare Administrative Contractor jurisdictions, so that a physician who opts out in one jurisdiction is opted out in all of them, and it extends to beneficiaries enrolled in Medicare Advantage as well as to those in traditional Medicare.

This uniformity is reflected in Medicare's administrative infrastructure. Claims are adjudicated against the rendering physician National Provider Identifier and opt-out status is applied at that level rather than at the level of a group, a location, or a particular enrollment record. Opt-out status overrides the participation status of any entity through which the physician bills. A physician therefore cannot presently opt-out for services furnished in a direct primary care practice while continuing to bill Medicare for services furnished in a hospital, hospice, or *locum tenens* assignment.

Opt-out should be distinguished from Medicare enrollment. Enrollment records are maintained at the level of the practice location and tax identification number, and a physician may be enrolled through more than one entity. Opt-out is a separate, practitioner-level election that applies to the physician regardless of how many enrollment records the physician holds. A physician who opts out remains enrolled but may not submit claims to Medicare for any covered service furnished to a beneficiary, in any setting.

Practice patterns have changed considerably since this framework was established. Physicians increasingly divide their professional time across multiple employment settings, and interest in direct primary care, concierge, and other cash-based practice models has grown. Resolution 209 reflects the concern that a framework designed for a period of more uniform practice arrangements now constrains physicians whose work spans several settings.

AMA POLICY

The AMA has existing policy addressing physician flexibility and voluntary participation in Medicare and other public programs. In addition to other extensive policy in the space, the AMA has several policies, noted below, that directly address the concerns raised by the resolution.

Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for Reform," provides that physicians have the freedom to choose whether to participate in a public option, and that public option proposals should not require provider participation or tie physician participation in Medicare, Medicaid, or any commercial product to participation in the public option.

Policy D-330.930, "Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans," directs the AMA to continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage, and to educate physicians and the public about the lack of secondary coverage with Medicare Advantage plans and how this may affect enrollees.

Policy D-390.966, "Inappropriate Changes to Physician Medicare Participation Status by the Centers for Medicare & Medicaid Services," directs the AMA, among other things, to educate

physicians, through appropriate means, about the option of electing Medicare non-participating status, together with simple instructions for effecting such a change in status.

Policy D-380.997, "Private Contracting by Medicare Patients," establishes that any patient, regardless of age or healthcare insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and the right to personally pay for those services. It directs the AMA to pursue appropriate legislative and legal means to permanently preserve that right; to pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the patient-physician relationship; and to seek suitable cases to reverse the limitations on private contracting imposed by CMS or the private health insurance industry. The policy further reaffirms the AMA's support for a pluralistic healthcare delivery system that includes fee-for-service medicine and commits the AMA to lobby for the elimination of any restrictions and physician penalties for the provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.

Policy D-390.957, "A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act," directs the AMA to initiate and sustain a well-funded grassroots campaign to secure public support for passage of the Medicare Patient Empowerment Act (MPEA), as directed by the House of Delegates at the 2010 Interim Meeting through Policy D-390.960.

Policy D-390.960, "Assuring Patients' Continued Access to Physician Services," was rescinded in the Council on Legislation's 2020 sunset review on the ground that it had been implemented and superseded by D-390.957 and related policies.[1] As adopted, it directed the AMA to formulate legislation for an additional payment option in Medicare fee-for-service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. It further committed the AMA to a legislative and grassroots campaign to ensure that Medicare patients can keep their benefits when they privately contract with any physician of their choice, with the MPEA as the centerpiece legislation. Because D-390.957 incorporates D-390.960 by reference, the substantive principle underlying the AMA's support for the MPEA is no longer set out in the text of current policy.

Taken together, these policies commit the AMA to advancing physician choice, flexibility, and reduced administrative burden in Medicare participation, to preserving the right of patients and physicians to contract privately without penalty, and to ensuring that physicians and patients alike understand the consequences of participation decisions.

DISCUSSION

Beneficiary financial exposure and the loss of advance notice

When a physician opts out, the beneficiary assumes the entire cost of care. An opted-out physician may bill any amount the physician determines is appropriate, without the limiting charge protections that cap what non-participating physicians may collect, and neither the physician nor the beneficiary may submit the claim to Medicare. Medigap and other supplemental coverage will not pay. The difference is substantial. In an illustration developed by the Kaiser Family Foundation, a colonoscopy with biopsy priced at approximately $500 on the Medicare fee schedule leaves a beneficiary responsible for $100 when furnished by a participating physician and approximately $166 when furnished by a non-participating physician billing at the limiting charge. Furnished under a private contract, the beneficiary is responsible for whatever the physician

charges, which in that illustration was approximately $1,200. There is no cap. Half of all Medicare beneficiaries live on yearly incomes of roughly $24,000 or less. [2] [3]

Current law manages that exposure by making it knowable in advance, and Congress designed it to work that way. The requirement that physicians who opt out do so for all Medicare patients and for all services they furnish, rather than selecting among patients or services, was adopted to prevent confusion among patients about whether a given visit would be covered by Medicare and how much they could expect to pay out of pocket. The requirement was also intended to address concerns about the program's ability to protect beneficiaries from improper billing. The two-year minimum opt-out period was established for a related reason, which is to allow beneficiaries to make knowledgeable choices in selecting their physicians rather than be subject to frequent changes in status. Uniformity is therefore not an artifact of how the framework was drafted. It is the mechanism by which Congress made private contracting compatible with beneficiary protection.[4]

A beneficiary needs to know whether the physician has opted out, and that fact does not change from one visit to the next. It is verifiable through a public CMS file, and it must be disclosed in a written private contract executed before services are furnished, in which the beneficiary acknowledges responsibility for the full charge, the absence of limiting charge protection, the unavailability of supplemental coverage, and the right to obtain covered services from a physician who has not opted out. Congress further prohibited private contracting with beneficiaries who receive full Medicaid benefits or assistance through the Qualified Medicare Beneficiary program, and with beneficiaries in the midst of an urgent or emergent event.[5]

A setting-specific framework would reintroduce the confusion the statute was written to prevent. A beneficiary who has confirmed that a physician participates in Medicare would have confirmed nothing durable, because the answer would depend on where the encounter occurs. The written notice requirement would attach to each encounter rather than to the physician relationship, and the practical likelihood of a beneficiary receiving, reading, and understanding that disclosure at the moment it matters diminishes accordingly. Beneficiaries with cognitive impairment or limited health literacy, and those who present without having selected the setting in advance, would bear that risk most heavily.

The resolution does not specify the unit to which opt-out would attach. Whether that unit is an enrollment record, a practice location, a tax identification number, or a specialty designation carries substantial consequences for administrability, for the design of the notice requirement, and for the potential for arrangements that direct Medicare-payable work to one setting while reserving higher-margin work for private contracting. Congress would have to resolve that question before any such framework could function, and the answer would determine whether the change operates as the flexibility the resolution describes or as something considerably broader.

Flexibility is available under current law

A physician who wishes to build a direct primary care or membership-based practice while continuing to furnish hospital, emergency department, or urgent care services may remain a participating physician and do both. That physician may decline to accept Medicare beneficiaries into the membership practice, may see Medicare beneficiaries in that practice and bill Medicare in the ordinary fee-for-service manner, or may bill Medicare for covered services while charging a separate membership fee for services Medicare does not cover, an arrangement commonly described as the concierge or hybrid model. None of these requires the physician to give up Medicare billing in the hospital or emergency setting, and none exposes beneficiaries to unlimited charges.

What a participating physician cannot do is charge a Medicare beneficiary privately for a service Medicare covers. That restriction arises from the mandatory claims submission requirement rather than from any rule about practice setting. A setting-specific opt-out framework would be an indirect and consequential way to reach it and would carry effects well beyond the circumstance that prompted the resolution.

Where the existing opt-out process is genuinely burdensome, Policy D-390.955 already directs AMA advocacy toward eliminating the reaffirmation requirement and establishing a safe harbor for physicians who fail to reaffirm inadvertently. That work addresses the administrative difficulty the resolution identifies without restructuring participation itself.

Private contracting without forfeiture of benefits

The narrower restriction that remains, the inability of a physician who has not opted out to contract privately with a beneficiary for a covered service, is one the AMA has long sought to remove directly. Policy D-380.997 commits the AMA to eliminating restrictions and physician penalties for fee-for-service care furnished to consenting patients, including Medicare patients, and Policy D-390.957 directs sustained advocacy for the MPEA, which the AMA has supported in successive Congresses, including as H.R. 1650 in the 114th Congress. Under the MPEA, a beneficiary and a physician could agree, in a written contract signed before services are furnished and specifying the physician's fees, to a fee that differs from the Medicare fee schedule. The beneficiary would retain Medicare benefits and would receive the amount Medicare would pay a participating physician for the service, and the physician would be treated as having opted out only with respect to that patient, remaining a participating or non-participating physician for all others. Contracts could not be entered into while a beneficiary faces an emergency medical condition or urgent healthcare situation, and could not be entered into with beneficiaries dually eligible for Medicare and Medicaid.[6]

That approach responds to the concerns underlying Resolution 209 more directly than a setting-specific opt-out framework would. It would allow physicians who wish to practice outside the fee schedule to do so for particular patients without leaving Medicare, reducing the pressure on physicians to opt out in order to sustain their practices and preserving beneficiary access to those physicians. It would do so while retaining the protections that make private contracting compatible with beneficiary interests: the beneficiary would know the physician's fee before receiving care, would agree to it in writing, and would not forfeit Medicare coverage for the service. Safeguards modeled on the "No Surprises Act," such as advance good faith estimates of expected charges and a notice-and-consent process that is unavailable in emergency situations, could further strengthen those protections. By supporting the viability of independent practices, the approach may also ease one of the pressures contributing to consolidation.

Continuity of care and the concentration of withdrawal

Medicare beneficiaries are disproportionately likely to require care that moves across settings, and continuity depends on the ability of a physician who knows the patient to furnish that care wherever the patient presents. A framework in which participation is setting-dependent would divide those episodes along payment lines rather than clinical ones. The frequency of that problem would depend on design. A physician furnishing professional services to the same patient in an office and then in a hospital is not practicing in two settings in any sense Medicare presently recognizes, and the resolution is best understood as addressing physicians who maintain genuinely separate practices.

Even so, real difficulties arise. A beneficiary who belongs to a physician's cash-based practice and requires urgent evaluation would be directed to whichever physician is available rather than to the physician who knows the patient, and the beneficiary would face a different payment posture depending on which of those physicians provided the care. Referral and ordering authority presents a further complication. An opted-out physician may still order prescription drugs and have them covered by Medicare Part D as well as laboratory, imaging, and durable medical equipment services for which Medicare pays, and a setting-specific framework would require rules governing whether orders originating in an opted-out setting remain payable and how a beneficiary would know. These details would determine whether care furnished across settings holds together for the beneficiary or breaks into separately administered pieces.

A related concern is where selective withdrawal would concentrate. Physician exit from Medicare is associated with reduced access to care, particularly in nonmetropolitan areas and Health Professional Shortage Areas where beneficiaries already face limited physician availability. If opt-out could be exercised selectively, the incentive would run toward opting out in the settings with the lowest payment and the highest administrative burden, which are frequently the settings serving the most vulnerable beneficiaries. Selective withdrawal would therefore concentrate its effects rather than distribute them.[7]

Physicians practicing in geographically distinct settings

The concerns described above apply with the least force to one group of physicians whose circumstances merit separate consideration. A growing number of physicians hold multiple employment or contractor arrangements, whether as W-2 employees, 1099 independent contractors, or locum tenens physicians, either concurrently or in succession within a single two-year opt-out period. The pattern is common in anesthesiology, hospital medicine, and emergency medicine, and among locum tenens physicians of every specialty. Where those arrangements are with separate practice entities in locations far enough apart that a beneficiary would not reasonably be expected to see the physician in both, the risk of beneficiary confusion that underlies the uniform opt-out rule is substantially diminished. A beneficiary in either community would encounter the physician under a single, consistent payment status, and advance disclosure could attach to that practice relationship much as it now attaches to the physician.

Medicare already accommodates entity-level variation in participation. Participation status generally follows the billing entity, so a physician who bills through more than one entity may be participating in one and non-participating in another. Opt-out is the exception. Because it is a practitioner-level election that overrides the status of every entity through which the physician bills and runs for at least two years, a physician who opts out to practice privately in one community is foreclosed from Medicare-billed employment or locum tenens work in another, and a physician who accepts such work must forgo or cancel an opt-out elsewhere.

An accommodation limited to these circumstances would preserve flexibility for a workforce that increasingly practices across multiple arrangements, without reintroducing the encounter-level uncertainty discussed above. Its design would need to address how geographic separation is defined, how entity-specific status would be recorded and published so that beneficiaries and referring physicians can verify it, how orders and referrals would be treated, and how to prevent arrangements that direct Medicare-payable work to one entity while reserving other work for private contracting. These questions warrant examination rather than a categorical answer, and the Board recommends that the AMA explore options accordingly.

Scale of the constraint and the underlying payment problem

The constraint Resolution 209 identifies affects a narrow population. Approximately 98 percent of physicians and practitioners billing Medicare are participating providers, and formal opt-out remains rare. As of November 2024, roughly 1.2 percent of non-pediatric physicians had opted out of Medicare, a share consistent with prior analyses in 2013 and 2022, and opt-out is concentrated in a small number of specialties, with psychiatrists accounting for roughly 39 percent of all physicians who have opted out. In 47 states, fewer than two percent of physicians have opted out. CMS analysis of the first years of private contracting reached a similar conclusion, finding that few providers found opting out attractive and that the departure of that small group did not appear to create access problems for beneficiaries.[8,9]

Inadequate Medicare physician reimbursement

The pressure giving rise to interest in opt-out flexibility is substantially a function of inadequate Medicare physician payment. Physicians are the only Medicare providers without an automatic annual inflation-based payment update. Medicare physician payment has declined approximately 33 percent since 2001 when adjusted for practice cost inflation, while the costs of operating a practice have risen sharply over the same period. Both the Medicare Trustees and the Medicare Payment Advisory Commission have warned about the consequences of that widening gap. MedPAC has cautioned that it could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, to stop participating in Medicare entirely, or to consolidate with hospitals, and has recommended that Congress replace current law updates with annual updates tied to the Medicare Economic Index.[10]

Understood in that context, the difficulty Resolution 209 identifies is a symptom. A setting-specific framework would not raise payment in any setting. It would permit withdrawal from the settings where payment is worst, relieving the individual physician while leaving the underlying problem intact and shifting its consequences onto beneficiaries. It would also provide an outlet that resolves the individual physician's circumstance without resolving the programs.

The AMA's advocacy is directed at that underlying problem. In July 2026, the AMA endorsed the "Patients First Act," (H.R. 9693), comprehensive and bipartisan legislation that would establish a permanent annual physician payment update tied to the Medicare Economic Index and built into the baseline. Under current law, the cumulative update for most physicians from 2026 to 2036 would be essentially flat, at 0.03 percent, while under the legislation it would grow by 7.7 percent. The bill pairs that update with a statutory floor for low-inflation years, an extended and increased work geographic practice cost index floor benefiting physicians in many rural areas and 34 states, and a five-year hybrid payment demonstration for independent primary care practices that is fully funded and exempt from budget neutrality. It incorporates the budget neutrality reforms of the "Provider Reimbursement Stability Act," raising the $20 million threshold that has gone unchanged since it was established and requiring the Centers for Medicare & Medicaid Services to reconcile utilization misestimates so that physicians are not penalized indefinitely for estimation errors. It also replaces the Merit-based Incentive Payment System with a simplified quality-measurement system developed through a clinician-majority process. Enactment of a permanent inflationary update would address the circumstances that lead physicians to reconsider Medicare participation in every setting at once, which is what Resolution 209 seeks to achieve for one setting at a time.

CONCLUSION

The Board of Trustees appreciates the concerns that prompted Resolution 209. The current opt-out framework was designed for practice arrangements that are no longer typical, and physicians who divide their time across multiple settings encounter a rule that does not reflect how they work. That frustration is legitimate, and the Board does not discount it.

The Board nevertheless concludes that the AMA should not advocate for the mechanism the resolution proposes. The decisive consideration is that the framework would transfer risk to beneficiaries in a form they cannot manage. Under current law, a beneficiary confronting an opted-out physician faces a large but knowable liability, disclosed in advance and verifiable independently. Under a setting-specific framework, that same liability would arise contingently, in settings the beneficiary may not have chosen, on the basis of a distinction the beneficiary has no practical means of anticipating. The AMA has consistently advocated for transparency in what patients owe and for advance disclosure of financial responsibility. A framework that makes the beneficiary's loss of Medicare coverage variable and encounter-dependent runs against that commitment.

The Board is also persuaded that the flexibility sought is, for most physicians, already available through membership and hybrid arrangements that require no change in law. The narrower restriction that remains, the inability to charge a beneficiary privately for a covered service, follows from the mandatory claims submission requirement rather than from any rule about setting. Restructuring opt-out would be a substantial change to reach a problem both narrower and differently situated than the resolution suggests.

The Board gives weight as well to the effect on continuity. A framework that divides a physician's participation by setting introduces breaks in care along lines unrelated to clinical judgment, for a population that moves across settings more often than any other, and the unresolved treatment of referrals and orders originating in an opted-out setting compounds that concern.

Weighing these considerations, the Board finds that a setting-specific opt-out framework would impose poorly bounded costs on beneficiaries in exchange for flexibility largely available already, without addressing the payment inadequacy that drives physicians to consider leaving Medicare. Existing AMA policy already commits the AMA to advancing physician choice, flexibility, and reduced administrative burden in Medicare participation, including advocacy to simplify the opt-out process itself, and to preserving the right of patients and physicians to contract privately without penalty. The circumstance Resolution 209 describes is best addressed by resolving its cause. The AMA is pursuing that remedy through its support for a permanent inflation-based update tied to the Medicare Economic Index, which would relieve the pressure on physicians in every practice setting. Advocating instead for selective withdrawal would divert effort from that work while transferring its costs to beneficiaries.

The Board does, however, see two avenues that respond to the concerns underlying Resolution 209 without imposing those costs. The first is the private contracting approach embodied in the MPEA, which would allow a physician and a patient to contract for a covered service without penalty to either party and without the patient forfeiting Medicare benefits. Because the contract must be executed in writing before services are furnished, may not be entered into during an emergency or urgent situation, and may not be used with dually eligible beneficiaries, that approach preserves the advance notice on which the Board's analysis rests while reducing the circumstances in which a physician would need to opt out at all. The second is a narrowly drawn accommodation for physicians who practice through separate entities in geographically distinct locations, where the

risk of beneficiary confusion is substantially reduced. The Board therefore recommends that existing policy supporting private contracting be reaffirmed, that the principle of rescinded Policy D-390.960 be restated as current policy, and that the AMA explore options to address the geographically distinct circumstance.

The remedy Resolution 209 proposes would make Medicare participation an attribute of the setting rather than of the physician. Beneficiaries would lose the ability to determine in advance whether Medicare will pay, and would face unlimited charges in settings they may not have selected and cannot readily identify. The Board of Trustees therefore recommends reaffirmation of existing policy, together with the targeted additions described above, in lieu of Resolution 209-I-25.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 209-I-25 and the remainder of this report be filed:

1. That Policies H-165.823, D-330.930, D-390.966, D-380.997, and D-390.957 be reaffirmed. (Reaffirm HOD Policy)

2. That our American Medical Association explore options to allow physicians who practice through separate practice entities in geographically distinct locations, where patients would not be likely to see the physician in more than one setting, to hold different Medicare participation or opt-out statuses with respect to those entities. (Directive to Take Action)

3. That our AMA support an additional payment option in Medicare fee-for-service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient, ensuring that Medicare patients can keep their benefits when they privately contract with any physician of their choice. (New HOD Policy)

Fiscal Note: Minimal.

REFERENCES

[1] American Medical Association, Board of Trustees Report 4-A-20, "Council on Legislation Sunset Review of 2008 and 2010 House Policies" (June 2020), app. 1, https://www.ama-assn.org/system/files/2020-05/sm20-bot04.pdf.
[2] Gretchen Jacobson et al., "Income and Assets of Medicare Beneficiaries, 2014-2030," Kaiser Family Foundation (September 2015), cited in Boccuti and Neuman, supra.
[3] Cristina Boccuti and Tricia Neuman, "Private Contracts Between Doctors and Medicare Patients: Key Questions and Implications of Proposed Policy Changes," Kaiser Family Foundation (January 2017), https://files.kff.org/attachment/Issue-Brief-Private-Contracts-Between-Doctors-and-Medicare-Patients.
[4] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4507; see also Boccuti and Neuman, supra (describing the all-patients, all-services requirement as intended to prevent confusion among patients as to whether a given visit would be covered and what they could expect to pay, and the two-year minimum period as intended to allow beneficiaries to make knowledgeable choices in selecting physicians).
[5] 42 C.F.R. pt. 405, subpt. D; Medicare Benefit Policy Manual, ch. 15, § 40. Private contracting is prohibited with beneficiaries who have full Medicaid coverage or who receive assistance through the Qualified Medicare Beneficiary program.
[6] American Medical Association, "Physicians FAQs: Medicare Patient Empowerment Act" (2015), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/medicare-patient-empowerment-act-physician-faqs.pdf; see also H.R. 1650, 114th Cong. (2015).
[7] Joanna Cantor et al., "US Physician Medicare Program Participation and Exit, 2013-2023," JAMA (published online October 20, 2025), doi:10.1001/jama.2025.15343.

[8] William Buczko, "Provider Opt-Out Under Medicare Private Contracting," Health Care Financing Review 26, no. 2 (Winter 2004-05), https://www.cms.gov/files/document/hcfreview2004winterpg43pdf.

[9] Alex Cottrill, Nancy Ochieng, and Tricia Neuman, "How Many Physicians Have Opted Out of the Medicare Program?" Kaiser Family Foundation (January 2025), https://www.kff.org/medicare/how-many-physicians-have-opted-out-of-the-medicare-program/ (analyzing CMS opt-out affidavit data as of November 2024). The 98 percent participation figure is drawn from MedPAC, Report to the Congress: Medicare Payment Policy (March 2024), ch. 4.

[10] MedPAC, Report to the Congress: Medicare and the Health Care Delivery System (June 2025); see also American Medical Association, "AMA urges action on Medicare payment reform at House hearing" (May 20, 2026). The 33 percent figure reflects the change in Medicare physician payment from 2001 through 2025 adjusted for practice cost inflation.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 08-I-26

Subject: Access to, and Retention of, Electronic Medical Records

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 211-I-25, "Access to, and Retention of, Electronic Medical Records," for report at the 2026 Interim Meeting. The resolution asks:

> 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; and be it further
>
> 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.

The Reference Committee heard mixed testimony for Resolution 211. Testimony broadly supported the goal of ensuring timely access to and retention of medical records to improve patient care, facilitate forensic and clinical processes, and prevent data loss during transitions between electronic medical record (EMR) systems. Testimony also supported the concepts of interoperability, accountability of EMR vendors, and continuity of care. However, some testimony expressed concern about aspects of the Resolution as written and offered amended language. Other testimony warned that federal standardization of medical record retention could conflict with or weaken existing state laws and impose costly burdens on smaller practices. Due to the complexity of the issue and in order to further address the complex overlap of federal and state regulations, vendor accountability, and data ownership issues before pursuing legislation, the HOD referred Resolution 211 for a report back at the 2026 Interim Meeting.

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BACKGROUND

Objectives of Resolution 211

Resolution 211 appears to be directed at reducing the risk of loss of patient data and ensuring that patients and physicians have the ability to access patient records in a timely manner, particularly in scenarios where the EMR vendor's contract with a medical provider has terminated, or the EMR vendor becomes insolvent. Regulations supporting these goals were promulgated under the 2003 Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule regulations, and made directly applicable to HIPAA business associates such as EMR vendors, under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

Ownership and Control of Medical Information

Protected Health Information (PHI) is generally collected from the individual by a medical provider, at which point it becomes subject to stringent privacy and security requirements under the HIPAA Privacy and Security Rules.

Medical providers, along with health plans and healthcare clearinghouses, comprise the definition of covered entities (CEs) under the HIPAA Rules and remain ultimately responsible to the individual and to regulators for as long as the individual's PHI that has been collected by the provider is used, disclosed, or maintained by them or on behalf of them. In order to facilitate the processing of PHI for claims payment, business analytics, and other purposes on behalf of the CE, each CE generally will contract with one or more entities that perform these services; HIPAA terms these entities "business associates" (BAs). The disclosure of PHI from the CE to the BA is strictly regulated and may only be done according to the terms of a business associate agreement. The required core terms of each business associate agreement (BA Agreement) are set forth in HIPAA regulations at 45 CFR §164.504(e), and obligate the BA to adhere to the same Privacy and Security Rule requirements as the CE to ensure protection of the PHI. Entities that compile and maintain EMRs are a prime example of a HIPAA BA, and may only handle the PHI disclosed to them by a medical provider or health plan, according to the terms of the BA Agreement that the EMR vendor has in place with each CE.

Retention of PHI by EMR Vendor BAs

As noted, an EMR vendor's handling of PHI is governed by the terms of each BA Agreement, which includes among its required provisions, 45 CFR § 164.310(d)(2)), mandating that each CE and BA implement policies and procedures to address the final disposition of electronic protected health information. Of note, this means that the medical provider has a responsibility and an opportunity to specify and negotiate (within limits) the terms for return or destruction of the PHI they have disclosed to a BA, at the time of engaging them pursuant to a BA Agreement. Each physician should understand the terms that they have agreed upon with their EMR vendor, prior to disclosing PHI to them. For employed physicians, these terms are generally negotiated by the CE that employs them – often a hospital.

To assist physicians in ensuring that appropriate terms are in place, the AMA maintains HIPAA Privacy & Security Resources, including a Sample Business Associate Agreement, with terms at Article V. that govern contract term and termination; Section 5.04 of the linked document at pages 15 – 16, specifically governs the return or disposal of PHI by the business associate.

Patient Access to Records Held by an EMR Business Associate

Individuals have a right to access their PHI maintained by a BA. However, the HIPAA Privacy Rule[1] dictates that the CE (such as a health plan or healthcare provider) is primarily responsible for fulfilling this Right of Access. The Rule requires each CE to specify in their BA Agreement, that the BA must make such PHI available if and when needed by the CE so that it can provide individuals with access to their information. However, the Privacy Rule also allows the CE, when disclosing data to the BA, to agree in their BA Agreement that the BA will provide individuals with access to their data; this arrangement may be appropriate where the BA is the only holder of the data that is sought by the individual. BAs are generally not required to give individuals direct access to their PHI. Instead, if an individual requests PHI directly from a BA, the BA typically must forward the request to the CE, or handle it according to the terms of their BA Agreement. The CE then processes the request and provides the information to the requesting individual within 30 days.

The Information Blocking Rule (IBR) Impact on Patient Access to Records

The IBR regulations were promulgated in 2020 pursuant to the 21st Century Cures Act and require entities such as EMR vendors to provide each user[2] with the ability to "timely create an export file(s) with all of a single patient's electronic health information."

The electronic health information (EHI) export certification criteria requires that all EHI produced and electronically managed by a developer's health IT be readily available to export for a single patient upon request for his or her health data, and for all patients when a physician seeks to change health IT systems. It further requires health IT developers to provide the format, such as a data dictionary or export support file, for the exported information to assist the receiving system in processing the EHI without loss of information or its meaning to the extent reasonably practicable using the developer's existing technology. These regulations were promulgated to ensure that patients and physicians can timely access their EHI as a patient right, and for medical purposes of treatment and continuity of care.

AMA POLICY

Given this analysis' focus on access and retention, the following policies are the highly relevant: Existing AMA policy supports the broader adoption of interoperable health IT and EHR systems when implementation improves care, protects patient safety, promotes usability and data portability, holds vendors accountable, and reduces, rather than increases, burdens on physicians (D-478.995). Additionally**,** AMA policy supports strong, practical privacy and security standards for electronic medical information while emphasizing that physicians should retain ownership and control of practice-generated data and receive support in meeting regulatory requirements (H-315.979, H-315.974).

Policy D-315.971 seeks to ensure that physicians have access to the medical and billing records necessary to protect their professional and legal interests. Key elements of this policy state that licensed physicians should have unrestricted access to their patients' billing records and related medical records while employed or under contract to provide care; physicians should be able to access billing records submitted under their name, even if they did not personally provide the item or service; where state law does not already require physicians to possess billing records, contracts should specify that physicians are entitled to copies after employment or contract termination when needed for liability defense, administrative investigations, or other proceedings; and, that our AMA supports legislation or regulation to eliminate contract terms that limit or bar physicians' access to

billing and associated medical records, including claims that such records are proprietary or trade secrets.

DISCUSSION

The transition process to a new EMR vendor can be disruptive for both patients and their physicians. Physicians are concerned by the potential for loss of critical patient data and the possible costs of transitioning to a new system. For patients, this can result in delays in treatment, gaps in medical history, and a breakdown in communication with their care team. However, in addition to existing laws that create inherent protections for accessing and retaining patient health records, the federal government has provided educational resources to help navigate contractual language to include additional rights and obligations related to the scope of transition services that could be provided, notice periods, and commitments to ongoing transition services.[3]

Resolution 211-I-25 – first resolve

The objective of the first resolve, to create a federal standard for medical record retention, is incompatible with the body of law that regulates the practice of medicine at the state level. Furthermore, as discussed above, such a federal standard is likely to impose conflicting compliance obligations where related laws are implicated, such as statutes of limitations. The second part of the first resolve targets "records of discharged patients," which is unclear if it refers to patients discharged from a facility or alternatively, patients discharged from a practice." If the former, creating a new time requirement for physicians at discharge does not help with record access and causes additional administrative burden. If the latter, record access is already preserved by the rules governing all other patient EMR records and thus it is unnecessary to call out this particular instance. Finally, in regard to the first resolve, as it is written in passive voice, the wording is unclear as to which entity would perform the compilation, review, and authentication within 30 days of discharge, that the resolution proposes. If the resolve intends to direct physicians to complete these tasks, that would add significant burden to perform those activities routinely, rather than providing the patient with access to their records upon request, as is the current practice. If, however, the resolve intends to direct EMR vendors to perform these tasks, the compensation for those services would be built into the business associate agreements that each EMR vendor has with the physician practices it serves. The cost allocation and responsibility to perform these services on a routine basis, as opposed to upon the request of a patient, would likely inflate the cost of an EMR vendor's services for the same duties that, as discussed above, they are already bound by regulation to perform.

Resolution 211-I-25 – second resolve

With three subparagraphs, the second resolve advocates first, that EMR vendors comply with state laws regardless of their contractual relationships, which is certainly unobjectionable, and is understood to be the current practice.

Secondly, subparagraph (b) of the second resolve proposes that EMR vendors be required to arrange for custodians of all electronic medical files in case of their insolvency. Such an extra step appears inadvisable, as it would add to practice cost, as discussed above. Finally, as discussed above, current federal regulations require that each medical provider enter into an agreement with their EMR vendor, for the return or destruction of the provider's PHI upon termination of the contract. An EMR vendor's insolvency, and the resulting impossibility of their performance, would be one ground of contract termination, so that the transition of data held by an EMR vendor is already provided for, by contract, statute, and regulation.

The third and final subparagraph of the second resolve, (c), aims to require EMR vendors to fulfill patient requests for their records. As discussed above, HIPAA mandates that with certain exceptions,[4] the covered entity, such as a physician, remains responsible to the patient to provide access to that patient's records. As further noted above, each medical provider may negotiate terms in their agreement with their EMR vendor, for the vendor to provide an individual's PHI directly to them. For these reasons, a mention of the "business associate agreement," should be inserted in the subparagraph.

State-Based Medical Record Retention Considerations and Federal Policy Outlook

Establishing a single federal standard for medical record retention would be highly challenging given the long-standing patchwork of state laws governing healthcare delivery, professional licensure, and related liability issues. State law generally determines clinical record retention periods, and requirements vary substantially by jurisdiction, patient age, and provider type. Statutes of limitations for medical liability claims, particularly those involving pediatric patients, further complicate any effort to impose a uniform national standard. Although federal law, including HIPAA, establishes certain retention obligations for privacy and compliance documentation, it does not prescribe comprehensive clinical record retention timelines, which remain largely a matter of state law.

Creating a federal standard for medical record retention could create major challenges for physicians by conflicting with existing state laws, increasing administrative and data storage costs, and raising legal liability risks. Currently, retention rules are set mostly by individual states and specific programs like Medicare, creating a complex landscape. Even if Congress created a federal minimum or "floor," physicians would still have to account for longer state retention requirements, state medical board rules, malpractice statutes of limitations, tolling rules for minors, and courts' application of discovery rules in litigation. Because those state-law obligations and litigation risks would remain, a physician who follows a shorter federal timeline could face exposure in liability litigation. Conversely, if the federal standard imposed a longer retention period than required by the state in which a physician practices, the storage of sensitive data whose retention is not currently required, incurs heightened risks for the physician practice in the event of a breach or unintentional, impermissible disclosure. In practice, a federal floor would add another layer of compliance without eliminating the conflicting legal regimes, particularly those enumerated above, that make medical record retention a complex compliance issue.

Congress has not recently demonstrated significant interest in adopting a universal federal medical record retention mandate for healthcare providers. Recent federal activity has focused more on patient access, affordability, privacy, and data security than on establishing nationwide storage and retention timelines.[5] As a result, retention obligations continue to be governed by a combination of state law, Medicare and Medicaid requirements, and agency-specific rules. Any federal proposal in this area would need to account for existing state frameworks and the practical implications of creating requirements that are more prescriptive than many current state standards.

CONCLUSION

Clinical and medical record retention remains principally a matter of state law; imposing a uniform federal standard would implicate numerous additional areas of state law with foreseeable, and likely unforeseeable, negative consequences. Existing federal and state laws already provide substantial protections for access, privacy, and related compliance obligations, while clinical medical retention timelines are administered under state frameworks. Accordingly, a blanket federal retention mandate would create friction with existing law and practice, and is unlikely to

provide the solution it appears to promise. Ensuring continued access to medical records is best addressed by enforcement of state and federal requirements, in addition to carefully drafted contract provisions clarifying physician ownership of records and uninterrupted rights of access to data.

RECOMMENDATIONS

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

1. That our American Medical Association support federal and state legislation, regulation, and certification standards requiring Electronic Medical Record (EMR) vendors and Health IT developers to retain, preserve, and provide complete export of patient data in an electronic, retrievable, interoperable, and transferable format for the period necessary to satisfy all applicable federal and state retention obligations, regardless of contract termination or vendor insolvency, without imposing unreasonable or punitive data extraction or archival fees on covered entities; (New HOD Policy) and
2. That our AMA support federal regulatory enforcement ensuring that EMR vendors fulfill their obligations as HIPAA Business Associates by promptly providing requested records to the covered entity that disclosed them, and where stipulated by contract or regulation, delivering records directly to patients or authorized third parties in a timely manner, at no more than the allowable cost-based fee, and in a standard, accessible, and usable format; (New HOD Policy) and
3. That our AMA advocate for federal health IT certification and bankruptcy reforms that establish clinical health records as protected custodial assets that cannot be withheld, deleted, or monetized during vendor insolvency, liquidation, or acquisition. (Directive to Take Action)

Fiscal Note: Minimal.

REFERENCES

[1] See Does the HIPAA Privacy Rule require a business associate to provide individuals with access to their protected health information? HHS Office for Civil Rights guidance published December, 2002. Note that this guidance precedes the 2009 HITECH Act, which made business associates directly subject to the Privacy Rule requirements and HHS-OCR enforcement, whereas business associates were previously made subject to the privacy and security requirements via the required terms of each business associate agreement.

[2] CFR §170.315(b)(10). The IBR does not place compliance burdens on a generalized "user," but instead regulates three distinct classes of entities known as Actors: Healthcare Providers, Health IT Developers, and Health Information Networks/Exchanges. While not labeled as regulatory "users" who must comply with the rule, patients and consumers are the intended beneficiaries whose rights to access, exchange, and use their electronic health information (EHI) are legally protected against blocking by the regulated Actors. *See* https://hiteqcenter.org/Resources/HITEQ-Resources/ArtMID/718/ArticleID/2013/preview/true.

[3] ONC Resource: EHR Contracts Untangled: Selecting Wisely, Negotiating Terms, and Understanding the Fine Print.

[4] "[T]he Privacy Rule does not prevent the parties from agreeing through the business associate contract that the business associate will provide access to individuals, as may be appropriate where the business associate is the only holder of the designated record set, or part thereof." Footnote 1, *supra*.

[5] E.g., Foster Introduces Medical Records Access Fairness Act (March 2026).

REPORT OF THE BOARD OF TRUSTEES

BOT Report 09-I-26

Subject: Medicare Should Not Unfairly Penalize Physicians

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim meeting of the American Medical Association (AMA) House of Delgates (HOD) Resolution 220-I-25, "Medicare Should Not Unfairly Penalize Physicians," was referred. It states:

> "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."

The Reference Committee considered Resolution 220-I-25 together with Resolution 223-I-25, "Halt the Rollout of New Payment Models by the Center for Medicare & Medicaid Innovation (CMMI)—A New Administration Offers an Opportunity," and it was also referred. It states:

> "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."

As the two resolutions were discussed together during the Reference Committee hearing, address the same topics, and were both referred, BOT Report 09-I-26 addresses both resolutions. The whereas clauses in Resolution 220-I-25 state that the administrative burdens created by value-based payment programs have fueled acquisition of independent practices by hospitals, insurance companies, and private equity firms. They also state that these programs present barriers to delivering better care at a lower cost by diminishing competition, and that value-based payment models inherently lead to conflicts of interest between physicians and patients. Whereas clauses in Resolution 223-I-25 cite studies finding that CMMI models have hurt quality of care, and whereas clauses in both resolutions cite a 2023 Congressional Budget Office report that found that CMMI payment models led to increased federal spending instead of savings in the agency's first decade and projected that the models will continue to generate more instead of less Medicare spending.[1]

Testimony on the resolutions acknowledged that CMMI payment models have imposed administrative burdens, financial penalties, and had negative impacts on care, but there was disagreement over how best to address these problems. Multiple people testified that current AMA policy should be reaffirmed in lieu of the resolutions due to the AMA's longstanding support for voluntary, physician-developed payment reform. Other testimony advised that referral would provide an opportunity to evaluate how to strengthen the AMA's advocacy so that future models reflect physician leadership, local flexibility, and data driven evaluation.

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BACKGROUND

For more than 20 years, there has been bipartisan interest in implementing alternative payment models (APMs) for physician services as a means of improving the quality and coordination of patient care and reducing Medicare spending growth. The goal of creating APMs was to ensure payments reward physicians for delivering good quality and health outcomes at a lower cost, rather than basing payment solely on the number and types of services they deliver. Physicians supported the creation of APMs that would provide additional or different payments that enable physicians to deliver care in higher-quality and/or more cost-efficient ways for a clinical condition, a care episode, or a patient population. In addition, physicians were willing to take accountability for efficiently delivering high-quality care if they had the flexibility and adequate resources to do so.

Physicians supported the creation of multiple types of APMs, including accountable care organizations (ACOs), bundled episode payments, and primary care medical homes. The goal of ACOs was to enable medical practices, hospitals, and other organizations involved in patient care to work together to coordinate care for a defined patient population in ways that can improve quality and control total spending. If successful, ACOs would earn a share of the savings they generated for Medicare. Bundled payments were intended to provide a single payment or budget for all services related to an episode of care, such as a surgical procedure or management of a chronic condition. In primary care medical home models, practices would receive monthly payments for comprehensive management of patients' primary care services and coordination of other services that patients need in addition to, or instead of, payments for office visits.

The creation of CMMI in 2010 aimed to significantly boost the creation of Medicare APMs. The AMA developed educational materials and convened seminars all over the country to inform physicians about opportunities to improve patient care under well-designed payment models and how to design effective APMs. Although the AMA and many specialty societies proposed APMs to CMMI, the agency did not adopt them and instead developed its own models. One exception was a CMMI grant program, the Health Care Innovation Awards, that, starting in 2012, provided grants ranging from $1 million to $30 million for three years to test new models. Many physicians applied for these grants and used them to deliver services in ways that were not possible under existing payment systems. Although evaluation of the models found that more than 20 of them achieved significant savings, the projects generally could not be sustained or expanded because the grant funding only lasted for 3 years and CMMI did not create any APMs that would support the services that were delivered in the projects.

In 2015, there were still too few APMs for physician services available. To facilitate development of more APMs for physicians, Congress included an APM pathway and six years of incentive payments in the Medicare Access and CHIP Reauthorization Act (MACRA). Congress recognized that to be successful, APMs need to be designed by physicians working on the front lines of care, so MACRA also created the Physician-focused Payment Model Technical Advisory Committee (PTAC) to review and recommend physician-designed APM proposals. Physicians responded immediately to the opportunity to design APMs that would support better patient care. More than 30 patient-centered APM proposals were developed and submitted to PTAC, several of which had been successfully pilot tested under a Health Care Innovation Award. Nonetheless, although PTAC recommended 19 APM proposals for further development, testing, implementation or other action by Medicare, none were implemented by CMMI.

Currently, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under MACRA. Moreover, most of the APMs that CMMI has created to date have not been designed in the ways that physicians expected or Congress intended. Most APMs

have provided "incentives" tied to higher quality or lower spending without providing physicians the resources or flexibility they need to deliver care in different ways. Many APMs have also placed physicians at financial risk for spending and outcomes that they cannot control. CMMI's primary care models have only been available in a small number of states or regions. In addition, because they must demonstrate savings for Medicare within a short timeframe, many APMs that had desirable characteristics were terminated instead of being improved, and others were continued but modified in ways that made them less likely to support patient-centered care. In a report on physician practices in rural or underserved areas, the Government Accountability Office noted that many lacked the capital to finance the upfront costs of transitioning to the APMs created by CMMI and faced challenges acquiring or conducting data analysis necessary for participation.[2] Instead of fixing these problems to make the models more financially sustainable for practices and attract more participants, CMMI is increasingly turning to APMs that mandate participation and impose large penalties for failure to reduce spending by arbitrary amounts, most recently with the Ambulatory Specialty Model and Comprehensive Joint Replacement Expanded model.

AMA POLICY

Current AMA Policy D-385.980, "CMMI Payment Reform Models," has guided the AMA's advocacy on mandatory APMs since 2021. It calls for the AMA to:

- continue to advocate against mandatory CMMI demonstration projects;
- advocate that the Centers for Medicare and Medicaid Services seek innovative payment and care delivery model ideas from physicians and groups such as medical specialty societies to guide PTAC's recommendations and CMMI's work to propose demonstration projects that are voluntary and can be appropriately tested; and
- advocate that CMMI focus on the development of multiple voluntary pilot projects in many specialties, tailored to the needs of local communities and different specialties.

AMA Policy H-160.915, "Accountable Care Organization Principles," outlines AMA principles for ACOs and reinforces the need for them to be voluntary for both physicians and patients. It also states that any physician organization or other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO, and that physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid, a private payer, or being admitted to a hospital medical staff.

The AMA also has several policies addressing APMs beyond those that oppose mandatory models:

- Policy H-385.901, "Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations," calls for the AMA to extend ongoing payment reform advocacy to address the needs of specialties and patient populations not served by current CMMI models and work with national medical specialty societies that are developing APMs for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties, and continue to advocate that CMMI, state Medicaid agencies and other payers implement physician-developed APMs.
- Policy H-450.931, "Moving to Alternative Payment Models," asks that the AMA work with CMS to establish an appropriate timetable for APM implementation accounting for the physician community's readiness to assume two-sided risk. It also asks that the AMA help practices optimize the quantity and content of physician work under APMs and address their concerns about operational details.

- Policy H-385.913, "Physician-Focused Alternative Payment Models," includes detailed lists of APM goals, guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members, and recommended technical assistance for CMS and private payers to provide to physician practices working to successfully implement APMs. The goals include avoiding placing practices at substantial financial risk and minimizing administrative burdens.

DISCUSSION

The AMA has often said that if CMMI would adopt the models that have been developed by the physician community, including those recommended by the PTAC, there would be many physicians willing to voluntarily participate in them. However, CMMI believes that voluntary APMs lead to selection bias that hurts its ability to fairly evaluate models; it thinks that only the participants who expect to succeed in the model will enroll, and those that do not succeed will drop out before the test has ended.[3] CMMI also believes that it needs to impose steep financial risk requirements to generate a sufficiently large amount of savings for Medicare. However, placing physicians at high risk for costs that they cannot influence, or control, further discourages them from voluntarily participating in models. Rather than creating models in which physicians want to participate, CMMI is increasingly mandating physician participation in the APMs it has created to get an adequate number of participants.

APMs that focus primarily on reducing healthcare spending and utilization rather than on improving the delivery of care, particularly those involving significant financial risk, have the potential to harm patients as well as physicians. It is inappropriate for CMMI to require physicians and their patients to participate in a new APM before any testing on a voluntary basis, or evaluation of the impacts on patient care, has been completed.

CMMI has implemented several voluntary APMs that physicians have willingly joined and used to redesign services and reduce avoidable spending without harming patients. For example, CMMI has created a series of primary care focused models, including the Comprehensive Primary Care Initiative, Comprehensive Primary Care Plus, Primary Care First, and Making Care Primary that have provided important additional funding and other types of support to primary care practices to help them adopt advanced primary care models. Large numbers of practices voluntarily enrolled in these models and used the payments to improve the way they delivered patient care. As with the Health Care Innovation Awards, however, these APMs have either been allowed to lapse without being extended or have been terminated early. Some participants in the voluntary programs for bundled surgical payment, oncology care, kidney care, and the ACO models developed by CMMI have also had positive experiences with them, but in most cases, CMMI has revised the models in ways that reduced the resources available to physicians and increased their financial risk for costs they cannot control. CMMI has recently begun to focus more on the need to engage non-primary care specialists in APMs, but it has done so with limited input from specialists. The Long-Term Enhanced ACO Design model (LEAD ACO)–includes a component focused on specialist management of episodes for patients attributed to an ACO, but it is not yet clear exactly how this model will be implemented.

The Board of Trustees believes that the AMA should continue to support the creation of APMs that enable both primary care physicians and specialists to deliver care in higher-quality, lower-cost ways. The AMA should also continue to oppose mandating physician participation in payment models that place physicians at high levels of financial risk for costs and outcomes they cannot control and that fail to provide the flexibility and resources physicians need to improve care for

patients. Current AMA policy strikes an appropriate balance between these objectives, and the Board recommends that they be reaffirmed.

In addition, new policies are needed that would establish AMA support for legislation that could provide an effective pathway to CMMI's adoption of physician-developed APM proposals and establish some guardrails on mandatory testing of models. Title III of the bipartisan Patients First Act, H.R. 9693, which focuses on APM improvements, takes some initial steps in this direction. It would require the Secretary of Health and Human Services to use the notice-and-comment rulemaking process for mandatory models as well as for when the Secretary either terminates, expands, or modifies an APM. It would also require the Secretary to report to Congress on the barriers to specialty physicians' participation in APMs, including specific policy recommendations to reduce these barriers.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 220-I-25 and 223-I-25 and the remainder of the report be filed:

1) That our American Medical Association (AMA) support legislation to create a program funded by the existing Center for Medicare and Medicaid Innovation (CMMI) appropriation to test alternative payment models developed by physicians or medical societies while not placing physicians at financial risk for costs and outcomes they cannot control. (New HOD Policy)
2) That our AMA support legislation to require CMMI to test all new payment models on a voluntary basis. (New HOD Policy)
3) That our AMA reaffirm:
    a. Policy D-385.980, "CMMI Payment Reform Models;"
    b. Policy H-160.915, "Accountable Care Organization Principles;"
    c. Policy H-385.901, "Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations;"
    d. Policy H-450.931, "Moving to Alternative Payment Models;" and
    e. Policy H-385.913, "Physician-Focused Alternative Payment Models. (Reaffirm HOD Policy)

Fiscal Note: Minimal.

REFERENCES

[1] Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation, Congressional Budget Office, September 23, 2023.
[2] Medicare: Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas, Government Accountability Office, GAO-22-10468, Nov. 17, 2021.
[3] Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program, Federal Register, Volume 90, Nov. 5, 2025, p. 49571.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 16-I-26

Subject: Ensuring Medical Liability Insurance Transparency and Continuity

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee B

At the 2025 Interim Meeting of the American Medical Association (AMA), the House of Delegates (HOD) referred the second resolve of Resolution 235 "Ensuring Medical Liability Insurance Transparency and Continuity" to the Board of Trustees (Board) which reads:

> 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.

BACKGROUND

Physicians obtain medical liability coverage in many ways. To take just a few examples, a physician's employer (e.g., a hospital, health system or large group practice) may purchase insurance from a carrier or it may self-insure. Here the physician may have little if any input concerning how his or her coverage is structured. Physicians in solo or smaller group practices frequently shop for and buy their own liability insurance. Physicians who are independent contractors also typically purchase their own policies, although sometimes they may be able to negotiate a deal where the other party pays or partially subsidizes the physician's insurance premiums.

Regardless of how the physician is insured, a disturbing trend has emerged where physicians in all practice settings find themselves without insurance and need subsequent protection. For example, some hospitals, health systems, large group practices or other entities that may have funded the physician's liability insurance have closed without giving physicians, patients, and communities any warning. Some of these closures have been disastrous and have drawn national attention.[1,2] Physicians are particularly vulnerable in such situations because the coverage is abruptly cancelled and the physician is robbed of any opportunity to develop a transition plan.

One must be clear, however, that potential interruptions in medical liability protection extend to physicians in all kinds of circumstances, no matter how their coverage is provided. Because physicians are most often insured under claims-made policies, physicians may have to address a potential gap in coverage for a great many reasons, e.g., leaving the practice of medicine for another career or because of burnout, working for or with another organization, opening a practice, selling or merging a practice, retiring, suffering a disability, moving to another part of the country, etc.

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AMA POLICIES

Policy D-225.970, "Addressing Anti-Physician Contractual Provisions," states that the AMA will develop model state legislation to prohibit the inclusion of clauses indemnifying employers in physician contracts, and 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.

Directive D-215.980, "Support Before, During, and After Hospital or Physician Group Closure or Reduction in Services," states in part that the AMA will work with appropriate federal and state bodies to assure that whenever there is a threatened, or actual, hospital or physician group closure a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship. Such a process should ensure financial reserves exist and are sufficient to cover any previous contractual obligations to physicians, e.g., medical liability tail coverage.

Policy H-310.943, "Closing of Residency Programs," states in part that the AMA will work with the Centers for Medicare & Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for the provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.

Also, Policy D-435.978, "Loss of Medical Staff Privileges for Lack of 'Tail Coverage," states in part that the AMA supports model medical staff bylaw language as follows, "Where continuous professional liability insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to 'tail' coverage) is not grounds for immediate termination of medical staff membership."

DISCUSSION

As noted above, in some cases the cancellation of claims-made coverage, whether abrupt or otherwise, may bring about a gap in a physician's medical liability protection. Physicians are typically insured under claims-made policies because they are less expensive than other alternatives such as occurrence policies or a tail coverage endorsement on a claims-made policy. Claims-made policies cover physicians if (1) the alleged harm occurs and (2) the associated medical liability claim is filed while the policy is in force. The cancellation of claims-made coverage may raise a couple issues. First, the physician may not be able to practice medicine until the physician can obtain coverage from another employer, carrier or any other means. Second, given the structure of claims-made coverage, the physician has no medical liability protection for claims filed after the coverage lapsed for alleged harm occurring while the prior claims-made policy was effective. For some specialties, particularly obstetrics and gynecology (OB/GYN) and emergency physicians providing OB/GYN services, claims may be filed decades after the alleged injury. While claims-made policies can provide adequate coverage during the policy, they offer less protection than occurrence policies and claims-made coverage with a pre-paid tail. Specifically, they offer no protection if the physician loses his or her medical liability insurance and the physician has no immediate prospect of obtaining a new policy that will insure the physician going forward and for claims filed for alleged harm(s) occurring during the policy period.

The interruption in coverage may be addressed generally in three ways, either by purchasing an occurrence policy, adding tail coverage to a claims-made policy, or through prior acts coverage. An

occurrence policy protects the physician for any incident that occurs during the policy period, and it makes no difference when any associated claim is filed, even decades later. In other words, occurrence policies offer life-time protection without the need to purchase a tail. The coverage also stays in place if the physician changes practice setting, practice status, or medical liability insurance carriers. As one would expect, occurrence policies are significantly more expensive than claims-made coverage. Not unexpectedly, many physicians may not be able to pay occurrence policy premiums so whether a physician has occurrence coverage will be up to another party. Notably, some medical liability insurers do not sell occurrence policies due to the unpredictable long-term risk of reserving funds for years or even decades to pay out claims filed long after a policy year ended, which increases financial exposure. Moreover, it must be noted that some insurers may not sell occurrence policies in particular markets or for certain specialties – again, due to increased financial exposure.

Adding tail coverage to a claims-made policy can eliminate the gap in coverage. Tail coverage is a medical liability insurance endorsement that allows a physician to report medical liability claims after the claims-made policy has ended, for incidents that occurred while the claims-made policy was in force. The tail coverage must have a retroactive date that matches the prior claims-made policy's retroactive date to ensure there is no interruption in coverage. As in the case of occurrence coverage, tail insurance may be cost-prohibitive for many physicians since premiums may be 1.5 to 3 times more than claims-made policies alone. For most physicians, the preferred way to obtain tail coverage protection is by having the tail purchased in advance, rather than attempting to do so after the fact. Importantly, it is possible that not all carriers will sell such coverage or limit such products to specific markets.

A prior acts or "nose" policy is another strategy to coverage gaps, although an occurrence or claims-made policy with a pre-paid tail may be preferrable, all things being equal. A prior acts policy is purchased from a new carrier to protect the physician from incidents that occurred before the new policy became effective. A prior acts policy may in some cases be more affordable than pre-paid tail or occurrence coverage, but it may have some downsides that the others do not. For example, since a prior acts policy are obtained from a new insurer, the physician's risk will be subject to the insurer's underwriting review, and there is no guarantee that the physician will qualify for coverage under the insurer's insurability criteria. Some carriers also do not sell prior acts medical liability insurance policies. And unlike an occurrence or a claims-made policy with a pre-paid tail, a prior acts policy does not protect a physician who retires or who decides to pursue a career outside the practice of medicine.

The HOD has asked the Board to study whether occurrence policies or claims-made coverage with a pre-paid tail should be recognized as the gold standard in medical liability insurance coverage. Since many physicians in all practice settings may at some point have to confront the prospect of interruptions in coverage that may result from claims-made policies, the Board believes that it is not only appropriate, but also timely, for the AMA to adopt policy stating that occurrence policies or claims-made coverage with a pre-paid tale provide more protection and are therefore preferrable, all things being equal, over other forms of coverage, including claims-made policies.

Adopting new policy would also be consistent with existing AMA policy and directives cited in the previous section of this report. (Directive D-215.980, "Support Before, During, and After Hospital or Physician Group Closure or Reduction in Services;" and Policy H-310.943, "Closing of Residency Programs;" Directive D-435.978, "Loss of Medical Staff Privileges for Lack of 'Tail Coverage.' ")

The Board, however, wants to be clear that recommending adoption of a gold standard policy for occurrence policies and claims-made policies with pre-paid tails does not in any way reflect negatively on claims-made policies. For many physicians, claims-made policies are perfectly adequate by themselves or in combination with prior acts coverage. The Board also understands that in some markets only claims-made policies are sold and a prior acts add-on may not be an option.

Nevertheless, physicians deserve to have the broadest medical liability coverage possible for themselves and for the sake of the patients and communities they serve. When compared with alternatives, occurrence or pre-paid tail coverage appears to offer physicians more comprehensive protection across all settings. The proposed new policy will further express the AMA's ongoing concern for the plight of so many physicians who have found themselves suddenly without medical liability insurance with no prospects of obtaining subsequent coverage. This policy would also make more physicians more aware of coverage limitations that may arise if their medical liability insurance is no longer effective. Finally, the policy proposed in this report would encourage physicians, where applicable, to explore the possibility of obtaining occurrence coverage or a claims-made policy with a pre-paid tail whether through employment, contract, or any other means that might be available.

CONCLUSION

After carefully examining the question of whether occurrence policies or claims-made coverage with a pre-paid tail should be taken as a gold standard in medical liability insurance, the Board recommends that the HOD adopt policy that recognizes 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 for physicians in all practice settings.

RECOMMENDATION

The Board of Trustees recommends that the second resolve of Resolution 235-1-25 be adopted and that the remainder of the report be filed.

Fiscal Note: Minimal.

REFERENCES

[1] "Steward Health Care raided its own medical malpractice insurance company," The Boston Globe, Spotlight Investigations, September 2024, https://apps.bostonglobe.com/metro/investigations/spotlight/2024/09/steward-hospitals/steward-traco/.
[2] Janis M. Orlowski, "Displaced Hahnemann Residents and Attending Physicians May Soon Lose Liability Insurance," AAMC News, January 7, 2020, https://www.aamc.org/news/displaced-hahnemann-residents-and-attending-physicians-may-soon-lose-liability-insurance.

REPORT 17 OF THE BOARD OF TRUSTEES (I-26)
Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform
BOT Report 04-I-25/RES 242-A-26

EXECUTIVE SUMMARY

At the 2024 Interim Meeting, the American Medical Association (AMA) AMA House of Delegates adopted Policy D-130.957, Addressing and Reducing Patient Boarding in Emergency Departments, calling for AMA to report at the 2025 Interim Meeting progress addressing and reducing patient boarding in emergency departments (EDs). BOT Report 04-I-25 provided a comprehensive review of the issue. At the 2025 Interim Meeting, Policy D-130.957 was amended to request a report back to the House of Delegates at the 2026 Interim Meeting on progress addressing and reducing patient boarding in EDs.

At the 2026 Annual Meeting of the House of Delegates, Res 242-A-26 ("Reducing Emergency Department Boarding through Payment Reform") was introduced. Because the AMA was already actively engaged on this issue through its work on BOT Report 04-I-25, Res 242-A-26 was referred and both reports were combined. Accordingly, this report satisfies both items of business and provides an update of AMA advocacy on this issue since BOT Report 04-I-25 was written.

ED boarding, which occurs when patients remain in the ED after admission or placement in observation status, is a persistent national crisis, with more than 90 percent of EDs reporting crowded conditions. Boarding delays treatment, worsens patient outcomes, contributes to staff burnout, and increases violence against healthcare workers. Boarding is a result of systemic dysfunction throughout our healthcare system and can only be solved through a concerted, multi-pronged solution that addresses the myriad drivers of ED boarding.

Since the previous report, the AMA has continued to provide input on new quality measures relevant to ED boarding, continued its support of the advancement of the *Addressing Boarding and Crowding in the Emergency Department Act of 2025*, (ABC-ED Act), and continues its work to mitigate the root causes of ED boarding.

Looking ahead, the AMA will continue to support the ABC-ED Act and weigh in on ED boarding quality measure development efforts, which continue to be the two paths currently most active at the federal policy level. Meanwhile, we will continue our ongoing advocacy to address the many root causes contributing to ED boarding, including strengthening the physician workforce, reforming prior authorization, and improving the reliability of federal payers, among others.

In addition, the AMA is excited to collaborate with the American College of Emergency Physicians (ACEP), the American Academy of Emergency Medicine (AAEM), and other national medical specialty societies, state medical societies, and other interested parties that are leading on this issue to amplify their initiatives, reinvigorate national attention, and pursue action at the federal and state levels to address the multi-faceted causes of ED boarding and mitigate its harmful impact on physicians and patients. The AMA continues to believe that increased collaboration with and amplification of initiatives by ACEP, AAEM, and other national and state medical societies is the most effective way to meaningfully advance advocacy on this issue in the coming year.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 17-I-26

Subject:	Addressing and Reducing Patients Boarding in the Emergency/Reducing Emergency Department Boarding through Payment Reform
Presented by:	Toluwalase A. Ajayi, MD, Chair
Referred to:	Reference Committee B

At the 2024 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-130.957, "Addressing and Reducing Patient Boarding in Emergency Departments," which directed the AMA to report back to the House of Delegates at the 2025 Interim Meeting on progress addressing and reducing patient boarding in emergency departments (EDs). At the 2025 Interim Meeting, BOT Report 04-I-25 provided a comprehensive review of the issue. The sixth bullet of Policy D-130.957 was amended to request a report back to the HOD at the 2026 Interim Meeting on progress addressing and reducing patient boarding in EDs.

1. Our American Medical Association will collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding.
2. Our AMA supports appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout.
3. Our AMA advocates for increased state and federal assistance to address the systemic factors contributing to emergency department boarding.
4. Our AMA supports other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness of the impacts of emergency department boarding and to identify and propose solutions.
5. Our AMA will continue to monitor the development of CMS quality measures related to patient boarding and work in collaboration with relevant medical specialty associations to support improvements in quality standards related to emergency department care.
6. Our AMA will report back to the House of Delegates at the 2026 Interim Meeting on progress addressing and reducing patient boarding in emergency departments.

Additionally, at the 2026 Annual Meeting of the House of Delegates, Res 242-A-26 ("Reducing Emergency Department Boarding through Payment Reform") was introduced.

RESOLVED, that our American Medical Association advocates for the Centers for Medicare & Medicaid Services (CMS) and other payors to tie admitted patients' hospital reimbursement to emergency department boarding performance, including payment reductions or creation of a lower-reimbursed status when boarding of admitted patients exceeds four hours (Directive to Take Action); and be it further

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RESOLVED, that our AMA adopts policy and advocates for making emergency department boarding metrics and mandatory quality measures incorporated into value-based payment programs, rather than reporting-only requirements without financial consequences. (Directive to Take Action)

Because the AMA was already actively engaged on this issue through its work on BOT Report 04-I-25, Res 242-A-26 was referred and both reports were combined. Accordingly, this report satisfies both items of business and provides an update of AMA advocacy on this issue since BOT Report 04-I-25 was written.

BACKGROUND

A "boarded patient" is one who remains in the ED after being admitted or placed into observation status, which can contribute to ED crowding.[1] ED boarding is widely considered a system-wide crisis, with harmful impacts on patients, hospital staff, public safety, and healthcare costs. Over 90 percent of EDs routinely report crowded conditions.[2] Patients can wait days to weeks after a physician has decided to admit them for an inpatient bed to become available, which can exacerbate issues like delirium and contribute to worse outcomes for individual patients and create a ripple effect due to bed shortages, worsening community-level outcomes.

The COVID-19 Public Health Emergency shed more light on and exacerbated ED boarding, but the problem has persisted. Because EDs serve as the last line of defense for patient care in their communities and patients can end up in the ED for myriad reasons, the contributors to ED boarding are multifactorial and span the entire healthcare ecosystem. Contributing factors include federal coverage and reimbursement issues, misaligned financial incentives where hospitals are paid inpatient rates for patients who are admitted but remain boarded in the ED, workforce shortages, inefficient coordination and transitions across settings, limited staffing of hospital beds, and others, as summarized in this American College of Emergency Physicians (ACEP) diagram. Accordingly, solving this problem will require a multifaceted approach.

It is important that efforts to address ED boarding, particularly data measurement efforts, do not take an overly punitive approach and penalize emergency physicians for factors outside of their control, such as availability of community resources, patients lacking access to reliable transportation for follow up medical appointments, or hospital decisions regarding staffing of inpatient beds. Instead, policy makers should look to adopt a range of policies aimed at enabling access to timely care in non-ED settings and improving efficiency and coordination throughout our healthcare system to keep patients healthy and prevent them from ending up in the ED in the first place. In addition, policies should aim to bolster ED resources to ensure patients are seen and treated in a timely fashion and eliminate barriers to transition those patients home or to alternative care settings when safe and appropriate to do so.

Summary of Recent Policy Developments

BOT Report 04-I-25 mentioned advocacy for Congress and the Administration to address ED boarding, including communications leading to a summit and report by the Agency for Healthcare Research and Quality (AHRQ), introduction and promotion of the *Addressing Boarding and Crowding in the Emergency Department Act of 2025* (ABC-ED Act), providing input on a new ED boarding measure as part of pre-rulemaking, and our advocacy on the myriad contributors to ED boarding. The following is a summary of developments since BOT Report 04-I-25 was written, several of which are expanded on in subsequent sections.

- September 2025: AMA comments on including the *Emergency Care Access and Timeliness* (ECAT) measure in the Outpatient Quality Reporting (OQR) and Rural Emergency Hospital Quality Reporting Program (REHQR) Programs.
- November 2025: CMS finalizes the ECAT measure for inclusion in the OQR program for optional reporting in 2026 and mandatory reporting in 2027, and as an optional measure in the REHQR Program starting in 2027.
- March 2026: CMS hosts a panel on hospital boarding at its annual Quality Conference.
- April 2026: CMS released its 2027 Inpatient Prospective Payment System (IPPS) Proposed Rule. In the rule, the Agency included a Request for Information (RFI) on potentially including the ECAT measure in the Inpatient Quality Reporting (IQR) and Hospital Value-Based Purchasing (VBP) Programs.
- June 2026: AMA comments on potentially including the ECAT measure in the IQR and Hospital VBP Programs.
- August 2026: AMA comments on the ECAT measure as part of its comments on the 2027 Outpatient Prospective Payment System proposed rule.

Current Policy Climate

Federal

Outside measure development, action has largely stalled at the federal regulatory level to address the ED boarding issue since the AHRQ issued its initial report on ED boarding in January 2025 following its October 2024 summit on the subject. Since January 2025, AHRQ has lost nearly 80 percent of its workforce as part of reductions across the federal workforce and restructuring of various agencies and sub-agencies by this administration. While in December 2024 AHRQ had issued a Special Emphasis Notice that describes its "strong and continued interest in receiving health services research grant applications for addressing ED boarding and hospital crowding," in July 2026, AHRQ canceled every active grant in its portfolio.[3] CMS hosted a session on ED boarding at its 2026 Quality Conference in March. However, the session focused on the experience of speakers from two health systems and did not provide insights into future plans for addressing this issue at a systemic level by this administration. The House and Senate introduced the ABC-ED Act in April and June 2025 respectively. See AMA's relevant advocacy on these efforts below.

State

Several states have created policies to address ED boarding using a variety of tactics. Maryland integrated ED boarding into its Quality-Based Reimbursement Program,[4] Connecticut established an ED Boarding and Crowding Working Group to develop targeted solutions[5] and launched the nation's first public-facing ED Boarding and Crowding Dashboard, and California is pursuing mandatory hospital reporting on ED boarding times. Other states have initiated public-private partnerships to mitigate ED boarding through enhanced community resources, expanded outpatient services, and improved care coordination.[6] Maine, Massachusetts, North Carolina, and Missouri have tackled pediatric behavioral health admissions, with specific approaches ranging from data tracking, to improving cross-sector coordination, to ED diversion and transition supports.[7]

RELEVANT 2025-2026 AMA EDUCATION AND ADVOCACY

The Addressing Boarding and Crowding in the ED (ABC-ED) Act of 2025

In April 2025, the "ABC-ED Act of 2025" (H.R. 2936/S. 1974) was introduced in the House. Two months later it was introduced in the Senate. The bipartisan legislation leverages existing public health modernization federal grant funding for real-time hospital bed capacity tracking systems, establishes public-facing dashboards to promote accountability and transparency, directs the Government Accountability Office to evaluate capacity-tracking best practices, and promotes pilot programs through the Center for Medicare and Medicaid Innovation (CMMI) to ED redesign, improved infrastructure and staffing, and better transitions of care for patients who are older adults or experiencing psychiatric emergencies.

In August 2025, the AMA sent letters to the House and Senate in support of the bill. Since then, the AMA has remained in continuous contact with ACEP staff regarding efforts to further advance and secure additional support for the bill. As of the writing of this report, the bill had 29 cosponsors in the House and 13 cosponsors in the Senate. The AMA intends to remain supportive of future iterations of the bill that may be introduced in future Congresses, pending review of any substantive changes, and welcomes future opportunities to collaborate with ACEP and other interested parties on ongoing efforts to secure additional cosponsors.

New Emergency Care Access and Timeliness (ECAT) Quality Measure

Over the last several years, CMS has been working to develop a new composite measure on ED boarding called the *Emergency Care Access and Timeliness* (ECAT) measure, which attempts to quantify access to and timeliness of care in an ED setting based on performance against four thresholds:

1. The patient waited longer than one hour after arrival to the ED to be placed in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical examination;
2. The patient left the ED without being evaluated;
3. The patient boarded in the ED for longer than four hours; or
4. The patient had an ED length of stay longer than eight hours.

Based on previous feedback from ACEP, the AMA, and others, CMS established clear and meaningful boarding thresholds, including a four-hour maximum timeframe for the period between the admission order (or documented intent to admit) and the patient's departure from the ED.

Outpatient Quality Reporting (OQR) and Rural Emergency Hospital Quality Reporting Program (REHQR) Programs

On July 15, 2025, CMS released its 2026 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center System (OPPS) proposed rule. In that rule, CMS proposed the ECAT measure for use in the OQR and REHQR Programs.

In our comments, the AMA expressed concern about the timeline for implementation due to the complexity of mapping the required data elements within Electronic Health Record (EHR) systems and time needed to evaluate the validity of the resulting data once mapped. We recommended CMS extend the voluntary reporting period from one to two years. Our letter raised concerns about applying the measure to rural emergency hospitals (REHs), noting that it was developed and tested for use in the hospital inpatient setting. REHs have key differences, including 50 or fewer beds, and they cannot have inpatient beds except those furnished in a distinct partial unit licensed as a skilled nursing facility. Furthermore, despite objections from the AMA, a physician is not required to provide or oversee the care delivered by non-physician practitioners in an REH, so an REH may

face external factors that contribute to extended wait times or boarding that are outside of its control. For example, REHs often struggle to find destination hospitals willing to accept patients with needs that exceed their capabilities, and additional time may be required to transfer the patient to the appropriate facility.

In the final rule, released on November 21, 2025, CMS finalized the ECAT measure for inclusion in the OQR program for optional reporting in 2026 and mandatory reporting in 2027, and as an optional measure in the REH Program starting in 2027. Under the Hospital OQR Program, measures are scored on a pay-for-reporting basis and hospitals receive a two-percentage point reduction to their OPPS annual payment update if they fail to report on all mandatory measures.

In the 2027 OPPS proposed rule, CMS does not propose any changes to the measure or implementation timeframe. Nonetheless, the AMA reiterated some of our chief concerns with the measure, including calls to delay mandatory reporting.

Inpatient Quality Reporting (IQR) and Hospital Value-Based Purchasing (VBP) Programs

On April 10, 2026, CMS released its 2027 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) Proposed Rule. In the rule, the Agency included an RFI on potentially including the same measure in the IQR and Hospital VBP Programs.

In our comments, the AMA strongly emphasized that the time-based thresholds must be treated as a maximum limit, not a mean or median performance target, and that hospitals should be expected to meet these standards for every admitted patient. We recommended CMS weigh outcome #3 more heavily than the other components (40 versus 20 percent), signaling the importance that boarding times should never exceed four hours. In addition, the AMA made several recommendations to improve the measure's accuracy and warned against penalizing individual ED physicians for factors beyond their control, such as regional specialized bed availability. We noted that framing boarding as purely an ED operational failure risks misdirecting improvement efforts away from the inpatient capacity constraints that are the true drivers of prolonged boarding and warned about the potential adverse impact on rural hospitals, which continue to close at disproportionate rates. Specifically, we noted that the measure should take into consideration locality and other potential factors that may make it difficult to "smooth" demand. We also recommended several technical refinements, including broadening the patient population beyond solely admitted or boarded patients and suggesting that stratifying the data by patient type could help to distinguish between hospital-level dysfunction versus external or regional factors. The AMA also cautioned against possible perverse incentives, such as incentivizing inappropriate use of observation status to evade accountability and spoke to the importance of avoiding "wrong-facility" accountability for transfer-related delays and urged CMS to consider whether responsibility appropriately lies with the receiving facility when capacity or acceptance limitations drive prolonged boarding.

Due to our several outstanding concerns with the measure and possible unintended consequences including patient safety implications, and doubts over CMS' ability to resolve these concerns, the AMA cautioned against proposing the measure without further development and stakeholder input. Should CMS propose the measure at any point in the future, we recommended mirroring the implementation process used in the outpatient program: phasing in the measure first through optional reporting, then, implementing improvements to the measure based on learned experience before finalizing the measure. Since this was an RFI, the AMA does not anticipate inclusion of this measure in the final rule. The AMA will monitor and plan to comment should such a measure be proposed for inclusion in the IQR and/or Hospital VBP Programs in future rulemaking.

Physician Education Efforts

The AMA continues efforts to positively address the ED boarding issue at the system level through our various physician education channels. On June 30, 2025, a new interview was posted to AMA's Education Hub as part of our Journal of the AMA (JAMA) Internal Medicine Author Interview series entitled *National Trends in Prolonged ED Length of Stay Among Older Adults: 2017-2024*. The interview with Adrian D. Haimovich, MD, PhD, Assistant Professor of Emergency Medicine at the Beth Israel Deaconess Medical Center, and Maura Kennedy, MD, MPH, Associate Professor of Emergency Medicine at Mass General Hospital, focuses on how often older adults remain for prolonged amounts of time boarded in EDs.

An AMA Steps Forward Podcast recorded in August 2025 discusses with Dr. Diana Savitzky, Chair of ACEP's Well-Being Section the unique stressors that emergency physicians face and how practical solutions to common problems can improve physician well-being and team operations. One example she noted was posting QR codes, which enabled ED staff to identify problems that slow down ED operations (e.g. a broken toilet) to senior management in real time. Also mentioned were "stoplight" reports, which categorize common issues into progress statuses.

Ongoing AMA Advocacy to Address the Root Causes of ED Boarding

Addressing the operational conditions that contribute to ED boarding is an important component of the AMA's commitment to ending the ED boarding crisis. As highlighted in the AMA's 2026 impact report, this work includes advocacy to reform Medicare physician payment, reduce administrative burdens and improve the conditions in which physicians deliver care, as detailed further below. Please note that this is not an exhaustive list of all ED boarding contributors and focuses on the areas where AMA's advocacy has been most active since BOT Report 04-I-25.

Curbing Increased ED Utilization for Individuals with a Mental Illness or Substance Use Disorder

ED utilization for individuals with a mental illness or substance use disorder (SUD) has been a long-standing problem. Between 2019 and 2026, monthly use of the ED for a mental illness ranged between 4,600 to 7,000 visits per month per 100,000 total ED visits.[8] Previous studies have found that more than 11 percent of patients who visit an ED have an SUD.[9] Some of the causes behind this high utilization include a lack of inpatient and outpatient beds due in part to closure of inpatient psychiatric facilities around the country. Patients, particularly those uninsured or under-insured, are often unable to access a full continuum of care services, including ambulatory care options, crisis intervention services, and community programs to help maintain stability and avert declines and relapses, and turn to EDs as a last resort. This rise in mental health and SUD-related admissions has become a major contributor to the ED boarding crisis.

The AMA remains committed to strengthening access to mental health and SUD treatment. Our 2025 Report on Substance Use and Treatment: Progress, Policy and Future Directions highlights several recent AMA advocacy actions to this end, including partnering with key medical societies to urge the U.S. Food and Drug Administration to clarify that higher doses of buprenorphine may be appropriate for patients with opioid use disorder (OUD), joining a physician-pharmacy coalition to urge the Drug Enforcement Administration to clarify policies that would reduce pharmacy and distributor reluctance in dispensing buprenorphine, and supporting new laws in several states to enhance mental health and substance use disorder parity. The AMA also joined with other partners to launch the Mental Health Parity Index, which uses payer claims data to demonstrate national, state, and county-level disparities in network adequacy and reimbursement rates for outpatient mental health and SUD providers.

In a July 2026 letter responding to a Department of Health and Human Services (HHS) Request for Comment on addiction, the AMA called for increased enforcement of the Mental Health Parity and Addiction Equity Act, reduced prior authorization and other barriers to access to medications for OUD, and continued investment in drug overdose prevention strategies—particularly for youth, expanding the mental health and SUD workforce, sterile needle and syringe services programs, and naloxone and test strips distribution efforts. We also underscored our support for prescription drug monitoring programs, which can prevent ED admissions for medication-related complications.

The AMA actively supports numerous pieces of relevant federal legislation including the "SUPPORT for Patients and Communities Reauthorization Act of 2025" (SUPPORT Act), which would reauthorize several crucial OUD and SUD policy programs, the "Modernizing Opioid Treatment Access Act" (MOTAA) 2.0, which would increase access to addiction specialist physicians to prescribe methadone for OUD and allow community pharmacies to dispense it, and the "Fatal Overdose Reduction Act," which would establish a Health Hub Demonstration Program.

Addressing Physician Workforce Limitations

Hospitals and EDs regularly deal with staffing limitations that constrict their ability to see patients, which contributes to ED boarding. Further, hospital and EDs often serve as de facto safety net providers of healthcare services for communities that lack robust access to an adequate physician workforce to address their health needs. As a result, patients end up in the ED for services that do not necessarily require that level of care, or due to complications that could have been avoided with effective disease management. Strengthening local health care workforces to better manage chronic conditions and avoid unnecessary ED visits is one critical tactic to avoid ED boarding, particularly in rural and underserved areas where boarding issues may already be exacerbated. The AMA actively supports myriad efforts to alleviate physician workforce limitations, particularly in rural communities, including but not limited to increasing the number of residency slots, fighting against recent caps on medical school loans, supporting legislation that would allow foreign-born physicians to stay in the U.S. if they work in a federally designated Health Professional Shortage Area or Medically Underserved Area, ensuring continued visa access for foreign born physicians, and authorizing loans for specialty physicians in rural areas. To see more on our work in this space, please visit our graduate medical education initiatives and advocacy webpage.

Telehealth and Remote Patient Monitoring

Telehealth and remote patient monitoring services can have the ability to help smooth demand and improve access to preventive services, improve management of chronic conditions, and prevent adverse events that land patients in EDs, particularly older Americans, who are also more likely to remain in EDs longer. Thus, expanding access to telehealth services can be another critical way to reduce ED boarding. The "Consolidated Appropriations Act of 2026" (CAA, 2026), extended flexibilities that allow Medicare telehealth services to be delivered nationwide and patients to receive services in their homes through 2027. Audio-only services were also extended, and in-person visit requirements for telehealth for mental health services were delayed through 2027. All these changes were strongly supported by the AMA. The AMA also continues to strongly support permanent access to Medicare telehealth services through the "CONNECT for Health Act." In addition, the AMA continues to advocate for Medicare reimbursement for at-home blood pressure (BP) monitors to help patients better manage their BP, as well as for value-based payment models that support improved care coordination and patient self-management of BP, asthma, Crohn's Disease, cancer, and other conditions. The more engaged patients are in managing their conditions at home, the more likely they are to be in a position to seek medical attention before it becomes an emergent situation, potentially avoiding the need to go to the ED.

Supporting Innovative Payment Arrangements that Address Root Causes of ED Boarding

The AMA supports innovative payment models designed to address the myriad root causes of ED boarding, including improved coordination and referral processes across settings, enhanced supports for patients to better manage their own health and have better access to non-acute care settings, and additional flexibilities and supports to emergency physicians to help get patients seen and treated in a timely fashion and transition them back to their home or an alternative care setting when safe to do so, with appropriate follow up care to help avoid repeat ED visits. Across our advocacy on Alternative Payment Models (APMs), the AMA frequently reiterates key themes which address ED boarding drivers, such as ensuring models include appropriate investment that allow physicians to make decisions based on best standards of care that keep patients healthy, as opposed to blunt short-term cost-cutting instruments; improving coordination across specialties and settings; rewarding physicians for improved care management and cost savings associated with reduced unnecessary ED visits; and reducing regulatory burden on physicians to get them back to treating patients. Some of our relevant advocacy is summarized below, though this is not an exhaustive list of our advocacy on all CMS value-based models or programs.

- The Acute Care Hospital at Home (HaH) Program: The AMA strongly supported extending the HaH program through 2030, which Congress included in CAA, 2026 (H.R. 7148), which became law in February 2026. The HaH Program waiver was originally created during the COVID-19 Public Health Emergency to help alleviate hospital capacity issues by allowing hospitals to provide acute care services in patients' homes. CMS has approved 365 hospital campuses across 137 health systems in 37 states to date. Numerous studies have found that patients and family caregivers prefer HaH, which delivers better clinical outcomes, decreased mortality rates, better patient and family experience, lower caregiver stress, high provider satisfaction, and lower costs of care.

- Long-term Enhanced ACO Design (LEAD) Model: The AMA issued a positive statement when the LEAD Model was announced as a better way for primary care physicians and specialists to work more closely together to deliver high-quality, coordinated care for patients—something the AMA has recommended for years. The LEAD ACO model focuses on better care coordination for patients with complex needs, including those who are dually eligible for Medicare and Medicaid and those who are homebound. Abe Sutton, the director of the CMMI and deputy administrator for CMS, and CMMI Chief Strategy Officer Gary Bacher spoke about LEAD with AMA CEO and Executive Vice President John Whyte, MD, MPH, on an episode of the "*AMA Moving Medicine*" podcast.

- Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model: In December 2025, the AMA issued a statement welcoming CMS' new ACCESS Model which aims to overcome Medicare coverage barriers for technology-based tools that could help patients more effectively manage chronic disease.

The AMA also continues to push for CMMI to solicit more input from the AMA and other stakeholders throughout model development and to adopt physician-designed payment models, such as ACEP's Acute Unscheduled Care Model, which would incentivize emergency physicians to safely discharge patients by taking on financial risk for managing care after an ED visit.

In addition, the AMA continues to advocate for an extension of APM incentives and modifications to APM Qualified Participant thresholds to encourage continued physician participation in APMs. Notably, the AMA-supported "Patients First Act" (H.R. 9693) would freeze current APM participation thresholds for three years, provide the Secretary with additional flexibility to further

reduce thresholds if necessary, require a formal notice and comment period for substantial model changes, and require a report to Congress on existing barriers to specialty participation in value-based models along with recommendation to reduce them.

Strengthening Federal Coverage and Reimbursement

Uninsured and under-insured patients are more likely to lack access to scheduled care when they need it, which can lead to exacerbated health issues, resulting in potentially avoidable ED admissions, which contributes to ED crowding and boarding. Furthermore, uninsured and underinsured patients can have difficulty affording care, particularly emergency services, which can contribute to uncompensated care costs, leaving EDs under resourced, another contributor to ED boarding.

The AMA believes healthcare is a fundamental right and fights every day for all Americans to be insured. We also fight to ensure reimbursement levels are sufficient for EDs as well as upstream providers to have the resources they need to appropriately maintain facilities, remain fully staffed, and invest in new technologies to improve care workflows and deliver care both more efficiently and effectively, all of which improve ED efficiency and prevent backups which lead to boarding.

- Medicaid: The AMA continues to vocally and vigorously oppose changes that would restrict patient access to or reduce federal funding for Medicaid coverage. We offered detailed comments in response to an interim final rule implementing new Medicaid community engagement requirements under Public Law 119-21. In our letter, we urged CMS to preserve the exceptions and patient protections Congress included in the statute, give states sufficient time to develop workable systems and processes, and streamline eligibility verification processes to minimize avoidable coverage losses. We urged CMS to reverse overly restrictive definitions of medical frailty requirements. When patients lose their health coverage, it reduces access to vital preventive care services, resulting in health complications and avoidable ED admissions, which contributes to crowding and boarding. On July 21, 2026, the AMA and the Massachusetts Medical Society filed an amicus brief in support of 26 plaintiff states that are challenging the medical frailty provisions of the interim final rule and seeking a preliminary injunction to block the provisions from taking effect in those states. On July 29, the U.S. District Court for the District of Massachusetts declined to issue a preliminary injunction blocking the rule. The court placed the litigation on an expedited schedule ahead of the January 1, 2027 compliance deadline for Medicaid changes. The AMA also commented on another proposed rule impacting Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments. In our letter, the AMA noted that the proposed rule limits funding sources beyond statutory requirements and hinders states' abilities to design workable reimbursement models that maintain sufficient beneficiary access.

- Medicare: When adjusted for inflation for rising practice costs, Medicare physician reimbursement has declined 33 percent from 2001 to 2026. Strengthening Medicare reimbursement remains one of the AMA's top advocacy priorities. Over the last year, the AMA has tirelessly pursued this through multiple avenues, culminating in an unprecedented number of relevant bills being introduced. The bipartisan "Strengthening Medicare for Patients and Providers Act" (H.R. 6160), introduced in November 2025, was strongly endorsed by the AMA and would permanently link Medicare payments to the real costs of running a physicians practice by tying them to the Medicare Economic Index (MEI). The "Provider Reimbursement Stability Act" (H.R. 8163), AMA-supported bipartisan legislation that was introduced in the House in March 2026, would raise the budget neutrality threshold for the first time in more than 35 years, require an inflation-based adjustment every five years thereafter, and would

require HHS to revise estimates that trigger cost-shifting redistributions in the Medicare Physician Fee Schedule (PFS) based on actual utilization, among other changes. The "Medicare Physician Data-Driven Performance Payment System Act of 2026" (H.R. 8622) would overhaul the flawed Merit-based Incentive Payment System. The AMA issued a letter of support when the legislation was introduced. On July 15, the three chairs of the GOP and Democratic Doctors Caucuses introduced the "Patients First Act" (H.R. 9693), comprehensive, bipartisan, AMA-supported MACRA reform legislation that includes an inflation-based update tied to MEI, budget neutrality reform, a MIPS replacement, APM reforms, and a new primary care payment pilot that would not impact budget neutrality. The AMA continues to lead Federation efforts to progress these legislative vehicles and enact meaningful, permanent Medicare payment reform for physicians. Strengthening Medicare reimbursement is critical to ensuring continued Medicare beneficiary access to a range of providers that appropriately manage patients' physical and mental health and keep them out of EDs, as well as solidify a critical revenue stream for hospitals and EDs that ensures they retain the necessary resources to staff at appropriate levels, invest in technologies that can improve the speed and efficiency of billing and care delivery functions, and ensure facilities are up to date and have capacity to meet their patient needs, all of which help to avoid ED boarding issues for Medicare patients, which is particularly important as older patients tend to stay in the ED longer.

- Affordable Care Act Exchange Coverage: The AMA provided comprehensive comments on recent proposed changes to ACA marketplace coverage for plan year 2027 emphasizing the importance of maintaining coverage that is not only affordable, but comprehensive, particularly for older and medically complex Americans. We encouraged strong guardrails to preserve meaningful coverage, maintain patient access to care, stabilize risk pools and markets, and lower patient out of pocket costs. We also asked HHS to reconsider several changes including expanding catastrophic coverage and non-network plans as qualified health plans. In response to our advocacy, CMS reversed a proposal to revise the minimum percentage of essential community providers. In separate comments in response to a CMS RFI on essential health benefits (EHBs), the AMA cautioned strongly against changes that could increase patient costs and decrease patient access to care, pointing to the fact that comprehensive EHB requirements are critical to ensuring patient access to a range of services, which can lead to better maintenance of chronic conditions. Access to affordable, comprehensive coverage is directly tied to a patient's ability to access preventive services, which reduces complications and preventable ED admissions, cutting down on ED crowding and boarding.

- Federal enforcement of *No Surprises Act* claims: The AMA continues to be vocal on the need to enforce *No Surprises Act* statutory timelines. This is critical for hospitals and physicians to avoid cash flow issues that can lead to under-resourcing and understaffing, which contribute to ED boarding. In April and May, the AMA led two sign-on efforts, one letter in support of the "No Surprises Act Enforcement Act," which includes increased penalties for parties that fail to comply with such statutory timelines, and another letter alerting the administration to repeated acts of payer noncompliance with the law and urging increased federal enforcement including but not limited to penalties for payer noncompliance.

- Redesigning Primary Care RFI: As of the writing of this report, the AMA is drafting a response to an RFI on redesigning primary care as part of our comments in response to the 2027 Medicare Physician Fee Schedule proposed rule. The RFI reflects an important shift in CMS' thinking about primary care payment signaling it may place greater emphasis on longitudinal patient outcomes, rather than reimbursement for discrete visits and services, which could improve patient access to a more robust fleet of preventive care and chronic disease management supports including those outside of discrete office visits. When patient care is

better managed, complications including ED admissions can be potentially avoided, reducing strain on EDs which contributes to boarding.

Reforming Prior Authorization (PA)

PA requests can delay transfers to other external hospitals or facilities or inpatient units at the same hospital, particularly psychiatric facilities. In addition, patients can arrive in the ED for tests or treatments that they were waiting on from a non-emergency setting since there are fewer requirements to obtain PAs for emergency services, which contributes to ED crowding and boarding. The results of the most recent AMA PA physician survey released in May 2026 found that 95 percent of physicians reported care delays, 22 percent reported that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage, and 47 percent reported the PA process led to "immediate care/ER visits."
H.R. 3514/S. 1816, the "Improving Seniors' Timely Access to Care Act," is legislation that would standardize PA requirements and require greater transparency about utilization management usage within the Medicare Advantage (MA) program. It has strong bipartisan support, passing out of the House Energy and Commerce Subcommittee on Health and the full Ways and Means Committee in June and July 2026. It was also added to a larger bill focused on health care transparency: H.R. 9393, "the Lower Costs, More Transparency Act," which passed out of the full Ways and Means Committee unanimously in July. The AMA sent a letter of support for H.R. 9393, which as of the writing of this report, had nearly 300 cosponsors in the House and 70 cosponsors in the Senate and is ripe for enactment either as a stand-alone bill or part of a larger healthcare package. AMA President Willie Underwood III, MD, MSc, MPH also outlined AMA's support for H.R. 9734, the "Protecting Patients from Automated Denials Act" in a July 2026 press release. This bipartisan legislation would require MA plans that utilize augmented intelligence (AI) for PA decisions to have an independent physician review the denial, as well as mandate MA plans to keep records to facilitate HHS audits on the use of AI in PA.

As a result of sustained AMA advocacy over many years, CMS passed the landmark 2024 Interoperability and PA Final Rule, which among other provisions, requires affected health plans to support electronic PA beginning January 1, 2027. In practical terms, the goal is that physicians should be able to use their EHRs at the point-of-care to identify a plan's documentation requirements, submit PA requests, and receive decisions electronically. Following implementation of this rule, the AMA audited PA plans' compliance with the new public-reporting requirements then summarized the findings in a letter to CMS identifying regulatory loopholes and recommending ways to strengthen requirements. In response, in August 2026 CMS issued updated guidance that strengthens enforcement of federal PA transparency requirements, addressing several concerns raised by the AMA.

In the 2027 PFS proposed rule, CMS also proposes making its electronic PA measure optional, delaying mandatory physician reporting until 2028. This proposal would reduce physician burden and provide time for payers and EHR developers to demonstrate that their systems work before physicians are held accountable.

In a separate February 2026 letter, the AMA noted the importance of stakeholder input as the National Standards Group continues discussions regarding technical standards, noting that the industry remains at varying levels of FHIR readiness and alignment, and that additional time may be needed.

In January 2026 comments responding to proposed 2027 changes to the MA program, the AMA urged CMS to finalize PA protections that preserve continuity of care, while encouraging the

Agency to retain certain Utilization Management Committee requirements, including its ongoing review and removal of unnecessary PA requirements. We also reiterated our principles for PA reform, including aligning MA with Medicare standards, and establishing clear oversight and accountability mechanisms.

In a September 2025 letter to the Medicare Payment Advisory Commission (MedPAC), the AMA highlighted the harms of unregulated AI automation and predictive tools in PA, and how it is increasingly overriding clinical judgment and generating coverage denials.

In July 2025, the AMA wrote a letter to CMS expressing significant concerns with its Wasteful and Inappropriate Service Reduction (WISeR) Model, a new voluntary model operating in six states that expands pre-payment PA reviews to certain services in traditional Medicare for the first time, leveraging AI and Machine Learning to expedite reviews. The AMA raised concerns over potential care disruptions and patient harms, as well as administrative burdens on physicians, which could exacerbate patient access issues. Since then, the AMA has been closely monitoring implementation of the model and actively engaging CMS to try to secure robust guardrails on WISeR including enhanced transparency, accountability, meaningful physician oversight, streamlined administrative processes, patient access to timely care, and greater use of evidence-based clinical guidelines consistent with AMA policy governing the use of AI in coverage determinations.

On June 9, 2026, the House Appropriations Committee unanimously adopted an amendment to the FY 2027 Labor-HHS spending bill to block funding for the WISeR model. However, since Congress is exceedingly likely to pass a temporary Continuing Resolution as opposed to a full government appropriations bill by September 30th, the bill is unlikely to become law.

On July 16, 2026, the Senate separately voted 46–50 along party lines to block a Democratic-led resolution to overturn the WISeR model. Of note, the resolution considered in the Senate is completely separate from the actions taken by the House Appropriations Committee to defund the WISeR Model. The Senate's actions were an attempt to rescind the WISeR model via the Congressional Review Act (CRA), which is a tool that allows federal lawmakers to vote on "resolutions of disapproval" to overturn certain regulatory actions if reported to Congress. The Government Accountability Office first had to issue a decision that the WISeR Model was, in fact, a regulation that qualified for consideration under the CRA, which it did on May 12. Once that happens, Congress has 30 days to act. Since the resolution failed, and we are now beyond the 60-day window, this effort to rescind the WISeR Model via the CRA is now considered "dead."

Finally, the AMA is actively working to create technical standards to support electronic PA. In July 2026, we announced a new initiative to develop and deploy royalty free Systematized Nomenclature of Medicine — Clinical Terms to Current Procedural Terminology (SNOMED CT-to-CPT) maps specifically for PA. These maps will connect the clinical concepts documented in EHRs using SNOMED CT with the CPT codes used to describe medical services, helping physician and payer systems exchange information more accurately and efficiently. This work is essential to ensuring that electronic PA reduces manual work, supports timely and consistent decisions, and ultimately meets the needs of patients and physicians. Senior HHS leadership, including CMS Administrator Mehmet C. Oz, MD, MBA has publicly recognized and supported the AMA's leadership in advancing these maps and broader PA reform.

Addressing the Negative Impacts of ED Boarding

ED boarding places sustained pressure on emergency physicians and other members of the care team, compromising the care environment and the patient experience, and contributing to stress,

exhaustion and burnout. Since boarding causes longer wait times for initial assessments and leads to higher complications and poorer outcomes, this can translate to worse community health. The AMA advocates for policies that address the broader workforce consequences of prolonged operational strain caused in part by ED boarding to help reverse some of the effects, such as increased staff turnover and accelerated decisions to reduce clinical hours or leave practice that in turn exacerbate staffing shortages, which inhibit patient access, leading to more ED crowing and boarding, creating a dangerous loop wherein stress and burnout contribute to staffing issues, which cause more backups leading to ED boarding, which further exacerbates staff stress, and so on.

In March 2026, the AMA signed onto two letters to the House and Senate in support of the Dr. Lorna Breen Health Care Provider Protection Act ("Lorna Breen Act"). Congress reauthorized the Lorna Breen Act through FY 2030 as part of the CAA, 2026 (P.L. 119-75).

In addition, the AMA established a successful national campaign to help states enact confidentiality laws that protect physicians seeking help for mental health concerns, burnout and fatigue, and to remove inappropriate, stigmatizing questions from physician licensure and renewal applications. The campaign also helps health systems and academic medical institutions remove or revise questions on credentialing and other applications that might discourage physicians, residents, and medical students from seeking needed mental health care.

ED boarding increases stress on patients and physicians alike and has been shown to contribute to increased incidents of violence against physicians and other hospital staff.[10] Workplace violence against physicians and other healthcare workers has increased in recent years, further compounding the risks associated with crowded and strained care environments. According to a January 2024 poll of ACEP members, 91 percent of emergency physicians said that they or a colleague had been a victim of violence in the previous year. The AMA continues to support a multipronged, "all-hands-on-deck" strategy to prevent and respond to violence against physicians, including support for continued research, stronger prevention policies and investments in enhanced security for hospital staff.

In June 2026, the AMA Advocacy Resource Center (ARC) updated its issue brief, "Campaign to Support Medical Student, Resident and Physician Health and Well-Being," to reflect recent legislative and policy developments and to provide state medical associations with current resources for advancing these protections.

Together, these efforts reflect the AMA's multifaceted approach to the consequences of ED boarding: advocating for system-level improvements that reduce operational strain while also protecting the safety, mental health and long-term sustainability of the physician workforce.

AMA Cross-Sector Collaboration

As the leading specialty organization for emergency physicians representing more than 38,000 emergency physicians, emergency medicine residents, and medical students, ACEP has been leading national efforts to address ED crowding and boarding for several decades. Over the last year, AMA staff members have proactively reached out to ACEP staff several times to directly inquire about their advocacy efforts to address ED boarding and lend our support. As the nation's largest physician organization representing virtually all major medical specialties and subspecialties, the AMA recognizes that we lend an important amplifying voice to this conversation. We continue to believe that the most effective path forward for physicians on this matter is leadership by ACEP, AAEM, and other specialties with specialized expertise on this issue. We look forward to continued collaboration in this regard and welcome future initiatives

from interested parties focused on addressing and reducing patient boarding in EDs. In particular, we believe efforts by relevant specialties such as ACEP and AAEM to collect updated data on the state of ED boarding in this country could help to underscore the magnitude of this concern and be leveraged to draw attention from a press or public relations level, and garner momentum for action from federal and state policymakers. The AMA commits our full ongoing support and willingness to help amplify these efforts, including through our capacity to engage the Federation and present a unified physician voice to help highlight the importance of addressing and reducing patient boarding in EDs, recognizing its cross-sectional nature across the healthcare industry and its impact on various specialties. The AMA's ARC team also remains committed to collaborating closely with state and national specialty societies to pass proposed state laws and regulations that address the hospital ED boarding issue.

CONCLUSION

The AMA will continue to work with relevant specialties, state medical associations, and other interested parties leading on this issue to advance federal and state efforts to address the multi-faceted causes of ED boarding and mitigate its harmful impact on physicians and patients.

Specifically, the AMA continues its support of the ABC-ED Act and continues to weigh in on ED boarding quality measure development efforts in various CMS value-based reimbursement programs, the two paths currently most active at the federal policy level. The AMA also will continue our ongoing advocacy to address the many root causes contributing to ED boarding, including advocating to strengthen the physician workforce and improve the reliability of federal and other funding for EDs.

The AMA understands this issue intersects with many areas of our healthcare system, recognizes the implications of addressing ED boarding on patient safety and the functioning of our healthcare system, and remains committed to continuing our advocacy on this important issue.

We understand the Federation is interested in staying abreast of the AMA's efforts to advance advocacy to address ED boarding and recognizes that there are alternative methods of communicating progress on this topic that would allow for more timely, concise and strategic updates than a formal report, while allowing staff time to be redirected toward direct advocacy on this important issue.

The AMA believes that increased collaboration with and amplification of initiatives by relevant national and state medical societies represents the most effective opportunity to draw renewed attention to this national problem and reinvigorate federal policymaking efforts in the coming year.

RECOMMENDATIONS

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

1. That our AMA continue to support federal legislative efforts to address ED boarding.
2. That our AMA continue to comment on CMS quality measure development efforts related to ED boarding, to ensure hospital payments are tied to ED boarding performance while ensuring emergency physicians are not penalized for factors that are beyond their control.
3. That our AMA continue to seek out opportunities to advance our policy and reduce ED boarding at the federal and state levels as appropriate.

4. That our AMA continue our advocacy on the myriad, system-wide causes of ED boarding, including but not limited to misaligned financial incentives for hospitals, workforce constraints, prior authorization reform, and strengthening federal coverage for care and physician reimbursement.
5. That our AMA continue our advocacy to address the negative impacts of ED boarding on physicians, health systems, and patients.
6. That our AMA continue to support initiatives led by state and specialty medical associations to advance action on ED boarding at the federal and state levels as appropriate.
7. That our AMA communicate updates on the AMA's ED boarding advocacy efforts through organizational communications channels such as the weekly Advocacy Update. (Directive to Take Action)
8. That the sixth bullet of policy D-120.957 be rescinded as it has been accomplished by this report."

Fiscal Note: Minimal

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REPORT 21 OF THE BOARD OF TRUSTEES (I-26)
Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2026 Annual Meeting, the American Medical Association House of Delegates referred the second resolve clause of Resolution 236-A-26, which called for the AMA Task Force to develop and maintain a centralized digital resource hub for gender-affirming care, modeled on the Reproductive Health Resource Navigator.

The Board of Trustees shares the significant concerns expressed by members of the House regarding the rapidly evolving legal and regulatory environment surrounding gender-affirming care and appreciates the desire for our AMA to play a leading role in providing practical resources to physicians. As state and federal laws, regulations, and litigation continue to evolve, physicians increasingly face uncertainty regarding their legal risk. The Board agrees that our AMA should continue to identify meaningful ways to support physician practices, protect the patient-physician relationship, and support access to medically necessary, evidence-based gender-affirming care. In June 2026, the Board extended the Task Force through the 2026 Interim Meeting, and the AMA is already implementing the broader directives adopted by the House.

At the same time, the Board notes that developing a comprehensive digital resource hub of the breadth envisioned in Resolution 236-A-26 would require careful assessment. The experience of developing the Reproductive Health Resource Navigator demonstrated that such a project requires substantial planning, coordination, legal review, technical infrastructure, governance, and long-term maintenance. Additionally, the landscape of comparable resources in the gender-affirming care space is more limited than in the reproductive health space.

The Board further recognizes that this work must proceed thoughtfully. In the current climate, organizations, physicians, and communities involved in supporting or providing gender-affirming care may face heightened legal, political, professional, or personal risk if publicly identified. Accordingly, any AMA effort to identify, compile, or direct physicians to resources must account for potential unintended consequences in a dynamic legal and enforcement environment.

To support an informed decision, the AMA has already begun evaluating the feasibility of such a resource and has engaged outside legal counsel to assess the legal implications of developing and maintaining a comprehensive hub. This due diligence will help inform the appropriate scope, governance, resource needs, and long-term sustainability of any future centralized platform.

Accordingly, the Board recommends that the AMA continue identifying existing resources and support development of additional resources, as appropriate, to help physicians navigate the legal, regulatory, and practice issues surrounding evidence-based gender-affirming care, while continuing to evaluate the feasibility and implications of a centralized digital resource hub. The Board will report back to the House of Delegates at the 2027 Interim Meeting.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 21-I-26

Subject:	Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care
Presented by:	Toluwalaṣé A. Ajayi, MD, Chair
Referred to:	Reference Committee B

At the 2026 Annual Meeting, the American Medical Association House of Delegates (HOD) referred the second resolve clause of Resolution 236-A-26, "Extending and Expanding the AMA Task Force to Preserve the Patient Physician Relationship to Ensure Access and Regulatory Clarity in Gender Affirming Care," which asked:

> RESOLVED, that our AMA direct the Task Force to develop, launch, and maintain a comprehensive, centralized digital resource hub—modeled on the Reproductive Health Resource Navigator—specifically dedicated to gender-affirming care no later than the 2026 Interim Meeting, including but not limited to:
> 1. State-specific legal summaries and regulatory guidance;
> 2. Shield law analyses and cross-state practice considerations;
> 3. Privacy and HIPAA compliance best practices;
> 4. Risk-mitigation guidance addressing civil, criminal, and professional liability;
> 5. Documentation and informed consent templates consistent with evolving legal standards;
> 6. Coding, billing, and reimbursement guidance;
> 7. Institutional policy templates and sample protocols;
> 8. Educational and training resources for undergraduate and graduate medical education;
> 9. Telehealth and interstate licensure guidance; and
> 10. Information regarding legal assistance and physician defense resources.

BACKGROUND

Following the Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*, the HOD established the Task Force to Preserve the Patient-Physician Relationship (Task Force) to help guide organized medicine's response to the rapidly evolving reproductive health landscape. The Task Force's original charge focused primarily on issues arising from abortion bans and other restrictions on reproductive healthcare. At the 2023 Interim Meeting, however, the HOD adopted policy directing the Task Force to consider payment and reimbursement issues related to gender-affirming care. In response, the Task Force devoted a full in-person meeting to examine the payment and reimbursement challenges facing physicians who provide gender-affirming care. Consistent with its original charge, much of the Task Force's work to date has focused on the impact of state abortion bans.

Over the course of its two-year charge, the Task Force undertook numerous initiatives to support physicians practicing in states with abortion restrictions, including development of a resource hub, strategy and messaging development, state law guidance, legal assistance for physicians,

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institution-level guidance, collaboration with concerned prosecutors, and support for medical students and residents. The Task Force's work has been described in a series of informational reports to the HOD (available as Board of Trustees Reports 9-I-23, 21-I-24, 12-A-25, and 33-A-26). Among its major initiatives, the Task Force identified the need for a central repository of legal and practice resources for physicians navigating abortion bans and oversaw the development of the Reproductive Health Resource Navigator (available at www.rhrnavigator.org). The Reproductive Health Resource Navigator required extensive planning, collaboration across multiple AMA departments and external vendors, and significant organizational resources to develop and launch, and it has become an important resource in the reproductive health space. Further, the experience gained through developing the Reproductive Health Resource Navigator provided valuable insight into the substantial planning, governance, legal review, technological infrastructure, and long-term maintenance required to create and sustain a centralized resource of this nature.

As the Task Force concluded the work for its initial charge, it developed recommendations for the Board of Trustees (the Board) regarding future AMA activities to support physicians practicing in evolving legal and regulatory environments. The Board has received those recommendations and is considering possible actions. Additionally, in June 2026, the Board extended the Task Force until the 2026 Interim Meeting. Similarly, new policy adopted at the 2026 Annual Meeting directed the AMA to extend and expand the work of the Task Force to focus on gender-affirming care.

AMA POLICY

Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted," was adopted at the 2022 Annual Meeting of the AMA HOD. Policy G-605.009 instructs that:

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.

e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.
f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.
g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
h. Work with interested parties to encourage the development of institution-level guidance and protection for physicians practicing in states with restrictions potentially interfering with the patient-physician relationship.

3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

At the AMA 2024 Interim Meeting, the HOD adopted Policy D-605.982, "Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance," which states:

1. Our American Medical Association's Task Force, to Preserve the Patient-Physician Relationship, will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed.

Adopted as policy at the AMA's Annual Meeting of the HOD in June 2026, Policy D-605.981, "Extending and Expanding the AMA Task Force to Preserve the Patient-Physician Relationship to Ensure Access and Regulatory Clarity in Gender-Affirming Care," states that:

1. Our American Medical Association extend and expand the work of the Task Force to Preserve the Patient-Physician Relationship When Evidence- Based, Appropriate Care Is Banned or Restricted to include a formalized and sustained focus on legislative and regulatory actions to protect access to and education in gender-affirming care.
2. Our AMA strengthen its advocacy efforts at the federal and state levels to oppose criminalization and punitive actions against physicians providing evidence-based gender-affirming care and to support legal protections safeguarding the patient physician relationship, with guidance by the Task Force.
3. Our AMA identify gaps in information and resources and develop a comprehensive advocacy and policy blueprint to prevent, counter, and mitigate restrictions on safe, evidence-based, and medically appropriate health care.
4. Our AMA report annually to the HOD regarding progress on these deliverables, including metrics on resource utilization, physician engagement, and identified advocacy outcomes.

AMA Policy D-5.995, "Protecting Access to Emergency Abortion Care Under EMTALA," states that:

1. Our AMA will advocate for the reinstatement of federal guidance affirming hospitals' obligation under EMTALA to provide necessary emergency pregnancy care, including, but not limited to, abortion care, to stabilize patients irrespective of state-level abortion

restrictions. Our AMA will collaborate with relevant stakeholders, including federal agencies, Congress, medical societies, and patient advocacy groups, to educate policymakers and healthcare providers on EMTALA obligations concerning emergency pregnancy care, including, but not limited to, necessary abortion care.

2. Our AMA task force established under AMA Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will provide ongoing recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care.

AMA Policy H-185.927, "Clarification of Evidence-Based Gender-Affirming Care," states that:

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to: advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence; oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care; support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

AMA Policy H-185.905, "Advocating for the Informed Consent for Access to Transgender Health," states that:

1. Our American Medical Association unambiguously supports access to and insurance coverage of medically necessary gender-affirming care but does not identify a preferred model of care for determining medical necessity. The AMA vigorously advocates for equitable payment policies, relying on the evidence-based professional guidelines and recommendations set by professional medical associations, as well as individual physician clinical judgment, on questions of appropriate clinical criteria.

AMA Policy D-275.942, "Ensuring Equitable and Timely Medical Licensure for Physicians Providing Abortion and Gender-Affirming Care," states that:

1. Our American Medical Association advocates 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.
2. Our AMA supports 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.
3. Our AMA will 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.

AMA Policy H-295.847, "Increasing Access to Gender-Affirming Care Through Expanded Training and Equitable Coverage," states that:

1. Our American Medical Association will advocate for expanded structured training for gender-affirming procedures by working with relevant stakeholders including but not limited to the Accreditation Council for Graduate Medical Education.

AMA Policy H-140.824, "Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population," states that:

1. Our American Medical Association supports shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers.
2. Our AMA supports treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process.

AMA Policy H-185.950, "Removing Financial Barriers to Care for Transgender Patients," states that:

1. Our American Medical Association supports public and private health insurance coverage for evidence-based gender-affirming care as recommended by the patient's physician.

DISCUSSION

The Board shares the significant concerns expressed by members of the HOD regarding the rapidly evolving legal and regulatory environment surrounding gender-affirming care and appreciates the desire for our AMA to play a leading role in providing practical resources to physicians. As state and federal laws and litigation continue to evolve, physicians increasingly face uncertainty regarding their legal risk. The Board agrees that our AMA should continue to identify meaningful ways to support physician practices in this increasingly complex environment.

The HOD has already adopted four of the five directives in Resolution 236-A-26 as Policy D-605.981, and the AMA is actively implementing them. In particular, AMA policy now directs the AMA to extend and expand the work of the Task Force to include a formalized and sustained focus on legislative and regulatory actions; strengthen federal and state advocacy efforts to oppose criminalization and punitive actions against physicians providing evidence-based care and to support legal protections safeguarding the patient-physician relationship; identify gaps in information and resources and develop a comprehensive advocacy and policy blueprint to ensure the provision of safe, evidence-based, and medically appropriate healthcare; and report annually to the HOD regarding progress on these deliverables, including metrics on resource utilization, physician engagement, and identified advocacy outcomes. The Board supports these directives, is actively implementing them, and views them as the operating framework for the AMA's ongoing work in this area. Progress for each will be reported to the HOD annually, as part of the charge from the fourth resolve clause.

The Board also notes that, as part of its charge, the Task Force has submitted recommendations to the Board regarding future AMA activities in this area. The Board is currently considering those recommendations. Because the issues raised by Resolution 236 intersect directly with those recommendations, the Board is considering them together so that the AMA's response is coherent and durable, rather than fragmented. Should any actions be taken before the Interim Meeting, the Board will provide the HOD with an update. Looking ahead, and as appropriate following further assessment, the extended Task Force will address these additional charges, and the Board looks forward to reporting on that work to the HOD.

The Board is committed to exploring how our AMA can best support physicians navigating challenges related to gender-affirming care and the patient-physician relationship. The work remaining, pending further assessment, is to define the scope, structure, implementation, and long-term maintenance of a resource of this breadth, so that any resource the AMA launches is accurate, sustainable, and genuinely useful to physicians.

The Board also recognizes the value of identifying resources that may already exist that could help inform or support physicians navigating the legal, regulatory, and practice issues related to gender-affirming care. AMA staff have been monitoring and identifying potentially responsive resources since the inception of the Task Force. That work has included ongoing assessment of the legal, policy, practice, educational, and advocacy landscape to better understand where useful materials may already exist and where substantial gaps remain. As the legal landscape evolves and the associated risks become better understood, AMA staff will continue to identify existing resources to support physicians navigating this environment.

While some general legal, policy, clinical, educational, and practice resources exist, few—if any—are specifically tailored to the provision of care in the manner contemplated by this resolution. Unlike the reproductive health space, where a more developed ecosystem of practice support and legal navigation resources has emerged in response to rapidly changing abortion laws, comparable resources for gender-affirming care remain limited. This underscores the challenge to determine what information can appropriately, safely, and sustainably be identified, maintained, and made available.

The resource envisioned by the resolution would encompass numerous complex subject areas—including state-specific legal summaries, regulatory guidance, privacy considerations, liability issues, institutional policies, educational resources, reimbursement information, and physician support resources—many of which, as noted above, do not currently exist in publicly accessible forums. Developing and maintaining such content would require substantial legal, policy, operational, and technical expertise, and ongoing processes to ensure that information remains accurate as laws, regulations, and litigation evolve.

The Board also notes that the Reproductive Health Resource Navigator, which serves as the model identified in the resolution, required extensive planning, cross-departmental collaboration, external expertise, vendor contracting, and significant time to develop. Establishing a comparable resource for gender-affirming care would similarly require careful assessment of staffing, technological needs, financial resources, governance, long-term maintenance, and sustainable processes for keeping content current. In addition, the AMA must conduct appropriate due diligence regarding the feasibility of the project, the resources required to develop and sustain it, and the legal and operational considerations associated with creating and maintaining content of this nature.

The Board further believes that any effort to identify, compile, or direct physicians to responsive resources must be undertaken with caution. In the current environment, organizations, physicians, other individuals, and communities involved in supporting or providing gender-affirming care—including LGBTQ populations—may face heightened legal, political, professional, or personal risk when publicly identified or highlighted. Accordingly, the AMA must carefully consider whether and how referencing particular entities, individuals, or resources could inadvertently increase scrutiny or expose them to harm.

These concerns arise within a broader legal, regulatory, and enforcement environment that remains highly dynamic. Organizations involved in developing, disseminating, or supporting clinical resources related to gender-affirming care have increasingly become the subject of governmental investigations, subpoenas, litigation, and other forms of legal scrutiny. At the same time, the legal landscape continues to change through executive actions and court decisions. Our AMA can develop resources to support physicians in this environment; however, these considerations shape how that could be done: they require the AMA to evaluate and appropriately manage the legal, operational, and organizational issues associated with building and maintaining such a resource.

The AMA has already begun this evaluation. As part of its due diligence, the AMA has engaged outside legal counsel to assess the legal considerations associated with developing and maintaining a comprehensive resource of this nature. That assessment will help inform the Board's evaluation of the resource's feasibility, appropriate scope, governance, and long-term sustainability.

RECOMMENDATION

The Board of Trustees therefore recommends adoption of the following and that the remainder of this report be filed.

> That our American Medical Association continue to identify existing resources and support the development of additional resources, as appropriate, to assist physicians in navigating the legal, regulatory, and practice issues surrounding the provision of evidence-based gender-affirming care, while evaluating the feasibility, scope, governance, resource requirements, and legal and operational considerations associated with developing and maintaining a centralized digital resource hub, and report back to the House of Delegates at the 2027 Interim Meeting. (New HOD Policy)

Fiscal Note: Minimal.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-26)

Introduced by: American Association of Clinical Urologists, Utah, Resident and Fellow Section

Subject: Artificial Intelligence Having Prescriptive Authority

Referred to: Reference Committee B

Whereas, Utah is the first state to allow patients to renew their medications online through a commercial Artificial Intelligence (AI) platform without needing a physician or other health care professional's prescription; and

Whereas, Utah has partnered with *Doctronic* for this pilot program which started December 2025; and

Whereas, the pilot allows 30-, 60-, and 90-day refills for 190 commonly prescribed drugs; and

Whereas, currently the program only covers refills, initial prescriptions still require a physician or health care professional's authorization; and

Whereas, delegating prescriptive authority to AI presents new concerns for patient safety and harm; therefore be it

RESOLVED, that our American Medical Association oppose the use of Artificial Intelligence (AI) without a physician or other health care professional's direct supervision to prescribe either new or refill prescriptions (New HOD Policy); and be it further

RESOLVED, that our AMA develops model state legislation regulating AI prescriptive authority so that both new and refill prescriptions are under the direct supervision and control of a physician or other licensed healthcare professional. (Directive to Take Action)

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

Received: 8/24/26

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3. NEWS RELEASE: Utah and Doctronic Announce Groundbreaking Partnership for AI Prescription Medication Renewals - commerce.utah.gov

RELEVANT AMA POLICY

Prohibiting the Independent Practice of Medicine by Artificial Intelligence D-480.947

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-26)

Introduced by: Medical Student Section, American Association of Public Health Physicians, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Rapid Response Framework for Unsupported Medical Claims by Public Officials

Referred to: Reference Committee B

Whereas, public statements by elected or appointed government officials regarding medical or public health matters can significantly influence patient behavior, health care decision-making, and public trust in scientific institutions[1,2]; and

Whereas, dissemination of medical claims that are inconsistent with established scientific evidence may contribute to confusion, erosion of public trust, and increased burden on physicians to address misinformation during clinical encounters[3,4]; and

Whereas, research in risk and health communication demonstrates that transparent acknowledgment of uncertainty and alignment with scientific evidence can strengthen public trust, even when recommendations evolve over time[5-9]; and

Whereas, while existing AMA policy supports the dissemination of accurate medical and public health information and urges organizations publicizing health guidelines to include supporting evidence, none of these policies establish a defined, transparent, or time-bound process by which the AMA itself evaluates and publicly responds to government officials' medical or public health claims that conflict with established scientific consensus or misrepresent the strength or certainty of available evidence[10,11,12]; therefore be it

RESOLVED, that our American Medical Association study and develop a transparent, time-bound evidence review and response framework for evaluating and publicly responding to medical or public health claims made by elected or appointed government officials outside formal regulatory rulemaking that materially conflict with established scientific consensus or misrepresent the strength or certainty of available evidence, including consideration of: criteria for identifying high-impact claims warranting review, the responsible organizational entity, and associated timelines and processes for evidence assessment and public communication. (Directive to Take Action)

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

Date Received: 9/3/26

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RELEVANT AMA POLICY

Evidence-Based Standard Requirement for Governmental Regulation H-270.956

Our American Medical Association supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded.
[BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21]

Health Care Standards H-450.935

Our AMA: (1) supports the ability of non-governmental organizations to evaluate appropriate medical diagnosis or therapy or current or new diagnostic or therapeutic tests, procedures, medications or other procedures that improve the quality of patient care; (2) supports the position that any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, whether developed or issued by government or non-governmental organizations, including those that result from any comparative effectiveness research or evidence-based medicine system, do not, and should expressly state that they do not, establish standard of care or create specific requirements for physicians that restrict the exercise of their clinical judgment; (3) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to include a statement that they are guidelines only; and (4) urges any organization, whether governmental or non-governmental, promulgating any practice guidelines, parameters, best practices models, or similar set of principles or clinical recommendations, to set and make publicly available a regular schedule for review and update and to include the level of evidence supporting the guidelines.
[Res. 205, A-10; Reaffirmation I-10; Reaffirmed: Res. 105, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

Subject: Set-Aside Federal Funding for Tribal Health Programs

Referred to: Reference Committee B

Whereas, The U.S. Indian Health Service (IHS) remains chronically underfunded relative to demonstrated need, limiting access to comprehensive and culturally grounded medical and behavioral health services[1]; and

Whereas, federal health funding that is distributed primarily through state governments can limit Tribal access to resources due to inconsistent consultation with tribal governments, differing state priorities, and state legislatures who oppose tribal sovereignty and block the dispersion of funding to tribal governments[2-6]; and

Whereas, the IHS, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), and other federal health agencies use set-aside funding, federal appropriations reserved specifically for Tribal governments and Tribal health organizations within broader federal grant programs, to advance American Indian and Alaska Native health and wellness, ensuring that Tribal communities have dedicated access to funding without competing against states and other municipalities[2]; and

Whereas, Tribal set-aside programs have demonstrated measurable success in improving health outcomes through culturally tailored interventions, including the Special Diabetes Program for Indians, which contributed to a 54% reduction in end-stage renal disease and an 84% reduction in hospitalizations for uncontrolled diabetes among AI/AN populations[3]; and

Whereas, Tribal set-asides in federal appropriations are inconsistently used due to the discretionary nature of appropriations for the Indian Health Service, unlike other federal health programs, including Medicare and Medicaid, which receive mandatory appropriations, leading to uncertainty in long-term planning, staffing, and service delivery[7]; and

Whereas, transitioning the Indian Health Service and American Indian and Alaska Native health programs administered by related federal agencies to mandatory appropriations is supported by a majority consensus of tribal leaders and their health advocacy organizations, including the National Congress of American Indians and the National Indian Health Board[8-10]; and

Whereas, adoption of new, specific, internal AMA advocacy targets will best position the AMA Board of Trustees and staff to advocate for the unmet health needs of American Indian patients and communities in concert with guidance provided by the AMA Advisory Committee on American Indian Affairs[4,11,12]; therefore be it

RESOLVED, that our American Medical Association supports dedicated set-aside appropriations for American Indian, Native Hawaiian, and Alaska Native governments and their associated healthcare entities that do not compete with states and other municipalities (New HOD Policy); and be it further

RESOLVED, that our AMA supports that the Indian Health Service, the Native Hawaiian Health Care Systems, and related federal agencies administering American Indian, Native Hawaiian, and Alaska Native health programs be transitioned from discretionary to mandatory appropriations. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

Health Care Access for American Indians and Alaska Natives H-350.939
Our American Medical Association supports the federal government continuing to enhance and develop alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health care, including within and outside of the established Indian Health Service (IHS) system.(2)Our AMA supports collaborative research efforts to better understand the limitations of IHS health care, including barriers to access, disparities in treatment outcomes, and areas for improvement.(3)Our AMA encourages studies between the IHS and the CDC to better evaluate regional health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care.(4)Our AMA supports federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices.[Res. 242, A-24]

Indian Health Service H-350.977
The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends: Indian Population: (1)In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (a)Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (b)Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (c)Improvement in transportation to make access to existing private care easier for the American Indian population. (2)Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3)will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. [Reaffirmed: CMS Rep. 03, A-24Reaffirmed: Res. 244, A-24Reaffirmed: BOT Rep. 31, A-24Modified: CMS Res. 305, A-24]

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
Our American Medical Association will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers. (2) will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service. (3) adopts a new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction. (4)In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.[Res. 233, A-13Appended: Res. 229, A-14Appended: Res. 812, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Federal Framework for Social Media Access by Minors Under Age 16

Referred to: Reference Committee B

Whereas, social media use among American youth has reached epidemic proportions, with approximately 95 percent of teenagers aged 13-17 reporting use of at least one social media platform and more than one-third reporting using social media “almost constantly;” and

Whereas, the average American adolescent spends 4.8 hours per day on social media platforms with some studied reporting even higher usage among girls and economically disadvantaged youth; and

Whereas, children as young as eight and nine years old are accessing social media platforms despite minimum age requirements of 13 and the majority of platforms employ algorithms specifically designed to maximize engagement and time on app, often at the expense of user wellbeing; and

Whereas, the United States Surgeon General issues an advisory in 2023 stating that social media poses a “profound risk of harm” to the mental health and wellbeing of children and adolescents and calling on Congress to enact age-appropriate health and safety standards; and

Whereas, multiple peer-reviewed studies have established statistically significant associations between heavy social media use and increased rates of depression, anxiety, loneliness, and suicidal ideation in adolescents, particularly among girls aged 10-14; and

Whereas, a 2022 study published in JAMA Psychiatry found that adolescents who spent more than three hours per day on social media had double the risk of experiencing poor mental health outcomes, including symptoms of depression and anxiety; and

Whereas, Dr, Jean Twenge’s longitudinal research published in Clinical Psychological Science documented sharp increases in adolescent depression and loneliness beginning around 2012 and coinciding closely with widespread adoption of smartphones and social media; and

Whereas, social media platforms expose minors to cyberbullying, harassment, sexual predation, and exploitation, the National Center for Missing and Exploited Children’s reported a 39 percent increase in online enticement of children between 2020 and 2022; and

Whereas, the adolescent brain is neurologically immature, with the prefrontal cortex—responsible for impulse control, risk assessment, and emotional regulation—not fully developed until the mid-twenties, making children and teenagers particularly vulnerable to the addictive design features and dopaminergic reward cycles embedded in social media platforms; and

Whereas, the American Psychological Association’s Health Advisory on Social Media Use in Adolescence in 2023 concluded that adolescents who use social media frequently are more

likely to be exposed to potentially harmful content and to experience negative social comparisons that damage self-esteem and body image; and

Whereas, exposure to eating disorder content, self-harm imagery, and extremist ideologies on platforms such as Instagram, TikTok, and others had been documented to have direct, measurable, harmful effects on vulnerable youth; and

Whereas, internal documents from Meta disclosed through litigation and congressional testimony revealed that company researchers were aware of Instagram's harmful effects on teenage girls' body image and mental health as early as 2019 and suppressed findings rather than remediate product design; and

Whereas, despite voluntary self-regulatory commitments, social media companies have consistently failed to meaningfully enforce minimum age requirements, implement effective parental controls, or redesign algorithmic systems to reduce harm to minor users; and

Whereas, excessive social media use has been linked to disrupted sleep patterns, with a majority of teens reporting that they check their phones within the last hour before bedtime, resulting in reduced sleep quality and duration that impairs learning, memory consolidation, and emotional regulation; and

Whereas, the Children's Online Privacy Protection Act (COPPA), enacted in 1998 and last updated in 2013, has proven wholly inadequate to address the modern social media landscape and provides no meaningful health protections for minors aged 13-15; and

Whereas, Australia enacted the Online Safety Amendment (Social Media Minimum Age) Act in November 2024, establishing a minimum age of 16 for social media use—making it the first country in the world to impose such a restriction—with platforms subject to significant financial penalties for non-compliance; and

Whereas, Norway enacted legislation in 2021 requiring parental consent for children under 15 to create social media accounts and in 2024 proposed raising the minimum age to 15 without exceptions; and

Whereas, France passed a law in 2023 requiring parental consent for minors under 15 to access social media platforms with platforms required to obtain verifiable consent; and

Whereas, the United Kingdom's Online Safety Act of 2023 imposed strict duties of care on platforms likely to be accessed by children, requiring age verification and risk assessments to protect minors from harmful content; and

Whereas, the European Union's Digital Services Act of 2023 prohibits platforms from using personal data to serve targeted advertising to minors and requires enhanced protections for users under 18; and

Whereas, Florida, Texas, Arkansas, and Montana have passed state-level legislation restricting social media access for minors under 16, though these laws face ongoing legal challenges, underscoring the need for uniform federal legislation; and

Whereas, the American Academy of Pediatrics (AAP) has published clinical guidance recommending that pediatricians counsel families on the risks of social media and advise against unrestricted access for adolescents; and

Whereas, the AMA has historically played a decisive role in shaping public health policy on issues ranging from tobacco to seat belt safety to firearm violence, setting a clear precedent for legislative advocacy when the scientific evidence of harm to children is substantial; and

Whereas, pediatricians and child psychiatrists in clinical practice are witnessing firsthand an unprecedented surge in anxiety, depression, eating disorders, and self-harm in patients aged 10-17 with many physicians identifying heavy social media use as a significant contributing factor; therefore be it

RESOLVED, that our American Medical Association will call upon Congress and the President to enact federal legislation establishing a minimum age of 16 for independent social media account creation with limited supervised access permitted for younger minors only through verifiable parental consent and platform-implemented safeguards (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation requiring social media platforms to deploy privacy-preserving, minimally intrusive age assurance technologies consistent with applicable law, subject to Federal Trade Commission oversight and meaningful penalties for non-compliance (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage platforms to (a) disable addictive design features (infinite scroll, autoplay) by default for minors, (b) limit daily usage, and (c) conduct transparent health impact assessments prior to algorithmic changes affecting youth (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for robust federal funding for longitudinal research into the effects of social media, including equity impacts on rural and underserved youth, to be administered through the National Institutes of Health and the Centers for Diseases Control and Prevention (Directive to Take Action); and be it further

RESOLVED, that our AMA support the development of clinical screening guidelines for harmful social media use and public education campaigns (New HOD Policy); and be it further

RESOLVED, that our AMA communicate its positions to the U.S. Congress, the White House Office of Science and Technology Policy, the Federal Trade Commission, the Federal Communications Commission, and all relevant state medical associations with policy reassessment required after five years based on outcomes data. (Directive to take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 8/19/26

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RELEVANT AMA POLICY

Teens and Social Media H-478.976

1. Our American Medical Association will study and make recommendations for teenage use of social media, including proposing model state and federal legislation as needed, with a report back at the 2024 Annual Meeting.
2. Our American Medical Association urges physicians to:
    a. educate themselves about social media;
    b. be prepared to counsel patients and/or their guardians about the potential risks and harms of social media; and
    c. consider expanding clinical interviews to inquire about social media use.
3. Our AMA encourages further clinical, epidemiological, and interdisciplinary research on the impact of social media on health.
4. Our AMA supports education of clinicians, educators, and the public on digital media literacy and the health effects of social media.
5. Our AMA recognizes that the relative risks and benefits of social media may depend on individual differences (e.g., social media engagement, pre-existing traits, and environment).
6. Our AMA supports legislative, regulatory, and associated initiatives that, at a minimum, provide youth with strong data privacy protections, require platforms to be designed to align with child development, and provide transparency into the potential harms posed by platforms to young people and any steps taken to mitigate those harms.
7. Our AMA will collaborate with professional societies, industry, and other stakeholders to improve social media platform privacy protections, transparency (e.g., algorithmic, data, and process), data sharing processes, and systems for accountability and redress in response to online harassment.

Citation: Res. 430, A-23; Appended: CSAPH Rep. 05, I-24

Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965

1. Our American Medical Association will collaborate with relevant professional organizations to:
    a. support the development of continuing education programs to enhance physicians' knowledge of the health impacts of social media and social networking usage; and
    b. support the development of effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing health sequelae of social media and social networking usage.
2. Our AMA advocates for schools to provide safe and effective, evidence-based educational programs so that:
    a. all students can learn to identify and mitigate the onset of mental health sequelae of social media and social networking usage; and
    b. all students develop skills in digital literacy to serve as an individual protective foundation for interaction with various types of digital media (including social media).
3. Our AMA affirms that use of social media and social networking has the potential to positively or negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions.

4. Our AMA advocates for and support media and social networking services addressing and developing safeguards tailored to youth users, including ensuring robust protections for youth online privacy, providing effective tools to manage screentime content and access, considering special circumstances for certain youth populations (such as LGBTQ+ youth and youth with disabilities), and promoting the development and dissemination of age-appropriate digital literacy training.
5. Our AMA advocates for the study of the positive and negative biological, psychological, and social effects of social media and social networking services use.

Citation: Res. 905, I-17; Modified: Res. 420, A-21; Reaffirmed: A-23; Modified: CSAPH Rep. 05, I-24

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

1. Our American Medical Association recognizes the positive role of the Internet in providing health information to children and youth.
2. Our AMA recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
3. Our AMA supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
4. Our AMA encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
5. Our AMA supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.
6. Our AMA actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications.

Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16; Appended: Res. 926, I-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs

Referred to: Reference Committee B

Whereas, health insurers, including Medicare Advantage organizations and commercial health plans, increasingly attribute patients to physicians and physician practices for purposes of quality measurement, star ratings, and value-based payment programs; and

Whereas, many attribution methodologies rely on administrative enrollment data, patient self-selection, or claims algorithms that may assign patients to physicians with whom they have no active clinical relationship; and

Whereas, physicians and practices are frequently held accountable for quality metrics, preventive care measures, and performance ratings for patients who have never been seen in their practice or who have not received care from the attributed physician during the measurement period; and

Whereas, inaccurate patient attribution may negatively affect physician performance scores, payer star ratings, public reporting metrics, and financial incentives tied to value-based care programs; and

Whereas, physicians often face a significant administrative burden when attempting to correct inaccurate patient attribution, and many health plans lack transparent processes, timely dispute mechanisms, or clear criteria for removing patients who are incorrectly assigned; and

Whereas, inaccurate attribution increases administrative burden and diverts physician resources from patient care; and

Whereas, inaccurate attribution undermines the integrity of quality measurement programs and may misrepresent the quality of care delivered by physicians and physician practices; and

Whereas, accurate attribution should reflect a meaningful clinical relationship between a patient and a physician, such as documented visits or a confirmed patient designation of a primary care physician; therefore be it

RESOLVED, that our American Medical Association advocate for federal and state legislation and regulation that ensures accurate patient attribution and prevent physicians from being evaluated on patients with whom they have no established care relationship, including enforcement mechanisms for payers who fail to maintain accurate attribution lists (Directive to Take Action); and be it further

RESOLVED, that our AMA develop model state legislation and regulatory policy addressing accurate patient attribution in health plan quality measurement and value-based payment

programs, based on the Universal Standards for Patient Attribution, with modular components adaptable to varying state legislative and regulatory environments (Directive to Take Action); and be it further

RESOLVED, that our AMA adopt as policy the following Universal Standards for Patient Attribution:

1. Clinical Relationship: Attribution must be based on a documented clinical relationship, defined by recent clinical encounter(s) within an appropriate timeframe or a verified patient designation of the physician as their primary care provider (PCP);
2. Prospective Notification: Payers must provide physicians with an option for retrospective or prospective attribution methodology and, if opting for prospective attribution, they should provide physicians with a list of attributed patients at least 30 days before the start of a measurement period;
3. Transparency: Payers must disclose the attribution algorithms, claims thresholds, and patient designation processes used to assign patients to physicians;
4. Mandatory Exclusion: Patients subject to an active attribution dispute must be excluded from all quality scoring and financial performance calculations until the dispute is resolved;
5. Dispute Resolution: Payers must provide a standardized, timely mechanism for physicians to correct or suppress inaccurate attributions, with a determination required within 30 days of submission;

(New HOD Policy); and be it further

RESOLVED, that our AMA Board of Trustees report back at the 2027 Annual Meeting with recommendations to align and consolidate existing AMA policies related to patient attribution to ensure a streamlined advocacy strategy. (Directive to take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 8/19/26

RELEVANT AMA POLICY

Physician-Focused Alternative Payment Models: Reducing Barriers H-385.908

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.
3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
   a. Continue to expand technical assistance;
   b. Develop IT systems that support and streamline clinical participation;
   c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;
   d. Identify methods to reduce the data collection burden; and
   e. Begin implementing the 21st Century Cures Act.
5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:

a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors;
b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;
b. Distinguish between services ordered by a physician and those delivered by a physician;
c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patient's and physician's responsibility for managing the condition; and
e. Provide physicians with lists of attributed patients to improve care coordination.
7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;
b. Account for costs that are not currently billable but that cost the practice to provide; and
c. Account for lost revenue for providing fewer or less expensive services.
Citation: CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20

Physician Payment Reform H-390.849

1. Our American Medical Association will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
    a. Promote improved patient access to high-quality, cost-effective care.
    b. Be designed with input from the physician community.
    c. Ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions.
    d. Not require budget neutrality within Medicare Part B.
    e. Be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.
    f. Ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.
    g. Make participation options available for varying practice sizes, patient mixes, specialties, and locales.
    h. Use adequate risk adjustment methodologies.
    i. Incorporate incentives large enough to merit additional investments by physicians.
    j. Provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols.
    k. Provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.
    l. Attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary.
    m. Include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Citation: CMS Rep. 6, A-09; Reaffirmed: A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmed: I-15; Reaffirmed: A-16; Reaffirmed in lieu of Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmed: A-19; Reaffirmed: BOT Action in response to referred for decision: Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision: Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmed: A-22; Modified: CMS Rep. 04, A-23; Reaffirmed: Res. 214; A-23; Reaffirmed in lieu of Res. 225, A-25; Reaffirmed: Res. 226, A-25

Medical Information and Its Uses H-406.987
DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.
Citation: BOT Rep. 6, A-15; Reaffirmed: I-18; Reaffirmed: CSAPH Rep. 2, I-19

Work of the Task Force on the Release of Physician Data H-406.990
Release of Claims and Payment Data from Governmental Programs
The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data only when it preserves access to health care and is used to provide accurate physician performance assessments.
Raw claims data used in isolation have significant limitations. The release of such data from government programs must be subject to safeguards to ensure that neither false nor misleading conclusions are derived that could undermine the delivery of appropriate and quality care. If not addressed, the limitations of such data are significant. The foregoing limitations may include, but are not limited to, failure to consider factors that impact care such as specialty, geographic location, patient mix and demographics, plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution.
Raw claims and payment data resulting from government health care programs, including, but not limited to, the Medicare and Medicaid programs should only be released:
1. when appropriate patient privacy is preserved via de-identified data aggregation or if written authorization for release of individually identifiable patient data has been obtained from such patient in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable regulations;
2. upon request of physicians [or their practice entities] to the extent the data involve services that they

have provided;
3. to law enforcement and other regulatory agencies when there is reasonable and credible reason to believe that a specific physician [or practice entity] may have violated a law or regulation, and the data is relevant to the agency's investigation or prosecution of a possible violation;
4. to researchers/policy analysts for bona fide research/policy analysis purposes, provided the data do not identify specific physicians [or their practice entities] unless the researcher or policy analyst has (a) made a specific showing as to why the disclosure of specific identities is essential; and, (b) executed a written agreement to maintain the confidentiality of any data identifying specific physicians [or their practice entities];
5. to other entities only if the data do not identify specific physicians [or their practice entities]; or
6. if a law is enacted that permits the government to release raw physician-specific Medicare and/or Medicaid claims data, or allows the use of such data to construct profiles of identified physicians or physician practices. Such disclosures must meet the following criteria:
(a) the publication or release of this information is deemed imperative to safeguard the public welfare;
(b) the raw data regarding physician claims from governmental healthcare programs is:
(i) published in conjunction with appropriate disclosures and/or explanatory statements as to the limitations of the data that raise the potential for specific misinterpretation of such data. These statements should include disclosure or explanation of factors that influence the provision of care including geographic location, specialty, patient mix and demographics, health plan design, patient compliance, drug and supply costs, hospital and service costs, professional liability coverage, support staff and other practice costs as well as the potential for mistakes and errors in the data or its attribution, in addition to other relevant factors.
(ii) safeguarded to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data.
(c) any physician profiling which draws upon this raw data acknowledges that the data set is not representative of the physicians' entire patient population and uses a methodology that ensures the following:
(i) the data are used to profile physicians based on quality of care provided - never on utilization of resources alone - and the degree to which profiling is based on utilization of resources is clearly identified.
(ii) data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties.
(iii) the data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians.
(d) any governmental healthcare data shall be protected and shared with physicians before it is released or used, to ensure that physicians are provided with an adequate and timely opportunity to review, respond and appeal the accuracy of the raw data (and its attribution to individual physicians) and any physician profiling results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release.
Citation: BOT Rep. 18, A-09; Reaffirmed: BOT Rep. 09, A-19; Modified: Speakers Rep., A-19

Work of the Task Force on the Release of Physician Data H-406.991
Principles for the Public Release and Accurate Use of Physician Data
The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:
1. Patient Privacy Safeguards
- All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).
- Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983).
2. Data Accuracy and Security Safeguards
- Effective safeguards are established to protect against the dissemination of inconsistent, incomplete,

invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).
- Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).
- Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961).
3. Transparency Requirements
- When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).
- The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).
- Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).
4. Review and Appeal Requirements
- Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).
- When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).
5. Physician Profiling Requirements
- The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961).
- Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (H-450.951).
- When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used.
- Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services.
- Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes.
6. Quality Measurement Requirements
- The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).
- Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).
- These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data.
7. Patient Satisfaction Measurement Requirements
- Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).
- Because of the difficulty in determining whether responses to patient satisfaction surveys are a

result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms.
- As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication.
Citation: BOT Rep. 19, A-09; Reaffirmed: A-10; Reaffirmed: BOT action in response to referred for decision: Res. 709, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed: I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of res. 824, I-10; Reaffirmed: A-11; Reaffirmed: BOT Rep. 17, A-13; Reaffirmed: Res. 806, I-13; Reaffirmed: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-26)

Introduced by: Kansas

Subject: Third-Party Litigation Funding in Medical Liability Claims

Referred to: Reference Committee B

Whereas, a fair, transparent, and stable medical liability system is essential to preserving patient access to physicians and a full range of health care services; and

Whereas, third-party litigation funding provides money for litigation fees, costs, or expenses in exchange for repayment or other consideration contingent on the outcome, giving a funder a financial interest in litigation that may be unknown to the court, parties, and insurers; and

Whereas, North Carolina's 2026 Prohibit Litigation Investments Act prohibits outcome-contingent litigation investment while preserving traditional contingency-fee representation, attorney advancement of litigation costs, insurer defense and indemnity obligations, qualifying nonprofit legal services, personal and household support not used for litigation expenses, immediate-family support, and financing not contingent on the outcome; and

Whereas, Montana and Wisconsin require disclosure of litigation funding agreements without awaiting a discovery request, and Montana requires continuing disclosure to the court, parties, and known insurers and prohibits funder influence over litigation strategy, expert selection, and settlement decisions; and

Whereas, AMA policies D-435.996 and H-265.994 support effective medical liability reform and oppose contingent fees for medicolegal consulting firms, respectively, but do not establish policy governing third-party litigation funding in medical liability claims; therefore be it

RESOLVED, that our American Medical Association support state legislation prohibiting outcome-contingent third-party litigation funding for the fees, costs, or expenses of a pending or potential medical liability claim or proceeding, while preserving traditional contingency-fee representation, attorney advancement of litigation costs, contractual defense or indemnity obligations, qualifying nonprofit legal services, personal and household support not used for litigation expenses, immediate-family support, and financing not contingent on the outcome (New HOD Policy); and be it further

RESOLVED, that our AMA support state laws requiring, in any medical liability claim or proceeding involving third-party litigation funding, automatic and continuing disclosure without awaiting a discovery request of the funding agreement and the identity of each funder and any person or entity with a direct or indirect right to receive payment contingent on the outcome to the court, all parties, and any known insurer with a duty to defend or indemnify, with appropriate protection of attorney-client privilege and attorney work product (New HOD Policy); and be it further

RESOLVED, that our AMA develop and advocate for model state legislation consistent with these principles, including provisions prohibiting a litigation funder from controlling or influencing

litigation strategy, expert selection, or settlement decisions and providing effective enforcement through voiding prohibited agreements and authorizing civil remedies or penalties, to promote a fair, transparent, and stable medical liability environment for patients and physicians. (Directive to Take Action)

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

Received: 9/11/26

REFERENCES

1. American Medical Association. *State Medical Liability Reform*. Updated January 23, 2026.
2. North Carolina Session Law 2026-14, House Bill 315, *Prohibit Litigation Investments Act*, N.C. Gen. Stat. §§ 66-511 through 66-515. Approved June 22, 2026.
3. Montana Code Annotated §§ 31-4-104 and 31-4-108 (2025).
4. Wisconsin Statutes § 804.01(2)(bg) (2025).
5. American Medical Association Policy D-435.996, Model State Legislation Incorporating Medical Malpractice Tort Reform.
6. American Medical Association Policy H-265.994, Expert Witness Testimony.

RELEVANT AMA POLICY

D-435.996, Model State Legislation Incorporating Medical Malpractice Tort Reform
Our American Medical Association will 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.
5. Expand circumstances where physicians are entitled to attorney fees.

[Res.205,I-25]

H-265.994, Expert Witness Testimony
(1) Regarding expert witnesses in clinical matters, as a matter of public interest the AMA encourages its members to serve as impartial expert witnesses.

(2) Our AMA is on record that it will not tolerate false testimony by physicians and will assist state, county and specialty medical societies to discipline physicians who testify falsely by reporting its findings to the appropriate licensing authority.

(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows:

(a) The AMA believes that the minimum statutory requirements for qualification as an expert witness in medical liability issues should reflect the following: (i) that the witness be required to have comparable education, training, and occupational experience in the same field as the defendant or specialty expertise in the disease process or procedure performed in the case; (ii) that the occupational experience include active medical practice or teaching experience in the same field as the defendant; (iii) that the active medical practice or teaching experience must have been within five years of the date of the occurrence giving rise to the claim; and (iv) that the witness be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or by a board with equivalent standards.

(b) The AMA opposes payment of contingent fees for all types of medicolegal consultations, including management services provided by firms engaged in locating physician consultants. Where necessary, the AMA supports state legislation making it illegal for medicolegal consulting firms to take a contingent fee in personal injury litigation. Such arrangements threaten the integrity and the compensation goals of the civil justice system. Like the individual expert witness, the role of the medicolegal consulting firm which locates

and supplies experts should be one of limited service to the judicial process. Contingent fee arrangements are plainly inconsistent with the scope of this responsibility.

(c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (i) the amount of compensation received for the expert's consultation and testimony; (ii) the frequency of the physician's expert witness activities; (iii) the proportion of the physician's professional time devoted to and income derived from such activities; and (iv) the frequency with which they testified for either plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony. [Sub. Res. 223, A-92; Appended: Sub. Res. 211, I-97; Reaffirmation A-99; Modified: BOT Rep. 8, I-04; Reaffirmed: Res. 2, I-05; Reaffirmed: BOT Rep. 10, A-15; Modified: Speakers Rep. 02, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-26)

Introduced by: Kentucky Delegation

Subject: Protecting Physician-Led Interventional Pain Medicine, Ending Unsupervised Nonphysician Practice, and Ensuring Patient Transparency and Safety

Referred to: Reference Committee B

Whereas, interventional pain medicine is a physician specialty requiring completion of medical school, residency, and a dedicated fellowship year devoted specifically to the diagnosis, risk stratification, image-guided procedural technique, and longitudinal management of chronic pain, training that no nonphysician pathway currently requires or replicates; and

Whereas, chronic interventional pain management is fundamentally distinct from perioperative anesthesia-related pain care, and involves independent medical decision-making including differential diagnosis, patient selection, procedural planning, interpretation of advanced imaging, rehabilitation planning, complex medication management, and longitudinal follow-up that exceeds the scope of nurse anesthesia training; and

Whereas, certified registered nurse anesthetists are trained in the management of acute, procedural, and obstetric pain occurring in the intraoperative and immediate perioperative period, a skill set that is valuable and appropriate within its intended context, but is categorically distinct from, and does not include, the fellowship-level training required to independently diagnose, select, and perform invasive image-guided procedures for the longitudinal management of chronic pain; and

Whereas, interventional pain procedures are invasive, image-guided interventions performed in close proximity to the spinal cord, nerve roots, and major vascular structures, carrying serious risks including epidural hematoma, infection, nerve injury, and paralysis, and demand the judgment and complication-management expertise obtained only through physician residency and fellowship training; and

Whereas, certified registered nurse anesthetists (CRNAs) and other nonphysician practitioners in Kentucky and surrounding states are increasingly establishing and operating so-called "pain institutes" or freestanding pain clinics that independently diagnose, select, and perform complex interventional pain procedures without onsite physician supervision, in direct conflict with the training, credentialing, and safety standards required of physicians practicing in this specialty; and

Whereas, this unsupervised expansion of practice creates a two-tiered system of pain care in which patients may unknowingly receive physician-level diagnostic and procedural decisions from practitioners who have not completed physician residency or pain medicine fellowship training, thereby endangering patient safety and undermining public trust; and

Whereas, patients are frequently unable to determine, from clinic names, advertising, or

signage alone, whether the professional diagnosing their pain condition, recommending a procedure, performing an invasive intervention, or managing their follow-up care is a physician, and deserve clear and enforceable transparency in this regard; and

Whereas, physician-led, team-based care remains fundamental to the safe and effective practice of interventional pain medicine, and this resolution affirms the valuable and appropriate contributions of certified registered nurse anesthetists, physician assistants, nurse practitioners, anesthesia assistants, and other nonphysician clinicians when practicing within, and under the active supervision of, a physician-led team; and

Whereas, payer, credentialing, and institutional policies too often fail to reflect meaningful differences in education, training, and demonstrated competency between physicians and nonphysician practitioners, resulting in reimbursement, privileging, and authorization structures that incentivize and enable unsupervised nonphysician practice in interventional pain medicine; and

Whereas, the unchecked proliferation of nonphysician-operated pain institutes, if left unaddressed by statute, regulation, and payer policy, threatens to establish independent nonphysician scope of practice in chronic pain management as a de facto standard, to the detriment of patients across the Commonwealth; therefore be it

RESOLVED, that our American Medical Association oppose the independent, unsupervised establishment and operation of pain clinics, pain institutes, or similar practices by certified registered nurse anesthetists or other nonphysician clinicians, and oppose any expansion of scope of practice permitting the independent performance of complex interventional pain procedures absent active, onsite physician supervision (New HOD Policy); and be it further

RESOLVED, that our AMA call upon relevant regulatory bodies to investigate pain practices reasonably suspected of operating outside applicable licensure scope-of-practice, or physician-oversight requirements and to enforce, where applicable, the physician ownership, on-site physician (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for enforceable transparency standards in advertising, clinic naming, informed consent, and other patient-facing communications that clearly identify the credentials and roles of the clinicians responsible for diagnosis, procedural selection, procedural performance, and longitudinal management. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

RELEVANT AMA POLICY

Pain Management H-410.950
Our American Medical Association adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:
Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:

1. Ablation of targeted nerves.
2. Procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality.
3. Surgical techniques, such as laser or endoscopic diskectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing.

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.

Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers H-410.958

1. Our American Medical Association encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that **interventional pain** management of patients suffering from chronic **pain** constitutes the practice of **medicine**.
2. Our AMA will work to ensure that **interventional pain** management is the practice of **medicine** and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in **pain** management and palliative care offered by nursing programs and medical schools in order to demonstrate adherence to current standards in **pain** management.

Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy D-35.984

1. Our American Medical Association will
    a. advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians.
    b. develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy.
2. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates.

Truth in Corporate Advertising: Using Professional Degrees in Advertising Listings H-405.967
The AMA opposes US West Yellow Pages or any other corporation which misrepresents physicians by failing to list their professional degrees in the corporation's advertising directory.

Clarification of Healthcare Physician Identification: Consumer Truth & Transparency D-405.974

1. Our American Medical Association will advocate for legislation that would establish clear legal definitions for use of words or terms “physician,” “surgeon,” “medical doctor,” “doctor of osteopathy,” “M.D.” , “D.O.,” or any other allopathic or osteopathic medical specialist.
2. Our AMA will advocate for “Truth & Transparency” legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, and board licensure in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. -ologist) that can mislead the public.

Definition and Use of the Term Physician H-405.951

1. Our American Medical Association Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Our AMA will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
    a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician.
    b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician.
    c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Our AMA urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Our AMA ensures that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Our AMA will review and revise its own publications as necessary to conform with the House of Delegates’ policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (*JAMA*) Editorial Governance Plan, which protects the editorial independence of *JAMA*.
7. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-26)

Introduced by: American College of Surgeons

Subject: Facilitating Short-Term Supervised Clinical Training for International Physicians

Referred to: Reference Committee B

Whereas, surgeons from low- and middle-income countries frequently seek short-term, procedure-specific training in areas such as trauma systems, minimally invasive surgery, oncology, transplantation, endoscopy, and critical care that cannot feasibly be obtained through multi-year residency or fellowship programs in their home countries; and

Whereas, current U.S. visa regulations limit such exchanges to observation without supervised participation in clinical care, which is not sufficient to train surgeons hoping to return to their home country with new skills to treat local populations; and

Whereas, AMA Policy H-255.989 supports exchange visitor physician programs that permit noncitizen physicians to participate in education, training, and research in the United States followed by return to their home countries to improve health care delivery; and

Whereas, AMA Policy H-255.969 encourages physician preceptors, medical associations, and medical organizations to establish observership programs utilizing the AMA International Medical Graduate Observership Guidelines and Evaluation Tools; and

Whereas, AMA Opinion E-8.14 recognizes that ethical global health partnerships should foster reciprocal learning, strengthen health systems, promote sustainable capacity building, and benefit patients and physicians in both host and partner countries; and

Whereas, existing *Exchange Visitor Program* regulations governing physicians generally permit graduate medical education under Educational Commission for Foreign Medical Graduates (ECFMG) sponsorship or observation, consultation, teaching, and research activities, but provide no practical mechanism for international physicians to participate in structured, short-term supervised hands-on clinical training as continuing medical education (CME) outside formal residency or fellowship programs[1]; and

Whereas, academic medical centers, teaching hospitals, and specialty societies throughout the United States maintain longstanding educational partnerships with physicians from around the world and frequently receive requests for brief supervised procedural and clinical skills training that cannot be accommodated under existing visa structures; and

Whereas, several states, including Tennessee and Ohio, have established limited licensure pathways for the purpose of allowing international physicians to participate in short- term, supervised, hands-on clinical training without meeting all requirements for unrestricted medical licensures. Yet, existing federal immigration and exchange visitor requirements may prevent otherwise eligible international physicians from entering the United States for the purpose of participating in such clinical training; and

Whereas, time-limited supervised clinical training conducted under the direct supervision of licensed U.S. physicians, pursuant to a defined educational curriculum and without authorization for independent clinical practice, would promote ethical international collaboration, strengthen global health systems, and improve patient care while maintaining appropriate safeguards; therefore be it

RESOLVED, that our American Medical Association amend Policy H-255.989, Exchange Programs for Visitor Physicians, by adding the following new directive:

"3. Our AMA supports modifications to the federal Exchange Visitor Program regulations governing J-1 physicians to establish a short-term supervised clinical training category that would permit qualified international physicians to participate in structured educational clinical experiences at accredited U.S. teaching hospitals and medical schools without enrollment in an ACGME-accredited residency or fellowship program or completion of USMLEs, provided that such training:

(a) is limited in duration and has an educational purpose;
(b) occurs pursuant to a structured curriculum established in advance that includes defined educational objectives, appropriate instruction and supervision, and a mechanism for evaluating whether those objectives have been achieved;
(c) is conducted under the direct supervision of appropriately licensed and certified U.S. physicians;
(d) complies with all applicable federal and state laws and institutional policies;
(e) does not authorize independent clinical practice or unrestricted patient care;
(f) is intended to facilitate the transfer of medical knowledge and procedural skills to improve health care delivery in participants' home countries;
(g) does not interfere with or diminish the clinical learning opportunities of residents, fellows, medical students, or other trainees at the hosting institution;
(h) does not substitute for physicians, residents, fellows, advanced practice professionals, or other health care professionals or personnel who would otherwise be employed or engaged to provide patient care, and is not used to address staffing shortages or increase the clinical or procedural capacity of the hosting institution or supervising physician;
(i) includes appropriate institutional oversight and safeguards to protect participating international physicians from exploitation and ensure that clinical activities are undertaken solely to advance the program's defined educational objectives"
(Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate before the U.S. Department of State, Department of Homeland Security, Educational Commission for Foreign Medical Graduates, and other appropriate federal agencies for modifications to the Exchange Visitor Program regulations consistent with this policy (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborates with specialty societies, academic medical centers, the ACGME, ECFMG, and other stakeholders to develop recommendations regarding appropriate program eligibility, supervision, duration, institutional sponsorship, patient safety safeguards, and educational standards for such a short-term clinical training category. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

REFERENCES

1. 22 CFR § 62.27, Exchange Visitor Program—Alien Physicians; see also 22 CFR Part 62. https://www.ecfr.gov/current/title-22/chapter-I/subchapter-G/part-62/section-62.27

RELEVANT AMA POLICY

H-255.989 Exchange Programs for Visitor Physicians

1. Our AMA supports non-citizen physicians participating in exchange visitor physician programs for purposes of education, training, and/or research followed by return to their home country. This is separate from the issues involving U.S. citizens who are graduates of foreign medical schools and non-citizen physician graduates of foreign medical schools who seek permanent residence in the U.S.
2. Our AMA urges government and private funding of the physician exchange visitor program under the auspices of an appropriate organization that will: consider the range and type of medical education and health care needs of those foreign nations sending exchange visitor physicians; the means to evaluate the level of knowledge and needs of prospective participants in graduate medical education programs; and identify truly outstanding public health, geographic medicine, basic medical science, and clinical training programs to answer the needs of the visitor's native land.

H-255.969 Create Local Observership Programs

Our AMA encourages physician preceptors, medical associations, and medical organizations to establish local observership programs by utilizing the IMG Observership Guidelines and Evaluation Tools.

AMA Code of Medical Ethics Opinion 8.14 Short-Term Global Health Clinical Encounters

Short-term global health clinical encounters, which send physicians and physicians in training from wealthier communities to provide care in under-resourced settings for a period of days or weeks, have been promoted as a strategy to provide needed care to individual patients and, increasingly, as a means to address global health inequities. To the extent that such encounters also provide training and educational opportunities, they may offer benefit both to the host communities and the medical professionals and trainees who volunteer their time and clinical skills.

Short-term global health clinical encounters typically take place in contexts of scarce resources and in the shadow of colonial histories. These realities define fundamental ethical responsibilities for participants, sponsors, and hosts to jointly prioritize activities to meet mutually agreed-on goals; navigate day-to-day collaboration across differences of culture, language, and history; and fairly allocate resources. Participants and sponsors must focus not only on enabling good health outcomes for individual patients, but on promoting justice and sustainability, minimizing burdens on host communities, and respecting persons and local cultures. Responsibly carrying out short-term global health clinical encounters requires diligent preparation on the part of participants and sponsors in collaboration with host communities.

Physicians and trainees who are involved with short-term global health clinical encounters should ensure that the trips with which they are associated:

1. Focus prominently on promoting justice and sustainability by collaborating with the host community to define project parameters, including identifying community needs, project goals, and how the visiting medical team will integrate with local health care professionals and the local health care system. In collaboration with the host community, short-term global health clinical encounters should prioritize efforts to support the community in building health care capacity. Trips that also serve secondary goals, such as providing educational opportunities for trainees, should prioritize benefits as defined by the host community over benefits to members of the visiting medical team or the sponsoring organization.

2. Seek to proactively identify and minimize burdens the trip places on the host community, including not only direct, material costs of hosting participants, but also possible adverse effects the presence of participants could have for beneficial local practices and local practitioners. Sponsors and participants should ensure that team members practice only within their skill sets and experience.
3. Provide resources that help them become broadly knowledgeable about the communities in which they will work and to cultivate the cultural sensitivity they will need to provide safe, respectful, patient-centered care in the context of the specific host community. Members of the visiting medical team are expected to uphold the ethics standards of their profession and participants should insist that strategies are in place to address ethical dilemmas as they arise. In cases of irreducible conflict with local norms, participants may withdraw from care of an individual patient or from the project after careful consideration of the effect that will have on the patient, the medical team, and the project overall, in keeping with ethics guidance on the exercise of conscience. Participants should be clear that they may be ethically required to decline requests for treatment that cannot be provided safely and effectively due to resource constraints.
4. Are organized by sponsors that embrace a mission to promote justice, patient-centered care, community welfare, and professional integrity. Physicians, as influential members of their health care systems, are well positioned to influence the selection, planning and preparation for short term encounters in global health. In addition, they can take key roles in mentoring learners and others on teams to be deployed. Physicians can also offer guidance regarding the evaluation process of the experience, in an effort to enhance and improve the outcomes of future encounters.

Sponsors of short-term global health clinical encounters should:

5. Ensure that resources needed to meet the defined goals of the trip will be in place, particularly resources that cannot be assured locally. This includes arranging for local mentors, translation services, and participants' personal health needs. It should not be assumed that host communities can absorb additional costs, even on a temporary basis.
6. Proactively define appropriate roles and permissible range of practice for members of the visiting medical team, so that they can provide safe, high-quality care in the host community. Team members should practice only within the limits of their training and skills in keeping with professional standards they would deem acceptable in their ordinary clinical practice, even if the host community's standards are more flexible or less rigorously enforced.
7. Ensure appropriate supervision of trainees, consistent with their training in their home communities, and make certain that they are only permitted to practice independently in ways commensurate with their level of experience in under-resourced settings.
8. Ensure a mechanism for meaningful data collection is in place, consistent with recognized standards for the conduct of health services research and quality improvement activities in the sponsor's country.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-26)

Introduced by: American College of Preventive Medicine

Subject: Protecting GME Subject to Funding Uncertainty

Referred to: Reference Committee B

Whereas, Graduate Medical Education (GME) is essential to developing a physician workforce capable of meeting the nation's current and future health care needs;[1] and

Whereas, Medicare is the single largest federal source of GME funding, providing over $21 billion dollars of mandatory funding for physician training, but statutes define that reimbursement for services tied to Medicare services, resident-to-bed ratios, and additional statutory requirements that are prohibitive of certain GME training environments;[2] and

Whereas, in addition to Medicare-supported residency positions, a variety of GME programs are administered by federal agencies such as the Health Resources and Services Administration and Centers for Disease Control and Prevention to support physician training through grants supported by discretionary appropriations such as the Children's Hospital GME program, the Teaching Health Centers GME program, and more;[1] and

Whereas, such GME programs subject to dependence on the annual discretionary appropriations process are subject to instability and uncertainty, which the AMA is opposed to;[3] and

Whereas, the American Medical Association has supported legislation fully authorizing discretionary GME programs, such as the Teaching Health Centers GME program;[4] and

Whereas, in the cases of disruption to discretionary funding, i.e. government shutdowns and delays in disbursement of funds due to inadequate staffing of federal agencies, incoming resident physicians having been unable to start their desired GME program, either being turned away from residency programs after having been matched or programs removing themselves from participating in the standardized recruitment process for resident physicians in fear of having to turn away matched physicians; and

Whereas, the passage of a continuing resolution or government shutdown extending into the beginning of the academic year would threaten progress and disbursement of funding for discretionary GME programs; and

Whereas, the AMA's Council on Legislation and Council on Medical Education publish a GME Compendium report to focus on viable ways to improve GME and ensure medical students have the opportunity to fulfill training requirements and become practicing doctors;[5] and

Whereas, the AMA's GME Compendium includes limited information surrounding discretionary GME programs;[5] therefore be it

RESOLVED, that our American Medical Association advocate for continuation of GME programs primarily supported by discretionary funding during government shutdowns and delayed appropriation timelines (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation that would convert funding for discretionary GME programs to mandatory funding (Directive to Take Action); and be it further

RESOLVED, that our AMA elevate the issue of threats to the physician workforce from interruptions to discretionary GME programs in the United States by including information and advocacy actions in the annual GME Compendium report (Directive to Take Action); and be it further

RESOLVED, that our AMA publish a report on discretionary GME programs and recommendations to strengthen physician training to the House of Delegates at the 2027 Interim Meeting. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

REFERENCES

1. Federal Support for Graduate Medical Education. (2026, June 3). https://www.congress.gov/crs-product/R48636
2. Medicare Graduate Medical Education, 2025. (2026, June 3). https://www.congress.gov/crs-product/IF13088
3. The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education. (2026, June 3) https://policysearch.ama-assn.org/policyfinder/detail/%22GME%22?uri=%2FAMADoc%2Fdirectives.xml-0-929.xml
4. Madara, J. (2021, June 10). *Letter to Representative Frank Pallone and Senator Patty Murray supporting the Doctors of Community Act, H.R. 3671. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-6-10-Letter-to-Pallone-and-Murray-re-HR-3671-the-DOC-Act.pdf*
5. 2025 Compendium of Graduate Medical Education Initiatives Report. (2026, June 10) https://www.ama-assn.org/system/files/2025-gme-compendium-report.pdf

RELEVANT AMA POLICY

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education
Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.

Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
Our AMA:

recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.

Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
Our AMA will:

- encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
- strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
- encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.

Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how

Direct GME funds are allocated on a per resident or fellow basis, for the previous year. [Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmation A-11 Appended: Res. 910, I-11 Reaffirmed in lieu of Res. 303, A-12 Reaffirmed in lieu of Res. 324, A-12 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 320, A-13 Appended: CME Rep. 5, A-13 Appended: CME Rep. 7, A-14 Appended: Res. 304, A-14 Modified: CME Rep. 9, A-15 Appended: CME Rep, 1, I-15 Appended: Res. 902, I-15 Reaffirmed: CME Rep. 3, A-16 Appended: Res. 320, A-16 Appended: CME Rep. 04, A-16 Appended: CME Rep. 05, A-16 Reaffirmation A-16 Appended: Res. 323, A-17 Appended: CME Rep. 03, A-18 Appended: Res. 319, A-18 Reaffirmed in lieu of: Res. 960, I-18 Modified: Res. 233, A-19 Modified: BOT Rep. 25, A-19 Reaffirmed: CME Rep. 3, A-21 Appended: Res. 202, I-22 Reaffirmed: Res. 244, A-24 Modified: Res. 310, A-24 Reaffirmed: Res. 227, A-26]

H-310.916 Funding to Support Training of the Health Care Workforce
Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.

Our AMA strongly advocates that:

> There be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions.
>
> There be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.

Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs. [Sub. Res. 913, I-09 Appended: Res. 917, I-15 Appended: Res. 309, I-20 Reaffirmed: Res. 305, A-21]

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs
It is AMA policy that:

> Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
> Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
> Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
> Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
> All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
> Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty. [CME Rep. 7, A-05 Reaffirmation I-06 Reaffirmed: Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmed: CME Rep. 15, A-10 Reaffirmation A-11 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13 Appended: CME 05, A-16 Appended: Res. 319, A-16 Reaffirmation A-16 Reaffirmed: Res. 310, A-24]

D-305.955 Funding for Teaching Health Center Graduate Medical Education Program

Our American Medical Association will encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs to continue the training of primary providers in community based health centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations. [Res. 214, A-15 Reaffirmed: BOT Rep. 09, A-25]

H-310.943 Closing of Residency Programs

Our American Medical Association:

encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs.

reminds all institutions involved in educating residents of their contractual responsibilities to the resident.

encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing.

will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.

urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on

remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements.

opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding.

will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.

Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.

Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.

Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;

Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and

Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents. [Sub. Res. 328, A-94 Appended by CME Rep. 11, A-98 Reaffirmed: CME Rep. 7, A-06 Appended: Res. 926, I-12 Modified: CME Rep. 1, A-15 Appended: Res. 310, I-19 Modified: CME Rep. 3, I-20 Reaffirmed: CME Rep. 01, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-26)

Introduced by: Indiana

Subject: Requiring Physician Oversight for Artificial Intelligence Tools

Referred to: Reference Committee B

Whereas, artificial intelligence (AI) diagnostic tools are increasingly integrated into clinical practice with the aim of improving accuracy and efficiency; and

Whereas, current AMA policies support physician oversight but do not specifically address mandated physician review of AI-driven diagnostic outputs or therapeutic decisions before patient communication or implementation; and

Whereas, research indicates AI tools can produce errors or perpetuate bias if not adequately supervised by physicians; and

Whereas, ensuring final diagnostic responsibility and treatment decision-making remain with a licensed physician protects patient safety and maintains public trust in medical care; therefore be it

RESOLVED, that our American Medical Association support federal and state policies requiring that any artificial intelligence-generated diagnostic or treatment recommendations be reviewed, interpreted, and communicated by a licensed physician. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

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RELEVANT AMA POLICY

Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software D-478.955
Our American Medical Association will pursue federal regulation of artificial intelligence (AI) scribe technologies that protects clinician and patient privacy.
Citation: Res. 007, A-26

Artificial Intelligence to Bolster Physician-Led Team-Based Care H-478.971

1. Our American Medical Association will make efforts to educate physicians on evidence-based artificial intelligence (AI) tools that can strengthen collaboration with non-physician clinicians through improved interdisciplinary communication, decision support, and workflow integration.
2. Our AMA supports the development and dissemination of best practices for AI integration into physician-led care teams, with emphasis on safety monitoring, transparency, cyber hygiene, and preserving physician leadership in clinical decision-making.
3. Our AMA encourages further research on AI interventions that demonstrate how AI can enhance physician-led team effectiveness, reduce misalignment of clinical risk perception, and improve coordination of care.

Citation: Res. 003, A-26

Prohibiting the Independent Practice of Medicine by Artificial Intelligence D-480.947

Our American Medical Association advocates for legislation and regulation related to the use of augmented and/or artificial intelligence (AI) in autonomous or semiautonomous circumstances in healthcare (including diagnostics, prescriptions, care management, or other functions) requiring that such tools must:

a. integrate with the physician-led team and be used at the direction of the treating physician,
b. respect the continuity of care and best practices related to transitions of care,
c. have transparent, auditable data demonstrating safety and efficacy,
d. be subject to relevant and appropriate regulations (including but not limited to those related to liability and documentation), and
e. adhere to our AMA policy on Augmented Intelligence in Health Care; and be it further

1. Our AMA will study emerging concepts around the regulation and licensure of autonomous and semiautonomous augmented and/or artificial intelligence performing clinical functions, and their potential impact on the profession and the physician-patient relationship.

Citation: Res. 238, A-26

Framework to Convey Evidence-Based Medicine in AI Tools Used in Clinical Decision Making D-480.950

1. Our American Medical Association recognizes and promotes the importance of transparency and explainability so physicians have sufficient information to make sound clinical decisions when using AI clinical decision support tools, which depending on the tool, may include information such as the grading of medical evidence including the data sources.
2. Our AMA will collaborate with medical specialty societies, relevant key parties, regulators, and AI developers to establish standards and develop a framework for evidence attribution, evaluation, and validation in AI clinical decision support systems.
3. Our AMA encourages medical education key parties to incorporate training on the utility, limitations and interpretation of evidence-based medicine practices when using AI tools in clinical decision-making.
4. Our AMA will monitor best practices and policies of AI transparency and evidence-based recommendations to improve the quality and reliability of patient care.
5. Our AMA supports that prior to the use of Artificial Intelligence (AI) in the medical record, training in the use of AI is highly recommended and to include the benefits of AI, as well as the potential harms that could exist in an AI generated document.

Citation: CSAPH Rep. 07, A-26; Res. 505, A-26;

Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence D-480.952

1. Our AMA recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence (AI) is used in the delivery of clinical care, in order to ensure the safe, transparent, and accountable use of AI-generated content in clinical and public-health settings.
2. Our AMA advocates that entities developing or deploying artificial-intelligence systems—including, but not limited to, generative AI, foundation models, neural networks, and other machine-learning approaches—in healthcare:
    a. establish and maintain a risk-based governance approach proportionate to the system's intended use and potential harm;
    b. implement relevant security measures and privacy protections;
    c. provide for clinically useful transparency, such as clear labeling of AI-generated outputs for end users, including disclosure of the algorithm's level of confidence in those outputs; and
    d. implement risk management approaches throughout the AI lifecycle with particular emphasis on appropriate monitoring of the system for safety, clinical effectiveness, accuracy, and reliability, to help ensure ethical and regulatory alignment across all deployment contexts.

Citation: Res. 507, A-25

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
    a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
    b. is transparent;
    c. conforms to leading standards for reproducibility;
    d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
    e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 505, A-26;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-26)

Introduced by: American College of Emergency Physicians

Subject: Fair and Clinically Appropriate EMTALA Investigations

Referred to: Reference Committee B

Whereas, the Emergency Medical Treatment and Labor Act (EMTALA) protects nondiscriminatory access to emergency medical screening and stabilizing treatment regardless of ability to pay; and

Whereas, EMTALA investigations are increasingly extending beyond questions of access, screening, stabilization, and appropriate transfer to retrospective review of the correctness of a physician's diagnosis or treatment, creating particular concern when reviewers lack sufficient EMTALA-specific training or emergency medicine expertise; and

Whereas, AMA policies support EMTALA's original patient-protection purpose, recognize that an EMTALA medical screening examination is the process necessary to determine with reasonable clinical confidence whether an emergency medical condition exists, and support due process for physicians subject to EMTALA enforcement; and

Whereas, an appropriate EMTALA medical screening examination does not require a correct final diagnosis, and retrospective quality-of-care concerns are appropriately addressed through established peer review, accreditation, licensure, and medical liability processes; and

Whereas, accurate and consistent EMTALA enforcement requires reviewers with appropriate EMTALA-specific training and clinical understanding and must distinguish physician conduct from institutional responsibilities outside a physician's control; therefore be it

RESOLVED, that our American Medical Association advocate for implementation and enforcement of EMTALA that preserves its guarantee of nondiscriminatory access to emergency care and:

1. distinguishes EMTALA compliance from retrospective quality-of-care review and evaluates clinical decisions based on information and resources reasonably available at the time;
2. requires standardized EMTALA-specific training and demonstrated competency for individuals conducting EMTALA investigations, including appropriate clinical expertise;
3. ensures that physicians are not held responsible for institutional administrative, staffing, on-call coverage, or resource deficiencies outside their control; and
4. requires corrective actions and sanctions to be related and proportionate to the nature and severity of the EMTALA deficiency identified, distinguishing administrative and documentation deficiencies from failures to screen, stabilize, or appropriately transfer.

(Directive to Take Action)

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

Received: 9/16/26

RELEVANT AMA POLICY

Definitions of "Screening" and "Medical Necessity" H-320.953

1. Our American Medical Association defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
2. Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."
3. Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:
4. in accordance with generally accepted standards of medical practice;
5. clinically appropriate in terms of type, frequency, extent, site, and duration; and
6. not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
7. Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".
8. Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
9. Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
10. Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.
11. Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations.

[CMS Rep. 13, I-98Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99Modified: Res. 703, A-03Reaffirmation I-06Reaffirmed: CMS Rep. 01, A-16Reaffirmed: CMS Rep. 05, A-23]

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950 Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA);
(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations;
(3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and.
(4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements.
[Sub. Res. 214, A-97Reaffirmation I-98Reaffirmation A-99Appended: Sub. Res. 235 and Reaffirmation A-00Reaffirmation A-07Reaffirmed: BOT Rep. 22, A-17]

EMTALA -- Major Regulatory and Legislative Developments D-130.982 Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA

regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.
[BOT Rep. 17, I-02Reaffirmation A-07Modified: BOT Rep. 22, A-17]

Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule D-130.976 Our AMA will: (1) ask the (EMTALA) Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the (EMTALA) regulations; (2) work with the (EMTALA) TAG and CMS to ensure that physicians staffing emergency departments and on-call emergency services be appropriately compensated for providing (EMTALA) mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by (EMTALA) for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing (EMTALA)-mandated services may bill, and from which those physicians shall receive prompt and fair compensation. [CME Rep. 3, A-05Reaffirmation A-07Reaffirmed in lieu of Res. 605, I-08Modified: CCB/CLRPD Rep. 2, A-14Reaffirmed: BOT Rep. 09, A-25]

Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975 Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status. [BOT Rep. 2, I-05Reaffirmation A-07Reaffirmed: CMS Rep. 01, A-17]

The Future of Emergency and Trauma Care D-130.971 Our American Medical Association will expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care. Our AMA, with the advice of specific specialty societies, will advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties. Our AMA will continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care. Our AMA will disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation. Our AMA supports demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care. Our AMA supports the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension. If an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.
[BOT Rep. 14, I-06Reaffirmation A-07Reaffirmation A-08BOT action in response to referred for decision Res. 204, A-11Appended: Res. 221, I-11Modified: CCB/CLRPD Rep. 2, A-14Reaffirmed: BOT Rep. 09, A-24]

Protecting Access to Emergency Abortion Care Under EMTALA D-5.995 Our AMA will advocate for the reinstatement of federal guidance affirming hospitals' obligation under EMTALA to provide necessary emergency pregnancy care, including, but not limited to, abortion care, to stabilize patients irrespective of state-level abortion restrictions. Our AMA will collaborate with relevant stakeholders, including federal agencies, Congress, medical societies, and patient advocacy groups, to educate policymakers and healthcare providers on EMTALA obligations concerning emergency pregnancy care, including, but not limited to, necessary abortion care. Our AMA task force established under AMA Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," will provide ongoing recommendations and updates on navigating conflicting state and federal regulations on emergency pregnancy care.
[Res. 014, A-25]

Confidentiality of Physician Peer Review D-130.993 (1) Our AMA will continue to assess the threat to the physician peer review process created by health care related federal regulation or statute, i.e. the Emergency Medical Treatment and Active Labor Act (EMTALA); and (2) If our AMA determines that Federal regulations or laws (including EMTALA) undermine state protections for the confidentiality of the peer review process, our AMA will take urgent action to establish protections for covering all Federal programs and related regulations for physician peer review.
[Res. 219. I-00Reaffirmed: BOT Rep. 6, A-10Modified: BOT Rep. 04, A-20]

On-Call Physicians H-130.948 Our AMA: (1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients. (b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients. (c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance. (d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services. (e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. (f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage. (g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care. (h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained. (i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff; (3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and (4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA.
[CMS Rep. 3, I-99Reaffirmation A-00Modified: Sub. Res. 217, I-00Reaffirmation I-01Reaffirmation A-07Appended and Reaffirmed: CMS Rep. 1, I-09Modified: Res. 818, I-17Reaffirmed: Res. 824, I-24]

Offsetting the Costs of Providing Uncompensated Care H-160.923 Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.
[CMS Rep. 8, A-05Reaffirmation A-07Modified: CMS Rep. 01, A-17]

Medicare's Appropriate Use Criteria Program H-320.940 Our American Medical Association will advocate to Congress and the Centers for Medicare & Medicaid Services (CMS) to delay implementation of and advance modifications to the Medicare Appropriate Use Criteria (AUC) Program in such a manner that exempts care mandated by EMTALA, adequately addresses technical and workflow challenges that add to clinician's administrative burden and practice expenses, maximizes alignment with the Quality Payment Program (QPP), and creates provider flexibility for the consultation of physician-developed, evidence-based and transparent AUC or advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow. [Res. 229, A-17Reaffirmed - BOT Action in response to referred for decision: Res. 245, A-19 and Res. 247, A-19Reaffirmation: A-22Modified: Res. 211, A-22]

Interpreter Services and Payment Responsibilities H-385.917 Our American Medical Association supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.
[CMS Rep. 5, A-11Reaffirmed: CMS Rep. 1, A-21Reaffirmed in lieu of: Res. 231, A-23]

Coverage of Emergency Services D-130.989 Our American Medical Association will promote legislation, regulation, or both to require all health payers to utilize the AMA's definition of "emergency medical condition". Our AMA will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy. Our AMA will in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules.
[Res. 229, A-01Reaffirmed: BOT Rep. 22, A-11Reaffirmed: BOT Rep. 7, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-26)

Introduced by: American Academy of Emergency Medicine, Florida Medical Association

Subject: Medical Staff Approval of Quality-of-Care Issues Prior to Exclusive Contract

Referred to: Reference Committee B

Whereas, federal regulations require hospitals to maintain an organized medical staff responsible for the quality of medical care provided to hospital patients, and require the governing body to ensure that contracted hospital services are provided safely and effectively [1,2]; and

Whereas, hospital accreditation standards similarly recognize the organized medical staff's responsibility for quality of care and its role in medical staff governance and accountability [3,4]; and

Whereas, exclusive contracts for physician services determine who may provide care within hospital departments and can directly affect physician staffing, continuity of care, medical staff privileges, and the quality and delivery of patient care; and

Whereas, AMA Policy H-225.985 supports medical staff review and recommendations before decisions to execute, renew, modify, or terminate exclusive contracts, and AMA Policy H-225.957 supports medical staff involvement in exclusive contracting and other hospital-based physician contracts [5,6]; and

Whereas, existing federal requirements and AMA policy provide for medical staff responsibility, involvement, and recommendations but do not require formal medical staff approval before a hospital establishes, replaces, renews, materially modifies, or terminates an exclusive physician services contract [1,2,5,6]; and

Whereas, recent disputes involving replacement of established emergency physician groups at PeaceHealth in Oregon and Valley Health in Virginia demonstrate the significant effects that changes in exclusive physician staffing contracts can have on physicians, medical staffs, patients, and the communities they serve; [7,8]; therefore be it

RESOLVED, that our American Medical Association amend current policy H-225.985 by addition and deletion to read:

Our American Medical Association believes that the medical staff should review, ~~and~~ make recommendations to the governing body, and ultimately approve arrangements related to exclusive contract ~~arrangements~~, prior to any decision being made, in the following situations:

1. ~~the~~ any decision to execute an exclusive contract in a previously open department or service;
2. ~~the~~ any decision to renew or otherwise modify an exclusive contract in a particular department or service;
3. ~~the~~ any decision to terminate an exclusive contract in a particular department or service; and

4. ~~prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.~~ (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services and hospital accrediting organizations to require the above recommendations (Directive to Take Action); and be it further

RESOLVED, that our AMA seek federal legislation requiring organized medical staff approval in the above listed situations, and develop model state legislation incorporating the same protections. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

REFERENCES

1. Centers for Medicare & Medicaid Services. 42 CFR § 482.22, Condition of Participation: Medical Staff.
2. Centers for Medicare & Medicaid Services. 42 CFR § 482.12, Condition of Participation: Governing Body.
3. The Joint Commission. Standard MS.01.01.01, Medical Staff Bylaws.
4. DNV. NIAHO Accreditation Requirements for Hospitals, MS.1, Organization, Accountability, and Responsibility.
5. American Medical Association. Policy H-225.985, Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract.
6. American Medical Association. Policy H-225.957, Principles for Strengthening the Physician-Hospital Relationship.
7. Office of Oregon Governor Tina Kotek. Governor Kotek and Speaker Fahey Applaud PeaceHealth for Changing Direction on Staffing Contract. May 6, 2026.
8. American College of Emergency Physicians and Virginia College of Emergency Physicians. Joint Statement on Due Process, Transparency, and Due Diligence in Emergency Medicine Contracting. April 14, 2026.

RELEVANT AMA POLICY

Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract H225.985
Our American Medical Association believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations:

the decision to execute an exclusive contract in a previously open department or service;
the decision to renew or otherwise modify an exclusive contract in a particular department or service;
the decision to terminate an exclusive contract in a particular department or service; and
prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.

Principles for Strengthening the Physician-Hospital Relationship H-225.957
The following twelve principles are our American Medical Association policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary

responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.

b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.

e. Establishing within the medical staff bylaws:

1. The qualifications for holding office.

2. The procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee.

3. The qualifications for election and/or appointment to committees, department and other leadership positions.

f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff

activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.

k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.

l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.

m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.

n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-26)

Introduced by: American Academy of Emergency Medicine, Florida

Subject: Clear Identification and Differentiation of Physicians and Nonphysicians in Clinical Rosters, Signage, and Listings

Referred to: Reference Committee B

Whereas, patients should be able to clearly identify and understand the professional qualifications and credentials of the individuals involved in their care; and

Whereas, studies have demonstrated that in clinical settings where physicians and non-physician practitioners, including nurse practitioners and physician assistants, provide care, patients may be unable to accurately determine whether they were evaluated or treated by a physician, a non-physician practitioner, or both [2]; and

Whereas, American Medical Association Policy H-405.951, Definition and Use of the Term Physician, defines the term “physician” and calls for references to physicians by health care entities to clearly distinguish physicians from nonphysicians; and

Whereas, AMA Policy H-405.968, Clarification of the Term “Provider” in Advertising, Contracts and Other Communications, supports requiring health care entities to identify health professionals by their recognized professional titles, so that their education, training, and licensure are clearly and unambiguously stated; and

Whereas, the AMA Truth in Advertising Campaign similarly supports clear and accurate identification of health professionals so that patients can easily understand the qualifications of the individuals providing their care; and

Whereas, signage, directories, websites, printed materials, and other clinician listings in some hospitals and clinical departments list physicians and nonphysician clinicians together, without clearly differentiating their professional roles; and

Whereas, listing physicians and nonphysicians separately would provide patients with greater transparency regarding the education, training, and professional qualifications of the individuals involved in their care and reduce the potential for confusion; therefore be it

RESOLVED, that our American Medical Association amend Policy H-405.951, Definition and Use of the Term Physician, by addition to read as follows:

Our AMA will advocate that, in all printed and electronic materials, signage, directories, and listings in clinical departments, hospitals, health care facilities, and similar settings, physicians be listed separately from nonphysicians and that this distinction be clear and unambiguous. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

REFERENCES

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5. American Medical Association. Opinion 10.8: Collaborative care. AMA Code of Medical Ethics. Accessed August 27, 2026. https://code-medical-ethics.ama-assn.org/ethics-opinions/collaborative-care
6. American Medical Association. Opinion 9.6.1: Advertising & publicity. AMA Code of Medical Ethics. Accessed August 27, 2026. https://code-medical-ethics.ama-assn.org/ethics-opinions/advertising-publicity

RELEVANT AMA POLICY

H-405.951 – Definition and Use of the Term Physician
H-405.968 – Clarification of the Term "Provider" in Advertising, Contracts and Other Communications
D-405.991 – Clarification of the Title "Doctor" in the Hospital Environment
H-35.984 – Proper Visual Identification of Nonphysicians Who See Patients
H-405.969 – Definition of a Physician
AMA Code of Medical Ethics Opinion 10.8 – Collaborative Care
AMA Code of Medical Ethics Opinion 9.6.1 – Advertising & Publicity

Definition and Use of the Term Physician H-405.951

1. Our American Medical Association Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Our AMA will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
    a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician.
    b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician.
    c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Our AMA urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Our AMA ensures that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.

6. Our AMA will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (*JAMA*) Editorial Governance Plan, which protects the editorial independence of *JAMA*.
7. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-26)

Introduced by: American Academy of Emergency Medicine, Florida Medical Association

Subject: Prohibiting Health Care Sale-Leaseback Transactions

Referred to: Reference Committee B

Whereas, AMA Policy H-160.891, as updated in 2025, lists various cautions for physicians contemplating sales of their practices to corporate investors, including concerns that are especially relevant when the investors are “Private Equity” (PE) firms; and

Whereas, when a PE firm purchases a corporation, the PE firm also typically imposes “Sale-Leaseback” terms, which obligate the PE-acquired entity to pay “rents” to the PE firm for the continued use of the same facilities that had been utilized without any “rent” obligation before the PE purchase, for the production goods and services [4]; and

Whereas, these Sale-Leaseback terms impose new debt for the acquired firm, via adding a new rent obligation payable to the PE owner. This new debt obligation causes a new negative impact upon the acquired corporation’s financial balance sheet, while also extracting capital from the acquired entity to the PE owner [4], as the PE firm seeks to further monetize its purchase; and

Whereas, this negative impact on the acquired corporation’s financial balance sheet typically leads to staffing or service cuts, increased patient charges, and other negative effects upon physicians, other health care workers, and the patients whom they serve; and

Whereas, this set of financial circumstances imposed by these rents lead to severe constraints on physician autonomy and authority, a topic addressed by AMA Policy HD-160.891; and

Whereas, nothing about this Resolution is to be construed as addressing the establishment of fair market rents that would be charged to clinical entities that did not ever own or partially own the physical facilities in which medical care is delivered, toward avoiding “Stark Law” penalties; therefore be it

RESOLVED, that our American Medical Association advocate for laws and regulations prohibiting purchasers or acquirers of hospitals, health systems, physician practices, and other health care entities, or their affiliates, from requiring or causing the acquired health care entity to enter into a sale-leaseback transaction involving its real property or other material assets (Directive to Take Action); and be it further

RESOLVED, that our AMA develops model federal and state legislation prohibiting the imposition of sale-leaseback provisions related to the purchase of health care entities as above. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

REFERENCES

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4. Wall Street Prep. Sale Leaseback. A Step by Step Guide to Understanding Sale Leaseback. February 20, 2024. https://www.wallstreetprep.com/knowledge/sale-leaseback/ Accessed June 28, 2026.

RELEVANT AMA POLICY

Corporate Investors and Other Corporate Entities H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:

a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity.

b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture.

c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.

d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.

e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.

f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment.

g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship.

h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity.

i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships.

j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to:

i. Determining which diagnostic tests are appropriate;

ii. Determining the need for referrals to, or consultation with another physician or licensed health professional;

iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient;

iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work;

v. Determining the content of patient medical records;

vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency;

vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities;

viii. Making decisions regarding coding and billing procedures for patient care services; and

ix. Approving the selection of medical equipment and medical supplies.

k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.

l. Clear protection and dispute resolution processes for physicians advocating on patient

care and quality issues should be incorporated into an agreement between physicians and corporate entities.

m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.

2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.

3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians in practicing in that specialty.

4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine.

5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.

(Rationale: AMA Policy and Advocacy is needed to specify that the Private Equity practice of the charging of “rents” must be constrained, because this PE business practice adds new expenses to health care enterprises’ corporate “bottom lines”, precipitates service cutbacks, drives increases in patient charges, and threatens physician autonomy).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-26)

Introduced by: Washington

Subject: Establishing Product Liability for Clinical Augmented Intelligence Failures

Referred to: Reference Committee B

Whereas, the U.S. Food and Drug Administration (FDA) has authorized over 1,450 AI-enabled medical devices for marketing in the United States (US) as of December 2025, with approximately 76 percent concentrated in radiology alone (1); and

Whereas, the FDA cleared 295 new AI-enabled medical devices in 2025, the highest single-year total for AI/ML-enabled device authorizations in the agency's history, reflecting an accelerating pace of AI deployment into clinical practice that outstrips the development of corresponding legal and liability frameworks; and

Whereas, a systematic review published in JAMA found that of 717 FDA-authorized radiology augmented intelligence and machine learning (AI/ML) devices with available documentation, only 5 percent underwent prospective testing, only 8 percent included human-in-the-loop evaluation, and only 29 percent incorporated any clinical testing, meaning the vast majority of AI/ML tools now used in clinical settings were cleared without rigorous real-world validation (2); and

Whereas, ninety-seven percent of all FDA-authorized AI/ML medical devices were cleared through the 510(k) pathway, which requires only a demonstration of "substantial equivalence" to a previously cleared device and does not require the clinical trial data demonstrating safety and effectiveness that the more rigorous Premarket Approval (PMA) pathway demands; and

Whereas, clinical AI tools are now used across nearly every medical specialty, from reading imaging scans to screening for cancer to recommending treatments, and when these tools get it wrong, patients are directly harmed; and

Whereas, the journal Radiology has documented a case in which an FDA-cleared AI algorithm misdiagnosed a finding as an intracranial hemorrhage in a patient who was ultimately diagnosed with an ischemic stroke, illustrating the real-world consequences of AI tool failures in clinical settings (3); and

Whereas, in Dickson v. Dexcom Inc. (4), a federal court considered product liability claims arising from an FDA-authorized continuous glucose monitor that allegedly malfunctioned, contributing to a dangerous hypoglycemic episode that caused a motor vehicle crash; although the Dexcom G6 is not itself an AI/ML-enabled device, as analyzed by Gerke and Simon in Science (2025), the case is directly relevant to AI/ML-enabled medical device manufacturers because many similar monitoring and diagnostic tools are now being developed using AI/ML, and the court’s ruling addresses the critical question of whether manufacturers can use the FDA’s De Novo authorization pathway to block product liability claims; and

Whereas, the Dickson decision is significant because, as more AI-enabled medical devices enter the market through the FDA's 510(k) and De Novo pathways, manufacturers may attempt to invoke federal preemption to shield themselves from state product liability claims, and the court's analysis of the boundaries of that preemption defense will shape the liability landscape for AI/ML-enabled devices for years to come; and

Whereas, established product liability law holds that when a medical device fails due to a defect in design, manufacturing, or warnings, the manufacturer bears liability for the resulting patient harm, not the physician who used the device, as demonstrated by the DePuy ASR hip implant litigation in which Johnson & Johnson paid over $2.5 billion in settlements for design defects while no liability was imposed on the orthopedic surgeons who implanted the devices, the Philips Respironics CPAP recall in which Philips paid $1.1 billion for device defects while no liability was imposed on the sleep medicine physicians who prescribed the devices, and the Medtronic SynchroMed implantable infusion pump Class I recall in which liability was directed at the manufacturer, not the physicians who implanted the pumps; and

Whereas, in each of these cases, the physician used the device as intended, had no ability to detect or correct the underlying defect, and was not held liable. Physicians who rely on AI tools that produce erroneous outputs due to defects in the algorithm, training data, or software design are in the identical position; and

Whereas, the FDA regulates AI-enabled clinical software as a medical device, yet unlike hip implants, pacemakers, and infusion pumps, AI software is not consistently treated under product liability law, meaning manufacturers of physical devices bear liability for defects while manufacturers of AI software performing equivalent clinical functions do not; and

Whereas, under current law, physicians face malpractice liability when they appropriately rely on an FDA-cleared AI tool that produces a defective output, bearing the legal risk for a product defect they had no ability to detect, control, or correct; and

Whereas, the Restatement (Third) of Torts: Products Liability already holds manufacturers strictly liable for defective products, including medical devices, and this framework should logically extend to AI-enabled medical software; and

Whereas, in May 2024, the American Law Institute approved a new Restatement of Torts: Medical Malpractice that shifts the standard of care toward evidence-based "reasonableness," meaning physicians may now face liability both for failing to use AI tools and for relying on AI tools that fail; and

Whereas, the European Union's revised Product Liability Directive (EU 2024/2853), in force since December 2024, explicitly defines software including AI systems as a "product" subject to strict manufacturer liability, with full Member State implementation required by December 2026, while the United States has no equivalent framework, leaving American physicians exposed to liability for AI product failures that EU law assigns to the manufacturer; and

Whereas, existing AMA Policy H-480.939 already states that "developers of autonomous AI systems with clinical applications are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability," yet no legal framework enforces this principle; and

Whereas, physicians cannot inspect, audit, modify, or independently verify the algorithms underlying AI tools they are required or encouraged to use, and are frequently bound by vendor

licensing agreements that prohibit reverse engineering or independent testing of the software; and

Whereas, malpractice insurers are already responding to AI-related risk by introducing policy riders and exclusions for AI-assisted clinical decisions, which threatens to shift financial exposure onto individual physicians for product failures outside their control; and

Whereas, physicians are increasingly required by their employers or hospital systems to use specific AI tools as part of their clinical workflow, often with no ability to opt out, choose an alternative, or participate in the selection or validation of the system, yet under current law these same physicians bear the full malpractice liability when a mandated AI tool produces a defective output; and

Whereas, no physician is held liable when an MRI machine malfunctions, a lab analyzer returns an erroneous result, or an infusion pump delivers a wrong dose, because the defect originates in the equipment, not the physician's judgment, and the same principle should apply when an AI tool produces a defective clinical output; and

Whereas, at least one AI manufacturer has already demonstrated that vendor-assumed liability works: Digital Diagnostics, maker of IDx-DR, the first FDA-authorized autonomous AI diagnostic device, carries its own medical malpractice insurance and assumes liability for injuries arising from the system's decisions (Price, Gerke, and Cohen, 2024), proving this is not theoretical but already in practice; and

Whereas, physicians who use AI tools as intended, within the scope of the tool’s marketed and cleared indications, and who exercise appropriate clinical judgment in conjunction with those tools, should not bear liability for errors that originate in the AI product itself; therefor be it

RESOLVED, that our American Medical Association advocate for federal and state legislation establishing that when a clinical AI product produces an erroneous output and a physician has used the product as intended while exercising appropriate clinical judgment, the liability for resulting patient harm constitutes a product liability claim against the AI vendor, manufacturer, or distributor, not a medical malpractice claim against the physician (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that AI vendors and manufacturers be held to the same product liability standards as manufacturers of other medical devices under the Restatement (Third) of Torts: Products Liability, including strict liability for manufacturing defects, and liability for design defects and failure to provide adequate instructions or warnings (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation requiring that AI vendors and manufacturers maintain product liability insurance adequate to cover claims arising from AI product failures in clinical settings, and that such insurance obligations be a condition of FDA marketing authorization (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation prohibiting contractual provisions, including end-user license agreements and vendor contracts, that attempt to shift product liability for AI tool failures from the manufacturer to the physician or health system end user (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal legislation requiring AI vendors and manufacturers to disclose known failure rates, limitations, and performance data for their clinical AI products, including performance across different patient populations, so that physicians can make informed decisions about the clinical appropriateness of AI tool outputs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that when a health system, hospital, payer, or other entity mandates the use of a specific AI tool and that tool produces an error resulting in patient harm, the mandating entity and the AI vendor bear the liability, and the physician who was required to use the tool and exercised appropriate clinical judgment is not liable for errors originating in the mandated product. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-26)

Introduced by: American Society of Plastic Surgeons; Michigan State Medical Society

Subject: Comprehensive Reform of the No Surprises Act Independent Dispute Resolution Process

Referred to: Reference Committee B

Whereas, the No Surprises Act (NSA) was enacted to protect patients from unexpected out-of-network medical bills while establishing an Independent Dispute Resolution (IDR) process for resolving certain payment disputes between health plans and physicians and other health care providers;[1] and

Whereas, since its launch in April 2022, the federal IDR process has received millions of disputes, substantially exceeding initial expectations and contributing to administrative burden, delays, and increased costs;[2] and

Whereas, eligibility determinations have been a significant source of IDR delay and administrative burden, and more than one million disputes were closed as ineligible between implementation of the federal IDR process and May 31, 2026;[3] and

Whereas, the 2026 Federal IDR Operations Final Rule established important reforms to improve eligibility determinations, communication between parties, and IDR efficiency, but additional safeguards are needed to discourage both submission of ineligible disputes and inappropriate payer eligibility challenges to otherwise valid disputes;[2,4] and

Whereas, final IDR determinations are binding under federal law, yet physicians continue to report late, incomplete, or unpaid IDR awards, as well as inappropriate patient cost-shifting following IDR determinations;[5,6] and

Whereas, the bipartisan No Surprises Act Enforcement Act (H.R. 4710/S. 2420), supported by the American Medical Association and numerous state and national medical organizations, would strengthen enforcement of statutory payment requirements and impose consequences for failure to comply with final and binding IDR determinations;[5,7,8] and

Whereas, the NSA's notice-and-consent provisions were intended to provide a limited mechanism through which eligible patients may voluntarily waive certain protections, and practices that condition scheduling, preauthorization, coverage, or access to care upon surrender of NSA protections may undermine the law's fundamental patient-protection purpose;[1] and

Whereas, health plan practices that shift financial responsibility to patients following IDR determinations or penalize or pressure facilities because of lawful out-of-network physician participation may undermine patient protections, physician contracting, and access to care;[6] and

Whereas, the integrity and long-term sustainability of the IDR process also requires accountability for systematic submission of ineligible disputes, appropriate oversight of high-volume filing entities and third-party IDR intermediaries, and reasonable, carefully designed safeguards against extreme outlier provider offers; and

Whereas, concerns remain regarding the accuracy, transparency, and consistency of Qualifying Payment Amount (QPA) calculations, making appropriate disclosure, auditing, and enforcement important to ensuring that QPAs comply with applicable federal requirements;[4] therefore be it

RESOLVED, that our American Medical Association advocate for comprehensive reform of the No Surprises Act Independent Dispute Resolution process, with particular emphasis on improving eligibility determinations, including appropriate pre-submission eligibility verification and attestation, timely and specific standards for payer eligibility challenges, meaningful accountability for patterns of ineligible filings or inappropriate eligibility challenges, and a consistent mechanism for resolving complex eligibility determinations before they unnecessarily burden the IDR process (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to support passage and implementation of the No Surprises Act Enforcement Act and advocate for additional mechanisms necessary to ensure timely compliance with final and binding IDR determinations, meaningful enforcement and recovery of unpaid or underpaid awards, appropriate remedies for noncompliance, and transparent reporting of health plan compliance with federal IDR payment requirements (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for preservation and strengthening of the patient protections underlying the No Surprises Act, including prohibiting practices that improperly increase patient financial responsibility following an IDR determination; condition scheduling, preauthorization, coverage, or access to care upon waiver of NSA protections; or penalize or coerce facilities or physicians solely because of lawful out-of-network physician participation in patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA support balanced safeguards to promote the integrity and sustainability of the federal IDR process, including accountability for systematic ineligible filings; appropriate oversight, registration, and transparency of high-volume filing entities and third-party IDR intermediaries; establishment of a reasonable, transparent, geographically adjusted cap on provider bids submitted through the federal IDR process, based upon an independent and credible benchmark, to prevent extreme outlier offers while preserving meaningful access to independent dispute resolution and appropriate reimbursement for complex, high-acuity care, and other out-of-network services; and accurate calculation, appropriate disclosure, auditing, and enforcement of Qualifying Payment Amount requirements. (New HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-26)

Introduced by: American Society of Plastic Surgeons; Michigan State Medical Society

Subject: Strengthening the Patients First Act and Medicare Physician Payment Reform

Referred to: Reference Committee B

Whereas, the continued instability of the Medicare physician payment system threatens the financial sustainability of physician practices and patients' access to care; and

Whereas, years of inadequate Medicare physician payment updates and payment reductions have occurred while the costs of operating physician practices have continued to rise, creating an increasing disconnect between Medicare reimbursement and the cost of providing patient care;[1,2] and

Whereas, H.R. 9693, the *Patients First Act of 2026*, represents a significant congressional effort to reform Medicare physician payment, including reforms to the Medicare Physician Fee Schedule intended to improve payment stability, such as changes addressing budget neutrality, utilization estimates, conversion factor volatility, and physician practice expense inputs, as well as provisions to modernize quality reporting, reduce administrative burden, and strengthen physician participation in value-based care;[3] and

Whereas, these payment stability reforms represent meaningful improvements to the Medicare Physician Fee Schedule but must be accompanied by an adequate annual physician payment update to achieve long-term payment stability; and

Whereas, the *Patients First Act* proposes an annual physician payment update based on the Medicare Economic Index (MEI), which is a measure of inflation in the costs of maintaining a physician practice, minus one percentage point, which would not fully account for increases in the costs measured by the MEI;[3] and

Whereas, the American Medical Association has advocated for an inflation-based Medicare physician payment update tied to the MEI to better reflect rising physician practice costs;[5] and
Whereas, the *Patients First Act* proposes the Patient Outcome Improvement National Tabulation System (POINTS) as a successor framework to the Merit-based Incentive Payment System (MIPS), while retaining a performance-based physician payment structure;[3] and
Whereas, meaningful reform of physician quality and performance measurement should reduce administrative burden, utilize clinically relevant measures, meaningfully engage the specialties and physicians it affects;[5,6] therefore be it

RESOLVED, that our American Medical Association advocate that Medicare physician payment reform proposals, including the *Patients First Act of 2026*, provide annual physician payment updates no less than the full MEI (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for preservation and advancement of Medicare Physician Fee Schedule reforms that improve payment stability, including appropriate reforms to budget neutrality, utilization estimates, conversion factor volatility, and regular updating of physician practice expense inputs (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that any replacement or reform of the Merit-based Incentive Payment System, including the proposed Patient Outcome Improvement National Tabulation System (POINTS), meaningfully reduce administrative burden; utilize clinically relevant measures that appropriately account for differences among medical specialties, practice settings, and patient populations; provide meaningful representation and input from affected specialties and practicing physicians in the development and review of such measures; and provide appropriate transition protections for existing clinically valid MIPS and Qualified Clinical Data Registry (QCDR) measures. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

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AMERICAN MEDICAL ASSOCIATION

Resolution: 218
(I-26)

Introduced by:	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Subject:	Firearm Manufacturer Accountability for the Cost of Gun Violence
Referred to:	Reference Committee B

Whereas, firearm injury is the number one cause of death for children, teens, and pregnant women;[1,2] and

Whereas, firearm injury is the most lethal and common method for suicide;[3] and

Whereas, the estimated total cost of firearm injury to American society, when including lost productivity and statistical value of lives lost, is approaching half a trillion dollars per year;[4] and

Whereas, the cost of firearm injury is disproportionately borne by Black communities and Medicaid and self-pay patients;[5] and

Whereas, despite this staggering financial and human toll, firearm manufacturers have been largely exempt, with few exceptions, from indirect regulation through tort liability since the 2005 federal law the Protection in Lawful Commerce in Arms Act;[6] and

Whereas, for over a century, no-fault systems like Workers' Compensation have successfully served as a proof-of-concept that legislation can work to balance economic responsibility with public welfare, demonstrating that these frameworks can protect communities and build trust in industries; and

Whereas, the tobacco, opioid, and other comparable industries have been held financially accountable for their for-profit activities' exorbitant societal costs;[7,8] and

Whereas, several types of state gun laws have been shown to be associated with a significant reduction in firearm-related violence and suicide, averting thousands of deaths and decreasing firearm suicide rates by up to 25%;[9–12] and

Whereas, there are several manufacturer-led gun modifications that can reduce the risk of firearm-related injury, misuse and theft, including user-authorization, automatic locking mechanisms, chamber/load-status indicators, magazine-disconnect safety mechanisms, tamper-resistant designs, theft-resistant features, and built-in forensic identifiers;[13,14] and

Whereas, gun manufacturers have been resistant to universally including these features in their firearms and have consistently lobbied heavily against federal and state legislation that seeks to regulate firearms or increase industry accountability;[15] and

Whereas, government-imposed financial disincentives have historically proved to be effective in motivating change across industries, including but not limited to carbon tax to reduce emissions,[16] excise taxes to phase out chlorofluorocarbons,[17] and significant HIPAA violation fines to improve hospital security and confidentiality measures;[18] and

Whereas, at the time of the writing of this resolution, Illinois and New Jersey have under active consideration state legislation that would require firearm manufacturers to financially contribute to a state fund aimed at supporting victims of gun violence in an amount proportional to the public costs associated with injuries and deaths related to their company's firearms;[19,20] and

Whereas, the Responsibility in Firearm Legislation (RIFL) Act proposed in Illinois has garnered widespread support, including from over 60 endorsing partner organizations representing both healthcare entities and victims of gun violence;[21] and

Whereas, legislation that ties fees on firearm manufacturers to the damage caused by their weapons creates a financial incentive for manufacturers to invest in prevention of firearm-related violence and to make their weapons safer and less prone to theft, tampering, and outfitting for mass murder; and

Whereas, manufacturer-led investment in firearm-related violence prevention and safer firearms would be expected to not only save lives but also decrease healthcare costs currently absorbed by patients, taxpayers, and hospitals; and

Whereas, in AMA policy H-145.985, our AMA already supports surtaxes on firearm manufacturers to generate revenue for health and law enforcement activities related to the prevention and control of violence in U.S. society, but does not tie the size of these surtaxes to the damage caused by the manufacturer, and thereby provides no financial incentive for manufacturer-led investments in increased firearm safety and violence prevention; and

Whereas, our AMA has robust existing policy that describes the gun violence epidemic as a public health crisis and recognizes the duty of our AMA to fight for policies that might reduce firearm injuries; therefore be it

RESOLVED, that our American Medical Association supports legislative, regulatory, and national advocacy efforts to require firearm manufacturers to pay a proportion of the public costs associated with firearm injuries and deaths related to their products (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for policies that would direct the revenue from firearm manufacturer harm-related payments towards evidence-based methods of firearm-related violence prevention and to support people and communities affected by firearm-related violence. (Directive to Take Action)

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

Received: 9/16/26

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Relevant AMA Policy

Further Action to Respond to the Gun Violence Public Health Crisis D-145.992

1. Our American Medical Association will make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence.
2. Our AMA will establish a task force to focus on gun violence prevention including gun-involved suicide.
3. Our AMA will support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics.
4. Our AMA will collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety.
5. Our AMA will report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

Firearms and High-Risk Individuals H-145.972

1. Our American Medical Association supports the establishment of laws allowing family members, intimate partners, household members, and state, federal, local, and tribal law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence.
2. Our AMA supports the establishment of laws and procedures through which physicians and other medical professionals can, in partnership with appropriate parties, contribute to the inception and development of such petitions.
3. Our AMA supports the prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms.
4. Our AMA supports the expanding domestic violence restraining orders to include dating partners.
5. Our AMA supports the requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons.
6. Our AMA supports the requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System.
7. Our AMA supports efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

Prevention of Firearm Accidents in Children H-145.990

1. 1. Our American Medical Association supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to:
    a. inquire as to the presence of household firearms as a part of childproofing the home;
    b. educate patients to the dangers of firearms to children;
    c. encourage patients to educate their children and neighbors as to the dangers of firearms; and
    d. routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms.
2. Our AMA encourages state medical societies to work with other organizations to increase public education about firearm safety.
3. Our AMA encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.
4. Our AMA supports enactment of Child Access Prevention laws and other types of comprehensive safe storage laws that are consistent with AMA policy.
5. Our AMA and all interested medical societies will educate the public about:
    a. best practices for firearm storage safety;
    b. misconceptions families have regarding child response to encountering a firearm in the home; and
    c. the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter.

Control of Non-Detectable Firearms H-145.994

1. Our American Medical Association supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms.
2. Our AMA supports a ban on the production and distribution of 3D firearm digital blueprints.

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Firearm Related Injury and Death: Adopt a Call to Action H-145.973

Our American Medical Association endorses the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our American Medical Association supports:
    a. federal and state research on firearm-related injuries and deaths;
    b. increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy;
    c. encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety;
    d. the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes;
    e. encouraging local projects to facilitate the low-cost distribution of gun locks in homes;
    f. encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and

   g. encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA:
   a. recognizes the role of firearms in suicides,
   b. encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and
   c. encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing Extreme Risk Protection Orders in their individual states.
6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.
7. Our AMA and all interested medical societies will:
   a. educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families;
   b. educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of our American Medical Association to:
1. Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
   a. Mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers.
   b. Bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21.
   c. Bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel).
   d. The imposition of significant licensing fees for firearms dealers.
   e. The imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society.
   f. Mandatory destruction of any weapons obtained in local buy-back programs.
2. Support legislation outlawing the Black Talon and other similarly constructed bullets.

3. Our AMA support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
4. Our AMA opposes “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
5. Our AMA supports the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Gun Violence as a Public Health Crisis D-145.995

1. Our American Medical Association will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution.
2. Our AMA will actively lobby Congress to lift the gun violence research ban.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our American Medical Association recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore our AMA:
    a. encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
    b. urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
    c. urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
    d. urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
    e. encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
    f. urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
    g. strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.
4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.
5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-26)

Introduced by:	American Academy of Child and Adolescent Psychiatry, Medical Student Section
Subject:	Opposing the Use of Artificial Intelligence to Produce Child and Adolescent Sexual Exploitative Material
Referred to:	Reference Committee B

Whereas, artificial intelligence (AI) is rapidly growing with the ability to produce more realistic media, including deepfakes or synthetic media where the human eye is unable to distinguish between real and fake[1]; and

Whereas, there are no federal guidelines regulating AI use at this time[2]; and

Whereas, AI may be employed to produce child sexual abuse material (CSAM) depicting minors under the age of 18 participating in sexually explicit content or being exploited sexually[3,4]; and

Whereas, across 11 countries, at least 1.2 million children have had their images manipulated into sexually explicit deepfakes using AI[3]; and

Whereas, a study conducted among American adolescents found that 55.3% reported creating and 54.4% reported receiving at least one AI-generated nude image[5]; and

Whereas, 36.3% of American adolescents experienced having a non-consensual AI-generated image created and 33.2% experienced having at least one AI-generated image non-consensually shared[5]; and

Whereas, in August 2026, *United States vs. Steven Anderegg* ruled that a person can privately own AI-generated CSAM as protected by the First Amendment[6]; and

Whereas, several leaders in the field of AI agree that greater federal oversight, alongside slowing the pace of development, is needed[7]; and

Whereas, there is a current “alignment problem” in AI, defined as the risk of AI becoming discordant with human values (e.g., avoiding the creation of child exploitative material)[8]; and

Whereas, AI-generated deepfakes directly harm children and may severely impact their mental health and jeopardize their safety if they are recognized by perpetrators[9,10,11]; therefore, be it

RESOLVED, that our American Medical Association oppose the use of artificial intelligence to produce any sexual and other exploitative material of minors (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation that opposes the use of artificial intelligence to produce sexual and other exploitative material of minors (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage State Delegations to adopt similar resolutions and advocate at the state level. (New HOD Policy

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

Received: 9/16/26

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RELEVANT AMA POLICY

Child Pornography H-60.990

Our AMA: (1) encourages and promotes awareness of child pornography issues among physicians; (2) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (3) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; (4) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities; (5) supports efforts to mitigate the negative public health impacts of pornography as it relates to vulnerable populations; and (6) supports research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence.
[BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Appended: Res. 913, I-18; Appended: Res. 528, A-19]

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

1. Our American Medical Association recognizes the positive role of the Internet in providing health information to children and youth.
2. Our AMA recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
3. Our AMA supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.

4. Our AMA encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
5. Our AMA supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.
6. Our AMA actively support legislation that would strengthen child-centric content protection by internet service providers and/or search engines in order to limit the access of pornography to minors on the internet and mobile applications.

[BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16; Appended: Res. 926, I-22]

Identifying and Reporting Suspected Child Abuse H-515.960

1. Our American Medical Association recognizes that suspected child abuse is being underreported by physicians.
2. Our AMA supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention.
3. Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse.
4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse.
5. Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust.
6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims.
7. Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers.
8. Our AMA will support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.

   [CSAPH Rep. 2, I-09; Appended: Res. 411, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-26)

Introduced by: Senior Physicians Section

Subject: Advocating for the Older Americans Act and Community-Based Services for Older Adults

Referred to: Reference Committee B

Whereas, The Older Americans Act (OAA) is the primary federal statute supporting comprehensive services that allow older adults to successfully “age in place”; and

Whereas, OAA programs, including home and congregate nutrition services, caregiver support, and chronic disease self-management, all of which improve health outcomes and prevent avoidable hospitalization and institutionalization with commensurate cost savings[1]; and

Whereas, reauthorization for the OAA and adequate funding has been caught up in congressional dysfunction leading to diminished services while the demand continues to be driven by demographics; and

Whereas, both the One Big Beautiful Bill Act (OBBBA) and recent proposed rule changes to the Affordable Care Act marketplace will indirectly increase demand further[2]; therefore be it

RESOLVED, that our American Medical Association advocate for the reauthorization and adequate funding for the Older Americans Act (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose federal or state policies that would reduce access, eligibility or funding for the Older Americans Act (OAA) programs (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with appropriate organizations to educate legislators and policymakers of the health benefits and fiscal effectiveness of the Older Americans Act (OAA). (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

REFERENCES

1. Administration for Community Living. *Chronic Disease Self Management Education Programs*. Accessed August 24, 2026. (acl.gov)
2. Centers for Medicare & Medicaid Services. 2025 Marketplace Integrity and Affordability Proposed Rule. CMS. March 10, 2025. (ama-assn.org)

RELEVANT AMA POLICY

H-440.817 Protecting the Integrity of Public Health Data Collection

Our AMA will advocate: (1) for the inclusion of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries; including but not limited to the Current Population Survey, United States Census, National Survey Survey Older Americans Act Participants, all-payer claims databases; and (2) against the removal of demographic data inclusive of sexual orientation and gender identity in national and state surveys, surveillance systems, and health registries without plans for updating measures of such demographic data.
[Res. 002, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-26)

Introduced by:	International Medical Graduates Section, Resident and Fellow Section
Subject:	Preserving Duration of Status for J-1 Physicians in Graduate Medical Education
Referred to:	Reference Committee B

Whereas, international medical graduates (IMGs) constitute approximately 25 percent of the U.S. physician workforce, nearly 325,000 physicians[6]; and that J-1 exchange visitor physicians, sponsored by Intealth, provide essential training and patient care in communities facing physician shortages; and

Whereas, under the longstanding Duration of Status (D/S) framework, J-1 physicians remained in lawful status for the full duration of their authorized training program, generally capped at seven years[2], subject to Intealth's rigorous annual sponsorship review and SEVIS oversight[3]; and

Whereas, the Department of Homeland Security has replaced D/S with a fixed four-year admission period[1], requiring J-1 physicians in training programs exceeding four years, or needing unanticipated extensions for illness, remediation, or board examinations, to separately file for a USCIS extension of stay; creating administrative burdens, legal costs, and delays that risk disrupting training and patient care; and

Whereas, our AMA formally urged the Department of Homeland Security to exclude J-1 physicians and their J-2 dependents from the rule, noting that approximately 17,000 J-1 physicians train at more than 770 teaching hospitals nationwide and that USCIS extension-of-stay processing times of six to nineteen months are incompatible with the annual residency and fellowship contract cycle[9]; and

Whereas, Intealth, the designated J-1 physician sponsor, formally recommended that the Department of Homeland Security preserve D/S or, alternatively, adopt a fixed admission period equal to the full training program plus six months, expand VSRE/SEVIS integration, and confirm that physicians may change training programs during a pending extension[11]; that Intealth has begun issuing multi-year Forms DS-20194 consistent with the U. S. Citizenship and Immigration Service's (USCIS) existing deference policy[10]; and that HRSA projects a shortage of approximately 187,000 physicians by 2037[12]; and

Whereas, maintaining the Duration of Status, or an equivalent physician-specific mechanism, would allow J-1 physicians to complete their authorized medical training without unnecessary immigration-related interruptions, while preserving existing federal oversight, Intealth sponsorship requirements, and the established limits on J-1 physician training; therefore be it

RESOLVED, that our American Medical Association advocate that the Department of Homeland Security maintain or restore the Duration of Status for J-1 physicians in graduate medical education, or, if not restored, allow a fixed admission period equal to the full training program plus six months (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the U. S. Citizenship and Immigration Service provide premium processing, deference to Intealth's multi-year DS-2019 sponsorship, automatic J-2 work-authorization extensions, and VSRE/SEVIS integration for J-1 extension-of-stay applications (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Department of Homeland Security, the U. S. Citizenship and Immigration Service, Intealth, and other stakeholders to confirm J-1 physicians may change training programs or employers during a pending extension of stay, minimizing administrative burdens on physician training and patient care. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

REFERENCES

1. AMA opposition to the 2020 proposal to eliminate J-1 Duration of Status - In 2020, our AMA joined the American Hospital Association, leading medical education organizations, and a bipartisan group of 36 members of Congress in formally opposing an earlier Department of Homeland Security proposal to eliminate Duration of Status for J-1 physicians, warning that the change would disrupt IMG training, threaten patient access to care, and sever the pipeline of physicians into the Conrad State 30 program.
2. U.S. Department of Homeland Security, "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media," Final Rule, 90 Fed. Reg. 44,976 (July 17, 2026) (DHS Docket No. ICEB-2025-0001), effective Sept. 15, 2026. https://www.federalregister.gov/documents/2026/07/17/2026-14439/
3. U.S. Citizenship and Immigration Services, USCIS Policy Manual, Vol. 2, Part D, Ch. 3, "Terms and Conditions of J Exchange Visitor Status" (describing duration of status and the general seven-year maximum program duration). https://www.uscis.gov/policy-manual/volume-2-part-d-chapter-3
4. U.S. Citizenship and Immigration Services, "Exchange Visitors." https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/exchange-visitors
5. AMA Comment Letter to DHS on the Fixed Time Period of Admission Rule (Sept. 24, 2025)
6. Our AMA formally urged DHS to exclude J-1 physicians and their J-2 dependents from the proposed rule, stating that J-1 physicians are "already thoroughly vetted and carefully monitored, making additional guardrails redundant for this cohort," and that the proposed extension-of-stay process would be "duplicative, unnecessary, and wasteful" given existing Intealth and SEVIS oversight. The comment letter is a matter of public record filed with DHS under Docket No. ICEB-2025-0001
7. Intealth's Comment Letter to DHS: Summary of Policy Recommendations (Sept. 2025) - Intealth, the sole Department of State-designated sponsor of J-1 physicians, submitted formal comments to DHS recommending: (a) preservation of Duration of Status for J-1 physicians; (b) if D/S is not preserved, a fixed admission period equal to the full approved training program plus six months; (c) expansion of the Voluntary Self-Report Exit (VSRE) pilot program integrated with SEVIS; (d) express regulatory language confirming that J-1 physicians may change training programs or employers, with an appropriately endorsed Form DS-2019, during the pendency of an extension-of-stay application, and a corresponding update to Form M-274, Employer Handbook; (e) premium processing service for extension-of-stay applications; and (f) automatic extension of work authorization for J-2 Employment Authorization Document holders who timely file renewal applications. This resolution incorporates each of these recommendations.
8. Intealth (ECFMG), "Update on U.S. Department of Homeland Security Rule to End Duration of Status Framework for J, F, and I Visa Holders," ECFMG/Intealth News, July 16, 2026. https://www.ecfmg.org/news/2026/07/16/update-on-u-s-department-of-homeland-security-rule-to-end-duration-of-status-framework-for-j-f-and-i-visa-holders/
9. Intealth's multi-year Form DS-2019 recommendation - Beginning fall 2026, Intealth plans to issue Forms DS-2019 reflecting a physician's full approved training program rather than annual increments, specifically to reduce administrative burden and align sponsorship documentation with the new fixed-period admission framework. Intealth has stated it will continue working with training programs, national GME organizations, and government stakeholders to identify further opportunities to mitigate the rule's impact. This resolution builds on that recommendation by asking USCIS to give appropriate evidentiary weight to Intealth's multi-year sponsorship determination when adjudicating extension-of-stay applications, consistent with USCIS's own existing deference policy.
10. American Medical Association, "Advocacy in action: Clearing IMGs' route to practice." https://www.ama-assn.org/education/international-medical-education/advocacy-action-clearing-imgs-route-practice

11. 7. American Medical Association, "Misguided J-1 visa proposal is a 'solution in search of a problem'," Nov. 23, 2020. https://www.ama-assn.org/education/international-medical-education/misguided-j-1-visa-proposal-solution-search-problem
12. American Medical Association, House of Delegates, International Medical Graduates Section, Resolution, "Ensuring Timely J-1 Visa Processing to Protect IMG Physicians" (Interim 2025). https://www.ama-assn.org/system/files/i25-imgs-resolution-2.pdf
13. American Medical Association (John Whyte, MD, MPH, EVP/CEO), Comment Letter to DHS Secretary Kristi Noem re: DHS Docket No. ICEB-2025-0001 / RIN 1653-AA95, "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure...," Sept. 24, 2025. https://downloads.regulations.gov/ICEB-2025-0001-21954/attachment_1.pdf
14. U.S. Citizenship and Immigration Services, USCIS Policy Manual, Vol. 2, Part A, Ch. 4, "Extension of Stay, Change of Status, and Extension of Petition Validity" (deference to prior determinations of eligibility absent material error, material change, or new material information). https://www.uscis.gov/policy-manual/volume-2-part-a-chapter-4
15. Intealth, Comment Letter to U.S. Department of Homeland Security, Re: DHS Docket No. ICEB-2025-0001, "Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media" -- Summary of Policy Recommendations (Sept. 2025). On file with the AMA International Medical Graduates Section; a publicly posted copy was not independently located on regulations.gov at the time of drafting.
16. Health Resources and Services Administration, National Center for Health Workforce Analysis, "Physician Workforce: Projections, 2022-2037" (Nov. 2024) (projecting a shortage of approximately 187,130 full-time equivalent physicians by 2037). https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/physicians-projections-factsheet.pdf

RELEVANT AMA POLICY

AMA Principles on International Medical Graduates H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.

5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:

    a. completion of medical school and residency training outside the U.S.;

    b. extensive U.S. medical practice; and

    c. evidence of good standing within the local medical community.

13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

16. Our AMA membership outreach to IMGs to include

    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;

    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;

    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and

    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.

24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.

25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training.

BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17Reaffirmation: A-19 Modified: CME Rep. 2, A-21 Modified: CME Rep. 1, A-22 Modified: CCB/CLRPD Rep. 1, A-22 Reaffirmed: CME Rep. 03, A-23 Reaffirmed: Res. 312, A-25 Reaffirmed in lieu of the first resolve: Res. 234, A-25Reaffirmed: Res. 241, A-25

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966

Our American Medical Association will 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.

Res. 216, I-25; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-26)

Introduced by: International Medical Graduates Section

Subject: Increasing Legislative Advocacy and Dedicated National Educational Programming for International Medical Graduates (IMGs)

Referred to: Reference Committee B

Whereas, International Medical Graduates (IMGs) constitute approximately 25% of the active physician workforce in the United States, providing critical medical care across primary care and subspecialty fields; and

Whereas, IMGs disproportionately serve in federally designated Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and rural communities, providing care to over 20 million Americans who reside in regions where foreign-trained physicians account for at least half of the local physician pipeline; and

Whereas, the Association of American Medical Colleges (AAMC) projects a severe shortage of up to 86,000 to 124,000 physicians, underscoring the indispensable necessity of recruiting, retaining, and supporting IMG physicians to preserve healthcare access; and

Whereas, IMG physicians navigate complex regulatory, administrative, and immigration hurdles, including visa processing delays, Conrad 30 waiver caps, and green card backlogs which frequently disrupt clinical training, delay entry into practice, and jeopardize continuity of patient care; and

Whereas, federal and state legislators, policymakers, and health system leaders often lack comprehensive education regarding the structural barriers IMGs face and the vital role they play in sustaining the U.S. healthcare safety net; and

Whereas, creating dedicated, recurring advocacy tracks, legislative education forums, and unique programming focused on IMGs at national venues (such as the AMA National Advocacy Conference and House of Delegates meetings) would elevate the IMG voice, build legislative allies, and foster proactive policy solutions; therefore be it

RESOLVED, that our American Medical Association expand its federal and state advocacy efforts to actively educate legislators, administrative agencies, and health system policymakers on the critical role International Medical Graduates (IMGs) play in addressing national physician workforce shortages and improving healthcare access in underserved populations (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with the AMA International Medical Graduates Section (AMA-IMGS), state medical societies, and relevant specialty organizations to establish unique, dedicated events and educational programming, including legislative briefings, advocacy workshops, and policy panels focused on IMG workforce integration at national meetings such as the AMA National Advocacy Conference (Directive to Take Action); and be it further

RESOLVED, that our AMA develop educational materials and policy toolkits highlighting key IMG workforce issues (such as visa reauthorization, green card backlog relief, and licensing equity) for distribution to federal and state lawmakers to support targeted healthcare workforce legislation. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-26)

Introduced by:	Resident and Fellow Section, Underrepresented in Medicine Advocacy Section
Subject:	Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine
Referred to:	Reference Committee B

Whereas, a systematic scoping review of 79 studies found that people experiencing homelessness face profound structural barriers to health care, including transportation-related costs, lack of documentation, administrative barriers, and poor continuity and integration of service, which contribute to unmet health needs and delayed, fragmented care[1]; and

Whereas, a review of 42 studies found that people experiencing unsheltered homelessness often lack health insurance and use health care less despite disproportionately high rates of chronic illness, serious mental illness, substance use, and premature mortality[2]; and

Whereas, street medicine brings health and social services directly to people experiencing unsheltered homelessness in their own environments, and has emerged as a patient-centered model that improves engagement, insurance enrollment, housing linkage, and some health outcomes for people experiencing homelessness, with more than 150 programs operating across the United States[3-5]; and

Whereas, street medicine programs have demonstrated the potential to reduce health care utilization and costs, including reductions in hospital admissions and length of stay among individuals experiencing homelessness[3,5,6]; and

Whereas, federal and state policy landscapes are rapidly evolving to recognize and reimburse care delivered outside traditional clinical settings, including federal designation of “outreach site/ street” as reimbursable sites for Medicare and Medicaid services and state Medicaid innovations such as California’s AB 543 (2025), creating new opportunities while introducing variability in implementation[4,7,8]; and

Whereas, significant barriers to access persist for patients experiencing homelessness, including low Medicaid reimbursement rates and administrative reimbursement challenges disincentivizing providers, administrative churn due to frequent eligibility redeterminations, delays in enrollment, and work/reporting requirements that disproportionately disrupt coverage for individuals experiencing homelessness, contributing to delayed clinical presentation, increased reliance on emergency departments, and higher rates of hospitalization[9-11]; and

Whereas, emerging federal policies, including Medicaid work requirements enacted under H.R.1 (2025), risk further exacerbating coverage instability among the high-risk population of patients experiencing homelessness[12]; and

Whereas, strategies including presumptive eligibility to facilitate point-of-care enrollment and flexible network access have been shown to improve coverage continuity and access to care for

marginalized populations but remain inconsistently implemented and insufficiently aligned with street medicine delivery models[13-15]; and

Whereas, existing AMA policy supports innovative care delivery models, such as street medicine, but does not fully address the evolving reimbursement framework, administrative barriers to Medicaid access, or the need for standardized policies supporting physicians practicing in nontraditional care environments; therefore be it

RESOLVED, that the following American Medical Association policy, "Payment for Physicians who Practice Street Medicine H-160.886," be amended by addition to read as follows, and that the title be revised to "Advancing Physician Payment and Medicare and Medicaid Access for Street Medicine":

a. Our American Medical Association supports the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long-term costs.
b. Our AMA supports the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with "street medicine" defined, in keeping with the Street Medicine Institute, as "the provision of health care directly to people where they are living and sleeping on the streets."
c. Our AMA supports presumptive eligibility and point-of-care Medicaid enrollment for individuals experiencing homelessness, reduced eligibility redeterminations to promote continuous coverage, and access to street medicine services regardless of network assignment.
d. Our AMA supports exemptions or alternative pathways for individuals experiencing homelessness from Medicaid work and reporting requirements, including automatic or data-driven exemptions based on clinical and socioeconomic risk factors.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

1. Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.
2. Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless.
3. Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.
4. Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance.
5. Our AMA recognizes the need for an effective, evidence-based national plan to eradicate homelessness.
6. Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7. Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8. Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9. Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients.
10. Our AMA:
    a. supports laws protecting the civil and human rights of individuals experiencing homelessness, and
    b. opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available.
11. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
12. Our AMA:
    a. supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties;

b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and
c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.

13. Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

Payment for Physicians who Practice Street Medicine H-160.886

a. Our American Medical Association supports the development of street medicine programs to increase access to care for populations experiencing homelessness and reduce long- term costs.
b. Our AMA supports the implementation of Medicare and Medicaid payment for street medicine initiatives by advocating for necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers for Medicaid & Medicaid Services asking that it establish a new place-of-service code to support street medicine practices for people eligible for Medicare and/or Medicaid, with “street medicine” defined, in keeping with the Street Medicine Institute, as “the provision of health care directly to people where they are living and sleeping on the streets.”

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-26)

Introduced by: Resident and Fellow Section

Subject: Modernize the Medicare Primary Care Exception to Ensure Appropriate Reimbursement for Services Provided by Residents

Referred to: Reference Committee B

Whereas, resident clinics serve disproportionately vulnerable patient populations characterized by higher psychosocial complexity, lower socioeconomic status, and greater barriers to care compared to faculty and attending physician patient panels[1,2]; and

Whereas, resident clinics generally experience financial difficulty that can be attributed, in part, due to suboptimal coding and billing practices. with outpatient clinics considered to be a net negative cost to health systems[3,4]; and

Whereas, the Medicare Primary Care Exception (PCE) permits teaching physicians to bill for evaluation and management services when residents performed low- and middle- complexity visits in primary care settings without the teaching physician being physically present during the key portion of the service, promoting graduated autonomy in a training context[5,6,7]; and

Whereas, the PCE has implications on billing practices and may contribute to billing for lower complexity visits that would otherwise qualify for higher complexity coding in part, due to in-person supervision requirements, with estimated financial losses of $2,558 per resident and $57,569 per year for an average residency, and up to 72.1% of visits billed at lower complexity that could have been billed at higher complexity[8,9,10]; and

Whereas, temporarily from March 31, 2020, to January 1, 2022 during the COVID-19 Public Health Emergency, Medicare expanded the PCE to cover all patient visits regardless of complexity level, allowing teaching physicians to bill for higher complexity visits under indirect supervision without an in-person assessment required[11]; and

Whereas, studies examining coding and billing patterns during and after the COVID-19 Public Health Emergency noted a significant increase in higher complexity billing code utilization during the expansion period and then a notable decrease in higher complexity billing code utilization after its expiration[12,13]; and

Whereas, the persistent inappropriate use of lower complexity billing codes may result in significant revenue losses in outpatient practices of numerous fields in which the Medicare PCE applies, including family medicine, outpatient internal medicine, geriatric medicine, pediatrics, and obstetrics & gynecology[7]; and

Whereas, limited single-institution data suggests that trainees further along in their training (Post Graduate Year 3) may utilize higher complexity billing codes less frequently than their more junior peers, with potential revenue implications estimated to be greater than $300,000 per fiscal year[13]; and

Whereas, the current regulatory requirement for teaching physicians to be directly present in-person for moderate- or high- complexity visits may therefore influence senior trainees to underutilize higher complexity codes despite delivering higher complexity level of care to avoid supervision requirements[9,11,13]; and

Whereas, underutilization of higher complexity codes may negatively impact clinic sustainability, staffing, productivity metrics (including Relative Value Units), case mix index, audit burden, and resource allocation; and

Whereas, analyses of the PCE by a working group from the Society of General Internal Medicine and by a group of academic teaching physicians offers recommendations for reform, including allowing moderate complexity visits to be eligible for the Primary Care Exception[14,15]; and

Whereas, our American Medical Association is currently actively advocating to the Centers for Medicare & Medicaid Services on modernizing standards for appropriate supervision of residents, including recent changes to the Medicare Physician Fee Schedule permanently allowing virtual supervision of residents providing telehealth services in all training settings, a regulation that was temporarily allowed via the CMS Interim Final Rule issued during the COVID-19 Public Health Emergency[16,17]; therefore be it

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

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

Received: 9/16/26

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RELEVANT AMA POLICY

H-385.952: Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services
Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed. [Reaffirmed: CMS Rep. 01, A-19]

H-385.942: CMS Use of Regulatory Authority to Implement Reimbursement Policy
The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies. [Reaffirmed: Res. 105, A-18]

H-200.949: Principles of and Actions to Address Primary Care Workforce
…17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS. [Reaffirmed: Res. 237, I-25]

H-330.939: Reimbursement by Medicare for Psychotherapy Provided by Residents
Our AMA will work with CMS to accomplish regulations for Medicare Part B payment for attending physicians' services that would not require the "physical presence" of the attending physician in the room at the same time that a resident provided psychotherapy. [Reaffirmed: BOT Rep. 09, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-26)

Introduced by: Resident and Fellow Section, Underrepresented in Medicine Advocacy Section

Subject: Supporting a Common Legal Framework for Medical Capacity Holds

Referred to: Reference Committee B

Whereas, patients often lack decision-making capacity regarding the need to stay in the hospital for treatment[1-4]; and

Whereas, loss of decision-making capacity can occur due to both general medical conditions or primary psychiatric disorders[1-3,5]; and

Whereas, surrogate decision-making policies, guardianship laws, and practices are complex and vary dramatically across states, courts, and institutions[6-8]; and

Whereas, physicians, facilities, and other healthcare providers may face legal liability for permitting a patient who lacks decision-making capacity to leave the healthcare setting and subsequently suffer harm[2,9,10]; and

Whereas, physicians, facilities, and other healthcare practitioners can be held liable for unlawful detention of a patient except in situations explicitly authorized by law[1,2,11]; and

Whereas, there is currently no comprehensive federal statutory framework that specifically permits physicians or facilities to detain an adult patient who lacks decision-making capacity due to medical causes such as delirium, acute brain injury, dementia, or severe metabolic derangement[1,2,9]; and

Whereas, five states (Arkansas, Hawaii, Illinois, Maryland, and New York) enable the involuntary detainment of patients without requiring that patients be diagnosed with a mental illness, and Virginia allows physicians to petition the court to issue a temporary detention order for a patient in a medical facility who is incapable of informed decision-making “due to a mental or physical condition”[1]; and

Whereas, states across the country have adopted psychiatric holds that provide clear standards for who qualifies, protections of patient’s rights with due process, and appropriate protections for healthcare workers and healthcare systems to use them[1,2,12]; and

Whereas, psychiatric holds are commonly misused for patients lacking decision-making capacity due to a condition other than a primary psychiatric condition or related substance use disorder, with one large academic medical center finding 17.6% of involuntary psychiatric holds were placed on patients who did not qualify for them, initiated for medical conditions rather than psychiatric ones[1,2,9]; and

Whereas, in the absence of statutory authority, healthcare systems have come to rely on ad hoc institutional policies to detain medically incapacitated patients, policies that operate without any

explicit legal framework, standardized due-process protections, or liability protection for those involved[1,2,9]; and

Whereas, the lack of standardized legal frameworks for medical capacity holds may result in inconsistent protections of patient rights, with the potential to exacerbate health inequities given that this population includes older adults, patients with cognitive impairment, and those with limited social support[1,6,8,9,13]; and

Whereas this issue affects all inpatient hospital settings and medical specialties, and appropriate solutions may reduce the inappropriate use of involuntary psychiatric holds[1,2,9]; therefore be it

RESOLVED, that the American Medical Association study existing laws, institutional practices, and ethical frameworks related to the use of medical holds for patients who lack medical decision-making capacity, with the goal of identifying best practices and informing potential model legislation. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

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RELEVANT AMA POLICY

E-2.1.2 Decisions for Adult Patients Who Lack Capacity
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is

impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.
When a patient lacks decision-making capacity, the physician has an ethical responsibility to:
(a) Identify an appropriate surrogate to make decisions on the patient's behalf:
(i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
(ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
(c) Provide advice, guidance, and support to the surrogate.
(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
(i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
(ii) the patient's views about life and how it should be lived;
(iii) how the patient constructed his or her life story; and
(iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
(i) the pain and suffering associated with the intervention;
(ii) the degree of and potential for benefit;
(iii) impairments that may result from the intervention;
(iv) quality of life as experienced by the patient.
(f) Consult an ethics committee or other institutional resource when:
(i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
(ii) ongoing disagreement about a treatment decision cannot be resolved; or
(iii) the physician judges that the surrogate's decision:
a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
b. could not reasonably be judged to be in the patient's best interest; or
c. primarily serves the interests of the surrogate or other third party rather than the patient.

E-1.2.7 Use of Restraints
All individuals have a fundamental right to be free from unreasonable bodily restraint. At times, however, health conditions may result in behavior that puts patients at risk of harming themselves. In such situations, it may be ethically justifiable for physicians to order the use of chemical or physical restraint to protect the patient.
Except in emergencies, patients should be restrained only on a physician's explicit order. Patients should never be restrained punitively, for convenience, or as an alternate to reasonable staffing.
Physicians who order chemical or physical restraints should:
(a) Use best professional judgment to determine whether restraint is clinically indicated for the individual patient.
(b) Obtain the patient's informed consent to the use of restraint, or the consent of the patient's surrogate when the patient lacks decision-making capacity. Physicians should explain to the patient or surrogate:
(i) why restraint is recommended;
(ii) what type of restraint will be used;
(iii) length of time for which restraint is intended to be used.
(c) Regularly review the need for restraint and document the review and resulting decision in the patient's medical record.
In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. In such situations, the least restrictive restraint reasonable should be implemented and the restraint should be removed promptly when no longer needed.

Involuntary Civic Commitment for Substance Use Disorder H-95.912
Our American Medical Association opposes civil commitment proceedings for patients with a substance use disorder unless:
A physician or mental health professional determines that civil commitment is in the patient's best interest consistent with our AMA Code of Medical Ethics.
Judicial oversight is present to ensure that the patient can exercise their right to oppose the civil commitment.
The patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by their physician.
The facility is separate and distinct from a correctional facility.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Physician-Led Governance of the Use of Augmented Intelligence in Hospital Credentialing, Privileging, and Peer Review

Referred to: Reference Committee B

Whereas, state medical boards are increasingly regulating the clinical use of augmented intelligence by physicians through professional standards and oversight of physician practice, including guidance issues by the Federation for State Medical Boards, and credentialing bodies are left to translate that into hospital privileges and competency requirements[1]; and

Whereas, hospitals and health systems are increasingly incorporating augmented intelligence into administrative and clinical governance workflows, with emerging applications supporting credentialing, privileging, peer review, quality review, and other professional practice evaluation processes[2]; and

Whereas, organized medical staff has overall responsibility for the quality of professional services provided by physicians and other practitioners who hold privileges, including oversight through credentialing, privileging, peer review, and ongoing professional practice evaluation[3]; and

Whereas, physicians must have the ability to access, understand, and, when appropriate, challenge the data, methodology, and rationale underlying the use of augmented intelligence within administrative governance workflows, particularly when such information informs credentialing, privileging, peer review, quality review, or any adverse medical staff action; and

Whereas, as per AMA policy H-225.942, physicians who report patient safety concerns must be protected from retaliation; therefore be it

RESOLVED, that our American Medical Association advocate that any use of augmented intelligence in credentialing, privileging, peer review, quality review, or corrective action requires physician-led oversight and this be codified in medical staff bylaws (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the requirement of hospital and health systems to fully disclose the data sources, validation, limitations, governance, and intended use of any augmented intelligence tool used in medical staff processes (New HOD Policy); and be it further

RESOLVED, that our AMA will communicate its policy on requiring physician-led oversight of augmented intelligence when used in credentialing, privileging, peer review and quality review on a continuing basis to the American Hospital Association, Federation of American Health System, and other appropriate organizations (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm policy H-225.942, Physician and Medical Staff Member Bill of Rights, that opposes any retaliatory peer review privileging action, corrective action, or

employment action taken against a physician for good-faith safety reporting advocacy, or participation in organized medical staff governance. (Reaffirmed HOD Policy

Fiscal Note: Moderate – between $10,000 - $50,000

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RELEVANT AMA POLICY

Physician and Medical Staff Member Bill of Rights H-225.942
Our American Medical Association adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble
The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.
The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.
Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. **Our AMA recognizes the following fundamental responsibilities of the medical staff:**
   a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
   b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
   c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. **Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:**
   a. The right to be self-governed, which includes but is not limited to
      i. initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations,
      ii. selecting and removing medical staff leaders,
      iii. controlling the use of medical staff funds,
      iv. being advised by independent legal counsel, and
      v. establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
   b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
   c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
   d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.
   e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
   f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. **Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:**
   a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
   b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
   c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
   d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
   e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
   f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
   g. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. **Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to their patients, the medical staff, and the health care organization:**

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.
g. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21; Reaffirmed: A-22; Modified: Speakers Rep. 02, I-24

Economic Credentialing H-230.975

The AMA (1) adopts the following definition of economic credentialing: economic credentialing is defined as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges;
(2) strongly opposes the practice of economic credentialing;
(3) believes that physicians should continue to work with their hospital boards and administrators to develop appropriate educational uses of physician hospital utilization and related financial data and that any such data collected be reviewed by professional peers and shared with the individual physicians from whom it was collected;
(4) believes that physicians should attempt to assure provision in their hospital medical staff bylaws of an appropriate role for the medical staff in decisions to grant or maintain exclusive contracts or to close medical staff departments;
(5) will communicate its policy and concerns on economic credentialing on a continuing basis to the American Hospital Association, Federation of American Health Systems, and other appropriate organizations;
(6) encourages state medical societies to review their respective state statutes with regard to economic credentialing and, as appropriate, to seek modifications therein;
(7) will explore the development of draft model legislation that would acknowledge the role of the medical staff in the hospital medical staff credentialing process and assure various elements of medical staff self-governance; and
(8) will study and address the issues posed by the use of economic credentialing in other health care settings and delivery systems.
Citation: CMS Rep. B, I-91; Reaffirmed: BOT Rep. 14, A-98; Reaffirmed: A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: CMS Rep. 4, I-20

Hospital Medical Staff Self-Governance H-235.980
1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.
2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.
3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:
(a) Application, reapplication, credentialing and privileging standards;
(b) Fair hearing and appeal process;
(c) Selection, election and removal of medical staff officers;
(d) Clinical criteria and standards which manage quality assurance, utilization review;
(e) Structure of the medical staff organization;
(f) Rules and regulations that affect the entire medical staff.
4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.
Citation: Sub Res. 201, A-89; Reaffirmed: Sub Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmed: A-05; Appended: res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 01, A-25

Credentialing and the Quality-of-Care H-225.971
1. It is the policy of our American Medical Association that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care.
2. It is the policy of the AMA that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges.
3. It is the policy of the AMA that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care.
4. It is the policy of the AMA that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals.
5. It is the policy of the AMA that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities.
6. It is the policy of the AMA that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws.
7. It is the policy of the AMA that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff.
8. It is the policy of the AMA that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital.

Citation: BOT Rep. T, I-92; Reaffirmed: Rep. 10, A-03; Modified: CMS Rep. 4, A-13; Reaffirmed; CMS Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-26)

Introduced by: American Society of Addiction Medicine

Subject: Increasing Access to Long-Acting Injectable Medications for SUD

Referred to: Reference Committee B

Whereas, long-acting injectable (LAI) medications, also commonly described as extended-release injectable medications, have been approved by the Food and Drug Administration (FDA) to treat opioid use disorder (OUD) and alcohol use disorder (AUD); and [1,2]

Whereas, LAIs expand treatment options for patients with OUD or AUD by reducing the need for daily medication administration and may support treatment continuity while reducing risks associated with lost, stolen, or diverted medication; and [3]

Whereas, medication acquisition and billing requirements, mandatory specialty-pharmacy distribution, and utilization-management protocols such as prior authorization, step therapy, and fail-first policies can delay or impede access to LAI medications; and [4,5]

Whereas, patient cost-sharing requirements, including deductibles, copayments, and coinsurance, may reduce adherence to and retention in medication treatment for OUD; and [6]

Whereas, permitting appropriately trained pharmacists to administer lawfully prescribed long-acting injectable medications for substance use disorders in pharmacy settings, after the initial dose and with appropriate patient-safety safeguards and communication with the prescribing clinician, could expand access to treatment; and [7]

Whereas, federal controlled-substance registration requirements generally require a separate registration for each principal place of professional practice where controlled substances are dispensed, creating administrative and financial barriers when practitioners furnish controlled-substance LAIs at multiple practice locations; and [8]

Whereas, FDA-approved prescribing information for extended-release buprenorphine permits a second injection as early as one week after the initial injection based on patient need; and [9]
Whereas, Medicare OTP coding and payment distinguish between weekly and monthly injectable buprenorphine bundles, and payment policies should clearly account for every medically necessary dose permitted under FDA-approved initiation and dosing protocols, including a second injection administered as early as one week after the first; therefore be it [10]

RESOLVED, that our American Medical Association reaffirm its support for coverage of all FDA-approved medications for SUDs without prior authorization, step therapy, fail-first requirements, or other non-evidence-based utilization-management restrictions (New HOD Policy); and be it further

RESOLVED, that our AMA support the elimination of patient cost-sharing for FDA-approved medications used to treat SUDs and their administration (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for payer payment policies for LAIs that appropriately account for each medically necessary dose and its preparation and administration (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal and state rules and regulations permitting appropriately trained pharmacists to administer lawfully prescribed LAI medications for substance use disorders, after the initial dose, pursuant to a physician's prescription and with appropriate communication with the prescribing physician, in pharmacy settings that satisfy applicable federal and state registration, certification, medication-security, and patient-safety requirements (New HOD Policy); and be it further

RESOLVED, that our AMA urge the Drug Enforcement Administration (DEA), FDA, and other relevant federal agencies to study and support opportunities to reduce unnecessary and duplicative administrative and financial barriers to furnishing LAIs for SUDs across multiple sites of care, including by developing pathways that allow qualified practitioners to administer such medications at multiple appropriately licensed or certified locations without duplicative registrations, fees, or site-enrollment requirements, while preserving appropriate medication-security and patient-safety safeguards. (New HOD Policy)

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

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RELEVANT AMA POLICY

D-95.948 Acknowledging Flexibility on Buprenorphine Mono-product Use for Opioid Use Disorder
Our AMA advocates 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. [Res. 221, I-25]

D-95.968 Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders
Our American Medical Association will:

a. advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and

b. develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder and other evidence-based options are first-line treatments for this chronic medical disease.

Our AMA will support further research into how primary care practices can implement medications for opioid use disorder into their practices and disseminate such research in coordination with primary care specialties.

Our AMA Substance Use and Pain Care Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy and publicize those resources to the Federation.

Our AMA will support increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders. [Res. 222, A-18; Appended: BOT Rep. 02, I-19; Modified: Res. 228, A-23]

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

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

Our AMA continues to monitor implementation of the National Provider Identifier system and work with physicians and payers to ensure proper and prompt payment for physician claims. Additionally, the AMA will monitor physician privacy concerns associated with the public consumption of the NPI database. [Reaffirmed: Res. 302, A-26]

D-100.980 One Fee, One Number
Our AMA will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific. [Reaffirmed: Res. 302, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(I-26)

Introduced by: American Society of Addiction Medicine

Subject: Hospital-Based Substance Use Disorder Care

Referred to: Reference Committee B

Whereas, almost 12 percent of inpatient hospitalizations and approximately 9 percent of emergency departments (ED) visits were for patients with substance use disorder (SUD) between 2014 and 2018;[1] and

Whereas, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated 8.4 million drug-related visits (including visits involving alcohol) to hospital EDs in 2024, up more than 10 percent from the year prior;[2] and

Whereas, in 2017 alone, the medical costs associated with SUD care in US hospitals and EDs exceeded $13 billion;[3] and

Whereas, some studies show a 12-month mortality rate of 8 percent for patients hospitalized with opioid use disorder (OUD) after discharge [4] and 6 percent for patients with fentanyl use after an ED visit[5]; and

Whereas, SUD often is unaddressed in hospital settings despite existence of effective treatments; and

Whereas, substantial gaps remain in the availability of hospital-based addiction services, particularly in rural and underserved communities; and

Whereas, the lack of treatment is associated with increased rates of premature hospital discharge;[6] and

Whereas, the lack of training, education, and guidance on how to manage SUD and the limited integration of SUD treatment into hospitals and EDs may also contribute to stigma among clinicians; [7, 8] and

Whereas, evidence exists that initiating SUD treatment in hospital settings can improve clinical outcomes,[9] reduce subsequent acute care utilization,[10] overdose risk[11] and post-discharge mortality;[12] and

Whereas, there are consensus standards and implementation guidance[13] identifying core competencies for hospital-based SUD care; and

Whereas, this guidance identifies prominent models of care, such as addiction consultation services (ACS), practice-based models, and bridge clinics that have demonstrated effectiveness in increasing medication initiation and linkage to ongoing care; and

Whereas, the Medicare Hospital Outpatient Quality Reporting Program does not currently

include quality measures that assess hospital performance in delivering evidence-based outpatient addiction treatment;[14, 15] and

Whereas, existing private and public payment systems inadequately recognize the resources and staffing, including multidisciplinary clinical expertise, care navigation, peer support, and community-based services necessary to deliver comprehensive hospital-based addiction treatment as described in these models; [16, 17] therefore be it

RESOLVED, that our American Medical Association support the development, implementation, and dissemination of evidence-based competencies for SUD care in hospitals and emergency departments, including screening, assessment, withdrawal management, overdose care, initiation and continuation of FDA-approved addiction medications, risk-reduction services, and linkage to ongoing treatment (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for increased availability of and access to hospital-based addiction treatment services, as appropriate to hospital size, patient volume, and community need (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the development, testing, adoption, and public reporting of hospital quality measures related to SUD treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to the Centers for Medicare & Medicaid Services and other payers for evaluation and modernization of hospital payment systems to ensure adequate recognition and reimbursement of resources required to deliver evidence-based hospital-based SUD care. (Directive to Take Action)

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

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RELEVANT AMA POLICY

D-95.967 Treating Opioid Use Disorder in Hospitals

Our AMA's Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.

Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.

Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations. [Res. 223, A-18]

D-95.968 Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders

Our American Medical Association will:

a. advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and

b. develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder and other evidence-based options are first-line treatments for this chronic medical disease.

Our AMA will support further research into how primary care practices can implement medications for opioid use disorder into their practices and disseminate such research in coordination with primary care specialties.

Our AMA Substance Use and Pain Care Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy and publicize those resources to the Federation.

Our AMA will support increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders. [Res. 222, A-18; Appended: BOT Rep. 02, I-19; Modified: Res. 228, A-23]

H-450.966 Quality Management
Our AMA continues to advocate for quality management provisions that are consistent with AMA policy.

Our AMA seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures.

Our AMA continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures.

Our AMA emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts.

Our AMA urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures.

Our AMA advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts:

a. Standards and measures shall have demonstrated validity and reliability.

b. Standards and measures shall reflect current professional knowledge and available medical technologies.

c. Standards and measures shall be linked to health outcomes and/or access to care.

d. Standards and measures shall be representative of the range of health care services commonly provided by those being measured.

e. Standards and measures shall be representative of episodes of care, as well as team-based care.

f. Standards and measures shall account for the range of settings and practitioners involved in health care delivery.

g. Standards and measures shall recognize the informational needs of patients and physicians.

h. Standards and measures shall recognize variations in the local and regional health care needs of different patient populations.

i. Standards and measures shall recognize the importance and implications of patient choice and preference.

j. Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured.

k. Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. [BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed: CMS Rep. 7, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(I-26)

Introduced by: Colorado

Subject: Protecting Individual Rights in the Era of Developing Neurotechnologies, Including for Mental Augmentation

Referred to: Reference Committee B

Whereas, neurotechnologies are devices capable of recording, interpreting, or altering the response of an individual's central or peripheral nervous system to its internal or external environment; and[1]

Whereas, the AMA House of Delegates adopted Resolution 503 of June 11, 2025, creating a new policy stating: "RESOLVED, that our AMA recognizes that neural data is information obtained by measuring the activity of a person's central or peripheral nervous system through the use of neurotechnologies, but neural data does not include data inferred from nonneural information"; and[1]

Whereas, in Resolution 503, the House of Delegates also created a new policy stating: "RESOLVED, that our AMA oppose any efforts to broaden the consensus medical definition of neural data to include data inferred from nonneural information gathered by biosensors (including biometric devices), as this is a distinct category of data with its own independent qualities and regulatory needs"; and[1]

Whereas, advances in neurotechnology increasingly permit modulation of neural functions associated with memory, attention, perception, communication, mood, learning, and other cognitive capacities, creating opportunities both to treat neurological and psychiatric disease and to augment human capabilities, although the distinction between therapy and augmentation may not always be scientifically or clinically discrete; and[2–5]

Whereas, mental augmentation may provide substantial benefits to individuals and society, including improvements in cognition, communication, independence, education, occupational performance, and human flourishing; and[2–5]

Whereas, the increasing availability of mental augmentation neurotechnologies may expose individuals to coercion or undue pressure from employers, educational institutions, governments, health insurers, military organizations, or other entities, implicating individual autonomy and the freedom both to use and to decline such technologies; and[4–6]

Whereas, unequal access to effective mental augmentation neurotechnologies could create or exacerbate disparities in health, education, employment, economic opportunity, and participation in society; and[4–7]

Whereas, neurotechnologies capable of augmenting mental function may generate sensitive neural data and alter cognition, behavior, perception, emotion, or decision-making, raising distinct concerns regarding mental privacy, identity, agency, and continuity of the self; and[1,4,5,8]

Whereas, physicians and medical specialty societies possess important expertise regarding the safety, efficacy, appropriate use, and consequences of technologies that alter neurological and cognitive function, while their broader social use also implicates ethical, legal, and human-rights considerations; therefore be it[4,5,9]

RESOLVED, that our American Medical Association strongly supports a hybrid approach to improving state consumer data privacy laws that both (1) defines neural data consistent with existing AMA policy and protects neural data as sensitive data; and (2) provides heightened protections based on use for data inferred from nonneural information gathered by biosensors, including biometric devices, when such data is used to infer sensitive information about an individual's mental or cognitive states. Any such use-based category should be precisely defined to distinguish mental or cognitive inferences warranting heightened protection because their sensitivity approaches that of neural data from other inferences derived from nonneural information that do not warrant such protection (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes the right of individuals to make voluntary and informed decisions whether to use mental augmentation neurotechnologies, consistent with applicable standards governing safety, efficacy, and informed consent, and supports protections against coercion, undue pressure, or unjust discrimination based on an individual's decision to use or decline such technologies, except where otherwise ethically and legally justified under narrowly defined circumstances (New HOD Policy); and be it further

RESOLVED, that our AMA support policies promoting equitable access to safe and effective mental augmentation neurotechnologies when lack of access would create or substantially exacerbate disparities in health, education, employment, or participation in society (New HOD Policy); and be it further

RESOLVED, that our AMA support appropriate protections for the mental privacy, neural data, identity, and agency of individuals using mental augmentation neurotechnologies, including meaningful control over the collection, use, disclosure, and commercialization of neural data generated through such technologies (New HOD Policy); and be it further

RESOLVED, that our AMA encourage physicians, neuroscientists, patients, ethicists, disability advocates, and other relevant stakeholders to participate in developing evidence-based standards and ethical frameworks governing the safety, efficacy, voluntary use, and equitable availability of mental augmentation neurotechnologies. (New HOD Policy)

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

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RELEVANT AMA POLICY

H-315.957 Safeguarding Neural Data Collected by Neurotechnologies

1. Our AMA supports legislative and regulatory efforts to protect the privacy and security of individuals' neurological data as well as protection from discrimination and inequality that may be caused by the use of neurotechnologies.
2. Our AMA recognizes that neural data is information obtained by measuring the activity of a person's central or peripheral nervous system through the use of neurotechnologies, but neural data does not include data inferred from nonneural information.
3. Our AMA opposes any efforts to broaden the consensus medical definition of neural data to include data inferred from nonneural information gathered by biosensors (including biometric devices), as this is a distinct category of data with its own independent qualities and regulatory needs.
Policy Timeline: Res. 503, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(I-26)

Introduced by: Private Practice Physicians Section

Subject: Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities

Referred to: Reference Committee B

Whereas, health insurers increasingly delegate prior authorization (PA) and utilization management (UM) determinations to third-party vendors such as EviCore (now part of Evernorth, a Cigna subsidiary), which issues coverage recommendations for advanced imaging, oncology, cardiology, pain management, and other services on behalf of more than 100 insurers whose plans cover approximately 100 million Americans; and

Whereas, these delegated UM entities are retained and compensated by health plans — not by patients, plan enrollees, or treating physicians — and therefore owe no contractual duty, fiduciary obligation, or professional accountability to the patient whose care they adjudicate or to the physician who ordered it; and

Whereas, investigative reporting has documented that such entities market their services to insurers on the promise of a return on investment as high as 3-to-1 — three dollars in reduced medical spending for every dollar of vendor fees — creating a direct financial incentive to deny rather than approve medically necessary care; and

Whereas, that same reporting describes proprietary algorithmic controls, referred to internally as "the dial," which can be adjusted to raise or lower the proportion of requests routed for manual clinical review, permitting effective denial rates to be calibrated to financial targets rather than to clinical evidence or patient need; and

Whereas, peer-reviewed appraisal of one such entity's advanced diagnostic imaging guidelines for the spine found material departures from national medical specialty society recommendations and the published evidence base, and the HHS Office of Inspector General has repeatedly found that Medicare Advantage organizations deny prior authorization requests that meet Medicare coverage rules, with denials overturned on appeal at very high rates; and

Whereas, AMA Policy H-480.940 calls for insurer use of augmented intelligence in claims and prior authorization review to include review by physicians "with no incentive to deny care," and AMA Policy H-320.939 calls for adverse determinations to be reviewed directly by a physician of the same medical specialty or subspecialty as the ordering physician, yet no federal requirement operationalizes either standard when review has been delegated to a financially interested third-party entity; and

Whereas, AMA Policy H-285.939 establishes that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities must be held accountable and liable for those decisions, but delegation to a third-party entity allows a health plan to place its own medical director beyond the reach of the treating physician while retaining the coverage decision; and

Whereas, existing federal frameworks — the ERISA claims procedure regulation at 29 CFR 2560.503-1, the Affordable Care Act internal appeals and external review requirements, the Medicare Advantage utilization management rules at 42 CFR Part 422 Subpart M as strengthened by CMS-4201-F, and the Interoperability and Prior Authorization Final Rule (CMS-0057-F) — govern the plan's obligations but do not require a plan to make its own medical director available for peer-to-peer review following a delegated adverse determination, do not require disclosure of the financial terms of delegated UM contracts, and do not prohibit compensation contingent on denial or savings targets; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation and/or regulation requiring that, whenever a delegated third-party utilization management entity issues an adverse determination denying, reducing, or terminating requested care, the health plan make its own medical director — licensed in the state in which the patient is receiving care and of the same specialty or subspecialty as the ordering physician — directly available to the treating physician for peer-to-peer review, and that the health plan's medical director, rather than the delegated entity's reviewer, bear final accountability for the coverage determination (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate for federal legislation and/or regulation when appropriate, irrespective of contract type, requiring health plans and their delegated utilization management entities to publicly disclose the material financial terms of their utilization management contracts, in particular whether any portion of compensation is contingent upon or proportional to denial rates, cost-savings targets, or return-on-investment guarantees (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal legislation and/or regulation establishing that delegated third-party utilization management entities and their clinical reviewers are subject to the same accountability standards applicable to health plan medical directors under AMA Policy H-285.939, and that the contracting health plan remain jointly accountable for adverse determinations issued on its behalf. (Directive to Take Action)

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

Received: 9/18/26

References:

1. Rucker P, Miller M, Armstrong D. "Not Medically Necessary: Inside the Company Helping America's Biggest Health Insurers Deny Coverage for Treatments Doctors Recommend." ProPublica. October 23, 2024. https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations
2. Bukowiec L, Stahl B, Imam N, et al. A critical appraisal of EviCore's guidelines for advanced diagnostic imaging of the spine for lower extremity pain with neurological features. J Spine Surg. 2023;9(1). PMCID: PMC10082428.
3. U.S. Department of Health and Human Services, Office of Inspector General. Reports on the use of prior authorization and denials of medically necessary care in Medicare Advantage. https://oig.hhs.gov/reports-and-publications/
4. American Medical Association. 2024 AMA Prior Authorization Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
5. American Medical Association. "AMA adopts policy calling for more oversight of AI in prior authorization." June 14, 2023. https://www.ama-assn.org/press-center/ama-press-releases/ama-adopts-policy-calling-more-oversight-ai-prior-authorization
6. Centers for Medicare & Medicaid Services. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), 89 Fed. Reg. 8758 (February 8, 2024). https://www.cms.gov/priorities/key-initiatives/burden-reduction/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
7. Centers for Medicare & Medicaid Services. Medicare Advantage Utilization Management Requirements, 42 CFR Part 422, Subpart M, as amended by CMS-4201-F, 88 Fed. Reg. 22120 (April 12, 2023).
8. U.S. Department of Labor. ERISA Claims Procedure Regulation, 29 CFR 2560.503-1. https://www.ecfr.gov/current/title-29/section-2560.503-1

RELEVANT AMA POLICY

Managed Care Medical Director Liability H-285.939
AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.
Citation: Sub. Res. 202, A-98; Appended: Res. 201, I-98; Reaffirmation A-99; Reaffirmed: BOT Rep. 18, I-00; Reaffirmation A-07; Reaffirmed in lieu of Res. 235, A-11; Reaffirmed: BOT Rep. 7, A-21; Reaffirmed: CMS Rep. 4, A-21.

Prior Authorization and Utilization Management Reform H-320.939
Our AMA will continue its widespread prior authorization advocacy and outreach; will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician; supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access and clinical outcomes, including the extent to which these processes contribute to patient harm; and will advocate for health plans to minimize burden when updates must be made to previously approved and/or pending prior authorization requests.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22.

Medical Necessity and Utilization Review H-320.942
Our AMA supports efforts to ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care.
Citation: Res. 810, I-16; Reaffirmation: A-18; Reaffirmation: A-22.

Utilization Review, Medical Necessity Determination, Prior Authorization Decisions D-320.977
Our AMA will advocate for implementation of a federal version of a prior authorization "gold card" law, and that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization.
Citation: Res. 727, A-22; CEJA Rep. 01, A-23.

Augmented Intelligence in Health Care H-480.940
Our AMA will advocate for greater regulatory oversight of insurers' use of augmented intelligence for review of patient claims and prior authorization requests, including that the process be based on accurate and up-to-date clinical criteria, include review by physicians and other health care professionals with expertise for the service under review and no incentive to deny care, and require human examination of patient records prior to a care denial.
Citation: BOT Rep. 41, A-18; Appended: A-23; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(I-26)

Introduced by: Puerto Rico

Subject: Medicare and Medicaid Payment Equity for Puerto Rico

Referred to: Reference Committee B

Whereas, existing American Medical Association policy supports eliminating inequities in Medicare reimbursement for physicians' services in Puerto Rico so that payment is determined under the Medicare rules applicable in the continental United States; and

Whereas, adequate and sustainable Medicare and Medicaid payment is essential to physician participation and meaningful patient access to care; and

Whereas, Puerto Rico continues to face physician workforce shortages, accelerated population aging, a substantial burden of chronic disease, and economic pressures that threaten the stability of its health care delivery system; and

Whereas, low Medicaid payment and unstable financing can limit physician participation and create barriers to timely care for patients with low incomes; and

Whereas, temporary federal funding measures have helped preserve coverage and continuity of services in Puerto Rico, but the scheduled expiration of enhanced support in September 2027 could create a severe financing shortfall for the Puerto Rico Medicaid program; and

Whereas, this resolution concerns federal advocacy and seeks action before the next Annual Meeting, consistent with the criteria for business at the 2026 Interim Meeting; therefore be it

RESOLVED, that our American Medical Association reaffirm Policy H-390.953, "Medicare Payments for Physicians' Services in Puerto Rico," supporting elimination of inequities in Medicare reimbursement for physicians' services in Puerto Rico (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA advocate before the United States Congress, the Centers for Medicare & Medicaid Services, and other pertinent federal agencies for long-term legislative and regulatory measures that provide equitable and sustainable Medicare Advantage and physician reimbursement policies for Puerto Rico (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for long-term, adequate, and sustainable federal financing for the Puerto Rico Medicaid program and oppose interruptions or reductions in federal support that would impair patient access to care or physician workforce stability (Directive to Take Action); and be it further

RESOLVED, that our AMA work with the Puerto Rico Medical Association and other relevant stakeholders to advance policies that strengthen Puerto Rico's health care infrastructure, physician recruitment and retention, and long-term health system sustainability. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/21/26

REFERENCES

1. American Medical Association. Strengthening Medicaid. Updated June 2, 2025.
2. American Medical Association. Medicare Reform & Medicaid Payment. Updated June 2, 2026.
3. American Medical Association. 2026 Interim Meeting of the HOD: Sept. 2 Speakers' Update. September 2, 2026

RELEVANT AMA POLICY

H-390.953 Medicare Payments for Physicians' Services in Puerto Rico
Our AMA supports the elimination of inequities in Medicare reimbursement so that physicians' fees for Medicare patients in Puerto Rico are adjusted according to the Medicare regulations applicable in the continental United States.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(I-26)

Introduced by:	American Society of Interventional Pain Physicians, American Academy of Pain Medicine, American Academy of Hospice and Palliative Medicine, American Society of Regional Anesthesia and Pain Medicine
Subject:	Timely Processing of DEA Practitioner Registrations to Protect Patient Access to Care
Referred to:	Reference Committee B

Whereas, Federal law requires health professionals licensed to prescribe, administer, or dispense controlled substances to register with the Drug Enforcement Administration (DEA), subject to limited exceptions; and

Whereas, DEA's Diversion Control Division is responsible for more than 1.9 million medical practitioners; and

Whereas, Physicians in most specialties and practice settings depend on timely DEA registration to begin practice, change practice locations, practice in additional states, and maintain uninterrupted care for their patients; and

Whereas, DEA's published Customer Service Plan for Registrants does not include a processing-time standard for practitioner registrations; and

Whereas, recently published guidance has advised physicians to expect roughly four to eight weeks for a new application; and

Whereas, as recently as 2024, new DEA applicant registrations were approved in 24-48 hours and renewals were processed automatically; and

Whereas, approximately 1.5 million renewal applications were approved automatically by DEA's registration system in fiscal years 2022 through 2024; and

Whereas, DEA's published policy allows a registrant who submits a timely renewal application to continue operating beyond the expiration date until final action is taken, but that published policy addresses only renewal applications; and

Whereas, In September 2026, DEA's national Registration Service Center advised physician applicants that registration processing queues exceeded one month, and registration staff stated in writing that pending applications are processed in the order received, depending on the workload of the assigned Registration Specialist, and that no timeframe can be given; and

Whereas, Hospitals, health systems, and payers commonly require a current DEA registration to complete physician credentialing and privileging, so registration delays can leave credentialing files incomplete, postpone start dates, threaten lapses in prescribing authority, worsen workforce shortages, and delay patient care, including for our nation's veterans; and

Whereas, a July 2026 audit by the U.S. Department of Justice Office of the Inspector General (OIG Report 26-069) found that, as of July 2025, DEA had 81 Registration Program Specialists located across its 23 field divisions, that Specialist staffing had declined by six positions from July 2024 to July 2025, and that this decline together with an extended 2025 hiring freeze produced a 19 percent vacancy rate against a ceiling of 100 positions; and

Whereas, DEA informed the OIG that Diversion Investigators were assisting Registration Program Specialists as a temporary solution that cannot be sustained long-term, and DEA stated in its response to the OIG that it remains under a federal hiring freeze and will close its Specialist staffing gap once the freeze is lifted; and

Whereas, the OIG reported that the DEA registrant population is growing an estimated 3 percent annually, about 66,000 new registrants per year; and

Whereas, the OIG reported that DEA's Diversion Control Program is fully funded by registrant fees, collecting over $1.8 billion between January 2022 and December 2024, and received over 94 percent of those fees from practitioners, whose registration fee is $888 for a three-year registration period; and

Whereas, the OIG also recommended, and DEA concurred, that DEA implement standardized quality assurance measures for registration applications and include medical practitioners in its scheduled investigation workplan, and the OIG noted the potential need to incorporate new quality assurance measures alongside Specialists' existing duties; and

Whereas, Federal law and DEA regulations require a separate DEA registration in each state in which a practitioner prescribes or dispenses controlled substances, so physicians who practice in multiple states, relocate, provide locum tenens coverage, or deliver care by telehealth must obtain, pay for, and renew multiple registrations, and each new registration exposes physicians and their patients to the risk of processing delays; and

Whereas, a single DEA registration number usable in every state in which a physician is authorized to practice, as envisioned by Policy D-100.975, would reduce the number of applications physicians must file and DEA must process, and with it the opportunities for such delays; and

Whereas, a review of AMA PolicyFinder identified policy supporting timely and expedited processing of physician visas (D-255.980, D-255.966, H-255.961) and state medical licensure (D-275.994), and policy on DEA registration fees and structure (D-100.970, D-100.975, D-100.980), but identified no policy specifically addressing the timeliness of DEA registration processing; and

Whereas, no publicly available comprehensive data was identified on the extent of DEA registration processing delays or their effect on physicians and patients; therefore be it

RESOLVED, that our American Medical Association advocate that the Drug Enforcement Administration restore timely processing of complete practitioner registration applications, including initial, renewal, and modification applications, consistent with its historical processing times (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the Drug Enforcement Administration provide each practitioner registration applicant with an estimated date of issuance and timely status updates, and publicly report average practitioner registration processing times by field division (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that the Drug Enforcement Administration establish a transparent expedited review process for practitioner registration applications when a processing delay would interrupt patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that no physician who has submitted a complete and timely Drug Enforcement Administration registration application experience a lapse in controlled substance prescribing authority due to agency processing delays, including through continuation of an existing registration or issuance of a provisional registration while the application is pending (New HOD Policy); and be it further

RESOLVED, that our AMA urge Congress and the Department of Justice to fill vacant Drug Enforcement Administration Registration Program Specialist positions, exempt fee-funded registration positions from federal hiring freezes, and ensure that practitioner registration fees are used to maintain timely registration services (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates that any new quality assurance or review procedures the Drug Enforcement Administration adopts for practitioner registration applications be developed with input from organized medicine, be adequately staffed, and be implemented without lengthening registration processing times (Directive to Take Action); and be it further

RESOLVED, that our AMA survey its membership, in collaboration with interested state and specialty medical societies, to assess the extent of Drug Enforcement Administration registration processing delays and their effects on physician practice, credentialing, employment, and patient access to care, and report findings to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, that our AMA work with Congress, the Department of Justice Office of the Inspector General, and the Government Accountability Office to monitor Drug Enforcement Administration practitioner registration processing times and staffing and their effect on patient access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm Policy D-100.970, “Drug Enforcement Administration Licensure Fees,” and Policy D-100.975, “One Fee One Number,” in its entirety, which directs our AMA to work with the Drug Enforcement Administration and Congress toward a registration system in which a single DEA registration number can be used by physicians who prescribe, dispense, or administer controlled substances in multiple states, and in which the full DEA registration fee is paid only once, at initial registration, with only a small re-registration fee every three years thereafter. (Reaffirm HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/22/26

References:
1. U.S. Department of Justice, Office of the Inspector General. *Audit of the Drug Enforcement Administration's Registration Process for Medical Practitioners*. Audit Division Report 26-069. July 2026. https://www.oversight.gov/sites/default/files/documents/reports/2026-07/26-069.pdf
2. U.S. Drug Enforcement Administration, Diversion Control Division. Registration and Customer Service Plan for Registrants. https://www.deadiversion.usdoj.gov/drugreg/registration.html; https://www.deadiversion.usdoj.gov/pubs/docs/cs_plan.html. Accessed September 18, 2026.
3. South Dakota Department of Health. Controlled Substance Registration (stating that new practitioners applying for both a South Dakota controlled substance registration and a new DEA registration can expect the process to take a minimum of six weeks, according to DEA). https://doh.sd.gov/healthcare-professionals/health-facility-licensure/controlled-substance-registration/. Accessed September 18, 2026.
4. CompHealth. How to Obtain a DEA License: Application, Fees, and Renewal Guide (stating first-time applicants should expect four to six weeks). https://comphealth.com/resources/how-to-obtain-a-dea-license. Accessed September 18, 2026.
6. U.S. Drug Enforcement Administration, Miami Field Division, Diversion Registration. Written correspondence to applicant, September 2026. [Author to retain copy.]
7. 21 U.S.C. § 822(e)(1); 21 C.F.R. § 1301.12(a); U.S. Drug Enforcement Administration, Diversion Control Division. Registration Q&A (stating that DEA requires a practitioner to obtain a separate DEA registration in each state). https://www.deadiversion.usdoj.gov/faq/registration-faq.html. Accessed September 18, 2026.
8. U.S. Drug Enforcement Administration, Registration Service Center (1-800-882-9539). Communication to applicant, September 2026.

RELEVANT AMA POLICY

Drug Enforcement Administration Licensure Fees D-100.970

Our American Medical Association will work through appropriate channels to freeze Drug Enforcement Administration (DEA) licensure fees for physicians.

[Res. 219, I-13; Reaffirmed: BOT Rep. 09, A-23]

One Fee One Number D-100.975

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

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

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

[BOT Rep. 5, I-08; I-18; Reaffirmed: Res. 302, A-26]

One Fee, One Number D-100.980

Our American Medical Association will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific.

[Res. 701, I-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmed: Res. 302, A-26]

Evidence-Based Standard Requirement for Governmental Regulation H-270.956

Our American Medical Association supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ

evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded.

[BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21]

Reducing Risk of Federal Investigation or Prosecution for Prescribing Controlled Substances for Legitimate Medical Purposes D-120.916

Our American Medical Association will advocate to the U.S. Department of Justice to rely on state medical board definitions of "the practice of medicine" to guide investigations into whether a practitioner has acted without a legitimate medical purpose.

Our AMA will advocate to the U.S. Department of Justice to work more closely with the AMA and its interested medical association partners to more clearly identify the factors it uses during an investigation to minimize disruptions to patient care.

Our AMA supports the U.S. Centers for Disease Control and Prevention Opioid Rapid Response Program and similar state-based efforts that seek to ensure continuity of care when patients lose access to care due to a law enforcement or other action that results in the closure of a physician's practice.

[BOT Rep. 13, A-26]

Protecting the Prescriptive Authority of Plenary Licensed Physicians D-120.920

Our American Medical Association will work with state medical boards, pharmacy boards, and appropriate federal agencies to protect the authority of plenary licensed physicians to prescribe all legal medications in accordance with their training and medical judgment.

Our AMA will reaffirm and publicize existing policy opposing unauthorized medication substitution, inappropriate pharmacy inquiries, and unauthorized treatment modification by pharmacists.

Our AMA supports legislation or regulatory action requiring pharmacists and pharmacy chains to either fill a valid prescription or immediately refer the patient to an alternative dispensing pharmacy, with notification to the prescribing physician.

Our AMA encourages interprofessional collaboration to clarify scope-of-practice boundaries, educate interested parties on the legal authority of plenary licensure, and promote policies that ensure timely patient access to physician led care.

[Res. 204, A-25; Modified: BOT Rep. 15, A-26]

Impact of Immigration Barriers on the Nation's Health D-255.980

Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.

Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

[Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26]

Ensuring Timely J-1 Visa Processing to Protect IMG Participation in Residency Programs D-255.966

Our American Medical Association will 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.

[Res. 216, I-25; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26]

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians.

[Res. 222, A-25; Reaffirmed: Res. 207, A-26; Reaffirmed: Res. 226, A-26]

Facilitating Credentialing for State Licensure D-275.994

Our American Medical Association encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible.

Our AMA will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions.

Our AMA encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license.

Our AMA supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.

[Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14; Reaffirmed: Res. 215, A-22]

Access to Health Care for Veterans H-510.985

Our American Medical Association will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system.

Our AMA will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system.

Our AMA will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans.

Our AMA will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician.

Our AMA will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans.

Our AMA will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

[Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17; Reaffirmation: A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(I-26)

Introduced by: Association for Clinical Oncology, American Society of Hematology, American Academy of Hospice and Palliative Medicine, American Society for Radiation Oncology

Subject: Medicaid Protections & Continuous Coverage for Active Cancer Care

Referred to: Reference Committee B

Whereas, oncology treatment regimens require sustained, uninterrupted adherence across multi-month or multi-year cycles, and disruptions in coverage or treatment delivery have been shown to directly increase cancer morbidity and mortality; and

Whereas, new Medicaid community engagement and work requirements enacted under federal statute risk disenrollment of vulnerable individuals with severe health conditions unless they are explicitly classified as medically frail; and

Whereas, recent federal regulations have narrowed medical frailty definitions by imposing burdensome functional impairment standards, requiring extensive documentation and retrospective encounter claims that penalize cancer patients whose treatment side effects vary between chemotherapy or immunotherapy cycles; and

Whereas, lack of federal standardization creates a patchwork of state attestation procedures, forcing physicians and clinical staff to absorb significant uncompensated administrative burden to complete complex state recertification forms to keep patients covered; and

Whereas, existing AMA policy opposes work requirements as a condition of Medicaid eligibility (H-290.961) and urges clinically grounded exemptions, yet lacks explicit directives addressing continuous coverage across full therapeutic courses and dedicated physician compensation for complex administrative eligibility attestations; therefore be it

RESOLVED, that our American Medical Association advocate for federal and state policies that require Medicaid medical frailty exemptions for individuals under active treatment for cancer or other medically complex chronic conditions and their caregivers remain in continuous effect throughout treatment and survivorship follow-up and prohibit mid-treatment disenrollment or procedural terminations. (Directive to Take Action).

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

Received: 9/22/26

REFERENCES

1. American Medical Association. AMA Adopts Policy Calling for Exemptions for Medicaid Work Requirements. Press Release, June 2026.
2. American Cancer Society Cancer Action Network (ACS CAN). The Impact of New Medicaid Work Requirements on People with Cancer. ACS CAN Policy Report, August 2026.
3. Centers for Medicare & Medicaid Services (CMS). Guidance on Medical Frailty Exclusions and Work Requirements Implementation. September 2026.
4. Association for Clinical Oncology (ASCO). ASCO Advocacy Priorities: Administrative Burden Reduction and Medicaid Access. 2026.

RELEVANT AMA POLICY

H-290.961 Opposition to Medicaid Work Requirements: Our AMA opposes work requirements as a criterion for Medicaid eligibility. [CMS Rep. 1, A-18; Reaffirmed: A-26]

AMA Policy on Medical Frailty Exemptions (Adopted A-26): The AMA urges states and the federal government to define “medical frailty” and “complex medical conditions” to include life-threatening or complex chronic medical conditions, ensuring automatic exemptions from community engagement and work requirements for patients and primary caregivers to avoid administrative burden and improper disenrollment.

H-385.913 Overcoming Administrative and Paperwork Burdens on Physicians: Our AMA supports initiatives that identify and reduce administrative burdens that detract from patient care, advocating for the elimination of redundant paperwork and promoting compensation models that recognize time spent on regulatory and administrative compliance.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(I-26)

Introduced by: Association for Clinical Oncology, American College of Rheumatology, American Society of Hematology, American Society for Radiation Oncology

Subject: Research Infrastructure & Overcoming Non-Medical Clinical Trial Barriers

Referred to: Reference Committee B

Whereas, participation in clinical trials offers access to life-saving, cutting-edge therapies; and

Whereas, socioeconomically disadvantaged populations remain underrepresented in clinical trials due to indirect non-medical expenses including transportation, long-distance lodging, childcare, and lost wages; and

Whereas, clinical trial sponsors, non-profit institutions, and patient advocacy foundations are often discouraged from reimbursing participants for travel and ancillary expenses due to legal concerns surrounding the federal Anti-Kickback Statute (AKS) and Beneficiary Inducements Civil Monetary Penalty (CMP); and

Whereas, financial stipends or direct expense reimbursements provided to low-income participants can be classified as taxable income, inadvertently triggering disqualification from essential public assistance programs such as Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Supplemental Security Income (SSI); and

Whereas, distance hinders trial participation when patients must travel long distances for routine laboratory testing or routine follow-up that could be delivered safely via local facilities, decentralized clinical trial models, and telehealth; and

Whereas, financial burdens associated with trial participation act as a critical social determinant of health (SDOH) that disproportionately excludes lower-income patients, thereby restricting study cohorts to higher socioeconomic classes and compromising the generalizability of trial results; and

Whereas, current AMA policy supports third-party coverage for clinical trials and AKS safe harbors for cost-sharing (H-460.965), but does not fully address tax penalties, safety-net eligibility preservation, or explicit coordination between clinical trial protocols and Medicaid community engagement requirements; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation and Anti-Kickback Statute safe harbors allowing trial sponsors to cover patient non-medical trial costs (travel, lodging, childcare) without tax penalties or safety-net benefit disqualification (Directive to Take Action); and be it further

RESOLVED, that our AMA support modernizing trial access by advocating for telehealth payment parity, cross-state licensure flexibilities, and local lab/imaging use (New HOD Policy); and be it further

RESOLVED, that our AMA advocate to ensure trial participation counts toward Medicaid community engagement or confers a reporting hardship exemption. (Directive to Take Action)

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

Received: 9/22/26

REFERENCES

1. U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). Request for Information Regarding the Federal Anti-Kickback Statute and Beneficiary Inducements CMP on Clinical Trial Remuneration. 89 FR, June 2026.
2. Association for Clinical Oncology (ASCO). Addressing Financial Barriers in Clinical Trials: Policy Statement Update. October 2026.
3. Food and Drug Administration (FDA) & HHS. Operation TrialBlazer: Expanding Clinical Trial Access and Modernization. 2026.
4. American Society of Clinical Oncology. ASCO Policy Statement: Telemedicine in Oncology. JCO Oncol Pract, 2021.

RELEVANT AMA POLICY

H-460.965 Viability of Clinical Research Coverages and Reimbursement: Our AMA believes that legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/deductibles, otherwise not covered clinical care, and non-clinical ancillary costs in the context of nationally approved clinical trials. [Modified: A-22]

D-480.969 Decoupling Licensure from Telemedicine Delivery: Our AMA supports legislative and regulatory reforms to streamline interstate medical practice, supporting interstate compacts and cross-state licensure flexibilities that facilitate remote care while protecting physician autonomy and patient safety.

H-480.946 Coverage of and Payment for Telemedicine: Our AMA advocates for payment parity for telehealth services comparable to in-person services when clinically appropriate.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(I-26)

Introduced by: American Thoracic Society

Subject: Assisting Physicians in Navigating Changes to Medicaid Medical Frailty Exemptions

Referred to: Reference Committee B

Whereas, Public Law 119-21 established Medicaid community engagement requirements for certain adults as a condition of Medicaid eligibility and provides an exemption for individuals who are medically frail; and

Whereas, the Centers for Medicare & Medicaid Services subsequently issued an interim final rule implementing Medicaid community engagement requirements and establishing requirements related to medical frailty exemptions; and

Whereas, the interim final rule requires certain individuals seeking a medical frailty exemption to demonstrate that their medical condition significantly impairs their ability to comply with Medicaid community engagement requirements and limits states' use of self-attestation to verify medical frailty; and

Whereas, implementation of these requirements may require physicians and physician practices to assist patients in navigating medical frailty determinations, documentation, verification, and related processes; and

Whereas, our AMA, together with the Massachusetts Medical Society and other medical associations, has prepared an amicus curiae brief in Massachusetts v. Oz emphasizing that the interim final rule's medical frailty requirements may cause eligible patients to lose Medicaid coverage, impose unnecessary administrative burdens on patients and physicians, and require physicians to make individualized assessments of patients' ability to satisfy Medicaid community engagement requirements without validated criteria or clear standards; and

Whereas, physicians will need clear and practical information regarding federal and state implementation of medical frailty exemptions as states implement Medicaid community engagement requirements; therefore be it

RESOLVED, that our American Medical Association collaborate with state and specialty medical associations to develop and disseminate guidance, educational materials, and other resources to assist physicians and physician practices in navigating changes to Medicaid medical frailty exemptions resulting from Public Law 119-21 and its implementing regulations, including medical frailty determinations, documentation, verification, and related requirements. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/22/26

REFERENCES

1. One Big Beautiful Bill Act, Pub. L. No. 119-21, § 71119, 139 Stat. 72 (2025).
2. Centers for Medicare & Medicaid Services. Medicaid Program; Community Engagement Requirement for Certain Individuals. 91 Fed. Reg. 33348 (June 3, 2026).
3. American Medical Association. "AMA adopts policy calling for exemptions for Medicaid work requirements." June 9, 2026.
4. American Medical Association. Comments regarding the Centers for Medicare & Medicaid Services interim final rule implementing Medicaid community engagement requirements, 2026.
5. Brief of Amici Curiae American Medical Association, Massachusetts Medical Society, and Other Medical Associations in Support of Plaintiffs' Motion for Summary Judgment, Commonwealth of Massachusetts, et al. v. Mehmet Oz, M.D., et al., No. 1:26-cv-12962-RGS (D. Mass. 2026).

RELEVANT AMA POLICY

Standardizing Medical Frailty to Streamline Medicaid Community Engagement & Work Exemptions D-290.969

Our AMA supports collaboration with CMS, state Medicaid agencies, and state and specialty medical associations to establish clinically grounded standards for medical frailty and complex medical conditions in connection with Medicaid community engagement requirements. AMA policy also supports automatic exemptions for patients and primary caregivers of patients with complex medical conditions and streamlined verification processes that minimize administrative burdens for patients and physicians. [Res. 243, A-26]

Reference Committee C

Report(s) of the Council on Medical Education

01 Medical Education Program and Content
02 Medical Education Systems
03 Professional Regulation of Physicians
04 Physician as Medical Professional
05 Entry into and transition through the medical education continuum
06 Obligations to Students and Trainees
07 Mission of Medical Education
08 Hardship for International Medical Graduates in Humanitarian Crisis or Conflict

Resolutions

302 Augmented Intelligence Use in Assessment Development During Medical Education
304 Transparency in AI-Assisted Admissions
305 Certification for Hospice Medical Directors
306 Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-26

Subject: Medical Education Program and Content

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

Adopted at the 2024 American Medical Association (AMA) Interim meeting, AMA Policy D-295.299, "Updates to Recommendations for Future Directions for Medical Education," called for the following:

> "Our American Medical Association will study the restructuring of AMA Policy H-295.995, 'Recommendations for Future Directions for Medical Education,' to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:
>
> - Mission of medical education.
> - Professional regulation.
> - Entry into and transition through the medical education continuum.
> - Medical education curricula.
> - Physician as medical professional.
> - Medical education systems.
> - Obligations to students and trainees."

This report addresses the theme of medical education curricula, referred to in this report as "medical education program and content."

BACKGROUND

The above policy was initially introduced via the Council on Medical Education's self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, "Recommendations for the Future Directions for Medical Education" that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding "medical education curricula":

> "A vast number of technological changes have occurred since 1982, including but not limited to the advent of widely available internet access in the 1990s in addition to more specific technological shifts in medical education over time. Virtual education is now prominent. More recently, the increasing attention to generative artificial intelligence or augmented intelligence (AI) prompted the AMA to release 'Principles for Augmented Intelligence Development, Deployment, and Use' in November 2023. AI technology and its opportunities and challenges are increasingly woven into the field of medical education.

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> From 2013-2022, the AMA's Accelerating Change in Medical Education Consortium [gave] $30 million in grants to 32 medical schools to jumpstart curricular and process changes and disseminate ideas, and in 2019, AMA launched the Reimagining Residency initiative to support innovations to transform residency training. The consortium became ChangeMedEd in 2023, and lessons from ChangeMedEd are informing ideas on future directions in medical education as intended. Curricular innovations include health systems science, the Master Adaptive Learner model, and a renewed emphasis on equity and social determinants of health."

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 50 of them were sorted into this report. They address policies related to pre-medical education, content and teaching of the whole continuum, curricular topics, program evaluation, faculty development, technology, AI, ChangeMedEd work, and precision education. This report does not address policies where the main point of the policy fell outside of the purview of "medical education program and content," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 50 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 28 policies remain relevant and should be retained:

- Holocaust Remembrance D-295.300
- Telemedicine in Medical Education D-295.313
- Communication and Clinical Teaching Curricula D-295.329
- Clinical Skills Training in Medical Schools D-295.960
- Support for Standardized Interpreter Training D-300.976
- Increasing Access to Gender-Affirming Care Through Expanded Training and Equitable Coverage H-295.847

- Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice H-295.848
- Representation of Dermatological Pathologies in Varying Skin Tones H-295.853
- Augmented Intelligence in Medical Education H-295.857
- Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
- Supporting Two-Interval Grading Systems for Medical Education H-295.866
- Education in Disaster Medicine and Public Health Preparedness During Medical School and Residency Training H-295.868
- Medical School Language Electives in Medical School Curriculum H-295.870
- Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
- Medical Treatment of Prisoners of War and Detainees H-295.877
- Medical Education on Sleep and Sleep Disorders H-295.894
- Alternative Medicine H-295.902
- Education of Medical Students and Residents about Domestic Violence Screening H-295.912
- Medical Training and Termination of Pregnancy H-295.923
- Use of Animals in Medical Education H-295.957
- Departments of Family Medicine in all LCME-Accredited Medical Schools H-295.959
- Medicolegal, Political, Ethical and Economic Medical School Course H-295.961
- Education Regarding Prescribing Controlled Substances H-295.972
- Family Medicine as a Fundamental Subject in Medical Schools H-295.984
- Humanism in Graduate Medical Education H-295.985
- Scholarly Activity by Resident and Fellow Physicians H-310.905
- Improving Residency Training in the Treatment of Opioid Dependence H-310.906
- Graduate Medical Education Faculty Evaluations H-310.945

The remaining 22 policies are listed in the appendices with recommended actions. They are:

- Sex and Gender Based Medicine in Clinical Education D-295.310
- Update on the Uses of Simulation in Medical Education D-295.330
- Suggested Revision in ACCME Evaluations D-300.979
- Medical Education and Training in Women's Health H-295.890
- Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945
- Recognition of Those Who Practice Addiction Medicine H-300.962
- Resident Education in Laboratory Utilization H-310.960
- Senior Living Community Training for Medical Students and Residents D-295.305
- Geriatric and Palliative Care Training For Physicians D-295.969
- Palliative Care and End-of-Life Care H-295.875
- Geriatric Medicine H-295.981
- Management and Leadership for Physicians D-295.316
- Health Care Economics Education D-295.321
- Future Directions for Socioeconomic Education H-295.924
- Practice Options and Skills Curriculum in Medical Education H-310.953
- Curriculum Orientation of Medical Staff Membership in Teaching Programs H-310.994
- Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327
- Service Learning in Medical Education H-295.880

- Medical Student, Resident and Fellow Legislative Awareness H-295.953
- Increasing Education on Physician-Led Care and Advocacy in Residency Training H-310.898

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, the Council identified the possible need for a policy supporting education on evidence-based care and principles across all topic areas, reducing the need for individual subject areas to be addressed in policies every time new medical literature and evidence arises. Other gap areas to address are precision education and adaptive expertise, entrustment in training, workplace-based assessment, telemedicine in medical education, and augmented intelligence in medical education. Such topics may be addressed in future reports, educational sessions, forums or other mechanisms as determined by this Council and/or the House of Delegates.

RELEVANT AMA POLICIES

There are multiple AMA polices impacted by this report:

Appendix A individually lists current policy language side-by-side with recommended actions (e.g., amend, rescind) related to that specific policy. These actions are collectively addressed in Recommendation 1 of this report.

Appendices B-F provide the language for related groups of current policy. Your Council recommends combining/consolidating these policies into alternate language for clarity and conciseness which is presented in Recommendations 2-6 of this report, respectively. The content of the original policies was maintained whenever possible, as was the spirit of the original policies.

CONCLUSION

This report reviewed 50 of the 237 policies originally identified and categorized as focusing on medical education and offered multiple recommendations for consideration. In this way, your Council is working to modernize and update our policy compendium as it relates to medical education and make it easier to identify and understand our policies moving forward.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:

1. The House of Delegates policies listed in Appendix A of this report be acted upon in the manner indicated. (Directive to Take Action)

2. That policies Senior Living Community Training for Medical Students and Residents D-295.305, Geriatric and Palliative Care Training For Physicians D-295.969, Palliative Care and End-of-Life Care H-295.875, and Geriatric Medicine H-295.981 (policy language available in Appendix B) be rescinded and the following policy be adopted:

GERIATRIC AND PALLIATIVE CARE TRAINING

a) Our AMA recognizes that not all palliative care is related to geriatric care, though they significantly intersect.
b) Our AMA recognizes the critical need for geriatrics and palliative care training, including but not limited to geriatric pharmacotherapy training, for all physicians who care for older adults and/or terminally ill patients, across all specialties.
c) Our AMA encourages further education and research on aging and healthcare of the aged.
d) Our AMA encourages development of opportunities for medical students and resident/fellow physicians to train in senior living communities (for example, nursing homes and assisted living facilities), as appropriate to the educational objectives of the program.
e) Our AMA endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities.
f) Our AMA encourages the inclusion of palliative medicine and geriatric medicine in the core curriculum of undergraduate, graduate, and continuing medical education.
g) Our AMA encourages the training of all healthcare professionals in the use of palliative care techniques and interdisciplinary team care.
h) Our AMA will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care.

3. That policies Management and Leadership for Physicians D-295.316, Health Care Economics Education D-295.321, Future Directions for Socioeconomic Education H-295.924, Practice Options and Skills Curriculum in Medical Education H-310.953, and Curriculum Orientation of Medical Staff Membership in Teaching Programs H-310.994 (policy language available in Appendix C) be rescinded and the following policy be adopted:

MANAGEMENT AND LEADERSHIP FOR PHYSICIANS

Our AMA:
a) supports and participates in the creation and promotion of management and leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to achieving financial literacy and leading interprofessional healthcare teams;
b) encourages the organizations responsible for the education of future physicians to implement programs throughout medical training to develop management and leadership competencies and financial literacy capabilities;
c) encourages key interested parties to collect and analyze data on the effectiveness of management and leadership training and share such information with the medical education community;
d) promotes the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health;
e) encourages medical schools and residencies to include basic content related to the structure and financing of the current healthcare system, including the organization of healthcare delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance;
f) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented at educationally appropriate times during undergraduate and graduate medical education;

g) assists medical societies, medical schools, and residency programs in the development of model curricula regarding practice options and management skills, including information on CPT and ICD coding, as well as resource-based relative value scale (RBRVS) and the AMA/Specialty Society RVS Update Committee (RUC).
h) believes that residency and fellowship programs should incorporate information on the privileges and responsibilities of medical staff membership into their education program's orientation materials.

4. That policies Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327 and Service Learning in Medical Education H-295.880 (policy language available in Appendix D) be rescinded and the following policy be adopted:

PUBLIC HEALTH AND SERVICE LEARNING IN MEDICAL EDUCATION

a) Our American Medical Association encourages medical schools, schools of public health, graduate medical education programs, and key organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.
b) Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.
c) Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.
d) Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.
e) Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties.
f) Our AMA will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.

5. That policies Improving Sexual History Curriculum in the Medical School H-295.879 and Clinical Training in Sexually Transmitted Infections H-295.980 (policy language available in Appendix E) be rescinded and the following policy be adopted:

IMPROVING SEXUAL HISTORY AND STI TRAINING IN MEDICAL EDUCATION

Our AMA:
a) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of healthcare;
b) urges medical schools to provide supervised training for sexually transmitted infections for all medical students and physicians in training;
c) supports public messaging that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being.

6. That policies Medical Student, Resident and Fellow Legislative Awareness H-295.953 and Increasing Education on Physician-Led Care and Advocacy in Residency Training H-310.898 (policy language available in Appendix F) be rescinded and the following policy be adopted:

LEGISLATIVE AWARENESS AND ADVOCACY IN MEDICAL EDUCATION

a) Our AMA strongly encourages state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
b) Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
c) Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
d) Our AMA will support and encourage institutional, state, and specialty organizations to offer real-world health policy and advocacy opportunities at local, state, and/or national levels for medical students, residents, and fellows.
e) Our AMA will develop, provide, expand upon, and promote the educational resources in the AMA GME Competency Education Program, as well as toolkits and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with healthcare policymakers and organizations.

Fiscal Note: Minimal

APPENDIX A: RECOMMENDATION 1 POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Sex and Gender Based Medicine in Clinical Education D-295.310	1. Our AMA will collaborate with Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to disseminate the work produced by medical schools participating in the Accelerating Change in Medical Education consortium and distribute pertinent information and a comprehensive bibliography about the influence that sex and gender have upon clinical medicine. 2. Our AMA will work collaboratively with the Liaison Committee on Medical Education and other interested organizations for the inclusion of sex- and gender-based differences within the curricular content for medical school accreditation. Res. 958, I-17 Appended: Res. 306, A-18	Rescind policy D-295.310. *Rationale: Clause 1 accomplished and available on AMA website. Clause 2 already reflected within existing policy, such as Medical Education and Training in Women's Health H-295.890.*
Update on the Uses of Simulation in Medical Education D-295.330	Our AMA will: 1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment; 2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;	Amend policy D-295.330 with a change in title as follows: ~~UPDATE ON THE USES OF~~ SIMULATION IN MEDICAL EDUCATION Our AMA will~~:~~ ~~1.~~ continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment; ~~2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate~~

Title and Policy Number	Text and Timeline	Recommendation
	3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance; 4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands; 5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and 6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum. CME Rep. 8, A-09 Reaffirmed: CME Rep. 01, A-19	~~Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;~~ ~~3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance;~~ ~~4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands;~~ ~~5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and~~ ~~6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum.~~ *Rationale: Simulation is effectively ubiquitous, though advocacy for funding and research remains important. Some of these policy items are outdated and no longer relevant.*
Suggested Revision in ACCME Evaluations D-300.979	Our American Medical Association will: communicate to the Accreditation Council for Continuing Medical Education that programs on the history of medicine have relevance for improvements in physicians' knowledge and competence. Sub. Res. 310, A-10 Appended: Res. 320, A-11 Modified: CME Rep. 1, A-21	Rescind policy D-300.979. *Rationale: Accomplished.*
Medical Education and Training in Women's Health H-295.890	Our American Medical Association encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women's health/gender-based biology that have	Amend Clause 1 of policy H-295.890 as follows: Our American Medical Association encourages the coordination and

Title and Policy Number	Text and Timeline	Recommendation
	been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum. Our AMA does not support the designation of women's health as a distinct new specialty. Our AMA supports that each specialty should define objectives for residency training in women's health, based on the nature of practice and the characteristics of the patient population served. Our AMA supports surveys of undergraduate and graduate medical education, conducted by the AMA and other groups, should periodically collect data on the inclusion of women's health in medical school and residency training. Our AMA encourages the development of a curriculum inventory and database in women's health for use by medical schools and residency programs. Our AMA encourages physicians to include continuing education in women's health/gender-based biology as part of their continuing professional development. Our AMA encourages its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education (ACGME), and the various ACGME Review Committees to promote attention to women's health in accreditation standards. Our AMA will work with the ACGME to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health, including training in contraceptive counseling, family planning, and counseling for unintended pregnancy.	synthesis of the knowledge, skills, and attitudinal objectives related to women's health~~/gender-based biology~~ that have been developed for use in the medical school curriculum. Medical schools should include attention to women's health throughout the basic science and clinical phases of the curriculum. Amend Clause 6 as follows: Our AMA encourages physicians to include continuing education in women's health~~/gender-based biology~~ as part of their continuing professional development. *Rationale: Clarify language.*

Title and Policy Number	Text and Timeline	Recommendation
	Our AMA encourages the ACGME to ensure clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics. Jt. Rep. CME and CSA, A-99 Reaffirmed: CME Rep. 2, A-09 Reaffirmed: CME Rep. 01, A-19 Appended: CME Rep. 01, A-23	
Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945	Our American Medical Association believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas. Our AMA recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR. Our AMA encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term and or prior to clinical clerkships. CCB/CLRPD Rep. 3, A-14 Modified: CME Rep. 1, A-22	Amend Clause 3 of policy H-300.945 as follows: Our AMA encourages that training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term and ~~or~~ prior to clinical clerkships. *Rationale: Important to encourage this to occur prior to clinical clerkships.*
Recognition of Those Who Practice Addiction Medicine H-300.962	1. It is the policy of the AMA to: (a) encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance abuse; (b) direct its representatives to appropriate Residency Review Committees (RRCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance abuse. Those RRCs that already require such instruction should consider greater emphasis for this subject. (c) encourage treatment of substance abuse as a subject for continuing medical education; and (d) affirm that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation	Amend policy H-300.962 with a change in title as follows: ~~RECOGNITION OF THOSE WHO PRACTICE ADDICTION MEDICINE~~ PHYSICIAN EDUCATION FOR SUBSTANCE USE DISORDERS 1. Our AMA: (a) encourages all physicians~~, particularly those in primary care fields,~~ to undertake education in treatment of substance use disorders ~~abuse~~; (b) directs its representatives to appropriate ~~Residency~~ Review Committees (~~R~~RCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance use disorders ~~abuse~~. Those

Title and Policy Number	Text and Timeline	Recommendation
	of such treatment, and should be entitled to compensation. 2. Our AMA commends the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards. 3. Our AMA recognizes the ABPM for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder. 4. Our AMA recognizes the American Osteopathic Association Bureau of Osteopathic Specialists for developing and providing a pathway for all qualified physicians to obtain subspecialty certification in addiction medicine, in order to improve access to care for patients with substance use disorder. 5. Our AMA recognizes the American Osteopathic Association (AOA) for developing and providing a pathway for qualified physicians (DOs and MDs) with an active primary AOA board certification in any specialty to obtain subspecialty certification in Addiction Medicine, in order to improve access to care for patients with substance use disorder. CME Rep. I-93-5 Reaffirmed: CME Rep. 10, I-98 Reaffirmed: CME Rep. 11, A-07 Appended: Res. 314, A-16 Modified and Appended: CME Rep. 4, I-19	~~R~~RCs that already require such instruction should consider greater emphasis for this subject; (c) encourages treatment of substance use disorders ~~abuse~~ as a subject for continuing medical education; and (d) affirms that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance use disorders ~~abuse~~, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation. ~~2. Our AMA commends the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards.~~ ~~3. Our AMA recognizes the ABPM for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder.~~ ~~4. Our AMA recognizes the American Osteopathic Association Bureau of Osteopathic Specialists for developing and providing a pathway for all qualified physicians to obtain subspecialty certification in addiction medicine, in order to improve access to care for patients with substance use disorder.~~ ~~5. Our AMA recognizes the American Osteopathic Association (AOA) for developing and providing a pathway for qualified physicians (DOs and MDs) with an active primary AOA board certification in any specialty to obtain subspecialty certification in Addiction Medicine, in order to improve access to~~

Title and Policy Number	Text and Timeline	Recommendation
		~~care for patients with substance use disorder.~~ *Rationale: Update language to align with existing AMA policy Destigmatizing the Language of Addiction H-95.917, and to correct other out-of-date language. Removing specific recognition statements as accomplished since original policy from 1993. No need to indicate specific parties while retaining statements of overall AMA values.*
Resident Education in Laboratory Utilization H-310.960	Our American Medical Association endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. Res. 84, A-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CME Rep. 2, A-11 Reaffirmed: CME Rep. 1, A-21	Rescind policy H-310.960 and amend policy Support for the Concepts of the Choosing Wisely Program D-155.988 to add an additional clause to read as follows: Our American Medical Association endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. *Rationale: Policy consolidation.*

APPENDIX B: CURRENT TEXT OF GERIATRIC AND PALLIATIVE POLICIES RECOMMENDED FOR RECISION

Senior Living Community Training for Medical Students and Residents D-295.305
Our American Medical Association encourages development of opportunities for medical students and resident/fellow physicians to train in senior living communities (for example, nursing homes and assisted living facilities), as appropriate to the educational objectives of the program.

Res. 319, A-22

Geriatric and Palliative Care Training For Physicians D-295.969
Our American Medical Association encourages geriatrics and palliative care training for physicians caring for elderly and terminally ill patients in long-term care facilities.

Our AMA endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities.

Res. 305, A-02 Reaffirmed: CCB/CLRPD Rep. 4, A-12 Reaffirmed: BOT Rep. 05, I-16 Modified: CME Rep. 01, A-20 Reaffirmed: BOT Rep. 18, I-24

Palliative Care and End-of-Life Care H-295.875
Our AMA:
1. Reaffirms the Council on Medical Education's support of palliative medicine as a medical subspecialty with certification recognized by the American Board of Medical Specialties, and also encourages the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education.

2. Encourages the training of all allied health workers in the use of palliative care techniques and interdisciplinary team care.

3. Will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care.

4. Our AMA will work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics.

BOT Rep. 5, A-06 Appended: Res. 322, A-14 Reaffirmed: BOT Rep. 05, I-16 Reaffirmed: BOT Rep. 18, I-24

Geriatric Medicine H-295.981
1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine into the curricula of medical school departments and its encouragement for further education and research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs.

2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties.

Res. 137, A-85 Reaffirmed by CLRPD Rep. 2, I-95 Appended: CSA Rep. 5, A-02 Appended: Res. 301, A-10 Reaffirmed: BOT Rep. 05, I-16

APPENDIX C: CURRENT TEXT OF ECONOMICS AND LEADERSHIP POLICIES RECOMMENDED FOR RECISION

Management and Leadership for Physicians D-295.316

Our American Medical Association supports collaborative programs among medical schools, residency programs, and related schools of business and management to give physicians the opportunity to assume administrative, financial, and leadership responsibilities in medical management.

Our AMA:
a. supports and participates in the creation and promotion of management and leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills, and management techniques integral to achieving financial literacy and leading interprofessional health care teams.
b. encourages the organizations responsible for the education of future physicians to implement programs throughout medical training to develop management and leadership competencies and financial literacy capabilities.
c. encourages key stakeholders to collect and analyze data on the effectiveness of management and leadership training and share such information with the medical education community.

Our AMA will expand efforts to promote the tenets of health systems science to prepare trainees for leadership roles and address prevalent challenges in the practice of medicine and public health.

Our AMA will create a central online directory of its management and leadership resources that is searchable on our AMA website and promote the directory and these resources to AMA members and the medical education community.

Sub. Res. 918, I-14 Appended: Res. 306, I-16 Reaffirmed in lieu of: Res. 307, A-17 Modified: Res. 313, A-18 Appended: Res. 327, A-22 Reaffirmation: A-23 Modified: CME Rep. 07, A-23

Health Care Economics Education D-295.321

Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician’s professional life, including undergraduate medical education, graduate medical education and continuing medical education.

Res. 320, A-09 Reaffirmation I-15 Modified: CEJA Rep. 01, A-20

Future Directions for Socioeconomic Education H-295.924

The AMA:
(1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum;

(2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is

presented at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum.

CME Rep. 1-I-94 Reaffirmed and Modified: CME Rep. 2, A-04 Reaffirmation A-12 Reaffirmation I-15 Reaffirmed in lieu of: Res. 307, A-17 Modified: CME Rep. 2, I-19

Practice Options and Skills Curriculum in Medical Education H-310.953

Our American Medical Association will assist medical societies, medical schools, and residency programs in the development of model curricula regarding practice options and management skills, including information on CPT and ICD coding, as well as RBRVS and RUC.

Sub. Res. 311, I-92 Reaffirmed: CME Rep. 2, A-03 Reaffirmed: CME Rep. 2, A-13 Modified: CME Rep. 01, A-20

Curriculum Orientation of Medical Staff Membership in Teaching Programs H-310.994

Our AMA believes that teaching programs in hospitals with residencies throughout the US should incorporate information on the privileges and responsibilities of medical staff membership into their education program's orientation materials.

Res. 142, A-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: CME Rep. 2, A-05 Reaffirmed: CME Rep. 1, A-15 Reaffirmed: CME Rep. 01, A-25

APPENDIX D: CURRENT TEXT OF PUBLIC HEALTH POLICIES RECOMMENDED FOR RECISION

Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327

1. Our American Medical Association encourages medical schools, schools of public health, graduate medical education programs, and key stakeholder organizations to develop and implement longitudinal educational experiences in public health for medical students in the pre-clinical and clinical years and to provide both didactic and practice-based experiences in public health for residents in all specialties including public health and preventive medicine.

2. Our AMA encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to examine their standards to assure that public health-related content and skills are included and integrated as appropriate in the curriculum.

3. Our AMA actively encourages the development of innovative models to integrate public health content across undergraduate, graduate, and continuing medical education.

4. Our AMA, through the Initiative to Transform Medical Education (ITME), will work to share effective models of integrated public health content.

5. Our AMA supports legislative efforts to fund preventive medicine and public health training programs for graduate medical residents.

6. Our AMA will urge the Centers for Medicare and Medicaid Services to include resident education in public health graduate medical education funding in the Medicare Program and encourage other public and private funding for graduate medical education in prevention and public health for all specialties.

CME Rep. 11, A-09 Reaffirmed: CME Rep. 03, I-18 Reaffirmed: CSAPH Rep. 2, I-21

Service Learning in Medical Education H-295.880

Our American Medical Association will support the concept of service learning as a key component in medical school and residency curricula, and that these experiences should include student and resident collaboration with a community partner to improve the health of the population.

Res. 321, A-04 Reaffirmed: CME Rep. 2, A-14 Reaffirmed: CME Rep. 01, A-24

APPENDIX E: CURRENT TEXT OF SEXUAL HEALTH POLICIES RECOMMENDED FOR RECISION

Improving Sexual History Curriculum in the Medical School H-295.879

Our AMA (1) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) supports public messaging that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being.

Res. 314, A-05 Modified: CME Rep. 1, A-15 Reaffirmed: CSAPH Rep. 01, A-25

Clinical Training in Sexually Transmitted Infections H-295.980

Our AMA urges medical schools to provide supervised training in sexually transmitted infections for all medical students and physicians in training.

Sub. Res. 88, A-85 Reaffirmed by CLRPD Rep. 2, I-95 Reaffirmed: CME Rep. 2, A-05 Reaffirmed: CME Rep. 1, A-15 Modified: CME Rep. 01, A-25

APPENDIX F: CURRENT TEXT OF ADVOCACY POLICIES RECOMMENDED FOR RECISION

Medical Student, Resident and Fellow Legislative Awareness H-295.953

1. Our AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.

2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.

3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.

4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

Res. 14, A-91 Reaffirmed: Sunset Report, I-01 Appended: Res. 317, A-10 Appended: Res. 307, A-15 Reaffirmed: CME Rep. 01, A-25

Increasing Education on Physician-Led Care and Advocacy in Residency Training H-310.898

Our AMA will develop, provide, expand upon, and promote the educational resources in the AMA GME Competency Education Program, as well as toolkits and workshops that residency programs can implement to teach residents about physician-led care, advocacy strategies, and how to effectively engage with health care policymakers and organizations.

Our AMA encourages residency programs to promote opportunities for residents and trainees to engage in real-world advocacy efforts at the local, state, and national levels, in collaboration with state societies and other medical organizations.

Res. 309, A-25

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-26

Subject: Medical Education Systems

Presented by: Shannon Kilgore, MD, FAAN, FANA, Chair

Referred to: Reference Committee C

Adopted at the 2024 Interim Meeting, AMA Policy D-295.299, "Updates to Recommendations for Future Directions for Medical Education," calls for the following:

> "Our American Medical Association will study the restructuring of AMA Policy H-295.995, 'Recommendations for Future Directions for Medical Education,' to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:
>
> - Mission of medical education.
> - Professional regulation.
> - Entry into and transition through the medical education continuum.
> - Medical education curricula.
> - Physician as medical professional.
> - Medical education systems.
> - Obligations to students and trainees."

This report addresses the theme of "medical education systems."

BACKGROUND

The above policy was initially introduced via the Council on Medical Education's self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995," Recommendations for the Future Directions for Medical Education," that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding "medical education systems":

> "The overall role of the physician and the practice of medicine in U.S. society has shifted. There has been a shift away from independent practice, influenced by economic, administrative, and regulatory burdens.[48] Due to the increasing complexity of health systems, in 1999, systems-based practice was introduced as one of the core competencies[49] endorsed by the ACGME and the ABMS, with Milestones introduced in 2013 as a developmental framework related to competencies and harmonized across specialties in 2017. There have been other updates since then.[49] Challenges continue to emerge in the clinical learning environment, requiring new approaches.[40] There are increasing concerns about the impact of corporate interests and private equity, as discussed in Council on Medical Education Reports 01-I-22, "The Impact of Private Equity on Medical Training,"[50] and 01-I-20, "Graduate Medical Education and the Corporate Practice of Medicine."[51] Other systems factors also influence medical education, such as high demand for clinical placements[52], physician

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workforce disparities[53], and scope of practice concerns, the latter of which led to the formation of the AMA's Scope of Practice Partnership in 2006.[54]"

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 37 of them were sorted into this report. They address policies related to scope of practice, GME funding (including funds from the Centers for Medicare & Medicaid Services), external groups outside medical education, systems-based practice, corporate interest, private equity, burdens to training (economic, administrative, regulatory), and the wider social environment. This report does not address policies where the main point of the policy fell outside of the purview of "medical education systems," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 37 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 26 policies remain relevant and should be retained:

- Promoting and Reaffirming Domestic Medical School Clerkship Education D-295.309
- Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934
- Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures D-300.998
- Preserving the Specialty of Occupational and Environmental Medicine D-305.947
- Promote Awareness of Federal Gainful Employment Regulations and Transparency Provisions D-305.948
- Increase in Children's Hospital Graduate Medical Education Funding D-305.949
- CMS to Pay for Residents? Vacation and Sick Leave D-305.968
- Strategies to Combat Mid-year and Retroactive Tuition Increases D-305.983
- Accounting for GME Funding D-305.992
- Coding for Services Involving Teaching Activity D-305.996

- Timely Issuance of Social Security Number D-310.960
- Promoting Transparency in Medical Education and Access to Training H-295.860
- Improving Medical School/Community Practice H-295.916
- Faculty/Staff Appointments at More Than One Medical School H-295.929
- Medical School Affiliations With Veterans Affairs (VA) Medical Centers H-295.933
- Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
- Payment Cuts to Teaching Programs H-305.927
- The Ecology of Medical Education: The Infrastructure for Clinical Education H-305.942
- Fairness in Publication of Names of Loan Defaulters H-305.950
- Financing of Medical Education Programs D-305.973
- Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988
- The Impact of Private Equity on Medical Training H-310.901
- Graduate Medical Education and the Corporate Practice of Medicine H-310.904
- Securing Funding for Graduate Medical Education H-310.917
- Training Physicians in Non-Traditional Sites H-310.946
- Residency Interview Costs H-310.966

During the drafting of this report, one of the policies reviewed was rescinded via the sunset report (CME 1-A-26) adopted at the 2026 Annual Meeting. It has therefore been removed from this report.

Nine policies are listed in the Appendix with recommended actions. They are:

- Medication Reconciliation Education D-300.973
- Implications of the "Stark II" Regulations for Continuing Medical Education D-300.988
- Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic D-305.951
- Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953
- Funding for Teaching Health Center Graduate Medical Education Program D-305.955
- Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion D-305.964
- Funding for Preventive Medicine Residencies D-305.974
- Reduction in Student Loan Interest Rates D-305.984
- Corporate Compliance Consolidation H-300.944

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, Policies D-305.973 and H-305.925 listed above, both extensive, could benefit from review given the brevity and evolving nature of the financing of medical education and impact on student debt. Also, the Council will consider a study of the role that the AMA and the Council play within the medical education community. This topic may be addressed in a future report, educational session, forum, or other mechanism as determined by this Council and/or the House of Delegates.

Upon further review of the issues raised in The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967, the Council determined that it should be studied to reshape its content to offer clearer guidance and a more future-oriented perspective as well as to update language and outdated references. Thus, the Council has added a recommendation to this report regarding such study.

RELEVANT AMA POLICIES

See the bulleted list above as well as policies in the Appendix.

CONCLUSION

This report reviewed 37 policies out of the 237 policies originally identified and categorized. The Appendix offers recommended actions for the remaining policies addressing "medical education systems."

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:

1. The House of Delegates policies listed in the Appendix of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

2. The AMA will study AMA Policy D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, to update its contents (Directive to Take Action).

Fiscal Note: Minimal

APPENDIX: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Current Policy Text and Timeline	Recommendation
Medication Reconciliation Education D-300.973	Our American Medical Association encourages the study of current medication reconciliation practices across transitions of care to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including the potential need for additional training, to reduce medical errors and ensure patient safety and quality of care. Policy Timeline: Res. 805, I-23	Append policy D-300.973 to policy D-120.965, "Medication Reconciliation to Improve Patient Safety." Rescind policy D-300.973. *Rationale: Policy consolidation.*
Implications of the "Stark II" Regulations for Continuing Medical Education D-300.988	Our American Medical Association will monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs. Policy Timeline: CME Rep. 6, I-04; Reaffirmed: CME Rep. 2, A-14; Modified: CME Rep. 01, A-24	Append policy D-300.988 to policy H-300.883, "Community Hospital Continuing Medical Education." Rescind policy D-300.988. *Rationale: Policy consolidation.*
Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic D-305.951	Our American Medical Association will study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students and physicians. Policy Timeline: Res. 301, A-22	Rescind D-305.951. *Rationale: Accomplished in Council on Medical Education reports "Medical Student Debt and Career Choice" (CME 04-I-21) and "Financing Medical Education" (CME 02-A-22).*
Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953	In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt. Policy Timeline: Res. 202, I-20	Rescind policy D-305.953. *Rationale: No longer necessary. AMA has policy in support of financial relief for physicians related to educational debt.*
Funding for Teaching Health Center Graduate Medical Education Program D-305.955	Our American Medical Association will encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs to continue the training of primary providers in community-based health centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations. Policy Timeline: Res. 214, A-15; Reaffirmed: BOT Rep. 09, A-25	Append policy D-305.955 to policy D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education." Rescind policy D-305.955. *Rationale: Policy consolidation.*

Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion D-305.964	Our American Medical Association will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. Policy Timeline: Res. 301, A-08; Reaffirmed: CME Rep. 01, A-18; Reaffirmed: CME Rep. 03, I-18; Reaffirmed: CSAPH Rep. 2, I-21	Append policy D-305.964 to policy D-305.974, "Funding for Preventive Medicine Residencies" (see next row). Rescind policy D-305.964. *Rationale: Policy consolidation.*
Funding for Preventive Medicine Residencies D-305.974	Our American Medical Association will work with the American College of Preventive Medicine, other preventive medicine specialty societies, and other allied partners, to formally support legislative efforts to fund preventive medicine training programs. Policy Timeline: Res. 324, A-05; Reaffirmed: CME Rep. 8, A-08; Reaffirmation I-14; Reaffirmed: CME Rep. 03, I-18; Reaffirmed: CSAPH Rep. 2, I-21	Amend policy D-305.974 by addition to read as follows: Our American Medical Association will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. *Rationale: Policy consolidation.*
Reduction in Student Loan Interest Rates D-305.984	1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%. 2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program. 3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates. 4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.	Append policy D-305.984 to policy H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt." Rescind policy D-305.984. *Rationale: Policy consolidation.*

	Policy Timeline: Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16; Modified: CME Rep. 02, A-23; Reaffirmed in lieu of: Res. 224, A-25	
Corporate Compliance Consolidation H-300.944	Our American Medical Association encourages reciprocity for corporate compliance curricula between institutions to minimize duplicate training and assessment of physicians. Policy Timeline: Res. 321, A-23	Rescind policy H-300.944. *Rationale: Addressed by more recent policy H-270.949.*

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 3-I-26

Subject: Professional Regulation of Physicians

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

Adopted at the 2024 American Medical Association (AMA) Interim meeting, AMA Policy D-295.299, "Updates to Recommendations for Future Directions for Medical Education," states:

> "Our American Medical Association will study the restructuring of AMA Policy H-295.995, 'Recommendations for Future Directions for Medical Education,' to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:
>
> - Mission of medical education.
> - Professional regulation.
> - Entry into and transition through the medical education continuum.
> - Medical education curricula.
> - Physician as medical professional.
> - Medical education systems.
> - Obligations to students and trainees."

This report addresses the theme of professional regulation, referred to in this report as "professional regulation of physicians."

BACKGROUND

The above policy was initially introduced via the Council on Medical Education's self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, "Recommendations for the Future Directions for Medical Education" that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding "professional regulation of physicians":

> "Medical education maintains commitment to the concept that the regulation of the medical profession should be guided by physicians. A 2015 memorandum of understanding between the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association, and American Association of Colleges of Osteopathic Medicine began a five-year transition to single U.S. graduate medical education (GME) accreditation, which finalized in 2020, though some express concerns. AMA policy currently supports work toward a single licensure exam (Single Licensing Exam Series for Osteopathic and Allopathic Medical Students D-275.947), and inequities between Doctors of Osteopathic Medicine (DOs) and Doctors of Medicine (MDs) continue to be addressed.

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Significant overall shifts in how standardized assessments are designed and discussed have also taken place since the 1980s. This includes the notion of competence as actual competencies linked to patient outcomes rather than personality traits, an understanding that did not develop until the late 1990s and early 2000s, with awareness of assessor bias and the limitations of assessments emerging in scholarly literature even later. In 2021, the United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) was permanently discontinued after a COVID-19 related 2020 suspension. In 2022, the USMLE Step 1 exam converted from numeric to pass-fail."

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Of the 237 policies, 26 were sorted into this report. They address policies related to regulatory bodies, competency linked to patient care, self-regulation (non-interference), accreditations, credentialing, assessments (i.e., USMLE/COMLEX), and the process of developing standards/requirements. This report does not address policies where the main point of the policy fell outside of the purview of "professional regulation of physicians," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 26 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 17 policies remain relevant and should be retained:

- Remediation Programs for Physicians D-295.325
- Update on Development of Branch Campuses of International Medical Schools D-295.996
- Physician Reentry D-300.984
- Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations H-295.841
- Physician Participation in the AMA Physician's Recognition Award H-300.959
- Residency Review Committee Representation and Requirements H-310.972

- Accreditation of Graduate Medical Education Programs H-310.997
- Disclosure of Compliance Issues Related to Joint Providership D-300.974
- Reduced Continuing Medical Education (CME) Fees for Retired Physicians D-300.994
- Registration of Accredited CME Sponsors D-300.999
- Dissemination of Information Regarding CME Activities H-300.952
- Inappropriate Use of Social Security Numbers in CME Accreditation H-300.946
- Restructuring of Continuing Medical Education Credits H-300.955
- Protocol for Recognition of State Medical Society Accreditation Programs H-300.968
- Unification of Continuing Education Credits H-300.974
- Community Hospital Continuing Medical Education H-300.983
- National Accreditation of AMA as Provider of Continuing Medical Education H-300.992

One policy reviewed, Residency Program Responsibility for Resident Education H-295.915, was rescinded by the A-26 Sunset report during the process of writing this report and therefore no longer needs to be acted upon in this report.

The remaining policies are listed in the appendices with recommended actions. They are:

- Independent Regulation of Physician Licensing Exams D-295.939
- Opposition to Increased CME Provider Fees D-300.980
- Proposed Fee Increase by the Accreditation Council for Continuing Medical Education D-300.981
- Evaluation of Increasing Resident Review Committee Requirements D-310.962
- Unification of Education Credits H-300.976
- Restoring Integrity to Continuing Medical Education H-300.988
- Federal Intervention in the Setting of Educational Standards H-295.921
- Legislative Threats to the Voluntary Accreditation Process H-295.947

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, the Council identified the possible need for a policy related to physician reentry as well as further study on how legislative restrictions and government regulatory agencies impact AMA efforts. Such topics may be addressed in future reports, educational sessions, or other mechanisms as determined by this Council and/or the HOD.

RELEVANT AMA POLICIES

There are multiple AMA polices impacted by this report:

Appendix A individually lists current policy language side-by-side with recommended actions (e.g., amend, rescind) related to that specific policy. These actions are collectively addressed in Recommendation 1 of this report.

Appendix B provides the language for related groups of current policy. Your Council recommends combining/consolidating these policies into alternate language for clarity and conciseness which is presented in Recommendation 2 of this report. The content of the original policies was maintained whenever possible, as was the spirit of the original policies.

CONCLUSION

This report reviewed 26 of the 237 policies originally identified and categorized as focusing on medical education and offered multiple recommendations for consideration. In this way, your Council is working to modernize and update our policy compendium as it relates to medical education and make it easier to identify and understand our policies moving forward.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:

1. The House of Delegates policies listed in Appendix A of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)
2. That policies Federal Intervention in the Setting of Educational Standards H-295.921 and Legislative Threats to the Voluntary Accreditation Process H-295.947 (policy language available in Appendix B) be rescinded and the following policy be adopted:

   LEGISLATIVE THREATS TO MEDICAL EDUCATION STANDARDS

   The AMA strongly opposes:
   a) federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians;
   b) infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place;
   c) legislation that would dismantle national accrediting agencies and that would substitute state standards for a uniform level of national standards in medical education, and
   d) legislation that would limit professional participation in the setting and evaluation of quality standards in medical education.

Fiscal Note: Minimal

APPENDIX A: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Independent Regulation of Physician Licensing Exams D-295.939	1. Our American Medical Association will continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system. 2. Our AMA will continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination. 3. Our AMA will continue to promote and disseminate the rules governing USMLE in its publications. 4. Our AMA will continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP). 5. Our AMA will work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). CME Rep. 10, A-08 Modified: CME Rep. 01, A-18 Reaffirmation: A-22	Amend policy D-295.939 by addition and deletion to read as follows: 1. Our American Medical Association ~~will continue to~~ works with ~~the National Board of Medical Examiners~~ relevant organizations to ensure that the AMA is given appropriate advance notice of any major potential changes in the United States Medical Licensing Examination (USMLE) and Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) examination systems. ~~2. Our AMA will continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination.~~ ~~3. Our AMA will continue to promote and disseminate the rules governing USMLE in its publications.~~ ~~4. Our AMA will continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP).~~ ~~5. Our AMA will work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX).~~ *Rationale: Amendment to clause 1 makes clauses 2 and 5 redundant. Clauses 3 and 4 are no longer relevant as the Committee to Evaluate the USMLE Program (CEUP) was disbanded.*

Title and Policy Number	Text and Timeline	Recommendation
Opposition to Increased CME Provider Fees D-300.980	1. Our American Medical Association will: a. continue to work with the ACCME to: i. Reduce the financial burden of institutional accreditation and state recognition. ii. Reduce bureaucracy in these processes. iii. Improve continuing medical education. iv. Encourage the ACCME to show that accreditation criteria improve patient care. b. continue to work with the ACCME to i. Mandate meaningful involvement of state medical societies in the policies that affect recognition. ii. Reconsider the fee increases to be paid by the state-accredited providers to ACCME. 2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees." CME Rep. 14, A-10 Appended: CME Rep. 9, A-11 Modified: CCB/CLRPD Rep. 4, A-12 Modified: CCB/CLRPD Rep. 2, A-14 Appended: Res. 302, A-17 Modified: CME Rep. 1, A-21	Amend policy D-300.980 by addition and deletion with a change in title to read as follows: ~~OPPOSITION TO INCREASED CME PROVIDER FEES~~CONTINUING MEDICAL EDUCATION ACCREDITATION 1. Our American Medical Association will: a. continue to work with the ACCME to: i. Reduce the financial burden of institutional accreditation and state recognition. ii. Reduce bureaucracy in these processes. iii. Improve continuing medical education. iv. Encourage the ACCME to show that accreditation criteria improve patient care. ~~b.~~ continue to work with the ACCME to ~~i. M~~mandate meaningful involvement of state medical societies in the policies that affect recognition. ~~ii. Reconsider the fee increases to be paid by the state-accredited providers to ACCME.~~ ~~2. Our AMA will continue to work with the ACCME to accomplish the directives in policy D-300.980, "Opposition to Increased Continuing Medical Education (CME) Provider Fees."~~ Our AMA will investigate and recommend ways by which physicians may receive appropriate, accredited continuing medical education other than through ACCME-accredited activities. *Rationale: Clause b(ii) is outside the purview of the AMA. Clause 2 is redundant. Addition is consolidated from D-300.981 below.*

Title and Policy Number	Text and Timeline	Recommendation
Proposed Fee Increase by the Accreditation Council for Continuing Medical Education D-300.981	Our AMA will strongly urge the Accreditation Council for Continuing Medical Education (ACCME) to reconsider the proposed fee increase and, if the ACCME refuses to reconsider the proposed fee increase, our AMA will investigate and recommend ways by which physicians may receive appropriate, accredited continuing medical education other than through ACCME-accredited activities. Res. 312, A-09 Reaffirmed: CME Rep. 01, A-19	Rescind policy D-300.981. *Rationale: First part of policy was accomplished by notifying the ACCME of this adopted policy. Second part of policy is recommended to be appended to D-300.980 above.*
Evaluation of Increasing Resident Review Committee Requirements D-310.962	Our American Medical Association will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. Res. 315, A-08 Reaffirmed: CME Rep. 01, A-18	Amend policy D-310.962 by addition and deletion to read as follows: Our American Medical Association will collaborate ~~work~~ with ~~and monitor~~ the Accreditation Council for Graduate Medical Education ~~and American Osteopathic Association~~ in ~~studying~~ evaluating residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement as needed. *Rationale: The AMA is in communication with ACGME on this and related matters. AOA is no longer the appropriate organization to list here. AMA does not monitor ACGME.*
Unification of Education Credits H-300.976	It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies. Policy Timeline: Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20	Amend policy H-300.976 by addition and deletion to read as follows: ~~It is the policy of the~~ AMA will ~~develop~~, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies. *Rationale: Cleaner phrasing.*

Title and Policy Number	Text and Timeline	Recommendation
Restoring Integrity to Continuing Medical Education H-300.988	1. Our American Medical Association supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."). 2. Our AMA urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities. 3. Our AMA believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education. 4. Our AMA encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education. 5. Our AMA encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the	Amend policy H-300.988, Clause 4 by addition and deletion, with a change in title, to read as follows: INTEGRITY IN CONTINUING MEDICAL EDUCATION~~RESTORING INTEGRITY TO CONTINUING MEDICAL EDUCATION~~ 4. Our AMA encourages ~~the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation,~~ oversight bodies to monitor instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education and intervene accordingly. *Rationale: Cleaner phrasing.*

Title and Policy Number	Text and Timeline	Recommendation
	prerogative of defining the continuing education it will accept for credit. Policy Timeline: CME Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, A-13; Reaffirmation: A-22	

APPENDIX B: CURRENT TEXT OF LEGISLATIVE POLICIES RECOMMENDED FOR RECISION

Federal Intervention in the Setting of Educational Standards H-295.921

The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor such activities and notify the AMA when such intrusions take place.

Res. 323, A-95 Appended: CME Rep. 4, I-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 01, A-17

Legislative Threats to the Voluntary Accreditation Process H-295.947

It is the policy of our American Medical Association to strongly oppose legislation which would:

1. Dismantle national accrediting agencies and which would substitute state standards for a uniform level of national standards in medical education.

2. Limit professional participation in the setting and evaluation of quality standards in medical education.

Res. 225, I-91 Modified: Sunset Report, I-01 Reaffirmed: BOT Rep. 22, A-11 Reaffirmed: BOT Rep. 7, A-21

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-26

Subject: Physician as Medical Professional

Presented by: Shannon Kilgore, MD, FAAN, FANA, Chair

Referred to: Reference Committee C

Adopted at the 2024 Interim Meeting, AMA Policy D-295.299, "Updates to Recommendations for Future Directions for Medical Education," calls for the following:

> "Our American Medical Association will study the restructuring of AMA Policy H-295.995, 'Recommendations for Future Directions for Medical Education,' to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:
>
> - Mission of medical education.
> - Professional regulation.
> - Entry into and transition through the medical education continuum.
> - Medical education curricula.
> - Physician as medical professional.
> - Medical education systems.
> - Obligations to students and trainees."

This report addresses the theme of "physician as medical professional."

BACKGROUND

The above policy was initially introduced via the Council on Medical Education's self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, "Recommendations for the Future Directions for Medical Education," that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding "physician as medical professional":

> "Due in part to the rapid growth of managed care in health insurance in the late 1980s and early 1990s, a much larger proportion of physicians began seeking board certification.[42] Rapid changes in medicine and the exponential growth of medical knowledge also caused shifts in patient and payer concerns about physician knowledge.[43] In 1990, internal medicine board certification became time-limited rather than one-time, and in 2002, all member boards of the American Board of Medical Specialties agreed on recertification requirements and evaluation of performance in practice.[42] These changes led to continuous assessment programs called maintenance of certification (MOC)[43] in the early 2000s, which offered both benefits and challenges, and translated to varying options for continuing board certification depending on specialty, such as a longitudinal knowledge assessment pathway for the American Board of Internal Medicine (ABIM) in 2022.[43]

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> With regard to physician lifelong learning, the Accreditation Council for Continuing Medical Education was still new when the 1982 report was written, having been established in 1981, and has evolved over time.[44] AMA's own Physician Recognition Award (PRA) Credit System also shifted over time, including official booklet updates in 2017 and in-progress changes since then.[45] Many factors related to lifelong learning have also emerged into greater awareness, such as ageism and principles to guide physician competence assessment at any age[46] and substance use disorder destigmatization and interventions.[47]"

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 28 of them were sorted into this report. They address policies related to professionalism, burnout, lifelong learning, board certification, PRA operations, and continuing medical education. This report does not address policies where the main point of the policy fell outside of the purview of "physician as medical professional," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 28 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 24 policies remain relevant and should be retained:

- Promoting Physician Lifelong Learning D-295.328
- Criminal Background Checks for Medical Students D-295.949
- Continuing Medical Education Resources for Preceptorship D-300.972
- Increased Credit for Continuing Medical Education Preparation D-300.975
- Alternative Funding for Continuing Medical Education D-305.965
- Physician and Medical Student Burnout D-310.968
- Protections for Trainees, Faculty, and Staff Experiencing Retaliation in Medical Education H-295.837
- Curricular Structure Reform to Support Physician and Trainee Well-Being H-295.838
- Addressing Professionalism Standards in Medical Training H-295.839
- The Impact of Midlevel Providers on Medical Education H-295.849
- Conscience Clause: Final Report H-295.896
- Continuing Medical Education Activities for Procedural Skills H-300.948

- Credit for Reading Medical Journals H-300.951
- Content-Specific CME Mandated for Licensure H-300.953
- Support for Continuing Medical Education H-300.958
- Medical Ethics and Continuing Medical Education H-300.964
- Promoting Quality Assurance, Peer Review, and Continuing Medical Education H-300.973
- Fraudulent/Legitimate Continuing Medical Education Activities H-300.975
- Focused Continuing Education Programs for Enhanced Clinical Competence H-300.980
- Community Hospital Continuing Medical Education H-300.983
- National Accreditation of AMA as Provider of Continuing Medical Education H-300.992
- Support of Voluntary Continuing Medical Education H-300.994
- Reaffirmation of Support for Continuing Medical Education H-300.996
- ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities H-310.911

The remaining four policies are listed in the Appendix with recommended actions. They are:

- Fostering Professionalism During Medical School and Residency Training D-295.983
- Continuing Medical Education for Physicians in the Hospital Setting H-300.966
- Revisions to the Physician's Recognition Award H-300.977
- "Medical Education" Travel H-300.997

Gaps identified

Upon review of the 28 policies, the Council identified important topics that could be further illuminated in AMA policy. They include physician wellness, augmented intelligence (AI)/emerging technologies and the future of medical education, competency-based medical education (CBME) in continuing medical education, and principles related to physician re-entry into clinical practice. Such topics may be addressed in future reports, educational sessions, forums, or other mechanisms as determined by this Council and/or the House of Delegates.

RELEVANT AMA POLICIES

See the bulleted list above as well as policies in the Appendix.

CONCLUSION

This report reviewed 28 policies out of the 237 policies originally identified and categorized. It offers recommended actions for four of those policies addressing "physician as medical professional."

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:

1. The House of Delegates policies listed in the Appendix of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

APPENDIX: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Fostering Professionalism During Medical School and Residency Training D-295.983	(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics. (b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism. (c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees' acquisition of professionalism. (d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism. (2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training. Policy Timeline: CME Rep. 3, A-01; Reaffirmation I-09; Reaffirmed: CME Rep. 01, A-19; Modified: CME Rep. 01, A-20	Amend policy clause (2) of D-295.983 by addition and deletion to read as follows: (2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to foster~~ing~~ the development of professionalism.~~, to~~ Methods should include an evaluation of professional behavior, to be carried out at regular intervals and ~~employing methods~~ shown to be valuable in adding to ~~the information that can be obtained from~~ observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident/fellow physicians aimed at improving their performance and for summative decisions about progression in training. *Rationale: Amended to provide clarity.*

Continuing Medical Education for Physicians in the Hospital Setting H-300.966	It is the policy of our American Medical Association that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws. Policy Timeline: Res. 318, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13; Reaffirmed: CME Rep. 01, A-23	Amend policy H-300.966 to read as follows: ~~It is the policy of o~~ Our American Medical Association ~~that the~~ encourages continuing medical educational programs offered to physicians in the hospital setting be created collaboratively ~~the responsibility of the hospital medical staff and directed by~~ with the medical staff as defined in the hospital bylaws. *Rationale: Policy implied that only the medical staff office can offer continuing medical education. For large organizations, this policy could be prohibitive and burdensome. Amended language provides broader educational opportunities.*
Revisions to the Physician's Recognition Award H-300.977	Our American Medical Association has adopted the following changes in the Physician's Recognition Award: 1. To accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate. 2. To allow credit for international conferences when these have been approved by the AMA prior to the event. 3. To allow credit for teaching to be reported for *AMA PRA Category 2 Credit*™ toward the award. Policy Timeline: CME Rep. D, I-90; Reaffirmed: Sunset Report, I-00; Modified and reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16; Reaffirmation: A-22	Rescind policy H-300.977. *Rationale: Changes listed in clauses 1-4 were accomplished. For more information, see AMA PRA Booklet.*

"Medical Education"" Travel H-300.997	Our AMA (1) deplores excessive charges for continuing medical education programs which exploit physicians or distort the real purposes of education programs; (2) encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges; and (3) supports making a concentrated effort to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost. Policy Timeline: Sub. Res. 84, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20	Amend policy H-300.997 by addition and deletion with a change in title to read as follows: CONTINUING MEDICAL EDUCATION FEES Our AMA (1) ~~deplores~~ opposes excessive charges for continuing medical education (CME) programs ~~which~~ that exploit physicians or distort the real purposes of education programs; (2) encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges; and (3) supports ~~making a concentrated~~ efforts to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost. *Rationale: Amended to provide clarity and accuracy.*

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-I-26

Subject: Entry into and transition through the medical education continuum

Presented by: Shannon Kilgore, MD, FAAN, FANA, Chair

Referred to: Reference Committee C

Adopted at the 2024 Interim Meeting, AMA Policy D-295.299, "Updates to Recommendations for Future Directions for Medical Education," calls for the following:

> "Our American Medical Association will study the restructuring of AMA Policy H-295.995, 'Recommendations for Future Directions for Medical Education,' to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:
>
> - Mission of medical education.
> - Professional regulation.
> - Entry into and transition through the medical education continuum.
> - Medical education curricula.
> - Physician as medical professional.
> - Medical education systems.
> - Obligations to students and trainees."

This report addresses the theme of "entry into and transition through the medical education continuum."

BACKGROUND

The above policy was initially introduced via the Council on Medical Education's self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, "Recommendations for the Future Directions for Medical Education," that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding "entry into and transition through the medical education continuum":

> "Application and selection processes have also changed over time. In 1995, the Association of American Medical Colleges (AAMC) developed the Electronic Residency Application Service (ERAS), replacing cumbersome paper mail residency applications with newer technology—first floppy disks, followed by web-based services.[18] In more recent years, specialties have considered and tested alternatives to ERAS, such as the obstetrics and gynecology (OB/GYN) specialty's shift to the Residency Centralized Application Service in 2024.[19] This new platform will still work in conjunction with the National Resident Matching Program (NRMP) for the Match. Although the NRMP was established in 1952,[20] significant changes have also taken place over the years to modernize infrastructure and shift strategic priorities in response to modern needs.[21] The NRMP formalized its Specialty Matching

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Service and conducted its first fellowship Match in 1984.[22] A single Match for DOs and MDs began in 2020.[6]

The COVID-19 pandemic, declared officially in 2020, sparked both a major crisis within medical education and devastation for many within society at large, prompting opportunities for transformations of existing systems[23] in both education and patient care.[24] AAMC now recommends virtual interviewing for all residency and fellowship programs.[25] On the heels of COVID-19 related upheaval, the Coalition for Physician Accountability commissioned an independent body to review the UME-to-GME transition and provide recommendations. The Undergraduate Medical Education to Graduate Medical Education Review Committee (UGRC) released a report with 34 recommendations in August 2021.[26]

For international medical graduates, the Educational Commission for Foreign Medical Graduates (ECFMG) established the Foundation for Advancement of International Medical Education and Research (FAIMER) in 2000,[27] launched electronic verification of medical credentials in 2012,[28] developed certification Pathways in 2020 following the suspension of USMLE Step 2,[29] and in 2023, ECFMG and FAIMER became divisions of a private nonprofit organization, Intealth.[29] In 2024, the Federation of State Medical Boards (FSMB), Intealth, and the ACGME established an Advisory Commission on Alternate Licensing Models to 'provide guidance on alternative pathways for state licensure of physicians who have completed training and/or practiced outside of the United States,' with work in progress at the time of this writing.[30]"

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 21 of them were sorted into this report. They address policies related to application and selection processes, match processes, demonstrating readiness to progress, ERAS, and Intealth. This report does not address policies where the main point of the policy fell outside of the purview of "entry into and transition through the medical education continuum," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 21 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 19 policies remain relevant and should be retained:

- Modifying Financial Assistance Eligibility Criteria for Medical School Applicants D-305.950
- Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310.945
- Fellowship Application Reform D-310.958
- Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education H-295.844
- Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance H-295.851
- Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status H-295.854
- Extramural Clerkships and Early Career Decisions H-295.983
- Progress in Medical Education: Structuring the Fourth Year of Medical School H-295.895
- The Ecology of Medical Education: Physician Self-Directed Learning and Continuing Medical Education H-300.949
- Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding H-305.971
- Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter H-310.897
- Unmatched Graduating Physicians H-310.899
- Resident and Fellow Physicians Seeking to Transfer GME Program H-310.900
- Preliminary Year Program Placement H-310.910
- Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
- Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949
- In-Service Training Examinations - Final Report H-310.959
- Reevaluation of Residency Selection Process H-310.982
- Residency Positions for Sale H-310.983

The remaining two policies are listed in the Appendix with recommended actions. They are:

- Clinical Skills Assessment During Medical School D-295.988
- Tools to Support Achievement of Competencies Across Learning Continuum H-295.862

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, efforts in the medical education community are currently focused on the transition from UME to GME (and GME into practice). These efforts provide an opportunity to leverage early lessons learned from competency-based medical education, precision education, and other initiatives to revisit policies like H-295.895 (listed above). Also, the Council may consider future study of the transitions that occur throughout the course of medical training. This complex topic could be addressed in a future report, educational session, forum, or other mechanism as determined by this Council and/or the House of Delegates.

RELEVANT AMA POLICIES

See bulleted list above as well as policies in the Appendix.

CONCLUSION

This report reviewed 21 policies out of the 237 policies originally identified and categorized. The Appendix offers recommended actions for the two remaining policies that address "entry into and transition through the medical education continuum."

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:

1. The House of Delegates policies listed in the Appendix of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

APPENDIX: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Clinical Skills Assessment During Medical School D-295.988	1. Our American Medical Association will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills. 2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination. 3. Our AMA will work to: a. ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners. b. encourage a significant and expeditious increase in the number of available testing sites. c. allow international students and graduates to take the same examination at any available testing site.	Amend policy D-295.988 by addition and deletion to read as follows: ~~1. Our American Medical Association will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.~~ ~~2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.~~ ~~3. Our AMA will work to:~~ ~~a. ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners.~~ ~~b. encourage a significant and expeditious increase in the number of available testing sites.~~ ~~c. allow international students and graduates to take the same examination at any available testing site.~~

	d. engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization. e. include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. 4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills. 5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed. 6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: a. Identify areas of satisfactory or better performance. b. Identify areas of suboptimal performance. c. Give students who fail the exam insight into the areas of unsatisfactory performance on the examination. **7.** Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with stakeholders as necessary should updates to this policy become necessary. Policy Timeline: CME Rep. 7, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: Alt. Res. 311, A-16; Appended: CME Rep. 9, A-17; Reaffirmation: I-19; Reaffirmed: Res. 306, I-20; Reaffirmed in lieu of: Res. 308, A-21	~~d. engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization.~~ ~~e. include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.~~ ~~4.~~ Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills. ~~5.~~ Our AMA will continue to work with appropriate ~~stakeholders~~ parties to ~~assure~~ ensure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed. ~~6.~~ Our AMA encourages development of a post-examination feedback system for all USMLE and COMLEX-USA test-takers that would: a. Identify areas of satisfactory or better performance. b. Identify areas of suboptimal performance. c. Give students who fail the exam insight into the areas of unsatisfactory performance on the examination. ~~7.~~ Our AMA, through the Council on Medical Education, will continue to monitor relevant data and engage with ~~stakeholders~~ relevant parties as necessary should updates to this policy become necessary. *Rationale: Retain clause 4. Clauses 1-3 are no longer relevant. Updated clause 6 to include DO students. Updated terminology in clauses 5 and 7.*

Tools to Support Achievement of Competencies Across Learning Continuum H-295.862	Our AMA supports the development and implementation of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum. Policy Timeline: CME Rep. 4, A-14; Appended: CME Rep. 10, A-15; Modified: CME Rep. 01, A-25	Append policy H-295.862 to policy D-295.317, "Competency Based Medical Education Across the Continuum of Education and Practice." Rescind policy H-295.862. *Rationale: Policy consolidation.*

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-I-26

Subject: Obligations to Students and Trainees

Presented by: Shannon Kilgore, MD, FAAN, FANA,, Chair

Referred to: Reference Committee C

Adopted at the 2024 Interim Meeting, AMA Policy D-295.299, "Updates to Recommendations for Future Directions for Medical Education," calls for the following:

> "Our American Medical Association will study the restructuring of AMA Policy H-295.995, 'Recommendations for Future Directions for Medical Education,' to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:
>
> - Mission of medical education.
> - Professional regulation.
> - Entry into and transition through the medical education continuum.
> - Medical education curricula.
> - Physician as medical professional.
> - Medical education systems.
> - Obligations to students and trainees."

This report addresses the theme of "obligations to students and trainees."

BACKGROUND

The above policy was initially introduced via the Council on Medical Education's self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, "Recommendations for the Future Directions for Medical Education," that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding "obligations to students and trainees":

> "Since 1982, there has been increased attention to the needs of students and trainees, in a variety of forms. Student well-being is now better researched, and a variety of interventions have been tested[50] and implemented on an ongoing basis.[55] Resident working conditions and duty hours have become major issues in GME, particularly after the Libby Zion case in 1984[56] and adoption of ACGME duty hour standards.[57] In 2011, the AMA released the Residents and Fellows' Bill of Rights H-2 31.912, last updated in 2023, and there is increasing awareness of the need to address growing stressors and burnout within medical education, both for learners[58] and faculty.[59] Research is ongoing on how other aspects of the medical education field have shifted over time and how these changes may impact learners and public health.[60]"

Citations denoted above are provided in CME 2-I-24.

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In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 42 of them were sorted into this report. They address policies related to protection of learners, well-being, needs of learners, resident working conditions, duty hours, bill of rights, burnout/stress, and equity in access for DOs. This report does not address policies where the main point of the policy fell outside of the purview of "obligations to students and trainees," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 42 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 25 policies remain relevant and should be retained:

- Accreditation Standards to Address Sexual Harassment in Medical Training Programs D-295.304
- Decreasing Bias in Evaluations of Medical Student Performance D-295.307
- Parental Leave and Planning Resources for Medical Students D-295.308
- Facilitating Access to Health Care Facilities for Training D-295.941
- Pharmaceutical Federal Regulations -- Protecting Resident Interests D-295.964
- Increased Education and Access to Fertility Resources for U.S. Medical Students H-295.846
- Support for Institutional Policies for Personal Days for Undergraduate Medical Students H-295.850
- Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Allopathic and Osteopathic Medical Undergraduate and Graduate Education Programs H-295.856
- Access to Confidential Health Services for Medical Students and Physicians H-295.858
- Equal Fees for Osteopathic and Allopathic Medical Students H-295.876
- Color Blindness H-295.889
- Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment H-295.908
- Protecting Medical Trainees from Hazardous Exposure H-295.939

- Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students H-295.943
- Teacher-Learner Relationship in Medical Education H-295.955
- Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs H-295.993
- Psychological Testing Without Informed Consent H-295.996
- Due Process H-295.998
- Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid H-305.941
- Taxation of Federal Student Aid H-305.962
- Resident/Fellow Clinical and Educational Work Hours H-310.907
- Physician Extenders H-310.913
- Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923
- Shared Residency Positions H-310.990
- Resident Participation on Hospital Committees H-310.993

Sixteen policies are listed in Appendix A with recommended actions. They are:

- HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970
- Reimbursement for Post-Exposure Protocol for Needlestick Injuries H-295.855
- The Effect of the COVID-19 Pandemic on Graduate Medical Education D-310.946
- Protecting Trainees' Breastfeeding Rights D-310.950
- Accommodating Lactating Individuals Taking Medical Examinations H-295.861
- Resident Pay During Orientation D-310.967
- Impairment Prevention and Treatment in the Training Years H-295.863
- Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year H-295.867
- Eliminating Benefits Waiting Periods for Residents and Fellows H-295.873
- Insurance Coverage for Medical Students and Resident Physicians H-295.942
- Residents' Salaries H-305.930
- Resident and Fellow Access to Fertility Preservation H-310.902
- Financial Protections for Doctors in Training H-310.903
- Funding to Support Training of the Health Care Workforce H-310.916
- The Educational and Work Environment of Resident Physicians H-310.935
- Anonymity for Resident Inquiries to Residency Review Committees H-310.995

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, Policy H-295.955 addresses an important and complex topic that could be further explored in terms of the evolving learning environment in medical education.

Review of these 42 policies also illuminated for the Council the opportunity to investigate how undergraduate, graduate, and continuing medical education must innovate with augmented intelligence (AI) as well as other emerging technologies to fulfill medical education's obligations to students and trainees. This topic may be addressed in future reports, educational sessions, forums or other mechanisms as determined by this Council and/or the House of Delegates.

Upon further review of the issues raised in the Residents and Fellows' Bill of Rights H-310.912, the Council determined that it should be studied. This policy has grown significantly over time. Such review provides an opportunity to reshape its content to offer clearer guidance, reduce redundancies, and a more future-oriented perspective as well as to update language and outdated references. Thus, the Council has added a recommendation to this report regarding such study. Of note, it also raises consideration for the possibility of a bill of rights for medical students.

RELEVANT AMA POLICIES

See bulleted list above as well as policies in Appendix A. Also, Appendix B lists current language for two policies the Council has recommended for recission as a themed grouping. Recission does not mean the topic is no longer relevant. Rather, the topics and language from Appendix B policies have been used to create new consolidated language in the report recommendations, for clarity and conciseness. The Council's intention is to make it easier to find and understand AMA's stance on specific topics, rather than having similar policies scattered in many areas of Policy Finder.

CONCLUSION

This report reviewed 42 policies out of the 237 policies originally identified and categorized. It offers recommended actions for four of those policies addressing "obligations to students and trainees."

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:

1. The House of Delegates policies listed in Appendix A of this report be acted upon in the manner indicated. (Directive to Take Action)

2. The AMA will study Policy H-310.912, Residents and Fellows' Bill of Rights, to update its contents (Directive to Take Action).

3. That Policies D-310.948, Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure, and H-310.943, Closing of Residency Programs, (policy language available in Appendix B) be rescinded and the following policy be adopted:

   PROTECTIONS IN THE CASE OF HOSPITAL OR TRAINING PROGRAM CLOSURE

   1. Our American Medical Association (AMA) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in graduate medical education (GME) funding.

   2. Our AMA encourages residency programs and teaching hospitals to:
      a. Uphold their contractual responsibilities to the residents.
      b. Undergo monitoring by the applicable Review Committees to ensure that reductions in resident and fellow numbers do not unduly burden remaining residents and fellows through adverse effects on work hours or working conditions, consistent with Review Committee requirements.

3. Our AMA encourages the Centers for Medicare & Medicaid Services (CMS) to:
   a. Stipulate in its regulations that residency slots are not assets that belong to the teaching institution.
   b. Establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
      i. Notice by the training hospital intending to file for bankruptcy within 30 days to all residents and fellows primarily associated with the training hospital as well as those contractually matched at that training institution who may not yet have matriculated of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.
      ii. Revise the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.
      iii. Improve provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.
      iv. Protect against the discrimination of displaced residents and fellows consistent with "Nondiscrimination Toward Residency Applicants H-295.969."

4. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to:
   a. Address the problem of non-educational closing or downsizing of residency training programs.
   b. Include in its Institutional Requirements that sponsoring institutions provide:
      i. Professional liability coverage for residents in the event of an institution or program closure.
      ii. Information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger by sponsoring institutions to residents/fellows and applicants.

5. Our AMA encourages the American Board of Medical Specialties (ABMS) and its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity of care requirements and granting residents credit for partial years of training.

6. Our AMA encourages relevant organizations to:
   a. Develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure.
   b. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions.
   c. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions.
   d. Develop pathways that ensure closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.
   e. Identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

f. Monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.
g. Advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps) in the event of temporary or permanent residency program closure.
h. Coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity.

Fiscal Note: Minimal

APPENDIX A: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Current Policy Text and Timeline	Recommendation
HIV Postexposure Prophylaxis for Medical Students During Electives Abroad D-295.970	1. Our American Medical Association recommends that US medical schools ensure that medical students who engage in clinical rotations abroad have immediate access to HIV postexposure prophylaxis. 2. Our AMA encourages medical schools to provide information to medical students regarding the potential health risks of completing a medical rotation abroad, and on the appropriate precautions to take to minimize such risks. Policy Timeline: Res. 303, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Modified: CME Rep. 1, A-22	Amend policy D-295.970 by change in title to read as follows: HEALTH RISKS FOR MEDICAL STUDENTS DURING ELECTIVES ABROAD *Rationale: Title should be broader to encompass clause (2).*
Reimbursement for Post-Exposure Protocol for Needlestick Injuries H-295.855	Our AMA will encourage medical schools to have policies in place addressing diagnosis, treatment, and follow-up at no cost to medical students exposed to an infectious or environmental hazard in the course of their medical student duties. Policy Timeline: Res. 801, I-19	Amend policy H-295.855 by addition to read as follows: Our AMA will encourage medical schools to have policies in place addressing diagnosis, treatment, and follow-up at no cost to medical students exposed to an infectious or environmental hazard in the course of their medical student duties, including when abroad. Append amended policy H-295.855 to policy D-295.970. Rescind policy H-295.855. *Rationale: Addition makes policy more comprehensive. Appendage allows for policy consolidation.*
The Effect of the COVID-19 Pandemic on Graduate Medical Education D-310.946	Our AMA will: (1) work with relevant stakeholders to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their specialty training; and (2) urge the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning, given the	Amend policy D-310.946 by addition and deletion with a change in title to read as follows: THE EFFECT OF NATIONAL CRISES ON GRADUATE MEDICAL EDUCATION Our AMA will: (1) work with relevant ~~stakeholders~~ parties to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their

	drastic educational barriers confronted during the COVID-19 pandemic. Policy Timeline: Res. 319, A-21	specialty training; and (2) urge the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning~~, given the drastic educational barriers confronted during the COVID-19 pandemic~~ during national crises, which have a significant impact on graduate medical education such as pandemics. *Rationale: Policy should be broader to apply to other national crises.*
Protecting Trainees' Breastfeeding Rights D-310.950	1. Our American Medical Association will work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk. 2. Our AMA will work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding people in regular program reviews. Policy Timeline: Res. 302, I-16; Modified: Speakers Rep. 02, I-24	Amend policy D-310.950 by addition and deletion with change in title to read as follows: PROTECTIONS FOR LACTATING INDIVIDUALS 1. Our American Medical Association will work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of ~~breast~~ human milk. 2. Our AMA will work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for ~~breastfeeding people~~ lactating individuals in regular program reviews. *Rationale: Policy should use inclusive language in accordance with Policy D-65.969, "Use of Inclusive Language in AMA Policy."*

Accommodating Lactating Individuals Taking Medical Examinations H-295.861	1. Our American Medical Association urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk. 2. Our AMA encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. Policy Timeline: Sub. Res. 903, I-14; Modified: Res. 310, A-17; Modified: Speakers Rep. 02, I-24	Amend policy H-295.861 by addition and deletion to read as follows: 1. Our American Medical Association urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give ~~breastfeeding~~ lactating individuals additional break time and a suitable environment during examinations to express milk. 2. Our AMA encourages that such accommodations to ~~breastfeeding~~ lactating individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. Append amended policy H-295.861 to policy D-310.950,. Rescind policy H-295.861. *Rationale: Policy should use inclusive language in accordance with Policy D-65.969, "Use of Inclusive Language in AMA Policy." Appendage allows for policy consolidation.*
Resident Pay During Orientation D-310.967	Our American Medical Association will advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities. Policy Timeline: Res. 302, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmed: CME Rep. 01, A-24	Append policy D-310.967 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy D-310.967. *Rationale: Appendage allows for policy consolidation.*
Impairment Prevention and Treatment in the Training Years H-295.863	1. Our American Medical Association affirms the importance of preventing and treating psychiatric illness, alcoholism, and substance use in medical students, residents, and fellows.	Append policy H-295.863 to policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians." Rescind policy H-295.863.

	2. Our AMA encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents, and fellows. 3. Our AMA urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance use. 4. Our AMA advocates: . further study (and continued monitoring of other studies) concerning the problem of substance use among students, residents, and faculty in U.S. medical schools; and . development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents, and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians. Policy Timeline: CCB/CLRPD Rep. 3, A-14; Modified: CME Rep. 01, A-24	*Rationale: Appendage allows for policy consolidation.*
Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year H-295.867	1. Our American Medical Association strongly encourages the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA)-accredited medical schools. 2. Our AMA supports and encourages the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by COCA and teaching institutions not affiliated with a medical school.	Rescind policy H-295.867. *Rationale: Policy is no longer necessary since start of Visiting Student Learning Opportunities™ (VSLO®) program.*

	3. Our AMA encourages the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation continue to have a mechanism for accepting such applications of osteopathic medical students. Policy Timeline: Res. 910, I-09; Reaffirmed: CME Rep. 01, A-19	
Eliminating Benefits Waiting Periods for Residents and Fellows H-295.873	Our AMA: (1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training; (2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and (3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. (4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees. Policy Timeline: BOT Action in response to referred for decision Res. 318, A-06; Appended: CME Rep. 5, A-10; Reaffirmed: CME Rep. 01, A-20	Amend clause (3) of policy H-295.873 by addition and deletion to read as follows: (3) will work with the ACGME, ~~and with the~~ Liaison Committee on Medical Education (LCME), and Commission on Osteopathic College Accreditation to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. Append amended policy H-295.873 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy H-295.873. *Rationale: Policy should be inclusive of DO students. Appendage allows for policy consolidation.*
Insurance Coverage for Medical Students and Resident Physicians H-295.942	1. Our American Medical Association urges 1. all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students.	Amend policy H-295.942 by deletion to read as follows: 1. Our American Medical Association urges ~~3. medical schools and residency training programs to pay for or offer comprehensive~~

	2. all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans. 3. medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance. 4. carriers offering disability insurance to: a. offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by our AMA for employer-provided health insurance. b. include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. 5. Our AMA: a. actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians. b. will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all	~~and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance.~~ 5. Our AMA: a. actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance~~,~~ ~~including human immunodeficiency virus positive indemnity insurance,~~ for all medical students and resident and fellow physicians. b. will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, ~~including human immunodeficiency virus positive indemnity insurance,~~ for all medical students, resident and fellow physicians. ~~3. Our AMA supports the continuation of comprehensive medical insurance benefits for inactive students taking an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence.~~ Append amended clause (1.2) to policy H-310.912, "Residents and Fellows' Bill of Rights." *Rationale for deletions:* ● *Clause (1.3): This is already addressed in H-310.912, "Residents and Fellows' Bill of Rights."* ● *Clause (1.5): Modern policies now cover HIV-related illnesses.* ● *Clause (3): Coverage over leaves of absences is often tied to federal loan funding.*

	medical students, resident and fellow physicians. c. will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. 2. Our AMA encourages medical schools to allow students and their families who qualify for and enroll in health insurance plans other than the institutionally offered health insurance plans, to be exempt from an otherwise mandatory student health insurance plan requirement, provided that the alternative plan has comparable care coverage and is accepted at the primary geographic locations of training. 3. Our AMA supports the continuation of comprehensive medical insurance benefits for inactive students taking an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. Policy Timeline: BOT Rep. W, I-91; Reaffirmed: BOT Rep. 14, I-93; Appended: Res. 311, I-98; Modified: Res. 306, A-04; Modified: CME Rep. 2, A-14; Appended: Res. 304, I-23	*Rationale: Appendage allows for policy consolidation.*
Residents' Salaries H-305.930	Our American Medical Association supports appropriate increases in resident salaries. Policy Timeline: Res. 307, A-05; Reaffirmed: CME Rep. 1, A-15; Reaffirmed in lieu of: Res. 307, I-22	Append policy H-305.930 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy H-305.930. *Rationale: Appendage allows for policy consolidation.*
Resident and Fellow Access to Fertility Preservation H-310.902	1. Our American Medical Association encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs. 2. Our AMA supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility	Append policy H-310.902 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy H-310.902. *Rationale: Appendage allows for policy consolidation.*

	treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion. Policy Timeline: Res. 302, A-22	
Financial Protections for Doctors in Training H-310.903	Our American Medical Association supports the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees. Policy Timeline: BOT Rep. 18, I-21	Append policy H-310.903 to policy H-310.912, "Residents and Fellows' Bill of Rights." Rescind policy H-310.903. *Rationale: Appendage allows for policy consolidation.*
Funding to Support Training of the Health Care Workforce H-310.916	1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs. 2. Our AMA strongly advocates that: a. There be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions. b. There be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions. 3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.	Amend policy H-310.916 by deletion to read as follows: ~~1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.~~ ~~2. Our AMA strongly advocates that:~~ ~~a. There be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions.~~ ~~b. There be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.~~ 3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.

	Policy Timeline: Sub. Res. 913, I-09; Appended: Res. 917, I-15; Appended: Res. 309, I-20; Reaffirmed: Res. 305, A-21	*Rationale:* ● *Clauses (1) and (2) are out of date given single accreditation.* ● *Clause (2a) use of "GME" outside of MD/DO training is problematic.* ● *Clause (3) adequately addresses intent of policy.*
The Educational and Work Environment of Resident Physicians H-310.935	AMA policy is that there should be resident organizations in place at institutions that sponsor graduate medical education programs to facilitate the ability of residents to negotiate about issues related to their working environment. Policy Timeline: CME Rep. 11, A-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 01, A-18	Rescind policy H-310.935. *Rationale: Policy already addressed in H-310.912, "Residents and Fellows' Bill of Rights."*
Anonymity for Resident Inquiries to Residency Review Committees H-310.995	Our AMA supports a detailed procedure to guarantee anonymity of a resident physician who initiates an inquiry by a residency review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints. The procedure includes a mechanism for the resident who elects to forward a complaint to the residency review committee (RRC), outlines options for RRC action; and identifies possible final actions open to the RRC. Policy Timeline: CME Rep. C, A-83; Reaffirmed: CLRPD Rep. 1, I-93: Reaffirmed: CME Rep. 2, A-05; Reaffirmed: CME Rep. 1, A-15; Reaffirmed: CME Rep. 01, A-25	Amend policy H-310.995 by addition and deletion to read as follows: Our AMA ~~supports~~ encourages ~~a detailed~~ procedures ~~to guarantee~~ that support the anonymity of a resident physician who initiates an inquiry by a ~~residency~~ review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints. ~~The~~ Such procedures should include~~s~~ a mechanism for the resident who elects to forward a complaint to the ~~residency~~ review committee (~~R~~RC), outline~~s~~ options for ~~R~~RC action~~;~~, and identifies possible final actions open to the ~~R~~RC. *Rationale: While it is not possible to guarantee anonymity in this situation, reports should be confidential and protected. Review Committees use the abbreviation "RC."*

APPENDIX B: CURRENT TEXT OF RESIDENCY PROGRAM CLOSURE POLICIES RECOMMENDED FOR RECISSION (SEE RECOMMENDATION 3 OF REPORT)

Closing of Residency Programs H-310.943

1. 1. Our American Medical Association:
    a. encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs.
    b. reminds all institutions involved in educating residents of their contractual responsibilities to the resident.
    c. encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing.
    d. will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training.
    e. urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements.
    f. opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding.
    g. will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:
    a. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed.
    b. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.
    c. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution.
    d. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
    a. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
    b. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
    c. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Policy Timeline: Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20; Reaffirmed: CME Rep. 01, I-22

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948

1. Our American Medical Association will ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution.
2. Our AMA will encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger.
4. Our AMA will work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity.
5. Our AMA will encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure.
6. Our AMA will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.

Policy Timeline: CME Rep. 3, I-20; Modified: CME Rep. 01, I-22; Modified: Res. 301, I-23

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 7-I-26

Subject: Mission of Medical Education

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

Adopted at the 2024 American Medical Association (AMA) Interim meeting, AMA Policy D-295.299, "Updates to Recommendations for Future Directions for Medical Education," called for the following:

> "Our American Medical Association will study the restructuring of AMA Policy H-295.995, 'Recommendations for Future Directions for Medical Education,' to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education, in a series of seven future reports based on the topics of:
>
> - Mission of medical education.
> - Professional regulation.
> - Entry into and transition through the medical education continuum.
> - Medical education curricula.
> - Physician as medical professional.
> - Medical education systems.
> - Obligations to students and trainees."

This report addresses the theme of workforce and medical education values, referred to in this report as the "mission of medical education."

BACKGROUND

The above policy was initially introduced via the Council on Medical Education's self-initiated report, CME 2-I-24, with the intention of proposing a framework to consolidate and modernize AMA medical education policy. During their research for the CME 2-I-24 report, the Council noted the breadth of medical education policies, including Policy H-295.995, "Recommendations for the Future Directions for Medical Education" that contains 33 clauses and had not been reassessed in its entirety since 1982. CME 2-I-24 provided the following commentary regarding the "mission of medical education":

> "Medical education's mission is to train a competent physician workforce that meets the needs of patients and populations. Though efforts by groups and individuals have been made throughout history to improve conditions for the most marginalized, a heightened awareness of equity concerns within medical education has emerged over the past few decades. In the context of the AMA, since the original 1982 Council report on the future of medical education, the Minority Affairs Consortium was created in 1992, the Commission to End Health Care Disparities began in 2004, and in 2008, the AMA officially apologized for its history of harms against Black physicians and patients. The AMA's Center for Health Equity was launched in 2019, with the AMA's strategic plan to embed racial justice and advance health equity released in 2021. Council

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on Medical Education Report 05-J-21, 'Promising Practices Among Pathway Programs to Increase Diversity in Medicine' discussed the harms of the 1910 Flexner Report and called for an external study focused on reimagining the future of health equity and racial justice in medical education, which was published in 2024. In the greater U.S., milestones such as the 1990 Americans with Disabilities Act (ADA), the 2008 ADA Amendments Act, and the 2015 legalization of same-sex marriage via the *Obergefell v. Hodge* Supreme Court decision have also drawn attention to disability and lesbian, gay, bisexual, transgender, queer, and more (LGBTQ+) rights within medical education.

In recent years, there is an unprecedented demand for health care, with increasing physician workforce shortages nationally as well as in certain underserved areas. There are also current and pending shortages in specific specialties, such as urology. Many of these shortages may be attributed to maldistribution, rather than purely insufficient numbers of physicians nationwide, with certain areas remaining underserved, particularly rural areas, with medical education playing a major role in influencing physicians to meet these needs. The transition toward competency-based medical education (CBME) is one of the most pivotal shifts in medical education in recent years and one of AMA's ChangeMedEd 2023 areas of strategic focus, alongside equity, diversity, and belonging; precision education; and transitions across the continuum."

Citations denoted above are provided in CME 2-I-24.

In order to provide consistency across the seven reports, guardrails were established:

- Policies explored include the entirety of the medical education continuum, including pre-medical education, UME, GME, and CME.
- The scope of each report will focus on updating a selection of existing related policies for accuracy as well as consolidation.
- Though the reports seek to consolidate existing policy and improve accuracy of language only, the recommendations may also make note of areas where future reports might be warranted to develop additional AMA policy on important topics not currently represented.
- Each report utilizes the well-established Appendix table format as seen in the annual Sunset Review reports.

To begin the process of selecting relevant policies for the seven reports, AMA Policy Finder was utilized. Starting on the home page, the "Search" button was selected. It provided a list of "policy topics," one of which was "medical education." By selecting this filter, it identified a total of 244 relevant policies. Implemented in September 2025, this process generated a numerical, comprehensive list of 244 policies to be categorized across the seven reports. A single policy is not listed in more than one report. Among them, seven policies were deemed not for inclusion in these reports given their length and/or complexity; 237 policies remained for categorization.

Among the 237 policies, 28 of them were sorted into this report. They address policies related to workforce, competency-based medical education, philosophical stances on diversity, equity and inclusion, and training competent physicians. This report does not address policies where the main point of the policy fell outside of the purview of the "mission of medical education," even if tangentially related. Such topics are addressed in the other six reports.

DISCUSSION

Policies considered

As mentioned earlier, 28 policies related to this theme were reviewed for this report. Among them, the Council determined that the following 19 policies remain relevant and should be retained:

- Recommendations for Future Directions for Medical Education H-295.995
- Increased Inclusivity and Admission Policies Clarification for DACA-Eligible Medical School and Residency Applicants D-295.302
- Competency Based Medical Education Across the Continuum of Education and Practice D-295.317
- Medical Student Debt and Career Choice D-305.952
- Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958
- Title VII Funding D-305.972
- Support for the Establishment of Indigenous-Led Medical Schools in the United States H-295.840
- International Applicants to U.S. Medical Schools H-295.842
- Humanism in Anatomical Medical Education H-295.843
- Against Legacy Preferences as a Factor in Medical School Admissions H-295.845
- Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants H-295.852
- Guidelines for Students Shadowing Physicians H-295.859
- Discrimination Against Patients by Medical Students H-295.865
- Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871
- Recruiting Students of Medicine at the Elementary and High School Levels H-295.940
- Nondiscrimination Toward Residency Applicants H-295.969
- Financial Aid to Medical Students H-305.999
- Preserving Accreditation Standards on Diversity, Equity, and Inclusion H-310.896
- Gender-Based Questioning in Residency Interviews H-310.976

The remaining policies are listed in the Appendix with recommended actions. They are:

- Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools D-295.306
- Competency-Based Portfolio Assessment of Medical Students D-295.318
- Increasing Medical School Class Sizes D-295.938
- Continued Support for Diversity in Medical Education D-295.963
- Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878
- Enhancing the Cultural Competence of Physicians H-295.897
- Educating Competent and Caring Health Professionals H-295.975
- Maintaining Competence of Health Professionals H-300.982
- Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

Gaps identified

This review process has illuminated opportunities where policies could be re-examined and reframed in the future to be more forward-thinking. For example, the Council identified that there may be a benefit to further study on increasing diverse representation in medical schools. Such a topic may be addressed in future reports, educational sessions, forums or other mechanisms as determined by this Council and/or the House of Delegates.

RELEVANT AMA POLICIES

There are multiple AMA polices impacted by this report:

The Appendix individually lists current policy language side-by-side with recommended actions (e.g., amend, rescind) related to that specific policy. These actions are collectively addressed in Recommendation 1 of this report.

Recommendation 2 highlights one policy that requires study for additional consolidation.

CONCLUSION

This report reviewed 28 of the 237 policies originally identified and categorized as focusing on medical education and offered multiple recommendations for consideration. In this way, your Council is working to modernize and update our policy compendium as it relates to medical education and make it easier to identify and understand our policies moving forward.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:

1. The House of Delegates policies listed in the Appendix of this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)
2. Our AMA study Recommendations for Future Directions for Medical Education H-295.995 for further modernization and consolidation. (Directive to Take Action)

Fiscal Note: Minimal

APPENDIX: POLICIES AND RECOMMENDED ACTIONS

Title and Policy Number	Text and Timeline	Recommendation
Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools D-295.306	Our American Medical Association will work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurately reported race and ethnicity demographic data regarding students and faculty. Res. 316, A-22	Amend policy D-295.306 to read as follows: Our American Medical Association will work with the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to encourage their respective accredited medical schools to make publicly available without charge transparent and accurate~~ly reported~~ race and ethnicity demographic data regarding students and faculty when collection of such data is legal. *Rationale: States may have different laws in place regarding this.*
Competency-Based Portfolio Assessment of Medical Students D-295.318	Our American Medical Association will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs. Res. 314, A-10 Appended: Res. 311, A-14 Reaffirmed: CME Rep. 04, A-23	Rescind clause 2 of policy D-295.318. *Rationale: Accomplished and now out of date.*
Increasing Medical School Class Sizes D-295.938	Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. Res. 309, A-08 Reaffirmed: CME Rep. 01, A-18	Amend policy D-295.938 by addition and deletion to read as follows: Our AMA supports ~~increasing the number of medical students, provided that such expansion would not jeopardize~~ appropriate

Title and Policy Number	Text and Timeline	Recommendation
		medical student class sizes that contribute to ~~the~~ quality ~~of~~ medical education. *Rationale: This policy was retained in the 2018 sunset report as "still relevant" with no further notes. Currently, Council feedback notes that there is no clear goal articulated for increasing class size which may not be effective to increase workforce and may have the opposite effect, such as in the case of innovations involving 3-year medical schools. Schools may also require a particular class size for an endowment, which will ultimately attract more students to the school and assist medical students.*
Continued Support for Diversity in Medical Education D-295.963	1. Our American Medical Association will publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training. 2. Our AMA will request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups. 3. Our AMA will work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations. 4. Our AMA will advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical	Amend policy D-295.963 clause 2 to read as follows: 2. Our AMA ~~will~~ encourages the Liaison Committee on Medical Education to regularly share relevant diversity statistics, if any, ~~related to compliance with accreditation standards IS-16 and MS-8~~ with medical schools and with other interested parties ~~stakeholder groups~~. Rescind clauses 3 and 9. *Rationale: Updating for accuracy and current legal environment. Clause 3 is accomplished.*

Title and Policy Number	Text and Timeline	Recommendation
	schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population. 5. Our AMA will directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education. 6. Our AMA will advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement. 7. Our AMA will investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty. 8. Our AMA will recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts. 9. Our AMA will collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. 10. Our AMA will 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. Policy Timeline: Res. 325, A-03 Appended: CME Rep. 6, A-11 Modified: CME Rep. 3, A-13 Appended: CME Rep. 5, A-21 Modified: CME Rep. 02, I-22 Appended: Res. 319, A-22	

Title and Policy Number	Text and Timeline	Recommendation
Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878	Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education. Res. 323, A-05 Modified in lieu of Res. 906, I-10 Reaffirmation A-11 Reaffirmation A-12 Reaffirmation A-16 Modified: Res. 16, A-18 Modified: Res. 302, I-19	Amend policy H-295.878 clause 1 and 2 to read as follows: Our AMA: (1) supports the right of medical students and residents to form groups and meet ~~on-site~~ to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct ~~on-site~~ educational seminars and workshops on health issues related to sexual orientation and gender identity; and *Rationale: AMA cannot specify policies certain private locations may have about activities they allow on their grounds.*
Enhancing the Cultural Competence of Physicians H-295.897	1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence and cultural humility, using existing mechanisms such as the annual medical education surveys. 3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations. 4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency	Amend policy H-295.897 by addition and deletion to read as follows: 1. Our American Medical Association continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing humble, ~~culturally~~ structurally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues to support research into the need for and effectiveness of training in ~~cultural~~ structural competence and cultural humility, using existing

Title and Policy Number	Text and Timeline	Recommendation
	from community health workers, when this exposure can be integrated into existing rotation and service assignments. 5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills. 6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide. 7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. CME Rep. 5, A-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-11 Appended: Res. 304, I-16 Modified: CME Rep. 01, A-17 Appended: Res. 320, A-17 Reaffirmed: CMS Rep. 02, I-17 Appended: Res. 315, A-18 Modified: Res. 322, A-22	mechanisms such as the annual medical education surveys. 3. Our AMA ~~will assist physicians in obtaining information about and/or training in~~ promotes resources on culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations. 4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn structural competence and cultural humility ~~competency~~ from community health workers, when this exposure can be integrated into existing rotation and service assignments. 5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural humility ~~competence~~ with clinical skills. 6. Our AMA will encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide. 7. Our AMA supports the development of national standards for cultural humility training in the medical school curricula. Amend title as follows: Enhancing the Structural Competence and Cultural Humility ~~Competence~~ of Physicians

Title and Policy Number	Text and Timeline	Recommendation
		Rationale: This is a subject that should be approached from the perspective of continual opportunity for growth, and therefore, cultural humility is a better term. The competence component relates to structural awareness, and skills navigating these systems, as referenced here.
Educating Competent and Caring Health Professionals H-295.975	(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate. (2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities. (3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are	Rescind policy H-295.975. *Rationale: This policy was created in 1987 and is accomplished. Language use throughout policy is substantially different 40 years later, and other AMA policies cover similar topics.*

Title and Policy Number	Text and Timeline	Recommendation
	demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced. (4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students. BOT Rep. NN, A-87 Modified: Sunset Report, I-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 01, A-17	
Maintaining Competence of Health Professionals H-300.982	(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education. (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by practitioners throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to practitioners. (3) Health professions organizations and faculty of programs of health professions education should develop standards of competence. Such standards should be reviewed and revised periodically. (4) When reliable and cost-effective means of assessing continuing competence are developed, they should be required for continued practice.	Amend policy H-300.982 clause 2 by addition and deletion to read as follows: (2) Professional schools and health professions organizations should develop additional continuing education self-assessment programs, should prepare guides to continuing education programs to be taken by ~~practitioners~~ professionals throughout their careers, and should make efforts to ensure that acceptable programs of continuing education are available to professionals ~~practitioners~~. *Rationale: Though policy discusses all health professionals, not just physicians, practitioners is not the appropriate umbrella term when physicians are included in the statement.*

Title and Policy Number	Text and Timeline	Recommendation
	(5) Patient relations and ethics are appropriate subjects for continuing education; educational providers should increase the offering in these fields. BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: BOT Rep. 17, A-04 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: BOT Rep. 13, A-19	
Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929	1. It is AMA policy that: A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved. C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding. D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.	Amend policy H-305.929 clause 1A by addition and deletion to read as follows: 1. ~~It is AMA policy that:~~ Our AMA supports the following: A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public. Amend Clause 1B by deletion to read as follows: B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions ~~are preserved~~. Amend Clause 1C by addition to read as follows: C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs

Title and Policy Number	Text and Timeline	Recommendation
	F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training. H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs. I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties. 2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large. 3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.	regardless of external funding uncertainties. Our AMA and the federation should advocate for medical education funding. Amend Clause 1D by addition and deletion to read as follows: D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. ~~Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions~~. Clear value should be consistently ascribed to medical education. F. Full Medicare direct medical education funding should be available for the number of years required for initial board ~~certification~~ eligibility. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage. *Rationale: Edits for clarity. Emphasize importance of funding even during challenges. Balance is difficult to measure and therefore wording clarified slightly. The number of years between a resident finishing residency and taking boards to become certified could be up to 7 years, and new language eliminates confusion regarding coverage.*

Title and Policy Number	Text and Timeline	Recommendation
	4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publicly report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead. 5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty. CME Rep. 7, A-05 Reaffirmation I-06 Reaffirmed: Sub. Res. 314, A-07 Reaffirmation I-07 Reaffirmed: CME Rep. 4, I-08 Reaffirmed: Sub. Res. 314, A-09 Reaffirmed: CME Rep. 3, I-09 Reaffirmed: CME Rep. 15, A-10 Reaffirmation A-11 Reaffirmation A-13 Reaffirmed: CME Rep. 5, A-13 Appended: CME 05, A-16 Appended: Res. 319, A-16 Reaffirmation A-16 Reaffirmed: Res. 310, A-24	

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 8-I-26

Subject: Hardship for International Medical Graduates in Humanitarian Crisis or Conflict

Presented by: Shannon M. Kilgore, MD, Chair

Referred to: Reference Committee C

Resolution 313-I-25, "Hardship for International Medical Graduates from Palestine," was introduced at the American Medical Association (AMA) 2025 Interim meeting and was referred. The resolution asked the following:

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

BACKGROUND

AMA Deliberations at the I-25 House of Delegates Meeting

The language of this resolution's resolve one mirrors existing AMA policy D-255.974, "Hardship for International Medical Graduates from Ukraine." Testimony was mixed, though all supported the spirit of the resolution and acknowledged the moral imperative to support those experiencing hardships from humanitarian crises. Additional testimony noted that AMA policy has precedent for naming specific groups, such as Ukraine in past policy, and emphasized the significant challenges experienced by Palestinian physicians, including the U.S. federal government's suspension of visas for Palestinians specifically.

Some testimony expressed concerns about varying definitions of Palestine, though Council on Medical Education testimony noted that the Educational Commission for Foreign Medical Graduates (ECFMG) maintains a definition for Palestine relevant to their verification work. One amendment, supported by the resolution author, was offered to recognize hardships for Palestinian physicians while not limiting policy to this group. The Council noted that advocacy on these matters should not be limited by the end of an immediate humanitarian crisis, as even after crises are resolved there may still be hardships with verification. Additionally, normal verification processes may resume even amidst crises. Discussions also focused on balancing the immediate needs of this specific group with policy that stays evergreen in future situations. After additional concerns that other groups in need, such as those in Sudan, were not directly referenced, Resolution 313 was referred.

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Context of the Original Resolution

In 2024 and 2025, the only two medical schools in Gaza, Al Azhar University-Gaza (AUG) and the Islamic University of Gaza (IUG), were destroyed.[1] These were once considered ECFMG-eligible schools, previously listed under Pathway 3, which is a "Medical School Accredited by Agency Recognized by World Federation for Medical Education (WFME)"[2] and approximately 2,500 medical students had been enrolled as of October 2023.[3] Furthermore, Al-Israa University, which had just announced the formation of a medical school, and Gaza's largest hospital, Al-Shifa, which housed the most extensive medical library used for training, were also destroyed in 2023 and 2024.[4]

Additionally, in 2025, the U.S. State Department suspended all visas for people with Palestinian passports, regardless of their physical residence.[5] This is not in agreement with AMA policy H-255.966, "Abolish Discrimination in Licensure of IMGs," which states, "Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate."

Of note, the healthcare system in Gaza has significantly relied on graduates from AUG and IUG.[6] As these graduates advance in their careers and pursue specialization, they typically follow one of two pathways: enrolling in local specialty training programs or seeking international postgraduate training opportunities, including in the United States. Those who pursue international training acquire advanced qualifications in their respective specialties and often return to Gaza to work, thereby addressing critical gaps in specialized medical care and strengthening the overall healthcare infrastructure.[7]

It is important to recognize that even if international medical graduates (IMGs) leave after training in the U.S., IMGs nonetheless contribute substantially to the physician workforce within the U.S.[8] They also add value to the U.S. healthcare system, including in leadership, mentorship, new cultural perspectives, and improved quality of care.[9]

DISCUSSION

How the System Usually Works and Noted Exceptions

Council on Medical Education Report 08-A-23, "Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict," previously studied the topic of primary source verification issues in a different context, that of Russia and Belarus. This report describes in detail the role that the ECFMG, a member of Intealth, serves in verifying qualifications of IMGs pursuing U.S. graduate medical education (GME) and in credentialing practicing IMGs seeking to practice medicine in the U.S.

The Council report from 2023 states that: "ECFMG staff also indicated that the ECFMG pursues alternative options if the customary primary source verification process is not workable—for example, when there is international conflict or the medical school or ministry of health in a given country is not responding to ECFMG queries. Through one alternative option, the applicant for ECFMG certification can request that three medical school classmates or faculty who are now practicing in the U.S. swear on their U.S. medical license that the applicant did indeed graduate. This process requires completion of a notarized form and submission of a letter describing the facts of the matter. The ECFMG tries to assist individual applicants throughout the certification process (while maintaining the integrity of its procedures), to include postponement of examinations and refunding fees, where appropriate."[10]

This specific alternative option is particularly challenging for learners from Gaza seeking to verify their medical education credentials in the face of widespread destruction: many classmates, academic faculty, and health professionals who would verify attendance and graduation were casualties of conflict.[11]

Well-Established Intealth Processes

During the writing of this report, AMA staff engaged in conversations with Intealth's Senior Vice President and ECFMG's Executive Director on primary source verification and the Senior Vice President, Regulatory Affairs, and Chief Communications Officer on visas. Intealth noted sensitivity to distressing situations of humanitarian crisis and emphasized long-standing, flexible processes in place that work even in unusual and challenging circumstances. Primary source verification and, when needed, rigorous alternate processes have been safely established at Intealth since 1986. Intealth is also engaged in addressing visa issues.

Discussions with Intealth, as well as House of Delegates testimony, revealed that there are a wide variety of locations around the world facing humanitarian crisis. Therefore, Intealth does not maintain country-specific policies, but rather treats each situation seriously and individually. Intealth does not request additional AMA support other than in educating the medical education community that these resources already exist. Intealth prefers to broadly and flexibly respond to any given situation, whether a widespread crisis or one individual's situation: this may be an entire cohort, on any or all "sides" of a conflict, or even one specific person who is politically targeted or experiences other safety issues.

A dedicated team assists these individuals; regions and crises change rapidly, but the process is rigorous yet flexible enough to address these situations. The Intealth intake process identifies needs and directs people to necessary resources. In fact, less than 1% of those who work with Intealth need alternate processes. For those who cannot meet ECFMG's primary-source verification requirement through regular means or established alternate processes, a subcommittee of the Intealth Board of Trustees reviews these applications. The subcommittee considers the safety of both IMGs seeking verification and the U.S. public, including patients.

Intealth also works on issues related to visa and entry restrictions and sponsors J-1 visas for physicians. At the Council on Medical Education's Forum on "Impacts of H1-B Visa Restrictions on Medical Education" in June 2026, which included Intealth leadership, discussion also occurred around wider visa issues, noting the impact of travel bans. Intealth released resources for those impacted and continues to work extensively to exempt physicians from these restrictions, as IMGs are well-vetted, necessary, and serve the U.S. national interest.[12] However, Intealth also noted challenges even when physicians are exempted—for instance, a physician who is not able to reunite with a spouse and infant child due to a travel ban. According to data presented at the Forum, in 2025, 98% of IMGs were able to join their programs in the U.S., though some joined late. Typically, this number is 99%. Data from 2026 has not yet been determined, and Intealth is monitoring closely to review the impact. Intealth continues extensive advocacy efforts as well as work with individuals who need assistance.

Regarding the visa issues discussed above, at the time of this writing (August 2026), the Council noted publicly available testimonies of Palestinian physicians who matched into U.S. residency programs and whose J-1 visas have been delayed in administrative processing by the U.S. Department of State since June 2026, disrupting their GME training, though ongoing advocacy efforts are underway to urge processing speed.[13] Organizations, such as the Hanoon Foundation, also assist

displaced learners with fundraising, such that their medical educations can continue, and, unrelated to the main topics of the proposed resolution, there are continued needs in this area.[14]

RELEVANT AMA POLICY

AMA has several policies related to credentialing, visas, support for IMGs, support for Intealth's work, and protection of education and lives within humanitarian crises. These are listed in Appendix A.

CONCLUSION

AMA's existing policy D-255.974, "Hardship for International Medical Graduates from Ukraine," referred Resolution 313-I-25, and CME Report 08-A-23, refer to medical education events in specific locations of humanitarian crises. The Council recognizes the pain and frustration, underscored in House of Delegates testimony, when some crises are more widely discussed than others or are more explicitly stated in policy. Resolution 313-I-25, "Hardship for International Medical Graduates from Palestine," sought to acknowledge the real suffering of Palestinian physicians, using AMA's past policy on Ukraine as a model. HOD testimony also expressed the need to acknowledge many other groups, such as those in crisis in Sudan[15] and likely many others. Other existing AMA policy H-255.988, "AMA Principles on International Medical Graduates," emphasizes that AMA "continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs." As the organization most involved for decades in assisting international physicians and learners during crises, the AMA should continue to support Intealth/ECFMG's processes. Intealth does not request additional AMA support other than in educating the medical education community that these resources already exist.

Therefore, striving for fairness as well as effective policy stewardship and support for ECFMG, AMA policy should therefore be broad enough to support every learner experiencing war or a humanitarian crisis. Proposed changes below do not reflect a removal of support from any one group, but rather a widening of support as deemed appropriate by Intealth, the expert in addressing these challenges.

RECOMMENDATIONS

The Council on Medical Education recommends that the following be adopted and the remainder of the report be filed:

1. Amend AMA policy D-255.974 "Hardship for International Medical Graduates from Ukraine" by addition and deletion to read as follows:

   Hardship for International Medical Graduates ~~from Ukraine~~ in Humanitarian Crisis or Conflict

   Our American Medical Association ~~will advocate with relevant stakeholders that advise~~ supports Intealth's processes for primary source verification, ~~state medical boards to grant hardship waiver for~~ including, when needed, alternatives to primary source verification of medical education for all licensing requirements for physicians who graduated from medical schools in ~~Ukraine until the current humanitarian crisis in Ukraine is resolved~~ areas of humanitarian conflict or crisis. (Modify HOD Policy)

2. Reaffirm AMA policy H-255.988, "AMA Principles on International Medical Graduates" (Reaffirm HOD Policy)

3. Reaffirm AMA policy D-65.993, “War Crimes as a Threat to Physicians' Humanitarian Responsibilities” (Reaffirm HOD Policy)
4. Reaffirm AMA policy H-520.985, “Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict” (Reaffirm HOD Policy)
5. Reaffirm AMA policy D-275.989, “Credentialing Issues” (Reaffirm HOD Policy)
6. Reaffirm AMA policy H-515.982, “Violent Acts Against Physicians” (Reaffirm HOD Policy)

Fiscal note: Minimal

APPENDIX A: RELEVANT AMA POLICY

Humanitarian and Medical Aid Support to Ukraine D-65.984

1. Our American Medical Association will advocate for continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US.
2. Our AMA will advocate for an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, their parents, pregnant people, and the elderly.
3. Our AMA will adovcate for educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people.

Expedited H-1B Pathways for International Medical Graduate Physicians in the USA H-255.961

Our American Medical Association supports the continuance of premium processing and other mechanisms that expedite H-1B visa applications and renewals for International Medical Graduate physicians.

Support for International Medical Graduates from Countries Facing Major Humanitarian Crises H-255.962

1. Our American Medical Association affirms its support and will advocate for immigrant physicians and trainees working in the United States when their country of origin faces major humanitarian crises, regardless of their country's political alignment, to promote an understanding of the challenges specific to immigrant physicians.
2. Our AMA will support the development and implementation of channels of communication for immigrant physicians to share their personal and professional journey when facing severe destruction, humanitarian crises, or personal losses in their country of origin, contributing therefore to improving the understanding of the difficulties faced by immigrant physicians.

International Medical Graduate Employment H-255.965

Our American Medical Association will support federal legislation that reduces the administrative burden and streamlines the process of hiring International Medical Graduates.

Abolish Discrimination in Licensure of IMGs H-255.966

1. Our American Medical Association supports the following principles related to medical licensure of international medical graduates (IMGs):
    a. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
    b. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
    c. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
    d. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

e. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.
3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.
4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.
5. Our AMA will:
    a. encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas.
    b. encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation.

Hardship for International Medical Graduates from Ukraine D-255.97

Our American Medical Association will advocate with relevant stakeholders that advise state medical boards to grant hardship waiver for primary source verification of medical education for all licensing requirements for physicians who graduated from medical schools in Ukraine until the current humanitarian crisis in Ukraine is resolved.

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

AMA Principles on International Medical Graduates H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training.

<u>Visa Complications for IMGs in GME D-255.991</u>

1. Our American Medical Association will
    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice.
    b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related

to the immigration and registration process required for International Medical Graduates.

c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Credentialing Issues D-275.989

Our American Medical Association encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept certification by the Educational Commission for Foreign Medical Graduates (a member of Intealth) as proof of primary source verification of an IMG's international medical education credentials.

Protection of Healthcare and Humanitarian Aid Workers in all Areas of Armed Conflict H-520.985

1. Our American Medical Association supports peace in the world in order to protect civilian lives and healthcare personnel.
2. Our AMA supports the safety of healthcare and humanitarian aid workers along with safe access to healthcare, healthcare facilities, and humanitarian aid for all civilians in areas of armed conflict.
3. Our AMA condemns targeting, detention, or attack of non-combatant healthcare workers and humanitarian personnel; and our AMA also condemns the use of healthcare workers, humanitarian personnel, and healthcare institutions for military purposes or as shields for military operations.
4. Our AMA recognizes the deliberate targeting of non-combatant healthcare workers, medical students, and healthcare facilities in all areas of conflict as a violation of medical neutrality and AMA policy.
5. Our AMA supports efforts to protect, release, and provide restitution to detained non-combatant healthcare workers in all areas of conflict.

Medical Neutrality H-520.998

Our American Medical Association supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-26)

Introduced by: Medical Student Section

Subject: Augmented Intelligence Use in Assessment Development During Medical Education

Referred to: Reference Committee C

Whereas, AI has a growing presence in medical education both within medical school and post-graduate education[1]; and

Whereas, a greater number of schools have turned their focus to the use of AI in examinations, for generating multiple-choice questions and developing machine learning to analyze student performance in Objective Structured Clinical Examinations (OSCEs)[2]; and

Whereas, the use of generative AI has the potential to increase the speed by which new question banks are created, it has also been found to include errors related to “inaccurate terminology, age-sensitive inaccuracies, and geographically insensitive inaccuracies” in up to 15% of questions[3,4]; and

Whereas, despite strong performance on multiple-choice benchmarks, AI models show an average drop of 39.43% in performance when assessed via free-response questions, requiring rigorous inspection to ensure that AI-generated content genuinely integrates knowledge with clinical reasoning rather than replicating surface-level patterns[5]; and

Whereas, medical schools utilizing AI-driven grading have identified that generative AI models lack transparency and the underlying processes by which GPT-4 applies grading rubrics are unknown beyond the prompt and rubric which is provided[6]; and

Whereas, newer studies in higher education outside of medicine have shown students’ distrust of an over-reliance on AI autograders by teachers and a preference for human graders[7]; and

Whereas, AI assessment tools in higher education outside of medicine have shown that even with high-accuracy autograders, there is significant misalignment between how AI is used and how students perceive it is used, which may contribute to suboptimal answer development amongst students[8]; and

Whereas, research on implementation of AI-tool-based grading in higher education outside of medicine has shown that a transparency statement on the use of AI in grading of exams led to students finding an AI autograder significantly more accurate, suggesting that explaining the use of AI and its past accuracy may help students better understand its use and view it as a helpful tool[7]; and

Whereas, major institutions such as the United States Medical Licensing Examination (USMLE) are now investigating AI-driven adaptive testing, where algorithms could modify questions in real time[9]; and

Whereas, prior American Medical Association policies emphasize physician oversight and responsible AI use, these expectations are not specifically outlined for AI use in medical assessment creation and learner performance evaluation; therefore be it

RESOLVED, that our American Medical Association supports disclosure to students along the medical education continuum regarding the use of generative augmented intelligence (AI) in the development and evaluation of performance on assessments. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

Augmented Intelligence in Medical Education H-295.857
Our AMA will: (a) encourage accrediting and licensing bodies to study how artificial intelligence should be most appropriately addressed in accrediting and licensing standards; (b) encourage medical specialty societies and boards to consider the development of specialty-specific educational modules related to artificial intelligence; (c) support research regarding the effectiveness of artificial intelligence instruction in medical education on learning and clinical outcomes; (d) encourage institutions and programs to be deliberative in determining when artificial intelligence–assisted technologies should be taught, including consideration of established evidence-based curricula and what existing curricular content may need to be modified or removed to accommodate new training modules; (e) support stakeholders in providing educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in artificial intelligence systems; (f) support the study of how differences in institutional access to artificial intelligence may impact disparities in medical education for students at schools with fewer resources and less access to artificial intelligence technologies; (g) support enhanced training across the continuum of medical education regarding the assessment, interpretation, and application of data in patient care; (h) support the study of how disparities in access to artificial intelligence educational resources may impact health care disparities for patients in communities with fewer resources and less access to artificial intelligence technologies; (i) encourage institutional leaders and academic deans to proactively include nonclinician experts, such as data scientists and engineers, on faculty rosters to assist learners in understanding and using artificial intelligence; and (j) support close collaboration with and oversight by practicing physicians in the development and implementation of artificial intelligence applications in medical education. [CME Rep. 04, A-19; Appended: Res. 307, I-25]

Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms D-480.954
To maximize the impact and trustworthiness **of** augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that: (a) Explainable AI with safety and efficacy data should be the expected form **of** AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval; (b) To be considered "explainable," an AI device's explanation **of** how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer; [CSAPH Rep. 08, A-25]

Assessing the Intersection Between AI and Health Care H-480.931
(1)General Governance (a)Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based…(2) Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient. [BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section, Resident and Fellow Section

Subject: Transparency in AI-Assisted Admissions

Referred to: Reference Committee C

Whereas, artificial intelligence (AI) involvement, referring to algorithmic or machine learning-based tools that influence applicant screening, scoring, ranking, summarization, or evaluation decisions, is increasingly being integrated into medical school and residency application review processes, including holistic file analysis, interview evaluation, and predictive ranking systems used to assist admissions committees and residency selection programs[1]; and

Whereas, proponents of AI-assisted review systems argue that such tools may improve administrative efficiency and help manage the growing volume of applications submitted through centralized systems such as the American Medical College Application Service (AMCAS) and the Electronic Residency Application Service (ERAS)[1]; and

Whereas, broader evidence from high-stakes decision-making systems demonstrates that artificial intelligence may perpetuate bias if not carefully designed and evaluated, and that standardized frameworks for assessing and reporting fairness remain incompletely developed as these technologies are increasingly adopted in selection processes[2-5]; and

Whereas, access to medical education and residency training represents a critical pathway into the physician workforce, and the use of artificial intelligence–assisted selection systems may influence not only individual admissions outcomes but also the composition, diversity, and equity of the future physician workforce, making fairness, transparency, and accountability in these systems essential[5]; and

Whereas, existing American Medical Association policy, including Augmented Intelligence in Health Care (H-480.940), Assessing the Intersection Between AI and Health Care (H-480.931), Augmented Intelligence in Medical Education (H-295.857), and Health Equity (H-180.944), supports responsible and transparent development and implementation of augmented intelligence technologies and emphasizes addressing systemic bias and advancing equity in health systems and decision-making processes[7-10]; and

Whereas, establishing transparent governance standards for AI-assisted admissions processes presents an opportunity to ensure that technological innovation supports equitable access to medical education while maintaining public trust in the integrity of the physician training pipeline[5,6]; therefore be it

RESOLVED, that our American Medical Association study and report back on the ethical, equitable, and transparent use of augmented intelligence (AI) in medical school and residency application review processes, including potential standards for notice, disclosure, and

explanation of AI involvement to applicants, including but not limited to, what stage AI is involved and to what extent (Directive to Take Action); and be it further

RESOLVED, that our AMA support approaches to promote fairness, accountability, and applicant due process, including access to human reevaluation and avenues to appeal or contest decisions influenced by such systems. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

H-480.940 Augmented Intelligence in Health Care
Our AMA supports the responsible, ethical, and transparent development and deployment of augmented intelligence (AI) technologies in health care, including safeguards to address bias, ensure accountability, and maintain appropriate physician oversight. (Res. 214, A-18; Reaffirmed: BOT Rep. 28, A-19)

H-480.931 Assessing the Intersection Between AI and Health Care
Our AMA encourages ongoing evaluation of the benefits, risks, and ethical implications of artificial intelligence technologies in health care to guide policy development and ensure safe, equitable, and effective implementation. (Res. 214, A-18; Reaffirmed: BOT Rep. 28, A-19)

H-295.857 Augmented Intelligence in Medical Education
Our AMA supports the thoughtful integration of artificial intelligence technologies into medical education, including the need for transparency, appropriate oversight, and the protection of educational equity in their use. (CME Rep. 1, A-19)

H-180.944 Health Equity
Our AMA supports efforts to identify and eliminate systemic bias and inequities in health systems and decision-making processes and to promote equitable access to care, medical education, and health outcomes. (BOT Rep. 8, I-18)

E-1.2.11 Ethics of Health Information Technology
Physicians and health systems should ensure that digital health technologies, including automated decision systems, are used in a manner that promotes transparency, accountability, patient safety, and safeguards against bias and unintended harm. (AMA Code of Medical Ethics)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-26)

Introduced by: American Academy of Hospice and Palliative Medicine

Subject: Certification for Hospice Medical Directors

Referred to: Reference Committee C

Whereas, hospice medical directors provide clinical leadership, interdisciplinary team support and oversight of quality care, for seriously ill patients and their families; and

Whereas, while Hospice and Palliative Medicine (HPM) board certification requires fellowship training, Hospice Medical Director Certification (HMDC) allows multiple pathways to certification eligibility, including an experiential pathway with a minimum of 400 hours of broad hospice-related activities and 2 years of hospice work experience during the prior 5 years; and

Whereas, HPM board certification and the HMDC credential demonstrate specialized knowledge and competency in the care of patients with serious illness, symptom management, communication, hospice regulations and end of life care; and

Whereas, Centers for Medicare and Medicaid services requires hospice organizations to designate a physician to serve as medical director who has responsibility for the medical component of the hospice’s patient care program; and

Whereas, the hospice medical director is not a category of medical practice but a position a hospice must designate under Medicare conditions of participation, in which a physician assumes on behalf of a certified provider the statutory duty to certify terminal illness, a determination that both authorizes federal payment and effects the beneficiary's waiver of Medicare coverage for curative treatment of the terminal condition; and

Whereas, Medicare conditions of participation and coverage already establish certification-based qualification standards for designated physician director positions, including 42 CFR 494.140(a)(1) for dialysis facility medical directors, with an alternative approval provision at 42 CFR 494.140(a)(2) where no qualified physician is available, and 42 CFR 493.1443 for laboratory directors of high complexity testing, which provides multiple qualification pathways and protection for incumbents; and

Whereas, our AMA advocates that coverage determinations affecting Medicare beneficiaries be made by board-certified physicians with clinical expertise in the relevant field; and

Whereas, physician certification of terminal illness is the sole clinical gate to the Medicare hospice benefit, and that gate is only as strong as the certifying physician's command of prognostication, eligibility criteria, and hospice regulations; and

Whereas, ongoing federal enforcement actions involving hospice providers have demonstrated vulnerabilities in hospice eligibility determinations and physician certifications of terminal illness; and

Whereas, the majority of the >5,000 hospice organizations in the United States do not demonstrate evidence their hospice medical directors hold HPM certification or the HMDC credential; and

Whereas, our AMA has policy on physician-directed hospice care (H-85.955), modernizing the hospice benefit (D-330.895), and improving hospice program integrity (D-85.991); and

Whereas, an increasing number of patients receiving hospice care rely completely on the hospice physician to guide their care; and

Whereas, patients and families receiving hospice services deserve access to physician leadership that meets established standards of expertise and competency; and

Whereas, the increasing complexity of hospice care delivery, regulatory oversight, and quality reporting creates a need for specialized knowledge and qualifications and;

Whereas, physician board certification is correlated with better quality of patient care; therefore be it

RESOLVED, that our American Medical Association advocate for recognition of Hospice and Palliative Medicine board certification or Hospice Medical Director Certification as qualification standards for physicians designated as hospice medical directors with an implementation period sufficient to avoid reducing beneficiary access to hospice care, particularly in rural and underserved communities (Directive to Take Action); and be it further

RESOLVED, that our AMA support the principle that hospice medical directors should obtain board certification in Hospice and Palliative Medicine or Hospice Medical Director Certification, and encourage hospice agency employers to support the time and cost of certification (New HOD Policy); and be it further

RESOLVED, that our AMA study the workforce, access and regulatory implications of hospice medical director qualification standards, including Hospice and Palliative Medicine or Hospice Medical Director Certification, and report its findings to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, that our AMA collaborate with relevant specialty societies, including but not limited to the American Academy of Hospice and Palliative Medicine, and accrediting organizations to promote standards supporting physician competency in hospice medical director roles. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/14/26

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RELEVANT AMA POLICY

Palliative Care and End-of-Life Care H-295.875
Our AMA:
1. Reaffirms the Council on Medical Education's support of palliative medicine as a medical subspecialty with certification recognized by the American Board of Medical Specialties, and also encourages the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education.
2. Encourages the training of all allied health workers in the use of palliative care techniques and interdisciplinary team care.
3. Will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care.

Hospice Care H-85.955
Our AMA will work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics.
Our American Medical Association approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care.
Our AMA encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment.
Our AMA supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare.
Our AMA believes that each patient admitted to a hospice program should have their designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program.
Our AMA supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers.
Our AMA seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure.
Our AMA will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.

On-Site Physician Home Health Care H-210.981
Our AMA: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.

(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or detrimental to the patient's health.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, including the development of programs for low-income families and older adults.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, severity of illness, and socioeconomic status.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.

Good Palliative Care H-70.915
Our American Medical Association: encourages all physicians to become skilled in palliative medicine.
Our AMA recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families.
Our AMA encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness.
Our AMA supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms.
Our AMA encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services.
Our AMA advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings.
Our AMA continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures.
Our AMA supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;"
Our AMA encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients.
Our AMA encourages research into the needs of dying patients and how the care system could better serve them.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-26)

Introduced by: International Medical Graduates Section, Resident and Fellow Section

Subject: Fee Parity for International Medical Graduates Taking USMLE Examinations Outside the United States

Referred to: Reference Committee C

Whereas, International Medical Graduates (IMGs) represent a vital component of the United States healthcare workforce, helping address critical physician shortages, particularly in rural and medically underserved areas; and

Whereas, examinees taking the United States Medical Licensing Examination® (USMLE®) Step 1 and Step 2 Clinical Knowledge (CK) at testing centers outside the United States and Canada are assessed substantial international test delivery surcharges ($210 for Step 1 and $235 for Step 2 CK) in addition to baseline registration fees; and

Whereas, these regional surcharges create a severe, compounding financial barrier for international medical students and graduates seeking to enter the US healthcare system; and

Whereas, the transition toward fixed USMLE examination schedules and the planned expansion of testing center infrastructure globally streamlines capacity planning, stabilizes operational overhead, and lowers per-candidate delivery costs; and

Whereas, economies of scale achieved through expanding global test site networks should reduce operational costs across the board rather than placing an asymmetric financial burden on candidates testing abroad; and

Whereas, the American Medical Association is committed to advancing health equity, eliminating arbitrary workforce entry barriers, and supporting a diverse global physician pipeline; therefore, be it

RESOLVED, that our American Medical Association advocate with the National Board of Medical Examiners (NBME), the Federation of State Medical Boards (FSMB), and Intealth/ECFMG to establish fee parity between domestic and international test-takers for all USMLE examinations by eliminating geographic test delivery surcharges; (Directive to Take Action) and be it further

RESOLVED, that our AMA work with testing sponsors to ensure that any restructuring of examination scheduling—including fixed exam administration windows and international center expansion—is implemented with transparent, standardized cost structures that do not disproportionately penalize candidates testing outside the United States. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

References:
1. Intealth / Educational Commission for Foreign Medical Graduates. 2026 Information Booklet: Fees and Payment. ECFMG; 2026.
2. National Board of Medical Examiners, Federation of State Medical Boards. USMLE Bulletin of Information. NBME/

AMA RELEVANT POLICY

AMA Principles on International Medical Graduates - H-255.988

1. Our AMA supports current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Our AMA supports current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. Our AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Our AMA supports cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Our AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Our AMA supports working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, our AMA supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. Our AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. Our AMA supports that special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. Our AMA supports that accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. Our AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. Our AMA supports the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement:
    a. completion of medical school and residency training outside the U.S.;
    b. extensive U.S. medical practice; and
    c. evidence of good standing within the local medical community.
13. Our AMA supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
14. Our AMA supports the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. Our AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such

as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Our AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. Our AMA membership outreach to IMGs to include
    a. using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians;
    b. publicizing its many relevant resources to all physicians, especially to nonmember IMGs;
    c. identifying and publicizing AMA resources to respond to inquiries from IMGs; and
    d. expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Our AMA supports recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Our AMA supports its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Our AMA supports institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Our AMA supports informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. Our AMA supports U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. Our AMA supports the Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
23. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
24. Our AMA supports continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.
25. Our AMA supports advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.
26. Our AMA will uphold its commitment to opposing discrimination against IMGs in all aspects of medical education and training.

BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17 Reaffirmation: A-19 Modified: CME Rep. 2, A-21 Modified: CME Rep. 1, A-22 Modified: CCB/CLRPD Rep. 1, A-22 Reaffirmed: CME Rep. 03, A-23 Reaffirmed: Res. 312, A-25 Reaffirmed in lieu of the first resolve: Res. 234, A-25 Reaffirmed: Res. 241, A-25 Appended: Res. 304, I-25 Reaffirmed: Res. 226, A-26

Financial Burdens and Exam Fees for International Medical Graduates H-255.964

1. Our American Medical Association encourages key stakeholders, such as the National Board of Medical Examiners, Federation of State Medical Boards, Educational Commission for Foreign Medical Graduates (a member of Intealth), Cambridge Assessment English and Box Hill Institute, and others to (a) study the most equitable approach for achieving parity across U.S. MD

and DO trainees and international medical graduatstes with regard to application, exam, and licensing fees and related financial burdens; and (b) share this information with the medical education and IMG communities.
2. Our AMA encourages relevant stakeholders to work together to achieve cost equivalency for exams required of all medical students and trainees, including IMGs. CME Rep. 03, A-23

Reference Committee F

Report(s) of the Board of Trustees

01 Study of Grading Systems in AMA Board Reports

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

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

01 Evaluation of the Size and Structure of the AMA House of Delegates

02 Underrepresented in Medicine Advocacy Section Five-Year Review

03 Integrated Physician Practice Section Five-Year Review

Report(s) of the Speakers

01 Election Rule Updates

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

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

Resolutions

601 Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy

602 Enhancing Equity in House of Delegates Resolution Processes by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus

603 Ensuring Relevance and Mission Alignment in House of Delegates Business

604 Increasing Time Between Handbook Release and Opening of Online Reference Committees

REPORT OF THE BOARD OF TRUSTEES

BOT Report 01-I-26

Subject: Study of Grading Systems in AMA Board Reports

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee F

Resolution 520-A-25, "Study of Grading Systems in AMA Board Reports" was referred. It asked that our American Medical Association (AMA):

> study the use of a system for assessing the quality of evidence and the strength of recommendations in board reports when appropriate.

BACKGROUND

Per the Constitution and Bylaws of the AMA, a report is a formal account providing the rationale for conclusions drawn relying upon experts in a specialized field of knowledge or philosophy that can be informational only or include recommendations for action by a deliberative body.[1] These reports may present recommendations for House of Delegates (HOD) action or provide information in response to existing policy directives. Reports of the Board of Trustees (BOT Reports), specifically, move through an established, deliberative process in which meeting materials are submitted, posted for review, assigned to a reference committee or online reference committee for testimony and comment, and then acted upon by the HOD through adoption, amendment, referral, or filing.

The development of these reports typically draws on the expertise of AMA physician leadership and professional staff across relevant subject areas, including health policy, advocacy, public health, science, ethics, governance, finance, and operations, depending on the topic of the report. Recent BOT Reports, for example, have addressed advocacy analysis, public health strategy, technology and AI, and annual organizational and financial matters. This process is longstanding and deeply embedded in AMA governance. The HOD meets twice each year to establish policy. The HOD Reference Manual serves as the standing procedural guide for our policy-development process, and the AMA maintains public archives of HOD proceedings and BOT Reports.

DISCUSSION

Evidence-based approaches emphasize the importance of systematically assessing the quality and strength of information used to inform decisions. As a result, there is growing interest in applying grading frameworks to policy-relevant documents, such as Board of Trustees reports, to better understand the rigor and transparency of the evidence they provide. However, these reports often incorporate expert judgment, contextual considerations, and other factors that may not be fully captured by traditional evidence-grading schemes. As a key component of clinical decision-making and embedded in medical education, the HOD frequently raises the importance of using EBM concepts and practices in policy development and analysis.

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Evidence-Based Medicine for Clinical Decision-Making

Evidence-based medicine (EBM) is the cornerstone of clinical decision making in medical practice to provide the best patient outcomes. EBM utilizes rigorous scientific method and critical appraisal to organize and systematize the application of research and data to ground health care decisions.[2,3] By utilizing EBM, physicians are able to implement the most up-to-date scientific information into their practice while also building confidence in medical decisions and discussions with patients.

Grading systems translate the level of evidence into a commonly understood alphabetic system for hierarchical consumption and application (Figure 1 and Table 1).[4–6] Clinical guidelines often utilize grading systems to demonstrate the strength of their recommendations based on the level of evidence used for their recommendations.[7,8] Multiple evidence-leveling and grading systems are used in evidence-based medicine (EBM), each with inherent limitations and challenges, particularly in the way some frameworks may disadvantage certain study designs.[5] By understanding these levels, practitioners can ensure that their clinical decisions are grounded in the most reliable and rigorous evidence available. These grading systems help to provide transparency in recommendations and support communication between patients and their physicians and ensure clear understanding of evidence-based practice for high-quality care. Evidence grading systems also vary in how they classify the quality of evidence and the strength of recommendations. There are a wide variety of grading systems for EBM (Table 2). While these systems work well for clinical practice, policymaking has different leadership and decision-making outcomes.

Evidence to Decision Frameworks for Public Health Decisions

Evidence-to-decision frameworks (EtD) are structured, multicriteria tools that guide panels of experts in moving transparently from a body of synthesized evidence to a health recommendation or decision.[12,13] Rather than leaving the reasoning behind a recommendation implicit, they force explicit judgments on a defined set of criteria, such as benefits and harms, certainty of evidence, values, resource use, equity, acceptability, and feasibility. EtD frameworks document those judgments so users can see how and why a recommendation was reached.[13] Empirically, using an EtD framework is associated with more comprehensive consideration of decision criteria, especially including values, equity, and acceptability as key measures and outcomes, and generating guidelines of higher quality and more credible, transparent, implementable recommendations for public health policy.[14]

The most widely adopted EtD framework is the GRADE EtD framework, which is structured into three components: the background with the public health question, assessment and conclusions.[13] Typical GRADE EtD frameworks include twelve criteria and are flexible, having been adapted to different public health decision types.[15] Assessment criteria for GRADE EtD frameworks include: priority of the problem, benefits and harms, certainty of the evidence, values and preferences patients place on outcomes, balance of effects, cost-effectiveness, equity, acceptability to stakeholders, and feasibility of implementation.[15] Conclusions utilizing this framework for public health decisions captures the recommendation, its strength and direction, justification, implementation considerations, monitoring/evaluation, and research priorities, even with capabilities of incorporating decision thresholds for judging the magnitude of benefits and harms for public health recommendations.[16,17]

Policymaking and Board Reports

Policymaking board reports typically do not use grading systems because board-level decisions require the consideration of multiple, often competing factors that cannot be accurately captured by

a single score, rating, or application.[18,19] Boards are responsible for evaluating evidence, weighing risks and benefits, considering strategic and operational implications, and exercising independent judgment.[18] As a result, governance guidance emphasizes the importance of balanced, decision-oriented reporting rather than simplistic rankings. A well-designed report from a board should provide a balanced assessment of principal risks and sufficient information to support effective decision-making, underscoring the need for context and analysis rather than summary grades alone.[19] The objective of a board report is typically not to rate a policy, but to equip decision-makers with the information necessary to make an informed and accountable choice. For the AMA, this also includes consideration of the current medical, legal, political and health policy landscape as well as the vast policy developed by the HOD.

Key Challenges to Grading in Board Reports

The GRADE framework and similar grading systems are highly technical and have grown increasingly complex over time. Many organizations charged with developing policy lack the methodological expertise, time, and financial resources to properly implement them.[20–22] GRADE requires independent, systematic reviews for each important clinical outcome associated with each question, a standard that exceeds even the highest trustworthiness criteria and is beyond the capacity of many guideline and policy efforts.[22] A qualitative study of experienced systematic review authors found that even experts struggle with specific domains such as imprecision and indirectness, and cite inadequate training as a major barrier.[20]

Despite the structured appearance of grading systems, substantial subjective judgment remains embedded in the process. Critics have highlighted that GRADE criteria for evidence-based medical decisions are poorly defined and subject to interpretational variability between clinicians, including a potentially circular relationship between rating evidence quality and designating outcomes as critically important.[22] Assessments of "directness" (applicability of evidence to real-world settings) are value-laden judgments that may not reflect the perspectives of end-users and stakeholders, yet they are folded into evidence quality ratings in ways that obscure their subjective nature.[22] GRADE EtD frameworks have alternatively supported a broader capability of GRADE criteria incorporating multiple layers of assessment criteria, including equity, cost-effectiveness, and perspectives of stakeholders, that can more aptly be applied to public health decisions. However, conversely with board reports, GRADE EtD frameworks are structured, technocratic, rational-choice tools, and that origin is exactly why they map poorly onto the realities of policy making and advocacy. Their core limitations for the political, values-laden, and contested nature of policy and advocacy are well documented.[23,24] Policy decisions are multidimensional, making the distillation of all the factors to a single grade obscure or mask important trade-offs in a decision.

Grading systems frequently produce conditional/weak recommendations, which create significant difficulties for a board charged with implementation of or recommendations to develop new policy. As the Surviving Sepsis Campaign guidelines note, conditional recommendations "may be less appropriate for policy or performance measure" because they acknowledge that the balance of benefits and harms varies by patient values, clinical context, and resource availability.[25] The ACP similarly states that conditional recommendations "are not directly suited to translation into performance measures".[26] This leaves policymakers in a difficult position: much of the evidence base yields recommendations that resist the binary yes/no decisions boards often need to make.

Your Board appreciates that the resolution is seeking to instill increased precision and certainty in BOT reports. As discussed above, given the types and range of issues contained in BOT Reports requested by the HOD, your Board does not advise using ratings systems to avoid giving a false sense of certainty or precision. Your Board does not believe that a grading system can accurately

negotiate the fact that public policy decisions are frequently made under conditions of uncertainty, incomplete information, and evolving evidence. Organizations such as the Organization for Economic Co-Operation and Development note that effective policymaking depends on evidence-informed decision-making and that governments often face challenges translating complex evidence into policy choices.[27] In such circumstances, a grade (e.g., A, B, or C) may imply greater certainty or consensus than actually exists, potentially obscuring important assumptions, limitations, and areas of disagreement. Additionally, grading systems can mask important trade-offs among decision criteria. A policy option may perform strongly in one domain, such as scientific effectiveness, while creating implementation challenges, budgetary concerns, or equity implications.

Also consider that the GRADE Public Health Group identified five key challenges in applying evidence grading to public health policy decisions. These include: 1. incorporating diverse stakeholder perspectives beyond the traditional patient-clinician relationship; 2. selecting and prioritizing important non-health outcomes, such as economic, social, and environmental impacts; 3. determining decision-making thresholds when evidence does not clearly support one option over another; 4. assessing the certainty of evidence from non-randomized studies, which often form the primary evidence base for policy questions but are initially rated as low certainty within GRADE; 5. and translating conditional recommendations into practical, actionable policy decisions.[28] The inherent bias against observational evidence is a particularly significant barrier, where the initial low starting level for non-randomized studies was identified as the major reported barrier to using GRADE in health policymaking.[29]

Evidence Transparency in Board Reports

For scientific and health policy, evidence is often presented in a multidimensional way in terms of the strength or certainty of evidence, quality of studies, benefit-risk assessments, confidence levels, and scenario analyses rather than simple grades. The GRADE framework, widely used by organizations such as Cochrane, World Health Organization, and the Centers for Disease Control and Prevention advisory committees, specifically evaluates the certainty and quality of evidence and communicates the degree of confidence decision-makers can place in study findings.[30,31] The U.S. Food and Drug Administration (FDA) employs a structured benefit-risk framework for regulatory decision-making that explicitly considers benefits, risks, risk management options, and the impact of uncertainty on decisions regarding drugs and biologics.[32] Additionally, policy and governance bodies increasingly use strategic foresight and scenario analysis to explore alternative futures, test assumptions, and inform decision-making under conditions of uncertainty. These approaches communicate uncertainty, transparency, and scientific rigor more effectively than a single summary grade because they provide decision-makers with information about the quality of the underlying evidence, the confidence that can be placed in conclusions, and the range of possible outcomes. At their core, BOT Reports provide recommendations, and the BOT has confidence that the HOD—as it has done historically—will continue to debate, evaluate, and make its own determinations about the strength and relevance of those recommendations.

CONCLUSION

Physicians use EBM to support confident clinical decision-making by applying grading systems and levels of evidence to clinical recommendations. Policymaking boards, in contrast, generally avoid grading systems because grades can oversimplify complex issues, obscure uncertainty, and weaken the board's responsibility to exercise informed judgment. Your Board works to provide reports to the HOD that emphasize evidence, benefits, risks, weigh different options, and provide recommendations for consideration. BOT reports incorporate the expertise of our professional

AMA staff and analysis of the current political, scientific and health care landscape. Recommendations are made weighing the risks and benefits of multiple factors and are supported by clear rationale and with full consideration of existing AMA policy. These complementary—and competing—considerations ultimately resist known grading systems.

RECOMMENDATION

The Board of Trustees recommends that Resolution 520, A-25, "Study of Grading Systems in AMA Board Reports" not be adopted and the remainder of the report be filed.

Fiscal Note: Minimal.

APPENDIX

Figure 1. Level of Evidence Pyramid[33]

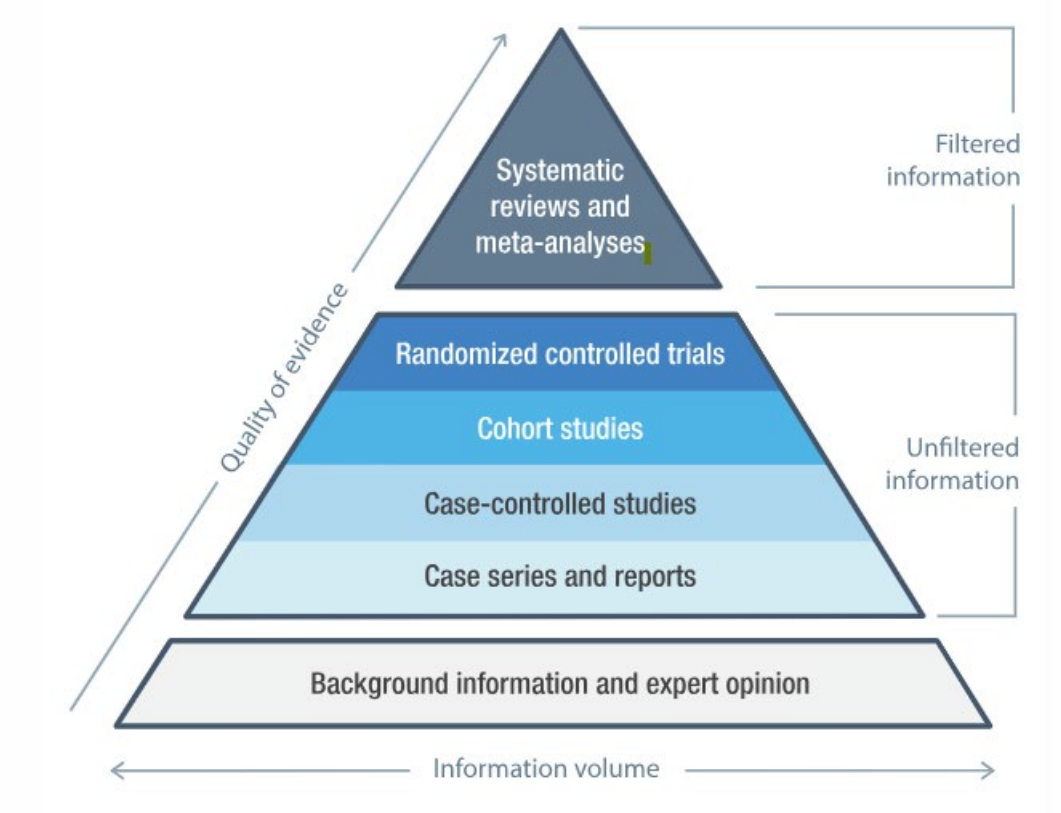


Table 1. Level of Evidence and Grades of Recommendations[6]

Grade of Recommendation	Level of Evidence	Type of Study
A	1a	Systematic review of (homogeneous) randomized controlled trials
A	1b	Individual randomized controlled trials (with narrow confidence intervals)
B	2a	Systematic review of (homogeneous) cohort studies of "exposed" and "unexposed" subjects
B	2b	Individual cohort study / low-quality randomized control studies
B	3a	Systematic review of (homogeneous) case-control studies
B	3b	Individual case-control studies
C	4	Case series, low-quality cohort or case-control studies
D	5	Expert opinions based on non-systematic reviews of results or mechanistic studies

Table 2. Comparison of Evidence-based Grading Systems

Grading System	Evidence Levels	Recommendation Strength	Key Features
GRADE[34]	High, Moderate, Low, Very Low	Strong, Weak/Conditional	Most widely adopted; explicit domains (bias, inconsistency, indirectness, imprecision, publication bias); can upgrade observational evidence
USPSTF[35]	High, Moderate, Low (certainty)	A, B, C, D, I (insufficient)	Focused on preventive services; grades reflect net benefit magnitude by certainty
ACC/AHA[36]	A, B-R, B-NR, C-LD, C-EO	Class I, IIa, IIb, III (benefit/harm)	Distinguishes randomized (B-R) vs nonrandomized (B-NR); expert opinion (C-EO); matrix format
Oxford CEBM[9]	1 to 5 (by study design)	No formal recommendation grading	Hierarchical by study type; question-specific (therapy, diagnosis, prognosis); levels vary by clinical question
AHRQ[10]	High, Moderate, Low, Insufficient	No formal recommendation grading	Endorses/uses GRADE; rates "strength of evidence" via Evidence-based Practice Centers
NICE[11]	High, Moderate, Low, Very Low (adopted GRADE)	Adopted GRADE (strong/conditional)	Transitioned to GRADE in 2007; UK-focused; incorporates cost-effectiveness

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 10-I-26

Subject:	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
Presented by:	Toluwalasé A. Ajayi, MD, Chair
Referred to:	Reference Committee F

At the 2024 Interim Meeting, the House of Delegates adopted Policy D-600.951, "Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates." This policy directs the following:

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program (HOD EAP).
2. Our AMA will provide the House of Delegates with reports on a regular cadence detailing ongoing work regarding House of Delegates meetings to mitigate costs, explore solutions, and maintain participation while reducing the financial burden on all parties over the long term.
3. Our AMA will not reduce by one day the 2025 Annual and Interim Meetings and will issue a report for consideration at the 2025 Annual Meeting outlining details for potential changes to the length and format of future House of Delegates meetings.

DISCUSSION

As stated in Board of Trustees Report 16-I-24, the AMA Board of Trustees established the Emergency Assistance Program (EAP) as a temporary program funded at no more than $1 million annually for two years, beginning with the 2025 Annual Meeting, and specifically provided that it would end after the 2026 Interim Meeting. The program provided financial assistance to eligible Federation organizations while the AMA considered ways to reduce the cost of HOD participation.

Societies were required to apply in each program year. For eligibility purposes, the estimated cost of attending two HOD meetings for nine nights was set at $5,000 per delegate or alternate delegate. A society qualified when its apportioned delegate and alternate positions multiplied by $5,000 exceeded 2 percent of the combined revenue reported on the most recent Forms 990 for the society's 501(c)(3) and related 501(c)(6) organizations. Approved societies then submitted a request for each meeting covering delegates, alternates, regional medical student delegates, and sectional resident and fellow delegates. The AMA paid 50 percent in advance and calculated the balance using verified attendance. Funding was capped at $100,000 per organization across both meetings in a calendar year.

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Summary of EAP Participation

The EAP operated in 2025 and 2026. The program funded 764 attendees and paid $1,066,000 through the 2026 Annual Meeting. Current requests for the 2026 Interim Meeting would bring the two-year total to 1,110 attendees and $1,446,200. Aggregate results are provided in Appendix A. The EAP did not require participating societies to submit financial remediation plans or report changes in their financial condition.

In 2025, 21 of 186 eligible constituent and national specialty societies applied and 18 qualified. The qualifying societies held 275 of the 1,288 delegate and alternate positions available to those organizations, or 21.4 percent. Two applicants did not meet the 2 percent revenue threshold, and one could not provide the required tax documentation.

In 2026, 24 of 189 eligible constituent and national specialty societies applied and 21 qualified. The qualifying societies held 315 of the 1,400 available delegate and alternate positions, or 22.5 percent. All 18 societies that qualified in 2025 qualified again in 2026, and three additional societies qualified. A further inquiry did not result in an application.

Funding requests for the 2026 Interim Meeting remain in process. Current requests cover 346 attendees and $380,200. If every eligible delegate, alternate, regional medical student delegate, and sectional resident or fellow delegate were funded, the maximum would be 352 attendees and $422,400. Final figures will be based on submitted requests and verified attendance.

Cost mitigation efforts

The AMA has continued to seek savings through hotel and travel discounts, negotiated food, beverage, audiovisual, power, internet, and meeting-room terms, virtual viewing options, and complimentary childcare. These measures reduce some expenses but do not eliminate the underlying cost of sending delegations to two national meetings each year. The AMA has also adjusted HOD schedules and processes to explore whether future meetings could be shortened. A shorter meeting could potentially reduce some travel expense and time away from practice.

Actual EAP funding was $653,500 in 2025. Based on current requests, 2026 funding is projected at $792,700, an increase of 21.3 percent. Funding could reach $834,900 if all eligible positions were funded for the 2026 Interim Meeting. Meeting and travel costs have increased by approximately 10 to 20 percent in several categories, and the HOD has continued to grow. A fixed subsidy would cover a declining share of participating societies' expenses. An indexed subsidy would create an increasing AMA obligation. For illustration, annual funding of $792,700 would exceed $1 million in the third year at 10 percent annual growth and in the second year at 20 percent annual growth.

CONCLUSION

The EAP provided the temporary assistance for which it was created and will conclude after the 2026 Interim Meeting. It was not designed to establish permanent AMA financing of delegation expenses. Extending the program in its current form would create a recurring obligation whose value would decline if funding remained fixed and whose cost would increase if adjusted for travel costs and HOD growth.

The Board therefore believes the EAP should sunset as planned. It reflects the program's stated duration and the need to use AMA resources in a fiscally responsible manner.

RECOMMENDATION

The Board of Trustees recommends that Policy D-600.951, "Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates," be rescinded as having been accomplished by this report and the remainder of the report be filed.

Fiscal Note: Minimal

Eligible-universe denominator: 1,288 delegate and alternate positions at each 2025 meeting and 1,400 at each 2026 meeting. Organization-level entries reproduce the V3 appendix; reconciled program totals are shown separately where V3 did not agree with the final aggregate accounting.

Table 1. 2025 Annual Meeting EAP Summary of Support

2025 EAP eligible organizations	2025 apportionmen		A-25 funding request					A-25 actual verified attendance						Total A-25 funding		
Eligible organization	Del.	Alt.	Del. & alt.	MSS	RFS	Requested grant	Initial payment	Del.	Alt.	MSS del.	MSS alt.	RFS del.	RFS alt.	Attendance grant	Less initial	Final installment
Arizona Medical Association	5	5	10	-	-	$15,000	$7,500	5	1					$9,000	$7,500	$1,500
Colorado Medical Society	6	6	12	1	3	$24,000	$12,000	6	5	1		2	1	$22,500	$12,000	$10,500
Connecticut State Medical Society	4	4	8	3	2	$19,500	$9,750	4	3	1	1	1		$15,000	$9,750	$5,250
Florida Medical Association	17	17	34	1	-	$52,500	$26,250	17	12	1				$45,000	$26,250	$18,750
Hawaii Medical Association	2	2	2	-	-	$3,000	$1,500	2						$3,000	$1,500	$1,500
Illinois State Medical Society	12	12	24	1	2	$40,500	$20,250	12	8	1		1	1	$34,500	$20,250	$14,250
Kansas Medical Society	3	3	6	2	-	$12,000	$6,000	3	3	1				$10,500	$6,000	$4,500
Kentucky Medical Association	5	5	10	-	-	$15,000	$7,500	5	5					$15,000	$7,500	$7,500
Louisiana State Medical Society	7	7	9	1	-	$15,000	$7,500	7	-	1				$12,000	$7,500	$4,500
Medical Society of Georgia	7	7	14	1	1	$24,000	$12,000	7	6	1		1		$22,500	$12,000	$10,500
Medical Society of the District of Columbia	2	2	4	-	-	$6,000	$3,000	2	1					$4,500	$3,000	$1,500
Medical Society of New Jersey	9	9	16	1	-	$25,500	$12,750	9	5	1				$22,500	$12,750	$9,750
Medical Society of the State of New York	23	23	41	3	2	$69,000	$34,500	23	12	2		2		$58,500	$34,500	$24,000
Michigan State Medical Society	14	14	23	-	2	$37,500	$18,750	13	6			1	1	$31,500	$18,750	$12,750
Missouri State Medical Association	6	6	9	1	1	$16,500	$8,250	6	4		1	1		$18,000	$8,250	$9,750
Ohio State Medical Association	12	11	19	3	1	$34,500	$17,250	12	7	1	2	2		$36,000	$17,250	$18,750
Rhode Island Medical Society	2	2	4	-	1	$7,500	$3,750	2	2			1		$7,500	$3,750	$3,750
West Virginia State Medical Association	2	2	2	-	-	$3,000	$1,500	2	-					$3,000	$1,500	$1,500
V3 source totals	**138**	**137**	**247**	**18**	**15**	**$420,000**	**$210,000**	**137**	**80**	**11**	**4**	**12**	**3**	**$370,500**	**$210,000**	**$160,500**
Reconciled program total								**216 D/A**		**16 MSS**		**14 RFS**		**246 attendees / $368,400**		

The V3 organization rows total 247 attendees and $370,500; final program accounting reports 246 attendees and $368,400.

Table 2. 2025 Interim Meeting EAP Summary of Support

2025 EAP eligible organizations	2025 apportionmen		I-25 funding request					I-25 actual verified attendance						Total I-25 funding		
Eligible organization	Del.	Alt.	Del. & alt.	MSS	RFS	Requested grant	Initial payment	Del.	Alt.	MSS del.	MSS alt.	RFS del.	RFS alt.	Attendance grant	Less initial	Final installment
Arizona Medical Association	5	5	10	3		$15,600	$6,000	5	3					$9,600	$6,000	$3,600
Colorado Medical Society	6	6	12	1	3	$19,200	$9,600	6	6	1		2	1	$19,200	$9,600	$9,600
Connecticut State Medical Society	4	4	8	3	2	$15,600	$7,800	4	3	1	2	2		$14,400	$7,800	$6,600
Florida Medical Association	17	17	28	2		$36,000	$17,400	17	11	1				$34,800	$17,400	$17,400
Hawaii Medical Association	2	2	3			$3,600	$1,800	2	1					$3,600	$1,800	$1,800
Illinois State Medical Society	12	12	24	1	2	$32,400	$16,200	12	7	1		1	1	$26,400	$16,200	$10,200
Kansas Medical Society	3	3	6	2	1	$10,800	$4,800	3	3	1	1			$9,600	$4,800	$4,800
Kentucky Medical Association	5	5	10			$12,000	$6,000	5	5					$12,000	$6,000	$6,000
Louisiana State Medical Society	7	7	14	1		$18,000	$9,000	6	-	1				$8,400	$9,000	$(600)
Medical Society of Georgia	7	7	14	2	1	$20,400	$10,200	7	6	1		1		$18,000	$10,200	$7,800
Medical Society of the District of Columbia	2	2	4			$4,800	$2,400	2	2					$4,800	$2,400	$2,400
Medical Society of New Jersey	9	9	15	1		$19,200	$9,600	9	4	1				$16,800	$9,600	$7,200
Medical Society of the State of New York	23	23	44			$52,800	$26,400	23	14	2		1	1	$49,200	$26,400	$15,100
Michigan State Medical Society	14	14	24	-	1	$30,000	$15,000	13	4			1		$21,600	$15,000	$6,600
Missouri State Medical Association	6	6	9	1	1	$13,200	$6,600	6	3		1			$12,000	$6,600	$5,400
Ohio State Medical Association	12	11	18	3	2	$27,600	$13,800	11	5	1	2	2		$25,200	$13,800	$11,400
Rhode Island Medical Society	2	2	3			$3,600	$1,800	2	1					$3,600	$1,800	$1,800
West Virginia State Medical Association	2	2	3			$3,600	$1,800	1		1				$2,400	$1,800	$600
V3 source totals	**138**	**137**	**249**	**20**	**13**	**$338,400**	**$166,200**	**134**	**78**	**12**	**6**	**10**	**3**	**$291,600**	**$166,200**	**$117,700**
Reconciled program total								**212 D/A**		**18 MSS**		**13 RFS**		**243 attendees / $285,100**		

The reconciled I-25 grant total reflects final accounting and application of the $100,000 annual organizational cap.

Table 3. 2026 Annual Meeting EAP Summary of Support

2026 EAP eligible organizations	2026 apportionmen		A-26 funding request					A-26 actual verified attendance						Total A-26 funding		
Eligible organization	Del.	Alt.	Del. & alt.	MSS	RFS	Requested grant	Initial payment	Del.	Alt.	MSS del.	MSS alt.	RFS del.	RFS alt.	Attendance grant	Less initial	Final installment
American College of Medical Quality*	1	1	1	-	-	$1,500	$750	1						$1,500	$750	$750
Arizona Medical Association	5	5	10	-	-	$15,000	$7,500	5	4					$13,500	$7,500	$6,000
Colorado Medical Society	6	6	12	2	1	$22,500	$11,250	6	6		1	2		$22,500	$11,250	$11,250
Connecticut State Medical Society	4	4	8	1	2	$16,500	$8,250	4	4	1	1			$15,000	$8,250	$6,750
Florida Medical Association	19	19	34	-	2	$54,000	$27,000	19	11	1	1			$48,000	$27,000	$21,000
Hawaii Medical Association	2	2	2	-	-	$3,000	$1,500	1						$1,500	$1,500	$0
Illinois State Medical Society	13	13	22	2	1	$37,500	$18,750	13	8	1		1	1	$36,000	$18,750	$17,250
Iowa Medical Society	4	4	7	-	-	$10,500	$5,250	4	3					$10,500	$5,250	$5,250
Kansas Medical Society	4	4	8	1	2	$16,500	$8,250	4	3	1	1	1		$15,000	$8,250	$6,750
Kentucky Medical Association	5	5	10	1	-	$16,500	$8,250	5	5				1	$16,500	$8,250	$8,250
Louisiana State Medical Society	7	7	10	-	-	$14,400	$7,200	5						$7,500	$7,200	$300
Medical Society of Georgia	7	7	14	2	1	$25,500	$12,750	7	7	1				$22,500	$12,750	$9,750
Medical Society of the District of Columbia	2	2	4	-	-	$6,000	$3,000	2	1					$4,500	$3,000	$1,500
Medical Society of New Jersey	10	10	15	-	2	$25,500	$12,750	10	4	1	1			$24,000	$12,750	$11,250
Medical Society of the State of New York	28	28	56	1	2	$88,500	$44,250	28	11	1	1	1		$63,000	$44,250	$18,750
Michigan State Medical Society	14	14	22	1	-	$34,500	$17,250	14	7			1		$33,000	$17,250	$15,750
Missouri State Medical Association	7	7	10	1	2	$19,500	$9,750	7	3	1	1	1		$19,500	$9,750	$9,750
Ohio State Medical Association	12	11	19	1	3	$34,500	$17,250	12	7	1	2	1		$34,500	$17,250	$17,250
Oregon Medical Association	4	4	7	-	-	$10,500	$5,250	4	3					$10,500	$5,250	$5,250
Rhode Island Medical Society	2	2	4	-	-	$6,000	$3,000	2	2					$6,000	$3,000	$3,000
West Virginia State Medical Association	2	2	4	-	1	$7,500	$3,750	2	2	1				$7,500	$3,750	$3,750
V3 source totals	**158**	**157**	**279**	**13**	**19**	**$465,900**	**$232,950**	**155**	**91**	**10**	**9**	**8**	**2**	**$412,500**	**$232,950**	**$179,550**
Reconciled program total								**246 D/A**		**19 MSS**		**10 RFS**		**275 attendees / $412,500**		

**National specialty society. All other organizations listed are constituent/state medical societies.*

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-26

Subject: Evaluation of the Size and Structure of the AMA House of Delegates

Presented by: G. Sealy Massingill, MD, Chair

Referred to: Reference Committee F

The American Medical Association (AMA) House of Delegates (HOD) has experienced sustained and accelerating growth over recent decades, causing logistical challenges and rising costs to attendees, the organizations that send delegations as well as to the AMA. HOD growth also raises questions regarding representational fairness and the efficacy of policymaking processes. The Council on Long Range Planning and Development (CLRPD), responding to a charge from the Board of Trustees (BOT), has undertaken a multi-year evaluation to study the size and apportionment practices of the HOD and propose actionable recommendations. Through partnership, education, and collective engagement, CLRPD is confident that consensus can be achieved.

TIMELINES AND PROCESS

CLRPD's efforts have been intentionally collaborative and data driven. Since the beginning of its efforts the Council has worked to ensure that any member of the House who wished to participate in CLRPD's deliberations had a variety of opportunities to do so. The recommendations contained in this report reflect themes most positively received by members.

CLRPD Report 2-I-25 recommended a one-year pause be placed on delegate growth. In that report the Council provided a comprehensive backdrop on the key policy decisions and historical developments that shaped the current structure of the HOD. While this proposal was not adopted by the House, it did underscore how complex and multi-layered the apportionment issue has become.

Recognizing the need for substantial member input, CLRPD convened an in-person listening session, BOT-appointed focus groups, and three virtual town halls with HOD delegates and alternates. These venues allowed members to engage directly with growth data and future projections as well as provide input on potential recommendations, ensuring the Council's deliberations remained grounded in perspectives from across the House. In addition, surveys distributed to HOD members and analysis conducted with assistance from AMA Strategic Insights, as well as regular communications with business units and executive leadership have contributed to a more nuanced understanding of the implications and feasibility of proposed changes. Through these efforts, more than 700 participants have been engaged.

The engagement process highlighted the necessity for education and consensus-building. Structural reform will require changes to AMA Bylaws and support from a two-thirds supermajority of voting delegates. Therefore, CLRPD's work has prioritized transparency, open communication, and the pursuit of solutions that are practical, equitable, and more likely to receive widespread endorsement

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by the House. To that end, the Council also offered informational CLRPD report 1-A-26 to enhance transparency in its process and encourage dialogue around the proposals under consideration. The Council encourages members of the House to review both CLRPD Report 2-I-25 and 1-A-26, which provide both historical context and detailed information on the processes the Council has used for its evaluation.

KEY CONSIDERATIONS

The evaluation of the HOD's current growth trajectory unearthed several critical themes. One of the most significant findings is the sharp acceleration in delegate numbers since the adoption of policy G-600.027 in 2016, which established parity between state and specialty society delegates (See Appendix A, Graphic 1). This policy, combined with no adjustment being made to the HOD's apportionment ratios as well as the House's current rounding practices by which states and specialties are granted an additional delegate for any fraction of 1,000 members, has led to rapid and compounding growth. Additional factors, including individuals being counted across multiple geographic associations and specialty societies for apportionment purposes, increases in group memberships, and the growth of resident sectional and student regional delegations have contributed to a 44 percent increase in the size of the HOD in the last decade.

As a result, the House now approaches 800 voting delegates and an equal number of apportioned alternates. Projections suggest that, should the current membership growth rate persist, without changes to policy, the HOD will surpass 1,000 members in about five years (See Appendix A, Graphic 2). Benchmarking with other medical and professional societies further emphasizes the anomaly of AMA's House size; very few, if any, comparable national interest associations' policymaking bodies approach the size of the HOD (See Page 3 in CLRPD Report 1-A-26).

Stakeholder feedback confirms a sense of urgency, with many delegates and alternates expressing concern about unchecked growth and a willingness to consider changes. A consistent sentiment from survey, focus group and town hall participation is that solutions must remain fair, protect the voices of smaller and underrepresented groups, and not create sudden or destabilizing disruption. There is also an awareness of the common logistical and financial strains imposed by a growing House, particularly regarding structural meeting costs, venue constraints of HOD policy, and overall manageability of policymaking sessions. The issue of increasing meeting costs has impacted a broad cohort of delegations, with some electing not to bring their full delegation to one or both meetings and/or choosing not to fill alternate delegate seats.

While much of the discussion regarding House growth has appropriately focused on the direct financial implications for the AMA, the Council recognizes that a substantial portion of the investment required to sustain the House is borne by constituent state medical associations and national specialty societies. These organizations incur significant expenses associated with delegate and alternate participation, including travel, lodging, registration, staff support, and other governance-related activities. As House representation grows, these investments likewise increase, requiring organizations across the federation to devote additional resources to maintaining full participation in the policymaking process.

These expenditures should also be viewed through the lens of opportunity cost. Representative governance is an essential investment in the Association and should not be evaluated solely as an expense. At the same time, every dollar committed to governance is a dollar that cannot be invested elsewhere in an organization's mission. Resources devoted to supporting larger delegations are resources unavailable for other mission-driven priorities, including:

- Legislative advocacy and regulatory engagement.
- Grassroots physician advocacy and public outreach.
- Leadership development programs for physicians at all career stages.
- Medical student and resident leadership training, scholarships, mentorship, and advocacy experiences.
- Continuing medical education and other scientific and educational programs for physicians and physicians in training.
- Member recruitment, retention, and engagement initiatives, including state and specialty society annual meetings.
- Investments in innovation, quality improvement, and other strategic organizational priorities.

Although the financial impact varies considerably among constituent organizations based on delegation size and travel requirements, the cumulative investment across organized medicine is substantial. By way of illustration, if the full annual cost of supporting a delegate and alternate for Annual and Interim meetings is approximately $5,000, then reducing four delegate and alternate positions would redirect approximately $20,000 annually toward these mission-driven priorities. While modest for any individual organization, these costs are incurred across dozens of constituent state medical associations and specialty societies, representing a collective investment of several million dollars each year. Evaluation of both the direct costs of governance and the associated opportunity costs provides a more complete understanding of the tradeoffs associated with continued House growth and should be considered alongside the logistical, representational, operational, and stewardship considerations evaluated by the Council. Recognizing venue considerations, event size and format, contractual and marketing factors, venue availability, and potential overall cost analysis, AMA Meeting Services is evaluating the feasibility of alternative venue options; findings from Meeting Services remain under review.

As a result of these financial pressures, the Emergency Assistance Program (EAP) was implemented at the 2024 Interim Meeting and expired at I-26. According to BOT Report 30-A-26, for the 2025 Annual and Interim Meetings, $751,200 was made available for 18 approved societies. Of this amount, $653,500 was distributed among 246 delegates and alternate delegates-- this includes 14 sectional residents and fellows and 16 regional students at A-25, and 243 delegates and alternates, 13 sectional resident/fellows and 18 regional students at I-25. Additionally, 21 organizations met the criteria for the EAP at A-26, with grants potentially amounting to $872,200 for 315 delegates and alternates, 22 regional medical students and 15 sectional residents and fellows for A-26 and I-26. The $121,000 increase in potential grants between 2025 and 2026 corresponded with an increase of 60 delegates year-over-year. The final amount distributed will be based on attendance at those two meetings.

In an era where organized medicine's value proposition to its members is increasingly measured by the outcomes it delivers, it is appropriate to evaluate not only the investment required for representative governance, but also the opportunities forgone when finite organizational resources are allocated to one mission rather than another. The question is therefore not whether representative governance is worth the investment, but whether the marginal investment in additional representation yields greater organizational value than alternative investments that advance the mission of organized medicine.

MEMBER INPUT

In its review, the Council has presented several possible solutions to HOD members, both through the BOT-appointed focus group and town hall polling and has used the results of these exercises to

guide its recommendations. One hundred and fifty-eight HOD members attended at least one of the town hall sessions, and the percentages reported in this section of the report reflect the opinions of those attendees. The delegate status and delegation affiliation of those attendees are as follows displaying a representative group of attendees:

Attendees	Percentage
Delegate Status	
Delegates	62.3%
Alternate Delegates	27.8%
Other	9.9%
Affiliation	
State Association	38.9%
Specialty Society	33.3%
AMA Sections	6.2%
Resident Sectional	8.7%
Student Regional	6.8%
Other National Associations	1.2%
Other	4.9%

The Council also acknowledges that there remains a sentiment among some that continued growth should not be viewed negatively, as well as persistent concerns about ensuring access and participation for new and diverse constituencies. While a subject this complex and personal to many is unlikely to garner unanimous approval, the Council has focused on identifying solutions viewed by most as reasonable and equitable while keeping in mind all these considerations.

Recommendations to adjust the apportionment ratio to one delegate per 1,500 members (and proportional changes for student and resident delegates) or one delegate per 1,250 members were considered and discussed in depth. While a recommendation to adjust the current apportionment ratio is not made in this report, the Council believes that the concept warrants further consideration.

Proposals that received the strongest support during town hall polling and focus group sessions, some of which exceeded two-thirds support among attendees, focused on a more gradual approach. The most widely supported options were placing a temporary cap on delegate growth (71.0 percent support) and removing the “or fraction thereof” clause from the apportionment bylaws for additional delegates (70.4 percent support), which would correct artificial inflation in delegate numbers and bring a measure of stability to the apportionment process. It is important to note that while all delegates and alternates were encouraged to attend; town halls were attended by a subset of HOD, not the full governing body (See Appendix C).

Town hall discussions further examined concerns about threats to small specialty societies, possible exclusion of new or underrepresented voices, and the need for alternate ways to participate in AMA advocacy and deliberation beyond participating directly in the House. These perspectives underscore the vital need for ongoing engagement and evaluation.

CONCLUSION

Drawing from extensive stakeholder engagement and policy review, CLRPD has outlined a set of proposals to temporarily stop the growth of the House and make a modest reduction in its size. The Council’s focus remains firmly on developing a structure for the HOD that upholds the principles of effectiveness and fairness, while respecting tradition and ensuring the future sustainability for

the body and the future of the AMA, and not simply a response to the current moment. A visualized timeline of proposed implementation of the recommendations and next steps can be found in Graphic 3 of Appendix A.

The first and second recommendations are to be made in conjunction to cap growth while also immediately implementing bylaws changes. The first recommendation suggests capping the size of the HOD at its current level of 793 delegates for 2027 apportionment, based on year-end 2025 membership figures. Constituent society allocation will be capped at 351 and specialty society delegates will likewise be capped at 351 to be apportioned according to Specialty and Service Society (SSS) procedures, with all other delegations maintaining 2026 apportionment levels. This recommendation is being made in accordance with the second recommendation to remove “or fraction thereof” from bylaws dealing with additional delegates via immediate proposed bylaws changes that would take effect for 2027 apportionment.

The rationale behind this first recommendation is to alleviate the immediate pressure caused by persistent growth while allowing time for implementation of other measures and further consideration by the HOD. Additionally, this temporary cap would allow the second recommendation in this report to be implemented based on already established figures, providing clarity to each delegation on how they are likely to be impacted by the proposal. The Council recognizes that this may mean that certain delegations will not increase in size in 2027 despite membership growth; however, it also believes that reapportioning the HOD at a higher delegate number in 2027 while simultaneously implementing bylaws changes to reduce the size of the House to be circuitous and counterproductive. As noted in the recommendation, this cap will apply only for one year, and in 2028 and moving forward, apportionment will proceed in accordance with new apportionment procedures and based on year-end membership figures from the previous year.

The Council’s second recommendation is to remove all apportionment language that includes "or fraction thereof" when apportioning additional delegates beyond the first for all delegations. The “or fraction thereof” language facilitated apportionment at a time when the process of obtaining updated accurate membership figures from associations could take months, whereas that information is now available within weeks of the new year. The phrase “or fraction thereof” first appears in AMA archives in a Report of the Committee of Reapportionment in the 1918 proceedings of the Annual Session when according to the AMA Constitution, “the total voting membership of the House of Delegates [could] not exceed 150.” Implementation of a standard rounding mechanism (rounding up at 1,500 members and so forth) was also proposed during town hall sessions, but the “fraction thereof” proposal received the most support among attendees.

The Council wishes to emphasize that this change will not cause the removal of any delegations from the HOD. All associations and societies that gain membership to the House through AMA and SSS policies will be granted at least one delegate; this recommended bylaw change would only apply to the addition of a second and subsequent delegates. This step is projected to bring a measured (93 delegates) reduction in the House’s size. A table projecting how this proposal may impact each delegation within the HOD can be found in Appendix B. The table contains both absolute delegate impact and potential impact to vote share. No delegation would be impacted by more than one delegate, and the impact to delegation vote share ranges from +0.7 percent to -0.1 percent. Note that these estimates are based on the apportionment figures provided in January 2026 and do not account for delegations added at A-26 and may not incorporate all unique apportionment practices contained in the bylaws and AMA policy, but they should give all delegations an idea of how they are likely to be impacted.

The third and fourth recommendations deal with specialty society membership figures. The third recommends that membership of specialty societies be obtained every three years, as opposed to the current process of obtaining the figures every five years to increase accuracy in apportionment and for the HOD to become more responsive to changes among specialty membership. The fourth recommendation encourages AMA to review its current apportionment processes with a report to the HOD, including the feasibility and costs associated with obtaining membership figures annually, which would align with the membership reporting timeline of constituent associations.

CLRPD offers these recommendations as initial steps toward relieving some of the immediate pressures associated with a rapidly expanding HOD. However, the Council acknowledges that further evaluation and action is still needed and offers its continued collaboration with the Board of Trustees, members of the House, executive leadership, and the broader membership to consider and assess the impacts of the recommendations in this report and potential future recommendations, including further consideration of the delegate apportionment ratios. The Council extends its sincere appreciation to all AMA members who have engaged throughout this process. We remain committed to continuing this dialogue and fostering a culture of ongoing assessment and thoughtful reflection on our AMA's HOD practices, with the shared goal of strengthening a House that is representative, effective and sustainable.

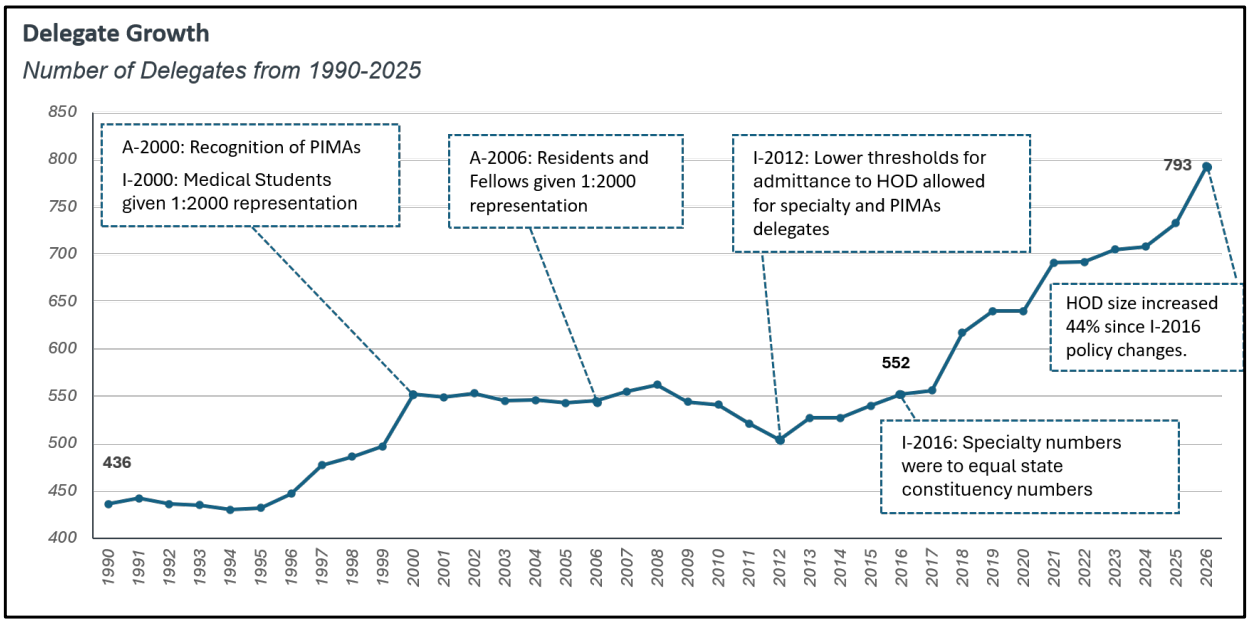
RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed:

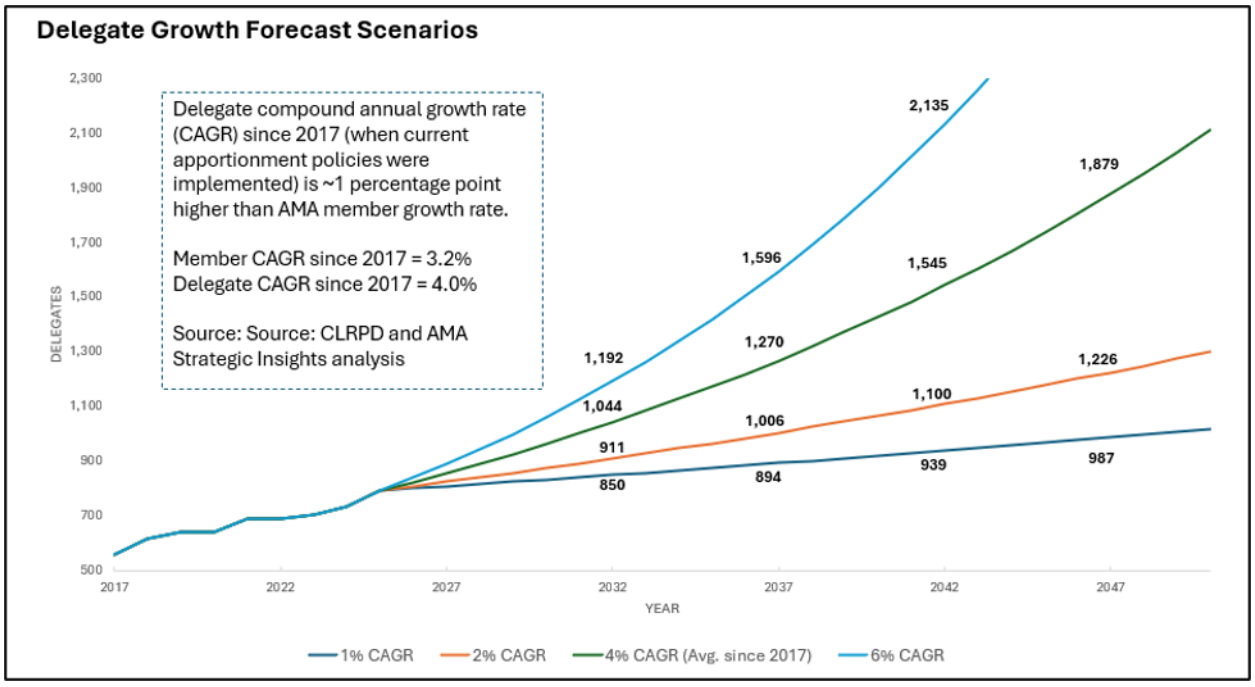
1. That delegate apportionment will be capped at its current level (793 delegates) for 2027 apportionment. Constituent association allocation will remain 351 with a corresponding number of 351 specialty society delegates to be apportioned according to established procedures. All other delegations will continue at their A-26 apportionment. 2028 apportionment will be based on year-end 2027 membership figures and so forth moving forward.
2. That, for 2027 apportionment and onward, the bylaws be amended to delete all apportionment language which includes "or fraction thereof" when apportioning any additional delegates beyond the first, so that additional delegates will not be added for a fraction of the recommended apportionment ratio.
3. That specialty society membership numbers will be obtained every three years as opposed to every five years for increased accuracy.
4. That there is a review of current apportionment rules and procedures with a report back to the HOD at the 2027 Interim Meeting, including assessing the ability to and costs associated with obtaining specialty society membership figures on an annual basis.

Fiscal note: Modest

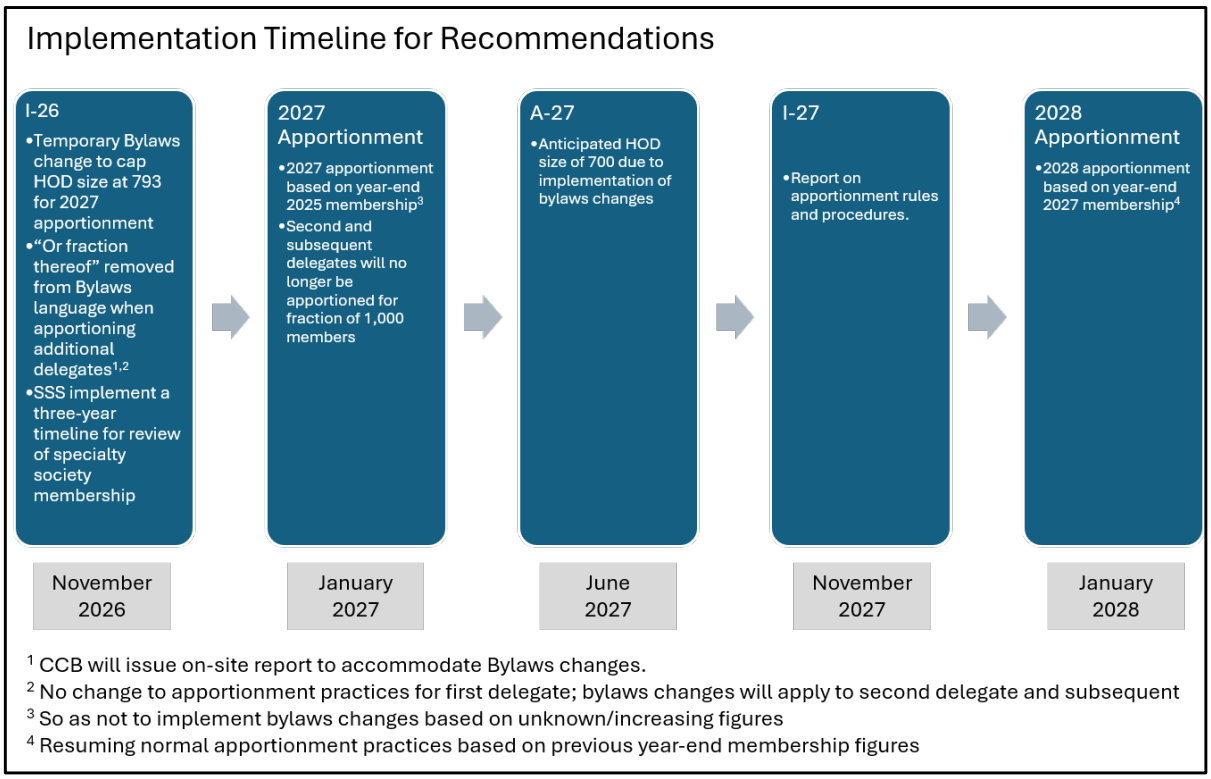
APPENDIX A



Graphic 1. Delegate Growth Timeline and Related Policy Decisions 1990-2026



Graphic 2. Delegate Growth Forecast Scenarios



Graphic 3. Implementation Timeline for Recommendations

APPENDIX B

Projected impacts of recommendations on delegations in the HOD

Association/Society	2026 Delegate Allocation	2027 Delegate Allocation (Proposed)	Difference	2026 Vote Share (Percentage)	2027 Proposed Vote Share (Percentage)	Difference (Percentage)
Academic Physicians Section (APS)	1	1	0	0.126	0.143	0.017
Academy of Consultation-Liaison Psychiatry	1	1	0	0.126	0.143	0.017
Academy of Physicians in Clinical Research	1	1	0	0.126	0.143	0.017
Aerospace Medical Association	1	1	0	0.126	0.143	0.017
Air Force	1	1	0	0.126	0.143	0.017
Alabama	4	3	-1	0.504	0.429	-0.076
Alaska	1	1	0	0.126	0.143	0.017
AMDA-The Society for Post-Acute and Long-Term Care Medicine	2	2	0	0.252	0.286	0.034
American Academy of Addiction Psychiatry	1	1	0	0.126	0.143	0.017
American Academy of Allergy, Asthma and Immunology	1	1	0	0.126	0.143	0.017
American Academy of Child and Adolescent Psychiatry	2	1	-1	0.252	0.143	-0.109
American Academy of Cosmetic Surgery	1	1	0	0.126	0.143	0.017
American Academy of Dermatology Association	5	4	-1	0.631	0.571	-0.059
American Academy of Emergency Medicine	3	2	-1	0.378	0.286	-0.093
American Academy of Facial Plastic and Reconstructive Surgery	1	1	0	0.126	0.143	0.017
American Academy of Family Physicians	26	25	-1	3.279	3.571	0.293
American Academy of Hospice and Palliative Medicine	2	2	0	0.252	0.286	0.034
American Academy of Insurance Medicine	1	1	0	0.126	0.143	0.017
American Academy of Neurology	4	3	-1	0.504	0.429	-0.076
American Academy of Ophthalmology	4	3	-1	0.504	0.429	-0.076
American Academy of Orthopaedic Surgeons	5	4	-1	0.631	0.571	-0.059
American Academy of Otolaryngic Allergy Inc.	1	1	0	0.126	0.143	0.017
American Academy of Otolaryngology-Head and Neck Surgery	4	3	-1	0.504	0.429	-0.076
American Academy of Pain Medicine	1	1	0	0.126	0.143	0.017
American Academy of Pediatrics	5	4	-1	0.631	0.571	-0.059
American Academy of Physical Medicine and Rehabilitation	3	2	-1	0.378	0.286	-0.093
American Academy of Psychiatry and the Law	1	1	0	0.126	0.143	0.017
American Academy of Sleep Medicine	2	1	-1	0.252	0.143	-0.109
American Association for Geriatric Psychiatry	1	1	0	0.126	0.143	0.017
American Association for Hand Surgery	1	1	0	0.126	0.143	0.017
American Association for Thoracic Surgery	1	1	0	0.126	0.143	0.017
American Association of Clinical Endocrinology	2	2	0	0.252	0.286	0.034
American Association of Clinical Urologists, Inc.	2	1	-1	0.252	0.143	-0.109
American Association of Gynecologic Laparoscopists	2	1	-1	0.252	0.143	-0.109
American Association of Hip and Knee Surgeons*	2	2	0	0.252	0.286	0.034
American Association of Neurological Surgeons	2	2	0	0.252	0.286	0.034
American Association of Neuromuscular & Electrodiagnostic Medicine	2	2	0	0.252	0.286	0.034
American Association of Physicians of Indian Origin	1	1	0	0.126	0.143	0.017
American Association of Plastic Surgeons	1	1	0	0.126	0.143	0.017
American Association of Public Health Physicians	1	1	0	0.126	0.143	0.017
American Clinical Neurophysiology Society	1	1	0	0.126	0.143	0.017
American College of Allergy, Asthma and Immunology	2	2	0	0.252	0.286	0.034
American College of Cardiology	9	8	-1	1.135	1.143	0.008
American College of Chest Physicians (CHEST)	3	2	-1	0.378	0.286	-0.093
American College of Emergency Physicians	9	8	-1	1.135	1.143	0.008
American College of Gastroenterology	4	3	-1	0.504	0.429	-0.076
American College of Legal Medicine	1	1	0	0.126	0.143	0.017
American College of Lifestyle Medicine	2	2	0	0.252	0.286	0.034
American College of Medical Genetics and Genomics	1	1	0	0.126	0.143	0.017
American College of Medical Quality	1	1	0	0.126	0.143	0.017
American College of Mohs Surgery	1	1	0	0.126	0.143	0.017
American College of Nuclear Medicine	1	1	0	0.126	0.143	0.017
American College of Obstetricians and Gynecologists	14	13	-1	1.765	1.857	0.092
American College of Occupational and Environmental Medicine	2	2	0	0.252	0.286	0.034
American College of Physicians	26	25	-1	3.279	3.571	0.293
American College of Preventive Medicine	1	1	0	0.126	0.143	0.017

Association/Society	2026 Delegate Allocation	2027 Delegate Allocation (Proposed)	Difference	2026 Vote Share (Percentage)	2027 Proposed Vote Share (Percentage)	Difference (Percentage)
American College of Radiation Oncology	1	1	0	0.126	0.143	0.017
American College of Radiology	8	7	-1	1.009	1.000	-0.009
American College of Rheumatology	2	2	0	0.252	0.286	0.034
American College of Surgeons	14	13	-1	1.765	1.857	0.092
American Contact Dermatitis Society	1	1	0	0.126	0.143	0.017
American Epilepsy Society*	1	1	0	0.126	0.143	0.017
American Gastroenterological Association	3	2	-1	0.378	0.286	-0.093
American Geriatrics Society	2	2	0	0.252	0.286	0.034
American Hernia Society	1	1	0	0.126	0.143	0.017
American Institute of Ultrasound in Medicine	2	2	0	0.252	0.286	0.034
American Medical Group Association	1	1	0	0.126	0.143	0.017
American Medical Women's Association	1	1	0	0.126	0.143	0.017
American Orthopaedic Association	1	1	0	0.126	0.143	0.017
American Orthopaedic Foot and Ankle Society	1	1	0	0.126	0.143	0.017
American Osteopathic Association	1	1	0	0.126	0.143	0.017
American Psychiatric Association	9	8	-1	1.135	1.143	0.008
American Rhinological Society	1	1	0	0.126	0.143	0.017
American Roentgen Ray Society	3	2	-1	0.378	0.286	-0.093
American Society for Aesthetic Plastic Surgery	1	1	0	0.126	0.143	0.017
American Society for Clinical Pathology	3	2	-1	0.378	0.286	-0.093
American Society for Dermatologic Surgery	3	2	-1	0.378	0.286	-0.093
American Society for Gastrointestinal Endoscopy	3	2	-1	0.378	0.286	-0.093
American Society for Laser Medicine and Surgery, Inc	1	1	0	0.126	0.143	0.017
American Society for Metabolic and Bariatric Surgery	1	1	0	0.126	0.143	0.017
American Society for Radiation Oncology	2	2	0	0.252	0.286	0.034
American Society for Reconstructive Microsurgery	1	1	0	0.126	0.143	0.017
American Society for Reproductive Medicine	2	2	0	0.252	0.286	0.034
American Society for Surgery of the Hand	2	2	0	0.252	0.286	0.034
American Society of Addiction Medicine	2	2	0	0.252	0.286	0.034
American Society of Anesthesiologists	8	7	-1	1.009	1.000	-0.009
American Society of Cataract and Refractive Surgery	2	1	-1	0.252	0.143	-0.109
American Society of Colon and Rectal Surgeons	2	2	0	0.252	0.286	0.034
American Society of Cytopathology	1	1	0	0.126	0.143	0.017
American Society of Dermatopathology	1	1	0	0.126	0.143	0.017
American Society of Echocardiography	2	1	-1	0.252	0.143	-0.109
American Society of Hematology	2	1	-1	0.252	0.143	-0.109
American Society of Interventional Pain Physicians	2	2	0	0.252	0.286	0.034
American Society of Maxillofacial Surgeons	1	1	0	0.126	0.143	0.017
American Society of Neuroimaging*	1	1	0	0.126	0.143	0.017
American Society of Neuroradiology	2	1	-1	0.252	0.143	-0.109
American Society of Nuclear Cardiology	2	1	-1	0.252	0.143	-0.109
American Society of Ophthalmic Plastic and Reconstructive Surgery	1	1	0	0.126	0.143	0.017
American Society of Plastic Surgeons	3	2	-1	0.378	0.286	-0.093
American Society of Regional Anesthesia and Pain Medicine	2	2	0	0.252	0.286	0.034
American Society of Retina Specialists	2	2	0	0.252	0.286	0.034
American Society of Transplant Surgeons	1	1	0	0.126	0.143	0.017
American Thoracic Society	2	1	-1	0.252	0.143	-0.109
American Urological Association	2	1	-1	0.252	0.143	-0.109
American Vein & Lymphatic Society	1	1	0	0.126	0.143	0.017
American Venous Forum	1	1	0	0.126	0.143	0.017
AMSUS - The Society of Federal Health Professionals	2	2	0	0.252	0.286	0.034
Arizona	5	4	-1	0.631	0.571	-0.059
Arkansas	3	2	-1	0.378	0.286	-0.093
Army	1	1	0	0.126	0.143	0.017
Association for Clinical Oncology	5	4	-1	0.631	0.571	-0.059
Association of Academic Physiatrists	1	1	0	0.126	0.143	0.017
Association of Academic Radiology	1	1	0	0.126	0.143	0.017
California	45	44	-1	5.675	6.286	0.611
College of American Pathologists	4	3	-1	0.504	0.429	-0.076
Colorado	6	5	-1	0.757	0.714	-0.042
Congress of Neurological Surgeons	2	2	0	0.252	0.286	0.034
Connecticut	4	3	-1	0.504	0.429	-0.076
Delaware	1	1	0	0.126	0.143	0.017
District of Columbia	2	1	-1	0.252	0.143	-0.109
Florida	19	18	-1	2.396	2.571	0.175

Association/Society	2026 Delegate Allocation	2027 Delegate Allocation (Proposed)	Difference	2026 Vote Share (Percentage)	2027 Proposed Vote Share (Percentage)	Difference (Percentage)
Georgia	7	6	-1	0.883	0.857	-0.026
GLMA: Health Professionals Advancing LGBTQ+ Equality	1	1	0	0.126	0.143	0.017
Guam	1	1	0	0.126	0.143	0.017
Hawaii	2	1	-1	0.252	0.143	-0.109
Heart Rhythm Society	3	2	-1	0.378	0.286	-0.093
Idaho	1	1	0	0.126	0.143	0.017
Illinois	13	12	-1	1.639	1.714	0.075
Indiana	6	5	-1	0.757	0.714	-0.042
Infectious Diseases Society of America	2	2	0	0.252	0.286	0.034
Integrated Physician Practice Section (IPPS)	1	1	0	0.126	0.143	0.017
International College of Surgeons - US Section	1	1	0	0.126	0.143	0.017
International Medical Graduates Section (IMGS)	1	1	0	0.126	0.143	0.017
International Pain and Spine Intervention Society	2	2	0	0.252	0.286	0.034
International Society for the Advancement of Spine Surgery	1	1	0	0.126	0.143	0.017
International Society of Hair Restoration Surgery	1	1	0	0.126	0.143	0.017
Iowa	4	3	-1	0.504	0.429	-0.076
Kansas	4	3	-1	0.504	0.429	-0.076
Kentucky	5	4	-1	0.631	0.571	-0.059
LGBTQ+ Section	1	1	0	0.126	0.143	0.017
Louisiana	7	6	-1	0.883	0.857	-0.026
Maine	2	1	-1	0.252	0.143	-0.109
Maryland	6	5	-1	0.757	0.714	-0.042
Massachusetts	14	13	-1	1.765	1.857	0.092
Medical Student Section (MSS)	1	1	0	0.126	0.143	0.017
Michigan	14	13	-1	1.765	1.857	0.092
Minnesota	5	4	-1	0.631	0.571	-0.059
Mississippi	3	2	-1	0.378	0.286	-0.093
Missouri	7	6	-1	0.883	0.857	-0.026
Montana	1	1	0	0.126	0.143	0.017
National Association of Medical Examiners	1	1	0	0.126	0.143	0.017
National Medical Association	1	1	0	0.126	0.143	0.017
Navy	1	1	0	0.126	0.143	0.017
Nebraska	3	2	-1	0.378	0.286	-0.093
Nevada	3	2	-1	0.378	0.286	-0.093
New Hampshire	2	1	-1	0.252	0.143	-0.109
New Jersey	10	9	-1	1.261	1.286	0.025
New Mexico	2	1	-1	0.252	0.143	-0.109
New York	28	27	-1	3.531	3.857	0.326
North American Neuromodulation Society	1	1	0	0.126	0.143	0.017
North American Neuro-Ophthalmology Society	1	1	0	0.126	0.143	0.017
North American Spine Society	2	1	-1	0.252	0.143	-0.109
North Carolina	6	5	-1	0.757	0.714	-0.042
North Dakota	2	1	-1	0.252	0.143	-0.109
Obesity Medicine Association	1	1	0	0.126	0.143	0.017
Ohio	12	11	-1	1.513	1.571	0.058
Oklahoma	4	3	-1	0.504	0.429	-0.076
Oregon	4	3	-1	0.504	0.429	-0.076
Organized Medical Staff Section (OMSS)	1	1	0	0.126	0.143	0.017
Outpatient Endovascular and Interventional Society	1	1	0	0.126	0.143	0.017
Pennsylvania	15	14	-1	1.892	2.000	0.108
Private Practice Physicians Section (PPPS)	1	1	0	0.126	0.143	0.017
Public Health Service	1	1	0	0.126	0.143	0.017
Puerto Rico	2	1	-1	0.252	0.143	-0.109
Radiological Society of North America	3	2	-1	0.378	0.286	-0.093
Renal Physicians Association	2	2	0	0.252	0.286	0.034
Resident and Fellow Section (RFS)	1	1	0	0.126	0.143	0.017
Resident Sectional	42	42	0	5.296	6.000	0.704
Rhode Island	2	1	-1	0.252	0.143	-0.109
Senior Physicians Section (SPS)	1	1	0	0.126	0.143	0.017
Society for Cardiovascular Angiography and Interventions	2	2	0	0.252	0.286	0.034
Society for Cardiovascular Magnetic Resonance	1	1	0	0.126	0.143	0.017
Society for Investigative Dermatology, Inc.	1	1	0	0.126	0.143	0.017
Society for Pediatric Dermatology	1	1	0	0.126	0.143	0.017
Society for Vascular Surgery	2	2	0	0.252	0.286	0.034
Society of American Gastrointestinal Endoscopic Surgeons	2	2	0	0.252	0.286	0.034
Society of Cardiovascular Computed Tomography	2	2	0	0.252	0.286	0.034

Association/Society	2026 Delegate Allocation	2027 Delegate Allocation (Proposed)	Difference	2026 Vote Share (Percentage)	2027 Proposed Vote Share (Percentage)	Difference (Percentage)
Society of Critical Care Medicine	2	1	-1	0.252	0.143	-0.109
Society of Hospital Medicine	3	2	-1	0.378	0.286	-0.093
Society of Interventional Radiology	2	2	0	0.252	0.286	0.034
Society of Nuclear Medicine and Molecular Imaging	1	1	0	0.126	0.143	0.017
Society of Thoracic Surgeons	2	1	-1	0.252	0.143	-0.109
South Carolina	4	3	-1	0.504	0.429	-0.076
South Dakota	2	1	-1	0.252	0.143	-0.109
Student Regional	26	26	0	3.279	3.714	0.436
Tennessee	6	5	-1	0.757	0.714	-0.042
Texas	25	24	-1	3.153	3.429	0.276
The American Society of Breast Surgeons	2	1	-1	0.252	0.143	-0.109
The Endocrine Society	2	1	-1	0.252	0.143	-0.109
The Society of Laparoscopic and Robotic Surgeons	2	1	-1	0.252	0.143	-0.109
The Triological Society	1	1	0	0.126	0.143	0.017
Underrepresented in Medicine Advocacy Section (UMAS)	1	1	0	0.126	0.143	0.017
Undersea and Hyperbaric Medical Society	1	1	0	0.126	0.143	0.017
Utah	3	2	-1	0.378	0.286	-0.093
Veterans Affairs (VA)	1	1	0	0.126	0.143	0.017
Vermont	1	1	0	0.126	0.143	0.017
Virgin Islands	1	1	0	0.126	0.143	0.017
Virginia	7	6	-1	0.883	0.857	-0.026
Washington	7	6	-1	0.883	0.857	-0.026
West Virginia	2	1	-1	0.252	0.143	-0.109
Wisconsin	5	4	-1	0.631	0.571	-0.059
Women Physicians Section (WPS)	1	1	0	0.126	0.143	0.017
Wyoming	1	1	0	0.126	0.143	0.017
Young Physicians Section (YPS	1	1	0	0.126	0.143	0.017
Total	**793**	**700**	**-93**	**100**	**100**	**0**

Table 1. Impact of Proposed Bylaws Changes on HOD

Delegation Size	2026 Percentage of Delegations	2027 Projected Percentage of Delegations with Bylaw Change Implementation
1[1]	41.6%	54.2%
2	26.6%	22.0%
3	7.9%	5.6%
4	5.6%	3.7%
5	3.7%	2.3%
6	2.3%	2.3%
7	2.3%	0.9%
8	0.9%	1.4%
9	1.4%	0.5%
10+	7.5%	7.0%

Table 2. Current and Projected Delegation Size Distribution 2026-2027

[1] Delegations comprised of one delegate and alternate delegate will not be impacted by proposed bylaw changes.

Appendix C

CLRPD Town Hall Polling

The Council convened three town hall sessions for HOD members to work toward further developing a shared understanding of the scope of growth of the HOD and the trajectory of future growth, the drivers of that growth, and the proposals under consideration. Across the three town halls, 301 AMA delegates and alternate delegates registered for participation, 184 of whom attended at least one of the sessions. While the poll results were obtained anonymously, it should be noted that 28 participants attended multiple sessions, so it is likely that some attendees responded to the poll more than once. While these sessions were comprised of a representative sample of HOD members, these results reflect only the opinions of those attendees and do not necessarily reflect the will of the House at large.

Attendees were polled on a Likert scale on their likeliness to support each of the proposals. In each poll, they were asked whether they were very likely, somewhat likely, unsure, somewhat unlikely, or very unlikely to support a given proposal. The council used a software platform called Slido to obtain anonymous poll results, which allowed results to be shared with participants in real time. Participation in polling was optional, and the results below reflect the opinions of those participants who chose to respond.

Proposal 1

This proposal suggested removing the language “and fraction thereof” from bylaws and policy related to apportionment of additional delegates after the first for all state and specialty delegations. Under current policy, a second delegate is apportioned to a delegation once they reach 1,001 delegates. Were this proposal to be adopted, a second delegate would be apportioned at 2,000 members, and so on. The size of the HOD would be reduced by 93 delegates across state and specialty delegations using 2026 apportionment figures.

Results

Total Responses: 142

Likely: 100 (70.4%)
Unsure: 16 (11.3%)
Unlikely: 26 (18.3%)

Proposal 2

This proposal was to pause delegate growth while other changes are phased in. This reflects the belief that some immediate stabilization may be necessary to prevent continued expansion while the House considers longer-term reform. This proposal would temporarily cap the total number of delegates at 793.

Results

Total Responses: 145

Likely: 103 (71.0%)
Unsure: 20 (13.8%)
Unlikely: 22 (15.2%)

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-I-26

Subject: Underrepresented in Medicine Advocacy Section Five-Year Review

Presented by: G. Sealy Massingill, MD, Chair

Referred to: Reference Committee F

American Medical Association (AMA) Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

The Council assessed information from the letter of application submitted by the Underrepresented in Medicine Advocacy Section (UMAS), formerly the Minority Affairs Section, for renewal of delineated section status.

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The UMAS serves as the AMA's central body for efforts to expand equitable opportunities and diversity in medicine; policy and advocacy initiatives for underrepresented physicians and patients; communication and partnerships with external underrepresented in medicine (URiM) national organizations; convening, education and mentorship for underrepresented members; and advocating to eliminate health disparities.

During the last five years the following priority issues have been the focus of the UMAS:

- Increase equitable opportunities for, and diversity of, medical students, trainees, and physicians: To amplify equitable opportunities and demonstrate representation in historically underrepresented student populations, UMAS co-founded the United Leaders in Advocacy (ULA), which convenes leaders from URiM student medical associations, such as the Student National Medical Association (SNMA), Latino Medical Student Association (LMSA), Association of Native American Medical Students (ANAMS), in addition to leaders from allied sections within our AMA. The bi-annual ULA sessions during each HOD meeting have resulted in increased communication and collaboration between student leaders within organized medicine and fostered opportunities for leadership development for underrepresented medical students.

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- Champion key policy initiatives and advocacy efforts on behalf of underrepresented physicians and patients: Since UMAS became a voting member of our HOD in 2011, the Section has served as the leading voice within the HOD on policy matters that impact underrepresented physicians, trainees, and students, and historically marginalized patient populations. This representation in the HOD was a vital step taken by our AMA to address and remedy historical harms and codified discrimination. The UMAS, alongside the International Medical Graduates Section (IMGS), co-founded a caucus within the Sections to convene on matters of health equity. The caucus expanded in recent years and is now also co-led by the LGBTQ+ Section and the Women Physicians Section (WPS).

- Strengthen communication and partnerships with URiM external organizations: For nearly thirty years, UMAS has served as a conduit between our AMA and URiM national organizations including the National Medical Association (NMA), SNMA, National Hispanic Medical Association (NHMA), LMSA, Association of American Indian Physicians (AAIP), ANAMS, and National Minority Quality Forum (NMQF). UMAS' strategic partnerships with these institutions and their underrepresented physician and medical student members continues to produce valuable relationships and coalitions on policy and educational programming, leadership opportunities on the UMAS Governing Council (GC), liaison between our AMA Board of Trustees leadership and the respective board leaders of these URiM organizations, and UMAS staff and membership presence at these organizations' annual conventions.

- Create space for underrepresented physicians to convene, learn, and mentor within our AMA: The Section has organized various mentorship sessions, such as the joint Medical Student Section (MSS)-UMAS bi-annual speed mentoring event; leadership development opportunities; educational programs with health equity as a foundational element; policy work groups like the American Indian and Alaska Native (AI/AN) work group; receptions and mixers. These efforts encourage professional development, continued, high-quality medical education, and personal well-being for underrepresented members of our AMA.

- Advocate to eradicate health disparities: In the past five years, UMAS has spearheaded initiatives alongside partners such as NMA, SNMA, NHMA, AAIP, the AMA Advocacy Center, and the AMA Center for Optimal Health Outcomes (COHO). UMAS has hosted and/or supported educational programs and webinars on the high rates of maternal morbidity and mortality among Black patients; amplified the Release the Pressure (RTP) campaign whose mission is to "reduce hypertension in women, especially where disparities hit hardest, through education, community and culturally responsive care"; and spotlighted the health disparities of historically marginalized patient populations in rural areas across the United States.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

UMAS contributes to the AMA's strategic direction through efforts to embed inclusion in medicine, build alliances, empower members to address upstream drivers of health, and create pathways for the next generation of underrepresented physicians. The Section is in alignment with our AMA's strategic objectives set forth in its 2024-2025 Organizational Strategic Plan to Advance Health Equity.

In August 2025, the UMAS GC developed its 2025-2026 strategic plan with the issues of concern above addressed in the plan's objectives, goals, and tactics. The section developed SMART

(Specific, Measurable, Achievable, Relevant, Timebound) goals that included increasing the engagement of UMAS members in policymaking activities to include at least ten non-GC members by A-26, resulting in at least five UMAS-sponsored resolutions to the HOD at A-26; collaborating with at least three URiM medical societies to advance UMAS policymaking and advocacy initiatives and completing at least two activities to influence and/or inform AMA policy on the state of public health infrastructure in the United States by A-26; facilitating and/or co-hosting at least four mentorship opportunities annually; and strengthening relationships with medical societies serving underrepresented physicians and/or medical trainees and collaborating on an annual joint program and/or initiative.

Tactics to increase member engagement in policymaking include further defining the UMAS policymaking process and developing a policymaking workshop and a standing committee on policymaking activities. UMAS also works to ensure that resolutions are informed or co-sponsored by other URiM organizations, convenes leaders and staff from URiM organizations to align policy priorities, and integrates ongoing initiatives led by COHO and URiM organizations with the efforts of the Section. The UMAS partners with AMA business units and external organizations to host events during HOD meetings that allow underrepresented physicians to convene, network, and mentor. Additionally, UMAS determined that it would connect with at least one URiM medical society on topics/policy issues of mutual interest and ensure bidirectional reporting, as well as support GC member attendance at URiM medical society conferences.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

Eligible voters with full rights and privileges are referred to as UMAS members. Membership in UMAS is initiated upon the request of the individual physician or medical student, open to any AMA member physician or medical student who expresses an interest in racial and ethnic underrepresented physicians or health matters affecting historically marginalized communities.

The UMAS GC meets remotely each month and at least four times per year in person. Officer positions on the GC are elected annually in closed session at the Annual Meeting of our HOD. Three URiM physician organizations (NMA, NHMA, and AAIP) nominate representatives to be elected to designated positions on the UMAS GC. Each of the three AMA Sections (MSS, RFS, and YPS) endorse their respective representatives, who are elected by the UMAS membership via electronic ballot. Only current AMA-UMAS members with an active AMA membership are eligible to be nominated to the designated positions on the GC. All UMAS affiliated pages on the AMA website are up to date with a current roster of UMAS leaders and how to best contact their Section leadership and staff through the operational support of UMAS staff.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

Over 27,000 underrepresented physicians and medical students are members of our AMA, with over 141,000 underrepresented physicians and medical students are in medicine nationally. According to the Association of American Medical Colleges' (AAMC's) 2023 Physician Workforce Data report (the most recent data available at the time of application), underrepresented physicians make up approximately 12% of the physician workforce. UMAS is able to accurately identify the number of underrepresented medical student and physician members and hosts events

during HOD meetings to encourage attendance from underrepresented members and allies creating inclusive spaces and community for all AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians, who will be represented by this section. Both the segment and the AMA will benefit from an increased voice within the policymaking body.

On average, UMAS expects between 100-150 attendees across in-person meetings held during annual and interim meetings. In recent years, the Section has seen a consistent increase in the number of attendees during assembly meetings, during which UMAS receives informational and organizational updates from business units such as COHO, MedEd, the Advocacy Resource Center, and the AMA Foundation.

The Section employs two primary modes of communication with its members. The first is through a monthly newsletter emailed to approximately 1,600 subscribers that includes Section-specific updates, enterprise-wide updates, and timely news articles and press releases related to health equity and underrepresented physicians. The second is through group chat platforms such as GroupMe for more timely updates, opportunities, and communications from UMAS leadership directly to members. The opportunities provide communication for accessible membership experience, resulting in an increase in UMAS membership over the past five years.

UMAS receives consistent and competitive interest when leadership opportunities arise. Throughout the year, the UMAS GC promotes leadership development opportunities that provide membership with the tools and education to be leaders within the section or otherwise.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

Work of constituencies like UMAS within our AMA allows for the fostering of opportunities to reconcile and transform policies and practices that perpetuate health inequities and racial injustices in the medical profession through institutional and structural means.

UMAS' representation in the HOD has allowed for the perspectives and policy positions of the Section to be conveyed through resolutions, testimony, and alliances formed with other Sections and delegations on matters of inclusion and health equity. UMAS supports AMA policy that aligns with the Section's mission and values throughout the HOD policymaking process, from acting as a leader among allied Sections, as a resource in resolution drafting, offering mentorship opportunities on the HOD policymaking process, showing support for resolutions that address health disparities and racial justice during the online and in-person reference committee processes, and during HOD policymaking sessions.

UMAS members have numerous opportunities throughout the year to engage in dialogue with Section leaders, contribute to the Section's work, and build consensus. UMAS utilizes online open forums prior to HOD handbook deadlines, assembly meetings during bi-annual HOD meetings, the convening of the Health Equity Caucus, ad-hoc or town-hall meetings, standing committees, two annual opportunities to submit resolution proposals for GC consideration, and other opportunities to provide comment or testimony virtually or in-person.

DISCUSSION

The UMAS serves a pivotal role within the AMA on matters that impact underrepresented physicians, residents and fellows, medical students, and the historically marginalized patient populations they serve. As a formalized body to facilitate and encourage the participation of underrepresented physicians in the deliberations of the HOD and other AMA activities, the Section fills a demonstrable need. The efforts of UMAS directly impact on AMA membership, particularly as it relates to the recruitment and retention of underrepresented medical students and physicians.

The efforts of the Section support the AMA's strategic direction through UMAS' own initiatives and in collaboration with internal and external partners. The UMAS acts as a crucial link between the AMA and other organizations representing the interests of underrepresented physicians and medical students, strengthening relationships between these organizations and creating and amplifying educational, networking and mentorship opportunities.

Since becoming a voting member of our HOD in 2011, the Section has served as the leading voice within the HOD on the policy matters that impact underrepresented physicians and students and on matters related to health care and historically marginalized communities. The Section remains a significant voice within AMA policymaking, and since the 2020 Interim Meeting, has authored or significantly contributed to more than 30 resolutions that align with the Section's mission and values, enhancing the AMA's policymaking process and the breadth of the HOD's knowledge and deliberations.

The Council appreciates the thorough work of UMAS leadership and staff in completing this letter of application and follow-up communications, as well as the thoughtfulness of the Section as it looks to build upon its already laudable work in the future.

CONCLUSION

The CLRPD has determined that the UMAS meets all required criteria; therefore, it is appropriate to renew the delineated section status of the UMAS.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Underrepresented in Medicine Advocacy Section through 2031 with the next review no later than the 2031 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 3-I-26

Subject: Integrated Physician Practice Section Five-Year Review

Presented by: G. Sealy Massingill, MD, Chair

Referred to: Reference Committee F

American Medical Association (AMA) Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

The Council accessed information from a letter of application submitted by the Integrated Physician Practice Section (IPPS) for renewal of delineated section status.

APPLICATION OF CRITERIA

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The IPPS seeks to advance the interests of physicians who practice in multispecialty, physician-led, integrated health care delivery systems, and groups actively working toward such systems of coordinated care.

During the last five years the following priority issues have been the focus of the IPPS:

- Develop and activate impactful policy on issues relevant to section constituencies: The IPPS Governing Council (GC) and Policy Development Committee developed work groups and policy around issues of significance to the Section, including social determinants of health (SDOH) and the hospital at home model of care. The Section also achieved the adoption of resolutions on ethical guidelines for private equity, SDOH and health information technology (IT), and the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as an Essential Health Benefit under the Patient Protection and Affordable Care Act.

- Cultivate physician leadership and section diversity: The IPPS has engaged in proactive outreach efforts to recruit executive level and diverse candidates for GC positions and other leadership positions at the AMA. As a result, most new GC members over the past five years have held senior leadership positions in their health systems and diversity in the GC has increased. Additionally, IPPS has worked successfully to encourage its members to

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pursue leadership roles outside of the Section.

- Retain and grow Section membership: The IPPS has combined collaborative outreach with the AMA Health System Member Program with personalized outreach from GC members, contributing to a 75 percent increase in IPPS membership from 2021 through 2025. The Section has also set a measurable target to increase membership by ten percent annually, with a particular focus on recruiting executive and influential physicians from their respective health systems, as well as revisiting membership criteria to attract new applicants and reduce barriers to participation.

- Advance physician-led integrated care and awareness: The Section has worked to expand awareness on its priority issues through showcasing members in a variety of formats and forums including webinars, podcasts, presentations, updates to health system partners, publications and collaborative events. The IPPS has also developed an inventory of opportunities for member participation in AMA advisory roles and committees, such as the Value-Based Care Workgroup. The Section also aims to position itself as a resource and support entity to AMA business units like Professional Satisfaction and Practice Sustainability (PS2) and the Health System Member Program.

- Strengthen Section engagement and collaboration within the AMA: The IPPS has worked to encourage involvement in Section activities between meetings, such as through participation in the Policy Development Committee and other workgroups, and promoted collaboration, policy development, and joint sessions with other sections like the Organized Medical Staff Section (OMSS) and the Private Practice Physicians Section (PPPS). Most recently, the IPPS, OMSS, and PPPS co-sponsored a panel session at I-25 titled *The Trillion-Dollar Cut: Impact of Medicaid Cuts on Health Care*. The panel focused on how providers can adapt clinical operations and financial models to respond to reduced payment and highlighted opportunities for physicians and health system leaders to advocate for policy solutions that protect patients, physicians and other health care providers. Over 110 AMA members attended the panel.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

Every year, the IPPS GC and staff collaborate to develop a comprehensive strategic plan for the Section. Strategic priorities include Section governance, policymaking, efforts to expand core membership and strengthen partnerships with other sections. The strategic plan is reviewed and updated regularly to ensure alignment and ongoing progress.

The IPPS has played a significant role in advancing the AMA's membership strategy, which increasingly emphasizes engagement with large health systems through the Health System Member Program. This focus has helped our AMA consistently meet and exceed its annual membership targets. The IPPS has aided in the recruitment and retention of health system members by helping systems discover that they have an active voice in shaping AMA policy and opportunities to participate meaningfully in organizational governance through IPPS engagement. Physician executives are also introduced to a network of peers and opportunities for collaboration and shared learning through events such as the Insight Network Summit, an invitation-only event held in conjunction with the IPPS Annual Meeting where participants engage in organized peer-to-peer presentations and discussions about their system's successes and challenges.

The Section also partners with staff from the PS2 business unit, which leads initiatives in health care quality. Collaborative efforts have included the co-development of educational programs and featuring PS2 leaders in IPPS roundtable discussions. These interactions create a mutually beneficial environment through which PS2 gains frontline perspectives from integrated practice leaders, while IPPS can influence and align with the latest developments in AMA quality improvement work. Additionally, IPPS has partnered with the Joy in Medicine program to celebrate and recognize IPPS members. These efforts demonstrate how the subject matter expertise provided by IPPS members can enhance both individual AMA initiatives and the strategic goals of the Association.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

The IPPS is structured to allow for open participation by any member on nearly all functions of the Section. While the GC is tasked with managing the operational functions of the Section, which is largely conducted through regular meetings, directional planning for the Section is presented to the general membership for discussion, debate, and approval.

Membership of the Section consists of associate members, defined in the Section's Internal Operating Procedures (IOP) as members of the AMA who are in physician-led, integrated health care organizations that coordinate patient care across specialties and among physicians who share common records and clinical care processes, and affiliate members, who are members of the AMA who practice in organizations moving toward physician-led integrated health care that do not yet satisfy the characteristics of organizations eligible to qualify their physicians as associate members. All members of the GC members must be associate members of the IPPS.

Physicians interested in IPPS membership must complete an application, which is reviewed by the Credentials Committee. IPPS membership ranges from the largest health systems to clinically integrated networks of smaller independent practices. There are slotted seats on the GC for larger groups (351+ members) and smaller groups (350 members and under).

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

In 2025 the IPPS represented a projected (at the time of application) 56 member organizations representing approximately 79,700 physicians. While it is difficult to determine the total number of physicians in the United States that could be represented by the IPPS, given recent trends of consolidation of health care systems, as well as the recent increases in IPPS membership and engagement with the Section, it can be safely inferred that well over 1,000 AMA members can be represented by the IPPS.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians, who will be represented by this section. Both the segment and the AMA will benefit from an increased voice within the policymaking body.

Since the 2021 Annual Meeting, IPPS meetings have averaged 52 attendees registered through the CVENT registration system, though the Section notes that actual attendance typically exceeds

registration. Recent additions of the Joy in Medicine Recognition Program and the Insight Network Summit have led to increased attendance at IPPS meetings. As noted previously, IPPS membership increased by 75 percent from 2021-2025.

The Section communicates with members primarily through its monthly newsletter that keeps members updated on all Section activities. That communication is sent to approximately 2,500 IPPS subscribers and has an average monthly open rate of 47 percent.

Members demonstrate consistent interest in serving in leadership roles within the IPPS, and positions have been filled without difficulty. The section has established a clear pathway to the GC by encouraging members to attend Assembly meetings, speak at events, participate in the Policy Development Committee, and attend the Insight Network Summit. Members who demonstrate active engagement in these activities often run for open Governing Council seats as they become available.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

Despite the growing prevalence of integrated physician practices like multispecialty groups and large health systems, members of the IPPS remain underrepresented in many aspects of AMA policymaking. Historically, the AMA's attention and advocacy efforts have focused more heavily on the perspectives of physicians in independent and smaller practice settings. As a result, the unique challenges faced by physicians practicing in integrated models, such as navigating complex group governance, implementing coordinated care across specialties, and adapting to system-wide technological changes, are often less recognized and insufficiently addressed in broader policy initiatives. With the rapid shift in the health care landscape toward integration and consolidation, physicians working within these practice settings will increasingly need a voice. Through its representation in the House of Delegates, IPPS has championed issues that are particularly relevant to integrated practice environments including advocating for streamlined regulatory requirements, fostering adoption of health IT and interoperability, and supporting team-based models of care.

Policy is openly debated through both an online forum open to all AMA members and through virtual and face-to-face meetings. Any IPPS member may submit a resolution for consideration at annual or interim meetings, and the IPPS Policy Development Committee reviews issues and draft resolutions. All resolutions are accepted provided they pass a review from the AMA Office of the General Counsel. The IPPS GC reviews resolutions and makes recommendations, which are shared with the IPPS Assembly. During IPPS Assembly meetings, policy discussions occur allowing all members to share input and during which final decisions are made on amendments and whether a resolution should be adopted on behalf of the Section. These sessions are typically led by IPPS Delegate/Alternate Delegate, helping familiarize others with the policymaking process. Before each Assembly, IPPS members also receive an HOD Handbook review report that identifies items relevant to IPPS from the HOD Handbook.

DISCUSSION

The IPPS is the only AMA component group that focuses on issues concerning integrated physician practices and physician-led coordinated health care, and IPPS provides a direct and ongoing relationship between the AMA and this cohort of physicians. Given recent evolutions in the health care environment toward consolidation, multispecialty groups and large systems, there has likely never been a greater need among organized medicine for representation for physicians

working in integrated practice settings. The Section's rapid growth in membership since its last review demonstrates its strong and growing necessity within the AMA.

In addition, as the AMA's growth and strategy are increasingly influenced by group recruitment and the Health System Member Program, and the IPPS serves as a crucial entry point for new members by helping large health systems discover a tangible home within the AMA; the IPPS has been instrumental in the recruitment and retention of health system members. The IPPS also collaborates closely with the Health System Member Partner team to identify shared goals and areas of mutual interest for physicians practicing within integrated health systems.

In policymaking, the IPPS acts as the central body to bring forward the needs of integrated practice physicians for deliberation. Maintaining section status for IPPS is essential to enhance representation and ensure that policies reflect the experiences of these physicians. With a distinct presence in AMA governance, the profession amplifies the contributions and challenges of integrated medical practices, making IPPS's continued advocacy and involvement highly relevant to AMA's mission.

The Council appreciates the thorough work of IPPS leadership and staff in completing this letter of application and follow-up communications, as well as the thoughtfulness of the Section as it looks to build upon its work in the future.

CONCLUSION

The CLRPD has determined that the IPPS meets all required criteria; therefore, it is appropriate to renew the delineated section status of the IPPS.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2031 with the next review no later than the 2031 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

REPORT OF THE SPEAKERS

Speakers' Report 1-I-26

Subject: Election Rule Updates

Presented by: Lisa Bohman Egbert, MD, Speaker and John H. Armstrong, MD, Vice Speaker

Referred to: Reference Committee F

Your Speakers, in consultation with the Election Committee (EC), review the American Medical Association's (AMA) policy G-610.090, "AMA Election Rules and Guiding Principles," following each election cycle. This report offers recommended clarifications to the election rules based on this review.

DISCUSSION

During the A-26 election cycle, candidates reported that some interviewing groups required candidates to complete questionnaires in addition to their interview. Requiring completion of a questionnaire unfairly expands the interview for these interviewing groups as candidates are asked to answer questions asynchronously in addition to their allotted in-person or virtual time. Additionally, the election rules state, "printed or digital campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the AMA Candidates' Page." There was some concern expressed by candidates that sending campaign materials to these groups could be interpreted as a violation of this election rule.

Current election interview rules make an exception for questionnaires. Several candidates reported that some groups were utilizing questionnaires to facilitate the group's internal assessment to "support" the candidate. However, groups who used this process did not submit information as an interviewing group. Candidates reported that some groups on the interview list asked candidates to fill out questionnaires in addition to their interview while other groups, not on the list, asked candidates to fill out questionnaires to gain the group's support. Candidates were concerned that completing either or both types of questionnaires could be a campaign violation. Not only does this contribute to the candidate confusion discussed in the preceding paragraph, but it also makes administering the interview process difficult for the HOD Office. Therefore, your Speakers recommend that questionnaires be treated as an interview and groups wishing to use them in lieu of a virtual or in-person interview be required to submit information to the Official Group Interview List.

Policy passed at the 2026 Annual Meeting regarding the endorsement process will have significant impact beginning with the A-28 election cycle (elections held at the 2028 Annual Meeting). Changes to policy include moving the deadline for groups to submit information about their endorsement process to be "no later than 30 days prior to the start of the Interim Meeting preceding the Annual Meeting at which the election is to take place." In addition, the endorsement window cannot open until the commencement of that Interim Meeting. Under current rules, formal questioning of an announced candidate is an interview, and therefore, any 2028 candidate who announces their candidacy at the 2027 Annual Meeting would not be able to participate in the

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endorsement window at the 2027 Interim Meeting. Therefore, your Speakers recommend a change in policy be made to allow candidates the ability to participate in the endorsement process during the identified endorsement window, even if they have previously announced their candidacy.

As communicated previously to members of the House, the terms "sponsored by" or "endorsed by" should be used when describing organizations on a candidates' announcement card or campaign materials. The terms "nominated by" or "supported by" should not be used. Sponsoring group and endorsing group are explicitly defined in the election rules glossary, however the term "support" is still occasionally used by groups. Your Speakers are recommending that a definition of "support" be added to the glossary of the election rules. Organizations may only use the term "support" when discussing within their closed group about an internal decision to recommend a given candidate to that group's members. This support may not lead to a public endorsement, nor may the candidate be apprised of having received a group's support. It is important for groups to specify to their members when providing such information that delegates should ultimately vote individually, with no implied or inferred repercussions should they choose not to vote for a "supported" candidate.

CONCLUSION

After a thorough review and debrief of the A-26 election cycle in consultation with the EC, recommendations for clarification to the election rules are being proposed to promote fairness across campaigns.

RECOMMENDATIONS

Your Speakers recommend that the following updates be made to the AMA election rules and that the remainder of the report be filed:

1. That any written or oral questioning of an announced candidate is considered an interview and subject to the interview rules. Groups may utilize either a written questionnaire or an oral interview process, but not both, in any given contest. No additional candidate or campaign information, other than pertinent contact information, may be requested from candidates or shared with the group by candidates.
2. That all candidates may participate in the endorsement interview process during the identified endorsement window for the election cycle in which they are running for office even if they have previously announced their candidacy.
3. That the term "support" be defined as an internal decision, made in a closed meeting (e.g. only members of the group are present) to recommend a specific candidate for a given contest. This support should not be shared with the candidate or otherwise announced or made public by the group and should not imply a requirement for group members to vote for the supported candidate.

Fiscal note: Minimal

Relevant AMA Policy

The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to

all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

Glossary of Election Terms

Active campaign window – Period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.
Active campaigning – Outreach by candidates or their surrogate(s), including but not limited to members of their campaign team, to members of the House of Delegates with the goal of being elected by the AMA House of Delegates.
Announced candidate – Person who has indicated their intention to run for elected position; announcement can be made only by sending an electronic announcement card to the Speakers via the HOD office by email to hod@ama-assn.org.
Campaign manager(s) – Person(s) identified by the candidate to the HOD Office as the person(s) responsible for running the campaign.
Campaign presentation – A written or verbal presentation about a campaign or a solicitation of votes for an AMA election to a non-sponsoring group. A candidate may attend and participate in the business of a non-campaign-related meeting or event of a non-sponsoring group or non-endorsing group, but the candidate shall not engage in campaigning of any kind.
Campaign team – Campaign manager(s) and/or staff identified by the candidate to the HOD Office.
Campaign-related – Any content that includes reference to an announced candidate in the context of their candidacy for an elected position within the AMA.
Digital – Relating to, using, or storing data or information in the form of digital signals; involving or relating to the use of computer technology; this includes, but is not limited to, social media and communication platforms.
Elected position(s) – Council or Officer position within the AMA elected by the House of Delegates of the AMA.
Endorsing group - Any group that wishes to endorse candidates other than the candidates they are eligible to sponsor. See definition of "Sponsoring Group."
Endorse - Any public acknowledgement by a candidate or members of a group of the group's support of a candidate. Internal discussions of support in a closed session of the group are not considered public for the purpose of this definition.
Featured – Identification of a candidate at an event by the host or organizer of the event, including but not limited to, written or verbal announcement of the candidate or their candidacy.
Sponsoring group

- Sponsoring group is an endorsing group that may offer endorsements to the delegate(s) and/or alternate delegate(s) representing that sponsoring group without the need to provide their endorsement process to the HOD Office.
- The association, society, AMA section, or other entity for which a prospective candidate serves as an AMA HOD delegate or alternate delegate as certified with the HOD office.
- The Section delegate and alternate delegate are the only individuals who may be sponsored by their respective AMA Section.
- Current trustees or Council members seeking re-election or election to president-elect may be sponsored by the delegation for which they served as an AMA HOD delegate or alternate delegate immediately prior to their election.
- Individuals may self-sponsor (self-nomination).

I. Guiding Principles

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

1. Our American Medical Association delegates should:
   a. avail themselves of all available background information about candidates for elected positions in our AMA.
   b. determine which candidates are best qualified to help the AMA achieve its mission.
   c. make independent decisions when voting for candidates.
2. Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.
3. Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
4. Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for our AMA leadership positions.
5. Incumbency should not assure the re-election of an individual to an AMA leadership position.
6. Service in any AMA leadership position should not assure ascendancy to another leadership position.
7. Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates.
8. Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.
9. Every state and specialty society delegation is encouraged to participate in a caucus, for the purposes of candidate review activities.

II. Guidelines for Candidacy for AMA Offices

1. Every effort should be made to have two or more candidates for each vacancy.
2. The Federation (in sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) should consider the need to enhance and promote diversity.

III. Candidate Announcement, Nominations and Open Positions

1. Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, the office sought, the sponsoring group, if any, and a list of endorsing groups, if any. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed to members of the House by any method.
2. Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website. Following each meeting, an "Official Candidate Notification" will be sent electronically to

the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out with regular Speaker communications to the HOD and with the Speaker's notice of the opening of active campaigning which generally follows the April Board meeting.

3. Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on the elected councils or the Board of Trustees, at any time by submitting an announcement card to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Candidate Notification. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than on Official Candidate Notifications.
4. The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.
5. If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled positions would remain unfilled until the next annual meeting.
6. Our AMA believes that:
   a. specialty society candidates for our AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides.
   b. elected specialty society members should be identified in that capacity while serving their term of office.
   c. nothing in the above recommendations should preclude endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.
7. Our AMA requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election. Conflict of interest forms must be submitted after an individual has announced their candidacy and before the active campaign window begins or, if not previously announced, within 24 hours of the conclusion of the HOD Opening Session. The HOD Office will post such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.
8. Candidates will be provided with a copy of the current election rules and will be required to attest to abiding by them. Candidates are responsible for any and all actions or inaction undertaken on their behalf that is campaign related.

IV. Communications, Campaign Memorabilia and Literature

1. Active campaigning for an elected AMA position may not begin until the active campaign window opens as announced by the Speaker following the Spring Board of Trustees

meeting immediately preceding the meeting at which the election is scheduled to take place.

2. An announced candidate may discuss their candidacy on an individual basis in private conversations after the announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy except in private conversations with the announced candidate on an individual basis. This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team or from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.
3. An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material they consider important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.
4. Our AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.
5. An AMA Candidates' Page will be created on our AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.
6. Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.
7. Active campaigning via mass outreach to delegates by candidates or on behalf of the candidate by any method is prohibited. A reduction in the volume of telephone calls and personal electronic communication from candidates and on behalf of candidates is encouraged. No part of this rule shall be interpreted to limit developing or communicating within a campaign team. Electronic messages must include a simple mechanism to allow recipients to opt out of receiving future messages.
8. Printed and digital campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the AMA Candidates' Page.
9. Displays of campaign posters, signs, and literature in public areas of the venue at which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.
10. Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

11. Candidates and campaigns may not produce a personal campaign-related website or other digital campaign-related content. Candidates may not direct to personal or professional websites as a method of campaigning other than to the AMA Candidates' Page.

V. Group Dinners and Meetings

1. Candidates for our AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.
2. At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.
3. Each participant in group dinners, if attended by an announced candidate in a currently contested election, must pay their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

1. Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information to both groups. Groups must indicate whether they wish to interview in-person or virtually and for which contest by the deadlines designated by the speaker.
2. Any formal questioning of an announced candidate, excluding a written questionnaire, is an interview and subject to the rules for interviews.
3. Interviews may be arranged between the parties once active campaigning is allowed.
4. Groups conducting interviews with announced candidates for a given office must offer an interview to all announced candidates at the time the group's interview schedule is finalized.

   a. A sponsoring group may meet with an announced candidate who is a member of their group during the active campaign window without meeting with other candidates for the same office.

   b. Interviewing groups may, but are not required to, interview persons who become announced candidates during the active campaign window. Should an interview be offered to such a candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.

   c. Any campaign-related presentation to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in their current formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.
5. Groups may elect to conduct interviews virtually or in-person.
6. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.

7. Virtual interviews are subject to the following constraints:
   a. Interviews may be conducted only during a 9-14 day window (preferably across two separate weekends) as designated by the Speaker beginning at least two weeks but not more than six (6) weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place.
   b. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.
   c. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.
8. Recording of interviews is allowed only with the knowledge and consent of the candidate.
9. Interviews are recommended to be recorded with consent of all participating individuals and disseminated to the interviewing group members when all are not able to be present for the interview.
10. Recordings of interviews may be shared only among members of the group conducting the interview.
11. A candidate is free to decline any interview request.
12. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.
13. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

VII. Campaign Receptions

1. Our AMA will sponsor the AMA Candidate Reception which will be open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA Candidate Reception. There will not be a receiving line at the AMA Candidate Reception. The rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception will apply to the AMA Candidate Reception.
2. A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, or (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

VIII. Election Process

1. At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place their name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.
2. Nominating speeches for unopposed candidates for office, except for President-elect, will not be heard.
3. AMA elections will be held on Tuesday at each Annual Meeting.
4. Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker.

5. All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes.
6. The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.
7. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

IX. Election Committee

1. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 9 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. The Speaker and Vice Speaker shall be full members of the Election Committee.

X. Campaign Complaint Reporting, Validation and Resolution Process

1. Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:
   a. The name of the person(s) thought to have violated the rules
   b. The date of the alleged violation and the location if relevant
   c. The specific violation being alleged (i.e., the way the rules were violated)
   d. The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.
2. A formal election complaint must be filed in writing by a HOD delegate or alternate delegate via the election website before the commencement of the election session at which the candidate is currently seeking election.
3. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.
   a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
   b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
   c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
   d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
   e. Deliberations of the Election Committee shall be confidential.
   f. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House, following each meeting at which an election

was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.

4. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by our AMA Office of General Counsel and kept confidential.
5. The Election Committee will review the Campaign Complaint Reporting, Validation and Resolution Process as implemented and make further recommendations to the House as necessary.

XI. Endorsements

1. Our American Medical Association requires all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner, no later than 30 days prior to the start of the Interim Meeting preceding the Annual Meeting at which the election is to take place.
2. Our AMA will then post this information on the election website in a timely manner, with the information being easily digestible and accessible.
3. Our AMA will not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle.
4. Our AMA will create a specific period (similar to virtual elections) during which endorsements may be sought, with the endorsement window opening at the commencement of the Interim Meeting immediately preceding the Annual Meeting at which the election is to take place.

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, I-2026

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Hilary Fairbrother, MD, MPH, FACEP, Chair

Referred to: Reference Committee F

This report by the committee at the November 2026 Interim Meeting documents the compensation paid to Officers for the period July 1, 2025, through June 30, 2026, including 2025 calendar year IRS reported taxable value of benefits, perquisites, and services for all Officers. The report also provides an updated analysis of Board leadership, Speaker and Vice Speaker compensation and recommends changes to the compensation of these positions based on these findings.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the "Committee"). The Officers are defined in the American Medical Association's (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to "Officer," which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

> The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted, or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association's definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance, including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

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CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these officers spent away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium, Per Diem for Representation and Telephonic Per Diem for External Representation.

The summary covers July 1, 2025, to June 30, 2026.

AMA Officers	**Position**	**Total Compensation**	**Total Days**
David H Aizuss, MD	Chair	$285,886	92
Toluwalase A. Ajayi, MD	Chair-Elect	$211,630	69
John H. Armstrong, MD	Vice Speaker, House of Delegates	$129,700	62.5
Geralyn R. Breig	Officer	$68,500	39
Alex Ding, MD, MS, MBA	Secretary	$77,800	51.5
Lisa Bohman Egbert, MD	Speaker, House of Delegates	$127,100	91.5
Scott Ferguson, MD	Officer	$70,825	42.5
Sandra Adamson Fryhofer, MD	Officer	$95,475	60.5
Melissa J. Garretson, MD	Officer	$89,425	62
Marilyn Heine, MD	Officer	$73,150	53
Pauline P. Huynh, MD	Officer	$68,500	40.5
Lynn Jeffers, MD, MBA	Officer	$75,475	56
Ilse R. Levin, DO, MPH & TM	Officer	$84,000	52
Justin W. Magrath, PhD	Officer	$89,425	58
Bobby Mukkamala, MD	President	$298,865	192
Sheila Rege, MD	Officer	$76,250	55
Bruce A. Scott, MD	Immediate Past President	$290,659	84.5
Michael Suk, MD, JD, MPH, MBA	Immediate Past Chair	$149,100	120
Willie Underwood, III, MD, MSc, MPH	President-Elect	$290,659	177.5
Marta J. Van Beek, MD	Officer	$69,275	47.5
David Welsh, MD, MBA	Officer	$85,550	61

President, President-Elect, Immediate Past President, and Chair
In 2025-2026, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 546 days on approved Assignment and Travel, or on average 136.5 days each.

Chair-Elect
This position received a Governance Honorarium of approximately 74% of the Governance Honorarium provided to the Chair.

All Other Officers
All other Officers received cash compensation, which included a Governance Honorarium of $68,500 paid in monthly installments and per diems for approved assignment days.

Assignment and Travel Days
As defined, these are Assignment and Travel Days that are approved by the Board Chair to externally represent the AMA. These days were compensated at a per diem rate of $1,550. The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President, and Chair) were 1,021.5.

EXPENSES

Total expenses paid for period, July 1, 2025 – June 30, 2026, was $1,119,773.84.

BENEFITS, PERQUISITES AND SERVICES

Officers are able to request benefits, perquisites and services, as defined in the "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business expenses are provided to assist the Officers in performing their duties.

- AMA Standard laptop computer or iPad
- American Express card (for AMA business use)
- Combination fax/printer/scanner (reimbursable up to $250)
- An annual membership to the airline club of choice offered each year during the Board member's tenure
- Personalized AMA stationery, business cards, and biographical data for official use
- Airline upgrade allowances of up to $5,000 per term for Presidents and $2,500 per term for all other Officers.

Additionally, all Officers are eligible for $305,000 term life insurance and are covered under the AMA's $500,000 travel accident policy and $10,000 individual policy for medical costs arising out of any accident while traveling on official business for the AMA. Life insurance premiums paid by the AMA are reported as taxable income. Also, travel assistance is available to all Officers when traveling more than 100 miles from home or internationally.

Secretarial support, other than that provided by the AMA's Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000, and $5,000 each for the President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses incurred by other Officers in conjunction with their official duties are paid up to $1,125 per year per Officer. This is reported as taxable income to the recipient. Calendar year taxable life insurance and taxable secretarial fees included in the 2025 compensation reported to the IRS for the above individuals totaled $20,826 and $45,313 respectively. An additional $10,125 was paid to third parties for secretarial services during 2025.

Officers are also eligible to participate in a service provided to AMA employees by Care@Work through Care.com. This service offers referral services at no cost and back-up care for children and

adults up to 10 days a calendar year at a subsidized rate. If a Board member uses back-up care, it will be reported to the IRS as taxable income.

METHODOLOGY

In November 2024, the Committee commissioned Ms. Becky Glantz Huddleston, a consultant expert in board compensation with Willis Towers Watson (WTW), to update the 2019 research on compensation of non-leadership Officers. The purpose of the review was to ensure non-leadership roles are compensated appropriately for their work performed on behalf of the AMA. As a result of this analysis, the Committee recommended an increase to the honorariums and per diems for non-leadership Board Officers. The following recommendations were approved by the HOD effective July 1, 2025: the Governance Honorarium for non-leadership Board Officers increased from $67,000 to $68,500, the Per Diem for Representation increased $1,400 to $1,550 and the Telephonic Per Diem increased from $700 to $775.

In June 2025, the Committee commissioned Ms. Becky Glantz Huddleston to review the compensation of the Speaker and Vice Speaker of the HOD. As a result of this analysis, the Committee recommended increases to the Governance Honorariums for the Speaker and Vice Speaker and the elimination of Per Diems for Internal Representation for all Officers. The following recommendations were approved by the HOD effective July 1, 2025: the Governance Honorariums for the Speaker and Vice Speaker increased to $125,000 and $115,000 respectively and Per Diems were eliminated in their entirety for those two positions. Additionally, Internal Per Diems were eliminated for non-leadership Officers.

In June 2026, the Committee commissioned Ms. Becky Glantz Huddleston to review the secretarial maximums and travel upgrade allowances for both leadership and non-leadership roles based on feedback from Board leadership. As a result of this analysis, the Committee recommended increasing the secretarial maximums for Speakers and non-leadership Officers and increasing the travel upgrade allowances for leadership and all other officers. These recommendations moved the Speakers to the same secretarial maximum as the President-Elect, Chair, Chair-elect and Immediate Past President but did not change the President's secretarial allowance of $15,000. The following recommendations were approved by the HOD effective July 1, 2026: Secretarial maximums were increased from $1,125 to $5,000 for the Speaker and Vice Speaker and from $1,125 to $1,200 for non-leadership positions; the travel upgrade allowance for Presidents was increased from $5,000 to $6,000 and the Chair was moved to same allowance as Presidents; the travel upgrade allowance for non-leadership roles was increased from $2,500 to $3,000.

In September 2026, the Committee commissioned Ms. Becky Glantz Huddleston to update the 2023 research on compensation of Board leadership and the 2025 research on compensation of the Speaker and Vice Speaker roles. The purpose of the review was to ensure leadership roles are compensated appropriately for their work performed on behalf of the AMA. The Speaker and Vice Speaker roles were included in this analysis given these roles transitioned to a Governance Honorarium in July 2025 that, like Board Leadership, is not eligible for Per Diem compensation.

FINDINGS

The Committee notes that Officers continue to make significant time commitments in supporting the AMA in governance and representation functions. Given the amount of time required by Board members, it is important that individuals seeking a position on the Board be aware of the scope of the commitment and the related compensation.

The compensation analysis conducted by WTW for the Chair position considered a not-for-profit peer group of organizations that compensate their directors. Due to the limited number of not-for-profit organizations that compensate directors, the search was broadened to extend beyond AMA's industry and focused on organizations with similar revenue size. The resulting peer group included 15 of the 17 organizations in the 2023 peer group.

Given the leadership structure at the AMA (with the exception of the Chair role) is unique to medical associations, WTW gathered data from a secondary/supplemental group of other not-for-profit associations, irrespective of size, to review against the AMA's other (non-Chair) leadership positions. However, given the small size of some of these associations, WTW recommended considering internal equity when evaluating the non-Chair leadership positions.

AMA's Board leadership has a significant level of responsibility in their roles, resulting in a time commitment well above that required by other not-for-profit boards. Accordingly, it is appropriate to assess the AMA compensation levels on an hourly rate basis, not simply total pay, when compared to the not-for-profit comparable markets.

2025/2026 hourly rates for AMA's positions range from the 41st to 62nd percentiles for leadership and the 25th to 31st percentiles for the Speaker/Vice Speaker compared against the peer group.

- Chair data reported by the not-for profit peer group grew at an annual rate of 5% since the prior study in 2023.
- President, President-Elect, and Immediate Past President data reported by the Association peer group grew, on average, at an annual rate of 12% since the prior study in 2023.
- Speaker and Vice Speaker were not included in the 2023 analysis; due to unavailability of Speaker and Vice Speaker market data, the positions were compared to the median officer pay from the primary not-for-profit peer group.

WTW indicated the overall market movement of salaries for 2027 was expected to be approximately 3.5%. Given Board Leadership positions were determined to be generally aligned to market median, and considering the anticipated market movement, WTW recommended increasing the Governance Honorariums for Board Leadership as well as the Speaker and Vice Speaker by 2 to 6 percent.

In addition to the Governance Honorariums, the Committee also considered the current travel upgrade allowance based on additional feedback from Board Leadership. WTW included the travel upgrade allowance in their assessment as follows:

- 2025-2026 travel allowance usage was reviewed against 2025-2026 and 2026-2027 maximum allowances.
- Seven Officers utilized the full 2025-2026 allowance; it's unclear whether these Officers would have reached the higher travel upgrade allowance maximums established for 2026-2027.

The Committee discussed the option of permitting travel upgrades on all flights greater than four hours in lieu of a travel upgrade allowance and agreed that allowing each Officer to choose between the existing policy and this new option would be administratively burdensome. The Committee further agreed that given the increase to travel allowances in July 2026, it was prudent for the Committee to review travel upgrade usage under the new policy before considering further changes.

The Committee also considered a new benefit for Board Leadership that would provide additional cyber security protection, recognizing the additional risk associated with public facing roles. The AMA Board of Trustees recently approved an advanced cyber security benefit for AMA senior executives effective January 1, 2027, that includes advanced security monitoring for the executive and family members and restoration services reimbursement of up to $3M. The estimated cost of this benefit is $2,000 per executive per year. The Committee agreed that providing this benefit to the Board President, President Elect, Immediate Past President and Board Chair was appropriate.

The Committee thanks our Officers for their representation of the AMA.

RECOMMENDATION

Based on the Committee's review of Board leadership, Speaker and Vice Speaker compensation and recent changes to Officer compensation approved effective July 1, 2025, and July 1, 2026, the Committee on Compensation of the Officers recommends the following changes to Officer compensation be adopted effective July 1, 2027:

1. That the Governance Honorariums for the President, President-Elect, Immediate Past President, Board Chair, Board Chair-Elect, Speaker and Vice Speaker be increased by 3.5% effective July 1, 2027.
2. That the Governance Honorariums under Rule I. Compensation and Travel Expense Reimbursement in the Standing Rules, section A, be changed as follows:

~~July 2026 - June 2027~~ July 2027 - June 2028 Governance Honorarium

~~$298,865~~ $309,325	President
~~$290,659~~ $300,832	President-Elect and Immediate Past President
~~$285,886~~ $295,892	Board Chair
~~$211,630~~ $219,037	Board Chair-Elect
~~$125,000~~ $129,375	Speaker of the House of Delegates
~~$115,000~~ $119,025	Vice Speaker of the House of Delegates
$68,500	All other officers

3. That a new cyber security benefit be provided to the Board President, President Elect, Immediate Past President and Board Chair effective January 1, 2027, that is consistent with the program provided to AMA senior executives.

4. That the remainder of the report be filed.

Fiscal Note: $64,619 additional expense on an annual basis.

APPENDIX

Board Leadership Honoraria during the Period of July 1, 2025, to June 30, 2026

POSITION	**GOVERNANCE HONORARIUM**
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630
Speaker	$125,000
Vice Speaker	$115,000

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-26)

Introduced by:	American Society of Plastic Surgeons; American Society for Maxillofacial Surgeons; Michigan State Medical Society; American Association for Hand Surgery; American Society of Aesthetic Plastic Surgeons; Missouri State Medical Association; American Society for Reconstructive Microsurgery
Subject:	Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy
Referred to:	Reference Committee F

Whereas, the American Medical Association House of Delegates serves as the legislative and policymaking body of the AMA, and the AMA Board of Trustees is responsible for conducting the affairs of the Association consistent with policies and directives adopted by the House of Delegates; and

Whereas, the AMA Board of Trustees exercises broad oversight and guidance of the AMA through its oversight of the Executive Vice President, while AMA management is responsible for the day-to-day activities of the Association, including advocacy activities; and

Whereas, state and federal health policy decisions can have substantial and long-lasting effects on patients, physicians, physician practices, and the health care system; and

Whereas, major state and federal advocacy initiatives and negotiations may develop rapidly and require timely AMA engagement, making effective communication and coordination among AMA management, the Board of Trustees, and other appropriate AMA leadership particularly important; and

Whereas, enhanced Board awareness and engagement regarding significant state and federal advocacy matters can help ensure that AMA advocacy remains aligned with House of Delegates policy and appropriately reflects the interests of patients and physicians; therefore be it

RESOLVED, that our American Medical Association develop and maintain an appropriate process to ensure that the Board of Trustees receives timely information regarding significant state and federal advocacy initiatives, negotiations, and policy developments that could substantially affect patients, physicians, physician practices, or the health care system (Directive to Take Action); and be it further

RESOLVED, that our AMA ensure that, except when immediate action is reasonably necessary, the Board of Trustees is informed and provided an appropriate opportunity for consultation before AMA management endorses, formally supports, or commits the AMA to a significant state or federal legislative or regulatory proposal that could substantially affect physician payment, patient access to care, administrative burden, or other significant aspects of the practice of medicine (New HOD Policy); and be it further

RESOLVED, that when immediate action is reasonably necessary and prior consultation is not practicable, our AMA inform the Board of Trustees of the action taken as soon as practicable thereafter (New HOD Policy); and be it further

RESOLVED, that our AMA report to the House of Delegates on the process developed pursuant to this resolution at the next meeting of the House. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

RELEVANT AMA POLICY

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

a. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.

b. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.

c. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

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

a. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.

b. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.

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

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

matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.

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

HOD C- Article IV

The House of Delegates is the legislative and policymaking body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The House of Delegates transacts all business of the Association not otherwise specifically provided for in this Constitution and Bylaws and elects the officers except as otherwise provided in the Bylaws.

[Last modified 2017]

B-5.3 Duties and Privileges

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-26)

Introduced by: Resident and Fellow Section

Subject: Enhancing Equity in House of Delegates Resolution Processes by Removal of the Resolutions Committee and Broadening of the Interim Meeting's Focus

Referred to: Reference Committee F

Whereas, one of the central tenets of parliamentary procedure, including the parliamentary authority of the AMA, The American Institute of Parliamentarians Standard Code of Parliamentary Procedure (B-11.1, G-600.054), is to protect the rights of minority viewpoints[1]; and

Whereas, at the Annual 2002 House of Delegates, Board of Trustees Report 23 was adopted, which included a recommendation establishing a Resolution Committee "to ensure that the emphasis of the Interim Meeting is placed on advocacy and legislation"[2]; and

Whereas, at the Annual 2003 House of Delegates, Council on Constitution and Bylaws Report 2 was adopted, which codified the establishment of the Resolution Committee in the AMA Bylaws "to formally reflect the defined scope of the Interim Meeting"[3], as currently reflected in B-2.13.3; and

Whereas, the Resolution Committee was repurposed during the COVID-19 pandemic to help the AMA House of Delegates transition to a virtual format and ensure smooth processing of business under extenuating operational challenges;[4] and

Whereas, the Resolution Committee fulfilled a critical role at that time, providing structure and predictability when the House of Delegates was adapting to new virtual technology, compressed timelines, and rapidly evolving public health demands;[4] and

Whereas, although the Committee has continued its work during subsequent Interim Meetings, its charge (e.g. reviewing and determining whether submitted resolutions meet criteria such as advocacy, legislation, and ethics) has, in practice, generated prolonged procedural debate within the House; and

Whereas, these deliberations, while well-intentioned, often shift focus away from the substance of proposed policies, thereby consuming time that could otherwise be dedicated to meaningful discussion, refinement, and evaluation of resolutions within the traditional Reference Committee process; and

Whereas, delegates may spend more time debating whether a resolution should be discussed than it would take to simply refer it to the appropriate Reference Committee, where expertise, testimony, and amendment processes are already well-established and designed to manage prioritization; and

Whereas, the pre-screening function may now inadvertently disadvantage smaller delegations and sections that rely heavily on the opportunity to have their unique perspectives heard through the standard Reference Committee process; and

Whereas, the introduction of preliminary Reference Committee reports and the streamlined deliberative structure at the 2025 Interim Meeting enabled the HOD to conclude its business a full day ahead of schedule, demonstrating that the current meeting format has adequate capacity to consider all submitted resolutions without the need for an additional pre-screening body; therefore be it

RESOLVED, that our American Medical Association rescind the Resolution Committee as defined in Bylaw 2.13.3 (Directive to Take Action); and be it further

RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings, which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

References:

1. American Institute of Parliamentarians. *American Institute of Parliamentarians Standard Code of Parliamentary Procedure.* New York, New York: McGraw-Hill; 2012.
2. Board of Trustees Report 23, American Medical Association Annual 2002 House of Delegates. https://ama.nmtvault.com/jsp/browse.jsp. Accessed September 16, 2026.
3. Council on Constitution and Bylaws Report 2, American Medical Association Annual 2003 House of Delegates. https://ama.nmtvault.com/jsp/browse.jsp. Accessed September 16, 2026.
4. Report of the Resolutions Committee, American Medical Association November 2020 Special Meeting of the House of Delegates. https://www.ama-assn.org/system/files/2021-01/nov-s20-call-to-order.pdf. Accessed September 16, 2026

RELEVANT AMA POLICY

Resolution Committee. B-2.13.3
The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.
2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.
2.13.3.2 Size. The committee shall consist of a maximum of 31 members.
2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.
2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.
2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.
2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.
2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

Parliamentary Procedure. B-11.1
In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the

then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

Procedures of the House of Delegates G-600.054

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.
3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly.
Report of the Speakers: Rep. 02, A-16; Modified: CCB Rep. 01, A-17

Introducing Business to the AMA House G-600.060

AMA policy on introducing business to our AMA House includes the following:
1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database

identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.
Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08; Modified: CCB/CLRPD Rep. 1, A-12

Meetings of the House of Delegates. B-2.12
2.12.1 Regular Meetings of the House of Delegates. The House of Delegates shall meet twice annually, at an Annual Meeting and an Interim Meeting.
2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.
2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one-third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.
2.12.3 Locations. The House of Delegates shall meet in cities selected by the Board of Trustees.
2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.
2.12.4 Meetings.
2.12.4.1 Open. The House of Delegates may meet in an open meeting to which any person may be admitted. By majority vote of delegates present and voting, an open meeting may be moved into either a closed or an executive meeting.
2.12.4.2 Closed. A closed meeting shall be restricted to members of the AMA, and to employees of the AMA and of organizations represented in the House of Delegates.
2.12.4.3 Executive. An executive meeting shall be limited to the members of the House of Delegates and to such employees of the AMA necessary for its functioning.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(I-26)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Ensuring Relevance and Mission Alignment in House of Delegates Business

Referred to: Reference Committee F

Whereas, the American Medical Association is the largest and only national association of physicians in the United States of America; and

Whereas, the House of Delegates (HOD) is the principal policy-making body of our American Medical Association (AMA), responsible for policies that improve patient care, the health of the public, and the practice of medicine; and

Whereas, the effectiveness and credibility of our AMA with lawmakers, government administration, and the public depends on maintaining focus on issues within its expertise and sphere of influence; and

Whereas, the introduction of resolutions addressing matters outside our AMA's mission, such as issues without a clear and direct connection to health or medical practice in the United States, may detract from the HOD's ability to address issues of primary importance to physicians and their patients in the United States; and

Whereas, the breadth of our AMA's mission encompasses the practice of medicine, the professional interests of physicians, and public health issues for which medical expertise, evidence, or physician advocacy can meaningfully contribute to the prevention of disease, physical injury, disability, or death; and

Whereas, House of Delegates policy is most effective when it clearly identifies the medical, health policy, or public health objective to be achieved and affords our AMA appropriate discretion to advance that objective in collaboration with policymakers and organizations possessing relevant subject-matter expertise; and

Whereas, policy outside our AMA's mission detracts from the ability of our staff in Washington to present a focused plan for improving health and the practice of medicine in America; and

Whereas, asking our AMA's Washington staff to lobby on a multitude of issues often results in legislators lacking understanding of what is truly important to physicians; and

Whereas, our AMA has finite time and resources during HOD meetings, necessitating prioritization of issues where the Association can have a direct and meaningful impact; and

Whereas, resolutions put forth to amend broad policies in the context of current events, or to reaffirm current policy, may be utilized to request action where the previous policy could have been applied with an internal organizational request, thus taking time away from HOD discussions on new topics; therefore be it

RESOLVED, that our American Medical Association require that all submitted resolutions include a brief statement describing the direct relevance within the United States to the mission of our AMA "to promote the art and science of medicine and the betterment of public health" and explaining how the subject matter and action requested of our AMA fall within its medical, health policy, or public health expertise (New HOD Policy); and be it further

RESOLVED, that our AMA direct reference committees, in collaboration with the Speakers, to consider relevance to the AMA's mission and jurisdiction and whether the action requested of our AMA by the resolution falls within its medical, health policy, or public health expertise when making recommendations on resolutions at meetings of the HOD (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage and publicize the use of alternative mechanisms for consideration of issues that do not meet criteria for policy actions or in lieu of resolutions asking for reaffirmation or minor changes which would not substantially alter the AMA's ability to take action based upon existing policy (Directive to Take Action); and be it further

RESOLVED, that our AMA report back at the 2028 Annual Meeting of the House of Delegates on the implementation and impact of these guidelines on the volume and scope of resolutions considered by the House of Delegates. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/20/26

RELEVANT AMA POLICY

G-640.050 Preserving the AMA's Grassroots Legislative and Political Mission
Our American Medical Association will ensure that all Washington activities, including lobbying, political education, grassroots communications and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner. Res. 619, A-00Reaffirmed: BOT Rep. 6, A-10CCB/CLRPD Rep. 3, A-12Reaffirmed: CCB/CLRPD Rep. 1, A-22

G-625.010 AMA Mission and Vision
Mission: To promote the art and science of medicine and the betterment of public health.
Core Values:

1. Leadership
2. Excellence
3. Integrity and Ethical Behavior.

Vision: To be an essential part of the professional life of every physician. BOT Rep. 1, A-01Consolidated: CLRPD Rep. 3, I-01Modified: BOT Rep. 2, A-02Reaffirmed, BOT Rep. 1, A-03Modified: BOT Rep. 14, I-03Modified: BOT Rep. 22, I-06Reaffirmed: BOT Rep. 5, A-11Reaffirmation A-11Reaffirmed: BOT Rep. 4, I-11Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

G-600.060 Introducing Business to the AMA House
AMA policy on introducing business to our American Medical Association House includes the following:

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and

include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.

3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which they consider significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.Sub. Res. 120, A-84BOT Rep. D and CLRPD Rep. C, I-91CLRPD Rep. 3 - I-94CLRPD Rep. 5, I-95Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99Res. 604, I-00Consolidated: CLRPD Rep. 3, I-01Modified: CLRPD Rep. 2, A-03Reaffirmed: BOT Rep. 19, A-04CC&B Rep. 3, I-08Modified: CCB/CLRPD Rep. 1, A-12Reaffirmed: CCB/CLRPD Rep. 1, A-22Modified: Speakers Rep. 01, A-24Modified: Speakers Rep. 02, I-24

G-600.061 Guidelines for Drafting a Resolution or Report

Resolutions or reports with recommendations to our American Medical Association House of Delegates shall meet the following guidelines:

1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:
    a. The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession.
    b. The proposed policy should be clearly identified at the end of the resolution or report.
    c. Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline.
    d. A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution or report is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers

(such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.

2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.
3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.
4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.
5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.
6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.
7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.
8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
    a. New HOD Policy
    b. Modify Current HOD Policy
    c. Consolidate Existing HOD Policy
    d. Modify Bylaws
    e. Rescind HOD Policy
    f. Reaffirm HOD Policy
    g. Directive to Take Action
9. Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.CLRPD Rep. 4, A-99Modified by BOT Rep. 15, A-00Consolidated: CLRPD Rep. 3, I-01Modified: CLRPD Rep. 2, A-02Modified: CLRPD Rep. 6, A-03Reaffirmed: BOT Rep. 19, A-04Appended: Res. 606, A-05Appended: Res. 611, A-07Modified: CCB/CLRPD Rep. 1, A-12Modified: Speakers Rep., A-18Reaffirmed: CCB/CLRPD Rep. 1, A-22

G-600.111 Consolidation and Reconciliation of AMA Policy

Our American Medical Association House of Delegates endorses the concept of consolidating its policies in order to make information on existing AMA policy more accessible and to increase the readability of our AMA Policy Database and our AMA PolicyFinder Program.

1. The policy consolidation process allows for:
    a. rescinding outmoded and duplicative policies.
    b. combining policies that relate to the same topic.
2. Our AMA House requests that each AMA council, AMA section, and Board of Trustees advisory committee accept ongoing responsibility for developing recommendations on how to consolidate the policies in specific sections of our AMA Policy Database. In developing policy consolidation recommendations, our AMA councils should seek input from all relevant AMA bodies and units. Other groups represented in the House of Delegates also are encouraged to submit consolidation recommendations to the Speakers.
3. The House encourages each AMA council to develop two or more policy consolidation reports each year, recommending changes that will result in significant improvements in the readability of our AMA Policy Database.

4. The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning.
5. Policy Reconciliation. The AMA's policy database should not include duplicative, conflicting or inconsistent AMA policies.
    a. If a new or modified policy supersedes or renders obsolete one or more existing AMA policies, those existing policies should be identified and presented to the AMA House of Delegates with a recommendation for rescission. The AMA Councils, with the input of appropriate AMA sections and Board advisory committees, have a role to play in reconciling existing policies by presenting reports with recommendations for policy reconciliation. Any organization that has representation in the AMA House of Delegates is encouraged to identify to the Speakers inconsistent or obsolete policies. The Speakers should then decide whether a policy reconciliation report is in order and which council or other entity should most appropriately be asked to develop the consolidation report.
    b. At each meeting, the Speaker will present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete. Where a report is needed to reconcile disparate policies, the Speakers will identify the appropriate council or group responsible for the reconciliation report on a specific topic.

CLRPD Rep. 1-A-94Modified by CLRPD Rep. 4, I-95Consolidated: CLRPD Rep. 3, I-01Reaffirmed: CC&B Rep. 2, A-11Modified: CCB/CLRPD Rep. 1, A-12Appended: CCB/CLRPD Rep. 2, A-12Reaffirmed: CCB/CLRPD Rep. 1, A-22

G-600.071 Actions and Decisions by the AMA House and Policy Implementation

1. AMA policy on House actions and decisions includes the following:
    a. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
    b. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
    c. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.
2. AMA policy on implementation of policy includes the following:
    a. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
    b. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
    c. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.
3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.
4. In urgent situations, the Board of Trustees will exercise its authority to take appropriate action. The Board shall make decisions that it deems to best represent the interests of patients,

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

5. Our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustees advocacy and action.
6. Our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health.
7. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

Res. 45, I-89Res. 609, I-95Res. 605, I-98Reaffirmed: Sunset Report and Modified: BOT Rep. 15, A-00Consolidated: CLRPD Rep. 3, I-01Appended: BOT Rep. 19, A-04Modified: CCB/CLRPD Rep. 1, A-12Appended: Res. 618, A-19Modified: Res. 602, A-25

G-600.100 AMA Programs for Delegates and Alternate Delegates

Our American Medical Association policy on programs for Delegates and Alternate Delegates includes the following:

1. The Speaker of the House of Delegates shall solicit proposals from various AMA departments to hold programs for AMA Delegates.
2. These programs should be held at our AMA Meetings at times that minimize scheduling conflicts with House of Delegates or Reference Committee meetings.
3. Materials from such programs shall be made available to those who are unable to attend.

Res. 609, I-97Consolidated: CLRPD Rep. 3, I-01CC&B Rep. 3, I-08Reaffirmed: CCB/CLRPD Rep. 3, A-12Reaffirmed: CCB/CLRPD Rep. 1, A-22

G-625.020 AMA Strategic Planning

1. Our AMA annual strategic planning cycle shall include the following dimensions:
    a. Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process.
    b. Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan.
2. Our AMA strategic planning process should generate:
    a. a multi-year plan that identifies the most critical strategic issues for the organization.
    b. the critical success factors for each issue.
    c. annual work plans with measurable performance objectives, tasks and timelines, assignments for implementation, and expected outcomes.
3. The Board must ensure that adequate resources - staff, funding, and material - are available for developing our AMA strategic plan.

4. The goals of our AMA strategic plan should become an overarching part of all Board and Council meetings. All ongoing initiatives and new undertakings must be regularly measured against the plan, and emerging issues that impact the plan should be identified.
5. Our AMA strategic plan will be presented to the HOD in a more visible, proactive, and interactive way.
6. Our AMA Board of Trustees will continue to:
    a. consider input from the House, CLRPD, and broad physician community when developing the Strategic Plan and making resource allocation decisions.
    b. exercise its fiduciary responsibilities with respect to allocating resources appropriately and consistent with the AMA's vision, goals and priorities.
    c. monitor the activity and results related to commitments established in the planning process.
7. Our AMA will continue to communicate activities, achievements, and opportunity for physician involvement through the Federation, Physician Grassroots Network, AMA publications (paper, email, and web-based), and other channels as appropriate.

Sub. Res 613, A-97CLRPD Rep. 2, A-99Consolidated: CLRPD Rep. 3, I-01Modified: CLRPD Rep. 1, A-03Rep. of the Speakers Special Advisory Committee on the House of Delegates, A-09Appended: BOT Rep. 5, I-11Appended: Res. 609, A-13Modified: Speakers Rep. 2, I-14Modified: CCB/CLRPD Rep. 01, A-23

G-600.045 Online Reference Committee Hearings in the House of Delegates

1. Our American Medical Association will convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for 21 days.

Prior to House of Delegates meetings, reference committees will convene after the close of the Online Reference Committee Hearings to develop a Preliminary Reference Committee Report. These reports shall include preliminary recommendations and will serve as the agenda for the in-person reference committee hearing.

BOT Rep. 8, A-13Modified: CCB Rep. 1, I-13Modified: Speakers Rep. 2, I-14Reaffirmed: CCB/CLRPD Rep. 01, A-23Appended: Res. 604, A-23Modified: Speakers Rep. 0

G-615.071 Activities of the Council on Legislation

1. Our Americal Medical Association Council on Legislation (COL) will continue to convene forums at AMA meetings to provide members of the Federation an opportunity to hear about and discuss major and emerging legislative and regulatory issues important to physicians and patients.
2. The COL will be represented at AMA-convened meetings focused on advocacy, such as the State Advocacy Summit and National Advocacy Conference.
3. COL members will actively represent, at the discretion of the Chair of the Board of Trustees, our AMA before state and federal government committees and agencies.

BOT Rep. 12, A-07Reaffirmed: BOT Rep. 4, I-10Modified: CCB/CLRPD Rep. 3, A-12Modified: CCB/CLRPD Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-26)

Introduced by: Texas

Subject: Increasing Time Between Handbook Release and Opening of Online Reference Committees

Referred to: Reference Committee F

Whereas, the HOD policy making process was updated by creation of online reference committees (G600.045) with an opening date to be ten days following the resolution submission deadline; and

Whereas, the current dates for the 2026 Interim meeting have the ORC opening one day after the handbook release; and

Whereas, there was much discussion at the 2026 Annual Speakers Forum regarding testimony in ORC coming late in the open period making commentary difficult; and that the time allowed to read, evaluate the handbook and to formulate testimony is too short therefore be it; and

RESOLVED, that our American Medical Association ensure that the House of Delegates handbook is released at least five business days before the opening of the Online Reference Committees to allow adequate time to read and evaluate handbook materials and formulate testimony, while also maintaining the current 21-day window of ORC comment period. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/22/26

REFERENCES

1. AMA Policy G-600.045, Online Reference Committees.

RELEVANT AMA POLICY

AMA Policy G-600.045, Online Reference Committees

Reference Committee J

Report(s) of the Board of Trustees

11 Opposing Unilateral Downcoding of Physician Services by Insurance Companies

Report(s) of the Council on Medical Service

01 Transparency with the Term "Emergency Department"
02 The Impact of the Inflation Reduction Act on Physician Practices
03 Non-Medical Switching of Prescription Drugs
04 Determining Fair Market Value when Contracting with Physician Practices
05 Improving Marketplace Affordability through Premium Tax Credits
06 Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries

Resolutions

801 Improving the External Appeals Process for Denied Claims
802 Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs
803 Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit
804 Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes
805 Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine
806 Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked
807 Continuing Care Retirement Communities (CCRC's)
808 Increasing Payment for Patient Portal Messages
809 Joint Commission Standards for Medical Staff Self-Governance
810 Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence
811 Government Support of Adaptive Sports Programming
812 Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions
813 Small Medical Practice Website and other Digital Service Compliance with ADA Regulation
814 Coverage of SMART Therapy for Asthma
815 Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies
816 Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services
817 Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care
818 Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment
819 Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers
820 Strengthening Emergency Interfacility Transfer Infrastructure

REPORT OF THE BOARD OF TRUSTEES

BOT Report 11-I-26

Subject: Opposing Unilateral Downcoding of Physician Services by Insurance Companies

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates adopted Policy D-70.940, which states:

1. Our American Medical Association (AMA) will work with state medical associations, specialty societies, and regulatory authorities to challenge payer-initiated downcoding policies through regulatory, legislative and when appropriate, legal channels.
2. Our AMA will report back on payer downcoding practices, their effects on physicians and patients, and strategies for collective advocacy at the 2026 Interim Meeting.
3. 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.

Accordingly, this report discusses the development of AMA model legislation and related state and federal advocacy efforts, as well as AMA guidance and educational materials to assist physician practices.

BACKGROUND

Effective January 1, 2021, major changes were made to the Evaluation and Management (E/M) services Current Procedural Terminology CPT® code set and reporting guidelines to reduce documentation burden and simplify medical coding. Under the 2021 guidelines, selection of the appropriate level for an outpatient E/M visit is based on the level of medical decision making (MDM) or total time spent on the date of the encounter; history and physical exam are no longer key components in selecting the appropriate E/M level. Notably, documentation from the medical record is needed to confirm the level of MDM or total time spent on the date of the encounter and establish the appropriate E/M CPT code.

Unfortunately, some health plans have implemented E/M downcoding programs that fail to align with the 2021 CPT guidelines. Downcoding policies reduce the level of service from what was submitted on the physician's claim, leading the physician to receive payment for a lower level of care than was provided. Many health plans downcode claims automatically, without first requesting and reviewing the underlying clinical record. Some payers use augmented intelligence (AI), software algorithms, and other automated decision-making tools to downcode claim payments. In many instances, the diagnosis code reported on a claim is used as a proxy for the level of care to adjust payment. Such methodology—and indeed any program that reduces E/M payment solely based on information on the claim—is wholly inappropriate, as documentation from the medical record is needed to confirm the level of MDM or total time spent on the date of the encounter. Notably, CPT guidelines for E/M reporting clearly discredit this approach: "The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may

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be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition."[1]

Automatic downcoding programs pose several critical problems for physician practices. First and foremost, inappropriate downcoding can lead to significant losses in practice revenue and sustainability. While the reduced payment for a lower-level E/M code may not appear substantial for an individual claim, the aggregated effect of decreased payment over many office visit claims adds up and can endanger practices' financial viability. This is particularly true when a health plan targets a physician's E/M claims for global prepayment review.

Beyond the obvious economic harms, the manner in which health plans implement downcoding programs presents additional challenges to physician practices. Some health plans implement downcoding policies without providing notice to individual physicians and instead rely on provider bulletins that are buried on payer websites. Additionally, health plans may pay E/M claims at the adjusted lower rate without changing the billed code or providing clear information on the remittance advice indicating that the service has been downcoded, making these changes extremely difficult to identify in revenue cycle audits. The lack of transparency with which health plans conduct downcoding means that without hypervigilance on claim payment details, physicians and practice staff may not identify reduced E/M payments until after months of lost revenue.

Finally, fighting inappropriately downcoded services results in significant administrative burdens for physicians and their staff. Assembling and submitting clinical documentation to health plans takes time and resources away from patient care—particularly when plans only offer manual data transmission options, such as a dedicated fax line, to appeal downcoded claims. Moreover, while practices face an overwhelming, claim-by-claim fight for correct payment, health plans deploy AI or automated systems, which can quickly reduce E/M levels for large claim volumes. The practice administrative costs associated with disputing downcoded claims, as well as the time spent waiting for the health plan to reconsider the E/M level, incentivizes many physicians to accept inappropriately reduced payments without appealing—or to refrain from billing higher level E/M codes altogether to avoid downcoding hassles.

Importantly, the negative consequences of payers' downcoding programs extend to patients' access to care. Lost revenue from downcoding threatens the financial viability of practices already struggling to stay afloat under the increasing pressures of payments that have failed to keep up with inflation. The culmination can result in practice closures and impede patient access to care. Similarly, physicians may be forced to leave plan networks if draconian downcoding programs threaten practice sustainability, also affecting patient access. Downcoding policies may also place pressure on physicians to shorten office visits or see more patients in order to keep their practices open. All of these factors can disrupt the patient-physician relationship, reduce patients' access to their physicians, and serve as barriers to medically necessary care.

A recent physician survey conducted by the Illinois State Medical Society (ISMS) quantifies the impact of payers' downcoding policies for physicians practicing in that state.[2] In the ISMS survey, a strong majority (72 percent) of physicians reported that their practice has experienced automatic downcoding of appropriately coded and documented claims, with 77 percent saying that automatic downcoding has increased in the past five years. Alarmingly, only 16 percent of physicians surveyed by ISMS indicated that their remittance advice usually or always provides information indicating that a claim has been downcoded, and 72 percent reported that even when the remittance advice indicates a downcoded claim, it rarely or never includes a specific reason for the payment reduction. These data clearly illustrate the characteristic lack of transparency of payers' downcoding programs. According to ISMS data, appeals of inappropriately downcoded claims

achieve mixed success, with surveyed physicians reporting that payers uphold over one-half (53 percent) of their original decisions on these payment reductions.

Health plans' downcoding programs have expanded to the degree that they are capturing national mainstream media attention. A recent NBC News story notes that payer downcoding has "taken off in the last few years" and showcases the specific challenges several physicians have faced with these policies.[3] The story also highlights the AMA's objections to automatic downcoding policies and advocacy to combat these practices.

AMA EFFORTS TO ADDRESS DOWNCODING

Direct Payer Engagement

The first component of the AMA's multi-pronged effort to fight insurers' automatic downcoding policies involves direct engagement with plans. For example, in a July 2024 letter, the AMA urged Aetna to halt implementation of an update to its Claim and Code Review Program that automatically downcodes E/M emergency department services for physician and facility claims.[4] In August 2025 correspondence, the AMA requested that Cigna rescind its E/M Coding and Accuracy policy, under which the plan reduces E/M codes "to a single level lower when the encounter criteria on the claim does not support the higher level E/M CPT code reported."[5] The AMA has also directly engaged health plan associations on this issue, including March 2025 letters to AHIP and Blue Cross Blue Shield Association.[6,7] In these letters and in follow-up conversations with health plan leaders, the AMA has repeatedly stated that automatic downcoding policies conflict with E/M coding guidelines and impose unfair, unwarranted payment reductions on practices at a time when physicians already face unprecedented financial challenges. Unfortunately, despite these ongoing efforts at direct payer advocacy, plans have largely refused to voluntarily rescind their downcoding programs, maintaining that these payment reductions are legitimate and justified.

Legislative Advocacy

Given payers' unwillingness to suspend automatic downcoding policies and the escalating harm on physician practices, the AMA has added a legislative strategy to its advocacy on this issue. This work stream includes the development of model legislative language and efforts supporting introduction and passage of state and federal bills that place guardrails around insurers' downcoding practices.

Model Legislation

Recognizing that legislative action was needed on payers' harmful downcoding programs, the AMA Advocacy Resource Center (ARC) began exploring legislative solutions. In June 2025, the AMA Council on Legislation and the Board of Trustees adopted a state model bill to address ongoing downcoding concerns entitled the "Transparency in Downcoding Act." The goal of the model bill is to assist in state efforts to curb the use of automatic downcoding tools by health insurers and increase transparency and clinical justification when downcoding is used. Specifically, the model bill:

- Prohibits automatic downcoding of claims without a documented review of clinical records;
- Prohibits downcoding based solely on diagnosis codes, requiring that any reduction in service level be based on actual clinical review;

- Requires the use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) to notify physicians when a claim has been downcoded and explain the reason for the change;
- Mandates that payers disclose a clear process for appealing downcoded claims;
- Permits physicians to batch similarly downcoded claims for appeal;
- Prohibits discriminatory downcoding practices targeting physicians who routinely treat complex patients or patients with chronic conditions; and
- Establishes enforcement mechanisms and penalties for noncompliance, including administrative fines and claim reprocessing orders.

AMA Advocacy staff worked to distribute the model bill to all state medical associations and national medical specialty societies. In addition, the model legislation and related resources have been presented in webinars and workgroup meetings to encourage Federation support and action.

State Activity

States have been active on the issue of downcoding in the past two legislative sessions, and state medical associations are doing significant work to educate lawmakers on the importance of increased transparency and guardrails to protect physician practices. In fact, more than a dozen states, including Arkansas, California, Connecticut, Illinois, Indiana, Missouri, Maryland, New Jersey, New York, Ohio, Tennessee, Oregon, Utah, and Virginia have introduced bills, and several have been able to push those bills across the finish line.

For example, in March 2026, after significant work by the Indiana State Medical Association (ISMA), and in collaboration with the AMA, Indiana's Governor signed legislation that reflects the AMA's model legislative solution in that it requires plans to notify physicians when a claim is being downcoded, bars a plan from downcoding a claim based on a diagnosis alone, and requires a clear appeals process that permits the batching of downcoded claims.[8] The new law also prohibits a plan from using an automated process, program, or tool, including AI, as the sole basis for downcoding a claim and prevents downcoding from being used to target physicians caring for patients with complex medical conditions. As with most legislative efforts, compromise was needed, and a provision in the new law prevents physicians from submitting an AI-generated claim that has not been reviewed by a clinician. ISMA worked closely with their members to vet this provision and determine the impact, which ultimately was accepted.

Similarly, the Illinois legislature recently passed Senate Bill (SB) 3114, the "Transparency in Downcoding Act," legislation supported by ISMS, and, at the time of this writing, awaiting the Governor's signature.[9] The legislation aims to address the use of automated downcoding programs by payers to reduce intensity levels and physician payment without justification or review of the patient's medical record. Specifically, SB 3114 would prohibit a health insurer from using an automated process, system, or tool to downcode a claim; ensure that a physician will be notified when a claim has been downcoded and reimbursed at a lower level, to include the clinical reason for downcoding; require health insurers to establish a clear and accessible process for disputing downcoded claims; and prevent health insurers from using downcoding to discriminate against physicians who commonly treat patients with complex or chronic conditions. The AMA worked closely with ISMS on this legislation, and ISMS received one of the first AMA State Accelerator grants to help develop the resources needed to achieve this victory, including the previously cited ISMS survey.[2]

In April 2026, the Governor of Virginia signed SB 164/HB 484.[10,11] This legislation places limits on plans' ability to downcode claims based solely on CPT codes and diagnosis, requires more detailed explanations when a claim is downcoded, and creates a more transparent appeals process in which claims can be appealed in batches to reduce burden.

Meanwhile, the Maryland Insurance Administration (MIA) recently determined that Cigna improperly downcoded E/M claims submitted by physicians, reducing reimbursement levels in violation of Maryland's insurance statutes governing claim payment and processing.[12] The MIA imposed an administrative penalty on Cigna and ordered that health plans stop the practice. MedChi, the Maryland State Medical Society, has long advocated for changes, including with the introduction of legislation earlier in the session, and applauded the MIA's actions.[13] The AMA ARC anticipates that state legislative and regulatory activity on this issue will continue in the 2027 legislative sessions, as staff work closely with state medical association to educate lawmakers about the need for reform.

Federal Legislative Advocacy

The proliferation of payer automatic downcoding programs and the resulting outcry from physician practices have also captured the attention of federal legislators. AMA Congressional Affairs staff have been working with members of Congress to introduce a federal downcoding bill. The AMA's model language on this issue has been shared with both House and Senate offices, and members of Congress have been receptive to AMA input on draft legislation. AMA Congressional Affairs staff will continue to meet with members of both the House and Senate to advocate for introduction and passage of federal legislation that would curb insurers' unfair automatic downcoding policies.

AMA Educational Material

While the AMA and the Federation of Medicine continue to advocate to health plans and legislatures for policy changes that will protect physicians from inappropriate downcoding policies, it is important that, in the meantime, physicians and practice staff have resources and tools to fight unjustified payment reductions. For that reason, the AMA has created an educational resource titled "Payer Evaluation and Management (E/M) Downcoding Programs: What You Need to Know."[14] This document provides an overview of E/M downcoding mechanics, including examples of downcoding scenarios and tips to help practices recognize downcoded claims. The resource reviews how to document and select the correct E/M level for an office visit based on MDM or time. Practices can also learn how to effectively challenge downcoded claims and take advantage of sample appeal letters. Finally, the resource links to an informal survey through which the AMA collects information on insurer downcoding policies to identify trends and support ongoing advocacy efforts. This material is currently being reviewed and updated to reflect anticipated E/M guideline changes for medication therapy management. The AMA will continue to monitor physicians' educational and advocacy needs related to downcoding and will create new and/or revised tools and resources as appropriate.

AMA POLICY

Although downcoding programs have accelerated in the last several years, at least in part due to health plans' use of AI and other automated tools, the AMA has extensive, long-standing policy opposing inappropriate lowering of service levels and corresponding payment. For example, Policy H-335.984 calls on the AMA to initiate regulatory amendments or legislation to abolish Medicare carriers' arbitrary downcoding of claims. Policy H-70.937 vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers and states that the AMA will develop a

national policy for intervention with carriers or payers that use unreasonable business practices to unilaterally recode or inappropriately bundle physician services and support legislation to accomplish this.

Policy H-320.948 calls for transparency in downcoding programs, stating that both physicians and patients should receive timely written notification containing the principal reason and clinical rationale for downcoded claims, as well as appeal instructions. Policy D-320.995 directs the AMA to work with the Federation of Medicine to gather information from physicians regarding downcoded claims and respond with appropriate legislation, advocacy, and communication initiatives. Policy H-70.924 states that the AMA Litigation Center will continue to support lawsuits seeking redress from insurers engaging in inappropriate or inaccurate downcoding practices. More recently adopted policy reflects the current landscape of plans' downcoding programs. Policy D-320.972 vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode E/M services, except correct coding protocol denials, based solely on the CPT/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim. This policy also states that in cases where it is appropriate to lower the level of service reported on a claim based on medical record review, health plans should clearly indicate downcoded services using CARCs and RARCs on the remittance advice. The policy directs the AMA to advocate for legislation prohibiting automated downcoding and requiring transparency on all claims processing, as well as to evaluate legal action. Most recently, Policy D-70.940, in addition to requesting this report, directs the AMA to challenge payer downcoding policies through regulatory, legislative, and legal channels, as well as to create and disseminate guidance and educational materials for physicians regarding downcoding practices.

DISCUSSION

This report provides an overview of the current landscape surrounding health plans' downcoding programs and details how they harm physician practices and patients. In response to these rapidly escalating concerns, the AMA has engaged in a multi-pronged campaign to address inappropriate automatic downcoding of claims, including direct payer engagement, efforts to introduce and pass both state and federal legislation that would place guardrails around downcoding programs, and creation of practice educational material to assist physicians and staff in addressing unfair downcoding programs. The AMA has also adopted numerous policies on this topic, including several in the last few years that focus on plans' use of automation and the lack of transparency characteristic of contemporary downcoding programs.

While the AMA already has adopted extensive policy on payer downcoding programs and developed a robust advocacy strategy, there are a few specific areas that could be further strengthened to meet emerging or newly identified needs. First, in order for practices to fully benefit from legislative guardrails, physicians and staff must be aware of these protections. The AMA, in partnership with state medical associations, could communicate these legislative wins to physician practices and encourage reporting of compliance failures to the appropriate regulatory body for enforcement. Physicians should be made aware of the importance of reporting violations of downcoding laws to regulators, as such individual complaints draw attention to compliance issues and lead to enforcement action. Secondly, Policy D-70.940 directs the AMA to create educational materials on downcoding practices. As discussed, the AMA already offers a comprehensive educational resource on E/M downcoding; however, the policy directive suggests that physicians are not aware of this tool. Therefore, the AMA could more widely promote this resource, including communication of any updates or additional downcoding materials. Finally,

reaffirmation of Policy H-70.294 recommits the AMA to supporting lawsuits that seek redress from insurers engaging in inappropriate or inaccurate downcoding practices.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA), in collaboration with state medical associations, communicate legislative guardrails on health plans' downcoding policies to physician practices and provide guidance on how any payer noncompliance can be reported to the appropriate regulatory body for enforcement. (New HOD Policy)

2. That our AMA amend Policy D-70.940[3] to read as follows:

   Our AMA will develop, regularly update, ~~and~~ disseminate, and widely promote 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. (Modify Current HOD Policy)

3. That our AMA reaffirm Policy H-70.924, which states that the AMA Litigation Center will support lawsuits that seek redress from insurers engaging in inappropriate or inaccurate downcoding practices. (Reaffirm HOD Policy)

4. That our AMA rescind Policy D-70.940[2] as it has been fulfilled by this report. (Modify Current HOD Policy)

Fiscal Note: Minimal.

Policy Appendix

Policy D-70.940, "Opposing Unilateral Downcoding of Physician Services by Insurance Companies"
(1) Our American Medical Association will work with state medical associations, specialty societies, and regulatory authorities to challenge payer-initiated downcoding policies through regulatory, legislative, and when appropriate, legal channels. (2) Our AMA will report back on payer downcoding practices, their effects on physicians and patients, and strategies for collective advocacy at the 2026 Interim Meeting. (3) 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. Res. 810, I-25

Policy D-320.972, "Automatic Downcoding of Claims"
(1) Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim. (2) Our AMA supports that, after review of the patient's medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes. (3) Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim. (4) Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims. Res. 714, A-24; Reaffirmed: Res. 810, I-25

Policy D-320.995, "Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans"
(1) Our American Medical Association will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization. (2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review. (3) AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims. (b) seek information on a regular basis from those associations that collect such information. (c) respond with appropriate legislation, advocacy, and communication initiatives. CMS Rep. 5, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation: A-18; Reaffirmation: A-22

Policy H-70.924, "Litigation Center Cases to Combat Automatic Downcoding and/or Recoding"
The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices. BOT Rep. 31, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22

Policy H-70.937, "Bundling and Downcoding of CPT Codes"
Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers; (2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards; (3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and (4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers. Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

Policy H-320.948, "Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans"
It is the policy of our American Medical Association, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) The principal reason(s) for the determination. (2) The clinical rationale used in making the determination. (3) A statement describing the process for appeal. CMS Rep. 5, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-08; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21

Policy H-335.984, "Medicare Regulatory Relief Legislation"
It is the policy of our American Medical Association to initiate modifications to the Regulatory Relief Amendments or introduce additional legislation to address further areas where unwieldy or inequitable federal regulations or legislation place unrealistic or unfair demands on physicians and their office staff to: (1) Abolish the A/B Data Link in which physician services provided during inpatient treatment, where payment to the hospital has been denied, are reviewed and can be denied as medically unnecessary years after the treatment has been provided. (2) Abolish the practice of downcoding claims where Medicare carriers arbitrarily alter physician claims so that physicians are paid for a lower level of service than the one actually provided. (3) Further clarify Section 6109 of OBRA 1989 that nullified the recoupment of funds from Texas physicians and patients so that the original intent of the legislation would be realized through repayment of funds to those physicians and beneficiaries who had already repaid funds to the government. (4) Include provisions that relieve patients and physicians of responsibility for implementation of the Medicare as a Secondary Payer provisions and that the Medicare carrier be charged with responsibility for obtaining payment from the proper insurer rather than from physicians or beneficiaries for any errors that may be made in the determination of a beneficiary's insurance status. (5) Include provisions that would nullify Section 6102(g)(4) of OBRA 1989 that all Medicare claims be filed by physicians so that physicians who have large numbers of claims for small amounts would not be burdened with the transaction costs of meeting the mandatory claims filing provision, particularly since the OBRA 1989 provisions explicitly forbid physicians from requesting or receiving any additional payment

for this costly and time-consuming service. Res. 213, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21

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REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Transparency with the Term "Emergency Department"
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, Resolution 226-I-25, Transparency with the Term "Emergency Department," was referred. It asked the following:

> RESOLVED, that our American Medical Association (AMA) 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; and be it further
>
> 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; and be it further
>
> 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.

This report discusses emergency department staffing requirements, the Emergency Medical Treatment and Labor Act (EMTALA), emergency service payment, Critical Access Hospitals, Rural Emergency Hospitals, emergency department signage and advertising requirements, the American College of Emergency Physicians' accreditation program, the emergence of Urgent Care Centers, and includes several policy recommendations.

The Council on Medical Service recommends new policy supporting the development of standardized emergency department descriptors that clearly identify each facility's level of on-site physician coverage and available services; and recommends that facilities dedicated to emergency care without an on-site physician use standardized, real-time language that allows a prudent layperson to readily understand the level of physician presence and services available, thereby promoting truth and transparency for patients. The Council also recommends limiting the designations "emergency department" and "emergency room" to facilities that meet EMTALA requirements and allowing any EMTALA-covered facility that meets those requirements to be classified as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage. Furthermore, the Council recommends requiring facilities without continuous on-site physician staffing to prominently disclose, through physical and online signage, that physicians are not continuously on duty and on site; and that our AMA support requiring advertisements for such facilities to include the same disclosure, consistent with Federal Trade Commission guidelines and community engagement to improve the education of patients. The Council also recommends reaffirming Policy H-130.929, which identifies an on-site physician whose primary duty is emergency department care as the AMA's preferred model; Policy D-35.976, which states that only physicians should supervise emergency care services in an emergency department; Policy D-130.958, which recognizes that staffing arrangements that do not allow physicians to properly provide emergency services are insufficient; Policy H-160.949, which opposes legislation allowing nonphysician groups to practice medicine without physician training or appropriate physician supervision; and Policy H-240.958, which recognizes the vital role of smaller, financially challenged facilities that provide emergency services.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-26

Subject: Transparency with the Term "Emergency Department"

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

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> 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; and be it further
>
> 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.

This report discusses emergency department staffing requirements, the Emergency Medical Treatment and Labor Act, emergency service payment, Critical Access Hospitals, Rural Emergency Hospitals, emergency department signage and advertising requirements, the American College of Emergency Physicians' accreditation program, the emergence of Urgent Care Centers, and includes several policy recommendations.

BACKGROUND

Emergency departments (EDs) are a critical—and increasingly strained—gateway to care in the United States (US). In 2025, there were 155.4 million visits to the 5,751 EDs in the US with 17.8 million resulting in hospital admission, and 3.1 million resulting in admission to a critical care unit.[1,2] Nearly 1 in 4 patients aged 18-64 use the ED for non-urgent issues, which could otherwise be treated in an urgent care center (UCC) or primary care setting.[3] A small percentage of patients (4.5 percent to 8 percent) utilize the ED at least four times per year, but account for 21 percent to 28 percent of all ED visits.[4] Regional disparities for ED visits are significant, driven largely by healthcare access, the density of rural populations, and the prevalence of chronic health conditions.[5] For instance, in rural states healthcare providers are overwhelmingly concentrated in a few urban centers which leave geographic stretches with limited local primary care or UCCs.[6] Hospital deserts are widespread in the US: 691 of the nation's 3,142 counties (22 percent) lack a hospital, including 258 counties in highly vulnerable states where residents also face socioeconomic, housing, and transportation barriers to care.[7]

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Patient expectations for physician-led emergency care often collide with staffing realities, particularly in rural and low-volume hospitals. According to an American College of Emergency Physicians (ACEP) poll from 2021, 80 percent of patients state they most trust a physician to lead their ED medical care compared with a nurse, physician assistant (PA), or nurse practitioner (NP).[8] However, one in 13 EDs did not have one or more on-duty attending physicians at all times.[9] In several states, more than 30 percent of the EDs lacked constant physician leadership and, among them, 92 percent had low annual visit volumes, 89 percent were in critical access hospitals (CAHs), and 72 percent were rural.[10]

Gaps in round-the-clock emergency physician coverage vary significantly across states and reflect more than rural geography alone. Several factors are associated with the absence of continuous physician coverage, including annual visit volume under 10,000, workplace shortages, permissive state-level scope of practice laws, challenging hospital economics, and rural location.[11] Fifteen states—including many largely rural states—reported no EDs operating without a physician on-site 24 hours per day/7days per week (24/7).[12] Some of these states (e.g., Nevada, New Mexico, and West Virginia) are adjacent to states with comparatively high numbers of EDs without continuous physician coverage. In the Dakotas, for example, more than half of EDs operated without an attending physician, and in Montana, 43 percent lacked 24/7 attending physician coverage.[13] Nine states reported that at least 20 percent of EDs did not have 24/7 attending-physician coverage; these states are disproportionately located in the central US.[14] Most EDs (89 percent) without 24/7 physician coverage are designated as CAHs, 72 percent were rural, and 2 percent were freestanding.[15] However, more than a quarter (28 percent) of these EDs are located in metropolitan areas and the vast majority of which represent specialized freestanding emergency departments rather than traditional main hospital campuses.[16]

US hospital closures have risen sharply since the early 2000s. From 2017 through 2023, rural closures outnumbered openings 61 to 11, yielding a net loss of 50 hospitals; from 2005 through 2024, 193 rural hospitals closed.[17] Urban hospitals also close frequently, often because of financial pressures. In both settings, closures force residents to travel farther for care. Rural residents, for example, have preventable ED visit rates up to 45 percent higher than urban residents, largely because primary care shortages, longer travel distances for primary and specialty care, and geographic isolation allow conditions to worsen.[18] At the same time, annual visits to remaining EDs have increased by about 30 percent, worsening wait times and overcrowding. Closures are driven primarily by unsustainable financial losses and operational challenges; nearly half of rural hospitals operate at a negative margin. Major contributors include uncompensated care, low patient volume, billing and administrative burdens, regulatory requirements, and staffing shortages, with rural and socioeconomically disadvantaged communities facing the greatest effects.[19]

EMERGENCY MEDICAL TREATMENT AND LABOR ACT

Ninety eight percent of EDs are subject to the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA requires Medicare-participating hospitals with EDs to screen and treat emergency medical conditions regardless of a patient's insurance status or ability to pay.[20] EMTALA obligations are triggered when an individual "comes to the emergency department," including by arrival via Emergency Medical Services, is present anywhere on hospital property within 250 yards of the main building, or is sent via a transfer request from another hospital's ED.[21] Federal law requires hospitals to maintain an on-call list of physicians available to provide stabilizing treatment for emergency medical conditions, but it does not require ED care to be physician-led.[22] When an individual presents at a hospital ED for examination or treatment, the hospital must provide an appropriate medical screening examination (MSE) by qualified medical personnel (QMP), which may include a physician, PA, or NP.[23] Physicians may be on call for multiple hospitals at once, but hospitals must have policies to manage that arrangement, including backup community call plans when a physician is unavailable.[24]

Regulations define a "hospital with an emergency room" as a hospital with a dedicated ED, whether located on or off the main campus.[25] A dedicated ED is one that meets any one of the following three criteria: (1) it is licensed by the state as an emergency room (ER) or ED; (2) it is presented to the public—through its name, signage, advertising, or other means—as providing urgent care for emergency medical conditions without a scheduled appointment; or (3) during the prior calendar year, at least one-third of its visits were for urgent treatment of emergency medical conditions without a scheduled appointment, based on a representative sample.[26] This definition also includes units, such as labor and delivery or psychiatric intake or assessment units, where unscheduled ambulatory patients are routinely evaluated and treated for emergency medical conditions.[27]

Hospital policies must specify when a QMP must consult an on-site or on-call physician. If a QMP cannot confidently rule out an emergency medical condition, a physician must be involved.[28] The Centers for Medicare & Medicaid Services (CMS) also permits the required MSE be performed via telehealth, even when the physician is elsewhere on campus or off-site, so long as the remote examination is clinically sufficient to determine whether an emergency medical condition exists.[29] Under EMTALA, a telehealth provider performing a MSE does not have to be a physician as long as they qualify as a QMP.[30] If video or other remote data are inadequate, an in-person examination is required. Any remote provider performing MSEs must be fully credentialed and privileged by the hospital, and hospitals may use proxy credentialing to streamline telemedicine services.[31] If the treating ED physician determines that an in-person specialist assessment is needed to stabilize the patient, the on-call specialist must come to the hospital.[32]

Although uncommon, some ED-like settings are not subject to EMTALA. Facilities that do not accept Medicare or Medicaid payments may fall outside the scope of EMTALA. Military and Veterans Affairs hospitals are also exempt and operate under separate federal requirements. UCCs that are not owned or operated by a hospital typically are not covered, and off-campus hospital departments that do not primarily provide emergency services may not qualify as dedicated EDs. Once a patient is formally admitted as an inpatient, EMTALA obligations generally end and other CMS Conditions of Participation apply.

EMERGENCY SERVICE PAYMENT

Emergency service payment typically uses the Current Procedural Terminology (CPT®) codes 99281–99285 evaluation and management (E/M) codes (five levels based on complexity), supplemented by critical care CPT codes 99291–99292 and facility revenue codes 0450, 0451, or 0456.[33] Additional CPT codes include observation (99221–99223) for patients placed in observation status and common procedure codes such as laceration repair (12001–12011) and splint application (29125–29515).[34,35] For hospital inpatient or observation care services (including admission and discharge services) CPT codes 99234–99236 are used.[36] A modifier may be used to indicate a significant, separately identifiable E/M service performed by the same physician on the same day as a procedure.[37] Ambulance services are billed with Healthcare Common Procedure Coding System codes A0021–A0999 (e.g., Basic Life Support or Advanced Life Support).[38] Payment for these services does not depend on whether the care is delivered in a facility labeled an "emergency department" or "emergency room."

Place of Service (POS) codes are two-digit codes placed on healthcare professional claims to indicate the setting in which a service was provided. While there are numerous codes, POS 23 is designated for, "a portion of a hospital where emergency diagnosis and treatment of illness or injury is provided."[39] For emergency services provided via telehealth, POS 23 should be paired with -95 to indicate remote care.[40] There is no regulation, directive, or guidance by CMS that POS code 23 must be within a location called an "emergency room" or "emergency department."[41]

EMERGENCY DEPARTMENT STAFFING REQUIREMENTS

Staffing requirements vary by state and are set by state regulations and hospital licensing standards. State differences in ED physician-led care are driven, in part, by varying state regulations on the corporate practice of medicine, differing scope-of-practice laws, and the availability of local residency programs. While some states require continuous on-site physician coverage, most do not. Indiana, Virginia, and South Carolina require a physician to be on site and on duty 24/7, and several other states have considered similar legislation. Although this approach may serve as a model for other states, its success may depend upon most EDs in those states already being staffed in this way. In Virginia, for example, there was no ED without a physician present.[42] It is unclear whether South Carolina and Indiana were staffed similarly. California and New Jersey have long had comparable mandates. California requires a qualified physician to oversee a hospital's emergency services and ensure they are staffed by an experienced physician.[43] New Jersey requires at least one licensed physician to be present in the ED to manage emergencies.[44]

Most states, however, mandate flexible physician staffing requirements. Illinois, for example, classifies EDs as Comprehensive, Basic, or Standby. Comprehensive and Basic emergency treatment services require a physician on site 24/7, while standby services require a physician to be on call.[45] In Florida, state law requires every hospital offering emergency services to have its ED directed by a physician who is a member of the organized medical staff.[46] At least one physician must be available within 30 minutes through a required call roster, and two-way voice communication may be used for the initial consultation.[47] In New York, regulations provide that hospitals with fewer than 15,000 unscheduled ED visits per year do not need a supervising or attending physician on site, so long as one is available within 30 minutes of the patient's arrival.[48] States, however, universally require every licensed ED to appoint an explicit, state-licensed physician to serve as the Emergency Department Medical Director.[49] This individual is legally responsible for quality control, protocols, and provider credentialing.

Several factors can explain why a physician may not be present in an ED, including recruitment and retention challenges. Hospital administrators report difficulty attracting and retaining physicians to staff EDs, and workforce data support this concern. A 2020 study found that only eight percent of emergency physicians practiced in rural areas, and only two percent practiced in small rural areas.[50] Rural physicians also were, on average, significantly older than their urban counterparts and near retirement age, with most having completed training at least 20 years before 2020.[51] Although rural EDs may be more likely to employ physicians who are not specialty trained in emergency medicine, workforce research shows that fewer than one-quarter of clinically active family medicine-trained emergency physicians practice in rural areas.[52] Staffing challenges can also reinforce themselves; for example, rural hospitals may require new physicians to cover ED shifts multiple nights per week as a condition of employment, which may deter physicians who do not want to provide emergency services or work overnight hours.

EDs without an on-site physician often use alternative staffing models centered on advanced practice providers (APPs), such as PAs and NPs, to perform MSEs and stabilize patients. These models commonly pair APP staffing with remote physician oversight and rapid transfer protocols for higher-acuity cases. One approach is 24/7 APP coverage with an emergency physician continuously available off-site through real-time audiovisual technology to guide assessments, interpret diagnostics, and support critical decisions.[53] Another is autonomous APP staffing, in which PAs and NPs operate the ED with remote or on-call supervision from an off-site collaborating physician.[54] Some facilities use hybrid inpatient/ED models, with one experienced provider covering both the ED and inpatient unit during low-acuity or overnight periods.[55] A less common model uses specialized emergency paramedics, working under the attending APP's direct supervision, to support care through tasks such as IV placement, protocol-directed medication administration, and continuous vital-sign monitoring.[56]

The capabilities of EDs with and without continuous physician leadership differ significantly. With an attending physician, there is usually the capability to independently perform complex procedures like intubation, chest tube insertion, and emergency surgeries while immediate, autonomous decision-making is possible with an interpretation of imaging and lab results.[57] Furthermore, specialty coverage is a possibility with direct, on-site management of acute trauma, severe strokes, and multi-system organ failure and procedural sedation with full capacity to manage deep sedation for acute fracture reductions or cardioversion on-site.[58] Without a physician present, an initial assessment and triage is likely to occur with basic stabilization, telehealth consultation for lab results and treatment of complex conditions, basic diagnostics (e.g., lab work), and emergency transfer if trauma is severe.[59]

The practice requirements for APPs vary by state. All PAs must graduate from an accredited program, pass the national certification exam, obtain state licensure, and complete 100 continuing medical education hours every two years. Most states require physician supervision or collaboration, although eight—Iowa, Montana, New Hampshire, North Dakota, South Dakota, Maine, Utah, and Wyoming—allow eligible PAs to practice without a formal agreement.[60] PAs may prescribe in all states, Washington, D.C., and Guam, subject to local registration or delegation rules. Advanced practice registered nurses (APRNs), including NPs, clinical nurse specialists, nurse anesthetists, and nurse-midwives, practice under full, reduced, or restricted authority. Full practice permits independent evaluation, diagnosis, testing, treatment, and prescribing; reduced or restricted practice limits at least one function and may require collaboration, supervision, or delegation.[61] APRNs generally must hold an accredited graduate degree, national certification for their role and population focus, and state licensure.

Trauma capabilities also vary by facility. Every trauma center has an ED, but not every hospital with an ED is a trauma center. Trauma centers provide specialized care for critical injuries, with trauma surgeons, neurosurgeons, orthopedic specialists, and other teams available around the clock for emergency surgery.[62] State or regional authorities, not healthcare organizations, designate trauma centers using criteria that vary by state. Levels I through V reflect the resources available to treat traumatic injuries: Level I centers offer the most comprehensive care for severe injuries, while Level IV and V centers stabilize patients for transfer to higher-level facilities.[63] Adult and pediatric trauma centers receive separate designations. The American College of Surgeons (ACS) conducts a separate verification process to improve trauma care.[64] Whereas designation establishes a facility's trauma-center status, ACS verification confirms that it meets defined standards for preparedness, policies, resources, operations, and quality improvement.[65] Verification remains valid for three years.

CRITICAL ACCESS HOSPITALS & RURAL EMERGENCY HOSPITALS

Congress created the CAH designation in the Balanced Budget Act of 1997 after many rural hospitals closed in the 1980s and early 1990s.[66] The program is intended to preserve access to care in rural communities, reduce financial vulnerability, and keep essential services available.[67] Congress later established the Rural Emergency Hospital (REH) designation to help struggling rural hospitals avoid closure by converting to facilities that provide 24/7 emergency and outpatient services without inpatient care.[68] CAHs and REHs receive enhanced Medicare payments for certain outpatient services and, for REHs, additional monthly facility payments.[69] CAHs, rural acute care hospitals, tribally operated hospitals, and Indian Health Service hospitals with 50 or fewer beds that were open on December 27, 2020, may apply for REH status. To qualify, a hospital must be in a rural area or have an active rural classification under the Office of Management and Budget's Core Based Statistical Areas.[70]

REHs must provide 24-hour emergency and observation services and may choose to offer other outpatient services.[71] As with CAHs, an MD or DO physician, PA, NP, or clinical nurse specialist with emergency care training or expertise must be on-site or on-call and able to arrive within 30 minutes, or within 60 minutes if the facility meets certain frontier or remote-area criteria.[72] States may impose stricter

requirements, including minimum staffing hours or specific personnel standards.[73] CAHs also must meet federal Conditions of Participation and comply with applicable state and local laws.[74] If state law is more stringent—such as California's nurse-to-patient ratio standards or Indiana's on-site physician staffing requirement—the facility must follow the stricter state standard.[75] CAH and REH eligibility rules do not mandate use of the terms "emergency department" or "emergency room."

EMERGENCY DEPARTMENT SIGNAGE

No federal regulation requires facilities that provide immediate, unscheduled care, diagnostic services, and stabilization for seriously ill or injured patients to be labeled "emergency departments." There is also no financial barrier preventing an "emergency department" from adopting alternative names (e.g., "unscheduled care center" or "rural immediate care center"). EMTALA does require conspicuous signage that is easily visible to all individuals entering the ED, including at entrances, waiting rooms, registration, and treatment areas.[76] Hospitals with dedicated EDs that do not have a physician present 24/7 must post clear public signage disclosing that fact under Medicare Conditions of Participation and EMTALA-related requirements.[77] Hospitals with continuous, on-site, qualified physicians are not required to post a physician-absence notice. When an MD or DO is not present on-site 24/7, the sign must state that the hospital does not have a physician present 24/7, and explain how the hospital will meet the immediate needs of patients with emergency medical conditions when a physician is not physically present, such as calling on-call physicians, using telehealth, or transferring the patient.[78] The notice must be posted conspicuously where patients and visitors are likely to see it, including emergency department entrances, waiting rooms, admitting areas, and patient treatment or examination areas, readable from 20 feet away, and written in clear, simple, and accessible language.[79]

Furthermore, hospitals must post notices explaining patients' rights to emergency treatment and to file complaints.[80] Signs must also state that the hospital provides an appropriate MSE, necessary stabilizing treatment (including for stabilization of the fetus), and whether the hospital participates in Medicaid.[81] Posted information must be in the language(s) understood by the population served, written in clear, simple terms, and readable from 20 feet away.[82] Updated model signage includes a QR code for additional information to meet 42 CFR § 489.20(q) requirements.[83] In addition, public ED entrances must be clearly marked from outside and from surrounding roads, readily distinguishable from ambulance entrances, and illuminated for visibility at night or in poor weather.[84]

Some states impose additional ED signage requirements. For example, Massachusetts requires highly visible, illuminated—and in some cases reflective—signage directing patients to 24/7 care and clearly marking emergency entrances as "EMERGENCY."[85] Illinois requires additional ED notices, including information on Affordable Care Act exchange enrollment, human trafficking, and charges for services such as x-rays, ER services, and room fees.[86] Some cities also have added requirements; Chicago, for instance, mandates approved emergency lighting and exit signage that may differ from national codes and requires local inspections.[87]

EMERGENCY DEPARTMENT ADVERTISING

Although EDs without 24/7 on-site physician coverage must post clear public signage disclosing that fact under Medicare Conditions of Participation and EMTALA-related requirements, they are not required to include the same disclosure in advertising. Healthcare advertising is governed by federal law, state licensing boards, and healthcare marketing standards intended to protect patient safety, promote transparency about pricing and facility capabilities, and prevent deceptive practices. The Food and Drug Administration regulates pharmaceutical and medical device marketing to ensure information is accurate and not misleading.[88] State medical boards enforce jurisdiction-specific advertising rules, while the Federal Trade Commission (FTC) broadly regulates healthcare advertising by requiring claims to be

truthful, evidence-based, and not misleading.[89] For example, claims about wait times, equipment, or staff qualifications must be accurate. FTC enforcement focuses on deceptive practices under a three-part standard: the representation, omission, or practice must mislead or be likely to mislead consumers; the consumer's interpretation must be reasonable under the circumstances; and the misleading representation, omission, or practice must be material.[90] States (e.g., California, Georgia, and Indiana) increasingly restrict or penalize non-physician clinicians from using the title "doctor" in clinical and advertising settings if it misleads patients into believing they are physicians.[91,92]

FTC guidance on claim substantiation and consumer endorsements is particularly relevant to healthcare marketing. Advertisers must have support for all express and implied claims an advertisement is likely to convey to reasonable consumers before the advertisement runs.[93] For example, ED wait-time claims must be substantiated before publication. If the comparison relies on a national standard for certain trauma or condition-specific care, such as heart attacks or strokes, the advertisement should clearly disclose that qualification. Healthcare providers that advertise treatment outcomes must also be able to support those claims.[94] Comparisons to regional or national averages should be clearly stated, and advertisers should avoid success-rate claims when the data may be distorted by an unusual patient population, small case volume, or another statistical anomaly. Healthcare marketing should also consider how prospective patients are likely to interpret an advertisement.[95] A patient who sees a facility claims a much higher success rate than the national average may reasonably assume the difference reflects better care at that facility, rather than differences in patient population or case volume.

State medical boards oversee ED advertising primarily to protect public health by preventing false, deceptive, or misleading claims.[96] Because emergency care is time-sensitive, boards scrutinize advertisements that could manipulate vulnerable patients or delay lifesaving treatment. Key compliance concerns include misrepresenting a facility's services, capabilities, licensing, or staff credentials.[97] For example, a practice or freestanding facility should not advertise itself as an "emergency room" or "emergency department" unless it has the required state license, trauma designation, and 24/7 capabilities.[98] Similarly, an ED should not claim to be "fully staffed by emergency specialists" if shifts are routinely covered by clinicians who lack the stated qualifications or required supervision.[99] Advertised wait times—whether displayed on billboards, websites, or apps—also must be based on legitimate, reliable data.[100] A board may investigate a hospital that presents door-to-triage time as total wait time rather than measuring the time until evaluation by a qualified medical professional. The ACEP advises prominent disclaimers explaining that published wait times do not apply to life-threatening emergencies, which receive immediate priority.[101] If a patient with a serious condition, such as a heart attack, delays care because of a posted wait time, a board may assess whether the advertisement created a public health risk.[102] State licensing boards also restrict fear-based or high-pressure marketing that exaggerates health threats or exploits patient panic to steer individuals toward a particular hospital network.[103] Although medical boards regulate individual professional licenses, they often coordinate with other agencies on ED advertising violations. Misleading, inaccurate, or unsafe marketing can result in public reprimands, financial penalties, practice restrictions, or suspension or revocation of the licenses of responsible physicians or medical directors.

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS' ACCREDITATION PROGRAM

The ACEP Emergency Department Accreditation Program (EDAc) is a voluntary national program recognizing EDs that meet defined standards for quality, safety, and clinical excellence and could be a roadmap to evaluate and distinguish EDs with and without continuous physician coverage. Its 33 multidisciplinary benchmarks address quality improvement, boarding policies, pediatric readiness, workplace fairness, performance monitoring, and resources such as ultrasound, interpreter services, and staff safety protocols.[104] EDAc evaluates facilities across four levels based on capabilities such as advanced imaging, social services, and, most importantly, staffing models. Gold Level I, the highest

designation, requires comprehensive staffing, a qualified emergency or pediatric emergency physician be physically on-site 24/7 365 days per year, advanced imaging, and on-site social services.[105] Silver Level II applies strong but less stringent staffing with integrated physician-led care and advanced diagnostic access but permits flexible on-call scheduling or slightly altered supervisor-to-midlevel (APP) staffing ratios.[106] Bronze Level III reflects compliance with the 33 foundational standards and focuses heavily on the structural administrative baseline and requires foundational advanced imaging and strict physician-led supervision frameworks but mandates fewer dedicated ancillary staff lines like standalone ED social workers.[107] Lastly, the Rural and Critical Access designation uses streamlined criteria for federally designated Rural Emergency Hospitals and Critical Access Hospitals.[108] Participating hospitals use EDAc to show they follow evidence-based policies and provide high-quality emergency care.

URGENT CARE CENTERS

While EDs address immediate, life-threatening emergencies, UCCs are free-standing same-day clinics for patients who need expedient, non-critical care. UCCs emerged in the 1970s as a convenient alternative to EDs for noncritical, acute illnesses.[109] In the 1980s, there was skepticism of their role due to a perceived lack of quality control which led to a decline in popularity.[110] However, they are now seen as an essential part of the healthcare system. Over the past two decades, they have expanded due to the high cost of ED visits, insurance company encouragement, and the need for immediate, non-scheduled care.[111, 112] From 2016 to 2025, UCCs have grown from 9,000 to 15,398 with 89.4 percent of the US population within a 20-minute drive.[113] Approximately, 185 million patients were cared for in an UCC setting in 2025.[114]

UCCs are largely physician-led with 94 percent of facilities employing at least one full-time physician.[115] Most UCCs legally require a physician for medical oversight, with a physician employed or contracted by the facility even if they are not physically in the building. Approximately 80 percent of UCCs employ a combination of physicians, PAs, and NPs.[116] The remaining 20 percent employ only physicians.[117] Sixty percent of UCCs are independent/private while 30 percent are hospital-owned.[118] Of the physicians practicing in UCCs, about 48 percent are family medicine physicians, 30 percent are emergency medicine physicians, and 8 percent are internal medicine physicians.[119] In 22 states and the District of Columbia, NPs have full practice authority and can practice without direct physician supervision. However, even in states with relaxed rules, corporate practice of medicine laws and insurance enrollment policies often require a physician on the business or licensing framework, making completely physician-free corporate urgent care structures extremely rare. Physician employment tends to attract physicians wishing to work part-time hours and those looking to transition into retirement.

There is a diverse, rapidly growing variability in the care, services, and staffing between UCCs and EDs.[120] While designed for immediate, non-life-threatening needs, UCC capabilities range from basic, NP-led care to advanced, hospital-affiliated facilities with specialized diagnostics.[121] Services vary, but they often include on-site x-rays, casting, and suturing.[122] However, only 14 percent had computed tomography scanners and 18.6 percent had ultrasound on site.[123] There also might be potential for high rates of discordant diagnoses compared to EDs, with some studies finding that 64 percent of patients transferred from a UCC to the ED had a discordant diagnosis.[124] This discrepancy may reflect limited services at some UCCs, less experience with advanced diagnostic interpretation, and care provided by APPs rather than physicians specializing in emergency medicine.[125] Some UCCs focus on primary care or occupational medicine, while others prioritize acute, low-acuity cases and increasing patient volume.[126] UCCs in cities with hospitals may have different patient demographics (younger) and shorter wait times, while corporate-owned or hospital-affiliated centers may offer different service menus than independent ones.[127]

RECENT REGULATORY ACTIVITY

Several states have mandated that a physician be present in the ED 24/7. Signed into law on May 4, 2023, Indiana's Senate Bill 400 (SB 400) requires that all hospital EDs in the state have a licensed physician on-site, on-duty, and responsible for the ED at all times. This legislation aims to ensure physician-led care in emergency settings. The law was driven by efforts to standardize care quality and ensure high-level training is available, particularly following concerns about solely staffing EDs with non-physician practitioners. Starting July 1st, 2025, Virginia law (Senate Bill 392) requires all hospital EDs to have a physician physically on site, on-duty, and responsible for the ED 24/7. Passed by the Virginia General Assembly and signed into law, the mandate ensures physician-led care for emergency patients, specifically enhancing care in rural locations. Previously, the law mandated there must be a physician on-call, but not physically present. South Carolina passed legislation in May 2025 (H. 4067) that requires all hospitals with EDs to always have at least one physician physically on-site while the department is open. This applies to all hospitals with EDs, regardless of their classification – rural, urban, public, or private.

AMA POLICY

Policy H-130.929 recognizes that the preferred model of emergency care is the on-site presence of a physician in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement.

Policy D-35.976 advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED.

Policy H-160.949 opposes legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision, and vigorously supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.

Policy H-130.976 reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services and asserts that physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.

Policy H-35.973 supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

Policy H-35.989 broadly outlines that the PA should function under the direction of and supervision by a duly qualified licensed physician and that the care provided by the PA be in concert and guidance by the physician.

Policy H-160.947 presents the guidelines developed by the AMA for guiding an appropriately developed physician/PA practice and that the AMA will develop a plan for identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

Policy H-160.888 supports any individual, company, or other entity that establishes and/or operates UCCs adhere to principles which, in part, suggests that UCCs should be prohibited from using the word "emergency" or "ED" in their name, any of their advertisements, or to describe the type of care provided.

Policy D-130.958 seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and supports all ED be staffed 24/7 by a qualified physician.

Policy D-35.985 outlines the advocacy of the AMA for physician led team-based care.

DISCUSSION

The Council recognizes that physician-led emergency care differs in scope, complexity, and depth from care provided by non-physician practitioners such as PAs and NPs. It also acknowledges that a growing number of EDs are not physician-led or lack on-site physician coverage around the clock. Rural and under-resourced facilities often face financial, recruitment, and retention challenges that make continuous physician coverage difficult. These pressures are contributing to facility closures, further limiting patients' access to care. Nonetheless, transparency remains essential. Patients seeking care at an ED should be clearly informed when a physician is not providing their care and when transfer to another hospital may be necessary for more complex treatment. Accordingly, the Council supports standardized ED descriptors that clearly identify each facility's level of on-site physician coverage and available services. It also recommends that facilities dedicated to emergency care without an on-site physician use standardized, real-time language that enables a prudent layperson to readily understand the physician coverage and services available. To further promote transparency, the Council supports requiring facilities without continuous on-site physician staffing to prominently disclose this fact through physical and online signage and in advertisements, consistent with FTC guidelines. The Council also supports community engagement and patient education to improve understanding of ED coverage and services and to help healthcare teams promote efficient, site-appropriate care. Finally, the Council recognizes the complexities of site-of-service payment, including the risk that emergency care may be improperly paid regardless of a facility's level of on-site physician coverage, and that facility terminology may confuse patients. To address these concerns, the Council supports limiting the terms "emergency department" and "emergency room" to facilities that meet EMTALA requirements and classifying any qualifying EMTALA-covered facility as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage.

The AMA has longstanding policy on key aspects of this issue, and the Council recommends reaffirming several policies to reassert its position. Because emergency medicine is complex, the preferred model is full-time, on-site physician presence, which should be pursued whenever possible and feasible. However, the Council recognizes that workforce shortages and financial constraints may warrant limited rural exceptions, and that alternative models may be necessary to meet some communities' needs. Accordingly, the Council recommends reaffirming Policy H-130.929, which recognizes the AMA's preferred model of on-site physician presence in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing appropriate limited rural exceptions. Additionally, the Council recognizes that an increasing number of facilities, including EDs, are substituting physicians with non-physician practitioners. The Council views this trend as concerning because physician-led care provides a level of training, scope, and clinical judgment that differs from care provided by non-physicians. As such, the Council recommends reaffirming Policy H-160.949, which opposes legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, vigorously supports and advocates for the requirement of appropriate physician supervision of non-

physician clinical staff in all areas of medicine, and states that the AMA will continue to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician healthcare workers.

Furthermore, the Council recognizes the important role of physicians in the supervision of emergency care. Therefore, the Council recommends reaffirming Policy D-35.976, which advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED, and Policy D-130.958, which seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED. Lastly, the Council recognizes the vital role of smaller, financially challenged facilities that provide emergency services and does not seek to undermine their viability. Accordingly, the Council recommends reaffirming Policy H-240.958, which advocates prohibiting insurers from denying or reducing payment for medically necessary procedures based solely on the site of service, provided the procedure can be safely performed in that location.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the development of standardized emergency department (ED) descriptors that reflect a facility's level of on-site physician coverage and available services, easily discernible by the prudent layperson. (New HOD Policy)

2. That our AMA recommend that emergency care facilities without a dedicated on-site physician utilize these standardized ED descriptors to promote truth and transparency for patients. (New HOD Policy)

3. That our AMA support limiting the designations "emergency department" and "emergency room" to facilities that meet Emergency Medical Treatment and Labor Act (EMTALA) requirements and allowing any EMTALA-covered facility that meets those requirements to be classified as an emergency place of service for billing purposes, regardless of its level of on-site physician coverage. (New HOD Policy)

4. That our AMA support requiring facilities without continuous on-site physician staffing to prominently disclose, through physical and online signage, that physicians are not continuously on duty and on-site; and that our AMA support requiring advertisements for such facilities to include the same disclosure, consistent with Federal Trade Commission guidelines. (New HOD Policy)

5. That our AMA support community engagement to improve the education of patients and allow other healthcare team members to promote efficient and site appropriate care. (New HOD Policy)

6. That our AMA reaffirm Policy H-130.929, which recognizes that the AMA's preferred model of emergency care is the on-site presence of a physician in the ED whose primary duty is to provide care in that ED and supports state medical associations in developing limited appropriate rural exceptions. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-35.976, which advocates for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an ED. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-160.949, which opposes legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, encourages state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician training or appropriate physician supervision, vigorously supports and advocates for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine, and states that the AMA will continue to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician healthcare workers. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy D-130.958, which seeks federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the ED and supports all EDs be staffed 24 hours per day/7days per week by a qualified physician. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-240.958, which advocates to prohibit insurers from denying or reducing payment for a procedure based solely on the site of service in which it was performed, provided that the procedure is medically necessary and can safely be performed in that location. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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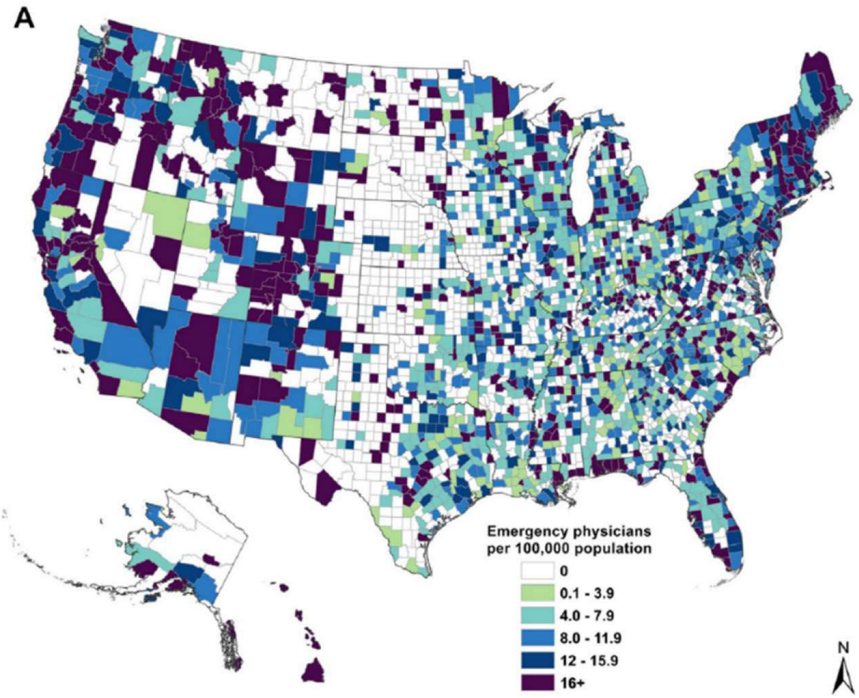
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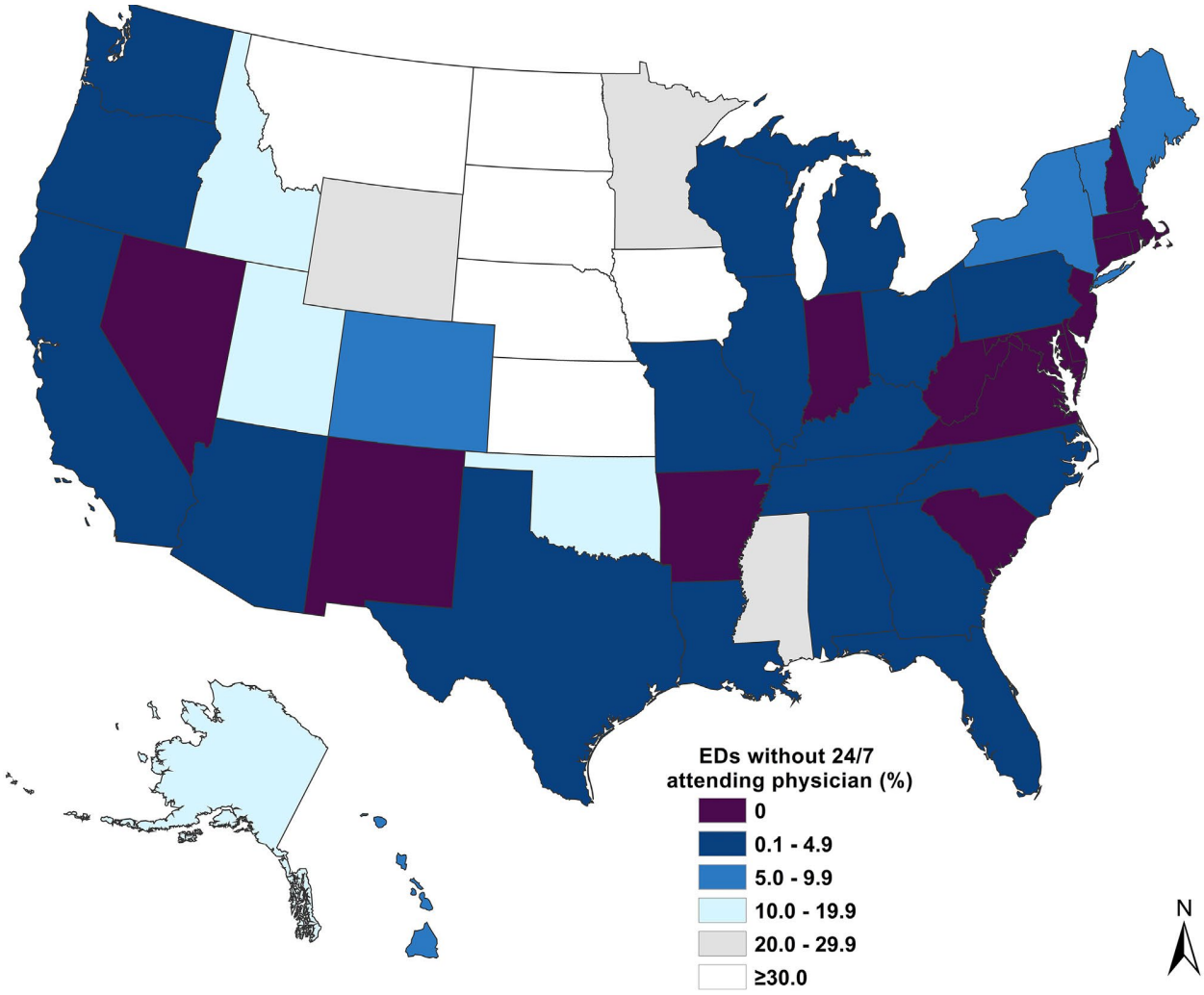
Appendix A

Density of emergency physicians across the country—emergency physicians per 100,000 population—includes physicians who are residency-trained or certified in emergency medicine and physicians trained in a nonemergency specialty. (*Supra* 47)



Appendix B

Percentage of US emergency departments without 24/7 attending physician coverage by state, 2022. (*Supra* 8)



Council on Medical Service Report 1-I-26
Transparency with the Term "Emergency Department"
Policy Appendix

On site Physician Requirements for Emergency Departments H-130.929

1. Our American Medical Association recognizes that the preferred model of emergency care is the on site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on site and on duty who is primarily responsible for the emergency department at all times the emergency department is open.
2. Our AMA, in the pursuit of any legislation or regulation requiring the on site presence of a physician who is primarily responsible for care in the emergency department (ED), supports state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on site care.

(BOT Rep. 02, I-24; Reaffirmed in lieu of: Res. 213, A-25)

Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976

Our American Medical Association will advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department.
(Res. 218, A-23; Reaffirmed in lieu of: Res. 213, A-25)

Practicing Medicine by Non-Physicians H-160.949

1. Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
2. Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
3. Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
4. Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
5. Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
6. Our AMA opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

(Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-

11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21; Reaffirmed in lieu of: Res. 213, A-25)

On site Emergency Care H-130.976
(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.
(BOT Rep. N, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17)

Scopes of Practice of Physician Extenders H-35.973
Our American Medical Association supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.
(Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: BOT Rep. 7, A-21)

Physician Assistants H-35.989
1. Our American Medical Association opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of their practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which:
    a. would unreasonably expand the professional scope of practice of the supervising physician;
    b. cannot be performed safely and effectively by the physician assistant, or
    c. would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal

presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to their physician assistant.
5. Our AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

(BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17; Reaffirmed: BOT Rep. 12, A-23; Reaffirmed: Res. 208, I-23; Modified: Speakers Rep. 02, I-24)

Physician Assistants and Nurse Practitioners H-160.947
Our American Medical Association will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

1. The physician is responsible for managing the health care of patients in all settings.
2. Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
3. The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
4. The physician is responsible for the supervision of the physician assistant in all settings.
5. The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
6. The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

7. The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
8. Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
9. The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
10. The physician is responsible for clarifying and familiarizing the physician assistant with their supervising methods and style of delegating patient care.

(BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22; Reaffirmed: CMS Rep. 09, A-23; Modified: Speakers Rep. 02, I-24; Reaffirmed in lieu of: Res. 213, A-25)

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our American Medical Association endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:

1. The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
2. The physician is responsible for managing the health care of patients in all practice settings.
3. Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
4. In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
5. The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
6. The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
7. These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
8. At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
9. Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
10. In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
11. Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

(CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: BOT Rep. 09, A-23)

Support for Physician Led, Team Based Care D-35.985

1. Our American Medical Association reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-

35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Our AMA will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Our AMA will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Our AMA will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.
5. Our AMA will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Our AMA will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Our AMA will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

(BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21)

Staffing Ratios in the Emergency Department D-130.958

1. Our American Medical Association will seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners in the Emergency Department.
2. Our AMA supports that all Emergency Departments be staffed 24-7 by a qualified physician.

(Res. 204, A-24; Reaffirmed in lieu of: Res. 213, A-25)

Urgent Care Centers H-160.888

1. Our American Medical Association supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
    a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community.
    b. UCCs must transfer a patient’s medical records to their primary care physician and to other health care providers, with the patient’s consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it.
    c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.
    d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made.
    e. UCCs should use local physicians as medical directors or supervisors and they should be clearly identified and posted.
    f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on site health care providers.

g. UCCs should be prohibited from using the word “emergency” or “ED” in their name, any of their advertisements, or to describe the type of care provided.

2. Our AMA will work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending.
3. Our AMA supports patient education including notifying patients if their physicians are providing extended hours care, including weekends, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, asking for their patients to notify their physician or usual source of care before seeking UCC services, and encouraging patients to familiarize themselves with their anticipated out-of-pocket financial responsibility for UCC services.

(CMS Rep. 6, A-21; Modified: Speakers Rep. 02, I-24)

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
The Impact of the Inflation Reduction Act on Physician Practices
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, the House of Delegates adopted Policy D-110.980, which asks that the American Medical Association (AMA) study the impact of the Inflation Reduction Act (IRA) drug price negotiation on physician-owned practices, with a focus on oncologic practices, and patient access.

The Council reviewed data related to drug pricing and payment in the United States, including the impact of drug affordability on patients and physicians. The Council discussed different drug payment models and how these models may, or may not, benefit patients and physicians. Among these payment models, the Council reviewed the commonly used Average Sales Price-based reimbursement payment model used for many physician-administered drugs, including those covered under Medicare Part B. This report highlights the challenges that this payment model can cause for physicians and physician practices, especially smaller/community-based practices, such as lagging and inadequate payments. Further, the Council reviewed information regarding updates to the IRA drug price negotiation and its initial implementation. The Council reviewed the potential impacts of these negotiated Maximum Fair Prices (MFPs) and how payment structures would change for physician practices, highlighting the potential revenue loss for practices that utilized a high number of Part B/physician-administered drugs. However, the report also outlines the uncertainty of this area as the IRA negotiated MFPs for Part D drugs have just begun to be implemented and the initial round of Part B negotiated MFPs are yet to be released. The Council highlights information on how these negotiated prices could affect physician practices, particularly in the specialties of oncology and hematology, as they are most likely to see the largest financial impact. Finally, the Council reviewed AMA advocacy efforts and existing policy which highlight the need for transparency, affordability, and fair payment for prescription drugs.

The Council firmly believes in the importance of ensuring that physician practices are able to remain financially viable, while also acknowledging that it will take time to realize the full impact of the IRA Medicare negotiated prices. The Council recommends adoption of new policy to advocate for Medicare prescription drug price negotiation and price effectuation toward ensuring that: 1) actual acquisition costs decrease in a manner commensurate with reductions in drug prices; and 2) all payments cover the cost of acquisition, storage, inventory, administration, and other necessary clinical services, highlight administrative simplicity, and are timely, affordable, and transparent for patients and physicians. The Council believes that this policy allows support for alternatives to the traditional payment models while also ensuring that the IRA negotiation does not have a negative impact on patients or physicians. Additionally, the Council recommends amendments to Policy D- 110.980 to support continued monitoring, reporting, and advocacy on Medicare drug price negotiation. Finally, the Council recommends the reaffirmation of Policy H-110.956, which works to safeguard fair and timely payment for physicians and practices for biologic/biosimilar drugs. The Council believes that the combination of the new policy, amended policy, and reaffirmed policy builds on a strong foundation to ensure not only patient access to affordable medications, but also to financially health physician-owned practices.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-26

Subject: The Impact of the Inflation Reduction Act on Physician Practices

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates adopted Policy D-110.980, "Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices," which asks that:

1. Our American Medical Association (AMA) 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.

2. Our AMA will specifically evaluate the potential impact on the sustainability of community-based physician practices, with a particular focus on oncology practices.

3. Our AMA will consider using the findings of this study 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.

This report provides an overview of drug pricing in the United States, drug payment models, and the IRA drug price negotiation provisions. Further, although the data are limited and preliminary, this report outlines potential impacts of IRA drug price negotiation on physicians, practices, and patients.

BACKGROUND

In the United States, prescription drug spending represents a major portion of overall health costs, leading to serious concern for many Americans. Prescription drug spending makes up approximately 10 percent of all national health dollars, and as much as 20 percent of spending for large employers and Medicare.[1,2] This is a major point of concern for many patients as 60 percent of adults report worrying about being able to afford prescription drugs, approximately 40 percent report rationing or skipping doses as a result of cost, and over two-thirds report that prescription drug price affordability is getting worse.[2,3] Further, this can also be a major obstacle for physician practices, especially when dealing with high-cost physician-administered drugs.

The American prescription drug pricing system is both complicated and opaque, with drug manufacturers, payers, and pharmacy benefit managers (PBMs) setting prices, and requiring physicians and patients to navigate the system.[4] Within employer sponsored plans, drug price

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negotiations are typically handled by PBMs who act as middlemen between the payer and the manufacturer, negotiating lower prices for the payers. Manufacturers often incentivize PBMs to place their drugs favorably on the formulary via rebates and discounts. Cost savings are often calculated based on a list price, which serves as the starting point for future negotiations and is commonly inflated to allow for larger rebates and/or discounts.[4] While these savings should be passed on to patients, they often are not, and as a result, patients often pay more out-of-pocket for higher-priced drugs.[4] To further exacerbate the issues around opacity and expensive drug prices, many PBMs are vertically integrated with payers and/or pharmacies, thereby enabling practices which may limit competition, often driving prices up further and limiting patient choice.[5]

DRUG PAYMENT MODELS

Under the commonly used buy-and-bill model, the purchasing entity, typically a physician office, hospital, or outpatient infusion center, will buy and store the medication, administer it to the patient, and bill the payer. The purchaser is then paid for the medication at a rate that is pre-set either by legislation with public payers or contractual agreement with private payers.[6,7] Drugs covered under Medicare Part B are typically administered in a healthcare setting and have a more complicated payment system, with the administering entity, often a physician's office, hospital, or infusion center, entering into this buy-and-bill system. In contrast to Medicare Part D drugs, which include mostly traditional, non-physician administered prescription medications, Part B drugs are typically those that require administration by a healthcare professional. These injectable/infused drugs often include chemotherapy, immunosuppressives, and certain vaccines such as influenza and COVID-19. Under Part B, reimbursement is set at the Average Sales Price (ASP) plus six percent, often referred to as ASP+6, with 20 percent cost-sharing paid by the patient. This is slightly modified for qualifying biosimilar medications in that these medications are paid at an ASP plus eight percent rate to incentivize their use over the typically more expensive reference biologic.[6,7] However, due to Medicare sequestration on Part B drugs, the actual payment rate is as low as ASP+4.3. This means that if the ASP of a medication is $100, the purchasing entity would be paid $104.30, or $106.30 if the drug is a qualifying biosimilar.

While this system seems to be straightforward, it does pose a number of distinct challenges for purchasing entities, especially smaller and community-based physician practices, as payment rate updates often lag, making them inadequate to cover actual costs. Since payment rates are updated quarterly, purchasing entities are paid based on the ASP rate from two quarters prior instead of the current rate.[8] Even when rates are updated accurately, research shows that in just over a third of cases, clinics are inadequately reimbursed.[9] Since the medications are typically administered in office settings, there are associated fixed costs such as complex drug storage, staffing, shipping, inventory management, compliance with drug compounding protocols, drug preparation, acquisition, and administration. These costs are unique to physician administered drugs and add to the typical costs associated with running a physician practice such as information technology, patient debt, prior authorization, and other administrative burdens.[10] As a result, physician practices that utilize these drugs, commonly oncology practices, struggle to remain financially viable.[6,10] Because larger health systems have more patients, the fixed cost per patient is lower which allows the ASP plus payment system to cover the costs. Further, larger health systems are often able to negotiate lower initial drug prices. However, for smaller community-based practices, the combination of the lower patient load with a less powerful negotiation position often leads to the ASP plus payment being inadequate to cover the actual costs of delivering medication therapy.[9] This system also places the financial risk on the purchasing entity instead of the pharmacy or payer as is more common with non-physician-administered drugs, such as Part D drugs.[10]
In response to criticisms of the buy-and-bill model, some experts suggest moving toward value-based payment models, which are sometimes referred to as "financial risk-based" or "outcomes-

based," but rely on associating a drug's performance with its cost.[11] For example, if a drug performs well and treats a disease effectively, the price may go up, but if a drug does not effectively treat the disease, then the price may decrease. Historically, this model has been challenging, as the collection of data faces many obstacles. While technology enables real-time patient data collection, making data more readily available, there are concerns around reliability, accessibility, operations, and data privacy that must be addressed before this pricing model can be successfully implemented.[11] These types of models are especially attractive to entities that purchase larger quantities of drugs, where contractual agreements include full or partial reimbursement to the purchaser if predetermined outcomes are not met.[11] For example, the University of Pittsburgh Medical Center (UPMC) entered a contract with AstraZeneca for the drug Brilinta, a blood thinner used to lower the risk of heart attack and stroke, in which payment depended on outcome and the health system was able to reduce the monthly cost for UPMC patients from $40 per month to just $10.[12]

Although outcomes-based payment models are relatively rare, with only a quarter of pharmaceutical executives reporting usage, reports have shown that a majority of pharmaceutical company and PBM directors seem to be open to entering into these types of models.[11] However, research suggests that while cost savings for consumers can result from these types of models, value-based drug pricing is often tied to significant price instability, which can result in less effective and/or lower long-term cost savings.[13] Further, there is often debate as to how "value" should best be defined with concerns about equity, especially for those with a disability or chronic illness. When drugs are not curative, the maximum health utility formula for patients who take it can be lessened and as a result the value of the drug can be artificially lowered.[14] Further, this type of drug pricing model may place smaller clinics and offices at a disadvantage as they may have less resources to track patient outcomes and lower bargaining power when negotiating with manufacturers.

While not applicable for all types of drugs, the so-called "mortgage" payment model could be utilized when the quantity and cost of a drug is appropriate. When a drug is extremely high cost, does not have direct competition, and is not widespread in its usage, purchasers may be able to utilize a mortgage buying model.[14,15] This model allows for the upfront costs to be spread over time and is relatively common with about half of surveyed pharmaceutical leaders reporting that they used this model at least once. Within this model the drug purchaser and drug manufacturer enter into an agreed upon payment schedule and/or financial payments when a treatment milestone is reached.[15] Proponents of this type of model argue that its implementation allows the payer to spread costs and potentially reduce downstream costs. However, critics of the mortgage model argue that it may not actually reduce any costs and that the tracking of milestones to trigger payment may place additional administrative burdens on physicians and their offices or practices.[15]

IRA NEGOTIATION

While none of these payment models are a perfect fit, research has shown that drug payment and reductions in cost are top issues for the majority of Americans. Polls show that 77 percent of Americans across political party affiliation support an increased focus on drug pricing affordability. Further, nine out of ten Americans support the need for federal legislative action to reduce the cost of drugs, with three-quarters supporting legislation limiting pharmaceutical company influence. Although many voters currently report a worsening in drug price affordability, the issue itself is not new. The IRA was enacted in 2022, and targeted a number of affordability issues, including drug pricing. The law included out-of-pocket spending caps, vaccine coverage for Medicare and/or Medicaid beneficiaries, and a requirement that if the price of a selected medication rises faster than the overall rate of inflation, the manufacturer is required to pay rebates to the Federal government.

A particularly impactful change included in the law was the allowance for the Centers for Medicare & Medicaid Services (CMS) to directly negotiate the prices of high expenditure drugs.[16] To be eligible for CMS selection for negotiation, drugs must be single source and not have a biosimilar/generic alternative. Negotiated prices are set as the Maximum Fair Price (MFP), and the medication must be available to all Medicare beneficiaries at, or below, the set MFP. Further, each year CMS is required to publish explanations of MFPs, called initial price applicability year (IPAY), which allows for greater insight to the negotiation process and what data points CMS is using.[17] IPAY summaries have been released for the first two rounds of negotiations and demonstrate that CMS seems to be relying on manufacturer-provided data, clinical evidence, and public comment to complete structured and evidence-heavy reviews.[17,18]

Currently, private payers are not required to match these prices for their beneficiaries, with experts divided on whether they will. Although some experts posit that MFPs may eventually serve as a benchmark for private payers which could lower the prices of those drugs, others advocate that the MFPs should be legislatively required to be honored by private payers as well.[19] While it will take time to see if private payers choose to incorporate Medicare negotiated MFPs, there may be some level of impact as research shows that around two percent of those with private plans are currently taking at least one of the drugs included in the initial round of negotiations.[19]

The initial list of 10 Part D drugs selected for negotiation was released in late 2023 with negotiations occurring in 2024 and the negotiated MFPs taking effect January 1, 2026. Negotiation for these 10 initial drugs resulted in an average savings of about 60 percent and largely targeted drugs that treated conditions such as diabetes, cancer, and heart diseases.[16,17] For example, Imbruvica, a drug used to treat blood cancers, saw a 38 percent reduction in cost while Januvia, a drug used to treat diabetes, heart failure, and kidney disease, saw a 79 percent cost reduction.[20] The second round of negotiations occurred in 2025 and included 15 Part D drugs, with the prices scheduled to go into effect at the start of 2027. Negotiated prices for the second round of 15 Part D drugs boasted savings as high as 85 percent for consumers.[16,17] For example, Janumet, a medication used in the treatment of Type 2 Diabetes, saw the greatest cost reduction with a negotiated price of $80 for a 30-day supply, down from a list price of $526. Further, although the smallest cost reduction was seen by the drug Calquence, which is used to treat types of blood cancer, this drug still had a cost decrease of 40 percent.[16] Notably, this round of negotiations also targeted popular GLP-1 medications Ozempic, Rybelsus, and Wegovy, resulting in a 71 percent decrease from the previous list prices.[17] The third cycle of drugs, currently being negotiated, includes for the first time Medicare Part B drugs. These prices will go into effect in January 2028 and include six drugs covered under Part B along with nine Part D covered drugs.[17] While MFPs have not been released for the drugs currently under negotiation, the first two cycles have resulted in an average cost reduction just over 60 percent. Although higher cost drugs, often those covered in Part B, have seen slightly lower cost reductions, if the current round of negotiation follows suit of the first two, selected Part B drugs may see a reduction between 40 and 60 percent. Full details on the drugs included in all rounds of negotiation can be found in Appendix A.

IMPACT OF IRA NEGOTIATION

Although the initial round of negotiated prices has only been in effect since the start of 2026, and Part B medications were not included in the first two rounds, some physicians and experts have begun to voice concerns about the potential impact of the negotiated MFP, especially on smaller/community-based physician practices. While the negotiated Part D prices are unlikely to have any major impact on physicians or practices, it is possible that the forthcoming Part B negotiated prices may.[10] For Part B drugs selected as a part of Medicare negotiation, physician payment will shift from ASP+6 to MFP+6, or 106 percent of the MFP. As a result of this shift, it is

likely that physician payment for the drugs will decrease. For example, should a drug's ASP be $1,000, the ASP+6 reimbursement for the physician would be $1,060. If the drug's negotiated MFP were to be set at the average cost reduction, 62 percent, the new price would be $380. Based on the updated physician payment model of MFP+6, the physician/practice would receive about $403. While the acquisition cost for the practice should also decrease, this drop in payment could be significantly problematic, especially for smaller community-based practices that do not have as much overhead capital to cover costs associated with elements like storage, staffing, or administration or if physician offices are required to pay the non-MFP cost for the drug upfront and be reimbursed later.[10] While these changes are only guaranteed to occur for medications selected for negotiation and only for Medicare beneficiaries, it is possible that private payers will seek to negotiate drug prices based on the publicly available IRA negotiated MFPs, potentially leading to further issues for physicians related to private payer rates.[19]

While many experts do believe that the lower negotiated MFPs will benefit physician practices that purchase the drugs as they may lead to lower costs, physicians who practice in these settings, especially smaller community-based practices, have voiced significant concern. Estimates anticipate reductions of approximately 64 percent, or as much as $19 billion, in Medicare add-on payments and an anticipated a 13-21 percent reduction in Medicare Advantage (MA) add-on payments for physicians/providers who administer negotiated oncology/hematology drugs. This means that if an oncology/hematology practice currently receives $100,000 in payment for these high-cost drugs, after the implementation, assuming the average 64 percent reduction, this could be reduced to as little as $19,000 from Medicare and MA. As previously mentioned, larger hospitals and health systems are likely better suited to be able to manage these payment and cost changes, however it is anticipated that smaller practices and/or hospitals may struggle significantly. The closures of these community clinics, hospitals, or physician practices are likely to exacerbate health disparities and create or expand care deserts for patients.[10]

Although the impacts of these negotiations on patients have yet to be seen, some experts believe that the negotiations have the potential to save patients money and may improve coverage. Some research has begun to show, however, that patient out-of-pocket (OOP) savings are marginal, if they are present at all. Differences in Part D plans will likely impact how much, or if, patients save money. Beneficiaries whose OOP cost is a set copayment will likely not save money, or not as much money, as beneficiaries whose OOP costs are calculated as a percentage of the cost.[21] While the Medicare plan would save money by paying the MFP instead of the non-negotiated price, the savings may not reach the patient. Further, since the IRA MFP prices are only required to be honored for Medicare beneficiaries, it is unknown if these prices would carry over to those with other forms of health insurance. Should payers choose to continue to use non-negotiated prices, it is possible that beneficiaries of non-Medicare plans may see no net benefit to the IRA negotiated prices. However, it is also possible that public payers will choose to rely on the negotiated MFPs, which could result in significant cost savings for both companies and patients. While initial research does support this prediction that patients may have reduced OOP spending, the full impact of the IRA on patient costs has yet to be seen as only 10 drug MFPs have been implemented. Further, since the IRA requires Part D plans to cover all the drugs selected for negotiation, preliminary results suggest that coverage has improved among Part D plans.

While some findings anticipate improvements for patients, others voice substantial concern regarding the potential for unintended consequences. Research shows that overall pharmaceutical gross margins have decreased as a result of the IRA negotiations. Since these funds are the primary source of funding for research and development (R&D), some studies have shown a link between decreases in gross margins and overall innovation, with one study projecting internal rates of return on negotiated drugs dropping between three and five percent. While this may not seem like a

substantial decrease, the authors argue that over the long-term drug companies may redirect funding away from R&D for products that are more likely be negotiated, potentially limiting innovation in this area.[22] However, since these reductions in internal revenue are still relatively small, there is no guarantee that R&D will be limited in practice given that experts posit that there is not a direct correlation between successful innovation and R&D dollars.[23] Further, there is concern that payers and/or PBMs may increase utilization management as a method to control costs and maintain formularies.[24] This could result in not only delays in patient access, but also to increased cost and time for physicians to combat the utilization management.

AMA POLICY AND ADVOCACY

The AMA has a relatively large body of policy related to ensuring that prescription medications are available and accessible to patients in a manner that is economically sustainable for physician practices. Policies H-110.980 and H-110.987 outline efforts to ensure that medications are affordable for patients through process transparency, limits on patents, legislative/regulatory changes, and limits on anticompetitive practices. Policy H-110.980 also ensures that price indexes should be multifaceted and ensure for patient access and limited burdens on physician practices. Policy H-110.956 works to ensure that payment to physician practices for biosimilars and biologic drugs is fair and timely. Policies D-110.987, D-120.988, and D-120.934 target PBM practices that negatively impact patients and physicians. Finally, Policy D-110.987 supports active PBM regulation and efforts to ensure transparency throughout PBMs and their coverage determinations.

To address Medicare drug price negotiation specifically, Policy D-330.954 indicates AMA support for federal legislation that allows the Department of Health and Human Services to negotiate contractual agreements with manufacturers for covered Part D medications. This policy also supports the elimination of Medicare prohibition on drug price negotiation, which was accomplished by the IRA, and directs the AMA to prioritize support for CMS negotiation of all applicable and covered medications. Policy D-110.980, the motivating policy for this report, outlines the need for study of the IRA negotiation on physician practices in order to guide future advocacy efforts.

The AMA also has pursued robust advocacy efforts to lower drug costs and ensure payment to physicians is reasonable. The AMA has an ongoing grassroots campaign, TruthinRx, designed to support patients and physicians in understanding and fighting the lack of transparency and subsequent high drug prices. In addition to this campaign, the AMA has continually supported PBM and drug pricing reform to legislators as well as provided guidance regarding regulation of drug pricing in Medicare to both CMS and the Department of Health and Human Services. The AMA has provided testimony to the House of Representatives Energy and Commerce Subcommittee on Health and Ways and Means Subcommittee on Health related to lowering health care pricing for Americans. Finally, the AMA has voiced concern to Congress and CMS related to issues surrounding physician drug reimbursement and the need for improvement to payment rates.

DISCUSSION

The cost of prescription medications, especially those administered in-office, is a major issue in American healthcare and one that the IRA was designed in part to address. The opacity of the current drug pricing system, paired with increasing drug prices, has further complicated the issue. Historically, a combination of PBMs, payers, and drug manufactures have negotiated the price of prescription drugs. However, with passage of the IRA and its Medicare drug price negotiation, this system now also includes the federal government. The IRA allows for CMS to negotiate with drug manufacturers to set an MFP for each of the selected drugs. In 2024, this included 10 Part D drugs,

in 2025 negotiations included 15 Part D drugs, and in 2026 includes six Part B drugs. Since the negotiated prices have not been released, it is still to be seen if Part B drugs see similar price reductions to the previously negotiated Part D drugs.

Currently, Part B drugs are paid based on a "buy-and-bill" model, meaning the purchasing entity buys and administers the drug and then is later paid for the cost. For Medicare, the payment rate for these physician-administered medications is ASP+6, or ASP+8 for some biosimilars. However, after sequestration, these payment rates can be as low as ASP+4.3. This payment system can be particularly problematic for smaller physician-owned/community practices as the payment rates do not cover the full cost of necessary fixed costs like staffing, administration, and procurement. While the aforementioned reductions in cost from the IRA may help in reducing patient costs, there is significant concern that practices, patient access, and/or drug innovation may be negatively impacted.

When the IRA negotiated Part B drug MFPs go into effect, the payment system will transition from ASP+6 to MFP+6. Estimates suggest that this could have significant impacts on the payments made to practices, especially those that administer the oncology/hematology drugs included in the negotiation schedule. While the cost of purchasing the drug should decrease, the aforementioned fixed costs for these practices may not dissipate at the same rate. Since payment is calculated as a percentage of MFP, the cushion designed to cover fixed costs will decrease at a rate that may not be sustainable for practices. While larger hospitals and health systems may be able to cover these costs and often face lower fixed costs due to higher patient volume, smaller community based/physician-owned practices are less likely to be able to. Experts voice concern that this change in payment may result in the closure of these smaller practices which would have detrimental impacts on patient access.

Due to the recency of its implementation, the full impact of the IRA Medicare drug price negotiation has yet to be seen; however, some initial steps can be taken now to maintain physician practice viability and patient access. In order to ensure that physician practices are able to acquire medications needed for patients, it will be essential to ensure that any drug price negotiation, and related price caps, should be set and implemented in a manner that does not require physicians or practices to "front" the related costs. Supporting alternatives to the traditional buy-and-bill model that ensures payment covers all associated costs, including acquisition, inventory, storage, administration, and associated clinical services, while also maintaining administrative simplicity and patient access and affordability will be essential. As the IRA Medicare negotiation MFPs are put into place the full impact will become clearer and additional, more specific action steps may be identifiable, thus ongoing monitoring is also important.

To address these potential concerns, the Council recommends the adoption of new policy that will ensure practice viability, administrative simplicity, timely access, transparency for negotiated drug prices, and that decreases in price are commiserate with acquisition cost. The Council notes that this policy advocates for adequate payment based on actual acquisition cost, and thus physicians/physician practices would be protected during a transition period between ASP and MFP calculated reimbursements. Further, the Council recommends amendments to Policy D-110.980 to reflect the completion of this report as well as ensure continued monitoring of this issue. The amendments also retain the portion of the policy that ensure advocacy efforts will balance sustainability of practices and drug innovation with patient access and affordability, and guarantee that the policy is applicable to any Medicare drug price negotiation, not just the negotiation related to the IRA specifically. Finally, to work to secure fair and timely physician payment the Council recommends the reaffirmation of Policy H-110.956 which focuses on fair and timely biosimilar and biologic drug payment.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate that Medicare prescription drug price negotiation and associated maximum fair price effectuation, for all Medicare-covered drugs, are implemented in a manner that minimizes financial risk and cash-flow burdens for physicians or community practices to front costs and supports the following:
   a. Practices' actual acquisition costs decrease commensurate with reductions in drug prices;
   b. Any drug payment covers the cost of acquisition, storage, inventory, drug administration, and any other necessary related clinical service(s);
   c. Administrative simplicity for physicians and their practices;
   d. Timely and affordable patient access to medications prescribed by their physician; and
   e. Drug price transparency for patients, physicians, and non-physician providers (New HOD Policy)

2. That our AMA amend Policy D-110.980 to read as follows:

   ~~Study on~~ Impact of ~~Inflation Reduction Act~~ Medicare Drug Price Negotiation on ~~Oncology, Other~~ Physician-Owned Practices

   ~~1. 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.~~

   ~~2.~~ 1. Our AMA will ~~specifically evaluate the potential~~ continue to monitor and, when relevant, report on the impact of ~~the Inflation Reduction Act~~ Medicare drug price negotiation on the sustainability of community-based physician practices~~, with a particular focus on oncology practices~~.

   ~~3.~~ 2. Our AMA encourages ~~will consider using the findings of the study on the impact of the Inflation Reduction Act (IRA) drug price negotiation provisions on the sustainability of community based practices to inform its advocacy efforts to ensure that~~ any future drug pricing policies to balance patient affordability and access, with the stability of physician practices~~, patient access,~~ and the continued advancement of drug innovation. (Modify Current HOD Policy)

3. That our AMA reaffirm policy H-110.956 which ensures fair and timely payment for physicians and physician practices for biologic and biosimilar drugs. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Policy Appendix

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our American Medical Association will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:

a. The arbitration process should be overseen by objective, independent entities.

b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel.

c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process.

d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question.

e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision.

f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer.

g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases.

h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision.

i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation.

b. The use of any international drug price index or average should preserve patient access to necessary medications.

c. The use of any international drug price index or average should limit burdens on physician practices.

d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.

3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22)

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.

3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

7. Our AMA supports legislation to shorten the exclusivity period for biologics.

8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing

pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports:
a. drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase;
b. legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and
c. the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
(CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmed: Res. 801, I-23; Reaffirmed: Res. 801, I-23; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 06, A-25)

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- Utilization information;
- Rebate and discount information;
- Financial incentive information;
- Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
(CMS Rep. 05, A-19Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: CSAPH Rep. 02, I-24; Reaffirmed: CMS Rep. 06, A-25; Reaffirmed: CMS Rep. 04, I-25)

Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers D-120.988
Our AMA, in cooperation with pharmacy benefit managers, pharmacy companies, and other drug retailing organizations, shall develop model procedures that physicians may use when prescribing off-formulary pharmaceuticals that are medically indicated and that these procedures be in compliance with the Health Insurance and Portability and Accountability Act of 1996. (Res. 528, A-02; Reaffirmation I-04; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care D-120.934
1. Our American Medical Association will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination. (Res. 233, I-17; Reaffirmed: CMS Rep. 05, A-23)

Prescription Drug Prices and Medicare D-330.954
1. Our American Medical Association will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS. (Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22; Reaffirmed in lieu of: Res. 810, I-22)

Study on Impact of Inflation Reduction Act on Oncology, Other Physician Practices D-110.980
1. 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.
2. 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.
3. Our AMA will consider using the findings of the study on the impact of the Inflation Reduction Act (IRA) drug price negotiation 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. (Res. 234, I-25)

Payment for Biosimilars H-110.956
1. Our American Medical Association supports the revision of the Average Sales Price (ASP) calculation of biologic/biosimilar drugs to more accurately represent the cost of drugs for the physician practice.
2. Our AMA encourages public and private payers to implement comprehensive payment structures that allow for fair and timely payment for biologic/biosimilar drugs that:
a. Maintain patient access to biologic/biosimilar drugs prescribed by their physician consistent with AMA Policy H-100.940;
b. Account for physician/practice administrative and acquisition costs, including but not limited to, obtaining, storing, and administering the drug through a payment rate that covers these costs;
c. Incentivize the use of biosimilars when safe, clinically appropriate, and agreed upon by the patient and physician; and
d. Ensure that patient out-of-pocket costs are affordable. (CMS Rep. 04, I-25)

Appendix A
Medicare Negotiation Drugs

Drug Name	Manufacturer	Common Uses	Negotiated MFP	List Price	Percent Discount	Start Date
Januvia	Merck & Co., Inc.	Type 2 Diabetes	$113	$527	79%	2026
NovoLog/ Fiasp	Novo Nordisk	Diabetes	$119	$495	76%	2026
Farxiga	AstraZeneca	Type 2 Diabetes, Heart Failure Chronic Kidney Disease	$178	$556	68%	2026
Enbrel	Amgen Inc.	Rheumatoid & Psoriatic Arthritis, Plaque Psoriasis, Ankylosing Spondylitis	$2,355	$7,106	67%	2026
Jardiance	Boehringer Ingelheim & Eli Lilly	Type 2 Diabetes, Heart Failure Chronic Kidney Disease	$197	$573	66%	2026
Stelara	Janssen Biotech Inc.	Plaque Psoriasis, Psoriatic Arthritis, Chron's Disease, Ulcerative Colitis	$4,695	$13,836	66%	2026
Xarelto	Bayer and Johnson & Johnson's Janssen	Blood Clots (DVT, PE, and AFib stroke prevention)	$197	$517	62%	2026
Eliquis	Bristol Myers Squibb & Pfizer	Blood Clots (DVT, PE, and AFib stroke prevention)	$231	$521	56%	2026
Entresto	Novartis Pharmaceuticals	Heart Failure	$295	$628	53%	2026
Imbruvica	Pharmacyclics LLC & Janssen Biotech Inc.	Blood Cancers and Autoimmune Conditions (CLL, SLL, WM, cGVHD)	$9,319	$14,934	38%	2026
Ozempic, Rybelsus, Wegovy	Novo Nordisk Inc.	Type 2 diabetes, Cardiovascular disease and obesity/ overweight	$274	$959	71%	2027
Trelegy Ellipta	GlaxoSmithKline Intellectual Property Development Ltd.	Asthma; Chronic obstructive pulmonary disease	$175	$654	73%	2027
Xtandi	Astellas Pharma US, Inc.	Prostate Cancer	$7,004	$13,480	48%	2027
Pomalyst	Bristol-Myers Squibb Company	Kaposi sarcoma; Multiple myeloma	$8,650	$21,744	60%	2027
Ofev	Boehringer Ingelheim Pharmaceuticals	Idiopathic pulmonary fibrosis	$6,350	$12,622	50%	2027
Ibrance	Pfizer	Breast Cancer	$7,871	$15,741	50%	2027
Linzess	AbbVie	Chronic idiopathic constipation; Irritable bowel syndrome	$136	$539	75%	2027
Calquence	AstraZeneca UK Limited	Chronic lymphocytic leukemia/small lymphocytic lymphoma; Mantle cell lymphoma	$8,600	$14,228	40%	2027
Austedo; XR	Teva Branded Pharmaceutical Products R&D LLC	Chorea in Huntington's disease; Tardive dyskinesia	$4,093	$6,623	38%	2027

Drug Name	Manufacturer	Common Uses	Negotiated MFP	List Price	Percent Discount	Start Date
Breo Ellipta	GlaxoSmithKline Intellectual Property Development Ltd.	Asthma; Chronic obstructive pulmonary disease	$67	$397	83%	2027
Xifaxan	Salix Pharmaceuticals Inc	Hepatic encephalopathy; irritable bowel syndrome	$1,000	$2,696	63%	2027
Vraylar	AbbVie	Bipolar I; Major depressive disorder; Schizophrenia	$770	$1.376	44%	2027
Tradjenta	Boehringer Ingelheim Pharmaceuticals	Type 2 Diabetes	$78	$488	84%	2027
Janumet; XR	Merck Sharp & Dohme LLC	Type 2 Diabetes	$80	$526	85%	2027
Otezla; Otezla XR	Amgen	Oral ulcers in Behçet's Disease; Plaque psoriasis; Psoriatic arthritis	$1,650	$4,722	65%	2027
Trulicity	Amgen	Type 2 diabetes; cardiovascular disease	*Currently under negotiation*			2028
Biktarvy	Gilead Sciences	HIV type 1 infection	*Currently under negotiation*			2028
Orencia*	Bristol Myers Squibb	Psoriatic & Rheumatoid arthritis;	*Currently under negotiation*			2028
Cosentyx*	Novartis	Plaque psoriasis; Psoriatic arthritis	*Currently under negotiation*			2028
Erleada	Janssen Biotech Inc. (Johnson & Johnson)	Prostate Cancer	*Currently under negotiation*			2028
Kisqali	Novartis	Breast Cancer	*Currently under negotiation*			2028
Entyvio*	Takeda Pharmaceutical Company Limited	Chron's Disease, Ulcerative Colitis	*Currently under negotiation*			2028
Verzenio	Eli Lilly	Breast Cancer	*Currently under negotiation*			2028
Botox*	Allergan Aesthetics (AbbVie)	Chronic migraine; Overactive bladder; Spasticity; movement disorders	*Currently under negotiation*			2028
Lenvima	Eisai Co. and Merck & Co	Thyroid cancer; Endometrial cancer; Liver cancer; Kidney cancer	*Currently under negotiation*			2028
Xolair*	Genentech & Novartis Pharmaceuticals	Asthma; Chronic spontaneous urticaria	*Currently under negotiation*			2028
Rexulti	Otsuka Pharmaceutical and Lundbeck	Major depressive disorder; Schizophrenia; Agitation associated with dementia due to Alzheimer's disease	*Currently under negotiation*			2028
Xeljanz; Xeljanz XR	Pfizer	Psoriatic arthritis; Rheumatoid arthritis; Ulcerative colitis	*Currently under negotiation*			2028
Anoro Ellipta	GlaxoSmithKline	Chronic obstructive pulmonary disease	*Currently under negotiation*			2028
Cimzia*	UCB, Inc. (Union Chimique Belge)	Crohn's disease; Plaque psoriasis; Psoriatic & Rheumatoid arthritis;	*Currently under negotiation*			2028

List price is based on the previous calendar year's price | Start date begins on the first day of the year
**Indicates the medication may be covered under Medicare Part B (all other medications covered under Medicare Part D)*

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-26

Subject: Non-Medical Switching of Prescription Drugs

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates adopted Policy H-125.971, "Non-Medical Switching," which states:

1. Our American Medical Association (AMA) opposes the practice of non-medical switching by pharmacy benefit managers (PBMs) and health insurers, except when clinically justified and approved by the prescribing physician.

2. Our AMA 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.

This report provides an overview of non-medical switching of prescription drugs and its impact on patients, physicians, and the healthcare system overall; related AMA policies; and offers recommendations to amend and reaffirm AMA policy.

BACKGROUND

While there are valid medical reasons for a medication to be changed, such as treatment efficacy and adherence or if a patient is experiencing concerning side effects, these choices should be made collaboratively between the patient and physician, not by insurance companies or PBMs. When a drug is switched for reasons outside of medical necessity, often driven by payment or coverage changes, it is referred to as non-medical switching.[1] Typically, payers and PBMs force these switches in order to reduce their own costs.[1] Non-medical switches are generally done through direct changes in drug formularies, the negotiated list of covered drugs, or coverage structures and driven either by the PBM, payer, or a combination of each entity. However, on occasion, switches can be strongly encouraged or forced on patients through pharmacy changes or limitations imposed by patient assistance programs.[2,3] While similar, non-medical switching is distinct from a change from a brand name drug to its biosimilar/generic drug. Non-medical switching occurs when the payer or PBM requires that the patient switch to a different drug altogether instead of a generic, but identical, version.[1]

Estimates show that non-medical switching is a relatively frequent occurrence, with over 50 percent of physicians reporting their patients experienced it on a regular basis. Surveyed psychiatrists reported that over 60 percent of their patients prescribed psychoactive medications experienced non-medical switching "frequently or very frequently."[4] Further, physicians practicing in specialties that utilize higher cost drugs, such as dermatology, oncology, rheumatology, and cardiology, reported as many as 80 percent of patients prescribed certain classes of drugs experienced frequent non-medical switching.[4] As an example, in 2025 anti-obesity medication

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(AOM) tirzepatide Zepbound was replaced on CVS Caremark's formulary with AOM semaglutide Wegovy, resulting in approximately nine percent of all patients prescribed Zepbound switched from that medication.[5] This illustrates the impact that these switches can have not only on individual patients, but also on the overall prescription drug landscape.

IMPACTS OF NON-MEDICAL SWITCHING

While the most frequent justification for non-medical switching is cost reduction, research suggests that in the majority of cases, the switch ends up costing more. As biologics and other expensive specialty drugs are a frequent target for non-medical switching, payers and PBMs force patients to switch from the more expensive drug to a less expensive alternative, potentially saving the payer up to 90 percent.[6] Yet these savings are often not seen by the patient and if savings are passed on to the patient, savings are much less than the amount seen by payers or PBMs.[6] Research also shows that in the long-term these savings are not maintained,[6] with over 86 percent of patients reporting higher out-of-pocket spending for the medication they were switched to compared to the original medication.[7] Compared to patients whose medication was not non-medically switched, patients who experienced non-medical switching had significantly higher total costs, resulting in an average increase in spending of about $4,500 per person.[6,8] These costs largely stem from greater utilization of the healthcare system after the switch.[9] Research has shown that non-medically switched patients have higher rates of surgery, hospitalization, emergency department visits, and medication intake either through dose escalation or the addition of other medications after a non-medical switch occurs.[9,10] Further, these negative impacts can have disproportionate consequences for those in minority communities as barriers to care, such as economic inequalities and systemic biases, compound the issues related directly to non-medical switching.[11]

Beyond the potential for increased costs and health system utilization, patients often face significant negative consequences to their health and well-being from non-medical switching. Nearly 40 percent of patients report that the medication they were switched to was less effective and with more disruptive side effects than the medication they were previously taking.[12] Further, over half of patients reported medical complications as a result of the new medication.[12,13] Of those patients reporting adverse impacts of the new medication, over half reported impacts on work and regular hobbies/activities, with about 40 percent also reporting impacts on their ability to provide care for children or other family members.[12] As a result of higher cost and poorer outcomes, patients often abandon treatment plans, which regularly leads to detrimental impacts on the patient's health.[12,14] Beyond physical health, patients report significant decreases in their overall mental health and well-being. After experiencing a non-medical switch, a majority of patients reported experiencing significantly higher levels of frustration, confusion, anxiety, and depression as well as a lower quality of life.[10,12,14]

Not only does non-medical switching cost more and harm patients, but research suggests that non-medical switching may adversely impact the patient-physician relationship. While patients reported that they eventually felt aligned with their physician in fighting the switch, a majority reported initial negative feelings that had an undermining effect on the patient-physician relationship.[12] Further, physicians consistently report that non-medical switching is a significant administrative burden to their practice, as it requires additional time and effort to find new, effective medication for the patient. Physicians reported significant increases in non-visit patient interactions, staffing needs, and contact with payers/PBMs and pharmacies after a non-medical switch.[12,15] Many physicians report increases in job stress related to non-medical switching as a result of ethical concerns and being forced to take responsibility for the decision of the payer/PBM. Physicians also report significant increases in stress and frustration, especially related to a lack of practice autonomy and poorer patient health outcomes.[12,15]

LEGISLATIVE ACTIVITY

Advocates suggest that a federal non-medical switching law could be a factor in ensuring long-term prescription drug affordability for patients.[16] At a basic level, advocates suggest that legislation preventing non-medical switching should include assurances that patients will continue to be able to access a medication that is prescribed by their physician/non-physician provider for at least the duration of the plan's coverage as plans are typically reevaluated at renewal.[16] Further, it is argued that such legislation should be distinct from anti-step therapy legislation as the two issues are distinct. Non-medical switching occurs *after* a patient has a stable medication routine, whereas step therapy typically occurs *while* a patient is attempting to establish a medication routine.[16]

While there has been no federal legislation successfully passed to prevent non-medical switching, 18 states have enacted some type of legislative protection against non-medical switching. Of these states, 12 have laws that prohibit all non-medical switching and six have laws that prohibit non-medical switching provided the prescriber can demonstrate the switch is likely to be harmful or an ineffective treatment.[17,18] Illinois law requires that payers provide 60-day notice of any formulary change to patients and provide a clear exception process. Further, if the prescribing physicians or non-physician providers provide a certification that the prescribed medication is medically necessary, the payer must cover it without any cost change to the patient through the remainder of the plan year.[19] Similarly, Texas law has established specific guidelines that require formulary changes to occur only at plan renewal and ensures that if a drug was covered, the patient will continue to be able to access coverage through the term of their plan year and requires allowance for physician appeal of any change in coverage if medically necessary.[20] It is important to note that application of such state laws to self-funded/employer-sponsored health plans varies, meaning that in some cases legal protections may not extend to beneficiaries of these plans.

AMA POLICY AND ADVOCACY

The AMA has a robust body of policy designed to ensure that patients are able to receive the medication prescribed by their physician without interference from payers, pharmacies, or PBMs. Policy H-125.971 details AMA opposition to non-medical switching, unless the switch is approved by the prescribing physician and clinically justified. Policy H-125.995, states AMA opposition to any changes by pharmacies/pharmacists to medications and outlines advocacy efforts to ensure that physician prescriptions cannot be substituted without physician approval. Policies H-115.974 and H-120.918 outline AMA support for the development and implementation of guidelines that detail the physician's ability to ensure that a prescription be dispensed exactly as written. Similarly, Policy D-120.923 outlines AMA advocacy to ensure that physicians are notified of any changes to a prescription and the origin of the change. To address biosimilar substitution, Policy D-125.989 outlines advocacy to ensure that any switches from biologic to biosimilar drugs will be done with express authorization of the physician and agreement of the patient. Further, Policy H-125.991 works to ensure that formularies meet a basic standard and that substitutions are not made without physician and patient approval. Finally, Policy D-125.992 outlines AMA opposition to administrative burden in prescription medication prior authorization and urges payers to minimize its usage.

The AMA Advocacy Resource Center (ARC) has worked extensively to prevent pharmacy interference in prescribing and altering drugs when dispensing. Additionally, to fight opaque practices in drug pricing, the AMA has developed a grassroots campaign, Truth in Rx. This campaign advocates for drug pricing transparency through public education and grassroots advocacy to legislators and regulators. Additionally, the AMA has submitted several comment letters and provided testimony on the importance of maintaining physician autonomy in prescribing

and increased transparency in drug pricing and formulary creation. Finally, the AMA has advocated to regulators, legislators, and payers, to urge patient access to the prescribed medication and support increased transparency in drug pricing and PBM practices.

DISCUSSION

Non-medical switching occurs when a medication is switched, often by a payer or PBM decision, without medical justification. Although these changes are common and typically done to save money, the savings generally begin and end with the payer and/or PBM. Not only do patients not share in the savings, but research also suggests they may actually end up paying more in out-of-pocket expenses for the new drug. Patients are more likely to experience adverse health events, such as side effects, hospitalization, or surgery, and report poorer mental health and quality of life after a non-medical switch occurs. Further, patients report that the switch may harm their relationship with their physician as patients are commonly confused as to the source of the switch. Additionally, physicians report significant increases in administrative burden and increases in stress and frustration after a patient's non-medical switch.

Currently, legislation to limit non-medical switching has been enacted in a number of states, but there is no federal restriction on the practice. Since the AMA has strong policy opposing the practice of non-medical switching, the Council recommends three amendments to strengthen and update the policy. First, the Council recommends the removal of the second clause of Policy H-125.971 as it is completed by this report. Second, it is recommended that a new second clause be added that outlines AMA advocacy to ensure that payers and PBMs honor coverage and prior authorization determinations through the duration of the most recent prior authorization approval. This will work to ensure that payers and PBMs cannot force a switch through extra utilization management requirements in order to skirt non-medical switching prohibitions. Third, the Council recommends a new third clause to advocate for payers to continue coverage for a medication while internal and external appeals processes are being adjudicated, thus ensuring patients are not left without their medication due to insurance company procedures. Finally, to ensure that physicians are not met with undue administrative burdens around prescription drug prior authorization, the Council recommends the reaffirmation of Policy D-125.992 which opposes prescription drug prior authorization and advocates for reduced administrative burdens for physicians.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association amend Policy H-125.971, "Non-Medical Switching," to read as follows:

    1. Our AMA opposes the practice of non-medical switching by pharmacy benefit managers and health insurers, except when clinically justified and approved by the prescribing physician.

    ~~2. Our AMA will 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.~~

    2. Our AMA advocate that all payers and pharmacy benefit managers honor coverage and prior authorization determinations for a prescription drug through the term determined in the most recent prior authorization approval or the plan year, whichever is longer.

3. Our AMA advocate that coverage be continued for a medication that is to be switched until all appeals regarding the prescription are adjudicated. (Modify Current HOD Policy)

2. That our AMA reaffirm Policy D-125.992, which outlines opposition to administrative burden in prescription medication prior authorization. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 3-I-26
Non-Medical Switching of Prescription Drugs
Policy Appendix

Non-Medical Switching H-125.971

1. 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.
2. Our AMA will 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. (Res. 811, I-25)

Opposition to Prescription Prior Approval D-125.992

Our American Medical Association will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed: CMS Rep. 1, A-21; Reaffirmation: A-22)

Therapeutic and Pharmaceutical Alternatives by Pharmacists H-125.995

The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to: (1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and (2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution). Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that treating physician's directions cannot be overruled or substituted without prior physician approval. (Res. 89, I-85; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CLRPD Rep. 2, I-95; Appended by Res. 501, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18)

Prescription Labeling H-115.974

1. Our American Medical Association recommends that when a physician desires to prescribe a brand name drug product, they do so by designating the brand name drug product and the phrase “Do Not Substitute” (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, they do so by designating the USAN-assigned generic name of the drug on the prescription.
2. Our AMA recommends that, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.
3. Our AMA recommends that when generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute [“branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]”.
4. Our AMA recommends that when a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug

manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed. (BOT Rep. 1, A-95; Amended: CSA Rep. 2, I-99; Modified Res. 512, I-00; Reaffirmed: CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmed: Sub. Res. 509, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Reaffirmation: A-19; Modified: Speakers Rep. 02, I-24)

Prescription Drug Dispensing Policies H-120.918

1. Our American Medical Association supports the development and implementation of clear guidelines and mechanisms to indicate that the quantity of a prescription should be dispensed only as written using such language as "dispense quantity as written" or "no change in quantity;".
2. Our AMA supports the development, implementation and/or use of electronic or other means of communication to provide cost and coverage information of various prescribing quantities at the point of care allowing physicians to make the best decisions with their patients regarding prescribed medication quantities. (CMS Rep. 05, A-23)

Automatic Pharmacy-Generated Prescription Requests D-120.923

Our American Medical Association advocates that pharmacy-generated requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify whether these requests are generated by the patient or patient's surrogates, or automatically by the pharmacy. (Res. 706, A-24)

Substitution of Biosimilar Medicines and Related Medical Products D-125.989

Our American Medical Association urges that State Pharmacy Practice Acts and substitution practices for biosimilars in the outpatient arena:

1. Preserve physician autonomy to designate which biologic or biosimilar product is dispensed to their patients;
2. Allow substitution when physicians expressly authorize substitution of a biologic or biosimilar product; and
3. In the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when;

a. the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and
b. there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product; and (c) the prescribing physician has been adequately notified by the pharmacist. (Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14; Modified: CSAPH Rep. 05, A-24; Reaffirmed: CMS Rep. 04, I-24)

Drug Formularies and Therapeutic Interchange H-125.991

It is the policy of the AMA:
(1) That the following terms be defined as indicated:
(a) Formulary: a compilation of drugs or drug products in a drug inventory list; open (unrestricted) formularies place no limits on which drugs are included whereas closed (restrictive) formularies allow only certain drugs on the list;
(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy and therapeutics committee, evaluates, appraises, and selects from among the numerous available drug entities and drug products those that are considered most useful in patient care;
(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication and liaison between the medical staff and the pharmacy department; its recommendations are subject to medical staff approval;
(d) Therapeutic alternates: drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses;
(e) Therapeutic interchange: authorized exchange of therapeutic alternates in accordance with previously

established and approved written guidelines or protocols within a formulary system; and
(f) Therapeutic substitution: the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.
(2) That our AMA reaffirms its opposition to therapeutic substitution (dispensing a therapeutic alternate without prior authorization) in any patient care setting.
(3) That drug formulary systems, including the practice of therapeutic interchange, are acceptable in inpatient hospital and other institutional settings that have an organized medical staff and a functioning Pharmacy and Therapeutics (P&T) Committee, provided they satisfy the following standards:
(a) The formulary system must:
(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods and criteria for the selection and objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval and dissemination of the drug formulary and for continuous and comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, and safe use of formulary and non-formulary drug products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards and clinical outcomes where substitution has occurred, and to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, and other professionals to carry out these activities;
(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, and that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, and whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary drug products that are medically necessary; and
(x) be in compliance with applicable state and federal statutes and/or state medical board requirements.
(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness and cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);
(ii) recommend for the formulary those drug products which are the most useful and cost-effective in patient care;
(iii) conduct drug utilization review (DUR) activities;
(iv) provide pharmaceutical information and education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of drug therapy;
(vi) make recommendations to ensure safe drug use and storage; and
(vii) provide protocols for the timely procurement of non-formulary drug products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.
(c) The P&T Committee's recommendations must be approved by the medical staff;
(d) Within the drug formulary system, the P & T Committee shall recommend, and the medical staff must approve, all drugs that are subject to therapeutic interchange, as well as all processes or protocols for informing individual prescribing physicians; and
(e) The act of providing a therapeutic alternate that has not been recommended by the P&T Committee and approved by the medical staff is considered unauthorized therapeutic substitution and requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.
(4) That drug formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, and must meet standards comparable to those listed above. In addition
(a) That our AMA continues to insist that managed care and other health plans identify participating physicians as their “medical staff” and that they use such staff to oversee and approve plan formularies, as well as to oversee and participate on properly elected P&T Committees that develop and maintain plan formularies;

(b) That our AMA continues to insist that managed care and other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, and that it include access to a formal appeals process for physicians and their patients; and
(c) That our AMA strongly recommends that the switching of therapeutic alternates in patients with chronic diseases who are stabilized on a drug therapy regimen be discouraged.
(5) That our AMA encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients so they cannot afford necessary drug therapies. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20)

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Determining Fair Market Value when Contracting with Physician Practices
(Reference Committee J)

EXECUTIVE SUMMARY

This report was self-initiated by the Council on Medical Service to address the need for further policy guidelines for physicians, especially independent physicians, in determining fair market value (FMV) under the Physician Self-Referral law, otherwise known as the Stark law, when contracting with a hospital or health system. The report examines the Stark law and its exceptions, various data sources for determining FMV, and the impact the law has on physician practices.

The Stark law was originally enacted in 1989 and applied only to physician referrals for clinical laboratory services. It has since undergone several revisions and expansions. As currently written, the law prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

Designated health services include: clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

Some of the most common Stark law exceptions include In-office Ancillary Services, Personal Service Arrangements, Fair Market Value Compensation, Group Practice Compensation Methods, and the Professional Courtesy Exception.

Burdensome regulatory and administrative requirements, including those associated with the Stark law, are some of the drivers that are leading independent physician practices to being sold to hospitals, health systems, and private equity companies which increases consolidation in already consolidated markets. Employment preferences vary across the profession, and while employment by a hospital system or a hospital-owned practice are attractive options to some, it is also important to maintain the sustainability of independent practice. In order to reduce administrative burden related to Stark law compliance, this report highlights several ways physician practices can mitigate risk and ensure compliance.

The Council offers a series of recommendations to empower physicians during contract negotiations and encourage transparency in FMV compensation calculations.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-26

Subject: Determining Fair Market Value when Contracting with Physician Practices

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

The Physician Self-Referral law, otherwise known as the Stark law (42 U.S.C. §1395nn), prohibits physicians from referring patients to receive "designated health services" (DHS) payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships must align with fair market value (FMV) definitions and can include both ownership/investment interests and compensation arrangements. Ownership or investment interests can include equity (stock or partnership shares) or debt interests (loans tied to an entity's revenue). The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required.

This report was self-initiated by the Council on Medical Service to address the need for further policy guidelines for physicians, especially independent physicians, in determining FMV under the Stark law when contracting with a hospital or health system. The American Medical Association's (AMA) position on the Stark law and physician compensation is clear. However, the Council sees a policy gap regarding the definition of FMV, guidelines for independent physicians when negotiating contracts with hospitals, and best practices to avoid a Stark law violation. As such, this report examines the Stark law and its exceptions, various data sources for determining FMV, the impact the Stark law has on physician practices, and makes policy recommendations.

BACKGROUND

The Stark Law, Anti-Kickback Statute, and False Claims Act

The Stark law was originally enacted in 1989 and applied only to physician referrals for clinical laboratory services. In 1993-94, Congress expanded the law to include additional DHS and applied certain aspects of physician self-referral laws to Medicaid. In 1997, Congress added a provision to permit the Secretary of Health and Human Services (HHS) to issue written advisory opinions concerning whether a referral relating to DHS (other than clinical laboratory services) is prohibited under Section 1877.

Designated health services include: clinical laboratory services; physical therapy, occupational therapy, and outpatient speech-language pathology services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

Related statutes include the False Claims Act (FCA) and Anti-Kickback Statute (AKS). The FCA makes it illegal to submit claims for payment to Medicare or Medicaid that a physician knows to be

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false or fraudulent. "Knowing" is defined to include not only actual knowledge but also encompasses cases when an individual acts in deliberate ignorance or reckless disregard of the truth or falsity of the information. AKS is a criminal law that prohibits the knowing and willful payment or remuneration (which includes anything of value, in any form) to induce or reward patient referrals or the generation of business involving any item or service payable by federal healthcare programs. AKS has broader coverage than the Stark law, requires intent, and is not limited to certain services. While there is often overlap between these three laws, this report will focus specifically on the impact of the Stark law, the definition of FMV, and the impacts on independent physicians.[1]

Exceptions to the Stark Law

Most physician practices rely on one or more of the exceptions to the Stark law to maintain clinical operations. Many of the exceptions are complicated and can impose significant administrative burdens on physicians and their practices.[2] Common exceptions include:

1. In-office Ancillary Services Exception. This exception is widely used in group medical practices and allows physicians to refer Medicare patients for DHS within their own practice, if certain conditions are met. For example, the referring physician must be part of a qualifying group practice, the DHS must be provided either in the same building where the group provides non-DHS services or in a centralized building used by the group for diagnostic or clinical services, and the physician or the practice of the physician performing the service must submit the bill.[3]
2. Personal Service Arrangement Exceptions. This exception allows physicians to be paid FMV for services when there is a written, signed agreement in place that does not tie compensation to referral volume or value.
3. Fair Market Value Compensation Exception. This exception protects arrangements where compensation reflects market rates and does not depend on referrals.
4. Group Practice Compensation Methods Exception. This exception allows group practices to compensate physician employees using productivity and profit-sharing methods as long as the formulas used to calculate salary do not tie compensation to the volume or value of that physician's own DHS referrals.
5. Professional Courtesy Exception. This exception allows practices to extend courtesy discounts or free services as long as these benefits are available to all staff or community members and are not tied to referrals. The benefits must be in writing and approved in advance by the practice's governing body. They cannot be extended to federal program beneficiaries unless based on demonstrated financial need and they cannot violate AKS.

Impact of Regulatory Changes

Following the original enactment, the Stark law has undergone several additional expansions and changes. In 2003, Congress authorized the Secretary of HHS to promulgate an exception to the physician self-referral prohibition for certain arrangements in which the physician receives non-monetary remuneration that is necessary and used solely to receive and transmit electronic prescription information and established a moratorium on physician referrals to certain specialty hospitals in which the referring physician has an ownership or investment interest. In 2010, the Centers for Medicare & Medicaid Services (CMS) published the Voluntary Self-Referral Disclosure Protocol pursuant to Section 6409(a) of the Affordable Care Act, which sets forth a process to enable providers of services and suppliers to self-disclose actual or potential violations of the physician self-referral law.[4]

More recently, in 2020, CMS issued "Modernizing and Clarifying the Physician Self-Referral Regulations." Established here were three new exceptions to the physician self-referral law applicable to compensation arrangements that qualify as "value-based arrangements." Notably, CMS defined "commercial reasonableness" in the regulation, which established an objective test for evaluating whether compensation takes into account the volume or value of referrals or other business generated between the parties. The definitions of "fair market value" and "indirect compensation agreement" were also revised.[5]

Also in 2020, HHS Office of the Inspector General (OIG) published the final rule "Revisions to the Safe Harbors under Anti-Kickback Statute and Civil Monetary Penalty Rules Regarding Beneficiary Inducements." The two rules create a dual regulatory environment where a value-based arrangement could meet the requirement for protection under one law but not the other. This could hinder transitions to value-based healthcare delivery and payment systems. The AMA submitted a letter in response the proposed rules.[6] Finally, CMS finalized clarifications to the regulations defining a "group practice" for the purposes of the Stark law.[7]

The Stark Law, Independent Physicians, and Increasing Market Consolidation

Burdensome regulatory and administrative requirements, including the Stark law requirements, may be some of the drivers that are leading independent physician practices to be sold to hospitals, health systems, and private equity companies. This in turn increases consolidation in already consolidated markets. According to AMA analysis, a substantial majority of hospital markets are highly concentrated, and concentration continues to increase over time. Between 2012 and 2024, the share of physicians who work in private practice dropped 18 percentage points from 60.1 percent to 42.2 percent.[8] Research has found that mergers in concentrated markets can lead to price increases and concerns about physician autonomy and leadership. The AMA is an advocate for competitive healthcare markets and antitrust relief for physicians and maintains that healthcare markets should be sufficiently competitive to allow physicians to have adequate choices and practice options.[9]

Employment preferences vary among physicians and employment by large hospital systems or hospital-owned practices remains an attractive practice option for some physicians. It is also important to maintain the sustainability of independent practice for physicians who wish to pursue this career path. An alternative to direct employment by a hospital or health system would be for independent physicians to contract with hospitals or other groups to provide certain services (either clinical, administrative, or quality-based). However, many facilities and physicians are concerned about inadvertent violations of the Stark Law and thus utilize FMV to set proposed payments lower than the value of services or assume that an employment relationship is required to provide more coordinated or integrated care. While some of these relationships may fit under exceptions to the Stark law, the fear of prosecution can lead to a failure of these relationships to be developed in a way that would support both patient care and the success of an independent physician practice.

The Stark law has the potential to negatively impact private practice by imposing strict liability for often unintentional financial relationship violations, leading to large financial penalties, forced repayment of all Medicare revenue for the impacted service, and high compliance costs. The law also requires rigorous, signed documentation for all financial relationships. Failure to maintain, sign, or update these arrangements can invalidate them and the cost of hiring legal counsel to ensure compliance with FMV and commercial reasonableness can be high.

Calculating Fair Market Value and Sources of Physician Compensation Data

CMS provides a broad definition of FMV in Section 1877 of the Social Security Act, describing it as "the value in arm's length transactions, consistent with general market value, and, with respect to rentals or leases, the value of a rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee."[10] FMV protections are not solely a regulatory burden on physicians. Properly applied, they can protect patients and the healthcare system from fraud and abuse when compensation arrangements are being used to influence referrals.

CMS has acknowledged that there is a desire for a "clear bright line" for how FMV should be defined but argues that the definition is intentionally kept broad to account for nuances of different specialties, geographic locations, and practice types across the country. Because there is no specific definition, physicians, practices, and hospitals must rely on outside data sources, namely physician salary surveys and databases, to calculate FMV for individual employment scenarios. Some examples of arrangements that may warrant FMV negotiations include a radiologist contracting to provide medical director services, an independent physician group contracting for hospital coverage, including call and weekend hours, a specialist with clinical work and administrative obligations, or a physician practicing in a geographically underserved area where average salary may exceed the national survey average.

There are several prominent data sources for this information, each with benefits and limitations. It is best practice to consult several of these resources to determine FMV. Many of the most utilized sources are accompanied by high price tags (often annual subscriptions) that may be costly for independent physicians to access. The following are a list of some of the most utilized:

- Medical Group Management Association (MGMA) has been the default source for salary data for decades, providing national provider compensation and production data, often broken down by specialty, geographic region, and practice setting. Data are collected from healthcare organizations (employers) and not directly from physicians, meaning the compensation figures reflect what organizations report paying, which can differ from the payment actually received by physicians. The cost of accessing the dataset is also a limitation, as access starts at $3,000/year, requiring annual renewals. Premium access costs are even higher.
- Sullivan Cotter provides comprehensive datasets tailored for hospitals, health systems, and larger clinical networks. These data focus on executive, physician, and non-physician provider compensation. Sullivan Cotter provides 30 years of survey history, but access can also be cost prohibitive and is reported from the employer perspective, which could report data that is different than physician take-home pay.
- American Medical Group Association publishes robust medical group compensation and financial survey metrics, reflecting data from over 200 specialties, with a particular strength in reporting multi-specialty group practice data. This dataset includes region breakdowns and organizational size segmentation. Membership to the Association and data access could be cost prohibitive for smaller organizations.
- The Association of American Medical Colleges (AAMC) provides a Faculty Salary Report that displays total compensation statistics for full-time medical school faculty broken out by degree, rank, department/specialty, medical school type, region, gender, and race/ethnicity. The reported total compensation is the sum of fixed/contractual salary,

medical practice supplement, and bonus or incentive pay. The survey is fielded annually and can be purchased for $75 or $1,500, depending on AAMC membership status.[11]

- Bureau of Labor Statistics Occupational and Wage Statistics offers free physician compensation data organized by Standard Occupational Classification codes. While costs are friendly, the data provides only very broad specialty groupings (i.e., Physicians & Surgeons, All Others), limited percentile granularity, and a publication lag of 12-18 months. As such, these data are best used as a cross-validation source rather than a primary benchmark measure.
- Other sources that can be used include SalaryDr (provides physician-reported on-demand reports for a fraction of the costs), Doximity (provides self-reported physician data from its physician social network), and proprietary datasets from independent, third-party valuation firms which can vary in cost, access, and reliability.[12]

When utilizing these resources to calculate FMV, there are a few best practices to keep in mind. First, the data should be used as a guide, and multiple sources should be referenced. Second, both median and percentile data should be used as reference points as this is more accurate than using the mean in these circumstances. This allows for the consideration of various aspects of compensation, such as a shortage of services, the qualifications of the physician, and the non-clinical work being requested in determining an appropriate percentile. For example, only looking at the median as a ceiling for FMV could be inaccurate, as those earning at the 90th percentile can also be receiving a FMV salary based on their individual circumstances and qualifications. Third, current practice realities should be examined and leveled with physician salary expectations before applying necessary filters to specific scenarios.[13]

Recent Legal Activity

The following are a few examples of recent cases that focus on hospital compensation practices and that highlight either an alleged lack of sufficient safeguards to ensure that physicians are paid within the range of FMV or a calculated plan to capture and retain referrals through excessive compensation. Each of these entities have been defendants in Stark law-based FCA lawsuits, whose allegations focus on above FMV compensation to referring physicians:[14]

- Community Health Network (Indiana) allegedly engaged in a scheme to recruit a variety of specialists by offering them significantly higher salaries than they received in private practice, in order to capture these specialists' lucrative downstream referrals.
- The University of Pittsburgh Medical Center (UPMC) settled a lawsuit after a neurosurgeon and two other UPMC clinicians filed suit, alleging that UPMC incentivized its neurosurgeons to perform unnecessary and overly complex procedures at UPMC facilities by providing base pay and productivity bonuses that far exceeded FMV.
- The Department of Justice (DOJ) intervened in a case against Steward Health Network (Massachusetts) that alleged that the hospital paid a $5 million incentive compensation to the Chief of Cardiac Surgery for increasing the number of surgical cardiovascular cases performed at the hospital and that resulted in the hospital's submission of more than 1,000 claims to Medicare in violation of the Stark law, equaling tens of millions of dollars in improper Medicare payments. Steward has since filed for Chapter 11 bankruptcy.
- There is an ongoing case against Erlanger Health System (Tennessee) that alleges that Erlanger violated both the Stark law and AKS by paying physicians above FMV for referrals. The DOJ has partially intervened and the settlement is expected to exceed $60 million.[15,16]

These examples highlight real and alleged abuses that need to be prevented and show the importance of the Stark law in protecting patients, physicians, and the healthcare system as a whole from fraud and abuse. As a goal, the Stark law should be modernized to ensure fair payment for physicians in a variety of contractual relationships without increasing administrative or regulatory burdens rather than weakening meaningful protections.

Compliance Concerns and Risk Management

The above cases highlight the importance of proper risk management. There are several ways that physician practices can mitigate risk of violating the Stark law and related statutes, although it is important to note that the administrative costs of keeping up with these requirements can be expensive for independent physicians:

- Make sure all compensation agreements are in writing and signed by all relevant parties. Revisit the agreements on a regular basis to ensure continued compliance.
- Document all financial relationships and referral patterns clearly.
- Verify compliance with Stark law exceptions and AKS safe harbors.
- Have a consistent valuation process in place and ensure that physician compensation is consistently evaluated and documented as falling within the range of FMV and does not rely on the volume or value of referrals.
- Make compliance programs a priority and integrate them into operations through measures such as compensation policies, training, audits, and evaluations.
- Conduct regular internal audits and monitor regulatory arrangements for changes.
- Take whistleblower complaints seriously.
- Seek legal guidance when necessary, including for complex or novel arrangements.
- Monitor regulatory updates and OIG advisory opinions.[17,18,19]

AMA POLICY

Policy D-385.940 states that the AMA recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs, supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral," and supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

Policy H-385.914 states that the AMA opposes and continues to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

Policy H-225.973(3) states that the AMA opposes financial arrangements between hospitals and physicians that: a) either require physicians to compensate hospitals in excess of the fair market value of the services or resources that hospitals provide to physicians; b) require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request; and c) require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals.

Policy D-405.988 states that the AMA supports preserving the value of the private practice of medicine and its benefit to patients.

Policy E-9.6.9 addresses ethical challenges for self-referral in which patients' medical interests can be in tension with physicians' financial interests.

DISCUSSION

The Stark law prohibits physicians from referring patients to receive DHS payable to Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Most physician practices rely on complicated exceptions to the Stark law to maintain clinical operations. The Stark law is not meant to solely be an administrative burden on physicians, but when applied properly, these guidelines can protect the healthcare system from fraud and abuse.

In recent years, CMS has attempted to more clearly define FMV with regulatory updates; however, it has not gone far enough, and the definitions continue to be vague. In its recommendations, the Council encourages further specificity in the definition of FMV and offers suggestions for factors that should be included in the calculation.

Transparency in how FMV is calculated, including specific factors and data sources used, can empower physicians entering into contracts with hospitals or health systems to best advocate for themselves and their practices. To this end, the Council recommends supporting transparency in the disclosure of financial relationships, compensation models, and ownership structures between physicians, hospitals, and other healthcare entities, as well as encouraging physicians to ask for transparency when negotiating an employment contract and ask for employers to disclose and provide methodology, data sources, and calculations used in determining FMV.

Burdensome regulatory and administrative requirements, including those associated with the Stark law, are some of the drivers that are leading independent physician practices to being sold to hospitals, health systems, and private equity companies which increases consolidation in already consolidated markets. Employment preferences vary across the profession, and while employment by a hospital system or a hospital-owned practice are attractive options to some, it is also important to maintain the sustainability of independent practice. In order to reduce administrative burden related to Stark law compliance, there are several ways physician practices can mitigate risk and ensure compliance. The Council recommends encouraging physicians to seek independent valuation or legal counsel when negotiating compensation and contractual agreements where FMV is an issue as well as recommends supporting policies that ensure contractual integrity in physician-health system relationships.

Finally, the Council recommends reaffirmation of Policies D-405.988, D-385.940 and H-385.914, which support preserving the value of the private practice of medicine, recognize the substantial impact of the Stark law's unequal restrictions on independent physicians, and oppose and continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support modernization of federal regulatory frameworks, including the Stark law and Anti-Kickback Statute, to reduce unnecessary administrative burden, mitigate penalties for technical or non-substantive violations, and better

enable value-based, patient-centered care while maintaining appropriate safeguards against fraud and abuse and protecting patients from conflicts of interest and inappropriate utilization. (New HOD Policy)

2. That our AMA support the Centers for Medicare & Medicaid Services (CMS) explicitly defining factors that can be utilized to calculate "fair market value" (FMV) as it relates to physician compensation including, but not limited to, the following factors:
   - Physician specialty, subspecialty, or physician services to be provided;
   - Geographic location;
   - Supervision of non-physician providers or trainees;
   - Whether a restrictive covenant is in place and its level of restrictiveness;
   - Additional roles and responsibilities (e.g., education, quality improvement duties, alternative payment model or value-based care participation, serving as licensed directors of hospital departments or laboratories);
   - Restrictions on outside activities or income opportunities (e.g. work at a Veterans Affairs facility, work at an academic institution, moonlighting, consulting, development of intellectual property owned by the physician, or other outside professional activities);
   - Specialty or subspecialty shortages, either locally or nationally; and/or
   - Other factors that impact value to the health system. (New HOD Policy)

3. That our AMA support CMS providing additional guidance on exceptions and/or safe harbors that physicians and employers can rely upon to adjust physician compensation, either through direct compensation, or through value-sharing of other payments that are based on the physician's contribution to the institution. (New HOD Policy)

4. That our AMA encourage physicians to ask for transparency when negotiating an employment contract and ask for employers to disclose and provide the methodology, data sources, and calculations used in determining FMV as it relates to the compensation of independent physicians contracting with the hospital whenever FMV is cited as a reason for the selected compensation level. (New HOD Policy)

5. That our AMA support transparency of ongoing and future proposed physician financial relationships, compensation models, and ownership structures between physicians, hospitals, and other healthcare entities during any negotiation to provide healthcare or administrative services between all parties. (New HOD Policy)

6. That our AMA encourage physicians, particularly those in independent practice that are entering contracting arrangements, to seek independent valuation, legal counsel, and third-party review when negotiating compensation and contractual agreements where FMV is an issue. (New HOD Policy)

7. That our AMA support policies that ensure fair and transparent integrity in physician-health system contractual relationships, including written, transparent, and time-limited agreements, appropriate limitations on restrictive covenants to protect patient access and continuity of care, and preservation of physician advocacy on behalf of patients. (New HOD Policy)

8. That our AMA reaffirm Policy D-405.988, which states that the AMA supports preserving the value of the private practice of medicine and its benefit to patients. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy D-385.940, which states that the AMA recognizes the substantial impact of Stark law's unequal restrictions on independent physicians, contributing

to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs, supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral," and supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-385.914, which states that the AMA opposes and continues to advocate against the misuse of the Stark law and regulations to cap or control physician compensation. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 4-I-26
Determining Fair Market Value when Contracting with Physician Practices
Policy Appendix

Stark Law Self-Referral Ban, D-385.940

1. Our American Medical Association recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs.
2. Our AMA supports comprehensive Stark law reform aimed at rectifying the disparities that disadvantage independent physician practices while preserving the intent of AMA Code of Ethics Policy 9.6.9, "Physician Self-Referral."
3. Our AMA supports equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

(BOT Rep. 03, I-25)

Stark Law and Physician Compensation, H-385.914

Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.
(BOT Rep. 6, I-15; Reaffirmed: BOT Rep. 09, A-25)

Financial Arrangements Between Hospitals and Physicians, H-225.973

1. Our American Medical Association opposes financial arrangements between hospitals and physicians that are unrelated to professional services, or to the time, skill, education and professional expertise of the physician.
2. Our AMA opposes any requirement which states that fee-for-services payments to physicians must be shared with the hospital in exchange for clinical privileges.
3. Our AMA opposes financial arrangements between hospitals and physicians that
    a. either require physicians to compensate hospitals in excess of the fair market value of the services and resources that hospitals provide to physicians.
    b. require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request.
    c. require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals.
4. Our AMA opposes financial arrangements between hospitals and pathologists that force pathologists to accept no or token payment for the medical direction and supervision of hospital-based clinical laboratories.
5. Our AMA urges state medical associations, HHS, the AHA and other hospital organizations to take actions to eliminate financial arrangements between hospitals and physicians that are in conflict with the anti-kickback statute of the Social Security Act, as well as with AMA policy.

(CMS Rep. C, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed and Appended: CMS Rep. 2, I-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22)

The Preservation of the Private Practice of Medicine, D-405.988

1. Our American Medical Association supports preserving the value of the private practice of medicine and its benefit to patients.
2. Our AMA will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care.

3. Our AMA will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians.
4. Our AMA will work through the appropriate channels to preserve choice and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt.
5. Our AMA will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine.
6. Our AMA will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice.
7. Our AMA will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.
8. Our AMA will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices.

(Res. 224, I-10; Appended: Res. 604, A-12; Reaffirmation: I-13; Appended: Res. 735, A-14; Reaffirmed in lieu of Res. 223, I-14; Modified: Speakers Rep. 01, A-17; Reaffirmed: Res. 724, A-22; Reaffirmation: A-22; Appended: Res. 602, A-22; Reaffirmed: BOT Rep. 14, A-23; Reaffirmed: CMS Rep. 08, A-24; Reaffirmed: BOT Rep. 19, A-26)

Vertical Consolidation in Healthcare – Markets or Monopolies, D-160.908

1. Our American Medical Association advocates against anticompetitive business practices that have the potential to adversely affect the physician patient relationship, to result in higher costs or decreased quality of care, or are not in the best interest of patients, the public and/or physicians.
2. Our AMA supports efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers that have the potential to negatively impact the healthcare industry.
3. Our AMA will work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the healthcare sector.

(Res. 723, A-23; Reaffirmed: Res. 813, I-25)

AMA Principles for Physician Employment, H-225.950

1. Addressing Conflicts of Interest
    a. Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
    b. In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
    c. Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, healthcare in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

d. A physician's paramount responsibility is to their patients. Additionally, given that an employed physician occupies a position of significant trust, they owe a duty of loyalty to their employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
    a. No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to their religious beliefs or moral convictions.
    b. No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because they either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates their religious beliefs or moral convictions.
e. Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession
    a. Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the healthcare system or setting in which physicians practice, or the methods by which they are compensated.
    b. Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting
    a. Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, healthcare systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
    b. Physicians should never be coerced into employment with hospitals, healthcare systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
    c. When a physician's compensation is related to the revenue they generate, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
    d. Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under their care. When a physician's employment status is unilaterally terminated by an employer, the physician and their employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by

the physician in their new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of their patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

e. Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
f. Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
g. Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
h. Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations
   a. Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
   b. Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
   c. Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d. Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations
    a. All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
    b. Peer review should follow established procedures that are identical for all physicians practicing within a given healthcare organization, regardless of their employment status.
    c. Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
    d. Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
    e. Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
    f. Upon termination of employment with or without cause, an employed physician generally should not be required to resign their hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
        a. The agreement is for the provision of services on an exclusive basis.
        b. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985.
        c. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Healthcare Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements
    a. Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
    b. Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
    c. The AMA will petition the appropriate legislative and/or regulatory bodies to establish the requirement that revenue cycle management entities, regardless of their ownership structure, and/or employers will directly provide each physician it bills or collects for with a detailed, itemized statement of billing and remittances for medical services they provide biannually and at any time upon request. Upon review of billing and remittance statements, physicians should reserve the right to override the initial decisions by revenue cycle management entities and submit billing that they believe to be best aligned and most reflective of the medical services that they have provided. Additionally, the physician shall not be asked to waive access to this information. Our AMA will seek federal legislation requiring this, if necessary.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

(BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19; Reaffirmation: A-22; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24; Appended: Res. 712, A-25)

E-9.6.9 Physician Self-Referral

Business arrangements among physicians in the healthcare marketplace have the potential to benefit patients by enhancing quality of care and access to healthcare services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a healthcare facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first.

When physicians enter into arrangements that provide opportunities for self-referral they must:

(a) Ensure that referrals are based on objective, medically relevant criteria.
(b) Ensure that the arrangement:
(i) is structured to enhance access to appropriate, high quality healthcare services or products; and
(ii) within the constraints of applicable law:
a. does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
b. does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
c. adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
(c) Take steps to mitigate conflicts of interest, including:
(i) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
(ii) establishing mechanisms for utilization review to monitor referral practices; and
(iii) identifying or if possible, making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
(d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

AMA Principles of Medical Ethics: II, III, VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

E-11.2.3 Contracts to Deliver Healthcare Services
Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the healthcare system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires that before entering into contracts to deliver healthcare services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.

Ongoing evolution in the healthcare system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for healthcare delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in healthcare, they can also put at risk physicians' ability to uphold professional ethical standards and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver healthcare services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while some arrangements have the potential to promote desired improvements in care, other arrangements have the potential to put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide healthcare services, physicians should:
(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel to assure themselves that the arrangement:
(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
(iii) ensures the physician can appropriately exercise professional judgment;
(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
(v) is transparent and permits disclosure to patients;
(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;
(vii) prohibits the corporate practice of medicine.
(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.
When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:
(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.
(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.
(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.
(f) Not enter into any contract that would require the physician to violate their professional ethical obligations.
When contracted by a corporate entity involved in the delivery of healthcare services, physicians should:
(g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.

AMA Principles of Medical Ethics: I, II, III, V, VI, VIII, IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Improving Marketplace Affordability through Premium Tax Credits
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, the House of Delegates referred a clause proposed as an additional recommendation to Council on Medical Service Report 1, Health Savings Account Reform. The clause asked the American Medical Association to advocate using the expanded Affordable Care Act (ACA) premium tax credits (PTCs) as a vehicle for improving health insurance affordability rather than converting those subsidies to health savings accounts (HSA) or other cash savings accounts. This report describes ACA PTCs, the enhanced subsidies available from 2021 through 2025, and the potential impacts of redirecting PTCs into HSAs.

The expiration of the enhanced PTCs at the end of 2025 contributed to sharp premium increases and precipitous enrollment declines this year, raising concerns about less stable ACA marketplaces and more financial stress on patients, hospitals, and physicians. To address affordability concerns, some healthcare proposals have promoted redirecting federal marketplace premium subsidies through HSAs or HSA-type accounts. Although the Council has heard support in the House of Delegates for the flexible use of HSAs when they are voluntary, we understand that HSAs are regressive and could worsen economic and racial disparities if policies require that marketplace subsidies be placed into such accounts. Notably, most marketplace enrollment growth between 2021 and 2025 stemmed from lower-income enrollees, who the enhanced PTCs helped the most but who would be least likely to benefit from an HSA. The Council is also concerned that HSA-focused ACA reforms could incentivize greater enrollment shifts into cheaper but less comprehensive plans, including catastrophic plans that have deductibles this year of $10,600 for individual and $21,200 for family coverage. Although the Council maintains that HSAs should be available to individuals purchasing qualified marketplace plans on a voluntary basis, we believe that increased premium assistance within the existing ACA PTC structure will be critical as healthcare costs, and the cost of coverage, continue to rise. Therefore, the Council recommends supporting enhancements to ACA marketplace subsidies, including PTCs, without redirecting subsidies into HSAs.

Of note, in a year of significant declines in marketplace enrollment, a few states opted to use state funds to help subsidize coverage for residents who had lost federal premium support. Although the Council recognizes that states face serious fiscal challenges and difficult funding choices, we hope that many states will at least consider investing in marketplace subsidies for their residents with lower incomes. Therefore, the Council recommends encouraging states, when possible, to consider supplementing federal premium subsidies.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-26

Subject: Improving Marketplace Affordability through Premium Tax Credits

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates referred a clause proposed as an additional recommendation to Council on Medical Service Report 1, Health Savings Account Reform. It states the following:

> Our American Medical Association (AMA) advocates for using the expanded Affordable Care Act (ACA) premium tax credits (PTC) as a vehicle for improving health insurance affordability rather than converting those subsidies to health savings accounts (HSA) or other cash savings accounts.

This report describes ACA PTCs, the enhanced subsidies available from 2021 through 2025, and the potential impacts of redirecting PTCs into HSAs; summarizes relevant AMA policy; and makes policy recommendations. The purview of this report is limited to PTCs and HSAs, and does not make recommendations for broader improvements to ACA affordability, which the Council continues to monitor.

BACKGROUND

Enrollment in the ACA marketplaces reached a record high of 24.3 million people in early 2025, more than double the 12 million individuals who were enrolled in 2021[1] when Congress increased the generosity of the ACA's PTCs as part of the American Rescue Plan Act (Public Law 117-2). The enhanced PTCs, which decreased the maximum required contribution for previously eligible enrollees and extended eligibility to people with incomes exceeding 400 percent of the federal poverty level (FPL), also led many enrollees to choose higher actuarial value plans that helped decrease their out-of-pocket expenses.[2]

As highlighted in a 2025 AMA Federation sign-on letter to congressional leadership, the enhanced PTCs increased the affordability of marketplace plans and drew in healthier people, thereby improving the risk pool and lowering premiums overall. Originally set to expire in 2022, the more generous subsidies were extended through 2025 by the Inflation Reduction Act (Public Law 117-169), and sunsetted at the end of that year when Congress did not extend them. Notably, both the American Rescue Plan Act and the Inflation Reduction Act were partisan bills that were enacted via the federal budget reconciliation process. The expiration of the enhanced PTCs, along with marketplace changes made by H.R. 1 (Public Law 119-21) and relevant rulemaking, have contributed to sharp premium increases and precipitous enrollment declines in 2026, raising concerns about less stable marketplaces and more financial stress on patients, hospitals, and physicians whose practice revenues could be negatively impacted.

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Healthcare proposals from the Trump Administration and Congress have promoted an expanded role for HSA-type accounts to address affordability concerns stemming from the expiration of the enhanced PTCs. An HSA is a tax-advantaged savings account that consumers enrolled in high-deductible health plans (HDHP) can use to set aside money, without paying taxes, for qualified medical expenses. Of note, HSAs do not constitute health coverage and, under current law, funds generally cannot be used to pay health plan premiums.

PREMIUM TAX CREDITS AND AFFORDABILITY

In addition to creating federally-regulated health insurance marketplaces, the ACA established federal subsidies, including PTCs that were intended to lower the cost of marketplace premiums for individuals with incomes up to 400 percent of the federal poverty level (FPL).[3] These credits can either be claimed at the end of the year when filing federal taxes, and then reconciled, or be paid in advance based on an enrollee's estimated income. Advance PTCs are paid directly to the insurer and applied to an enrollee's monthly premium.[4]

The ACA's eligibility limit around PTCs created a "subsidy cliff" by excluding people whose incomes exceeded 400 percent FPL by even a small amount from receiving federal subsidies. In 2021, as the costs of health coverage across markets continued to rise amid the COVID-19 pandemic, Congress enacted temporary federal ACA subsidy enhancements that were subsequently extended through 2025. These enhancements increased the value of subsidies, decreased the maximum required premium contribution for previously eligible enrollees, and extended eligibility for PTCs to people with incomes above 400 percent FPL. Because the PTCs effectively cap an eligible individual's premium liability at a percentage of household income, expanding PTC eligibility improved affordability for most people who depend on the ACA, including small business owners, self-employed people, gig workers, farmers, and early retirees. In 2025, for example, 92 percent of marketplace enrollees received advanced PTCs.[5]

After the enhanced PTCs expired at the end of 2025, the average marketplace premium more than doubled for a formerly subsidized individual who was no longer eligible for PTCs. As many consumers faced substantial premium increases in 2026 (average net premiums increased 58 percent from 2025),[6] marketplace coverage became less affordable and less attractive to some as an insurance option. During open enrollment for the 2026 plan year, initial sign-ups fell across a majority of states, and by 1.2 million people nationally.[7] Moreover, as premiums became due at the beginning of this year, a substantial number of enrollees dropped coverage instead of absorbing such large premium increases. By February 2026, effectuated enrollment in the ACA marketplaces—meaning those people who signed up for plans and maintained their coverage by making premium payments—had declined to 19.2 million individuals, down considerably from 2025 but still higher than pre-Covid era enrollment figures.[8] Fifty-state survey data from Manatt Health similarly highlighted enrollment declines and "buy-downs" to lower-value plans, especially in states using the federal platform (healthcare.gov). For example, silver plan selection, which allows lower-income people to qualify for cost-sharing assistance that is not available to individuals enrolled in other metal tiers, fell by 28 percent as many consumers switched to bronze and catastrophic plans.[9] Although every state except New Mexico experienced marketplace enrollment declines this year, some states (e.g., California, Colorado, Connecticut, Maryland, Massachusetts, and New Jersey) were able to mitigate the severity of the decreases by using state resources to at least partially make up for the loss of the enhanced federal subsidies.[10]

The full extent of attrition from ACA marketplaces had not yet been reported at the time this report was written; however, early estimates projected that enrollment would drop by 17 to 26 percent in 2026.[11] Such sizeable attrition, if it materializes, will negatively impact the risk pool if the people

dropping coverage tend to be younger and healthier. Changes to the risk pool could in turn destabilize the marketplaces in some states, causing further rate increases and less competition if insurers choose to exit the market. Early rate filings from plan issuers quickly signaled the potential for double-digit rate increases next year, on top of the significant increases in effect this year.[12] An analysis of preliminary rate filings in 16 states and DC found that insurers in most states had requested 10 to 20 percent premium increases for the 2027 plan year, on top of this year's rate increases. KFF estimates that between 2025 and 2027, marketplace premiums will increase by more than one-third, citing the expiration of the enhanced PTCs, Centers for Medicare & Medicaid Services (CMS) regulatory changes, and the rising cost of healthcare as contributing factors.[13]

The AMA has advocated against CMS marketplace changes that expanded less comprehensive coverage options and removed important network adequacy standards, among other provisions affecting marketplace affordability. In July 2026, a Federal District Court in Maryland issued a preliminary ruling and opinion in *City of Columbus v. Kennedy* (2026) that granted a stay of eight provisions in CMS rulemaking that were set to take effect for plan year 2027. Last year, the AMA also urged Congress not to allow the enhanced PTCs to expire, highlighting in an AMA Federation sign-on letter that extending the more generous subsidies would have continued to lower premiums across income levels, mitigated financial barriers to care, and sustained enrollment in the marketplaces. In addition to affordability concerns, the AMA argued that allowing the more generous subsidies to expire would reverse enrollment gains, increase the uninsured rate, and raise uncompensated care costs for hospitals and physician practices.

HEALTH SAVINGS ACCOUNTS (HSAs)

HSAs are closely tied to United States tax code and therefore must follow a complex web of guidelines and regulations governing their use. Pre-tax dollars can be saved in an HSA and the funds can be used at any time in a person's life to pay for co-pays, prescriptions, dental care, contacts and eyeglasses, bandages, x-rays, and other qualified medical expenses as defined by the Internal Revenue Service. Under current law, insurance premiums are generally not considered a qualified medical expense. Of note, once individuals turn 65, HSAs are treated similar to traditional retirement accounts.

The rationale behind the creation of HSAs in 2003 was that the accounts would incentivize people to choose HDHPs and therefore reduce health spending. In the years since, the use of these accounts has increased significantly, as has the number of goods and services that can be purchased using HSA funds, many of which are not typically covered by health plans.[14] Council on Medical Service Report 1-I-25 established new AMA policy (Policy H-165.818) intended to improve usability and flexibility for individuals who have HSAs. Importantly, this policy also decisively affirms that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability, such as PTCs. As highlighted in the Council's report, HSAs provide account owners with several tax advantages but are considered regressive because higher income people are more likely to use such accounts, exempt larger amounts, and navigate complex tax rules to maximum advantage.[15] Research also shows that HSAs are distributed unevenly across race and ethnicity, with Latino and Black individuals about half as likely to have HSAs as white and Asian individuals.[16] Finally, HSAs also tend to benefit patients who are healthy compared to those that have chronic care needs or substantial medical expenses.

High-Deductible Health Plans (HDHP)

Several Council reports have discussed HDHPs, which HSAs must be paired with and which typically have higher deductibles and lower premiums when compared to traditional health plans.

High-deductible plans generally require patients to pay the full cost of health services and medications until the high deductibles are met. Although an HDHP's lower premium may be attractive to some consumers, the responsibility for out-of-pocket expenses can become problematic when deductibles are too high for enrollees to afford and patients are unable to cover the cost of needed care. Not surprisingly, studies have found that reductions in health spending achieved through HDHPs are primarily due to patients simply receiving less medical care.[17]

An H.R. 1 (Public Law 119-21) provision allows ACA marketplace bronze and catastrophic plans to be treated as HSA-eligible HDHPs so that individuals who opt for these higher-deductible plans can take advantage of HSA tax and savings benefits. Regardless of actual deductible amounts, Policy H-165.828 supports bronze and silver plans being treated as HSA-qualified HDHPs, as long as appropriate guardrails are in place to ensure lower-income enrollees do not suffer financial hardships. As the Council noted in its 2025 report, HSAs can benefit some individuals but should not be considered a one size fits all approach, nor should they be considered a replacement for health insurance.

Proposals to Redirect ACA Subsidies into HSAs

In the months leading up to the expiration of enhanced PTCs at the end of last year, some Republicans in Congress proposed funneling subsidy amounts through HSAs or HSA-type accounts for eligible marketplace enrollees. For example, the Health Care Freedom for Patients Act (S. 3386), introduced by Senators Mike Crapo and Bill Cassidy, called for placement of enhanced subsidy amounts (but not baseline PTCs) into HSAs paired with bronze or catastrophic plans. Under this legislation, eligible individuals earning less than 700 percent FPL would receive $1,000 in an HSA if aged 18 to 49, and $1,500 if aged 50 to 64. Legislation introduced by Senator Rick Scott (R-FL) (S. 3264) would allow states to apply for waivers to place PTC and cost-sharing reduction amounts into HSA-type accounts called Trump Health Freedom Accounts. This bill would allow money in these accounts to be used for health plan premiums for any type of plan, including short-term limited duration policies, thus broadening the rules regarding qualifying medical expenses.[18] In January 2026, the Trump Administration announced the Great Healthcare Plan, which broadly proposes to "stop sending big insurance companies billions in extra taxpayer-funded subsidy payments and instead send that money directly to eligible Americans to allow them to buy the health insurance of their choice."[19] Although details of that plan were not yet available at the time this report was written, it may signal continued debate about using HSA-type accounts as a substitute for federal premium subsidies.

Channeling federal subsidies through HSAs in the ACA market could benefit both the healthiest enrollees whose spending on healthcare is relatively low, and those with the highest incomes who can afford high deductibles and out-of-pocket expenses. Presumably, these enrollees would be better able to set aside and roll over federal HSA contributions, allowing funds to grow tax free for future use. The availability of comprehensive coverage (e.g., bronze or silver plans) paired with HSAs could potentially incentivize such enrollees to keep marketplace coverage, which would improve the overall risk pool, although only catastrophic and bronze plans currently qualify as HDHPs. Proponents of HSA-focused options also argue that the accounts give patients more choice and control over their healthcare, incentivize consumers to price-shop and seek more value, and help HSA owners plan for future healthcare expenses.[20]

Under current law, plans that redirect federal premium subsidies into HSAs would reduce the total amount of federal premium assistance because HSA funds cannot be used to pay premiums. Since both the original and enhanced PTCs were designed to make marketplace premiums more affordable, plans substituting HSAs for PTCs may be viewed as pivoting away from the intended

purpose of direct premium assistance while shifting financial risk away from insurers and onto patients.

Redirecting subsidies into HSAs would also incentivize more consumers to choose cheaper, less comprehensive plans with deductibles so high that an unexpected illness could put them in financial straits. Notably, average bronze plan deductibles in 2026 are nearly $7,500; for catastrophic plans, deductibles are $10,600 for individuals and $21,200 for family coverage, the maximum allowed by the ACA,[21] sums that far exceed proposed federal contribution amounts for HSAs. Although such plans may work well for healthier and wealthier consumers, most marketplace enrollees are from lower- and middle-income households and are less likely to have sufficient disposable income to benefit from HSAs.[22] Thus, concerns have been raised that consumers incentivized to sign up for these plans may ultimately choose to delay or forego needed care if they cannot afford to pay for medical services before their high deductibles are met. Some enrollees in less comprehensive high-deductible plans may also incur increased medical debt. Furthermore, enrollment growth in bronze and especially catastrophic plans, even when paired with HSAs, could also make it more difficult for physician practices and other providers to be paid for services rendered, potentially increasing uncompensated care costs. Analysts have also expressed concern that, under a broad plan like Senator Scott's, healthier people could opt into less comprehensive plans (e.g., catastrophic or short-term limited duration plans) or not enroll at all, harming the risk pool and potentially destabilizing some marketplaces.[23]

AMA POLICY

Numerous AMA policies address the issues raised in the referred proposed recommendation, including policies supporting original and enhanced PTCs, and policies addressing HSAs and HDHPs.

PTCs, Enhanced PTCs: AMA policy supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage (Policy H-180.951). Policy H-165.865 maintains that tax credits should be refundable and advanceable, and large enough to ensure that health insurance is affordable for most people. Under Policy H-165.824, the AMA supports improving affordability in health insurance exchanges by expanding eligibility for PTCs beyond 400 percent of the FPL (up to 500 percent of the FPL); increasing the generosity of PTCs; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions. This policy also encourages state innovation, including consideration of state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize premiums without undercutting existing patient protections. Policy H-165.820 supports extending the enhanced PTCs established under the American Rescue Plan Act and the Inflation Reduction Act.

HSAs: Policy adopted by the House of Delegates in 2025 (Policy H-165.818) supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance, such as ACA premium tax credits. Policy H-165.818 also supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans as well as some HSA flexibilities.

The AMA also has policy on how HSAs fit into the larger health insurance landscape. For example, Policy H-165.852(3) states that advocacy of HSAs continues to be incorporated prominently in AMA's campaign for health insurance reform, indicating the organization's commitment to improving HSAs, while Policy H-165.833 states that as part of the AMA's organizational goal of improving the ACA, the AMA will advocate to expand the use of HSAs.

Policy H-165.828 supports individual market bronze and silver plans being treated as HSA-qualified HDHPs, with appropriate guardrails in place to ensure low-income enrollees in these plans do not suffer financial hardships. This policy also encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Policy H-165.865 states that tax credits should be applicable only for the purchase of health insurance, including all components of a qualified HSA, and not for out-of-pocket health expenditures.

Policy H-165.852 supports legislation promoting the establishment and the use of HSAs and allowing the tax-free use of such accounts for healthcare expenses, including health, dental, vision, hearing, and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. This policy also supports enhancing activities to educate patients about HSAs. Under Policy H-385.912, consumers should be able to use HSAs to access direct primary care.

Policy H-290.972 outlines principles for states to consider when deciding whether to offer HSA programs to Medicaid beneficiaries. These guidelines include, amongst other standards, making beneficiary participation voluntary, providing first-dollar coverage for preventive care, and allowing payments to non-Medicaid providers by beneficiaries to count towards deductibles and out-of-pocket spending limits. Under Policy D-165.962 the AMA will monitor pending regulations and take appropriate steps to ensure access to HSAs by all Medicare eligible individuals. Policy D-165.954 states that the AMA will monitor and support rigorous research on the impact of HSAs and health reimbursement arrangements on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

HDHPs: Policy H-165.852 states that deductible limits for families should be the lower of either the individual or family combined deductible. Policy H-185.918 encourages strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year. Policy D-180.979 encourages states and other stakeholders to monitor the growth of HDHPs to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability. This policy also advocates for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing obligations at the time of service. Policy H-165.849 similarly opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. Accordingly, the AMA has supported the right of individuals to choose the type of health coverage that best meets their needs, with an HDHP paired with an HSA being one such option. While supporting the use of HSAs for those who want them, AMA policy (Policy H-165.818) also underscores that HSAs should be complementary to—and not replace—health insurance coverage or other efforts to improve affordability, such as ACA PTCs.

In the ACA market, AMA policy supports treating bronze and silver plans as HSA-qualified HDHPs, with appropriate guardrails in place to ensure that lower-income enrollees do not suffer financial hardships (Policy H-165.828). Existing policy also supports tax credits that are large

enough to ensure that insurance is affordable for most people (Policy H-165.865), and expanding eligibility for PTCs beyond 400 percent FPL (Policy H-165.824).

The Council has heard support in the House of Delegates over the years for the flexible use of HSAs when they are voluntary. At the same time, we understand that HSAs can be regressive and could worsen economic and racial disparities if policies require that marketplace subsidies be placed into such accounts. Most marketplace enrollment growth between 2021 and 2025 stemmed from lower-income enrollees,[24] who the enhanced PTCs helped the most but who would be least likely to benefit from an HSA. The Council is also concerned that HSA-focused ACA reforms could incentivize even greater enrollment shifts into less comprehensive plans—including catastrophic and short-term limited duration plans—that provide less coverage, worsen healthcare affordability challenges, and cause patients to forego needed healthcare if they cannot afford their high deductibles. Furthermore, enrollment growth in marketplace high-deductible plans, even when paired with HSAs, could in turn increase physician's uncompensated care costs and/or add to patients' medical debt. Although the Council maintains that HSAs should be available to individuals purchasing qualified marketplace plans on a voluntary basis, we believe that increased premium assistance within the existing ACA PTC structure will be critical as healthcare costs, and the cost of coverage, continue to rise.

Although redirecting baseline or enhanced PTCs into HSAs or HSA-type accounts could benefit healthier marketplace enrollees and those with higher disposable incomes, the Council does not believe such policies would offset the loss of enhanced PTCs, lower costs for most marketplace consumers, or adequately mitigate affordability concerns. As previously noted, HSAs shift financial risk onto patients and should not be viewed as a replacement for federal premium assistance. Accordingly, the Council recommends that the AMA support enhancements to ACA marketplace subsidies, including PTCs, without redirecting subsidies into HSAs.

During the development of this report, the Council learned that a few states (e.g., California, Colorado, Connecticut, Maryland, Massachusetts, and New Jersey) used their own funds this year to help subsidize coverage in order to stabilize enrollment and improve affordability for residents who had lost federal premium support. In a time of general enrollment downturn, New Mexico actually increased enrollment in its marketplace by 17 percent by fully backfilling the lost federal enhanced subsidies, though it was the only state to fully make up for the expired enhanced PTCs.[25] Other states amended existing state subsidy programs to address a growing need for premium assistance, including Massachusetts, where an additional $250 million was invested and Connecticut, which spent an additional $51 million.[26] The Council recognizes that states cannot be expected to offset the loss of the enhanced federal PTCs, and that states face serious fiscal challenges and difficult funding choices due to federal cuts to Medicaid, SNAP, and other programs. However, since some states funded marketplace subsidies this year, we also believe that states should at least consider investing in marketplace subsidies, particularly for residents with the lowest incomes. Therefore, the Council recommends encouraging states, when possible, to consider supplementing federal ACA premium subsidies using state funds in order to stabilize enrollment and improve affordability. In addition, the Council recommends that the AMA reaffirm Policy H-165.818, which supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance, such as ACA premium tax credits. Finally, the Council continues to study marketplace affordability and will present future policy recommendations to the House of Delegates as needed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support enhancements to Affordable Care Act (ACA) marketplace subsidies, including premium tax credits, without redirecting subsidies into health savings accounts (HSAs). (New HOD Policy)

2. That our AMA encourage states, when possible, to supplement federal ACA premium subsidies using state resources in order to stabilize enrollment and improve affordability. (New HOD Policy)

3. That our AMA reaffirm Policy H-165.818, which supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance, such as ACA premium tax credits. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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Council on Medical Service Report 5-I-26
Improving Marketplace Affordability through Premium Tax Credits
Policy Appendix

Health Savings Account Reform H-165.818

1. Our American Medical Association (AMA) supports permitting health savings account (HSA) contributions from family members, employers, or other designated individuals and not limiting HSA contributions to the owner of the high-deductible health plan, provided that annual Internal Revenue Service contribution limits are not exceeded.
2. Our AMA supports contributions to HSAs by individuals who are Medicare enrollees with support for external research and/or demonstration projects to determine how best those distributions can be spent, with special consideration for low-resource Medicare enrollees.
3. Our AMA supports external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and other family members.
4. Our AMA supports Affordable Care Act (ACA) premium tax credits designed to allow individuals to contribute to HSAs through the application of unused or residual credit amounts.
5. Our AMA supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans, including those purchasing bronze plans and how that plan compares to purchasing a silver plan with subsidies.
6. Our AMA supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance such as ACA premium tax credits. (CMS Rep. 01, I-25)

Health Insurance Affordability H-165.828

1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA
    i. encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and
    ii. supports individual market bronze and silver plans, regardless of actual deductible amount, being treated as HSA-qualified high-deductible health plans, with appropriate guardrails in place (e.g., safe harbor provisions) to ensure low-income enrollees in these plans do not suffer financial hardships.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.
9. Our AMA supports that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan.
10. Our AMA supports incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, if and only if there is documentation that marketplace insurance pays sufficiently to ensure physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is best for themselves and their families.
11. Our AMA supports any incremental lifting of the firewall must be paired with a pause to review the relevant parameters, and the ability to pause permanently, or reverse if disruptive effects are detected.
12. Our AMA advocates that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay fair and equitable rates. (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701, I-21; Reaffirmed: Res. 826, I-24; Appended: CMS Rep. 02, A-25; Modified: CMS Rep. 01, I-25)

Principles for Structuring a Health Insurance Tax Credit H-165.865
(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.
(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.
(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. (CMS

Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmation I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 01, A-24)

Improving Affordability in the Health Insurance Exchanges H-165.824

1. Our American Medical Association will:
    a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
    b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
    c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
    d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports:
    a. eliminating the subsidy “cliff”, thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
    b. increasing the generosity of premium tax credits.
    c. expanding eligibility for cost-sharing reductions.
    d. increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 826, I-24)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-I-26

Subject:	Study of Physicians Utilizing Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries
Presented by:	A. Patrice Burgess, MD, Chair
Referred to:	Reference Committee J

Council on Medical Service Report 6, "Study of Practice Models for Physicians Performing Procedures Across State Lines," was introduced at the 2026 Annual Meeting and was referred. Council on Medical Service Report 6-A-26 initially addressed referred Resolution 711-A-25. This report focuses on physicians traveling out of state or to another area distant from their primary practice location, performing a procedure in an ambulatory surgical center (ASC), office-based laboratory (OBL), or office-based surgical (OBS) suite and subsequently leaving the area or state. The report recommends the adoption of a new set of related policy principles.

BACKGROUND

For the purposes of this report, an itinerant surgeon travels to a distant site from their home practice, performs surgery, and departs after completing the procedure, often leaving the postoperative care of the patient to another physician or member of the care team. Guidance holds that in order for this practice to be ethical, a surgeon must perform appropriate preoperative assessments and postoperative follow-up care or delegate this care to a physician familiar with the patient and trained in the same specialty as the surgeon performing the procedure. It should be noted that patients in rural settings can benefit from services provided by itinerant surgeons, granting them access to specialists they would otherwise have to travel long distances to see. Recent data from peer reviewed sources was not available on the impact of itinerant surgeons on patient outcomes or physician liability and/or malpractice. Studies on surgical workforce in the United States almost always omitted the effect of itinerant surgeons. In cases where itinerant surgery was taken into account, data on the impact of this arrangement was inconclusive.

ASCs are regulated health care facilities providing outpatient surgical care for patients who do not require an overnight stay, including preventive and diagnostic treatments. ASC procedures are often paid at rates 35-50 percent lower than those for comparable procedures performed at hospital outpatient departments and thus may be considered more cost efficient.[1] OBLs are similar non-hospital outpatient facilities, typically offering less complex procedures. Recently, OBS has become increasingly prevalent. In this arrangement, a physician will build a surgical suite within their practice to perform procedures, often with the same layout and standards as an ASC. As with other licensed surgical facilities, office-based surgical suites can utilize either Class A (oral sedation) or Class B (IV sedation) anesthesia.

ASCs account for over 60 percent of outpatient procedural care and represent a $30 billion market.[2] In recent years, ASCs have become an attractive target for private equity investment. The shift to outpatient surgical procedures presents investment opportunities for investors without having to directly acquire a hospital facility. Empirical evidence on quality of care in ASCs after private

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equity acquisition is still limited and relies on a small number of studies, which to date have not found significant changes in short-term quality metrics though they do show substantial changes in charges and payer mix.[3] A recent study found that private equity-owned ASCs do not increase surgical volume but do raise prices significantly – charging nearly 50 percent more per case within four to five years.[4]

RELEVANT POLICY

Policy H-475.984 establishes Core Principles on Office-Based Surgery. Most relevant to this report is Core Principle #4, which states that physicians performing OBS with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital or maintains an emergency transfer agreement with a nearby hospital.

The AMA Code of Ethics discusses related issues in Opinions 2.3.6, Surgical Co-Management, 1.1.3, Patient Rights, and 11.2.3, Contracts to Deliver Health Care Services. Opinion 2.3.6 states that physicians engaging in the practice of surgical co-management should do so following all ethical and legal guidelines, working with the patient to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner, and obtaining patient consent for the surgical co-management arrangement. This consent should include the disclosure of significant aspects of the arrangement, such as qualifications of clinicians, services each clinician will provide, and billing arrangements. Opinion 1.1.3 states that patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals. Further, the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care. Finally, Opinion 11.2.3 states that prior to entering into contracts to deliver health care services, physicians should consider the proposed contract to assure themselves that the terms do not create conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients.

The American College of Surgeons (ACS) has its own policy and ethics statements regarding itinerant surgeons and surgical co-management.[6] Other surgical specialty societies such as the American Academy of Ophthalmology, American Society of Plastic Surgeons, and American Academy of Otolaryngology-Head and Neck Surgery also have policies or statements that outline situations where itinerant surgery may be permissible. While these vary, they all generally indicate that the ultimate responsibility for arranging an appropriate level of continuity of care falls upon the operating surgeon.[7,8,9]

DISCUSSION

The lack of available data on patient outcomes and physician medical liability make it difficult to accurately gauge the impact of itinerant surgeons and their work at ASCs, OBLs, or OBS suites across state lines. There are plausible concerns regarding follow-up care or burdens on local physicians, although available data do not establish the extent of these effects.

There are varying opinions on the ethics of itinerant surgery. Despite some criticisms, it may be the most appropriate way to provide specialty surgical care in rural areas or other places with a shortage of specialty surgeons. Ethics statements from the AMA and ACS state that surgeons who perform elective surgery at a practice that is distant from their home have a professional obligation to also perform preoperative assessments and postoperative follow-up care. There is leeway, however, if perioperative care is designated to another physician who is equivalently qualified to

continue caring for the patient, as long as this arrangement is agreed to ahead of the procedure by all parties, including the patient.

While the original resolution mentioned corporate entities, the recommendations made by the Council are not specific to ownership type (e.g., private equity, physician-owned) as there is no evidence to date that ownership of an ASC has an impact on itinerant surgeon arrangements or outcomes for patients. When compared to non-private equity-owned ASCs, those owned by private equity did not have statistically significant differences in the probability of a patient having an unplanned hospital visit (i.e., complications during or post-surgery).[5]

The principles outlined in the recommendations below can be applied generally and highlight important considerations for those contemplating the practice of itinerant surgery. Of utmost importance is continuity of care for the patient and having both backup and transfer agreements in place with local physicians who are able to provide the necessary follow-up care, both in case of emergencies and to ensure proper healing and recovery. Itinerant surgery may not be appropriate in all cases, but the Council believes that it may be acceptable in certain circumstances, specifically providing planned specialty surgical care to areas of shortage. The Council concurs with the ethical standards reviewed and agrees that in cases where itinerant surgery is the best option, physicians should follow appropriate guidelines and ethical and legal standards.

When presented at the 2026 Annual Meeting, there was feedback shared on CMS Report 6-A-26 that indicated there could be unintended consequences with the recommendations as written, particularly related to reproductive health care. The report was referred to the Council for further consideration. The Council appreciated this feedback and has amended the recommendations to address these concerns. Specifically, the Council has deleted the original recommendations 1a and 1b from CMS Report 6-A-26. The Council believes the intent of this language is captured in AMA Ethical Opinions 2.3.6, 1.1.3, and 11.2.3, as well as Policy H-475.984. The Council has also incorporated amendments proposed at the 2026 Annual Meeting to what are now clauses 1a, 1a(iii), and 1b. Finally, the Council has added a recommendation to reaffirm Policy D-5.999 which states that the AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.

As written, the original resolved clauses of referred Resolution 711-A-25 have challenges to their feasibility but raise an important concern. Additionally, recent data could not be found to quantify the impact of the concerns raised in the original resolution. However, the Council believes there is a gap in AMA policy regarding the practice of itinerant surgeons and thus presents a set of guidelines for physicians who may practice across state lines, specifically at ASCs, OBLs, or OBS suites, to address the issues raised in Resolution 711-A-25.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed.

1. That our American Medical Association (AMA) supports the following principles for physicians utilizing ambulatory surgical centers (ASC), office-based laboratories (OBL), or office-based surgery (OBS) suites who may travel from their primary practice location to provide patient care, while asserting that regulatory requirements applicable to ASCs, OBLs,

and OBS should be evidence-based, proportional to patient risk, and should not create unnecessary barriers to medically appropriate care:

a. When applicable, transfer agreements and backup plans should be coordinated between physicians.
    i. In the event an institution coordinates these arrangements (i.e., a hospital system, an ASC, or an OBL), a physician who would be designated to be among those receiving and caring for the patient must give explicit consent to the agreement to provide follow-up care.
    ii. When patient transfer is required, an appropriate and timely handoff of the patient and the transfer of relevant patient records should be completed.
    iii. Transfer agreements should be evidence-based, proportional to patient risk, and should not create unnecessary barriers to patient access to medically appropriate care.

b. Protocols and agreements for ensuring continuity of care with physicians in the local community should be established when clinically indicated and feasible. Such protocols should be proportionate to patient risk and the services provided.

c. Consent from the patient regarding preoperative assessment and postoperative care should be obtained prior to the provision of any procedure, with clarity on which physician will be providing care during each step of the process.

d. Physicians entering into these arrangements should ensure that they are in keeping with ethical standards and legal requirements.

(New HOD Policy)

2. That our AMA reaffirm Policy D-5.999, which states that the AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services, and that the AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in order to deliver reproductive health services, including contraception and abortion. (Reaffirm HOD Policy)

Fiscal Note: Minimal.

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Council on Medical Service Report 6-I-26
Study of Itinerant Surgeons Practicing at Ambulatory Surgical Centers and Office-Based Laboratories or Performing Office-Based Surgeries
Policy Appendix

Preserving Access to Reproductive Health Services, D-5.999

1. Our American Medical Association (AMA) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right.
2. Our AMA opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion.
3. Our AMA will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion.
4. Our AMA supports shared decision-making between patients and their physicians regarding reproductive healthcare.
5. Our AMA opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients.
6. Our AMA opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services.
7. Our AMA will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services.
8. Our AMA will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.

(Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22; Reaffirmation: A023; Appended: Res. 711, A-23; Reaffirmed: Res. 014, A-25)

Office-Based Surgery Regulation, H-475.984
Our American Medical Association supports the following Core Principles on Office-Based Surgery:

Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: https://www.asahq.org/standards-and-guidelines/guidelines-for-office-based-anesthesia, https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia).

Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system).

Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified.

Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. (Med. Licensure Discipline. 2002; 88:-160-174).

Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. https://www.fsmb.org/siteassets/advocacy/policies/outpatient-office-based-surgery.pdf).

Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS).

Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training. (BOT Action in response to referred for decision BOT Rep. 23, A-03; Modified: CMS Rep. 4, A-13; Modified: CCB/CLRPD Rep. 1, A-23)

E-2.3.6 Surgical Co Management
Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:
(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.
(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.
(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.
(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.
(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.
(f) Employ appropriate safeguards to protect patient confidentiality.
(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.
(h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.
(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

AMA Principles of Medical Ethics: I, II, IV, V, VI
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
(Issued: 2016)

E-1.1.3 Patient Rights
The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

(a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
(c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
(d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
(e) To have the physician and other staff respect the patient's privacy and confidentiality.
(f) To obtain copies or summaries of their medical records.
(g) To obtain a second opinion.

(h) To be advised of any conflicts of interest their physician may have in respect to their care.
(i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

AMA Principles of Medical Ethics: I, IV, V, VIII, IX
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
(Issued: 2016)

E-11.2.3 Contracts to Deliver Health Care Services
Prioritizing profits over patients is incompatible with physicians' ethical obligations. No part of the health care system that supports or delivers patient care should place profits over such care. Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires that before entering into contracts to deliver health care services, physicians consider carefully the proposed contract to assure themselves that its terms and conditions do not create untenable conflicts of interest or compromise their ability to fulfill their ethical and professional obligations to patients. Those physicians who enter into contracts with corporate entities, such as private equity firms, management service organizations, professional services corporations, insurance companies, or pharmaceutical benefit managers, who act within their capacity as a physician, even as administrators or intermediaries, also have a duty to uphold the ethical obligations of the medical profession.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes are intended to enhance quality, efficiency, and safety in health care, they can also put at risk physicians' ability to uphold professional ethical standards and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians seek capital to support their practices or enter into various differently structured contracts to deliver health care services—with group practices, hospitals, health plans, investment firms, or other entities—they should be mindful that while some arrangements have the potential to promote desired improvements in care, other arrangements have the potential to put patients' interests at risk and to interfere with physician autonomy.

When contracting with entities, or having a representative do so on their behalf, to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts, preferably with the advice of legal and ethics counsel to assure themselves that the arrangement:
(i) minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
(ii) does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;

(iii) ensures the physician can appropriately exercise professional judgment;
(iv) includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
(v) is transparent and permits disclosure to patients;
(vi) enables physicians to have significant influence on, or preferably outright control of, decisions that impact practice staffing;
(vii) prohibits the corporate practice of medicine.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical or professional standards.

When entering into contracts as employees, preferably with the advice of legal and ethics counsel, physicians should:

(c) Advocate for contract provisions to specifically address and uphold physician ethics and professionalism.

(d) Advocate that contract provisions affecting practice align with the professional and ethical obligations of physicians and negotiate to ensure that alignment.

(e) Advocate that contracts do not require the physician to practice beyond their professional capacity and provide contractual avenues for addressing concerns related to good practice, including burnout or related issues.

(f) Not enter into any contract that would require the physician to violate their professional ethical obligations.

When contracted by a corporate entity involved in the delivery of health care services, physicians should:

(g) Terminate any contract that requires the physician to violate their professional ethical obligations and report any known or suspected ethical violations through the appropriate oversight mechanisms.

AMA Principles of Medical Ethics: I, II, III, V, VI, VIII, IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

(Issued: 2016)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-26)

Introduced by: Medical Student Section, Oklahoma, Mississippi, Florida, South Carolina

Subject: Improving the External Appeals Process for Denied Claims

Referred to: Reference Committee J

Whereas, insurers of qualified health plans (QHPs) sold on HealthCare.gov denied 19% of in-network claims in 2023 and 37% of out-of-network claims for a combined average of 20% of all claims, with some insurers denying up to 54% of in-network claims[1]; and

Whereas, the most common reason (34%) for claims denial cited by insurers was “Other”, followed by “Administrative reason” (18%), with only 6% based on lack of medical necessity[1]; and

Whereas, 58% of insured adults encountered issues with their health insurance in the past 12 months as of 2023, including claim denials, and 39% of those who struggled to pay medical bills indicated that denied claims contributed to their financial challenges[2]; and

Whereas, while insurers are required to allow for an internal appeals process, less 1% of all denials are appealed, with a majority of internal appeals ending with insurers upholding their initial decision, and while individuals are also allowed an independent *external* appeals process for denied claims, marketplace enrollees approximately filed only 5,000 external appeals in 2023[1]; and

Whereas, the low number of appeals are attributed to difficulty in obtaining accurate information, lack of provider and patient knowledge regarding the appeals process, and excessive administrative burden and extended timelines[3-6]; and

Whereas, in some states, up to 80% of external appeals are successful after the initial denial of a claim and failure of an internal appeal, and have allowed for lifesaving care that was otherwise denied[7,8]; and

Whereas, the external appeals process is severely hampered by the cessation of federal ACA funding for external review programs, ‘labyrinthic’ processes for filing for an external appeal, strict eligibility requirements, and lack of patient and physician education regarding external appeals processes[4,5,9]; and

Whereas, the insurer has between 30 to 60 days to respond to an initial internal appeal, depending on category, and the cumulative timeframes of the many levels to the appeals process delays crucial health care interventions[6,10]; and

Whereas, some UnitedHealthcare plans have appeal packets as long as 14 single-spaced pages, detailing three levels of standard and three levels of expedited appeals, all of which delay the start of an independent external appeal[6]; and

Whereas, only certain denials are eligible for external appeal, which primarily involve medical judgment, surprise medical bills, or an insurer deciding to retroactively cancel coverage or determining that a treatment was experimental, and the insurer must agree that a given denial meets the eligibility criteria for such an appeal, setting up a conflict of interest[11]; therefore be it

RESOLVED, that AMA Policy H-320.952, External Grievance Review Procedures, be amended by addition and deletion to read as follows:

Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components:

(1) It should apply to all health carriers and Accountable Care Organizations;

(2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician;

(3) ~~Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational;~~
Issues eligible for external grievance review should include, at a minimum, adverse benefit determinations that materially affect an enrollee's coverage of, access to, or financial responsibility for health care items or services, including, but not limited to: determinations based on medical necessity or other medical judgment, experimental or investigational status, plan terms or benefit classification, network status, coding or other administrative grounds, surprise billing protections, or rescission of coverage; provided that external review need not encompass disputes solely concerning practitioner payment that do not affect the enrollee's coverage, access, or financial responsibility;

(4) ~~Internal grievance procedures should generally be exhausted before requesting external review;~~
Internal grievance procedures should remain available, but an enrollee, the enrollee's authorized representative, or treating physician should be permitted to seek independent external review of an adverse benefit determination without first exhausting internal grievance procedures. A health plan may conduct internal review concurrently, provided that independent external review is not delayed;

(5) An expedited review mechanism should be created for urgent medical conditions;

(6) Independent reviewers practicing in the same state should be used whenever possible;

(7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review;

(8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information;

(9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

Medicare Advantage Plans Double Standard H-330.863
Our AMA will seek legislation to require all payors, including Medicare Advantage plans, to use uniform payment denial appeals processes, which includes external review, for all appeals regardless of whether the physician or provider is contracted with the payor.

External Grievance Review Procedures H-320.952
Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components:
(1) It should apply to all health carriers and Accountable Care Organizations; (2) Grievances involving adverse determinations may be submitted by the policyholder, their representative, or their attending physician; (3) Issues eligible for external grievance review should include, at a minimum, denials for (a) medical necessity determinations; and (b) determinations by carrier that such care was not covered because it was experimental or investigational; (4) Internal grievance procedures should generally be exhausted before requesting external review; (5) An expedited review mechanism should be created for urgent medical conditions; (6) Independent reviewers practicing in the same state should be used whenever possible; (7) Patient cost sharing requirements should not preclude the ability of a policyholder to access such external review; (8) The overall results of external review should be available for public scrutiny with procedures established to safeguard the confidentiality of individual medical information; (9) External grievance reviewers shall obtain input from physicians involved in the area of practice being reviewed. If the review involves specialty or sub-specialty issues the input shall, whenever possible, be obtained from specialists or sub-specialists in that area of medicine.

Full transparency - Explanation of Benefits D-320.973
Our American Medical Association advocates that the minimum information included in an explanation of benefits,..., what criteria is used for coverage and non-coverage, and includes detailed explanation on how to appeal…

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-26)

Introduced by: American College of Lifestyle Medicine

Subject: Payer Coverage and Tax-Advantaged Access for Physical Activity Professionals, Services, and Programs

Referred to: Reference Committee J

Whereas, existing American Medical Association policy supports the use of exercise for health promotion and rehabilitation, encourages payer and employer coverage for fitness club memberships and other physical activity programs, and supports evidence-based lifestyle interventions addressing physical activity and nutrition for chronic disease prevention and management (H-470.997; H-425.972); and

Whereas, the 2018 Physical Activity Guidelines Advisory Committee Scientific Report found substantial health benefits from regular physical activity across the life course, and the Physical Activity Guidelines for Americans recommend both aerobic and muscle-strengthening physical activity;[1,2] and

Whereas, inadequate aerobic physical activity is associated with substantial health care expenditures, with a 2025 analysis estimating approximately $192 billion in annual United States health care expenditures associated with inadequate aerobic physical activity during the study period;[3] and

Whereas, economic evaluations have demonstrated favorable returns on investment and cost savings for supervised exercise therapy in adults with chronic conditions in the United States, including positive returns on investment ranging from 1.15:1 to 1.7:1, while an Australian analysis estimated a return of A$4.75 for every A$1 invested in structured diet and physical activity interventions integrated into antenatal care;[11,12] and

Whereas, national policy efforts have identified gaps in integrating physical activity assessment, prescription, referral, and connections to qualified exercise professionals and evidence-based programs into health care delivery;[4] and

Whereas, the Calendar Year 2027 Medicare Physician Fee Schedule proposed rule identifies nutrition, physical activity, and healthy lifestyles as priorities in chronic disease prevention and management and includes proposals concerning health and well-being coaching, including the qualifications and certification standards for personnel eligible to furnish coaching services, as well as remote physiologic and therapeutic monitoring, shared medical appointments, and longitudinal and multidisciplinary care, creating multiple potential pathways to better integrate physical activity and lifestyle interventions and inform future roles for qualified exercise professionals;[5] and

Whereas, federal tax rules allow Health Savings Account and health flexible spending arrangement funds to be used for qualified medical expenses, including certain disease-prevention expenses, but generally exclude expenditures primarily for general health, including many nutrition, fitness, and exercise expenses;[6,7] and

Whereas, the Personal Health Investment Today Act of 2025, H.R. 2369 and S. 1144 of the 119th Congress, would amend the Internal Revenue Code to treat certain amounts paid for physical activity, fitness, and exercise as amounts paid for medical care;[8,9] and

Whereas, existing national exercise-professional infrastructure supports verification of recognized professional credentials, and the developing U.S. National Exercise Referral Framework seeks to align exercise-professional education, training, and demonstrated competencies with patient health status, clinical needs, and complexity;[10] and

Whereas, specific advocacy for coverage, clinically integrated referral pathways, and tax-advantaged benefits would further operationalize existing AMA support for physical activity and healthy lifestyles; therefore be it

RESOLVED, that our American Medical Association advocate for sustainable public and private payer coverage for evidence-based physical activity assessment, exercise prescription, and related behavioral counseling, referral, and longitudinal follow-up services (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for policies supporting clinically integrated referral pathways to evidence-based exercise programs and qualified exercise professionals with education, training, and demonstrated competencies appropriate to patient needs and clinical complexity (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal legislation and regulatory policies expanding eligibility under tax-advantaged, Health Savings Accounts and health flexible spending arrangements for physical activity and exercise services and programs, and related nutrition and behavior-change services and programs, for chronic disease prevention and general health promotion. (Directive to Take Action)

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

Received: 9/14/26

REFERENCES

1. U.S. Department of Health and Human Services. *2018 Physical Activity Guidelines Advisory Committee Scientific Report*. Washington, DC: U.S. Department of Health and Human Services; 2018.
2. U.S. Department of Health and Human Services. *Physical Activity Guidelines for Americans*. 2nd ed. Washington, DC: U.S. Department of Health and Human Services; 2018.
3. Matjasko JL, Chen Z, Whitfield GP, Whitsel LP, Rose K, Roy K. Inadequate aerobic physical activity and healthcare expenditures in the United States: an updated cost estimate. *Am J Health Promot*. 2025;39(7):1085-1087. doi:10.1177/08901171251357128.
4. Whitsel LP, Bantham A. It's Time to Move: Integrating Physical Activity Assessment, Prescription, and Referral through Policy and Systems Change. *J Healthy Eat Act Living*. 2023;3(1):1-6. doi:10.51250/jheal.v3i1.65.
5. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program. CMS-1848-P. RIN 0938-AV82. Proposed rule. 2026.
6. Internal Revenue Service. *Frequently Asked Questions About Medical Expenses Related to Nutrition, Wellness and General Health*. Internal Revenue Service, U.S. Department of the Treasury.
7. Internal Revenue Service. *Publication 502 (2025): Medical and Dental Expenses*. Internal Revenue Service, U.S. Department of the Treasury; 2025.
8. Personal Health Investment Today Act of 2025, H.R. 2369, 119th Cong. (2025). Introduced March 26, 2025; referred to the U.S. House Committee on Ways and Means.
9. Personal Health Investment Today Act of 2025, S. 1144, 119th Cong. (2025). Introduced March 26, 2025; referred to the U.S. Senate Committee on Finance.
10. United States Registry of Exercise Professionals. Medical Professionals: U.S. National Exercise Referral Framework. U.S. Registry of Exercise Professionals. Accessed September 10, 2026.
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12. Chase PJ, Owen CM, Bantham A, Stoutenberg M, Ajibewa T, Barclay J, Huang M, Kariuki J, McNamara G, Stoner L, Whitsel LP. A Review of the Cost-Effectiveness of Supervised Exercise Therapy for Adults with Chronic Conditions in the United States. *Transl J Am Coll Sports Med*. 2025;10(3):e000313. doi:10.1249/TJX.0000000000000313.

RELEVANT AMA POLICY

Exercise and Physical Fitness H-470.997

1. Our American Medical Association encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity. The AMA encourages other organizations and agencies to join in promoting physical fitness through all appropriate means.
2. Our AMA advocates for continued research towards development of structured physical activity treatment plans for the specific diagnoses of anxiety and depression, as well as longitudinal studies to examine the effects of physical activity on health outcomes, particularly later in life.
3. Our AMA encourages the education of health care professionals on the role of physical activity and/or structured exercise in treating and managing anxiety and depression; the need to screen for levels of physical activity of patients; the need to motivate and educate patients of all ages about the benefits of physical activity, including positive mental health benefits.
4. Our AMA encourages the provision of coverage by health care payers and employers for fitness club memberships and access to other physical activity programs.
5. Our AMA encourages the implementation, trending, and utilization of evidenced-based physical activity measures in the medical record for treatment prescription, counseling, coaching, and follow up of physical activity for therapeutic use.

Policy Timeline – BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14; Modified: Res. 421, A-23; Modified: CSAPH Rep. 09, A-24.

Healthy Lifestyles H-425.972

1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the *Journal of the American Medical Association* in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

Policy Timeline – Res. 423, A-12; Appended: Res. 959, I-17; Reaffirmed: Res. 302, A-25.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-26)

Introduced by:	American Society for Reproductive Medicine, American College of Obstetricians and Gynecologists, American College of Medical Genetics and Genomics, Endocrine Section Council (The Endocrine Society, American Association of Clinical Endocrinology, and the American Society for Reproductive Medicine)
Subject:	Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit
Referred to:	Reference Committee J

Whereas, monogenic disorders affect approximately 400 million individuals worldwide and collectively represent a significant cause of morbidity, mortality, disability, and healthcare utilization; and

Whereas, advances in genetic technologies have improved the accuracy, accessibility, and clinical utility of monogenic disorder screening, including carrier screening and preimplantation genetic testing for monogenic disorders (PGT-M); and

Whereas, screening embryos for known familial monogenic disorders can inform reproductive decision-making, reduce transmission of known monogenic disorders, and improve patient outcomes; and

Whereas, professional organizations, including the American Society for Reproductive Medicine (ASRM), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Medical Genetics and Genomics (ACMG) recognize the important role of genetic testing in the evaluation and management of individuals and families at risk for inherited disorders; and

Whereas, insurance coverage for carrier testing and embryonic monogenic disorder screening remains inconsistent and often absent across public and private payers, creating financial barriers that may disproportionately affect underserved populations and exacerbate existing healthcare disparities; and

Whereas, the lack of coverage for clinically indicated embryonic monogenic disorder screening may prevent patients from accessing appropriate reproductive planning options and specialized care, as well as increasing the need for invasive screening tests and procedures in pregnancy; and

Whereas, expanding insurance coverage for evidence-based embryonic monogenic disorder screening has the potential to improve health outcomes by reducing the genetic transmission of monogenic conditions to offspring from known carriers; therefore be it

RESOLVED, that our American Medical Association support public and private health insurance coverage for clinically indicated monogenic disorder screening, including carrier and

preimplantation embryo testing, when supported by evidence-based clinical guidelines and physician judgment (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for embryonic monogenic disorder screening to be recognized as a medically necessary covered benefit by public and private payers when such testing is recommended according to established professional society guidelines or based on individualized clinical assessment (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage insurers to develop transparent and standardized coverage policies for embryonic monogenic disorder screening that minimize administrative barriers, including burdensome prior authorization requirements, that may delay medically appropriate care (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for equitable access to medically indicated embryonic monogenic disorder screening to reduce disparities in reproductive healthcare decision-making among historically underserved populations (Directive to Take Action); and be it further

RESOLVED, that our AMA work with relevant medical specialty societies, patient advocacy organizations, and policymakers to promote education regarding the clinical utility and cost-effectiveness of embryonic monogenic disorder screening of embryos in improving patient outcomes and informing patient-centered care. (Directive to Take Action)

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

Received: 9/15/26

REFERENCES

1. American Society for Reproductive Medicine practice guideline, "Indications and management of preimplantation genetic testing for monogenic conditions: a committee opinion"
2. American College of Obstetricians and Gynecologists (ACOG) Committee Opinion, "Preimplantation Genetic Testing"
3. American College of Medical Genetics and Genomics (ACMG) practice resource, “Screening for autosomal recessive and X-linked conditions during pregnancy and preconception: a practice resource of the American College of Medical Genetics and Genomics”

RELEVANT AMA POLICY

H-185.919 Payment and Coverage for Genetic/Genomic Precision Medicine
H-185.923 Integrating Precision Medicine into Alternative Payment Models
H-480.944 Improving Genetic Testing and Counseling Services
2.2.5 Genetic Testing of Children
4.1.1 Genetic Testing & Counseling
4.1.2 Genetic Testing for Reproductive Decision Making

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-26)

Introduced by: Kentucky

Subject: Medicare Coverage of Continuous Glucose Monitoring for Non-Insulin-Treated Type 2 Diabetes

Referred to: Reference Committee J

Whereas, type 2 diabetes mellitus is highly prevalent among older adults and is associated with substantial morbidity, mortality, health care utilization, and expenditures; and

Whereas, older adults with type 2 diabetes who are not treated with insulin may experience clinically significant hyperglycemia, hypoglycemia, and glycemic variability, which may contribute to falls, cardiovascular events, cognitive impairment, hospitalization, and other adverse outcomes; and

Whereas, traditional self-monitoring of blood glucose by fingerstick provides intermittent glucose measurements and may be burdensome, painful, and insufficient to identify clinically important patterns of hyperglycemia, hypoglycemia, and glycemic variability; and

Whereas, continuous glucose monitoring (CGM) provides dynamic glucose information, including glucose trends and, for appropriate devices, alerts for hypo- and hyperglycemia, thereby supporting timely patient and clinician interventions and individualized diabetes management; and

Whereas, the American Diabetes Association's Standards of Care in Diabetes—2026 recommends CGM for adults with diabetes receiving insulin therapy, receiving noninsulin therapies that can cause hypoglycemia, and for individuals receiving any diabetes treatment for which CGM assists in management; and the Standards of Care report that randomized controlled trials in adults with type 2 diabetes not using insulin increasingly demonstrate improvements in A1C, time in range, time above, and other glycemic outcomes with CGM compared with blood glucose monitoring [1,2]; and

Whereas, current Medicare coverage criteria for CGM require that a beneficiary with diabetes either be treated with insulin or have documented problematic hypoglycemia meeting specified criteria, thereby excluding some Medicare beneficiaries with non-insulin-treated type 2 diabetes for whom CGM may be clinically appropriate[3] ; and

Whereas, Medicare currently classifies CGMs as durable medical equipment and recognizes their clinical utility for diabetes management, but its coverage criteria do not fully reflect the expanding evidence supporting CGM use in selected patients with non-insulin-treated type 2 diabetes[4]; and

Whereas, the American Medical Association already supports Medicare coverage of continuous and flash glucose monitoring systems for patients with insulin-dependent diabetes through AMA Policy H-330.885, and the AMA has previously recognized the importance of expanding access to clinically effective and cost-saving glucose monitoring technologies[5,6]; and

Whereas, expanding evidence-based access to CGM may improve diabetes self-management, facilitate individualized treatment decisions, reduce preventable complications, and support value-based care while allowing physicians and patients to determine whether CGM is clinically appropriate[7]; therefore be it

RESOLVED, that our American Medical Association amend Policy H-330.885, "Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes," by addition and deletion to read as follows:

Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Diabetes H-330.885

Our American Medical Association supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring ~~devices~~ systems for patients with diabetes, including patients with type 2 diabetes who are not treated with insulin, when it is evidenced-based and determined clinically appropriate by the treating physician~~s~~.

Our AMA advocate that the Centers for Medicare & Medicaid Services (CMS) revise Medicare coverage criteria for CGM to permit coverage for beneficiaries with non-insulin-treated type 2 diabetes when clinically appropriate, without requiring insulin use or a documented history of problematic hypoglycemia as the sole qualifying criteria.

Our AMA advocate for Medicare CGM coverage policies that preserve physician clinical judgment, incorporate evolving evidence and clinical guidelines, and avoid unnecessary administrative barriers to medically appropriate CGM access.

Our AMA support continued research evaluating the clinical effectiveness, health outcomes, health care utilization, quality of life, health equity, and cost-effectiveness of CGM among patients with non-insulin-treated type 2 diabetes.
(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

REFERENCES

1. American Diabetes Association Professional Practice Committee for Diabetes. 7. Diabetes Technology: Standards of Care in Diabetes-2026. Diabetes Care. 2026;49(Suppl 1):S150-S165.
2. American Diabetes Association Professional Practice Committee for Diabetes. 9. Pharmacologic Approaches to Glycemic Treatment: Standards of Care in Diabetes-2026. Diabetes Care. 2026;49(Suppl 1):S183-S215.
3. Centers for Medicare & Medicaid Services. Medicare Coverage of Diabetes Supplies. Medicare Learning Network. February 2026.
4. Centers for Medicare & Medicaid Services. LCD L33822: Glucose Monitors. Medicare Coverage Database.
5. American Medical Association. Policy H-330.885: Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes.
6. American Medical Association House of Delegates. Resolution 816 (I-22): Coverage for Continuous or Flash Glucose Monitoring Devices. 2022.
7. American Diabetes Association Professional Practice Committee for Diabetes. 6. Glycemic Goals, Hypoglycemia, and Hyperglycemic Crises: Standards of Care in Diabetes—2026. *Diabetes Care*. 2026;49(Suppl 1):S132-S149.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-26)

Introduced by: American College of Emergency Physicians

Subject: Meaningful Enforcement of Prohibitions on the Corporate Practice of Medicine

Referred to: Reference Committee J

Whereas, at the 2026 Annual Meeting, our American Medical Association substantially strengthened its corporate practice of medicine policy through Board of Trustees Report 25 and Resolution 241, and Policy H-215.981 now directs our AMA to create a state corporate practice of medicine template; and

Whereas, our AMA has established extensive policy protecting physician clinical autonomy, independent professional judgment, due process, patient advocacy, and physicians who report unsafe or unethical care; however, these protections may be ineffective when physicians lack meaningful mechanisms to report, challenge, or obtain relief from corporate interference; and

Whereas, prohibitions on the corporate practice of medicine exist in many states, but such protections have limited value without effective enforcement, meaningful remedies, and protection for physicians who exercise independent clinical judgment or report conduct that threatens patient safety or violates applicable law; and

Whereas, states have begun adopting statutory approaches that strengthen enforcement of protections against impermissible corporate interference and provide remedies for affected physicians; and

Whereas, Policy H-215.981 already supports enforcement of laws and regulations pertaining to corporate control of medical practice and directs our AMA to develop a state corporate practice of medicine template, creating an opportunity to ensure that these protections are accompanied by meaningful enforcement mechanisms; therefore be it

RESOLVED, that our American Medical Association amend Policy H-215.981, “Corporate Practice of Medicine,” by modification to read as follows:

1. Our American Medical Association vigorously opposes any effort to pass legislation or regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine.
2. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
3. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

4. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.
5. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected.
6. Our AMA will create a state corporate practice of medicine template to assist state medical associations and ~~national medical~~ specialty societies as they navigate the intricacies of corporate investment in physician practices and health care ~~generally at the state level~~ and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices, i<u>ncluding meaningful enforcement mechanisms, remedies, and protections against retaliation and provisions rendering unenforceable contractual restrictions that interfere with physicians' independent professional judgment, patient advocacy, or good-faith reporting]</u>
7. Our AMA supports <u>meaningful</u> enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority ~~is~~ <u>are</u> preserved and protected, <u>including appropriate enforcement authority and meaningful remedies for violations.</u>
8. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.
(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

RELEVANT AMA POLICY

Corporate Practice of Medicine H-215.981

1. Our American Medical Association vigorously opposes any effort to pass legislation or regulation that removes or weakens state or federal laws prohibiting the corporate practice of medicine.
2. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups.
3. Our AMA, at the request of state medical associations, will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.
4. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient centered care and other relevant issues.
5. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected.
6. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices.

7. Our AMA supports enforcement of existing regulations and legislation pertaining to corporate control of practices in the health care sector to ensure that physician clinical autonomy and operational authority is preserved and protected.
8. Our AMA supports capital reserve requirements and leverage standards that preserve access to care for patients and fulfillment of contractual obligations to physicians and trainees by providing stable financing for hospitals, clinics, and other health care facilities.

[Res. 247, A-91Reaffirmed: Sunset Report, I-01Reaffirmed: CMS Rep. 7, A-11Modified: CMS Rep. 6, I-13Reaffirmed: CMS Rep. 07, A-17Modified: Res. 713, A-18Reaffirmed: CMS Rep. 11, A-19Reaffirmed: CME Rep. 01, I-22Modified: Res. 710, A-24Modified: BOT Rep. 09, I-24Appended: CMS Rep. 03, A-25Modified: BOT Rep. 25, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-26)

Introduced by: Senior Physicians Section

Subject: Proration of Liability Insurance Premiums for Senior Physicians Based on Hours Worked

Referred to: Reference Committee J

Whereas, evidence continues to demonstrate a growing shortage of practicing physicians[1,2,3]; and

Whereas, the number of senior physicians who are no longer engaged in clinical practice continues to rise[1,2,3]; and

Whereas, a significant barrier to the increased utilization of senior physicians is the high cost of professional liability insurance[1,2,3]; and

Whereas, senior physicians engaged in part-time clinical practice are frequently charged the full premium for professional liability insurance[1,2,3]; therefore be it

RESOLVED, that our American Medical Association advocate for the development of prorated liability insurance policies for senior physicians to enhance incentives for them to remain in, or re-enter, medical practice on a part-time basis (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association develop a position paper addressing prorated professional liability insurance premiums as a means to expand access to medical care, with proration based on physician specialty, hours worked, and prior medical liability claims history, and report its findings back to the House of Delegates by A-28, thereafter to the major insurance carriers of professional liability. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

References

1. Pollich, M. *Understanding Part Time Malpractice Insurance and Policy Options*. CGAA. Published January 24, 2025. Accessed August 13, 2026. https://www.cgaa.org/article/part-time-malpractice-insurance
2. Mello, M.M., Frakes, M.D., Blumenkranz E., Studdert, D.M., Malpractice liability and health care quality: a review. *JAMA* 2020; 323 (4): 352-366.doi: 10.1001/jama.2019.21411. (jamanetwork.com)
3. Resident Advisor. *Going Part-Time or Per Diem: Adjusting Your Malpractice Without Gaps*. Published January 7, 2026. Accessed August 13, 2026 (residencyadvisor.com)

RELEVANT AMA POLICY

G-620.045 Medical Malpractice Discount Rates
Our AMA encourages member organizations of the Federation to offer access to discounted medical liability insurance premiums where legally permissible.
[Res.603, A-14; Reaffirmed: CCB/CLRPD Rep.01, A-24]

H-200.972 Primary Care Physicians in Underserved Areas
1. Our American Medical Association should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

a. encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care;

b. encourage the affiliation of these family health clinics with local medical schools and teaching hospitals;

c. advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies;

d. encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence;

e. urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations;

f. encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations and

g. urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to:

a. expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and

b. increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

[CMS Rep. I-93-2; Reaffirmation A-01; Reaffirmation I-03; Modified: CME Rep. 13, A-06; Reaffirmed: CMS Rep.01, A-16; Modified: CME Rep.04, I-18; Appended: Res. 206, I-19; Reaffirmation: I-22; Reaffirmed: BOT Rep. 11, A-23; Reaffirmed: Res. 724, A-23; Reaffirmed BOT Rep.07, I-24]

H-435.998 Equitable Risk Classification in Medical Liability Premiums
Our American Medical Association supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums
[Res.15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep.12, A-02; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: BOT Rep.09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-26)

Introduced by: Senior Physicians Section

Subject: Continuing Care Retirement Communities (CCRC's)

Referred to: Reference Committee J

Whereas, seniors have a great deal of difficulty understanding the complexity of the finances of Continuing Care Retirement Communities (CCRC's); and

Whereas, CCRC's are exploding in popularity among baby boomers; and

Whereas, there are approximately 1,900 CCRC's nationwide, with a 4% - 4.5% annual growth rate expected annually[1,2]; and

Whereas, deciding if a CCRC is right for each senior means puzzling out a complex business model that blends real estate, healthcare, and insurance; and

Whereas, there is a risk you may pay for care you do not need, as well as the risk of the CCRC not fulfilling its financial duties; and

Whereas, there is no federal oversight of CCRC's and there are no nationwide standards; and

Whereas, CCRC's are regulated primarily at the state level; therefore be it

RESOLVED, that our American Medical Association study the issue of Continuing Care Retirement Communities (CCRC's), including how they are regulated, disclosures needed, contract terms, and financial safeguards in an effort to advocate for and protect older adults and senior physicians (Directive to Take Action); and be it further

RESOLVED, that there be a report back to the HOD by I-27. (Directive to Take Action)

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

Received: 9/16/26

REFERENCES

1. AARP How Continuing Care Retirement Communities Work. AARP, January 27, 2022. (aarp.org)
2. National Investment Center for Seniors Housing & Care (NIC). 2026 Outlook for U.S. Continuing Care Retirement Communities (CCRC's). (nic.org)

RELEVANT AMA POLICY

H-160.897 Inclusion of Continuing Care Retirement Centers and Long-Term Care Facilities in Accountable Care Organizations Investment Model
Our American Medical Association supports participation of physicians practicing in Continuing Care Retirement Centers and other community-based long-term care settings in ACOs, medical homes, and other APMs.
[BOT Action in response to referred for decision: Res. 707, A-17]

H-280.984 Residential Facility Regulations
Our AMA advocates for patients in long-term care, group home and other residential settings and will: (1) strive to see that enhanced quality of care results from any new proposed state or federal regulations; (2) attempt to ensure that appropriate and necessary physician involvement be maintained for patients; (3) urge state regulatory bodies and HHS to seek consultation and advice from the AMA and other professional medical societies when developing rules and regulations that affect medical care; (4) support cooperative efforts with appropriate groups for the purpose of developing mutually supported positions regarding medical care regulations; (5) support efforts to monitor federal and state legislation and regulations which affect physicians involved in long-term, group home or other residential setting care, and provide testimony and information about appropriate medical management of patients to regulatory and/or licensing bodies; and (6) support actions to establish better understanding and cooperation among federal and state health agencies as they formulate health and safety standards.
[Res. 89, I-89; Sub. Res. 168, A-89; Sub. Res. 109, I-87; CMS Rep. 11, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Modified: CMS Rep. 3,A-10; Reaffirmed: CMS Rep.01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-26)

Introduced by: Women Physicians Section, Organized Medical Staff Section, Private Practice Physicians Section

Subject: Increasing Payment for Patient Portal Messages

Referred to: Reference Committee J

Whereas, a study of patient portal message volume estimate that patient authored portal messages have increased by 153% since the start of the COVID-19 pandemic [1] and show no signs of slowing down; and

Whereas, a retrospective study from the University of Wisconsin Department of Family Medicine showed that, over a 2 year period, female family physicians on average received 1754 messages each compared to an average of 1235 messages received per male family physician, equaling a 42% higher rate of patient portal messages received over their male colleagues [2]; and

Whereas, female physicians spend approximately 20% more time managing electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, patient portal messages, email and telephone communications than their male counterparts [3]; and

Whereas, much of the time and effort spent on managing electronic patient communications is unpaid work; and

Whereas, lack of protected time to manage electronic patient communications becomes time taken away from seeing patients, caring for oneself, and spending time with friends and family, leading to increased rates of burnout; and

Whereas, while Medicare does offer payment for some electronic patient communications that meet strict requirements, fewer than 1% of Medicare beneficiaries are billed for portal message services [4]; and

Whereas, more insurance companies are starting to cover reimbursement for electronic patient communications, physicians generally submit billing codes for only a tiny fraction of billable messages [5]; and

Whereas, our AMA's policy, advocacy and member education surrounding payment for electronic patient communications has been limited despite broad advocacy for overall physician payment reform; therefore be it

RESOLVED, that our American Medical Association amend Policy H-385.919, "Payment for Electronic Communication," by addition and deletion to read as followed:

1. Our American Medical Association will advocate that ~~pilot projects of innovative~~ physician payment models be structured to include ~~incentive~~ fair

market payment for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, patient portal messages, and email and telephone communications.
2. Our AMA will continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices.
3. Our AMA will educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians. (Update current policy); and be it further

RESOLVED, that our AMA advocate for employers to a.) educate physicians on how to effectively and fairly bill for electronic communications b.) create workflows and templates which make such billing easy to implement, and c.) incorporate protected time into a physician's schedule in order to adequately address patient portal messages (Directive to take Action); and be it further

RESOLVED, that our AMA prioritize the promotion of already available toolkits and member education resources pertaining to how to more effectively manage inbasket work and bill for patient portal messages. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

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RELEVANT AMA POLICY

H-385.919 Payment for Electronic Communication

1. Our American Medical Association will advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications.
2. Our AMA will continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices.
3. Our AMA will educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.

[CMS Rep. 1, A-10; Reaffirmed in lieu of Res. 705, A-11; Reaffirmation: I-18; Reaffirmed: Res. 801, I-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Joint Commission Standards for Medical Staff Self-Governance

Referred to: Reference Committee J

Whereas, autonomy and independence of the medical staff of a healthcare facility forms the backbone of quality care delivery; and

Whereas, when the independence of the medical staff and its leadership is compromised, the ability of medical staff to fulfill their responsibility to provide quality patient care is jeopardized; and

Whereas, selection of medical staff leadership and control over medical staff duties by a healthcare facility's board or other leadership is diametrically opposed to self-governance and threatens patient safety and physician professionalism; and

Whereas, the Joint Commission revised its hospital accreditation standards effective January 2025, significantly reducing references to medical staff self-governance and autonomy that appear to weaken support for these vital components of care delivery; and

Whereas, Joint Commission standards affect accredited hospitals but also influence national policy and practices in other care facilities throughout the healthcare industry; and

Whereas, AMA policy strongly supports medical staff self-governance to protect patients and preserve physician professionalism; therefore be it

RESOLVED, that our American Medical Association, through its appointees to the Joint Commission Board of Commissioners and other appropriate channels, advocate for restoring clear accreditation standards affirming medical staff self-governance and physician-led oversight of credentialing, privileging, peer review, professional competence, quality improvement, patient safety, and other matters involving the professional practice of medicine. (Directive to Take Action)

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

Received: 9/16/26

RELEVANT AMA POLICY

Hospital Medical Staff Self-Governance H-235.980
1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.

2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.

3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:
(a) Application, reapplication, credentialing and privileging standards;
(b) Fair hearing and appeal process;
(c) Selection, election and removal of medical staff officers;
(d) Clinical criteria and standards which manage quality assurance, utilization review;
(e) Structure of the medical staff organization;
(f) Rules and regulations that affect the entire medical staff.

4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.

Citation: Sub. Res. 201, A-89; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmed: A-05; Appended: Res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed; CMS Rep. 01, A-25

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence

Referred to: Reference Committee J

Whereas, the Medicare Conditions of Participation require hospitals to maintain an organized medical staff that operates under governing-body-approved bylaws, is responsible for the quality of medical care, and is well-organized and accountable to the governing body[1,2]; and

Whereas, the Centers for Medicare and Medicaid Services (CMS) interpretive guidance describes a collaborative system of checks and balances in which the medical staff exercised oversight through credentialing, privileging, peer review, policy approval, and quality improvement participation[2]; and

Whereas, the current Medicare Conditions of Participation address medical staff organization, accountability, composition, and bylaws but do not expressly prescribe the functional reporting relationship of medical staff office personnel or minimum protected budgetary, staffing, and independent-counsel resources for the organized medical staff[1,2]; and

Whereas, AMA Policies H-225.957 and H-235.980 recognize medical staff self-governance, control of medical staff funds, access to independent legal counsel, and the organized medical staff's role in determining the resources and financial support required to fulfill its responsibilities[3,4]; and

Whereas, AMA Policy H-375.962 recognizes the central role of confidentiality, privilege, good-faith participation, immunity, and protection from retaliation in effective peer review[5]; and

Whereas, because Medical Staff Office personnel administer credentialing, privileging, peer review, corrective action, quality improvement, and medical staff governance, exclusive administrative control over their medical-staff duties may create actual or perceived conflicts when the interests of hospital administration and the organized medical staff differ[2,3,5]; and

Whereas, CMS-approved accrediting organizations may survey hospitals for deemed compliance only through programs whose standards meet or exceed applicable Medicare requirements[6]; therefore be it

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) establish standards requiring, as a Condition of Participation for hospitals participating in Medicare, that Medical Staff Office personnel performing functions on behalf of organized medical staff have clearly defined functional accountability to the organized medical staff, through the Medical Executive Committee or its designee for credentialing, privileging, peer review, corrective action, medical staff governance, quality oversight, and other organized medical staff functions (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that CMS require hospital medical staff bylaws or related governing documents approved through the medical staff bylaw process to define the Medical Staff Office reporting structure, authority over medical-staff work assignments and performance evaluation, safeguards against administrative interference or retaliation, and standards governing access to, use of, and disclosure of confidential medical staff information (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that CMS-approved hospital accrediting organizations adopt uniform standards concerning Medical Staff Office functional accountability, protected medical staff resources, access to independent legal counsel when appropriate, and confidentiality of credentialing, privileging, peer review, quality-improvement, corrective-action, and disciplinary information (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that Joint Commission standards explicitly protect the organized medical staff's access to timely, transparent, and interpretable information, adequate resources, and independent authority necessary to meaningfully fulfill its self-governance responsibilities, regardless of how supporting personnel, technology, or administrative infrastructure are organized. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

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2. Centers for Medicare & Medicaid Services. State Operations Manual, Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, § 482.22. CMS State Operations Manual Appendix A Accessed August 4, 2026.
3. American Medical Association. Policy H-225.957, Principles for Strengthening the Physician-Hospital Relationship. AMA PolicyFinder Accessed August 4, 2026.
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8. American Medical Association. Policy H-235.976, Medical Staff Bylaws and Medical Staff Autonomy. AMA PolicyFinder Accessed August 4, 2026.
9. American Medical Association. Policy D-235.982, Model Hospital Medical Staff Bylaws; reproduced in Resolution 024 (A-24), Relevant AMA Policy section. AMA HOD source Accessed August 4, 2026.
10. American Medical Association. AMA Physician's Guide to Medical Staff Organization Bylaws, 7th ed. AMA guide landing page Accessed August 4, 2026.

RELEVANT AMA POLICY

Principles for Strengthening the Physician-Hospital Relationship H-225.957
Our American Medical Association adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include:
    a. duration of leave allowed before and after delivery;
    b. category of leave credited;
    c. whether leave is paid or unpaid;
    d. whether provision is made for continuation of insurance benefits during leave, and who pays the premium;
    e. whether sick leave and vacation time may be accrued from year to year or used in advance;
    f. how much time must be made up in order to be considered board eligible;
    g. whether make-up time will be paid;
    h. whether schedule accommodations are allowed; and
    i. leave policy for adoption.
3. Our AMA policy is expanded to include physicians in practice, reading as follows:
    a. residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled;
    b. staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and
    c. physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave, and with eligibility beginning at the start of employment without a waiting period.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. duration of leave allowed after abortion or stillbirth;
    d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);
    e. whether leave is paid or unpaid;
    f. whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance;
    g. extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;

   h. how time can be made up in order for a resident physician to be considered board eligible;
   i. what period of leave would result in a resident physician being required to complete an extra or delayed year of training;
   j. whether time spent in making up a leave will be paid; and
   k. whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements:
   a. leave policy for birth or adoption;
   b. duration of leave allowed before and after delivery;
   c. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
   d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
   e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
   f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.
15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely

means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.
21. Our AMA 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.

Citation: CCB/CLRPS Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23; Modified: Res. 302, I-24; Appended: Res. 306, I-25

Hospital Medical Staff Self-Governance H-235.980

1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.
2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.
3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:
   (a) Application, reapplication, credentialing and privileging standards;
   (b) Fair hearing and appeal process;
   (c) Selection, election and removal of medical staff officers;
   (d) Clinical criteria and standards which manage quality assurance, utilization review;
   (e) Structure of the medical staff organization;
   (f) Rules and regulations that affect the entire medical staff.
4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.

Citation: Sub. Res. 201, A-89; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmed: A-05; Appended: Res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 01, A-25

Medical Staff Bylaws and Medical Staff Autonomy H-235.976

Our AMA reaffirms that (1) medical staff bylaws are a contract between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application.

Citation: Res. 8, A-91; Modified: Sunset Report, I-01; Reaffirmed: BOT Rep. 9, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 01, A-24

Model Hospital Medical Staff Bylaws D-235.982

1. Our AMA will continue to update the Physician's Guide to Medical Staff Organization Bylaws to address emerging issues in medical staff affairs, including relevant changes to medical staff regulatory and accreditation requirements, such as those outlined in the Medicare Hospital Conditions of Participation and in the accreditation standards of The Joint Commission and other hospital accrediting organizations.
2. Our AMA will develop guidance for physicians on key state-by-state differences in medical staff bylaws requirements and best practices, and work with state medical societies to catalog state-specific medical staff resources available to physicians.
3. Our AMA will pursue opportunities to improve the accessibility and usability of the content contained in the Physician's Guide to Medical Staff Organization Bylaws, including but not limited to development of supplemental materials such as education modules, checklists, and so forth.

Citation: BOT Rep. 35, A-18

Legal Protections for Peer Review H-375.962

Definition and Purpose of Peer Review

Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; ie, professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.

Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process.

Composition of the Peer Review Committee

Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.

Definitions

Good Faith Peer Review. Peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains, or due to personal vendetta is not considered a good faith peer review.

Medical Peer Review Organizations. Any panel, committee, or organization that is composed of physicians or formed from a medical staff or formed by statute, such as physician wellness peer review boards, which engages in or utilizes peer reviews concerning the care and treatment of patients for the purposes of self-monitoring and maintaining the administration of patient safety and quality of care

consistent with optimal standards of practice is a medical peer review organization. The responsibility of a medical peer review organization is to ensure: (1) that all physicians consistently maintain optimal standards of competency to practice medicine; and (2) the quality, safety, and appropriateness of patient care services. The medical peer review committee's obligations include review of allegations of infirmity (e.g., fitness to practice medicine), negligent treatment, and intentional misconduct. Peer review protections and privilege should extend to investigation and subsequent correction of negligent treatment and intentional misconduct.

Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within their knowledge; but such witness cannot be asked about their testimony before a peer review organization or about opinions formed by them as a result of the peer review organization hearings.

Peer Review Activity. Peer review activity means the procedure by which peer review committees or quality assessment and assurance committees monitor, evaluate, and recommend actions to improve and ensure the delivery and quality of services within the committees' respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions.

Peer Review Records. Peer review records mean all complaint files, investigation files, reports, and other investigative information relating to the monitoring, evaluation, and recommendation of actions to improve the delivery and quality of health care services, licensee discipline, or professional competence in the possession of a peer review committee or an employee of a peer review committee.

Privilege. The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.

Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities.

Citation: BOT Rep. 10, A-09; Reaffirmed: BOT Rep. 13, I-11; Modified: BOT Rep. 05, I-17; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24

9.5.1 Organized Medical Staff

The organized medical staff performs essential hospital functions even though it may often consist primarily of independent practicing physicians who are not hospital employees. The core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care.

Members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concerns the interest of the organized medical staff and its members. This is ethical so long as there is no adverse effect on patient safety and the quality of care.

AMA Principles of Medical Ethics: IV,VI
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-26)

Introduced by: American Academy of Physical Medicine & Rehabilitation, American Academy of Pediatrics, Association of Academic Physiatrists, American Association of Neuromuscular & Electrodiagnostic Medicine, Medical Student Section

Subject: Government Support of Adaptive Sports Programming

Referred to: Reference Committee J

Whereas, only 53% of adults with disabilities report engaging in at least 10 minutes of dedicated aerobic physical activity in a given week, compared to 74% of adults without disabilities;[1,2] and

Whereas, adaptive sports provide a crucial outlet through which all individuals can engage in necessary physical activity, helping to address disparities in exercise engagement;[3] and

Whereas, participation in adaptive sports is associated with improved bone density, decreased adiposity, self-perceived improvement in fitness, and improved health-related fitness outcomes;[2,4-6] and

Whereas, adaptive sports are an effective rehabilitation tool for individuals with congenital or acquired illnesses or injuries such as central neurological lesions, including brain injury, spinal cord injury, stroke, and multiple sclerosis; limb amputation; vision loss, etc., with benefits for function and quality of life;[7] and

Whereas, individuals with disabilities who participate in adaptive sports form supportive communities, which are critical given the disproportionate rates of social isolation and mental health challenges among individuals with disabilities;[2,8-12] and

Whereas, adaptive sports can have a positive economic impact by reducing burden on the healthcare system through improved physical health, while also being positively associated with employment among individuals with disabilities;[5,13] and

Whereas, despite the clear physical, mental, and social benefits of adaptive sports, participation is often limited by barriers, including the cost of adaptive equipment, transportation challenges, inaccessible facilities, limited program availability, and lack of awareness of existing opportunities, all of which may be especially pronounced in rural and low-income communities;[2,14-17] and

Whereas, Congress and the Department of Veterans Affairs have previously funded veteran adaptive sports programming through grants for their development, implementation, and management that include direct operational costs such as equipment, training, event facilitation, and travel, at both the recreational and competitive levels;[18-20] and

Whereas, lawmakers continue to introduce, sponsor, or support legislation to increase funding for recreational sports and sporting infrastructure;[21,22] and

Whereas, our American Medical Association has existing policy addressing insurance coverage of activity-specific adaptive sports and exercise equipment including prostheses and orthoses (Policy H-90.961), and governmental incentives for the development of community recreational fitness facilities (Policy H-470.952), but has no policy addressing operational support for adaptive sports programming itself including coaching, trained personnel, transportation, and event facilitation; which the literature identifies as principal barriers to participation; therefore be it

RESOLVED, that our American Medical Association advocate for increased public funding for the development, expansion, accessibility, and sustainability of adaptive sports programming for athletes of all ages, particularly in low-income and rural communities (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the integration of adaptive sports and recreation into the rehabilitation care continuum, including physician counseling of patients of all ages with disabilities regarding the health benefits of adaptive sports participation and referral to community adaptive sports programs (New HOD Policy); and be it further

RESOLVED, that our AMA support the inclusion of appropriately trained medical and coaching personnel, pre-participation medical assessment, and proper fitting of adaptive sports equipment within publicly funded adaptive sports programming (New HOD Policy); and be it further

RESOLVED, that our AMA reaffirm Policy H-90.961, “Private and Public Insurance Coverage for Adaptive Sports Equipment Including Prostheses and Orthoses.” (Reaffirm HOD Policy)

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

Received: 9/22/26

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RELEVANT AMA POLICY

Exercise and Physical Fitness H-470.997
1. Our American Medical Association encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation and urges state and local medical societies to emphasize through all available channels the need for physical activity. The AMA encourages other organizations and agencies to join in promoting physical fitness through all appropriate means. [BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14; Modified: Res. 421, A-23; Modified: CSAPH Rep. 09, A-24]

Promotion of Exercise H-470.991
1. Our American Medical Association: a. supports the promotion of exercise, particularly exercise of significant cardiovascular benefit. b. encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. [Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Private and Public Insurance Coverage for Adaptive Sports Equipment Including Prostheses and Orthoses H-90.961
1. Our American Medical Association recognizes activity-specific adaptive sports and exercise equipment as assistive devices that are integral to the health maintenance of persons with disabilities in accordance with national exercise guidelines. 2. Our AMA recognizes activity-specific adaptive sports and exercise equipment, such as activity-specific prostheses and orthoses, as medical devices that facilitate independence and community participation. 3. Our AMA advocates for coverage by all private and public insurance plans for activity-specific adaptive sports and exercise equipment for eligible beneficiaries with disabilities in order to promote health maintenance and chronic disease prevention. [Res. 112, A-24]

Support for Persons with Intellectual Disabilities H-90.967
Our American Medical Association encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible. [Res. 01, A-16]

Government to Support Community Exercise Venues H-470.952
1. Our American Medical Association encourages towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities. 2. Our AMA encourages governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. [CSAPH Rep. 1, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-26)

Introduced by: New York

Subject: Protect Patient Choice and Physician Privileges in Hospitals Merger and Acquisitions

Referred to: Reference Committee J

Whereas, the proposed merger of Maimonides Medical Center in Brooklyn, New York and NYC Health+Hospitals appears to be inevitable; and

Whereas, the current patients in Brooklyn have a choice of seeing independent physicians or Maimonides employed physicians and having their surgery performed at Maimonides Hospital by board-certified surgeons, and private practice physicians have full and unrestricted admitting and surgical privileges at Maimonides Hospital; and

Whereas, malpractice carriers as well as insurance contracts require full admitting and surgical privileges for surgical specialists even to perform in-office procedures; and

Whereas, the NYC Health+Hospitals does not have a provision for private practice physicians to have full admitting and surgical privileges, and the merger will lead to the loss of full practice privileges for private practice physicians at Maimonides Hospital and the limitation of choices for patients in Brooklyn; and

Whereas physicians that provide in-patient care to their own patients require the ability to admit and operate on patients at hospitals, physicians are legally precluded from opening and operating independent hospitals in New York State; hospitals are essentially “utilities” in terms of physician livelihoods; and

Whereas insurance networks vary, with some hospitals out-of-network with particular plans and others in-network, surgeons and other hospital-care providing physicians require the ability to admit and treat patients at more than one facility to minimize patient costs; and

Whereas, the NYS Attorney General James concluded that court review would be more appropriate for Maimonides' deal to join the New York City public hospital network, due to pending litigation and significant community engagement with the merger; therefore be it

RESOLVED, that our American Medical Association advocate to protect the full admitting and surgical privileges of private practice physicians as a necessary condition of any hospital merger or acquisition and will advocate to protect the employment benefit for physicians, residents and fellows including preservation of salary and benefit levels and Public Service Loan Forgiveness (PSLF) eligibility as a necessary condition of any hospital merger or acquisition. (Directive to Take Action)

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

Received: 9/22/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-26)

Introduced by: New York

Subject: Small Medical Practice Website and other Digital Service Compliance with ADA Regulation

Referred to: Reference Committee J

Whereas, countless small medical practices across the country have been consolidated into large groups and health systems due to the extraordinary costs and requirements of maintaining a private medical practice; and

Whereas, recent Department of Justice (DOJ) rule specifically sets digital accessibility deadlines for public entities (Title II) to comply with Web Content Accessibility Guidelines (WCAG) 2.1 Level AA by April 24, 2026 (or April 26, 2027, for smaller populations); and
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Whereas, there is no specific, new, fixed compliance date for private/non-government entities (Title III). Non-government entities face compliance risk, as Title III of the Americans with Disabilities Act (ADA) requires public accommodations to be accessible, and the new Title II web standards are likely to be adopted as the industry standard for private litigation; and

Whereas, there have been numerous lawsuits filed against businesses in recent years for failing to comply with the requirements of the Americans with Disabilities Act with regard to the public websites, apps, or digital services of these businesses; and

Whereas, these lawsuits are flourishing because of court decisions and settlements that direct that websites of businesses must meet certain accessibility requirements; and

Whereas, there are no exceptions in the law or in these court decisions regarding applicability to small businesses that have far less resources to update these websites to meet standards; and

Whereas, the American Medical Association and medical associations across the country have been advocating on a number of fronts to ensure that physicians maintain a meaningful choice whether to practice as part of their own medical practice or as an employee of a hospital or health system; therefore be it

RESOLVED, that our American Medical Association educates its members on ADA compliance requirements as they apply to medical practice websites and other digital services (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation, regulation or other legal mechanisms to provide hardship exemption, financial assistance, enforcement flexibility and/or legal immunity for solo and small-group medical practices that do not meet requirements of the Americans with Disabilities Act as it applies to medical practice websites and other digital services. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/22/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-26)

Introduced by: American Thoracic Society

Subject: Coverage of SMART Therapy for Asthma

Referred to: Reference Committee J

Whereas, Single Maintenance and Reliever Therapy (SMART) is a guideline-recommended, high-value asthma treatment that reduces preventable exacerbations and downstream health care utilization; and

Whereas, SMART uses a single budesonide–formoterol inhaler for both maintenance and symptom relief, simplifying treatment and ensuring rapid delivery of anti-inflammatory therapy during symptom worsening; and

Whereas, compared with traditional regimens, SMART reduces severe asthma exacerbations by approximately 30–40%, leading to fewer emergency department visits, hospitalizations, and courses of systemic corticosteroids; and

Whereas, despite strong evidence and national guideline endorsement, SMART remains underutilized, due in part to formulary restrictions, non-preferred drug placement, prior authorization requirements, and inhaler quantity limits; and

Whereas, improving insurance coverage of SMART represents an opportunity to improve outcomes and reduce avoidable health care utilization; and

Whereas, budesonide–formoterol is explicitly supported for SMART by national and international guidelines, while mometasone–formoterol may be considered as an alternative where clinically appropriate; and

Whereas, both the National Asthma Education and Prevention Program (NAEPP) and the Global Initiative for Asthma (GINA) clinical practice guidelines for asthma recommend maintenance-and-reliever therapy using inhaled corticosteroid (ICS)–formoterol for appropriate patients; and

Whereas, our American Medical Association supports patient access to safe and effective treatments prescribed by physicians, including clinically appropriate off-label uses of FDA-approved medications, and supports reducing prior authorization and formulary barriers that impede access to necessary drug therapy; and

Whereas, our AMA Policy D-185.907, “Access to Single Maintenance and Reliever Therapy for Asthma,” supports removing or increasing quantity limits for inhaled corticosteroid/long-acting beta-agonist combination inhalers when prescribed in accordance with evidence-based guidelines and supports efforts to improve access to asthma inhalers in state Medicaid programs; and

Whereas, multiple state Medicaid programs have adopted coverage policies supporting access to budesonide–formoterol and/or mometasone–formoterol; therefore be it

RESOLVED, that our American Medical Association advocate that public and private health plans, including state Medicaid programs, provide formulary coverage of brand-name formulations and FDA-approved generic equivalents of budesonide–formoterol and mometasone–formoterol, without prior authorization requirements (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that health plans increase quantity limits per month, allow three-month supplies when possible, and adjust the days' supply per month and refill thresholds to support the dispensing of budesonide-formoterol and/or mometasone-formoterol in adequate quantities for patients to correctly follow SMART dosing without disruptions in inhaler dispensing (Directive to Take Action); and be it further

RESOLVED, that our AMA recommends that pharmacies adjust dispensing and claims-adjudication protocols to ensure that the National Drug Code (NDC) submitted reflects the patient's formulary coverage and preference for brand-name versus generic products. (New HOD Policy)

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

Received: 9/22/26

RELEVANT AMA POLICY

Access to Single Maintenance and Reliever Therapy for Asthma D-185.907
Our AMA supports working with CMS and major national insurance carriers to remove or increase quantity limits for inhaled corticosteroid/long-acting beta-agonist combination inhalers when prescribed according to evidence-based guidelines. The policy also directs AMA collaboration with state medical associations to advocate for removal of copays for asthma inhalers in state Medicaid plans.
[Res. 102, A-25]

Cost of Prescription Drugs H-110.997
Our AMA supports prescription-drug cost-containment programs only when patients retain access to medications necessary to treat their illnesses and physicians retain freedom to select the most appropriate drug and delivery method. AMA policy also affirms physician discretion to prescribe either brand-name or generic pharmaceuticals and supports expanded third-party coverage of prescription medications as necessary medical therapies.
[BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed: CMS Rep. 04, I-24; Reaffirmed: CMS Rep. 07, A-26]

Patient Access to Treatments Prescribed by Their Physicians H-120.988
Our AMA supports physicians' autonomous clinical decision-making authority, including clinically appropriate off-label use of FDA-approved drugs or devices when supported by sound scientific evidence or medical opinion. AMA policy also supports third-party coverage of safe and effective off-label therapies and emphasizes physicians' responsibility to interpret scientific information in the context of individual patient care.
[Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20; Reaffirmation: I-22; Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: CSAPH Rep. 02, A-23; Reaffirmed: CSAPH Rep. 02, A-24]

Prior Authorization and Utilization Management Reform H-320.939
Our AMA supports reducing prior-authorization administrative burdens and improving patients' access to necessary care. AMA policy supports measuring the effects of prior authorization and utilization-management processes on patient access and clinical outcomes and advocates that health plans minimize burdens on patients, physicians, and medical centers.
[CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22; Reaffirmed: BOT Rep. 20, A-26]

Managed Care Cost Containment Involving Prescription Drugs H-285.965
Our AMA supports formulary policies that adequately reflect the needs of individual patients and provide mechanisms for physicians to seek formulary additions or exceptions when medically appropriate. The policy specifically states that prescription caps, prior authorization, and other cost-containment mechanisms should not unduly burden physicians or patients in obtaining optimal drug therapy.
[CEJA Rep. 2, A-95; Res. 734, A-97; Appended by Res. 524 and Sub. Res. 714, A-98; Reaffirmed: Res. 511, A-99; Modified: Res. 501; Reaffirmed: Res. 123 and 524, A-00; Modified: Res. 509, I-00; Reaffirmed: CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmation A-08; Reaffirmation A-10; Reaffirmed in lieu of Res. 822, I-11; Reaffirmation A-14; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-26)

Introduced by: Florida

Subject: Improving Technology to Combat Automated and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies

Referred to: Reference Committee J

Whereas, the mechanism of automated downcoding, wherein payer algorithms reduce higher-level E/M codes such as 99214 and 99215 to 99213 based solely on proprietary statistical models and peer-comparison benchmarks applied at the point of claim adjudication without requesting or reviewing the physician's medical record, constitutes adjudication without adequate clinical review, violates standard billing practices, and conflicts with the AMA policy (1) and AMA CPT E/M guidelines that define service levels by Medical Decision Making (MDM) or total physician time, not by diagnosis codes or population-level outlier comparisons; and

Whereas, automated and artificial intelligence-directed downcoding of Evaluation and Management (E/M) services by commercial health insurance companies has increased sharply since 2022 despite AMA advocacy (2), driven by AI and machine learning algorithms deployed at scale by major payers including Medicare Advantage Plans (3); and

Whereas, a recent survey found that 75 percent of independent specialty practices report that insurer downcoding has increased over the past year, with thousands of E/M claims routinely downgraded, often by automated payer algorithms without any clinical review, and one practice reporting that 98 of 100 audited downcoded charts were originally coded correctly (4); and

Whereas, automated downcoding inflicts significant and often invisible financial harm on physician practices, with revenue erosion from algorithmic downcoding alone estimated at $28,000 to $74,000 per physician annually in family practice settings, and $40,000 to $180,000 annually for multi-specialty practices, with the loss frequently undetected because downcoded claims are posted as paid rather than denied, bypassing standard denial management workflows (5,6); and

Whereas, automated downcoding disproportionately threatens the financial viability and long-term sustainability of small independent practices, rural practices, and practices serving minority and underserved communities, which lack the administrative infrastructure and revenue cycle staffing capacity of large health systems to detect, track, and appeal downcoded claims; the American Academy of Family Physicians has stated that automated downcoding is an existential threat to many practices, especially those in rural and underserved areas who may be the only health care access point for entire communities (7); and

Whereas, because downcoded claims are processed and posted as paid rather than denied, they do not appear in denial queues, denial rate reports, or standard billing exception reports, making them effectively invisible to current revenue cycle management workflows, and the vast majority of EHR-integrated billing platforms and practice management systems currently lack

any native automated detection mechanism that compares the submitted CPT code against the paid CPT code and alerts billing staff to the discrepancy (8); therefore be it

RESOLVED, that our American Medical Association advocate with urgency, including through EHR certification criteria and standard billing and clearinghouse functionality, for electronic health record, billing, and practice management systems to automatically detect from the electronic remittance advice when a payer has adjudicated or reimbursed a claim at an E/M service level lower than the level submitted — whether by code reassignment or payment reduction — and to alert physicians or their billing staff, with the original and adjudicated codes, the payer's stated reason, and the applicable appeal deadline, within the time needed to appeal (Directive to Take Action); and be it further

RESOLVED, that our AMA increase awareness of automated, algorithmic, and artificial intelligence-directed E/M downcoding among physicians, medical societies, policymakers, regulators, and other stakeholders; develop, provide, and update resources — including downcoding-specific appeal templates, model contract language, and documentation guidance — to help physicians identify, document, and appeal inappropriate downcoding; and collect and periodically report data on the prevalence and payer-level patterns of such downcoding. (New HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

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RELEVANT AMA POLICY

Litigation Center Cases to Combat Automatic Downcoding and/or Recoding H-70.924
The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices.
Citation: BOT Rep. 31, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22; Bundling and Downcoding of CPT Codes H-70.937

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;
(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;
(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and
(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.
Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17;

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
It is the policy of our American Medical Association, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes:
1. The principal reason(s) for the determination.
2. The clinical rationale used in making the determination.
3. A statement describing the process for appeal.

Automatic Downcoding of Claims D-320.972
1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.
2. Our AMA supports that, after review of the patient’s medical record and determination that a lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.
3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.
4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995
1. Our American Medical Association will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization.
2. Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review.
3. AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to
a. develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims.
b. seek information on a regular basis from those associations that collect such information.
c. respond with appropriate legislation, advocacy, and communication initiatives.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-26)

Introduced by: Florida

Subject: Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services

Referred to: Reference Committee J

Whereas, several AMA policies exist to oppose health plans from using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode, and the AMA has created tool kits and model state legislation to oppose unjustified downcoding of medical claims, yet AI driven automatic downcoding continues to escalate and an update and enforcement of these policies is needed (1,2,3); and

Whereas, automated downcoding without medical record review may constitute a violation of state insurance claim-settlement laws requiring claims to be adjudicated based on reasonable investigation, a legal theory already applied when the Maryland Insurance Administration, on March 13, 2026, fined Cigna $80,000 and ordered it to cease automatic E/M downcoding under Policy R49, finding that the mechanism of applying a policy rule before any human reviewed the encounter independently constituted a violation of state law(4); and

Whereas, Medicare Advantage (MA) plans continue to automatically downcode physician E/M services using proprietary algorithms and internal edits not used in traditional Medicare, and despite CMS's 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) requiring MA plans to follow traditional Medicare billing standards and base determinations on the medical record, MA plans still downgrade claims without reviewing physician documentation; (2, 5); and

Whereas, state medical societies and patient advocates have made progress in curbing unjustified automatic AI driven downcoding by introducing and passing legislation against automatic downcoding (6), (7), (8), (9); therefore be it

RESOLVED, that our American Medical Association uses its legal and advocacy resources, when appropriate, to support litigation, including class action suits, challenging automated, algorithmic, or artificial intelligence-directed downcoding of properly documented E/M services without appropriate medical record review (New HOD Policy); and be it further

RESOLVED, that our AMA advocates and requests CMS to enforce and strengthen its 2024 Final Rule requirements applicable to Medicare Advantage plans regarding automated coverage and coding criteria, restricts downcoding without clear separate notification of each incident with the explanation of benefits, and establishes minimum transparency standards for all algorithmic claims adjudication policies including public disclosure of the criteria and methodologies used. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

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3. ASP-RCM Solutions. (March 2026). Maryland Cigna Downcoding Order: Analysis and Provider Guidance. Referencing Maryland Insurance Administration Order of March 13, 2026.URL: https://www.asp-rcm.com/maryland-cigna-downcoding-order
4. 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f
5. New Illinois law to curb the growing trend of health insurance companies automatically reducing fees paid to doctors. https://www.wbez.org/health-medicine/2026/08/26/blue-cross-blue-shield-lowers-payment-for-therapists-pediatricians-under-new-downcoding-policy
6. CMA sponsors legislation to prohibit automatic downcoding by insurance companies. https://www.cmadocs.org/newsroom/news/view/ArticleId/51132/CMA-sponsors-legislation-to-prohibit-automatic-downcoding-by-insurance-companies
7. AMA March 27, 2026: State Advocacy Update. https://www.ama-assn.org/health-care-advocacy/advocacy-update/march-27-2026-state-advocacy-update
8. 7 AI health insurance state laws passed in 2026. https://www.beckerspayer.com/policy-updates/7-ai-health-insurance-state-laws-passed-in-2026/

RELEVANT AMA POLICY

Litigation Center Cases to Combat Automatic Downcoding and/or Recoding H-70.924
The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices.
Citation: BOT Rep. 31, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22;

Bundling and Downcoding of CPT Codes H-70.937
Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;
(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;
(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and
(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.
Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17;

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
It is the policy of our American Medical Association, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes:
1. The principal reason(s) for the determination.
2. The clinical rationale used in making the determination.
3. A statement describing the process for appeal.

Automatic Downcoding of Claims D-320.972
1. Our American Medical Association vigorously opposes health plans using software, algorithms, or methodologies, other than manual review of the patient's medical record, to deny or downcode evaluation and management services, except correct coding protocol denials, based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th revision, codes, and/or modifiers submitted on the claim.
2. Our AMA supports that, after review of the patient’s medical record and determination that a

lower level of evaluation and management code is warranted, the explanation of benefits, remittance advice documents, or other claim adjudication notices provide notice that clearly indicates a service was downcoded using the proper claim adjustment reason codes and/or remittance advice remark codes.
3. Our AMA will advocate for legislation to provide transparency and prohibit automated denials, other than National Correct Coding Initiative denials, or downcoding of evaluation and management services based solely on the Current Procedural Terminology/Healthcare Common Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes, or modifiers submitted on the claim.
4. Our AMA will further evaluate what legislative and/or legal action is needed to bar insurers from automatic downcoding and to provide transparency on all methodology of processing claims.

Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995
1. Our American Medical Association will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization.
2. Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review.
3. AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to
a. develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims.
b. seek information on a regular basis from those associations that collect such information.
c. respond with appropriate legislation, advocacy, and communication initiatives.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-26)

Introduced by: American College of Emergency Physicians

Subject: Proposed revised H-450.982, Patient Satisfaction, Patient Experience, and Quality of Care

Referred to: Reference Committee J

Whereas, patient feedback and appropriately designed patient-experience and patient-satisfaction measures can provide valuable information about communication, patient-centered care, access, and the delivery of health care and can support quality improvement, formative feedback, and physician professional development; and

Whereas, patient-experience and patient-satisfaction measures vary in their design, reliability, validity, and suitability for different purposes, and continued evaluation is needed to better understand their relationship to clinical quality and health outcomes; and

Whereas, financial, employment, or other incentives tied to patient-experience or patient-satisfaction survey scores may create pressure to prioritize patient expectations over independent clinical judgment and evidence-based care; and

Whereas, physicians should be supported in providing medically appropriate care based on clinical judgment and the best interests of the patient without incentives to provide unnecessary, inappropriate, or unsafe care; and

Whereas, existing policy, H-450.982, Patient Satisfaction and Quality of Care states: Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality; therefore be it

RESOLVED, that our American Medical Association recognizes patient feedback and appropriately designed patient-experience and patient-satisfaction measures as valuable tools for improving communication, patient-centered care, health care delivery, quality improvement, formative feedback, and professional development (New HOD Policy); and be it further

RESOLVED, that our AMA supports continued efforts to improve the measurement of patient experience and patient satisfaction, including ensuring that such measures are valid, reliable, and used for the purposes for which they were developed (New HOD Policy); and be it further

RESOLVED, that our AMA opposes tying individual physician compensation, bonuses, hiring, employment retention or termination, promotion, credentialing, contracting, or network participation to patient-experience or patient-satisfaction survey scores (New HOD Policy); and be it further

RESOLVED, that our AMA opposes policies or incentives based on patient-experience or patient-satisfaction survey scores that may interfere with independent clinical judgment or

incentivize medically unnecessary, inappropriate, or unsafe care (New HOD Policy); and be it further

RESOLVED, that our AMA rescind policy H-450.982. (Rescind Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

RELEVANT AMA POLICY

Patient Satisfaction and Quality of Care H-450.982
Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality. [CMS Rep. E, A-89Reaffirmed: Sunset Report, A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed BOT Rep. 9, A-13Reaffirmed: CMS Rep. 02, I-17Reaffirmation: A-19]

Pain Management and the Hospital Value-Based Purchasing Program D-450.962
1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient Experience of Care (ED-PEC) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain.
2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined. [BOT Rep. 9, A-13Modified: BOT Rep. 5, I-15Reaffirmed: CMS Rep. 01, A-25]

Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment D-385.958
Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that (1) subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment; and (2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. [Res. 102, A-13Reaffirmed: Res. 806, I-13Reaffirmed in lieu of Res. 814, I-14Reaffirmed: CMS Rep. 02, I-17Reaffirmation: A-19]

Pain Medicine and Patient Adherence in Quality Care Assessment D-450.958
Our AMA continues to advocate that the Centers for Medicare & Medicaid Services not incorporate items linked to pain scores and adherence to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys. Our AMA encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. [BOT Rep. 5, I-15Modified: CMS Rep. 07, A-25Reaffirmed: Res. 210, A-26]

Accountable Care Organization Principles H-160.915
Our American Medical Association adopts the following Accountable Care Organization (ACO) principles:

1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.
2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions

are not based on commercial interests but rather on professional medical judgment that puts patients' interests first:

a. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.
b. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.
c. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.
d. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.
4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.
5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).
7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

8. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.
9. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.
10. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.
11. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
12. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.
13. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.
14. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.
15. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.
16. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.
17. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.
18. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

    [Res. 819, I-10Reaffirmation A-11Reaffirmed: Res. 215, A-11Reaffirmation: I-12Reaffirmed: CMS Rep. 6, I-13Reaffirmed: Sub. Res. 711, A-15Reaffirmation I-15Reaffirmation: A-16Reaffirmation: I-17Reaffirmation: A-19Reaffirmation: A-23Reaffirmed: CMS Rep. 1, I-23Reaffirmed: Res. 217, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-26)

Introduced by: American College of Emergency Physicians

Subject: Proposed Revised D-385.958 - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment

Referred to: Reference Committee J

Whereas, patient experience and patient satisfaction are important dimensions of health care and can provide valuable information for improving communication, access, and the overall delivery of care; and

Whereas, patient-experience and patient-satisfaction survey scores may be influenced by factors beyond an individual physician's control, including facility operations, staffing, wait times, access to services, and other aspects of the care environment; and

Whereas, the use of patient-experience or patient-satisfaction survey scores in individual physician compensation and employment decisions may attribute system-level factors to individual physicians and may use such measures for purposes for which they were not designed or validated; and

Whereas, measures used for consequential decisions regarding individual physicians should be valid, reliable, appropriately attributable to the physician being evaluated, and suitable for the specific purpose for which they were developed; therefore be it

RESOLVED, that our American Medical Association amend Policy D-385.958 by addition and deletion to read as follows:

Our American Medical Association will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers, hospitals, health systems, and physician employers to ensure that;

(1) subjective criteria, such as patient satisfaction surveys, ~~be used only as an adjunctive and not a determinative~~ not be used as a measure of physician quality for the purpose of physician payment, employment, credentialing, or contracting; and

(2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Modify Current HOD Policy)

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

Received: 9/16/26

RELEVANT AMA POLICY

Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment D-385.958 Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that (1) subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment; and (2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. [Res. 102, A-13Reaffirmed: Res. 806, I-13Reaffirmed in lieu of Res. 814, I-14Reaffirmed: CMS Rep. 02, I-17Reaffirmation: A-19]

Patient Satisfaction and Quality of Care H-450.982 Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality.[CMS Rep. E, A-89Reaffirmed: Sunset Report, A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed BOT Rep. 9, A-13Reaffirmed: CMS Rep. 02, I-17Reaffirmation: A-19]

Pain as the Fifth Vital Sign D-450.956 Our AMA will: (1) work with The Joint Commission to promote evidence-based, functional and effective pain assessment and treatment measures for accreditation standards; (2) strongly support timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient's access to care; (3) advocate that pain as the fifth vital sign be eliminated from professional standards and usage; and (4) advocate for the removal of the pain management component of patient satisfaction surveys as it pertains to payment and quality metrics. [BOT Rep. 19, A-16Reaffirmation: A-19]

Pain Medicine and Patient Adherence in Quality Care Assessment D-450.958 (1)Our AMA continues to advocate that the Centers for Medicare & Medicaid Services not incorporate items linked to pain scores and adherence to physician recommendations as part of the Consumer Assessment of Healthcare Providers and Systems Clinician and Group Surveys and the Hospital Consumer Assessment of Healthcare Providers and Systems scores in future surveys. (2) Our AMA encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation, employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain and better adherence to physician recommendations. [BOT Rep. 5, I-15Modified: CMS Rep. 07, A-25Reaffirmed: Res. 210, A-26]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-26)

Introduced by: Minnesota

Subject: Modifiers Indicating Independent Non-Physician Practitioner Use of Physician Consults and Transfers

Referred to: Reference Committee J

Whereas, non-physician practitioners (NPPs) provide a vital service in health care; and

Whereas, nurse practitioners now have independent practice authority in 29 U.S. states plus the District of Columbia and two U.S. territories and 34% of them plan on going into independent practice within the next 5 years[1]; and

Whereas, studies have found that independent practice authority for NPs has resulted in an increased interest in self-employment with a predicted 374.1% increase in the probability of being self-employed[2-3]; and

Whereas, the literature on quality of care provided by independently practicing NPPs does not account for consultations with physicians or when care is transferred to a physician, which could have a great impact on the proper diagnosis and treatment plans, and thus impact quality metrics; and

Whereas, when patient care is transferred from an NPP to a physician on the same day, the entire visit is attributed to the physician; and

Whereas, modifier SA only applies to NPPs in collaborative practice settings but is not used by NPPs in independent practice; and

Whereas, new modifiers to be used by NPPs when they consult with a physician on patient care could be used to better determine actual quality of care; and

Whereas, current coding modifiers do not adequately capture scenarios in which independently practicing NPPs consult with or transfer care to a physician, resulting in incomplete data on care patterns; therefore be it

RESOLVED, that our American Medical Association supports the development of new modifiers to improve coding accuracy and data collection when independently practicing non-physician practitioners consult with a physician or transfer care to a physician. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

REFERENCES

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2. Waite A . Highlighting the lived experience of nurse practitioners in independent practice. Journal for Nurse Practitioners. 2019 Nov-Dec;15(10), 787–791, doi:
3. DePriest K, D'Aoust R, Samuel L, Commodore-Mensah Y, Hanson G, Slade EP. Nurse practitioners' workforce outcomes under implementation of full practice authority. Nurs Outlook. 2020 Jul-Aug;68(4):459-467. doi: 10.1016/j.outlook.2020.05.008. Epub 2020 Jun 24. PMID: 32593462; PMCID: PMC7581487.Yadav KN, et al.

RELEVANT AMA POLICY

Coding of Physician and Non-Physician Services H-70.994

1) Our AMA opposes the development of modifiers to physicians' CPT to identify services rendered by non-physicians, but supports efforts to develop appropriate coding systems for non-physician services.

2) The AMA CPT Editorial Panel continues to identify areas where services performed by non-MD/DOs may be separately coded so that the AMA/Specialty Society RVS Update Committee (RUC) and the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board may develop work relative values which are reflective of the differential level of work between MD/DO and non-MD/DO services.

Practicing Medicine by Non-Physicians H-160.949

1) Our American Medical Association urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
2) Our AMA continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers.
3) Our AMA continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
4) Our AMA continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision.
5) Our AMA, through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine.
6) Our AMA opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-26)

Introduced by: American Academy of Emergency Medicine

Subject: Strengthening Emergency Interfacility Transfer Infrastructure

Referred to: Reference Committee J

Whereas, Interfacility transfer is an essential component of emergency care for patients who require services unavailable at the facility where they initially present, particularly in rural, geographically isolated, and other resource-limited settings; and

Whereas, patients awaiting interfacility transfer remain in emergency departments while awaiting definitive care, and transfer boarding can adversely affect the timeliness of care for all emergency department patients, with a disproportionate impact on low-volume rural emergency departments[1]; and

Whereas, successful emergency interfacility transfer requires both identification of an appropriate accepting facility and timely availability of medically appropriate transportation, and studies of interfacility transfer have identified transportation availability and delays in initiating transport as significant barriers to timely transfer[2,3]; and

Whereas, the fragmented process of separately locating an accepting facility and arranging transportation can contribute to delays in definitive care, while centralized transfer coordination can improve transfer efficiency; and

Whereas, use of the statewide Arkansas Trauma Communication Center to facilitate interfacility transfers was associated with a 21-minute reduction in emergency department length of stay at sending facilities for severely injured patients requiring transfer[4]; and

Whereas, regional emergency transfer coordination that provides real-time information regarding receiving-hospital capabilities and capacity and available medical transportation could allow transfer requests and transportation needs to be addressed through a single coordinated system rather than through multiple independent processes; and

Whereas, the Emergency Medical Treatment and Labor Act (EMTALA) already requires hospitals with specialized capabilities to accept appropriate transfers when they have the capacity to treat the patient[5]; and

Whereas, participation by Medicare-participating hospitals in regional emergency transfer coordination systems would facilitate identification of appropriate receiving facilities and operationalize access to capabilities and capacity already subject to federal emergency transfer requirements; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) Emergency Care Access & Timeliness measure identifies boarding for more than 240 minutes after a decision to transfer as a quality gap, demonstrating federal recognition of prolonged transfer boarding, but does not

itself provide a mechanism to locate an accepting facility, secure transportation, or escalate a time-sensitive transfer when either is unavailable[6]; and

Whereas, the Medicare Ambulance Fee Schedule provides payment for ambulance services furnished but does not establish a dedicated payment mechanism for maintaining advanced life support or critical-care interfacility transport resources in readiness for time-sensitive transfers [7]; and

Whereas, maintaining dedicated or regionally shared interfacility transport readiness could improve access to time-sensitive transportation while preserving emergency medical services resources necessary for community 911 response; therefore be it

RESOLVED, that our American Medical Association advocate for federally supported regional emergency transfer coordination systems providing a single point of access to real-time receiving-hospital capabilities and medical transport availability for time-sensitive interfacility transfers, with participation by Medicare-participating hospitals with relevant emergency or specialized capabilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to Congress and the Centers for Medicare & Medicaid Services for payment models that support emergency interfacility transport readiness, including dedicated or regionally shared advanced and critical-care transport capacity without compromising 911 response. (Directive to Take Action)

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

Received: 9/16/26

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2. Myers V, Nolan B. Delays to initiate interfacility transfer for patients transported by a critical care transport organization. Air Med J. 2021;40(6):436-440. doi:10.1016/j.amj.2021.06.005.
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4. Porter A, Wyrick D, Bowman SM, Recicar J, Maxson RT. The effectiveness of a statewide trauma call center in reducing time to definitive care for severely injured patients. J Trauma Acute Care Surg. 2014;76(4):907-912. doi:10.1097/TA.0000000000000142.
5. Centers for Medicare & Medicaid Services. Emergency Medical Treatment and Labor Act (EMTALA) & Surges in Demand for Emergency Department Services. QSO-24-02-Hospitals/CAHs/REH. CMS states that hospitals with specialized capabilities may not refuse an appropriate transfer under EMTALA when they have capacity to treat the patient.
6. Centers for Medicare & Medicaid Services. Emergency Care Access & Timeliness (REHQR), CMS1264v2. The measure identifies transfer boarding exceeding 240 minutes after a decision to transfer as a quality gap.
7. Centers for Medicare & Medicaid Services. Medicare Ambulance Fee Schedule. CMS national fee schedule for ambulance services and annual payment amounts.

RELEVANT AMA POLICY

Interfacility Patient Transfers of Emergency Patients H-130.982

1. Our American Medical Association supports the following principles for interfacility patient transfers:

a. All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay.

b. An interfacility patient transfer should be undertaken only for appropriate medical purposes, i.e., when in the physician's judgment it is in the patient's best interest to receive needed medical care at the receiving facility rather than the transferring facility.

c. All interfacility patient transfers should be subject to the sound medical judgment and consent of both

the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer;
2. Our AMA urges physician organizations to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians' Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and
3. Our AMA urges state medical associations to encourage and provide assistance to physician organizations that are developing such protocols and interhospital agreements with their local hospitals.

Refusal of Appropriate Patient Transfers H-130.965
1. Our American Medical Association opposes the refusal by an institution to accept patient transfers solely on the basis of economics;.
2. Our AMA supports working with the American Hospital Association (AHA) and other interested parties to develop model agreements for appropriate patient transfer.
3. Our AMA supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred.
The Future of Emergency and Trauma Care D-130.971
1. Our American Medical Association will expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care.
2. Our AMA, with the advice of specific specialty societies, will advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties.
3. Our AMA will continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care.
4. Our AMA will disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation.
5. Our AMA supports demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care.
6. Our AMA supports the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension.
7. If an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;
(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations;
(3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and.
(4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements.

Medicare's Ambulance Service Regulations H-240.978
1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patient's needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.
2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

Overcrowding and Hospital EMS Diversion H-130.945
1. It is the policy of our American Medical Association that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds.
2. It is the policy of our AMA to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department.
3. It is the policy of our AMA to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups.
4. It is the policy of our AMA that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities.
5. It is the policy of our AMA that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility.
6. It is the policy of our AMA to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions.

Emergency Transfer Responsibilities H-130.957
Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:
(1) require that the Office of the Inspector General (IG) request and receive the review of the Quality Improvement Organization (QIO) prior to imposing sanctions;
(2) make the QIO determination in alleged patient transfer violations binding upon the IG;
(3) expand the scope of QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;
(4) restore the knowing standard of proof for physician violation;
(5) recognize appropriate referral of patients from emergency departments to physician offices;
(6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;
(7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;
(8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and
(9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.

Addressing and Reducing Patient Boarding in Emergency Departments D-130.957

1. Our American Medical Association will collaborate with interested parties, such as hospitals, insurance companies, the Centers for Medicare & Medicaid Services (CMS), and accrediting bodies such as the Joint Commission, to address and reduce emergency department boarding and overcrowding.
2. Our AMA supports appropriate staffing and standards of care for all patients admitted to the hospital or awaiting transfer, including emergency department patients and admitted patients physically located in the emergency department, to mitigate patient harm and physician burnout.
3. Our AMA advocates for increased state and federal assistance to address the systemic factors contributing to emergency department boarding.
4. Our AMA supports other medical societies, hospital associations, accrediting organizations, and patient advocacy groups to raise awareness of the impacts of emergency department boarding and to identify and propose solutions.
5. Our AMA will continue to monitor the development of CMS quality measures related to patient boarding and work in collaboration with relevant medical specialty associations to support improvements in quality standards related to emergency department care.
6. Our AMA will report back to the House of Delegates at the 2026 Interim Meeting on progress addressing and reducing patient boarding in emergency departments.

Reference Committee K

Report(s) of the Board of Trustees

03 Reduce Environmental Impact of Medical Journals
04 Informed Consent for Genetic Testing
05 Increasing Access through Federated Healthcare Data Architecture
12 Rethink the Medicare Annual Wellness Visit

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

01 Drug Shortages: 2026 Update
02 Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup
03 Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing
04 Deprescribing in Clinical Practice
05 Battlefield Acupuncture

Resolutions

901 The Establishment of Mandatory National Reporting of Naegleria Fowleri and Other Amebic Encephalitides
902 Illegal Electronic Health Record Sharing and Patient Trust
903 Improving Health Outcomes in Native Hawaiian Populations
904 Regulation of Organ Transplant Open Offers
905 Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care
906 Establishing Menstrual Products as a Standard of Inpatient Care
907 Affirming Support for the National Institutes of Health Advisory Councils
908 Improving Access to Phenotype-Matched Blood for Transfusion-Dependent Patients
909 Public Emergency Alert Reporting Requirements on Private Platforms
910 Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation
912 Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products
913 Withdrawn
914 National Strategy to Close the Women's Health Gap
915 Ensuring Expert and Lived Experience Input in Federal National Health Plans
916 Opposition to Recreational Nicotine Products in Federal Correctional Facilities
917 Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health
918 Strengthening the Radiation Protection Standard
919 Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions
920 Improving Protection for Patient Medical Records and Health Care
921 Transgender and Gender Diverse Cancer Research
922 Eliminating Tax Barriers to Equitable Clinical Trial Participation
923 Research the Community Health Impacts of Data Centers
924 Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice
925 Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers
926 Support for One Health Approaches to Protect Human, Animal, and Environmental Health
927 Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement

Reference Committee K

928 Electric Bike and Scooter Safety, Regulation, and Enforcement
929 Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis
930 Supporting the Use of Firearm Suppressors to Prevent Hearing Loss
931 Allocation, Liability Protections, & Generic Drug Shortages
932 Recognizing the Challenge of Tobacco use in the Era of Commercial E-Cigarettes and Nicotine Products
933 Preventing Silicosis Associated with Engineered Stone Countertops

REPORT OF THE BOARD OF TRUSTEES

BOT Report 03-I-26

Subject: Reduce Environmental Impact of Medical Journals

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee K

This report is prepared in response to Resolution 406, which was referred by the House of Delegates at the 2026 Annual meeting. The resolution called for the following:

> RESOLVED, that our American Medical Association's medical journals be provided via electronic-only means by default, and that physicians and other recipients be required to opt in to receive print versions; and be it further
>
> RESOLVED, that our AMA encourage specialty societies to require physicians to opt in to receive print versions of journals, with the default option being to receive electronic-only versions.

In response to this referral, this report provides background and discussion of current practices to reduce print through an analysis of efforts at JAMA Network and in AMA's Marketing and Member Experience (MMX) business unit to reduce print, as well as the feasibility and implications of implementing electronic-only distribution as the default for JAMA Network journals through the AMA and as a recommendation to specialty societies.

DISCUSSION

Print circulation has already been substantially reduced through coordinated strategic efforts by JAMA Network and the MMX business unit to eliminate excess distribution and require members to opt in to receive print copies.

Overall, the strategy has balanced three key priorities:

1. Reducing unnecessary cost and waste
2. Advancing sustainability goals
3. Preserving print as a targeted Benefit of Membership (BOM) rather than a mass-distribution product.

Currently, only certain segments of AMA membership may opt to receive a print copy of *JAMA.*

- Students and Residents are now only offered digital access as their Benefit of Membership.
- Other members eligible for *JAMA* as a BOM are asked to choose print or digital delivery when they purchase a membership or renew.

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- Individuals who are not AMA members are not able to purchase print and are offered digital-only options.

Strategic Reductions in Print Circulation

Controlled Circulation

In 2023–2024, a major strategic reduction in *JAMA* print circulation occurred with the elimination of controlled circulation. Under that model, free copies were sent to physicians, with production and distribution costs often offset by advertising revenue from companies seeking to reach this specialized audience. However, the model was costly, particularly due to postage, and wasteful, as market research showed that many copies sent to offices were discarded immediately or left unread.

This full-year effort produced several positive outcomes, including significant financial savings (+3.7 million dollars in margin improvement in the 2024 Budget versus the 2023 Budget), a meaningfully lower carbon footprint (56 percent reduction in carbon use), and a clearer realignment of internal resources toward digital-first revenue growth.

Strategic Reductions in Print Circulation to Targeted Membership Segments

In late 2024, MMX worked with JAMA Network to launch a cost savings initiative with a goal to reduce total circulation by 1 million pieces (with an estimated impact of $1,000,000) by the end of 2025. By focusing on reducing circulation for Students and Residents, they cut circulation by 922,000. Continuing that momentum in 2026, MMX launched Physician tactics asking Physician members to confirm their digital or print preference. This effort further reduced circulation by an additional 1 million pieces in 2026.

Current Sources of Print Circulation

In 2027, the remaining print volume will be concentrated heavily in just three publications: *JAMA*, which will account for 86 percent of total print circulation due to Benefit of Membership*, JAMA Oncology*, which will account for seven percent, and *JAMA Dermatology,* which will account for five percent. Both specialty journals' print circulation is due to advertising-supported revenue opportunities. Together, these three titles will represent 99 percent of all remaining print volume across the JAMA Network.

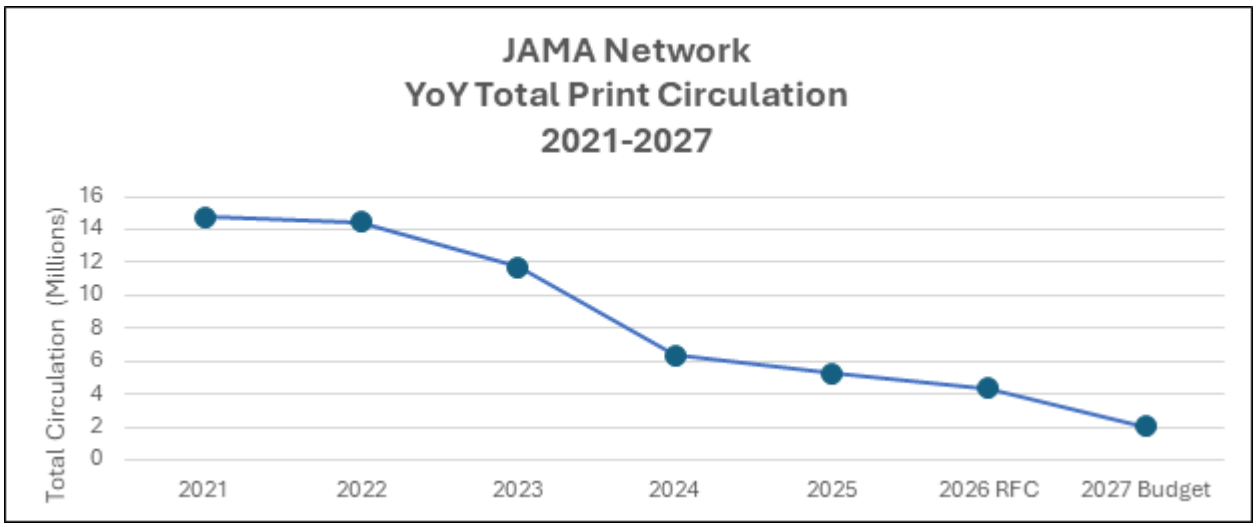
Print Frequency Reductions

Additionally, JAMA Network is in the process of establishing a reduced frequency of issues of *JAMA* from 48 per year to 24 to produce less print annually. This new frequency will be implemented in January 2027.

The Tables below detail reductions in print circulation Year over Year from 2021-2025, and further reductions made in 2026 – to the 2027 Budget.

JAMA Network
YoY Print Circulation Comparison
2021 - 2025 RFC/2027 Budget

	Actual Totals						Projected Totals				
Journal	2021 Total	2022 Total	2023 Total	2024 Total	2025 Total	2025 vs 2021 Reduction	2026 RFC	2026 RFC vs 21 Reduction	2027 Budget	2027 Budget vs 2021 Reduction	Notes
JAMA	14,077,562	13,903,284	11,227,434	5,896,530	4,953,096	65% ↓	4,064,801	71% ↓	1,782,395	87% ↓	2027 JAMA Budget - 48 to 24 yearly issues
Peds	33,302	29,844	3,532	2,894	2,459	93% ↓	1,967	94% ↓	1,929	94% ↓	
Derm	163,436	163,255	164,857	157,475	144,884	11% ↓	115,175	30% ↓	112,345	31% ↓	
Psych	48,613	5,386	4,606	3,823	3,259	93% ↓	2,853	94% ↓	2,690	94% ↓	
Int Med	49,011	5,648	5,141	4,083	3,162	94% ↓	2,705	94% ↓	2,515	95% ↓	
Neuro	65,343	61,587	57,601	55,137	2,716	96% ↓	2,385	96% ↓	2,305	96% ↓	
Ophth	124,044	119,641	114,067	105,489	2,784	98% ↓	1,191	99% ↓	990	99% ↓	
Otol	24,228	18,921	2,992	2,519	1,845	92% ↓	1,732	93% ↓	1,644	93% ↓	
Surg	3,429	2,378	2,409	2,172	1,894	45% ↓	1,571	54% ↓	1,394	59% ↓	
Onc	161,851	157,739	153,513	148,633	144,380	11% ↓	153,687	5% ↓	152,630	6% ↓	
Card	19,944	4,696	1,355	1,130	913	95% ↓	908	95% ↓	971	95% ↓	
Total	14,770,765	14,472,401	11,737,507	6,391,905	5,261,396	64% ↓	4,348,975	71% ↓	2,061,808	86% ↓	



Impact on Membership

The available data suggests that these print reductions have been operationally and financially beneficial, while concentrating remaining print access on the members who continue to value it most. Because *JAMA* print is now offered as an opt-in benefit for AMA members, the print program is more closely aligned with member preference rather than broad, automatic distribution.

At the same time, the steep intentional reductions across Student, Resident, and Physician segments show that print is already a more limited and a selective component of the membership value proposition. For many members, this shift is unlikely to reduce overall access to content, as digital access remains available and increasingly reflects user behavior. However, for some members, especially long-standing Physician readers who still prefer print, the reduced frequency and narrower distribution may be perceived as a change in the traditional BOM experience.

The implication for membership is that print is no longer a universal expression of member value, but a more focused, opt-in benefit for a smaller audience with demonstrated demand.

Plastic Packaging Evaluation

Plastic packaging wrappers are only used in specific instances of cover tips and loose advertisements. Over the past 5 years, the volume of both of these cases has declined

significantly. JAMA Network will work with our printer to identify and evaluate potential alternatives, such as recycled paper or bamboo.

CONCLUSION

Because of the targeted efforts outlined above, print circulation has declined significantly across the JAMA Network, and notably with *JAMA* as a Benefit of Membership. JAMA Network and MMX continue to constantly evaluate how to limit print to those members who choose the format as their preferred format for this member benefit. The resulting reductions in print circulation reflect a deliberate transition away from costly, low-engagement mass distribution and toward a more sustainable, member-directed, digital-first model, while still preserving limited print access where it continues to provide value.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 406-A-26 and the remainder of the report be filed:

Recommendation 1: That our AMA support continued efforts to reduce print circulation that weigh the impact to membership and Publishing revenue models.

Recommendation 2: That our AMA continue the current practice during the member onboarding process to require eligible members be asked to select their preferred delivery format—print or digital—for their subscription.

Recommendation 3: That our AMA support JAMA Network undertaking a study to evaluate options for climate friendly alternatives to the plastic packaging used for paper journals including recycled paper, bamboo, and other options the printers may recommend.

(New HOD Policy)

Fiscal note: Minimal

REPORT OF THE BOARD OF TRUSTEES

BOT Report 04-I-26

Subject: Informed Consent for Genetic Testing

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee K

At the 2025 Interim Meeting Resolution 918-I-25, "Remove Outdated Barriers to Genetic Testing," was referred by the House of Delegates and asked 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; and be it further
>
> 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.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2023 to June 2026, using the text terms "informed consent," "genetic testing," and "genomic testing." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from state and federal laws as well as conversations with several experts in the field.

BACKGROUND

Informed consent, the process by which clinicians gather autonomous authorization for medical intervention, is a cornerstone of medicine.[1] It assumes decision-making capacity, voluntariness, and comprehension of adequate information by the patient; if these assumptions are met, informed consent helps ensure ethical treatment decisions and patient-centered care.[2] The informed consent process typically involves the physician explaining the purpose, risks, benefits, and alternatives of the test; answering patient questions; and obtaining verbal consent from the patient.[2] While the informed consent process is generally left to physician discretion, genetic testing is often subject to more complex and prescriptive consent requirements than other medical tests.

Genetic testing entered clinical practice in the latter half of the 20th century, initially through chromosomal analyses such as karyotyping, which were used to identify Down syndrome (trisomy 21) and other conditions with large chromosomal abnormalities.[3] Advances in molecular genetics during the 1980s-90s enabled diagnostic testing for single-gene disorders, such as Huntington disease, cystic fibrosis, and sickle cell disease, while also expanding the use of carrier screening.[4]

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This was followed by the chromosomal microarray, which allowed clinicians to analyze thousands of genetic variants simultaneously, supporting a broader diagnostic approach for unexplained phenotypes such as developmental delay.[5] This broad approach was further accelerated by the completion of the Human Genome Project in 2003, which enabled exome and whole-genome sequencing assays that are now frequently used for precision oncology and diagnosis of rare diseases.[6–8] Although advances in testing technologies have led to distinctions between *genetic* and *genomic* testing in research and clinical practice, these terms are often collectively referred to as *genetic testing* in policy and public discourse. Accordingly, this report uses *genetic testing* to refer to any laboratory testing of an individual's DNA for clinical purposes, unless otherwise specified.[9]

Genetic testing has become increasingly common in clinical practice over the past several decades and is now used for a wide range of purposes beyond diagnosis, including predictive and pre-symptomatic testing, carrier screening, and prenatal and newborn screening. Reflecting this expanded role, genetic testing is now utilized across many medical specialties and is most frequently ordered by obstetrician-gynecologists, oncologists (often for somatic tumor testing in addition to hereditary cancer testing), and geneticists (Figure 1).[10] A study of patients at Vanderbilt University Medical Center found that the proportion of patients with genetic testing documented in their electronic health records (EHRs) increased from 1.0 percent in 2002 to 6.1 percent in 2022.[11] The most commonly ordered tests in 2022 were multigene panels, followed by single-gene and single-variant tests, whereas whole-genome sequencing remained relatively uncommon (Figure 2).[11]

In contrast to many routine laboratory tests, genetic testing can generate identifiable data and reveal information about biologically related family members. These considerations, together with the ability of genetic testing to provide information about future disease risk, generate incidental findings, and inform reproductive decision-making, have fueled ongoing debate regarding the appropriate scope of informed consent and whether genetic testing should be subject to consent requirements that differ from those used for other medical tests.[1,12,13] For most medical tests, such as ultrasounds or blood tests, physicians rely on ordinary informed consent and verbal agreement from the patient. Under federal law, this typical process is permitted for genetic testing. However, some states require the physician to obtain written informed consent from the patient before the sample can be gathered for genetic testing.[14] This process requires specific information to be provided to the patient and, in some states, for genetic counseling to be offered. Once the sample is collected, it is typically sent to a centralized laboratory for testing. The resulting genetic data are then uploaded into the EHR, where they are accessible to other clinicians and, through patient portals, to patients themselves (which is required under federal law). Genetic information may remain in the medical record indefinitely and can potentially be reinterpreted as scientific knowledge evolves.

The process for obtaining written informed consent, which varies by state and institution, can create delays to care and increase administrative burden for clinicians and patients, while simultaneously functioning to ensure patient comprehension of a complicated and consequential test.[14,15] The myriad of ethical and practical considerations are reflected in the numerous workgroups, manuscripts, frameworks, and guidelines that have been developed over the last several decades as technology has developed and genetic testing has been increasingly incorporated into clinical care.[15,16] While a full analysis of these considerations is outside the scope of this report, the question of whether genetic information is sufficiently unique to warrant special protections is integral to the development and application of informed consent policies for genetic testing.

DISCUSSION

Requirements for informed consent for genetic testing have been shaped by views of its similarities to and differences from other medical tests, with opinions varying widely.[17–20] Genetic exceptionalism is the concept that genetic information is distinct from other health data and should warrant additional protections.[17] Proponents of genetic exceptionalism point to several characteristics of genetic information, including its potential to reveal future disease risk, implications for biologically related family members, identifiable nature, and the possibility that genetic data may be reanalyzed as scientific knowledge evolves.[21] These considerations may be particularly relevant in genomic testing, where incidental or secondary findings can easily arise and where identifiable information can be generated from a single test.[22]

In contrast, genomic contextualism holds that while genetic information may have distinctive features, it should not be categorically separated from other types of medical information.[22] Proponents of contextualism argue that many non-genetic tests can also reveal sensitive information, reveal incidental or secondary findings, and influence medical management for patients and their families. Under this framework, the information that should be supplied to patients to ensure informed consent is evaluated in the context of the specific clinical situation rather than a separate set of principles applicable only to genetics.[22] While genetic contextualism has gained increasing attention in recent years, genetic exceptionalism was the dominant framework for several decades as testing technology developed and was incorporated into clinical care.[23] During this time, particularly the 1990s and early 2000s, several federal and state laws related to various aspects of genetic testing were enacted and still shape the landscape today.

Federal Law

No federal law specifically requires informed consent for clinical genetic testing. However, several federal laws govern patient access to genetic testing services and results, scientific research involving genetic data, privacy protections, nondiscrimination, and laboratory quality. Although most of these issues are outside the scope of this report, laws related to privacy and discrimination are particularly relevant because concerns regarding the use and misuse of genetic information have been central to debates over genetic exceptionalism and the development of written informed consent requirements.

The Health Insurance Portability and Accountability Act protects individually identifiable health information, including genetic information, when it is held by covered entities such as health care professionals and insurers. As a result, genetic information generally may not be used or disclosed without patient authorization except in certain circumstances. The Genetic Information Nondiscrimination Act (GINA), enacted in 2008, builds upon these protections by prohibiting the use of genetic information in employment decisions, such as hiring and firing, and health insurance underwriting, including coverage and premiums. These laws are intended to reduce concerns that genetic testing could result in discrimination or other adverse consequences.

However, GINA does not apply to life insurance, disability insurance, or long-term care insurance. As a result, genetic test results may, in some circumstances, be considered when individuals seek these forms of coverage. Many patients may be unaware of these limitations and may mistakenly assume that genetic information is protected across all insurance markets. In addition, GINA has been the subject of relatively limited litigation, leaving some uncertainty regarding the scope and practical application of its protections. For some individuals, particularly those undergoing predictive genetic testing for inherited conditions associated with significant morbidity or early mortality, the possibility that genetic information could influence future access to or affordability

of certain insurance products may be an important consideration when deciding whether and when to pursue testing. Physicians play a critical role in helping patients understand not only the potential clinical benefits and limitations of testing, but also the possible privacy, insurance, and family-related implications of obtaining genetic information.

Overall, federal law provides protections against discrimination on the basis of genetic information but does not address informed consent for clinical genetic testing. At the same time, the limitations of existing protections, particularly with respect to life, disability, and long-term care insurance, illustrate why genetic testing may raise considerations that extend beyond immediate clinical decision-making. These considerations reinforce the importance of physicians providing patients with sufficient information and context to understand the potential benefits, limitations, and consequences of testing before results are generated. Several states have enacted requirements governing both the form and content of written informed consent, reflecting the view that genetic testing may warrant additional safeguards beyond those applied to other medical tests.

State Law

Five states have written informed consent laws for clinical genetic testing: Massachusetts,[24] Michigan,[25] Nebraska,[26] New York,[27] and South Dakota (Table 1).[28] These laws were enacted between 1994 and 2000, prior to both the completion of the Human Genome Project and the enactment of GINA, at a time when genetic testing was largely limited to targeted analyses of individual genes or mutations, was less frequent in clinical care (Figure 2), and protections against genetic discrimination were more limited.[14] These laws were intended to promote patient autonomy, privacy, and informed decision-making regarding the use and disclosure of genetic information.

In these states, written informed consent must be obtained before a specimen is collected, and the required content of the consent document is prescribed by statute (Table 2). All five states require disclosure of the nature and purpose of the test, the meaning of potential results, and information regarding privacy and confidentiality. The scope of these requirements varies by state. In Michigan and Nebraska, the requirements apply only to presymptomatic and predictive tests, whereas in Massachusetts, New York, and South Dakota they apply more broadly to genetic testing, including diagnostic testing. Massachusetts and New York also require that genetic counseling be offered, and New York includes additional provisions governing disclosure and retention of genetic information.

These state laws operate alongside federal protections such as GINA and reflect longstanding efforts to address the unique ethical, privacy, and familial implications of genetic information.[29] At the same time, advances in genomic technologies have changed both the scale and scope of genetic testing since many of these laws were enacted. One analysis of state informed consent laws observed that certain statutory definitions and disclosure requirements can be difficult to apply to contemporary genomic testing, which often examines many genes simultaneously and may generate a broader range of findings than earlier genetic tests.[14] In addition, many of these laws were developed during a period when genetic testing primarily focused on inherited (germline) conditions, whereas contemporary clinical practice increasingly incorporates somatic tumor testing and broader genomic analyses. As a result, healthcare systems, laboratories, and clinicians may face challenges in translating statutory requirements developed for earlier forms of genetic testing into current clinical practice.[14]

Practical Implications

Many healthcare entities and laboratories that serve patients across multiple states have developed standardized consent procedures designed to comply with federal standards, including the Clinical Laboratory Improvement Amendments, as well as the most stringent applicable state requirements.[30] As a result, clinicians may encounter consent forms or attestation requirements that exceed those mandated by their own state's laws. Many laboratories require either a signed patient consent form or an attestation from the ordering physician that applicable informed consent requirements have been satisfied.[31,32] In addition to state and federal law, many laboratories and clinicians follow guidance from the American College of Medical Genetics and Genomics , which recommends discussing the purpose, risks, benefits, limitations, potential results, privacy considerations, and availability of genetic counseling as part of the informed consent process.[33]

Despite this degree of standardization, implementation varies considerably across healthcare systems, laboratories, and clinical settings. As a result, the practical burden of obtaining written informed consent may differ substantially depending on local workflows, technological infrastructure, and testing arrangements. For example, some consent forms can be completed electronically, while others must be printed, signed, and returned, potentially creating challenges for patients with limited access to technology. Hospitals and laboratories may also use different consent forms depending on the testing indication (e.g., diagnostic versus predictive testing), germline versus somatic testing, or the technology being used. Telemedicine can introduce additional complexity when informed consent, specimen collection, and testing occur at different times and locations, although it may also improve access to genetic counseling and specialty expertise.[34] Once testing is completed, genetic information is typically stored in the EHR and may be accessed by clinicians involved in a patient's care. However, the location and format of genetic test results and accompanying clinical documentation are often inconsistent across EHR systems, making relevant information difficult to locate and use in future clinical decision-making despite its potential long-term clinical relevance.[35,36] Consequently, despite statutory requirements, laboratory policies, and professional guidance, implementation remains heterogeneous and may increase administrative burden for both patients and clinicians while contributing to delays in testing and care.

An Individualized Approach

There are important advantages and disadvantages to requiring written informed consent for genetic testing, and there remains no clear consensus on the optimal approach. Written consent can help ensure that patients receive consistent information about a complex topic, including the purpose, benefits, risks, limitations, and potential implications of testing for themselves and, in some cases, their family members. It may also provide physicians with a structured framework for discussing genetic testing and create documentation that could be valuable in the event of a dispute regarding what information was disclosed. At the same time, written consent requirements may reduce physician flexibility in tailoring the consent process to individual patients and clinical circumstances, while adding administrative burden that could delay testing or care.

Ongoing discussions have therefore focused on whether written informed consent should be required for all genetic tests or reserved for specific categories of testing, such as predictive testing for adult-onset conditions, whole-genome sequencing, or tests with significant familial implications. A variety of alternative consent models have been proposed, including layered or tiered approaches that allow patients to receive information at varying levels of detail. However, these models may be logistically challenging to implement in routine clinical practice and potentially burdensome for both physicians and patients.[21] In response, some experts have

proposed a more individualized and flexible approach, leading to the development of conceptual frameworks and decision aids that can be adapted to the clinical context and physician judgment.[37,38] As genetic technologies continue to evolve, ongoing work by clinicians, ethicists, researchers, and professional organizations will likely play an important role in developing practical guidance that balances patient autonomy, physician workflow, and the unique considerations associated with genetic testing.

EXISTING AMA POLICY

Our AMA has extensive policy on numerous aspects of informed consent and clinical genetic testing. These policies include the fundamentality of informed consent and suggest that physicians document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner (Code of Medical Ethics 2.1.1). When the patient/surrogate has provided specific written consent, the consent form should be included in the record. Other AMA policies support appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists (H-480.944, "Improving Genetic Testing and Counseling Services"), as well as guidance on topics the physician ordering a genetic test should discuss with the patient (Code of Ethics 4.1.1, "Genetic Testing & Counseling"). In addition, AMA policy calls for advocating for extending the consumer protections of GINA by adding long-term care, disability insurance, and life insurance to the Act (D-315.970, "Consumer Genetic Testing and Privacy"). Collectively, current AMA policy emphasizes informed consent, patient privacy, appropriate use of genetic testing and counseling, and protection against genetic discrimination.

CONCLUSION

As genetic testing has become increasingly integrated into clinical practice, questions regarding informed consent and data sharing have grown in complexity. Written informed consent requirements may help ensure that patients receive consistent information about the purpose, risks, limitations, and potential implications of genetic testing, while also providing documentation and guidance for clinicians. At the same time, these requirements may create administrative burdens, introduce variability across jurisdictions, and contribute to delays in care, particularly as testing technologies and clinical applications continue to evolve. The impact of these requirements may differ depending on the clinical context, the type of genetic test being ordered, and the systems used to implement consent procedures.

The ongoing debate surrounding genetic exceptionalism extends to requirements for informed consent. The lack of consensus reflects a fundamental tension between promoting patient understanding of potentially far-reaching information and minimizing unnecessary barriers to testing and care. Existing federal and state laws, professional guidelines, and institutional policies reflect differing views on how genetic information should be managed and what information patients should receive before testing. As genetic testing becomes more commonplace across medical specialties, continued evaluation of consent processes, implementation challenges, and patient needs will be important to ensure that informed consent remains both meaningful and practical in contemporary clinical care. Existing AMA policy upholds the importance of informed consent in medical practice and recognizes the many considerations surrounding genetic testing.

RECOMMENDATION

The Board of Trustees recommends that the following policies D-315.970, "Consumer Genetic Testing and Privacy," H-480.944, "Improving Genetic Testing and Counseling Services," Code of Medical Ethics 2.1.1, "Informed Consent," and Code of Medical Ethics 4.1.1, "Genetic Testing & Counseling" be reaffirmed in lieu of Resolution 918-I-25 and that the remainder of the report be filed**.**

Fiscal Note: Minimal

CITED POLICIES

D-315.970 Consumer Genetic Testing and Privacy

Our AMA:

(1) will work with relevant stakeholders to advance laws and regulations that prevent genetic testing entities without explicit, informed, and non-coerced user consent from transferring information about a user such as birthdates and state of residence to third parties which may result in the re-identification of the user based on surname inference;

(2) supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identifiable information, including DNA, with other parties without informed consent of the user. An exception would be made when requested for a duly executed court order or when compelled for public health or safety reasons as outlined in existing AMA policy including H-315.983, "Privacy and Confidentiality," and Medical Code of Ethics 4.1.4, "Forensic Genetics." If a data security or privacy breach occurs with a direct-to-consumer (DTC) genetic company or its collaborators, then the company has the responsibility to inform all users and relevant regulatory bodies of the breach and the impact of the unprotected private data on those individuals;

(3) will advocate that research using consumer genomic data derived from saliva or cheek swabs or other human samples should be treated as research on human subjects requiring informed consent consistent with or similar to those required by the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt in" option to allow more consumer choice in the consent process; and

(4) will advocate for extending the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California.

H-480.944 Improving Genetic Testing and Counseling Services

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

Code of Medical Ethics 2.1.1 Informed Consent

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all medically appropriate options of treatment is critical to fostering trust and should extend to any discussions regarding who has access to patients' health data and how data may be used.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

Code of Medical Ethics 4.1.1 Genetic Testing & Counseling

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

Because genetic contribution to disease can be complex and highly variable, interpreting findings and helping patients understand the implications for their health and health care requires special skill and attention.

Genetic testing is most appropriate when the results of testing will have meaningful impact on the patient's care. Physicians should not encourage testing unless there is effective therapy available to prevent or ameliorate the condition tested for. Whether a genetic test is performed to help diagnose an existing health condition, or to predict future health risks, or to provide information for managing a disease, it is important that the patient receives appropriate counseling.

Physicians who order genetic tests (individually or as part of a multi-test panel or large-scale sequencing) or who offer clinical genetic services should:

(a) Have appropriate knowledge and expertise to counsel patients about heritable conditions, risks for disease, and implications for health management, and to interpret findings of individual genetic tests or collaborate with other health care professionals who can provide these services, such as licensed genetic counselors.

(b) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient.

(c) Discuss with the patient:

(i) what can and cannot be learned from the proposed genetic test(s) and reasons for and against testing, including the possibility of incidental findings. Physicians should ascertain whether the patient wishes to be informed about findings unrelated to the goal of testing;

(ii) medical and psychological implications for the individual's biological relatives;

(iii) circumstances under which the physician will expect the patient to notify biological relatives of test findings; and

(iv) that the physician will be available to assist in communicating with relatives.

(d) Obtain the individual's informed consent for the specific test or tests to be performed.

(e) Ensure that appropriate measures are taken to protect the confidentiality of the patient's and their biological relatives' genetic information.

APPENDIX

Figure 1. Total genetic test requests by ordering physician specialty across four regional health plans' commercial lines of business in May 2019[10]

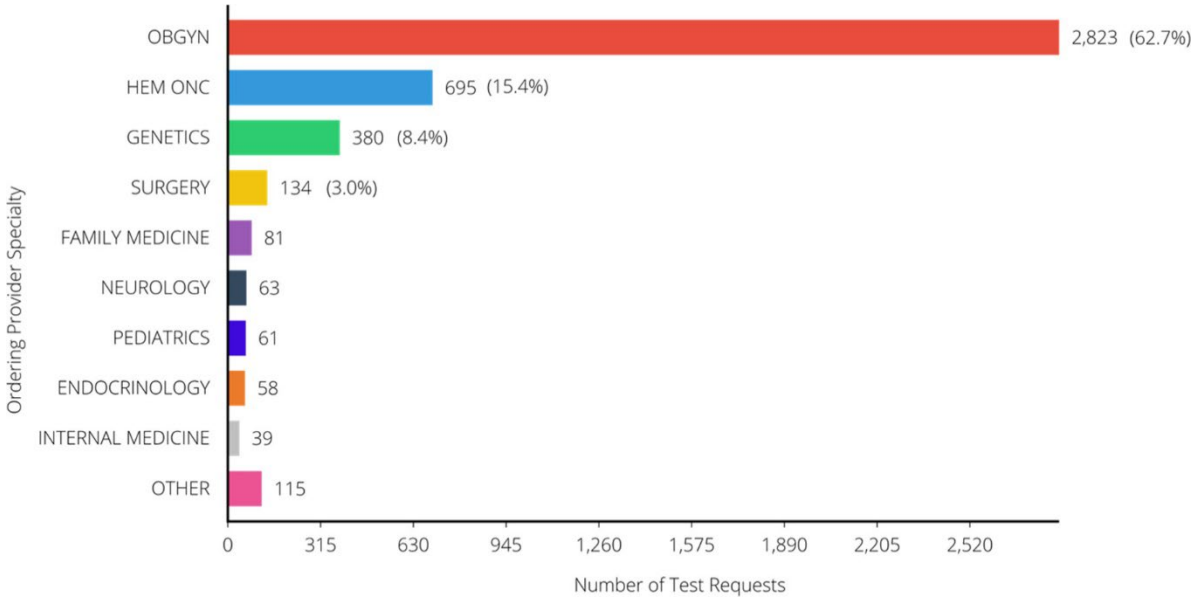


Figure 2. The cumulative number of clinical genetic tests ordered by year (2002, 2005, 2010, 2015, 2020, 2022) at Vanderbilt University Medical Center, stratified by test type[11]

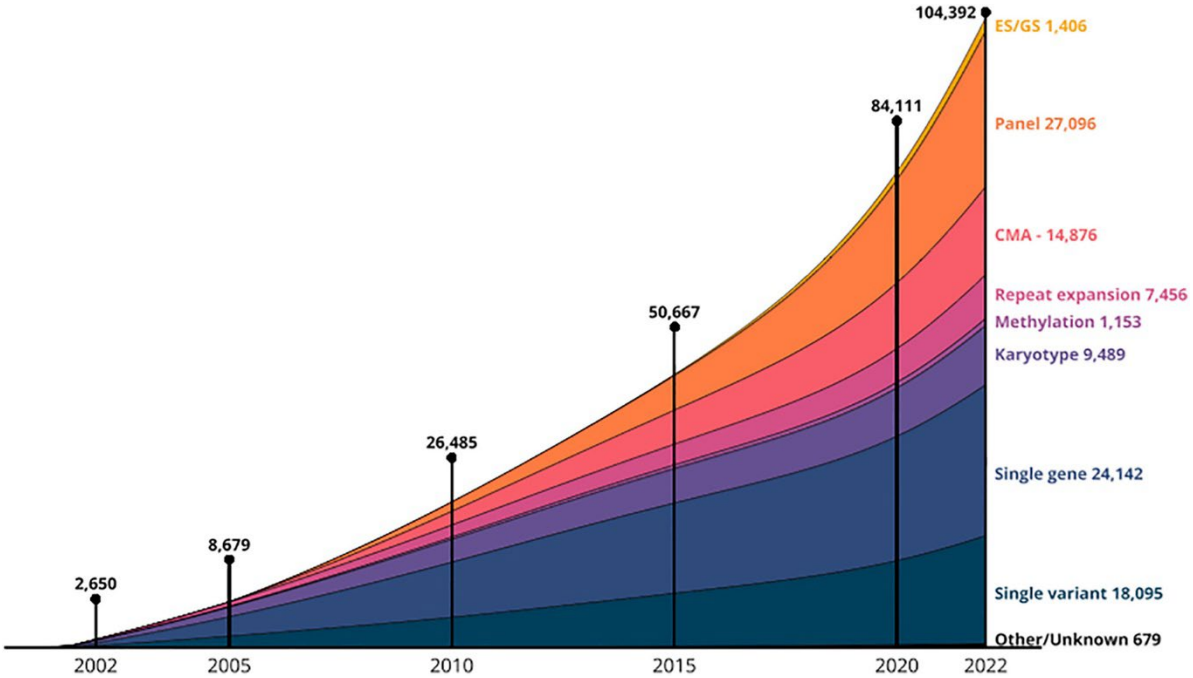


Table 1. Written informed consent for genetic testing in states with and without statutes

Aspect	States With Genetic Consent Statutes (MA, MI, NE, NY, SD[a])	States Without Genetic Consent Statutes
Consent format	Mandatory, written	Verbal or written, general
Timing	Must occur before sample collected	Flexible
Consent content	Statutorily prescribed	Clinician-determined
Legal risk	Statutory violation exposure	Malpractice standard only

[a] Massachusetts (MA), Michigan (MI), Nebraska (NE), New York (NY), South Dakota (SD)

Table 2. Aspects of state statutes for written informed consent for genetic testing

Aspect	MA	MI	NE	NY	SD
Applicable tests	All	Presymptomatic or predictive	Presymptomatic or predictive	All	All
Sample retention				Yes - sample must be destroyed after 60 days	
Genetic counseling information or recommendation	Yes			Yes	
Who will have access to sample and genetic data		Yes	Yes		Yes
Nature and purpose of the test	Yes	Yes	Yes	Yes	Yes
Description of the test and condition(s) being tested	Yes			Yes	
Test performance, including effectiveness, limitations, reliability, and predictive value	Yes	Yes	Yes	Yes	Yes
Risks, benefits, and implications of testing		Yes	Yes	Yes	Yes
Meaning of results and result notification procedures	Yes	Yes	Yes	Yes	Yes

Future uses of biological samples and/or genetic information		Yes	Yes	Yes	Yes
Privacy, confidentiality, and disclosure of results or genetic information	Yes	Yes	Yes	Yes	Yes
Who the results may be disclosed to	Yes			Yes	

*Shading indicates that area is not applicable

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 05-I-26

Subject: Increasing Access through Federated Healthcare Data Architecture

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee K

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-460.958, "Increasing Access through Federated Healthcare Data Architecture," which directs the AMA as follows:

> 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.

Testimony was supportive of this resolution, noting the need for broader multi-center healthcare research collaborations and federated data systems, while improving patient data safety by avoiding the centralization of protected health information (PHI) to accelerate ethical research and precision care. Supporters stated that it is critical to understand why other large-scale data coordination strategies have failed to advance despite decades of interest, and an amendment was suggested to broaden this study beyond federated data architecture to also include other data architecture.

BACKGROUND

There are several federated data architecture models and other initiatives that are being utilized across the healthcare system. The priorities for these new projects focus on enabling greater availability and access to patient data for all health system participants, especially patients. The underlying purpose is to ensure that patients are empowered with more control over their own data and in managing their healthcare journey. Creating a trust framework that all exchange partners agree on allows nationwide exchange to succeed. Participants need to trust the network where they are contributing their data—trust must be built-in to ensure that the network will be used responsibly, and data will be kept secure, private, and not shared inappropriately.

The Trusted Exchange Framework and Common Agreement (TEFCA)[1] is a public-private collection of state, regional, and national data exchange networks that help to enable the nationwide exchange of electronic health information (EHI) across disparate health information networks (HINs) by outlining a common set of principles, terms, and conditions to support the development of a Common Agreement. It establishes a universal floor for interoperability, allowing HINs to seamlessly connect and exchange patient data across the country and ensure that stakeholders have secure access to their EHI when and where it is needed. TEFCA data exchange is led by qualified health information networks (QHINs) that serve as secure intermediaries, connecting physicians, hospitals, labs, and pharmacies into a single, interoperable system. In

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addition, TEFCA currently defines six specific exchange purposes for which EHI can be requested or shared: treatment, payment, health care operations, public health, government benefits determination, and individual access services.

The Sequoia Project[2] serves as the federally designated Recognized Coordinating Entity (RCE) for TEFCA, managing the network's operational and oversight responsibilities. As the RCE, the Sequoia Project develops, updates, implements, and maintains the Common Agreement, and is also responsible for soliciting and reviewing applications from health information networks seeking QHIN status and administering the QHIN designation and monitoring processes. In addition, Sequoia engages with TEFCA stakeholders through routine public information sessions, ad hoc presentations, and other channels.

The Centers for Medicare & Medicaid Services (CMS) Interoperability Framework[3] is a voluntary, federally-led initiative that serves as a blueprint for enabling secure health data exchange. Organizations sign a pledge, agreeing to abide by an open, market-friendly set of guidelines designed to accelerate real-time health data exchange. CMS Aligned Networks are the health information networks, exchanges, and technology platforms that sign a pledge and voluntarily self-attest to meeting framework criteria.

The Framework is intended to empower patients with easy access to their medical records without added regulatory burdens by utilizing standardized, open technologies like Fast Healthcare Interoperability Resources (FHIR) application programming interfaces (APIs) to seamlessly connect patients, providers, and digital health applications. A foundational component of the framework is strong digital identity and verifiable trust, which protects patient privacy while breaking down institutional silos that may inhibit data exchange. Through shared infrastructure, the framework enables patients to use authorized apps to view their records and navigate their care without logging into multiple provider portals.

Many of the CMS Aligned Network entities are also QHINs under TEFCA, which expands the reach and reliability for exchanging health records outside of traditional exchange partners. The combination of the CMS Framework and Aligned Networks initiative helps fuel the growth of digital innovations like conversational artificial intelligence (AI), paperless office visit check-ins (the “Kill the Clipboard” initiative), and delivering real-time outcomes to patients.

Federal data privacy rules also shape what patient data can be shared and for what purposes. The “Health Insurance Portability and Accountability Act” (HIPAA) Privacy Rule[4] establishes national standards to protect individuals’ medical records and protected health information (PHI) by mandating that covered entities and business associates implement strict protocols to protect the confidentiality and integrity of this data. The HIPAA Security Rule[5] specifically requires these organizations to apply appropriate administrative, physical, and technical safeguards for electronic PHI. TEFCA and the CMS Interoperability Framework use HIPAA as the baseline privacy and security apparatus undergirding their initiatives. Because federated data architectures query data locally and return only aggregate or approved insights, they inherently align with HIPAA’s minimum necessary standards by eliminating the need to pool massive amounts of vulnerable PHI in a centralized repository.

TEFCA and the CMS Interoperability Framework combine to provide the foundational infrastructure upon which future federated data sharing models can be built. TEFCA provides a functional sharing model since federated data architecture capitalizes on patient data being distributed across institutions, not in a central repository, and information only being shared because of a query. In addition, with the CMS Interoperability Framework emphasizing FHIR-

based APIs, the data from the framework would be ideally suited for a federated data model since FHIR APIs help standardize and modularize the typically unstructured EHR patient data that is used for medical research. Together, TEFCA and the CMS Interoperability Framework are positioned to support a nationwide federated data sharing model.

AMA POLICY

Our AMA has longstanding policy on facilitating greater interoperability, maintaining confidentiality of patient data, and furthering medical research. Several policies are particularly relevant to this discussion:

Policy D-478.996, "Information Technology Standards and Costs"

1. Our American Medical Association will:
    a. Encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems . . .

Policy D-478.995, "National Health Information Technology"

1. Our American Medical Association will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care . . .

Policy H-315.962, "Research Handling of De-Identified Patient Information"

Our American Medical Association supports efforts to promote transparency in the use of deidentified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information.

Policy H-315.983, "Patient Privacy and Confidentiality"

1. Our American Medical Association affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
    a. That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
    b. That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
    c. That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;

d. That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and
e. That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received . . .

These policies combine to establish a comprehensive advocacy foundation that prioritizes patient-directed interoperability and helps further medical research while protecting patients' privacy rights. They provide a clear framework for the AMA's ongoing legislative and regulatory efforts to ensure that there is a privacy-preserving way for patient data to be shared and contribute to medical research advances.

DISCUSSION

The strength of nationwide health data exchange is growing—trust in the system is strong, and the availability of, and access to, data is increasing. For example, TEFCA has grown from sharing 10 million health records as of January 2025, to more than 1.2 billion health records as of June 2026. There are more than 21,000 organizations that live on TEFCA (QHINs, Participants, and Subparticipants) representing over 96,000 unique connections to clinicians, hospitals, clinics, post-acute care/long-term care facilities, public health authorities, and other facilities.

In terms of adopters of the CMS Interoperability Framework, all the categories of pledgees have grown since the initial announcement last year. For health systems and providers, there were 11 initial organizations signed up as of June 2025, and now there are over 58 pledgees. The AMA has signed a "Friend of the Ecosystem" pledge and is actively participating in the meetings to stay abreast of where the new Framework is headed.

As the TEFCA Network scales and grows in utilization, planning is underway to adopt additional exchange purposes, including clinical research. The current six authorized exchange purposes do not include clinical research. Patient health information can only be shared on TEFCA for the six designated purposes—queries by and responses to organizations on the network can only be for the current purposes.

Clinical research data sharing is expected to become an additional TEFCA Exchange Purpose in the near future. The use case will enable more secure sharing and streaming of patient data for clinical trials, observational studies, and public health research, while reducing the administrative burden on providers to manually aggregate medical records for research studies.

Moreover, TEFCA is officially integrating FHIR. The newest version of the Common Agreement requires participants to support FHIR-based API exchange. QHIN-to-QHIN work to facilitate FHIR is underway and increasing in importance as more participants become FHIR-enabled.

TEFCA is specifically designed to improve nationwide discovery and exchange of health information without creating a centralized federal database. Importantly, TEFCA facilitates exchange rather than data aggregation. Data remain within participating organizations and are shared upon authorized request. CMS, through its Interoperability Framework and other initiatives, describes interoperability as a core federal priority and has aligned its initiatives with TEFCA, FHIR, and nationwide data liquidity. CMS policies create standardized APIs that facilitate better data portability and empower the building of longitudinal health records. These capabilities support

future federated research environments by making data more accessible and standardized at the source.

Current centralized data models often limit large-scale research capabilities to well-resourced institutions that can afford exorbitant access fees or have established prestige. Federated architectures democratize clinical research by allowing smaller, less-resourced institutions to participate in multi-center queries, thereby ensuring that patient populations from community settings and diverse geographic areas are accurately represented in health systems research and algorithmic training. Federated architectures also benefit well-resourced institutions as well as the general community, as they allow access to data that likely would not have been easily available to the individual institutions. Increased data democratization, enhanced data access, and mitigated privacy risks support the utilization of federated data architecture.

The AMA continues to tout TEFCA data exchange and hold it up as an illustration of a successful nationwide data exchange model. In recent public comment letters[6] to federal government agencies, we stated that we see TEFCA as a means to enable enhanced information exchange that should remain as an option on the data exchange landscape. Our comments emphasized how TEFCA, by standardizing health information exchange across many different networks, can help to ensure nationwide network-to-network exchange of health information and simplify the work of physicians and other clinicians by reducing the number of connections needed to send and receive health information. We underscored TEFCA as a viable tool for exchanging data, and how it should remain an option among the many means of data exchange currently available. Future advocacy will focus on building on the successes of TEFCA and expanding the available exchange purposes to include clinical research.

CONCLUSION

TEFCA and the CMS interoperability initiatives help address the fragmentation of the patient journey across multiple providers and settings and are well-positioned to support a federated data model that directs a robust nationwide clinical research program. With these two initiatives, our nation is on track to achieve this goal.

As more physicians join TEFCA and the CMS Interoperability Framework, the volume of data exchanged will only increase and further bolster their use and opportunities to expand clinical research prospects. Federated data architectures support clinical research by minimizing unnecessary data movement and maintaining data stewardship at originating institutions. They support local governance by reducing the need for massive, centralized data repositories and preserve patient trust through their structure and functions.

The strongest long-term architecture for a national healthcare research ecosystem is likely built on TEFCA-enabled interoperability and CMS-driven FHIR standards. TEFCA provides the trust and connectivity layer; CMS provides the policy and standards layer; together, they create conditions where institutions can collaborate around large de-identified datasets without requiring widespread centralization of PHI.

From a policy perspective, federated data architectures offer the best alignment with the goals of interoperability, privacy, confidentiality, patient trust, ethical research, and precision medicine. The principal remaining challenges are not technical, but organizational: governance harmonization, adoption of common data models, patient consent management, sustainable funding, and incentives for participation across the healthcare ecosystem.

Chief among these organizational challenges is the adoption of Common Data Models. While federated networks elegantly address the issue of centralizing PHI, they require local standardization of unstructured data to enable multi-center queries to run seamlessly. Without targeted financial incentives or technical assistance, the administrative and financial burden of data mapping will deter community practices from participating. If left unaddressed, this burden will inadvertently preserve the research monopolies of larger institutions, undermining the core goal of equitable data access. Our community can address each of these challenges as we move toward a stronger, and even more connected, clinical research infrastructure.

The AMA will continue to advocate for a thriving and vigorous TEFCA network that adds an exchange purpose focused on clinical research. In addition, our participation in the CMS Interoperability Framework will help reinforce the importance of the initiative to the broader community and its core role in supporting patients, data exchange, and clinical research discoveries.

RECOMMENDATIONS

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

1. Our American Medical Association will work actively with interested parties, such as health information exchanges, exchange coordinating entities, government agencies, and medical research organizations, to advance federated health data architectures for clinical research, ensuring data security protocols and patient privacy are maintained while opposing restrictive data access fees. (Directive to Take Action)
2. Our AMA will prioritize support for expanded clinical research interoperability opportunities within federated healthcare data architecture models, engaging with influential multidisciplinary entities, such as The Sequoia Project, to ensure its inclusion in their ongoing information exchange efforts. (Directive to Take Action)
3. Our AMA supports policies and infrastructure that expand equitable access to large, de-identified healthcare datasets across diverse practice settings, aiming to prevent data gatekeeping, enhance multicenter collaboration, and accelerate ethical clinical research and precision care. (New HOD Policy)
4. Our AMA will advocate for targeted funding, technical assistance, and aligned financial incentives to offset the administrative and technological burdens for community practices and smaller institutions transitioning to the common data models required for federated health research. (Directive to Take Action)
5. Our AMA supports other medical societies, research organizations, and patient advocacy groups to raise awareness of the impacts of data availability on medical research and to identify and propose solutions. (New HOD Policy)
6. Our AMA will report back to the House of Delegates at the 2027 Interim Meeting on progress addressing and expanding interoperability for medical research purposes. (Directive to Take Action)
7. That Policy D-460.958 be rescinded as having been accomplished by this report. (Rescind HOD Policy)

Fiscal Note: Minimal.

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REPORT 12 OF THE BOARD OF TRUSTEES (I-26)
Rethink the Medicare Annual Wellness Visit
(Reference Committee K)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates referred Resolution 906-I-25, "Rethinking the Medicare Annual Wellness Visit," which calls for the AMA to reevaluate the Medicare Annual Wellness Visit (AWV) and consider advocating for its replacement with a more generously reimbursed annual comprehensive examination that includes preventive care, a thorough physical exam, and management of acute and chronic conditions. The referral followed mixed testimony over both the shortcomings of the AWV and whether the evidence supports replacing it with a routine comprehensive annual examination.

The resolution's whereas clauses identify several shortcomings of today's AWV: limited evidence of improved patient outcomes; its exclusion of disease management and a required physical exam; concerns that prioritizing AWVs can hamper timely physician access for patients with urgent needs and force some patients to seek care elsewhere; and concern that outreach promoting AWVs can direct scarce primary care appointments toward lower-risk, highly health-conscious beneficiaries rather than patients with higher-risk conditions or acute needs. The clauses further state that replacing the AWV with an annual comprehensive examination would address patients' needs more expeditiously, use limited primary care capacity more efficiently, and likely improve outcomes, and that the broader scope should be reimbursed at a higher rate.

In response to these concerns, the Board examined the purpose, limitations, and efficacy of the AWV and evaluated whether replacing it with an annual comprehensive examination would better serve Medicare beneficiaries and their physicians. Ultimately, the Board agrees that the AWV requires fundamental reform but does not support the proposed solution. Decades of evidence have failed to show that routine annual comprehensive examinations improve health outcomes for asymptomatic adults and instead suggest they may increase low-value care, including unnecessary testing and treatment, exposing patients to avoidable harm and increasing downstream spending without benefit. Moreover, like AWVs, routine annual examinations disproportionately reach healthier, better-connected patients and therefore would not resolve the concerns identified in the resolution about disparities in access to care. Finally, the proposed solution would reverse a longstanding AMA position—grounded in evidence when adopted decades ago and still supported by the evidence today—that favors periodic, individualized preventive evaluations over routine annual examinations for healthy adults.

The Board therefore recommends a different path forward. In the near term, the AMA should push for reforms that improve physician, patient, and clinical staff understanding of Medicare preventive visits; advocate for greater physician flexibility to tailor preventive visits to patients' individual circumstances and preferences; and promote payment policies and models that support longitudinal, team-based preventive care. Longer term, the AMA should engage national medical specialty societies in resolving fundamental questions about how to best prioritize, fund, and deliver preventive care, with the ultimate aim of developing a new national model that is evidence-based, cost-effective, and designed to alleviate disparities in access and outcomes.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 12-I-26

Subject: Rethink the Medicare Annual Wellness Visit

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

Referred to: Reference Committee K

At the 2025 Interim Meeting, the House of Delegates referred Resolution 906-I-25, "Rethinking the Medicare Annual Wellness Visit," which stated:

> 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. (Directive to Take Action)

The resolution's whereas clauses identify several concerns with the Medicare Annual Wellness Visit (AWV). They state that the AWV does not include disease management and need not include a physical exam (PE); that prioritizing AWVs hampers patients with urgent medical needs from securing timely physician appointments and often forces them to seek care elsewhere, which can increase costs and compromise quality; that little evidence demonstrates improved patient outcomes since the AWV was implemented; and that outreach promoting AWVs can direct scarce primary care appointments toward lower-risk, highly health-conscious beneficiaries rather than patients with higher-risk conditions or acute needs. The whereas clauses further state that replacing the AWV with an annual comprehensive examination would address patients' needs more expeditiously, use limited primary care capacity more efficiently, and likely improve outcomes, and that reimbursement should be higher to reflect the broader scope of the service.

Reference Committee K heard mixed testimony on the proposal. Testimony supporting adoption described the AWV as cumbersome and of limited benefit and argued that a comprehensive physical would make better use of physician time. Other testimony agreed that the AWV warranted scrutiny but emphasized that available evidence does not demonstrate a health benefit from routine complete examinations and urged further study. Given the mixed testimony and the complexity of the issue, the Reference Committee recommended referral for further study.

This report responds to the referral by reviewing the scope, payment structure, and limitations of the AWV; evaluating whether the evidence supports replacing it with an annual comprehensive examination; and exploring alternative models that better reflect today's longitudinal, team-based, and technology-enabled approach to preventive care.

BACKGROUND

Origins and Scope of the Annual Wellness Visit

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The Affordable Care Act (ACA) of 2010 established the AWV to give Medicare beneficiaries a recurring opportunity to assess their health risks and develop a personalized prevention plan without cost sharing. The AWV was intended to follow the one-time initial preventive physical examination (IPPE), commonly known as the "Welcome to Medicare" visit, which beneficiaries can receive during the first 12 months of Part B enrollment. Once that eligibility period has ended, a beneficiary may receive an initial AWV, provided that at least 12 months have passed since any IPPE, and may receive a subsequent AWV once every 12 months thereafter.

The ACA requires every AWV to include two core elements: a health risk assessment (HRA) and a personalized prevention plan. Although the statute also identifies additional preventive assessments, counseling services, and planning activities that may be included, it delegates to the Secretary of Health and Human Services the authority to determine which of those components are mandatory, whether they must be furnished during the initial AWV, and how frequently they must be furnished during subsequent AWVs. Under existing regulations, the Centers for Medicare & Medicaid Services (CMS) currently requires AWVs to include, as applicable:

- An HRA that includes beneficiary-reported information on demographic characteristics, health status, psychosocial and behavioral risks, and functional status;
- A review or update of the beneficiary's medical and family history, including current medications and supplements;
- A list of the beneficiary's current physicians and suppliers;
- Measurement of height, weight, body mass index or waist circumference, and other routine measurements deemed appropriate based on the beneficiary's medical and family history;
- Assessment of cognitive impairment, depression risk, fall risk, hearing impairment, and safety;
- Screening for potential substance use disorders and review of current opioid prescriptions;
- A written screening schedule and a list of risk factors, conditions, recommended interventions, and treatment options;
- Personalized health advice and referrals to preventive counseling, health education, and community-based lifestyle interventions; and
- Advance care planning, at the beneficiary's discretion.

Because the AWV focuses on preventive assessment and planning, it does not cover the evaluation and management of acute or chronic conditions. When physicians bill separately for these services during the same encounter, beneficiaries may be responsible for the applicable Part B deductible and coinsurance for that portion of the visit. Additionally, Medicare does not cover routine PEs, so beneficiaries who request one must pay the full cost out of pocket.

Annual Wellness Visit Payment, Valuation, and Billing

In the Calendar Year (CY) 2011 Medicare Physician Fee Schedule final rule, CMS established two Level II Healthcare Common Procedure Coding System (HCPCS) codes for the AWV: G0438 for the initial visit and G0439 for subsequent visits. CMS valued the new codes through direct crosswalks, linking G0438 to the level 4 new-patient office visit described by Current Procedural Terminology (CPT) code 99204 and G0439 to the level 4 established-patient office visit described by CPT code 99214. The work relative value units, time assumptions, and practice expense inputs for the AWV were therefore derived from related office visit services, and they have never been informed by data on the resources required to furnish the AWV itself.

Table 1. Annual Wellness Visit Payment Amounts and Billing Patterns

HCPCS Code	Visit Type	Payment (2026)	Assumed Physician Time (min)	Assumed Staff Time (min)	Specialty and Clinician Type	Share Billed with Same-Day E/M Service
G0438	Initial AWV	$174	60	54	Family medicine, 39%; internal medicine, 31%; NPs/PAs, 25%	47%
G0439	Subsequent AWV	$138	47	51	Family medicine, 41%; internal medicine, 39%; NPs/PAs, 17%	54%

Sources: CY 2011 Medicare Physician Fee Schedule final rule; RUC background data for Resolution 906-I-25, including 2026 national payment amounts, CMS time assumptions, 2024 Traditional Medicare claims, and same-day E/M billing rates.

Medicare payment amounts in 2026 are approximately $174 for G0438 and $138 for G0439. Because both codes rank among Medicare's highest-volume physician services and have never been surveyed for their underlying resource costs, the RVS Update Committee (RUC) previously identified them for review. However, no surveys or other service-specific data have been collected to date on the physician work, clinical staff time, and practice expense inputs associated with the visits. Thus, it remains unclear whether the current valuations of the AWV codes accurately reflect the resources required to furnish these visits.

Physicians may provide services beyond the scope of the AWV during the same encounter. When this additional work constitutes a significant, separately identifiable, and medically necessary office or outpatient evaluation and management (E/M) service, Medicare permits physicians to report the E/M service separately using modifier 25. Such same-day E/M billing is common: in 2024, an E/M service was reported alongside 47 percent of initial AWVs and 54 percent of subsequent AWVs.

Limitations of the Annual Wellness Visit

1. **Beneficiary misunderstanding of the AWV's scope can lead to frustration and unexpected cost sharing.**

Many Medicare beneficiaries misunderstand the purpose and scope of the AWV. A 2024 national survey of Medicare beneficiaries illustrates how pervasive this misunderstanding is: three in four respondents incorrectly indicated that the AWV includes a PE. Thus, beneficiaries routinely arrive expecting a comprehensive PE, routine laboratory testing, and evaluation and management of acute complaints or chronic conditions—none of which the AWV covers.

This mismatch in expectations places physicians in a difficult position. If they remain within the scope of the AWV and defer active medical concerns to a separate visit, patients leave frustrated that their most pressing concerns were not addressed and must schedule another appointment. If physicians instead address those concerns during the AWV and separately bill for the additional E/M services, patients face Part B deductible and coinsurance obligations during a visit they understood would be cost-free.

2. **AWVs disproportionately reach lower-risk, healthier beneficiaries rather than those with the greatest unmet preventive needs.**

According to national claims data, only 37 percent of beneficiaries received an AWV in 2019. AWV receipt is lower among Black and Hispanic beneficiaries; beneficiaries with lower income or educational attainment; rural residents; and those with multimorbidity or unmet social needs. The strongest predictor of AWV receipt is whether a beneficiary received one in the prior year, suggesting that the service continues to reach beneficiaries who are already well connected to care. Several factors contribute to these differences in receipt, including practice resources and patient mix, as well as payer and payment arrangements. Practices serving comparatively healthier and more socioeconomically advantaged populations are more likely to furnish AWVs, whereas those caring for larger shares of low-income, dual-eligible, rural, and medically complex beneficiaries furnish them less often. AWV receipt is also higher among beneficiaries enrolled in Medicare Advantage and those attributed to accountable care organizations, where stronger financial incentives and greater infrastructure support patient identification, outreach, and scheduling.

3. The AWV's extensive, uniform checklist leaves insufficient time for thorough assessment and individualized follow-up.

CMS requires physicians and care teams to complete the same extensive set of assessments and preventive care tasks for every beneficiary during every AWV, regardless of which components are most relevant or urgent for the patient being seen. This has two consequences. First, the sheer breadth and volume of required tasks exceed what physicians and care teams can reasonably complete in a single encounter, leading some required elements to be omitted and exposing practices to potential denial or recoupment of payment. A national American Academy of Family Physicians survey found that such omissions are relatively common: nearly one in five respondents did not use the required HRA, only 16 percent assessed driving safety, and only about half assessed home safety.

Second, the requirement to complete the full set of AWV elements limits physicians' ability both to prioritize the elements most relevant to an individual patient and to redirect time toward concerns that emerge during the visit. This directly harms patient care. Consider a beneficiary who presents with new memory concerns. In a visit structured around the patient's clinical needs, the physician would conduct detailed cognitive and functional assessments, evaluate hearing, review potentially contributing medications, obtain collateral information, and develop a follow-up plan. Those tasks would appropriately consume the entire visit. Yet, today's AWV would not allow that degree of flexibility. Instead, it would force the physician to continue through the other required checklist elements, even when they are far less consequential to the patient's health.

These constraints help explain why concerns surfaced during AWVs so often go without thorough evaluation and follow-up. In one health system study, among older adults who screened positive for cognitive impairment, nearly two-thirds received no documented dementia-related follow-up action, and confirmatory cognitive testing was performed in fewer than one in seven. A separate study of beneficiaries who screened positive for fall risk and failed a confirmatory mobility test found that only 7.5 percent had a follow-up geriatrics visit. This evidence suggests that by prioritizing completion and documentation of a fixed set of tasks over individualized care, the AWV can undermine the central purpose of preventive medicine, which is not merely to identify and document risk, but to act on it.

4. The AWV and comparable preventive visits have not been shown to improve health outcomes and may cause harm through unnecessary testing and treatment.

Select observational studies have found that beneficiaries who receive AWVs are more likely to use certain preventive services. However, these associations do not establish that the AWV caused

the increase because beneficiaries who obtain AWVs may already be more inclined to seek preventive care and engage in health-promoting behaviors. In the strongest national analysis designed to account for this selection bias, practices that adopted the AWV initially appeared to achieve modest increases in evidence-based screening and reductions in emergency department visits, but once researchers accounted for trends that predated adoption, those apparent benefits disappeared: AWV adoption was not associated with increased cancer screening or reductions in emergency department visits, hospitalizations, or total Medicare spending.

Studies of comparable preventive visits are similarly unpersuasive. A 2019 Cochrane review of 17 randomized trials found that offering general health checks—defined as preventive visits for asymptomatic adults—did not reduce all-cause, cancer, or cardiovascular mortality. The authors offered two probable explanations: physicians frequently identify and manage elevated risk during other clinical encounters, and the patients at greatest risk are the least likely to attend a health check or to complete its recommended follow-up. They concluded that general health checks are unlikely to confer benefit and may expose patients to harm through unnecessary testing and treatment.

Studies of the AWV confirm the harms the Cochrane review anticipated. In a national study of asymptomatic Medicare beneficiaries who received an AWV, 18.6 percent underwent a low-value electrocardiogram, urinalysis, or thyroid-stimulating hormone test despite the absence of any clinical indication. The electrocardiograms and urinalyses in turn generated 6.1 and 5.4 additional services or new diagnoses per 100 recipients within the following 90 days, at cascade-attributable costs of $9.62 and $7.46 per beneficiary. Importantly, because the analysis examined only three tests that were ordered during an AWV, it almost certainly understates both the volume of unnecessary downstream care and the harms initiated during the visit.

5. The AWV is increasingly misaligned with today's longitudinal, team-based, and technology-enabled approach to preventive care.

The AWV treats a single dedicated annual encounter as the principal mechanism for identifying, coordinating, and addressing a patient's preventive needs, and it assumes that the physician personally performs and coordinates each component within, before, and after that encounter. This approach no longer reflects how preventive care is delivered today.

First, physicians increasingly address preventive needs throughout the year rather than deferring them to an annual preventive visit. This often happens through the "opportunistic delivery of preventive care," in which physicians incorporate prevention into visits for acute and chronic illness. This is already how preventive care is overwhelmingly furnished today: one JAMA analysis found that more than 80 percent of eight preventive and counseling services occurred outside dedicated preventive examinations.

Advances in technology even allow physicians and care teams to monitor patients' health risks and address preventive needs outside of traditional encounters altogether. Real-time hospital admission and discharge notifications, for example, alert physicians when their patients are hospitalized, signaling increased risk and prompting the care team to arrange timely post-discharge follow-up. Patient-generated data similarly allow care teams to monitor and manage important risk factors between visits. Home blood pressure monitoring, for instance, gives physicians access to repeated measurements collected over time. These readings not only provide a more reliable picture of blood pressure control than the single office measurement collected during an AWV, but also allow physicians to intervene promptly when blood pressure is uncontrolled—whether by adjusting

medications, scheduling an in-office visit for counseling, or urgently escalating care to prevent serious complications.

Technology has also transformed one of the traditional functions of the preventive visit: identifying which preventive services are due and reminding patients to obtain them. Electronic health record (EHR)-based registries and clinical information systems can now continuously identify patients with overdue preventive needs and trigger outreach when care is due, rather than waiting for an annual visit to determine what each patient needs. Mailed fecal immunochemical testing (FIT) programs demonstrate the potential of this approach. Practices can identify patients due for colorectal cancer screening, send test kits directly to their homes, provide reminders, and arrange diagnostic follow-up after an abnormal result. Randomized trials have found higher screening completion with these programs than with usual care. In one study of rural Medicaid beneficiaries, a mailed FIT and navigation program increased screening completion from 4.5 percent to 11.8 percent, demonstrating how technology-enabled, proactive outreach can reach patients who might otherwise be missed by encounter-based preventive care.

Finally, the delivery of preventive care is increasingly shifting from a model in which physicians personally perform and coordinate every service to one in which the physician leads a clinical team whose members each contribute to the patient's preventive care needs according to their role and expertise. The AMA is already helping practices put this approach into practice through its STEPS Forward practice transformation resources, which highlight practical models for implementing physician-led, team-based care. In one such model, medical assistants trained as care coordinators are assigned a panel of the physician's patients and, working under standing orders and physician-directed protocols, engage those patients in chronic and preventive care throughout the year. Coordinators proactively review panels for overdue screenings and other preventive needs, contact patients to arrange services, track completion of testing and referrals, and escalate abnormal findings or concerns to the physician. This distribution of work allows care teams to identify and address preventive needs as they arise while preserving physician time for interpreting findings, addressing complex medical needs, and engaging patients in shared decision making. Importantly, team-based models have been shown to be particularly effective in smaller, resource-constrained practices, which currently face the greatest challenges in delivering recommended preventive care.

The same principles can extend beyond individual practices to entire health systems, where shared infrastructure can coordinate prevention across patient populations, specialties, and points of care. Kaiser Permanente Southern California's Complete Care program, for example, uses EHR tools and population registries to identify outstanding needs and distribute responsibilities across the care team: pharmacists update medication lists; medical assistants and nurses review records for care gaps, pend pre-visit orders, and provide patient education; and panel managers coordinate outreach to patients requiring additional care. In designing the model, Kaiser also convened primary care and specialist physicians to determine which preventive care gaps each specialty is best positioned to address during its patient encounters and incorporated those activities into specialty workflows. This has created additional opportunities to address patients' preventive needs every time they interact with the health system. In its first six years, Kaiser's program improved performance across 51 Healthcare Effectiveness Data and Information Set measures, including clinical outcomes such as glycemic, blood pressure, and cholesterol control, by an average of 13 percent, compared with a 5.5 percent improvement nationally.

RELEVANT AMA POLICY

Individualized and evidence-based preventive care

- **Policy H-425.984, "Clinical Preventive Services,"** states that physicians should provide preventive services appropriate to each patient's age, gender, and individual and environmental risk factors at every opportunity, including during episodic and acute care visits. It further states that recommendations for clinical preventive services should be based on outcomes research and effectiveness data and calls for additional funding to study the outcomes, implementation, and public policy implications of these services.
- **Policy H-425.994, "Medical Evaluations of Healthy Persons,"** supports periodic evaluation of healthy individuals while emphasizing that the appropriate frequency and content of those evaluations should reflect each patient's age, socioeconomic status, heredity, occupation, and other individual factors. It also calls for continued research on the usefulness of tests intended to detect disease in asymptomatic populations.
- **Policy H-410.967, "Clinical Preventive Services,"** recommends the U.S. Preventive Services Task Force guidelines to clinicians and medical educators as one resource for guiding preventive care, while clarifying that its recommendations should not replace clinical judgment or individualized decision making. It also supports the development of practice guidelines based on the best available evidence and continued collaboration among expert groups and specialties.
- **Policy H-460.894, "Value of Preventive Services,"** calls for organizations that issue preventive service recommendations to incorporate specialty society input, use transparent methods, rely on the best available evidence, provide enough specificity to inform cost-effectiveness analyses, identify and de-prioritize services that lack evidentiary support or are not cost-effective, and to address both primary and secondary prevention. It also advocates for increased comparative-effectiveness research on secondary prevention.

Longitudinal, coordinated, and team-based delivery

- **Policy H-425.997, "Preventive Services,"** supports policies and mechanisms that ensure the continuity, coordination, and continuous availability of cost-effective preventive services and states that any preventive service covered by public or private insurance should be supported by evidence demonstrating improved outcomes or quality of life and cost-effectiveness. The policy also emphasizes that preventive care should ideally be coordinated by the patient's physician.
- **Policy H-330.879, "Providers and the Annual Wellness Visit,"** states that the AWV is most appropriately furnished by a physician or a member of a physician-led healthcare team. It also states that any clinician furnishing the AWV must enumerate all relevant findings and make provisions for appropriate follow-up care. In addition, the policy calls on CMS to give physicians a way to determine whether Medicare has paid for an AWV for a patient within the preceding 12 months and to educate beneficiaries about scheduling AWVs with their primary care physicians.

Coverage and financial incentives

- **Policy H-185.954, "Coverage for Certain Types of Well Care Examinations by Health Insurers,"** supports regular evaluation of the benefits and cost-effectiveness of preventive-service guidelines and encourages health insurers to offer policies that cover preventive services.
- **Policy H-165.840, "Preventive Medical Care Coverage for All,"** advocates for insurance coverage of evidence-based preventive care and its delivery in all appropriate settings, including primary care practices, specialty practices, workplaces, and community settings.
- **Policy H-425.987, "Preventive Medicine Services,"** supports continued collaboration with national medical specialty societies to develop and coordinate practice parameters for

preventive services, insurance coverage of general preventive services, and appropriate coding and reimbursement for established preventive services.

- **Policy D-185.979, "Aligning Clinical and Financial Incentives for High-Value Care,"** recognizes that the clinical benefit of a service depends on the individual receiving it and on when, where, and by whom it is furnished. It also supports aligning physician, patient, and payer incentives to promote high-value care; covering evidence-based preventive services without cost sharing; and developing guidance to help physicians explain when related services may still create patient financial obligations.

Access to Medicare preventive services

- **Policy D-330.935, "Promoting the Utilization of New and Old Medicare Preventive Services,"** directs the AMA to collaborate with specialty societies, state medical associations, federal agencies, the Partnership for Prevention, and other stakeholders to promote the Welcome to Medicare visit, the tobacco cessation benefit, and other Medicare-covered preventive services to the medical profession and the public, with particular emphasis on reaching under-resourced and previously uninsured individuals.
- **Policy H-425.973, "CMS Should Provide Date Eligibility Information to Beneficiaries,"** encourages CMS to establish user-friendly mechanisms through which beneficiaries can quickly verify their eligibility dates for covered preventive services.

Education, guideline development, and implementation

- **Policy H-425.988, "The US Preventive Services Task Force Guide to Clinical Preventive Services,"** directs the AMA to work with the federal government, national specialty societies, and other stakeholders to develop guidelines for preventive services and effective delivery methods.
- **Policy D-330.967, "Medicare Payment for Preventive Examinations,"** directs the AMA to disseminate evidence-based recommendations on the appropriate use of preventive services to physicians, the public, and policymakers; collaborate with national specialty societies to support implementation; and advocate for prioritizing the delivery of preventive services to high-risk populations.

DISCUSSION

The Board agrees that the AWV requires fundamental reform. It does not, however, support the resolution's proposed solution: replacing the AWV with an annual visit that combines preventive care, a comprehensive PE, and the management of acute and chronic conditions. Although this approach might better align Medicare coverage with beneficiary expectations, it would preserve many of the AWV's existing shortcomings and exacerbate others.

First, successive reviews and guidelines spanning more than four decades have consistently concluded that routine annual PEs do not improve health outcomes for asymptomatic adults and may expose patients to potential harms. As early as 1981, this lack of supporting evidence led the American College of Physicians to recommend replacing the annual complete PE with individualized preventive care tailored to each patient's age, sex, risk factors, and clinical circumstances. A 1989 systematic review reinforced those recommendations when it found no evidence supporting the need for a complete PE for asymptomatic, nonpregnant adults of any age. More than two decades later, a 2011 Department of Veterans Affairs review evaluated individual components of the examination and found evidence of benefit for only three: blood pressure screening every one to two years, periodic measurement of body mass index, and age-appropriate

cervical cancer screening. The same review also weighed the relational value long cited in the examination's defense—the "laying on of hands"—and found no evidence that it improves patient outcomes.

Most recently, in 2022, the Society of General Internal Medicine (SGIM) completed a comprehensive review that not only confirmed the limited evidence of clinical benefit but also documented affirmative harms, including overdiagnosis and unnecessary laboratory testing and imaging that produce false-positive findings, trigger costly downstream care, and expose patients to additional cost sharing. Based on those findings, SGIM issued two recommendations: routine checkups should not occur annually unless an individual patient is likely to benefit, and, when they do occur, they should not include a comprehensive physical exam or routine laboratory testing.

Furthermore, replacing the AWV with a universal annual PE would perpetuate, rather than correct, the disproportionate use of preventive care by healthier and better-connected patients. Like AWVs, annual PEs predominantly reach adults who are insured, connected to a regular source of care, comparatively healthy, and likely to have their conditions identified even without the visit. These patients are also more likely to receive unnecessary testing and treatment during their visits. Adding a comprehensive PE and problem-oriented care would only lengthen their appointments, generating additional opportunities for low-value care, and consuming even more time that could otherwise be spent on patients with greater unmet needs and greater potential to benefit.

Finally, the proposed solution would return the AMA to a position it deliberately abandoned more than forty years ago. In 1983, after reconsidering its earlier support for annual medical examinations of healthy adults, the AMA rejected the premise that every patient should receive the same examination on the same schedule and instead endorsed periodic, individualized evaluations. Since then, AMA policy has endorsed tailoring both the frequency and content of preventive evaluations to a patient's age, socioeconomic circumstances, and other individual characteristics. Resolution 906-I-25 would move in precisely the opposite direction. For these reasons, the Board recommends that the resolution not be adopted.

RETHINKING THE ANNUAL WELLNESS VISIT: PATHS FORWARD

As chronic disease places a growing burden on patients and the healthcare system, physicians must intensify efforts to deliver evidence-based, high-value, equitable preventive care. The resolution raised important questions about how best to achieve that goal, and after careful deliberation, the Board has concluded that the path forward lies not in choosing between two flawed annual visits, but in fundamentally rethinking how preventive care is funded and delivered in the United States. Developing a new approach and building consensus will take time, but in the short term, several policy changes, educational efforts, and practice-level reforms can address many of those concerns and improve Medicare preventive care for both beneficiaries and physicians.

Near-Term Reforms to Medicare Preventive Care

1. **Improve understanding of preventive visits and evidence-based preventive care.**

The concerns raised by the resolution reflect, in part, widespread confusion about Medicare preventive visits and the purpose of preventive care more broadly. Consistent with AMA policy, the AMA should support the development and dissemination of clear, audience-specific education for beneficiaries, physicians and trainees, clinical staff, and scheduling and administrative staff. **Beneficiaries.** The AMA should partner with CMS to explore whether clearer terminology for and descriptions of the AWV and IPPE on Medicare.gov and in beneficiary-facing materials could

improve patients' understanding of each visit's purpose and scope. The AMA should also develop plain-language resources that distinguish preventive visits from illness visits, clarify when additional same-day services may trigger cost sharing, and explain what to expect during the encounter.

Physicians and trainees. To help physicians make the most of Medicare preventive visits, the AMA should create educational resources that explain the purpose and scope of these visits; address billing and coding requirements and their implications for patient cost sharing; and provide tips for setting clear expectations with patients.

Beyond developing visit-specific resources, the AMA should partner with specialty societies to promote evidence-based, cost-effective preventive care more broadly. These efforts could build on the success of Choosing Wisely, an AMA-endorsed initiative led by the American Board of Internal Medicine (ABIM) Foundation. Through the campaign, more than 80 specialty societies produced over 700 recommendations identifying potentially harmful or unnecessary tests, treatments, and practices within their respective specialties, and translated those recommendations into educational resources for physicians and patients. The initiative helped shift professional norms toward more judicious care and improved patient-physician conversations about evidence-based, high-value care.

Yet, when the ABIM Foundation ended the Choosing Wisely campaign in 2023, it dissolved the central repository that housed specialty recommendations and left no successor to promote their uptake in medical education or clinical practice. The AMA is well positioned to help fill that gap by supporting specialty societies in updating their recommendations, exploring options for creating a centralized repository of recommendations to promote high-value care, developing educational programming, and building on existing efforts to translate Choosing Wisely recommendations into practical resources and tools for clinics, health systems, and hospitals.

Nonphysician clinical staff. The AMA should continue developing resources that help nonphysician clinical staff understand and carry out their roles in preventive care. These materials should explain the purpose and structure of Medicare preventive visits; provide training on administering, scoring, documenting, and escalating standardized screenings and assessments; and teach staff how to use EHR registries to identify care gaps and support patient outreach, tracking, coordination, and follow-up.

Scheduling and front-desk staff. The AMA should also continue developing educational resources for scheduling and administrative staff, informed by input from physicians about how these team members can best support practice workflows during, before, and after preventive visits. At minimum, these resources should help staff counsel patients about the purpose and scope of Medicare preventive visits, explain how they differ from annual PEs and problem-oriented visits, and set appropriate expectations. They should also help staff use available information about recent care and outstanding services when scheduling preventive visits, including by flagging potentially duplicative or poorly timed appointments for review by the physician or care team.

2. Give physicians greater flexibility to tailor preventive visits to patients' needs.

The AMA should urge CMS to use its existing regulatory authority to give physicians greater discretion over the content and structure of the AWV. Although statute requires the visit to include an HRA and personalized prevention plan, CMS has discretion over which additional components must be furnished and how frequently. CMS should use that authority to allow physicians to prioritize assessments, counseling, and planning activities based on the patient's current risks,

clinical circumstances, and preferences; rely on recent information when an assessment does not need to be repeated; and defer lower-priority components when more consequential preventive needs require attention. Physicians should be able to exercise this clinical judgment without risking denial or recoupment of payment.

3. Adopt payment models and policies that support longitudinal, team-based preventive care.

The AMA should continue to advocate for payment models and policies that support longitudinal, team-based preventive care. One model in which CMS has recently signaled interest is prospective primary care payment. By giving practices predictable funding for each beneficiary in their care, this approach can support outreach, care coordination, and follow-up that encounter-based billing often fails to reimburse adequately. The AMA should urge CMS to advance this concept by establishing voluntary, opt-in prospective payment models that strengthen physician-led, team-based care while preserving physicians' ability to choose the payment arrangements that best serve their practices and patients. Congress can advance the same goal through the Patients First Act of 2026, which the AMA has strongly supported and should continue to champion. The legislation would establish a fully funded, five-year hybrid payment demonstration for independent primary care practices that combines predictable per-beneficiary payments with reimbursement for in-person and telehealth care, care management, and ongoing patient communication.

Furthermore, the AMA should continue its efforts to secure adequate payment for the services on which effective longitudinal preventive care relies. These efforts should include advocating for the elimination of Medicare beneficiary cost sharing for chronic care management services, including through continued support for the Chronic Care Management Improvement Act of 2026, which would eliminate the 20 percent coinsurance for those services**,** as well as urging CMS to continue to support remote physiologic monitoring, remote therapeutic monitoring, and related services that allow care teams to detect changes in patients' health as they emerge and intervene between visits.

Long-Term Redesign of Preventive Care

The near-term reforms outlined above would address important shortcomings in Medicare's preventive care model, but they would not answer the more fundamental questions raised throughout this report: what preventive care should seek to accomplish; how and for whom it should be delivered; and what payment models and incentives can support it. Answering those questions will require reconsidering assumptions that have shaped preventive care for decades, but doing so would also create an opportunity to redesign preventive care in a way that better reflects current evidence, advances in technology, and innovations in how medical care is delivered today. Physicians are particularly well positioned to lead this work. In addition to possessing clinical expertise and firsthand knowledge of how preventive care can be integrated into practice, physicians retain a trusted role in matters of health and public health that could help build confidence in—and ultimately support adoption of—new approaches to preventive care.

As part of this effort, physicians should examine five broad areas: the goals of preventive care and how success should be measured; the prioritization of interventions based on evidence; approaches to identifying patients with unmet needs and targeting outreach; innovative models for delivering care; and payment approaches that support individualized, longitudinal, team-based care. Table 2 identifies specific questions within each area. This work should draw on expertise in epidemiology, biostatistics, implementation science, and other relevant disciplines, as well as input from patients—particularly those from populations that have historically faced the greatest barriers to care—and other healthcare stakeholders.

Table 2. Key Questions to Guide the Future of Preventive Care

Objective	Key Questions
Defining the goals of preventive care and measuring success	What outcomes should preventive care aim to improve, and over what time horizons should benefits be anticipated and measured?
	How should progress toward those outcomes be measured, and what roles should process measures and patient outcomes play in assessing success?
Prioritizing preventive care interventions based on evidence and value	Which preventive interventions have sufficient evidence of improving patient outcomes, and which require additional evidence to justify their use?
	How should preventive interventions be prioritized based on the magnitude and certainty of their benefits, potential harms and burdens, and cost-effectiveness?
	How should evaluations of preventive interventions account for delayed outcomes, selection bias, and differences between increased healthcare utilization and improved patient outcomes?
Identifying patients with unmet needs and improving targeted outreach	Should risk stratification estimate a beneficiary's risk of experiencing an adverse health outcome, the likelihood that the beneficiary will benefit from a particular preventive intervention, or both?
	Which data and indicators should inform risk assessment, and how should they be weighed based on predictive value, reliability, and actionability?
	Which data and indicators are independently verifiable and thus least susceptible to practices that use coding or documentation to inflate measured risk scores?
	What events or thresholds should prompt reassessment of a patient's preventive care needs?
	How should risk assessment incorporate data generated outside the clinical encounter to identify beneficiaries whose preventive needs have changed between scheduled contacts?
	How should the type, intensity, and frequency of preventive interventions and follow-up vary according to the patient's type and level of risk and likelihood of benefit?
	How should the method, intensity, and frequency of outreach vary according to the patient's risk, specific barriers to care, and consequences of delayed intervention?
Developing new models for delivering preventive care	How should the timing, setting, and modality of preventive care vary across different interventions and patient needs?
	How can preventive care delivery models preserve and strengthen the physician-patient relationship if care is distributed across multiple visits, settings, and care team members?
	How should responsibility for different preventive care functions be allocated among physicians, members of the physician-led care team, patients, and technology?
	How can various stakeholders, including practices, health systems, hospitals, and health information technology developers, support access to and coordination of preventive care?
Optimizing payment and incentives to support preventive care	What payment approaches can best support longitudinal, team-based preventive care—accounting for services furnished during and between visits, across settings, by different team members, and through different modalities?
	How can payment incentives promote high-value preventive care while minimizing unintended consequences?

Defining the goals of preventive care and measuring success

This work should begin by defining the objectives of preventive care and the measures used to evaluate its effectiveness. Specifically, experts should reach consensus on which outcomes preventive interventions should be expected to influence—for example, whether effectiveness should be assessed in terms of morbidity and mortality, functional status, quality of life, or other outcomes—and the appropriate time horizon for assessing them. A stronger measurement framework should also distinguish between process measures that assess whether recommended

preventive services were delivered and outcome measures that assess whether those services achieved their intended effects. Clearly defined objectives, measures, and time horizons would provide a consistent basis for evaluating preventive services and delivery models and generating stronger evidence to inform policy and practice.

Prioritizing preventive care interventions based on evidence and value

Once the goals of preventive care are established, the next step should be to develop a framework for determining which interventions warrant the greatest priority. Consistent with AMA policy, the framework should consider the quality and quantity of the available evidence, the magnitude and certainty of the expected clinical benefit, and the intervention's cost-effectiveness. It should also account for potential harms and burdens, including false-positive findings, unnecessary downstream care, and the time and resources required of patients and care teams. These considerations would allow preventive interventions to be distinguished not simply by whether evidence supports their use, but by the strength of that evidence and the value they are likely to produce.

Identifying patients with unmet needs and improving targeted outreach

Despite decades of guidelines calling for preventive care to be targeted toward patients most likely to benefit, the healthcare system still lacks reliable ways to identify those patients. Existing risk-stratification models are designed to predict a disparate set of outcomes, often have limited predictive accuracy, and frequently rely on inputs such as diagnosis codes that can be influenced by documentation and coding practices. More fundamentally, even accurate prediction of an adverse outcome does not establish whether preventive intervention can reduce that risk or which patients are most likely to benefit.

Physicians should therefore establish a more rigorous, clinically useful approach to risk stratification that identifies both patients at elevated risk and those most likely to benefit from additional preventive attention. This should begin with determining which outcomes are most important to predict and which factors most reliably predict them, while also assessing whether identified risks are amenable to preventive intervention and which patients are most likely to benefit. In selecting data for these assessments, experts should consider not only predictive value, but also whether the information is reliable, verifiable, and resistant to manipulation.

This work should also consider how risk assessments should guide outreach and follow-up. The appropriate intensity of outreach, mode of care, and frequency of follow-up may differ according to the nature of the risk and the likelihood of benefit. For example, patients at higher risk or substantially overdue for recommended preventive services may warrant more frequent care coordination visits, in-person evaluation, and more intensive care team outreach, while others may be appropriately managed through automated reminders, preventive care incorporated into routine visits, or telehealth when an in-person encounter is not necessary.

Ultimately, this framework should be designed for integration into EHRs and other clinical systems so that relevant data can be drawn automatically from the patient's record and used to identify patients at elevated risk and those most likely to benefit from preventive intervention. These systems could continuously update risk assessments as new clinical information becomes available, prioritize patients for outreach, and prompt the care team when follow-up is warranted. Physicians should be closely involved in their design to ensure that the new technologies integrate into clinical workflows and support, rather than supplant, physician judgment.

Existing clinical systems illustrate this principle in practice. Kaiser Permanente Northern California's Advance Alert Monitor, for example, continuously analyzes EHR data to identify hospitalized patients whose changing clinical condition warrants rapid reassessment and routes those alerts through a defined clinical workflow. Although preventive care would require different data, thresholds, and interventions, physicians should consider how similar principles could be adapted to preventive care, with the goal of translating routinely generated information into timely, physician-directed action.

Developing new models for delivering preventive care

Physicians should explore care delivery models that support preventive care as an ongoing function of the healthcare system rather than a service concentrated in a single annual encounter. This work should consider how preventive activities can be integrated across visits; how responsibilities can be appropriately distributed among primary care physicians, specialists, other members of the physician-led care team, patients, and technology; and how these approaches can extend the reach of clinical practices while preserving and strengthening the physician-patient relationship.

Efforts should also address the infrastructure and broader stakeholder roles needed to support longitudinal preventive care across care settings and encounters. This includes interoperable information exchange; coordination among practices, health systems, payers, and other organizations involved in a patient's care; and systems that support follow-up without imposing unnecessary administrative burden.

Optimizing payment and incentives to support preventive care

Finally, physicians should consider how various payment models and incentives can better support innovative approaches to delivering preventive care. Specifically, this work should examine which payment approaches would give practices the flexibility and resources to deliver care across visits, settings, modalities, and members of the physician-led care team, and how to incentivize payers, health systems, and practices to support, coordinate, and deliver high-value preventive care.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-425.984, "Clinical Preventive Services;" Policy H-425.994, "Medical Evaluations of Healthy Persons;" Policy H-460.894, "Value of Preventive Services;" and Policy H-160.908, "Payment Mechanisms for Physician-Led Team-Based Health Care." (Reaffirm HOD Policy)
2. That our AMA develop and promote educational resources to improve understanding and appropriate use of Medicare preventive visits among beneficiaries, physicians and other members of physician-led healthcare teams, and support broader education on evidence-based, high-value preventive care. (Directive to Take Action)
3. That our AMA advocate for greater physician flexibility to tailor the content and delivery of Medicare preventive visits to patients' individual risks, needs, clinical circumstances, and preferences. (Directive to Take Action)
4. That our AMA continue to advocate for payment policies and models that support individualized, longitudinal, physician-led, team-based preventive care. (New HOD Policy)

5. That our AMA, in collaboration with national medical specialty societies, explore approaches to modernizing preventive care, including how to prioritize evidence-based services according to individual patient needs, support longitudinal and physician-led team-based care, and align payment and incentives with effective preventive care. (Directive to Take Action)
6. That our AMA amend Policy H-425.997, "Preventive Services," paragraph 3, as follows:

    3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician, or, under the physician's supervision, by members of the physician-led care team. (Modify Current HOD Policy)

7. That our AMA amend Policy H-330.879, "Providers and the Annual Wellness Visit," paragraphs 2 and 3, as follows:

    2. Our AMA supports that, at a minimum, any ~~clinician~~ physician or member of the physician-led care team performing the AWV must enumerate all relevant findings from the visit and make provisions for all appropriate follow-up care.
    3. Our AMA supports that the Centers for Medicare & Medicaid Services (CMS) provide a means for physicians, patients, and members of physician-led care teams to determine whether or not Medicare has already paid for an AWV for a patient in the past 12 months. (Modify Current HOD Policy)

Fiscal Note: Minimal.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-26)
Drug Shortages: 2026 Update
(Reference Committee K)

EXECUTIVE SUMMARY

INTRODUCTION. American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue. CSAPH has issued 16 reports on drug shortages, with the most recent presented at the 2025 Interim Meeting. This report will provide an update on drug shortages since the 2025 report was developed.

METHODS. English-language reports were selected from a PubMed and Google Scholar search from September 2023 to June 2026 using the text term "drug shortages." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the websites of the U.S. Food and Drug Administration; National Academies of Sciences, Engineering, and Medicine; U.S. Department of Health and Human Services; American Society of Health-System Pharmacists; Duke Margolis Institute for Health Policy; and contemporary media reporting.

DISCUSSION. Although the number of new drug shortages has fallen to a 20-year low, active drug shortages remain widespread and are lasting longer, suggesting that underlying vulnerabilities in the pharmaceutical supply chain persist. Concentrations of manufacturing for key starting materials (KSMs); for active pharmaceutical ingredients; and for finished products continue to create single points of failure that can prolong shortages and increase the risk of disruption from geopolitical events, natural disasters, or production problems. Recent federal initiatives aimed at improving supply chain transparency, strengthening shortage reporting requirements, promoting strategic reserves of critical medicines, and encouraging more resilient manufacturing practices may help reduce future shortages, but sustained attention to supply chain diversification and resilience remains necessary and cost-effective for the nation as a whole.

CONCLUSION. Drug shortages continue to pose significant challenges to patient care despite encouraging reductions in the number of newly reported shortages. Current trends indicate that improving supply chain transparency, expanding communication among stakeholders, monitoring vulnerable medicines, and reducing overreliance on geographically concentrated manufacturing sources are critical to ensuring reliable access to essential medications. Ongoing collaboration among federal agencies, manufacturers, healthcare organizations, and the AMA will be essential to prevent future shortages and mitigate their impact on patients and physicians. Proposed changes to AMA policy support these efforts by recommending tariff exemptions for generics and essential medicines, encouraging the use of evidence-based essential medicines lists to guide prioritization, strengthening supply chain transparency and surveillance to support early identification of potential shortages, and investing in the resiliency of the drug supply chain.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-26

Subject: Drug Shortages: 2026 Update

Presented by: Tamaan Osbourne-Roberts, MD, MBA, Chair

Referred to: Reference Committee K

American Medical Association (AMA) Policy H-100.956, "National Drug Shortages," directs the Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue. CSAPH has issued 16 reports on drug shortages, with the most recent presented at the 2025 Interim Meeting. The remainder of this report will provide an update on drug shortages since the 2025 report was developed.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2023 to June 2026, using the text terms "drug shortages." Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the U.S. Food and Drug Administration (FDA), National Academies of Sciences, Engineering, and Medicine, U.S. Department of Health and Human Services (HHS), American Society of Health-System Pharmacists (ASHP), Duke Margolis Institute for Health Policy, and contemporary media reporting.

BACKGROUND

Drug shortages remain an ongoing and complex public health concern in the United States (U.S.), with continuing challenges to the supply chain alongside encouraging trends. The FDA defines a drug shortage as "a period of time when the demand or projected demand for the drug within the United States exceeds the supply of the drug."[1] Drug shortages may occur for a variety of reasons, including disruptions to the supply chain, a limited number of manufacturers, small profit margins, regulatory burdens, natural disasters, or surges in demand.[2–4] Shortages often require physicians to alter the drug of choice or postpone prescribing; spend time on tradeoff decisions regarding efficacy, safety, and cost of alternative treatments; make triage decisions regarding how to limit use; and endure increased administrative burdens such as prior authorization.[5]

The two primary data sources for information on drug shortages in the U.S. are the Drug Shortage Program at the FDA and the Drug Shortage Resource Center maintained by ASHP in cooperation with the University of Utah Drug Information Service (see Box 1 for links to these resources). The FDA collects drug shortage information for its database directly from the drug manufacturers via their voluntary submission of information and includes a drug on the shortage list when a manufacturer cannot meet current market demand as self-identified. Alternatively, the ASHP defines a drug product shortage as "a supply issue that affects how the pharmacy prepares or

dispenses a drug product or influences patient care when prescribers must use an alternative agent."[6] The ASHP drug shortages database is based on reports from healthcare practitioners or patients/caregivers, which is then verified with manufacturers by the University of Utah Drug Information Service to confirm the shortage status for inclusion in its list. Since the FDA database has a more limited definition of a drug shortage and requires self-reporting from manufacturers, its drug shortage numbers and statistics tend to be smaller and vary somewhat from those reported in the ASHP drug shortages database statistics; for this reason, ASHP drug shortage statistics are primarily used in this report.

CURRENT TRENDS IN DRUG SHORTAGES

New Drug Shortages Have Reached a 20-Year Low but Average Duration Has Lengthened

According to ASHP statistics, the number of new drug shortages has been declining each year for the past four years and in 2025 reached its lowest level since 2006 at 89 (see Figure 1).[7] The number of active drug shortages, 223, is also significantly lower than the all-time high of 323 in 2024. However, the number of shortages has been trending upward the past few quarters, indicating that many of the current shortages have persisted across multiple quarters/years (see Figure 2).[7] Indeed, according to U.S. Pharmacopeia (USP), the average duration of FDA-verified drug shortages has lengthened to 5.3 years in 2025 from 4.3 in 2024 and 2.0 in 2019 (see Figures 3 and 4).[8] The reasons for this trend are not entirely clear; however, it is possible that, as the overall number of shortages has declined, the shortages that remain are inherently more complex and difficult to resolve, thereby increasing the average duration of active shortages.

The majority of new drug shortages (58 percent) continue to involve sterile injectables, which tend to be low-profit generics that lack supply chain redundancy (see Figure 5). So far in 2026, the five classes of drugs facing the largest numbers of shortages are central nervous system therapies (n = 47), antimicrobials (n = 33), hormone agents (n = 23), chemotherapies (n = 22), and autonomic drugs (n = 17) (see Figure 6). Of the 75 drugs on the FDA drug shortage list at the end of 2025, 16 were pediatric drugs, followed by medications for gastroenterology (n = 11), anesthesia (n = 10), and endocrinology/metabolism (n = 10) (see Figure 7).[9] ASHP also notes that 15 percent of active drug shortages are controlled substances, potentially impacting access to prescriptions for chronic pain and attention deficit hyperactivity disorder (ADHD), as well as supplies for surgeries and procedures.[7]

Factors Contributing to Fewer New Drug Shortages

Most shortages have unknown or unreported causes (59 percent) so it is difficult to understand the decline in new drug shortages (see Figure 8).[7,10] However, one driving factor is likely the gradual recalibration to normal levels of production following disruptions during the COVID-19 pandemic as well as Hurricane Helene in 2024 (discussed in the CSAPH 2025 drug shortages report).[10] For example, the number of electrolytes in shortage ranged from 27 to 32 every year from 2021-2024 but plummeted to 12 in 2025, reflecting both a recovery of active shortages and an avoidance of new shortages (see Figure 9). Similarly, antibiotic shortages have decreased to near pre-pandemic levels after COVID-19-related increases in demand and supply chain disruptions.[11]

Another factor contributing to fewer new shortages may be earlier notification of production interruptions paired with FDA intervention; in its 2024 annual report on drug shortages, the FDA noted that several regulations have helped it mitigate and prevent shortages.[12] Specifically, the CARES Act of 2020 enhanced the FDA's visibility in drug supply chains by expanding the

requirement for manufacturers to provide information to the FDA on discontinuances and interruptions in manufacturing. The Act also required the FDA to prioritize the review of certain applications and inspections that could help mitigate or prevent a drug shortage and required manufacturers to maintain a redundancy risk management plan.[13] The Food and Drug Omnibus Reform Act (FDORA) of 2022 required increased coordination across FDA offices, including mandatory sharing of inspection reports by field investigators with the FDA's Drug Shortage Staff (DSS).[14] This increased communication has allowed DSS to work with manufacturers to take preventive action sooner.[12] Indeed, in 2024, the FDA worked with manufacturers to avoid 283 shortages, an increase from the prior two years, potentially resulting in the lower number of new shortages in 2025 and early 2026. These prevented shortages resulted from a combination of efforts by the Center for Drug Evaluation and Research (CDER), which has dedicated DSS and is responsible for most prescription and over-the counter drugs, and the Center for Biologics Evaluation and Research (CBER), which oversees biologics including vaccines and gene therapies (see Figure 10).[12] These patterns suggest that recent federal actions to improve supply chain transparency, increase coordination across FDA departments, and work effectively with manufacturers to preempt shortages may be reducing the incidence of new shortages.

ONGOING CHALLENGES FOR DRUG SHORTAGES AND THEIR DURATION

Overall, however, the decline in new drug shortages may reflect the prolonged duration of existing shortages rather than a fully stabilized system. In its 2025 annual drug shortages report, USP identified four primary risk factors contributing to the onset and persistence of drug shortages: low drug price, manufacturing complexity, quality concerns, and geographic concentration of manufacturing.[8] These unique challenges have been examined in previous CSAPH drug shortages reports, with this report focusing on geographic manufacturing impacts that potentially impede progress on reducing drug shortages and their duration.

Challenge: Geographic Distribution of Manufacturing

Manufacturing of key starting materials (KSMs) and active pharmaceutical ingredients (APIs) have become increasingly concentrated in single countries and facilities (both domestic and abroad) over the past few decades. This consolidation is creating structural vulnerability in the U.S. drug supply chain.[15] Consistent with this, a recent study in the Veterans Health Administration found that drugs with fewer manufacturers were more likely to experience disruptions, affecting patient access to medications.[16]

The Senate Special Committee on Aging reported in October 2025 that more than 40 percent of generic drugs sold in the U.S. have just one manufacturer and that China alone supplies approximately 95 percent of ibuprofen, 70 percent of acetaminophen, and 45 percent of penicillin imports as of 2023.[17] Sterile injectables, which make up the majority of drug shortages, are particularly prone to concentrated manufacturing. For instance, as of January 2025, a single manufacturing facility in India supplied a substantial portion of the U.S. supply of several oncology injectable drugs, producing 24 percent of cisplatin, 84 percent of temsirolimus, 43 percent of carmustine, and 8 percent of carboplatin.[18] Supply disruptions can arise even when manufacturing is concentrated in allied countries. A study of ADHD medications in 2022-2023 found that shortages were linked to disruptions originating in a partner European Union country.[19] A core risk lies in concentration of manufacturing, regardless of geographic location.

While much focus has been on manufacturing of APIs, upstream concentration of the drug supply chain in KSM production creates single points of failure for multiple drugs simultaneously (see Figure 11). According to USP, 44 percent of the FDA-verified drugs in shortage in 2025 (n = 75)

have at least one KSM that is solely manufactured in a single country (see Table 1).[8] Transparency into these supply chains remains limited. The 2025 Senate report noted that the FDA relies heavily on manufacturer-reported data to track shortages and that the U.S. government has limited information about KSM supply chains, which are not readily reported.[17] In response to the Senate report findings of concentrated manufacturing, unbalanced trade (see Figures 12 and 13), and limited transparency, the CLEAR LABELS Act of 2026 (Senate Bill 3788) was introduced. The Act would require manufacturers to identify the original source of finished drugs and their APIs on labels.[20] According to the sponsors, this Act would provide more information on potential supply chain vulnerabilities and increase transparency for patients, pharmacists, and healthcare professionals.[21]

Challenge: Potential Global Disruptions to Supply Chains

Because the U.S. depends heavily on other countries for pharmaceuticals, global conflict can worsen drug shortages through disruptions to manufacturing, transportation, trade, and supply chains.[22] As of the writing of this report, there are no data indicating whether the ongoing conflict in the Middle East has impacted the drug supply chain, but available manufacturing data indicate that several pharmaceutical products depend substantially on production capacity in the region. While just 0.3 percent of APIs and 0.6 percent of oral solid dose drugs come from the region, there are a handful of products that are substantially produced in the Middle East: 48 percent of amoxicillin oral suspension (Jordan), 73 percent of flumazenil API (Israel and Jordan), 48 percent of etomidate API (Jordan), and 24 percent of doxycycline hyclate capsules (Jordan).[23] More broadly, India uses the Red Sea corridor to transport pharmaceutical products to the U.S. and relies on the Strait of Hormuz to import 40 percent of its crude oil, which is used to create petrochemicals, a KSM for nearly all medications.[24,25] Rising costs and transit times could arise from conflict and closures in these shipping corridors, potentially leading to drug shortages in the U.S. This is particularly relevant for generics, which are already produced on slim profit margins and account for about 90 percent of prescriptions in the U.S., nearly half of which are produced in India.[26]

It is not clear whether current conflicts in the Middle East will affect drug shortages in the U.S., but the situation warrants continued monitoring. Historically, military conflicts, as well as natural disasters and other geopolitical disruptions, have affected manufacturing operations, transportation networks, trade routes, and energy supplies, all of which can influence pharmaceutical production and distribution.[27–29] Such disruptions may increase costs, lengthen transit times, and reduce production capacity, potentially increasing the risk of drug shortages. Given the increasingly global nature of pharmaceutical manufacturing and supply chains, visibility into potential disruptions may help policymakers, manufacturers, and regulators anticipate and respond to emerging supply challenges. Although FDA currently has limited visibility into many aspects of the global pharmaceutical supply chain, enhanced surveillance and supply-chain monitoring could improve the ability to identify vulnerabilities and support efforts to prevent or mitigate shortages.

FDA ACTIONS AND THEIR EFFECTS ON MEDICATION ACCESS

The FDA plays a central role in shaping medication access through its regulatory, enforcement, and policy decisions and has undergone significant changes in recent years, as discussed in last year's report. The following examples illustrate how FDA policies in the last year have influenced drug availability, demand, and supply chains across multiple dimensions.

Estrogen Patches: FDA Safety Warning Removed

The demand for estrogen patches has surged following the removal of a long-standing FDA safety warning in November 2025.[30] Beginning in 2003, the FDA required "black box" warnings on hormone replacement therapy (HRT) products, including estrogen patches, due to evidence linking their use with increased risk of heart disease, breast cancer, stroke, and dementia.[31,32] The FDA has since cited more recent studies showing no association with cancer mortality and, in fact, evidence of reduced risk of all-cause mortality, fractures, heart attack, cognitive decline, and Alzheimer's disease that led to the reversal of the black box warning.[33] Following the FDA expert panel on HRT safety in July 2025, prescriptions of estrogen-based HRT products rose 19.1 percent and use of estrogen patches rose 26.1 percent between then and February 2026 (see Figures 14 and 15).[34] Manufacturers of estrogen products have since reported difficulty keeping pace with demand and have warned that supply constraints could persist for up to three years, noting that estrogen patches are low-margin generic drugs and that production scale-up is slow and capital intensive.[30] This case illustrates how FDA regulatory decisions can rapidly affect demand and strain manufacturing capacity.

GLP-1s: Increased Restrictions on Compounding

Recent FDA regulations have restricted compounding of glucagon-like peptide-1 receptor agonists (GLP-1s), shutting down a lucrative compounding market.[35] Under the Federal Food, Drug, and Cosmetic Act, outsourcing facilities, which manufacture large batches of drugs for hospitals and healthcare professionals, may compound drugs from bulk substances only if those substances appear on the FDA's 503B bulks list or if compounding is otherwise eligible due to an active drug shortage.[36] In recent years, this led many companies to market and sell compounded GLP-1s amid ongoing drug shortages. However, once semaglutide, tirzepatide, and liraglutide were removed from the FDA's drug shortage list in late 2024 and early 2025, routine compounding of these products no longer met the shortage-based exception, and these products could not be legally compounded. Continued compounding led the FDA to issue over 30 warning letters to telehealth companies in March 2026 for illegal sales and misleading marketing of compounded GLP-1 products.[37] On May 1, 2026, the FDA reinforced the restriction on GLP-1 compounding by proposing to exclude semaglutide, tirzepatide, and liraglutide from the 503B bulks list on the basis of no clinical need.[38] A formal rulemaking to that effect would effectively foreclose lawful compounding of GLP-1s.

While legal compounding of GLP-1s has been halted, there remains a significant "gray market," whereby consumers purchase raw APIs and prepare the medications themselves.[39] This presents significant patient safety risks given variability in purity, potency, and dosing. However, for many patients, the availability and low cost of gray market GLP-1s seemingly outweigh these risks.[40]

Peptides: Potential Easing of Restrictions on Compounding

While the FDA has imposed tighter restrictions on GLP-1 compounding, it is simultaneously considering whether to permit the compounding of certain synthetic peptide compounds that have gained traction, despite the absence of FDA-approved products or established safety and efficacy data. In recent years, a class of unapproved and understudied synthetic peptide compounds has gained popularity amongst celebrities, through social media influencers, and in the longevity and wellness spaces. These peptides are frequently sold on the gray market and marketed with claims related to muscle growth, injury recovery, weight loss, sexual function, and lifespan extension and are self-administered by injection. Clinical evidence on these peptide compounds is extremely limited, and concerns have been raised regarding patient safety due to variability in product

potency, purity, and labeling. A recent large-scale study found that 41.6 percent of gray market peptide compounds failed to meet basic quality criteria and 15 percent of samples had measurable endotoxin contamination, creating a public health risk.[41]

In 2023-2024, the FDA designated 19 peptide bulk drug substances as raising significant safety concerns and prohibited their use in compounding by 503A pharmacies, which are traditional pharmacies that compound medications for an individual patient's prescription. Despite little new research, seven of these peptides (BPC-157, KPV, TB-500, MOTS-c, Emideltide, Semax, and Epitalon) are now under FDA review for potential inclusion on the Section 503A bulks list, which would permit compounding following formal rulemaking (see Table 2).[42] While inclusion on the 503A bulks list would allow these peptides to be prescribed, there are no FDA-approved products that contain these agents and little safety or efficacy data on the agents themselves. Additionally, no FDA-registered manufacturers currently produce pharmaceutical-grade APIs necessary for the compounding of these peptides, thereby preventing pharmacies from filling hypothetical prescriptions.[43]

The potential capability of compounding these agents may place additional strain on the drug supply chain as well as increase challenges if a drug in shortage needs to be compounded emergently. If these peptides become widely prescribed, demand for active pharmaceutical ingredients, manufacturing capacity, and compounding services could increase substantially. To the extent that these resources are limited, expanding production of unapproved synthetic peptides could compete with the production or compounding of medically necessary drugs, including medications in shortage.

ENSURING ACCESS TO ESSENTIAL AND VULNERABLE MEDICINES

Given continuing supply chain disruptions and uncertainty, efforts to ensure access to essential and vulnerable medicines are ongoing. These efforts include identifying critical drugs, assessing approaches to buffer stocks, and expanding communication around potential supply disruptions.

HHS Developing a List of 26 "Critical Drugs"

Executive Order (EO) 14336, Ensuring American Pharmaceutical Supply Chain Resilience, signed by the President in August 2025, directs the Office of the Assistant Secretary for Preparedness and Response (ASPR) within HHS to develop a list of approximately 26 "critical drugs" that are especially important to the health and security interests of the nation.[44] The EO directs ASPR to obtain and maintain a 6-month supply of the APIs needed to make those critical drugs, with a preference for domestically manufactured APIs, and to identify available funds that may be used to do so. The list of 26 drugs is being developed from an existing list of 86 essential medicines that were identified by the FDA, ASPR, and clinical stakeholders in 2022 as part of the Administration's work to secure critical supply chains and increase domestic manufacturing.[45] The 86 drugs are those the clinical stakeholders identified as most critically needed for acute patient care, most of which are generic sterile injectables and at high risk of shortage.[46] As required by EO 14336, the list of 86 is currently under review by ASPR and is scheduled to be updated in 2026.

USP Adds KSMs to Vulnerable Medicines List

Beginning last year, USP published an annual listing of 100 clinically important medicines (50 for acute care and 50 for chronic conditions) that are at heightened risk of supply disruption, even when no current shortage exists.[47] This year, for the first time, the analysis expanded beyond finished dosage forms and APIs to include KSMs, which is particularly important given the

increasing concentration of KSM manufacturing, as discussed above. The USP report found that 48 of the 100 clinically important medicines rely on at least one KSM that is manufactured exclusively in a single country.[47] As a result, even medicines with multiple API manufacturers worldwide may depend on a single source for KSMs, leaving the overall supply chain highly fragile. Additionally, 29 of the 100 drugs on the list were not included on the World Health Organization (WHO) or FDA essential medicines lists and, as of February 2026, 70 percent were structurally vulnerable, but not in shortage yet. These findings underscore the necessity of monitoring upstream supply-chain resilience of KSMs in addition to APIs and finished products.

CMS Seeking Input on Domestic Procurement and Buffer Stocks

The Centers for Medicare & Medicaid Services (CMS) issued an Advance Notice of Proposed Rulemaking (ANPRM) in January 2026 seeking public input on potential approaches to strengthen the domestic supply chain for personal protective equipment (PPE) and essential medicines.[48] In particular, CMS is considering a new "Secure American Medical Supplies" friendly designation for hospitals that demonstrate commitment to domestic procurement and payment adjustments for hospitals to encourage engagement. CMS is also soliciting comment on existing policies that provide payment to hospitals for the additional costs of maintaining optional buffer stocks of essential medicines. The Drug Shortage Task Force,[49] a collaborative including the AMA and other stakeholders, responded to the ANPRM with six recommendations:[50]

1. Encourage Procurement Policies That Reward Reliability, Not Just Lowest Price: The Task Force appreciates CMS' recognition that price pressures have created market dynamics that can undermine domestic and quality producers. Prioritizing reliability over lowest costs can help create a more predictable market that supports sustainable U.S. manufacturing and protects patients. For participating hospitals, the shift may also help to reduce the administrative burden of managing shortages and improving continuity of care by ensuring that essential medicines are consistently available when patients need them.
2. Center CMS Policy on Supply Chain Resilience, Reliability, and Quality: The Task Force supports integrating resilience measures into any procurement incentives and establishing a mechanism to differentiate manufacturers based on objective indicators of reliability. By embedding resilience, reliability, and quality in Medicare-related procurement expectations, CMS can shift incentives toward manufacturers that invest in dependable production practices and help the market function more predictably by supporting procurement decisions that prioritize stability alongside affordability.
3. Use a Data-Driven Vulnerable Medicines List to Guide Prioritization: The Task Force encourages CMS to utilize a Vulnerable Medicines List to provide predictability for hospitals and to help ensure that procurement incentives target medicines where intervention will produce the greatest impact.
4. Ensure Goals for Domestic Production Informed by Upstream Supply Chain Data: Rigid or overly broad domestic sourcing thresholds risk unintended disruptions or shortages of highly vulnerable medicines and may not reduce or address the root causes of shortages. The Task Force recommends a phased approach that uses real-world API and KSM data to set achievable domestic sourcing expectations and adjusts them as domestic capacity grows.
5. Support Modernized Domestic Manufacturing and Advanced Manufacturing Technologies: The Task Force supports policies that would expand U.S. manufacturing capacity, promote diversification, and accelerate adoption of advanced manufacturing technologies (AMTs)—all needed to address the structural causes of shortages. AMTs can improve efficiency, enhance product reliability, reduce environmental impact, and support more geographically distributed production networks. CMS can play a transformative role by

encouraging procurement from manufacturers that adopt AMTs and by supporting policies that reward investments in modernized, resilient manufacturing infrastructure.

6. Promote Interagency Coordination and Sustain Cross Sector Collaboration: The Task Force encourages CMS to work closely with partners across HHS, FDA, ASPR, and other agencies to align policies, share insights, and harmonize data. Ongoing engagement with industry, providers, and patient groups will help ensure that emerging solutions are practical, scalable, and responsive to the real-world experiences of those directly impacted by shortages.

Our AMA continues to monitor the use of buffer stocks as an effective strategy to mitigate drug shortages and opposes the use of punitive fees for those who do not participate in buffer stocks.

The Drug Shortage Prevention Act of 2025

The Drug Shortage Prevention Act of 2025 was introduced in Congress in August 2025 and would expand the drug shortage notification framework established by the CARES Act of 2020.[51] Under the CARES Act, manufacturers of certain critical drugs are required to provide HHS with at least six months' advance notice of permanent discontinuance or manufacturing interruptions likely to cause a meaningful supply disruption.[13] The Drug Shortage Prevention Act of 2025 would further require manufacturers to notify HHS of increased demand, export restrictions, and other circumstances that could prevent a manufacturer from meeting U.S. demand, as well as provide information on API sources, alternative suppliers, and expected interruption duration. Manufacturers would also be required to disclose supplier names and production amounts twice a year, rather than the current annual reporting requirement. In turn, HSS would be required to share these manufacturer notices with appropriate organizations, including physician, health provider, and patient organizations. Overall, this bill aims to increase transparency, take a preventive approach to drug shortages, and strengthen the CARES Act, which, as discussed above, the FDA cites as one factor contributing to its ability to mitigate and prevent drug shortages.[12]

DOMESTIC AND ALLIED MANUFACTURING

The current administration continues its interest in increasing domestic manufacturing of pharmaceuticals. The FDA's 2027 budget proposal includes a legislative proposal that would allow domestic generic drug manufacturers to submit FDA applications for marketing a generic drug one month earlier than foreign manufacturers.[52] This would increase the likelihood that a domestic manufacturer qualifies for the 180-day generic market exclusivity, which typically provides substantial profits. The FDA is also requesting funding to upgrade and establish new drug manufacturing facilities in the U.S., as well as funding to expand resources for its foreign inspection program to better oversee an increasingly globalized supply chain.

Tariffs have also played a significant role in the effort to increase domestic manufacturing. In April 2026, Proclamation 11020 was signed by the President, which establishes tariffs of up to 100 percent on imported patented pharmaceuticals and pharmaceutical ingredients.[53] No tariff is placed on companies that are building drug manufacturing facilities in the U.S. and have signed a Most Favored Nation (MFN) pricing deal, meaning the U.S. price must be no higher than that in comparable foreign countries. A 20 percent tariff would apply to companies that do not have an MFN deal but are building facilities in the U.S.; that tariff would increase to 100 percent in 2030. Notably, at this point, generics and biosimilar drugs are exempt from these tariffs. Our AMA supports legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare system, ensuring that patient care, medical supplies, and pharmaceuticals remain accessible and affordable.

Pharmaceutical production is capital intensive, highly regulated, and dependent on specialized infrastructure and workforce expertise. Establishing new manufacturing capacity, whether for KSMs, APIs, or finished drugs, requires multi-year investment, regulatory approval, and supply chain development. Despite efforts to increase domestic manufacturing, the U.S. will remain dependent on existing global supply chains.[47] USP has identified countries with shared regulatory standards and clinical priorities, such as India, Japan, South Korea, and members of the European Union, that possess existing pharmaceutical infrastructure that can support high-quality production.[47] Rewarding U.S. manufacturers with partnerships and investments in these regions, such as technical assistance, regulatory harmonization, and procurement commitments, could potentially diversify supply chains more rapidly and at lower cost than domestic reshoring alone, reducing reliance on concentrated sources while maintaining supply continuity. Additionally, as noted in USP's 2025 annual drug shortages report, it is critical to diversify the drug manufacturing base as geographic concentration anywhere, including in the U.S., increases risk of drug shortages.[8]

CURRENT AMA ACTIVITIES

The AMA continues to remain engaged in drug shortage activities. The AMA is involved in the Drug Shortage Task Force, a multi-stakeholder, national task force effort to remain current on policies and drug shortage and supply chain issues and to develop group recommendations on the topics, many of which are already contained within AMA policy. The effort includes over 20 organizations, including AMA, ASHP, American Hospital Association, USP, American Society of Anesthesiologists, and the American Society of Clinical Oncology, to raise awareness of the severe harms of shortages and the causes behind them; provide insights to inform data-driven solutions; and advocate for reforms in a collaborative and productive manner.[49] Additionally, the AMA is represented on the FDA-funded ASHP Risk Assessment Advisory Panel. This panel is composed of supply chain and clinical experts who will provide input on the development of a matrix scoring tool that will be used to prioritize drugs by clinical need and supply chain vulnerability. Additional advocacy efforts have been taken since the 2025 drug shortages report, including communication with the U.S. Trade Representative regarding import tariffs on medical products and with the FDA supporting its proposal to exclude GLP-1s from the 503B bulks list. [54,55] At the 2026 AMA Annual Meeting, Policy D-110.979, "Access, Safety, and Affordability of GLP-1 Receptor Agonists" was adopted to encourage the use of GLP-1s in accordance with evidence-based clinical indications and risk-benefit analysis. The policy also asks that our AMA advocate for affordable access to GLP-1s for diabetes and obesity through insurance coverage, pricing transparency, and cost-containment strategies.

CONCLUSION

Drug shortages remain a persistent and complex challenge for physicians, patients, and policymakers. This annual update highlights several trends, including a decline in the number of new drug shortages alongside longer shortage durations and highly concentrated manufacturing. In response, both governmental and nongovernment stakeholders are increasingly focused on strategies to ensure access to essential medicines through maintaining buffer stocks, improving transparency and communication, and securing entire supply chains. Existing AMA policy aligns closely with many of these efforts, and the AMA continues to advocate for and collaborate with key stakeholders to prevent future shortages and mitigate their impact on patient care.

This report recommends several amendments to existing AMA policy to address emerging risks and evolving supply chain challenges. Tariffs may increase supply chain instability for generic medications and essential medicines, making targeted exemptions an important safeguard against avoidable shortages. Likewise, evidence-based essential medicines lists can help ensure that

prioritization efforts are guided by clinical need and public health impact. Lastly, enhanced supply chain transparency and real-time surveillance can further strengthen shortage prevention efforts by improving stakeholders' ability to identify and address supply disruptions before they result in patient harm. Taken together, these amendments address key vulnerabilities identified in this report and support the AMA's ongoing efforts to prevent drug shortages.

RECOMMENDATIONS

CSAPH recommends that the following be adopted and that the remainder of the report be filed:

1. That Policy D-110.981, "Impact of Tariffs on Healthcare Access and Costs," be amended by addition to read as follows:

    1. Our American Medical Association will actively monitor and assess the impact of current and proposed tariffs on healthcare costs and patient access to medical services.
    2. Our AMA supports legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare system, ensuring that patient care, medical supplies, and pharmaceuticals remain accessible and affordable.
    3. Our AMA recommends that generic pharmaceuticals, biosimilars, designated essential medicines, and brand-name and biologic drugs that lack therapeutic alternatives be exempt from import tariffs, in order to minimize adverse health impacts from tariffs. (Modify Current Policy)

2. That Policy D-100.959, "Access to Important and Essential Drugs," be amended by addition to read as follows:

    1. Our AMA will work with policymakers, regulatory bodies, drug manufacturers, and the healthcare community to address access issues and drug shortages by identifying solutions to ensure long-term stability and preserve patient access to treatments.
    2. Our AMA urges Congress to pass comprehensive legislation to mitigate existing drug shortages and prevent future shortages of lifesaving and life-prolonging drugs. A comprehensive approach would include, but not be limited to the following:
        a. address economic factors that drive generic manufacturers out of the market and consider stabilizing the market with long-term contracts and guaranteed prices;
        b. reward reliable U.S. manufacturing of critical and supportive medications through prices that support continued quality production and investment in continuous manufacturing or other advanced manufacturing for critical drugs and active pharmaceutical ingredients (APIs)~~, which could include onshoring or nearshoring as components of a solution~~;
        c. recognize that while onshoring and nearshoring are components of increasing access, geographically diverse and quality assured sources remain the overall objective;
        d. recognize potential shortages earlier by increasing the Food and Drug Administration's (FDA) visibility into the supply chain, including APIs and key starting materials (KSMs), so the agency can predict and respond to potential shortages earlier;
        e. relay information about potential shortages to health systems and providers to help them prepare for and mitigate possible supply challenges.

3. Our AMA will work with stakeholders to make sure essential medicines lists are data driven and evidence based to satisfy priority health needs and provide predictability for physicians and hospitals. (Modify Current Policy)

3. That Policy H-100.956, "National Drug Shortages" be amended by addition and deletion:

1. Our AMA urges the FDA and other appropriate agencies to develop a coordinated, real-time data infrastructure by ~~to~~ require~~e~~ing manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product supply and demand such as import flow changes and pricing variability, and ~~provide~~ more detailed information regarding the causes and anticipated duration of drug shortages. (Modify Current Policy)

Fiscal Note: Minimal

CITED POLICIES

National Drug Shortages H-100.956

1. Our American Medical Association considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing, and supports the use of incentives such as prioritized regulatory review, reduction of user fees, and direct grant opportunities for manufacturers seeking to invest in manufacturing processes.

15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.
21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.
23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary.
24. Our AMA opposes increasing drug prices or waiving fee exemptions in a manner that incentivizes a drug manufacturer to have its drug be declared in shortage.
25. Our AMA opposes the use of punitive fees on physician practices that do not maintain buffer supplies of drugs.
26. Our AMA encourages the FDA, the FTC, or other relevant oversight entities, to examine the practice of compounding pharmacies and the entities that utilize them advertising drugs actively in shortage, particularly when targeted to new patients.

Access to Important and Essential Drugs D-100.959

1. Our AMA will work with policymakers, regulatory bodies, drug manufacturers, and the health care community to address access issues and drug shortages by identifying solutions to ensure long-term stability and preserve patient access to treatments.
2. Our AMA urges Congress to pass comprehensive legislation to mitigate existing drug shortages and prevent future shortages of lifesaving and life-prolonging drugs. A comprehensive approach would include, but not be limited to the following:
    a. address economic factors that drive generic manufacturers out of the market and consider stabilizing the market with long-term contracts and guaranteed prices;
    b. reward reliable U.S. manufacturing of critical and supportive medications through prices that support continued quality production and investment in continuous manufacturing or other advanced manufacturing for critical drugs and active pharmaceutical ingredients (APIs), which could include onshoring or nearshoring as components of a solution;
    c. recognize potential shortages earlier by increasing the Food and Drug Administration's (FDA) visibility into the supply chain so the agency can predict and respond to potential shortages earlier; and
    d. relay information about potential shortages to health systems and providers to help them prepare for and mitigate possible supply challenges.

Drug Shortages: 2024 Update D-100.961

1. Our American Medical Association opposes laws, regulations, or business practices which create artificial scarcity of drugs, such as limitations on pharmacy procurement or restrictions on which pharmacies a patient can use, which prevent the filling of an otherwise valid prescription from their physician.
2. Our AMA advocates for pharmacies and distributors subject to the national opioid litigation settlement to make public the specific metrics, formulas, data sources, algorithms, thresholds and other policies and analyses that are used to delay or deny orders to pharmacies, restrict physicians' prescribing privileges and other actions that impede patients' access to medication.
3. Our AMA advocates for pharmacies and distributors to provide physicians with all due process rights and opportunities to contest any decision to restrict a physician's prescribing privileges based on a pharmacy or distributor metric, formula, algorithm or other policy before such restriction is put into effect.
4. Our AMA urges the Centers for Medicare & Medicaid Services to implement policies to temporarily halt financial and other penalties for affected quality metrics during periods of documented medication and IV fluid shortages as well as in other emergencies in order to prevent physicians and hospitals from being penalized for circumstances beyond their control.

Impact of Tariffs on Healthcare Access and Costs D-110.981

1. Our American Medical Association will actively monitor and assess the impact of current and proposed tariffs on healthcare costs and patient access to medical services.
2. Our AMA supports legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare system, ensuring that patient care, medical supplies, and pharmaceuticals remains accessible and affordable.

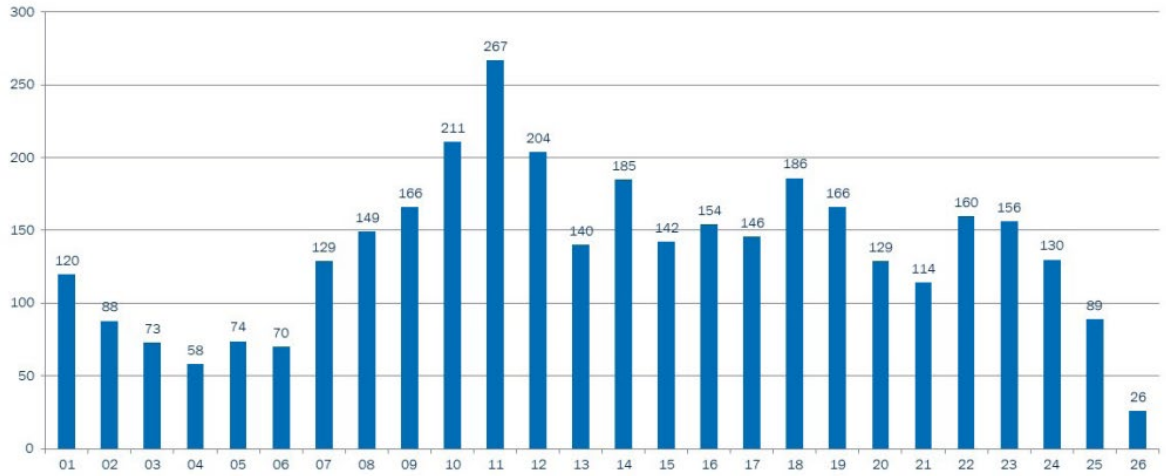
Pharmacy Compounding H-120.945

Our AMA:

1. recognizes that traditional compounding pharmacies must be subject to state board of pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications;
2. encourages all state boards of pharmacy to reference sterile compounding quality standards, including but not limited to those contained in United States Pharmacopeia Chapter 797, as the standard for sterile compounding in their state, and to satisfy other relevant standards that have been promulgated by the state in its laws and regulations governing pharmacy practice;
3. supports the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce be recognized as compounding manufacturers subject to FDA oversight and regulation;
4. supports the view that allowances must be made for the conduct of compounding practices that can realistically supply compounded products to meet anticipated clinical needs, including urgent and emergency care scenarios, in a safe manner; and
5. in the absence of new federal legislation affecting the oversight of compounding pharmacies, continues to encourage state boards of pharmacy and the National Association of Boards of Pharmacy to work with the United States Food and Drug Administration to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding.

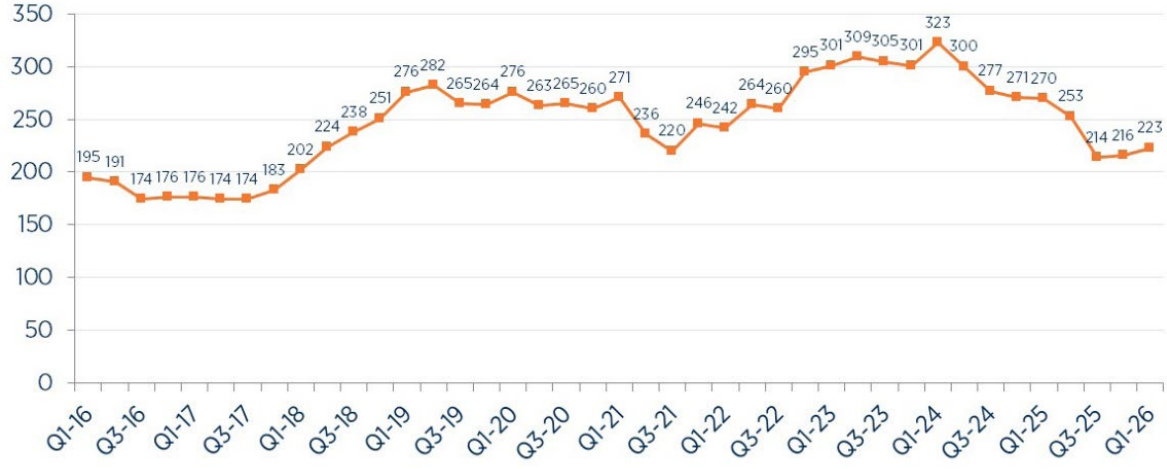
APPENDIX

Figure 1. New Drug Shortages by Year: January 2001 to March 30, 2026[7]



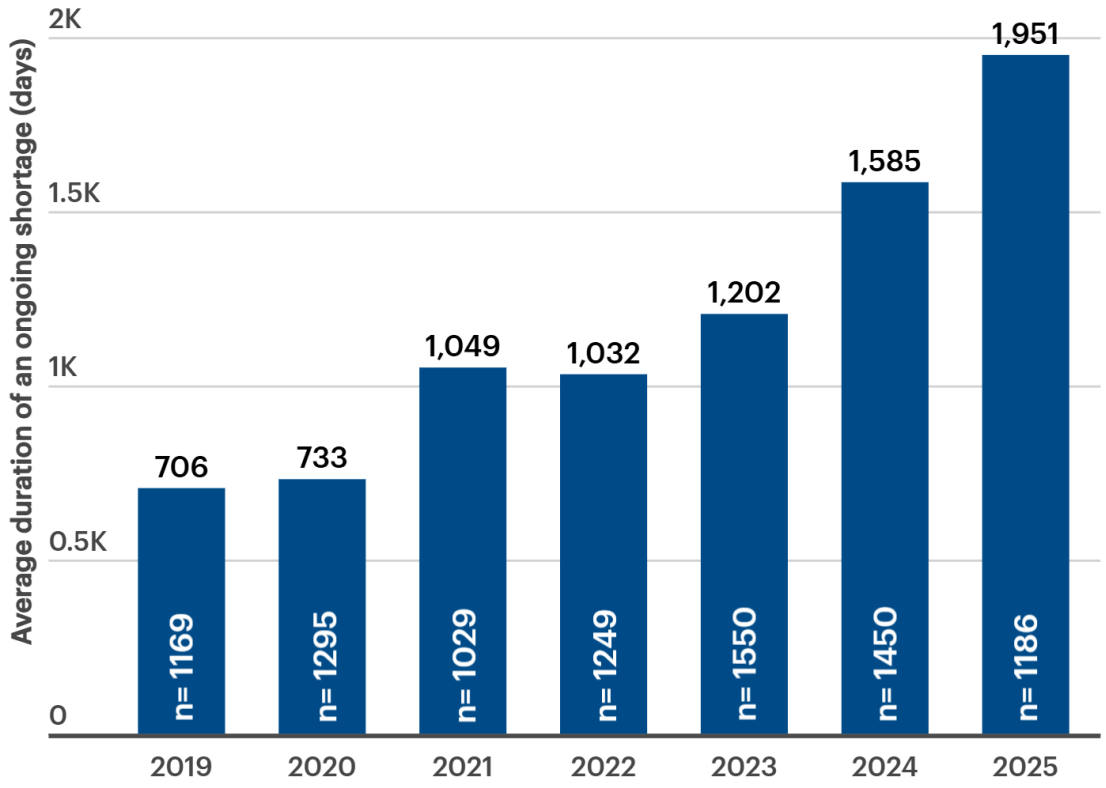
Note: *Each column represents the number of new shortages identified during that year.*
University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr

Figure 2. National Drug Shortages: Active Shortages by Quarter: 10 Year Trend[7]



Note: Each point represents the number of active shortages at the end of each quarter.
University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr

Figure 3. Average Duration of Year-End Drug Shortages, By Year (2019-2025)[8,a]



[a] n is the count of approved drug products corresponding to the National Drug Code (NDC), which is a unique, three-segment numerical identifier assigned to every medication approved for sale in the U.S. by the FDA. The NDC identifies the labeler, product, and package size, thereby aiding in the regulation, distribution, and inventory management of drugs.

Figure 4. Duration of Ongoing Drug Shortages in 2025 [8]

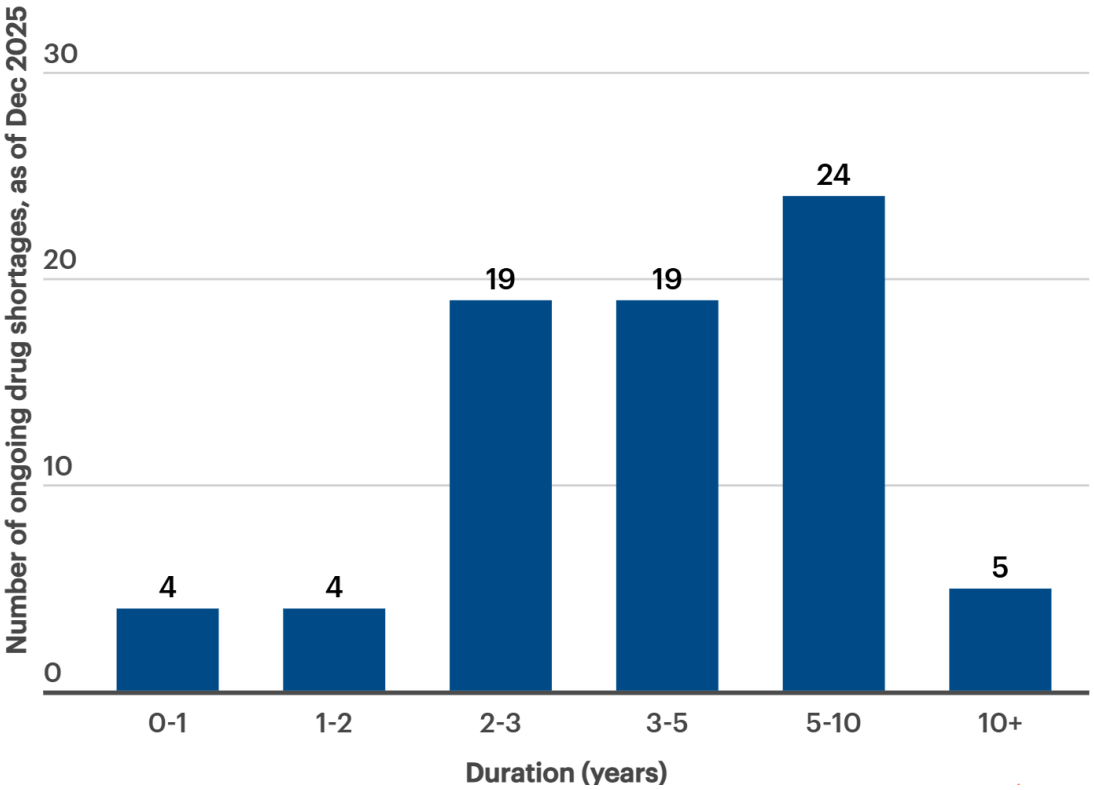
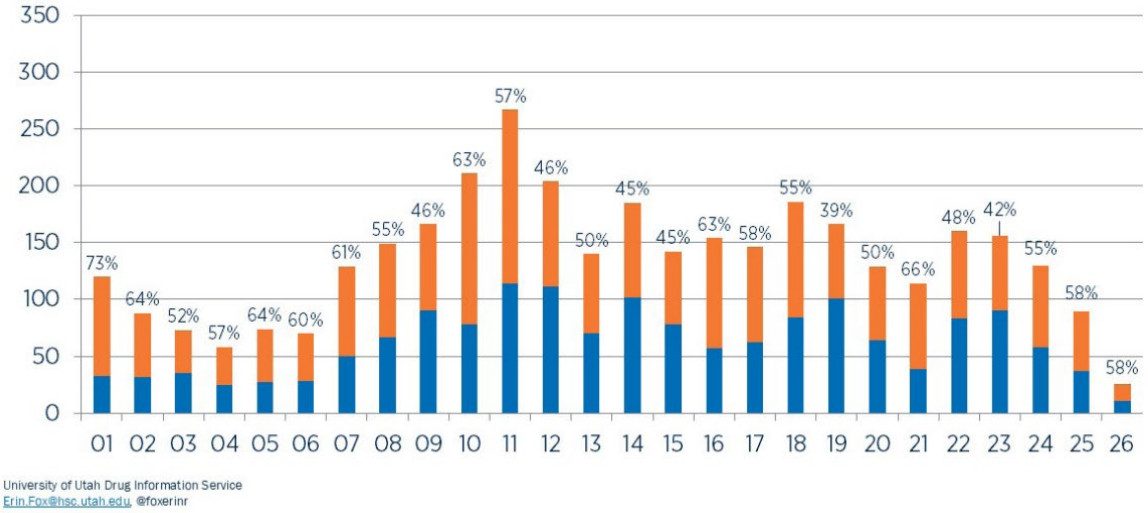


Figure 5. National New Drug Shortages by Year: January 2001 to March 2026, Percent Injectable[7,a]



[a] Injectables are shown in orange (top bar)

Figure 6. National Active Drug Shortages: Top 5 Drug Classes[7]

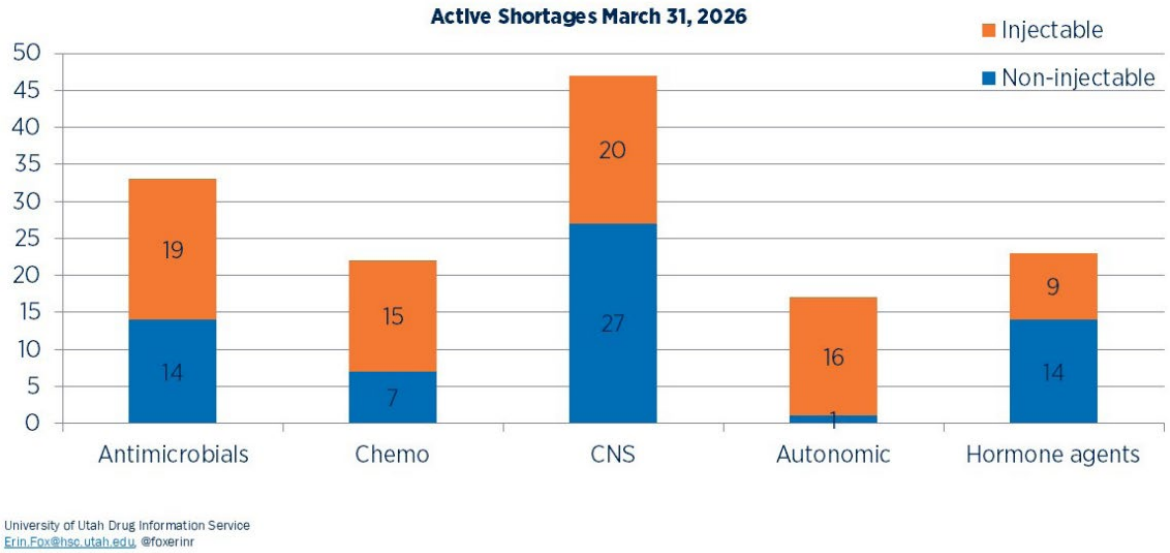


Figure 7. Top 10 Therapeutic Categories by Number of Drug Shortages[8]

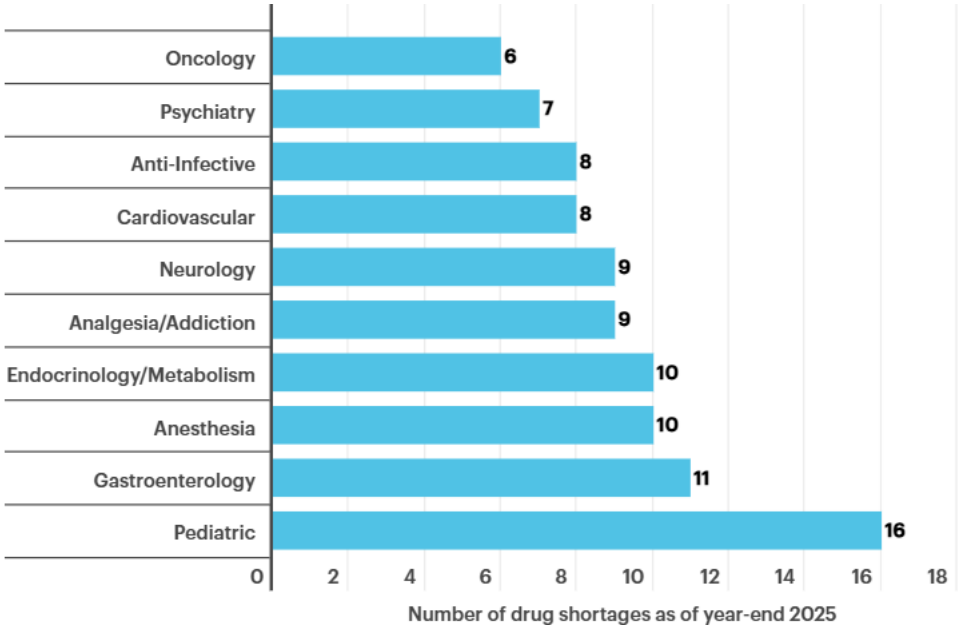


Figure 8. Reasons for Drug Shortages as Reported by Manufacturers[7]

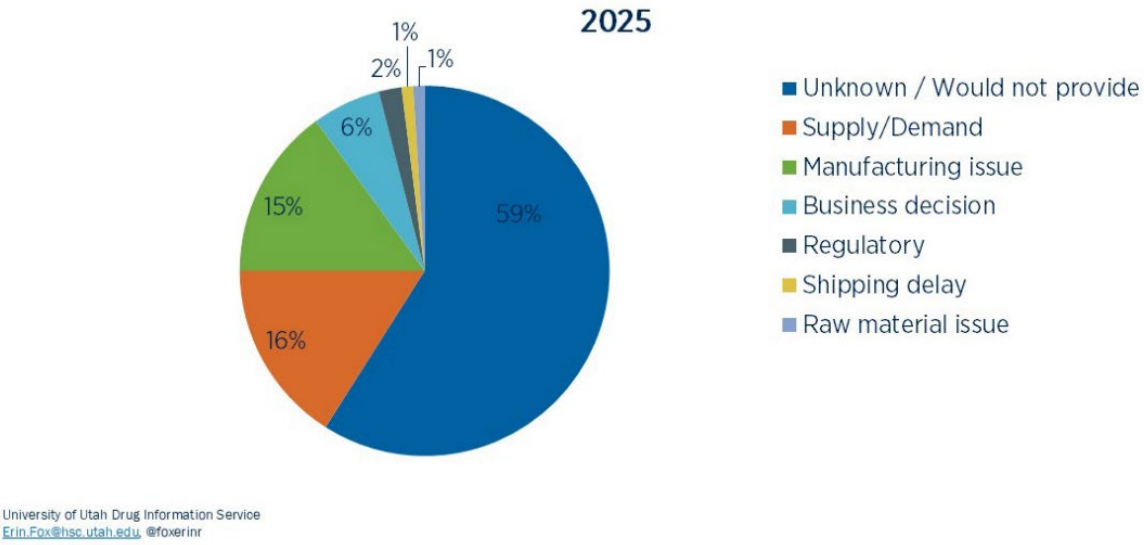


Figure 9. Common Drug Classes in Short Supply: 5 Year Trend[7]

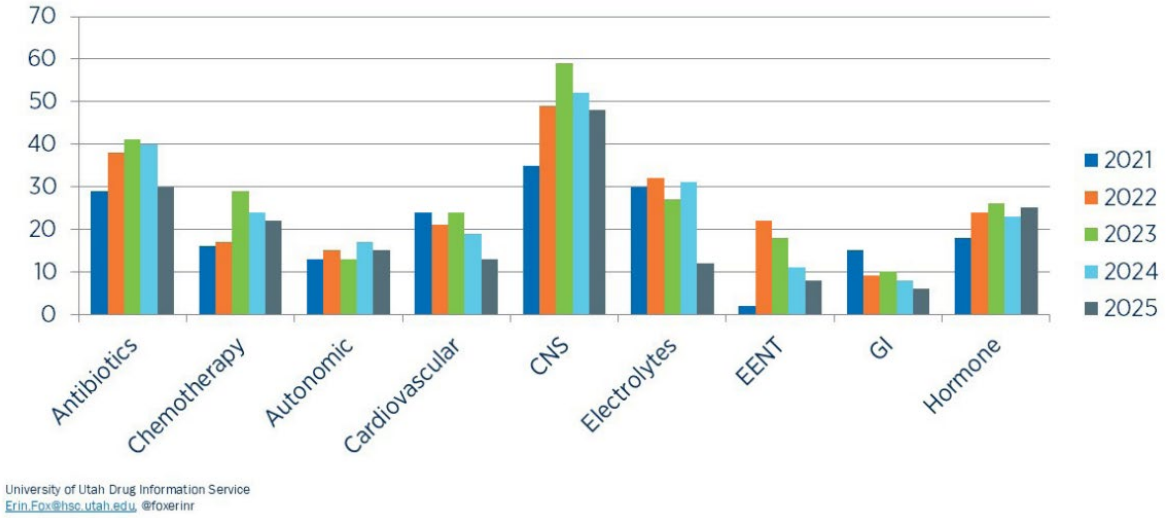


Figure 10. Number of Prevented Drug Shortages by the FDA Per Calendar Year, 2010-2024[12]

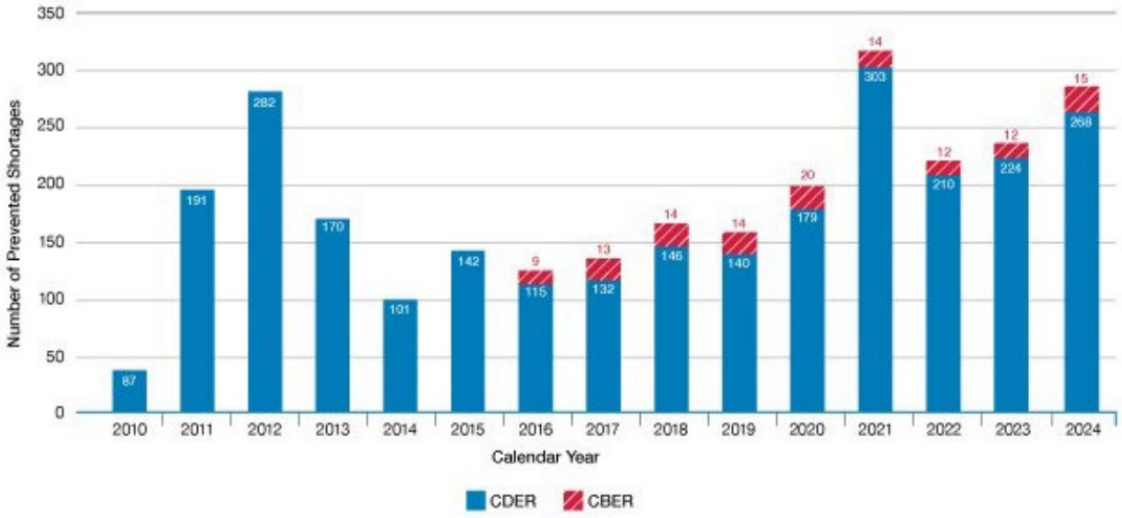
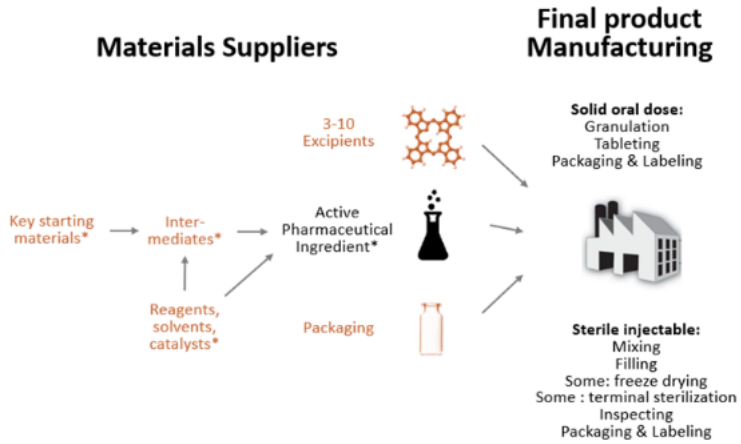


Figure 11. Typical drug supply chain for small molecule drugs[56]



Note: Items marked in orange are not used exclusively in drug supply chains. For biologics, steps marked with * would be replaced with cell culture and purification, all done in one facility.

Figure 12. U.S. Pharmaceutical Imports, 2000-2024[15]

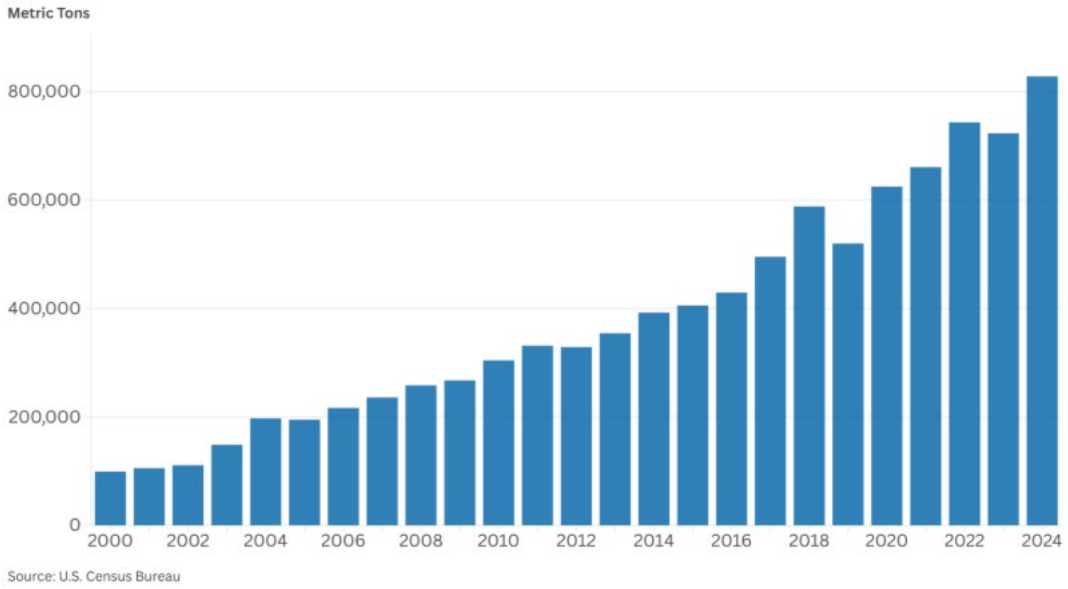


Figure 13. U.S. Pharmaceutical Trade Balance, 2000-2024[15]

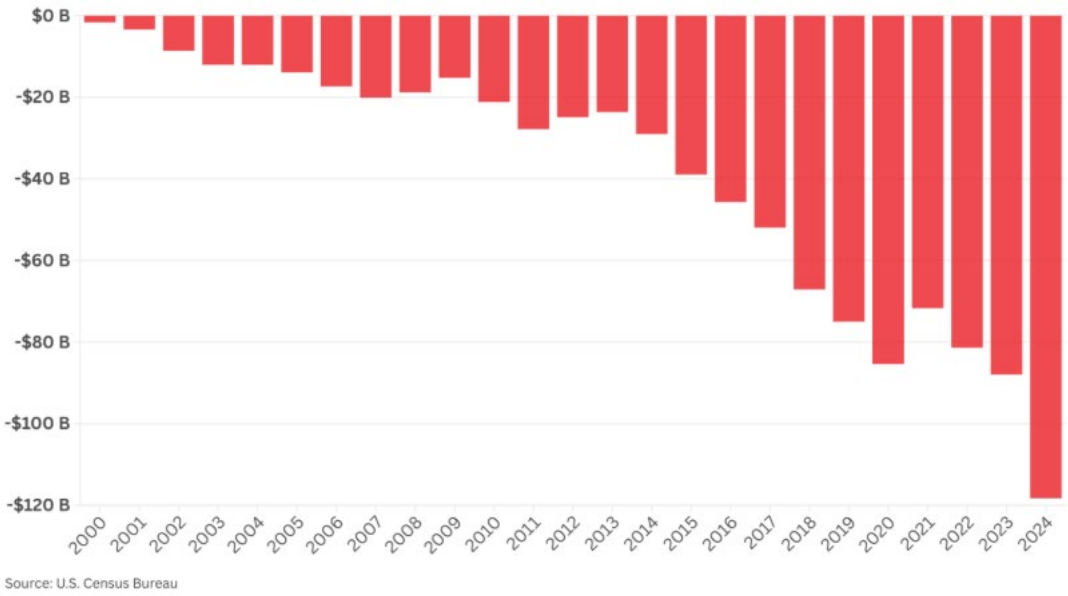


Figure 14. Estrogen-based hormone replacement therapy prescriptions per 1,000 women, by age group[34]

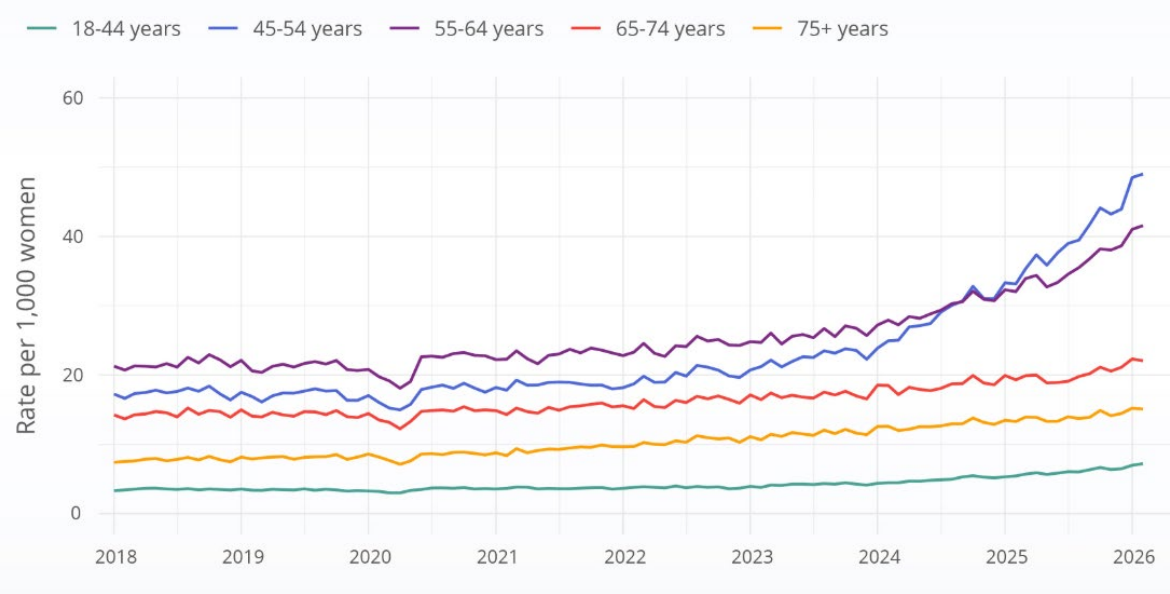


Figure 15. Estrogen-based hormone replacement therapy dispenses per 1,000 women by type[34]

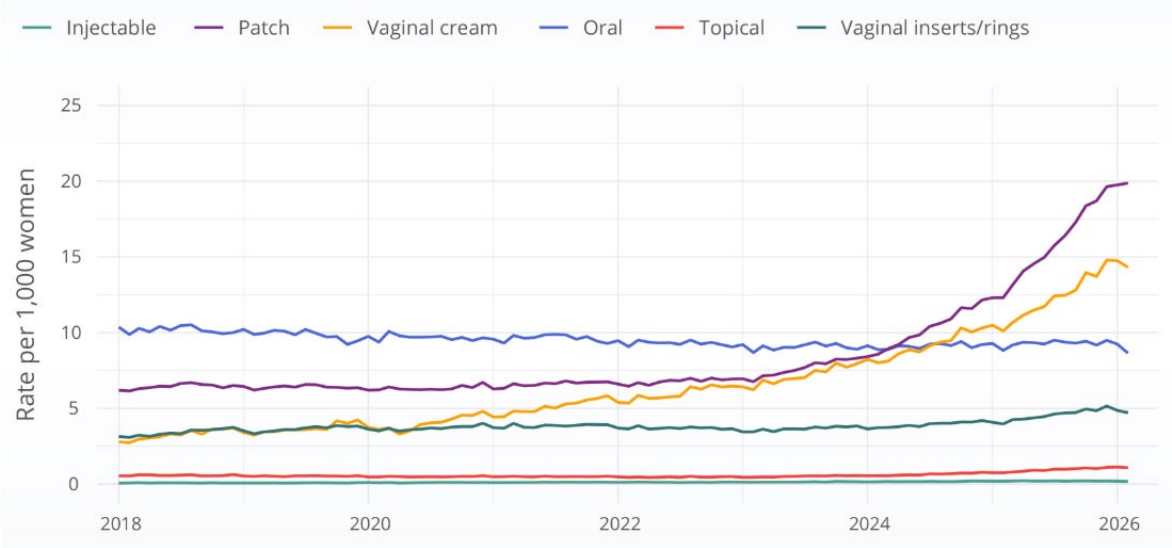


Table 1. Upstream KSM concentration among 2025 drug shortages (n=75)[a]

Upstream KSM Indicator	Count of Shortage Drugs	Share of Shortage Drugs
At least one KSM solely manufactured in one country	33	44%
All KSMs solely manufactured in one country	6	8%
China is the primary KSM supplier (>50% market share)	26	35%
India is the primary KSM supplier (>50% market share)	18	24%
China or India is the primary KSM supplier	44	59%

[a] Adapted from USP 2025 Annual Drug Shortages Report[8]

Table 2. Seven synthetic peptides considered for inclusion on the 503A Bulks List by the Pharmacy Compounding Advisory Committee, July 23-24, 2026 meeting[42]

Bulk Drug Substance[a]	Uses Evaluated
BPC-157	Ulcerative colitis
KPV	Wound healing and inflammatory conditions
TB-500	Wound healing
MOTs-C	Obesity and osteoporosis
Emideltide	Opioid withdrawal, chronic insomnia, narcolepsy
Semax	Cerebral ischemia, migraine, trigeminal neuralgia
Epitalon	Insomnia

[a] Free base and acetate forms will be considered for all bulk drug substances

Table 3. Resources available to assist in mitigation of drug shortages

1. FDA Drug Shortages Page
2. ASHP Resource Center
3. ASHP Drug Shortages List
4. AMA Drug Shortages Resource Webpage

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-26)
Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup
(Reference Committee K)

EXECUTIVE SUMMARY

BACKGROUND. Resolution 917-I-25, "Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup," was referred and called for the American Medical Association to: (1) support stronger safety protocols and regulatory oversight of food additives to protect the health and well-being of the American public and (2) advocate for federal policies requiring comprehensive scientific research and safety testing of industry-engineered food additives, including high fructose corn syrup and other similar substances, prior to their approval by federal regulators for use in the food supply. This report provides a brief history of the current regulatory framework for food additives in the U.S. and compares that to similar countries. It also includes a high-level summary of the available evidence on the health impacts and safety concerns of some groups of synthetic food additives (as there are thousands), noting where data is lacking, and outlines opportunities for improving and strengthening regulations to ensure and protect the health and well-being of Americans.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms "food additives" AND "health," "high fructose corn syrup" AND "health," and "food additives" AND "safety." Additional articles will be identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies, such as the U.S. Food and Drug Administration (FDA), European regulatory agencies, and applicable professional and advocacy organizations, will also be reviewed for relevant information.

DISCUSSION. Food additives, as defined by the FDA, are "any substance the intended use of which results or may reasonably be expected to result – directly or indirectly – in it becoming a component or otherwise affecting the characteristics of any food."[1] Food additives are supposed to be regulated under the Food Additives Amendment (FAA), but this regulation contains an exception for substances "generally recognized as safe" (GRAS), which are allowed to be determined by food manufacturers. While the GRAS provision of the FAA was originally intended to permit substances commonly used in food to remain in the food supply, it has become a mechanism whereby thousands of chemicals have entered our food supply with little to no oversight or safety testing. Additionally, FDA relies on outdated science to assess the safety of chemical additives, and there are major data gaps in the safety profiles of many additives that were previously approved by the agency. As a result of growing public health concerns, several states have passed legislation regulating food additives, and many more are considering legislation restricting or banning food additives, particularly food dyes, from food entirely or in public-school lunches specifically.

CONCLUSION. The federal regulatory framework for food additives in the U.S., specifically the GRAS exemption process, does not adequately ensure the safety of chemicals added to our food. With an estimated 10,000 food additives in our foods, compared to a few hundred in similarly developed countries, and evolving evidence showing negative health impacts from many additives previously considered safe, reform is clearly needed. Changes to the federal regulatory framework are recommended to protect the health of the public and create consistency and transparency across our food system.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-26

Subject: Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup

Presented by: Tamaan Osbourne-Roberts, MD, MBA, Chair

Referred to: Reference Committee K

Resolution 917-I-25, "Urging Comprehensive Research and Safety Testing of Industry-Engineered Food Additives (IEFAs), Including High Fructose Corn Syrup," was referred and called for the American Medical Association (AMA) to:

- Support stronger safety protocols and regulatory oversight of food additives to protect the health and well-being of the American public; and
- Advocate for federal policies requiring comprehensive scientific research and safety testing of industry-engineered food additives, including high fructose corn syrup and other similar substances, prior to their approval by federal regulators for use in the food supply.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms "food additives" AND "health," "high fructose corn syrup" AND "health," and "food additives" AND "safety." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies, such as the U.S. Food and Drug Administration (FDA), European regulatory agencies, and applicable professional and advocacy organizations, were will also be reviewed for relevant information. Additionally, a review of state legislation on this topic was conducted by performing a Westlaw search using the search term "food additives," as well as an internet search using the term "state food additives regulations 2026."

BACKGROUND

A food additive, as defined by the FDA, is "any substance the intended use of which results or may reasonably be expected to result – directly or indirectly – in it becoming a component or otherwise affecting the characteristics of any food."[1] According to the FDA, additives are added to food typically to improve food safety and freshness, maintain or improve nutritional value, or improve taste, texture, and appearance.[2] There are both natural and artificial or synthetic food additives. Natural flavors or additives are compounds derived from or extracted directly from plants or animals found in nature.[3] Examples of natural food additives include salt, vinegar, and citric acid for preservation; beet powder and turmeric for coloring; and lecithin as an emulsifier. Synthetic or artificial additives are produced through chemicals by humans and nearly 60 percent of synthetic additives used are petroleum based.[4]

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This report provides a brief history of the current regulatory framework for food additives in the U.S. and compares that to similar countries. A snapshot of state legislative activity on this topic is also provided. It also includes a high-level summary of the available evidence on the health impacts and safety concerns of some groups of synthetic food additives (as there are thousands), notes where data are lacking and outlines opportunities for improving and strengthening regulations to ensure and protect the health and well-being of Americans.

DISCUSSION

The U.S. Regulatory Framework for Food Additives – A Brief History

The regulatory framework for food safety was established over a century ago. In 1906, Congress prohibited the introduction of adulterated or misbranded food and drugs into interstate commerce with the Pure Food and Drugs Act.[5] This was in response to widely publicized examples of industry abuse and contamination of food, such as those presented in Upton Sinclair's novel 'The Jungle,' which told of the abuses of the meat packing industry.[5]

A few decades later, Congress updated the 1906 law with the passage of the Federal Food, Drug, and Cosmetic Act (FDCA) in 1938.[6] This foundational law authorized the FDA to oversee the safety, manufacturing, and labeling of foods, drugs, medical devices, and cosmetics to protect the public from adulterated or misbranded products.[6,7] The passage of this law came from mounting public concern over adulteration of consumer products, in particular a high-profile incident referred to as the "Elixir Sulfanilamide" tragedy, in which a well-known medication, safe in tablet and powder form, was dissolved in diethylene glycol and marketed without safety testing. The "Elixir Sulfanilamide" incident resulted in as many as 100 deaths.[6] With the passage of the FDCA in 1938, the concept of premarket approval became law, but at this time it only applied to drugs and not food ingredients.[7]

Following World War II, there was a growth in the use of synthetic chemicals in foods, including artificial sweeteners and preservatives, and the mass production of processed foods.[8] This led to increased food safety concerns from the public and Congress. A Congressional report from the early 1950s noted that there were about 700 known food additives in use but only about 430 were known to be safe, and there were serious concerns about the lack of information on the long-term risks of chemicals already being used in foods.[5] As a result, Congress updated the FDCA with the Food Additives Amendment (FAA) of 1958.[5,7] The FAA gave the FDA the authority and responsibility to require food manufacturers to provide safety assessments for all new food additives, with some exceptions.[9] Under the FAA, prior to market usage, a food additive manufacturer is supposed to first seek approval from the FDA by submitting a food additive petition, which needs to include evidence that the substance is safe for the ways in which it will be used. Within this regulatory framework, regulators must show evidence of harm from the proposed additive; otherwise it is considered safe.[7]

Exceptions to required safety assessments include substances that are "generally recognized as safe," known as GRAS. Based on the FAA, these include substances that were authorized prior to 1958, as well as dietary ingredients in dietary supplements and certain color additives and pesticides that went through other premarket approval requirements.[7] Originally, the GRAS provision of the FAA was intended to permit substances commonly used in food at the time to remain in the food supply (e.g., vinegar, salt, pepper) without companies having to prove safety, thus reducing the administrative burden and preserving FDA's finite resources to review such data.[10] GRAS substances, as defined by the FAA, are legally distinct from food additives and thus

are explicitly exempted from food additive regulations and do not require a premarket review process.[7,10]

The FAA also included a provision, commonly referred to as the Delaney Clause (Congressman James Delaney chaired the Congressional committee that investigated food additives at the time), that was intended to ensure that no new added ingredients or food additives were approved if they were found to cause cancer when consumed by humans or animals.[9,11]

In 1960, Congress updated the FDCA again with the passage of the Color Additive Amendments, which defined color additives and required that only color additives deemed "suitable and safe" for a given use be used in foods, drugs, cosmetics, and medical devices.[12] The Color Additive Amendments does not include exemptions for GRAS substances but includes a Delaney Clause similar to the 1958 FAA. However, food additives deemed GRAS could also impart color into foods and be used de facto as a color additive.[12]

In 1972, FDA began a voluntary GRAS affirmation process in which manufacturers had the option to voluntarily submit a GRAS affirmation petition with data for review, as opposed to FDA reviewing all GRAS determinations.[10] Around the same time, the FDA was asked to review the safety of GRAS substances in the food supply due to lingering public concerns around food additives. A scientific committee was established that reviewed 422 substances between 1972 and 1982, finding safety issues with 35 of the substances and recommending the removal of GRAS status for 30 of them .[10,13] However, the FDA did not adopt the scientific committee's recommendations on what substances should remain under the GRAS category and provided no explanation for its reasons for doing so.[10,13]

The voluntary GRAS affirmation process remained in place until 1997 when FDA proposed a rule to replace the GRAS voluntary affirmation with a voluntary notification process.[7] This proposed rule was not finalized until 2016 but is essentially how the GRAS process has operated since 1997.[10] Under the GRAS notification rule, food manufacturers have the choice of either engaging in a "self-GRAS" determination process or submitting a notification to FDA that a substance is considered GRAS based on available scientific data and evidence. Companies choose to submit a voluntary notification to FDA of a substance considered GRAS to receive official acknowledgement by the FDA which reduces regulatory uncertainty, reduces their potential liability, and helps assure retailers and consumers that the ingredient's safety has independent scientific.[14] Under the voluntary notification rule, there are three possible outcomes if a food additive manufacturer decides to submit a GRAS notification to FDA:[7]

- The FDA does not have any issues or concerns with the company's GRAS decision and the evidence it supplied at the time of notification to make that determination; the FDA issues a "no question letter," which states that it does not question the company's GRAS decision.
- The FDA issues an "insufficient basis" letter, meaning the FDA finds insufficient information to substantiate the GRAS claim and generally asks the company to submit additional data.
- A company submits a GRAS notification but then chooses to withdraw it, in which case the FDA issues a "cease to evaluate" letter. In this circumstance, the company can still go to market with the substance despite not having received the "no question letter."[10,15] Companies may choose this route if they believe they will receive an insufficient basis letter, which could reflect poorly on their product if made public and reduce marketability.

The key takeaways from this process are: (1) a company can still use a food additive in food products even if FDA found insufficient scientific basis for safety or it withdraws its voluntary

GRAS notification; and (2) a company can forego the process of notifying the FDA of food additives it is using by saying it did its own GRAS determination and not notifying the FDA, which is currently legal.[15] This system has created "a strong impetus … for the food industry to self-GRAS so it can manufacture and market food products with new substances without ever notifying the FDA of either its determination or the research underlying its determination that the substance is safe."[10]

For several decades, the GRAS provision has been under scrutiny as a loophole used by food and chemical manufactures to get approval for their food additive products by FDA with little to no safety testing.[10,15,16] Based on an analysis by the Environmental Working Group, it is estimated that, since 2000, food and chemical companies have used the GRAS loophole and FDA's voluntary submission process to approve nearly 99 percent of new food chemicals introduced to the market with little evidence on potential health risks.[17] As a report from the Pew Charitable Trusts put it, "Today, virtually all new chemical additives added directly to food go through the GRAS exemption: This loophole has effectively swallowed the law."[16]

In addition to the voluntary nature of the GRAS notification process, food additive manufacturers are responsible for completing the GRAS determination. Whom manufacturers choose to contract with or hire to make that determination has come under scrutiny.[15,18,19] Multiple reports and studies have identified potential conflicts of interest of those serving on panels that make decisions, or, in some cases, those responsible are employees of the company making the GRAS determination, creating a direct conflict of interest.[15,16,18] Despite the FDA developing best practices guidance for companies doing GRAS determinations to address conflict of interest concerns, which were developed following a 2010 Government Accountably Office report, a 2023 study that analyzed GRAS panel composition found that potential conflicts of interest and bias among panelists were still an issue.[19,20]

Lastly, the evolution of scientific evidence and available methods for toxicological testing has advanced significantly since the FAA was first introduced.[21] As such, FDA has relied on outdated science to assess the safety of chemical additives, and there are major data gaps in the toxicological and safety profiles of many additives that were previously approved by FDA.[16,21] These shortcomings highlight the need for periodic reassessment of approved food additives as the scientific evidence improves.

The current federal administration has taken recent action on food additives, in particular food dyes and has brought increased attention to the potential health harms of GRAS and food additives in its Make America Healthy Again report.[20] The Secretary of the Department of Health and Human Services (HHS), in March of 2025, urged the FDA to explore potential rulemaking that would eliminate the voluntary GRAS process.,[21] In April 2025, the FDA announced a series of new measures to phase out all petroleum-based synthetic dyes from the nation's food supply.[24] In August 2026, HHS announced a proposed rule that would update the FAA to require manufacturers and companies to submit their GRAS determinations to the FDA.[25] Action on this issue has not been limited to the executive branch: in 2023, the Ensuring Safe and Toxic-Free Foods Act was introduced in the Senate (and reintroduced in 2025).[26]

Regulatory Differences Between the U.S. and Other Similar Countries

In most other developed countries of the world, all food additives need to be reviewed for safety before being allowed for use in food; the U.S. GRAS system is essentially nonexistent elsewhere. In both Canada and the European Union (EU), all food additives must be evaluated for safety and approved by the appropriate regulatory agencies before use in the food supply.[27,28] Canada and the

EU employ the precautionary principle, which essentially states that if there is any possible threat to harm or safety, even if not fully understood, precautionary measures should be taken. The EU also has an ongoing process for reviewing the state of the evidence on additives in order to assess whether substances should be removed or daily allowable limits should be lowered.[29] Under this program, the original scientific evaluation for approved food additives is reassessed periodically and incorporates new data generated since the previous evaluation, which can result in a decision of further regulatory action.

As a result, the U.S. food supply contains a significantly greater number of food additives, although the exact number is unknown. While the FDA maintains a public database, Substances Added to Food (formerly known as Everything Added to Foods in the U.S.) of about 3,900 substances, it is estimated that there are more than 10,000 chemical additives in the U.S. food supply.[30,31] In contrast, the EU permits a little over 300 food additives.[29] All additives must be evaluated for safety by the European Food Safety Authority (EFSA) and are searchable in the EU's Additives Database.[32] Canada also maintains a food additives database with 390 permitted food additives.[33] Notably, additives like Yellow Dye No. 5, butylated hydroxyanisole, and potassium bromate are banned in Europe but allowed in the U.S.[34] Red Dye No. 3 was only recently banned in the U.S., 30 years after its European ban.[35,36]

State Legislation

In addition to movement at the federal level, several states have passed legislation regulating food additives, and many more are considering legislation restricting or banning food additives, particularly food dyes, from food entirely or public school lunches specifically.[37] California became the first state to pass such legislation in 2023, with the passage of the California Food Safety Act, which banned four toxic chemicals from food sold, manufactured, or distributed in the state.[38] In 2024, it also passed the California School Food Safety Act, which banned the food additives Red Dye No. 40, Yellow Dye No. 5, Yellow Dye No. 6, Blue Dye No. 1, Blue Dye No. 2, and Green Dye No. 3 from food served in public schools.[38] Texas also made headlines in summer 2025 when it passed legislation requiring consumer warning labeling on foods containing any of 44 chemical food ingredients.[39]

In total, 156 food additive-related or food color-related bills have been introduced nationwide in over half of states. However, only 20 bills have thus far been successfully enacted.[38] Adopted legislation has most commonly focused on prohibiting a limited number of dyes and additives in schools.[40] The measures that seem to be stalling are broad statewide prohibitions that attempt to mirror the California Food Safety Act. Some possible reasons for the volume of pending legislation are federal preemption issues and concern that too many different state laws will cause significant issues for manufacturers and confuse consumers. See Appendix A for a list of states with enacted legislation.

Health and Safety Concerns

Due to the ubiquitous nature of food additives in our current global food supply and without a consistent system for measuring exposure, it is almost impossible to understand the true level of risk for many food additives in our food supply. There is also a lack of data and research on the cumulative impacts of these substances. These issues are of particular concern for young children, who eat higher levels of processed foods, which in general contain higher levels of synthetic additives and are heavily advertised.[21]

As there are thousands of food additives, a review of the health and safety data for all of them is not feasible within the scope of this report. As such, this section provides a high-level summary of health concerns for specific categories of food additives (e.g., synthetic food colors) that have more research, have garnered more public attention, and thus have a higher chance of possible regulatory action. In some cases, additives once considered GRAS have been removed from the market.

Azo Food Dyes. Azo food dyes are synthetic, petroleum-based colorants in the food industry that are widely used due to their availability, affordability, and capacity to provide intense color.[41] Common azo dyes that have come under scrutiny include Tartrazine, Sunset Yellow, Carmoisine, Amaranth, Ponceau 4R, Allura Red AC, Brilliant Blue FCF, and Brown HT. Despite their widespread usage in the U.S., their safety remains controversial, as studies have connected them to various health risks. Azo food dyes are characterized by a double bond between nitrogen atoms.[41] When azo dyes are consumed, their characteristic azo chemical bond can be reduced by intestinal bacteria, resulting in the formation of aromatic amines. Aromatic amines are essentially chemicals consisting of a nitrogen compound attached to an aromatic hydrocarbon and are a regular byproduct in processes that involve the burning of fossil fuels.[42,43] Some of these food dyes and the amines produced during digestion have demonstrated genotoxic and carcinogenic potential in laboratory settings, raising concerns about their long-term effects in humans.[41] In addition to genotoxicity and carcinogenicity, azo dyes have been implicated in allergic reactions and hypersensitivity, especially among children.[41] Studies have found associations of certain azo dyes like Tartrazine and Sunset Yellow to hyperactivity and exacerbation of behavioral symptoms in susceptible individuals.[44] Another emerging area of concern is the potential impact of azo dyes on gut health; recent studies suggest that these dyes might disrupt the gut microbiota, leading to inflammation and dysbiosis.[45] This growing body of evidence suggests that periodic reevaluation is needed as additional research reveals more about these dyes' possible health harms.

Emulsifiers. Synthetic emulsifiers are widely used in processed foods to improve texture, extend shelf life, and stabilize mixtures of ingredients that would otherwise separate.[46] However, growing research indicates they may pose health risks, especially with regular or high consumption. Studies have shown that common synthetic emulsifiers, such as polysorbate 80 and carboxymethylcellulose, can disrupt the gut microbiota's balance.[45,47] This disruption has been linked to increased intestinal inflammation and has been associated with the development of metabolic syndrome, obesity, and inflammatory bowel diseases in animal models.[47] Some evidence suggests these additives may contribute to greater intestinal permeability (sometimes called "leaky gut"), which can allow potentially harmful substances to enter the bloodstream.[47] These effects are particularly concerning for individuals predisposed to digestive or metabolic disorders, but the potential long-term impact on the general population is not well understood.

Non-caloric Sweeteners. Noncaloric sweeteners, such as sucralose, aspartame, saccharin, and acesulfame-K, have been widely adopted as sugar substitutes in diet and "sugar-free" foods to impart a sweet taste. While considered safe by the FDA and by other countries, growing evidence suggests that higher levels of consumption may pose several health risks.[46-49] Research has linked noncaloric sweeteners to disruption of the gut microbiome, which in turn can lead to inflammation and metabolic issues.[45] For example, studies indicate that sucralose and other artificial sweeteners may promote gut bacterial changes that increase liver inflammation and risk factors for metabolic syndrome and cardiovascular diseases.[45] Additionally, consumption of noncaloric sweeteners has been associated with impaired blood sugar regulation and decreased insulin sensitivity.[45,52] Clinical studies have shown that exposure to these additives may increase fasting insulin and HbA1c levels, markers of poor metabolic health.[51] The World Health Organization in 2023 advised against using noncaloric sweeteners for weight control or reducing the risk of noncommunicable diseases.[53]

There is a need for more rigorous evaluation of the long-term health effects of artificial sweeteners, especially regarding their interactions with the gut microbiota and metabolic pathways.

Another health concern of noncaloric sweeteners is their potential association with increased cancer risk, for which the evidence is mixed and still evolving.[54] The FDA and the EFSA have generally concluded that noncaloric sweeteners are safe for consumption within established daily limits and do not show conclusive evidence of carcinogenicity in humans.[48,55] These assessments are primarily based on animal studies and human epidemiological data that have failed to demonstrate strong, consistent links between typical consumption and cancer. However, newer research has cast doubt on these previous findings. The NutriNet-Santé cohort study from France found a modest but statistically significant association between higher intake of artificial sweeteners, particularly aspartame and acesulfame-K, and increased cancer risk, notably for breast and obesity-related cancers.[49] Similarly, the International Agency for Research on Cancer (IARC) classified aspartame as "possibly carcinogenic to humans" in 2023, reflecting limited evidence in humans and animals.[50] Despite these findings, most studies emphasize that the overall evidence is not yet strong enough for definitive conclusions, especially at normal dietary intakes.

High Fructose Corn Syrup. High fructose corn syrup (HFCS) is a widely used sweetener in processed foods and beverages due to its affordability and shelf stability. HFCS can be found in sodas, sweetened cereals, condiments, sauces, and baked goods (to name a few). However, overconsumption of HFCS has been shown to contribute to several negative health outcomes, including insulin resistance, obesity, liver disorders, and diabetes.[56] HFCS contains a higher fraction of fructose compared to regular corn syrup and rapidly breaks down in the liver, encouraging fat production. This metabolic pathway can promote the accumulation of triglycerides, contributing to nonalcoholic fatty liver disease (NAFLD), obesity, and elevated blood lipids.[56] Excessive intake of HFCS is also associated with insulin resistance, which is a precursor to type 2 diabetes, as well as chronic inflammation and increased risk of cardiovascular diseases.[57,58]

Another important concern with HFCS is appetite regulation. Unlike glucose, the fructose in HFCS does not stimulate the release of insulin or the satiety hormone leptin, which means HFCS-containing foods and drinks may not trigger a sense of fullness.[59] This lack of satiety can lead to overconsumption, further fueling weight gain and its related health consequences. The health effects of HFCS are compounded when consumed in large amounts through a variety of highly processed goods, particularly in sugary beverages. A petition was submitted to the FDA in August 2025 urging it to reevaluate the GRAS status of many refined carbohydrates, including HFCS, to limit population level exposure.[60]

Trans Fat. Trans fats, also known as trans-fatty acids, are unsaturated fats both found naturally in some animal products and, more commonly, produced industrially through the partial hydrogenation of vegetable oils.[61] Industrially produced trans fats are found in many processed foods, including margarine, vegetable shortening, baked goods, and fried foods.[61] Trans fats pose serious health risks and are associated with more than 278,000 deaths globally each year.[61,62] High intake of trans fats has been associated with arterial blockage, increasing the risk of heart attacks, stroke, and coronary heart disease.[62] Trans fats are particularly dangerous because they raise "bad" low-density lipoprotein (LDL) cholesterol while lowering "good" high-density lipoprotein (HDL) cholesterol in the blood.[63] This imbalance contributes significantly to the buildup of fatty deposits in arteries, increasing the risk for cardiovascular diseases.[64] Trans fat intake is also linked to a higher risk of developing type 2 diabetes and, according to some studies, may increase the risk for other health problems such as breast cancer, shortened pregnancy, preeclampsia, and certain nervous system disorders.[63]

The health risks of trans fats have been understood for several decades. There were studies in the 1990s documenting harmful effects of trans fats, and in 2005 the Institute of Medicine issued a report on the health harms of trans fats, recommending reduced consumption.[10] Although artificial trans fats were once considered a GRAS substance, mounting safety concerns led the FDA to revoke their GRAS status in 2015, which required all U.S. food manufacturers and restaurants to eliminate trans fats from packaged foods and restaurant menus by 2020.[65]

Trans fats represent an example of an additive that was considered GRAS, but, after mounting evidence and public health concerns, it had its GRAS status revoked by the FDA, a process which took nearly 20 years after health and safety concerns became evident. While this important action was taken eventually, the long timeline for removal highlights how important it is for FDA to have a process for regularly evaluating the safety of substances that have been deemed GRAS.[10,16,21]

Opportunities for Regulatory Improvement

There are several consensus themes that have surfaced in academic articles, reports or position statements from multiple reputable organizations, including the American Academy of Pediatrics, the Pew Charitable Trusts, and the Government Accountability Office.[16,18,21] First, to better understand potential public health risks from food additives, the FDA must know what food additives are being used. The FDA needs to develop a strategy to require any company that conducts a GRAS determination to provide the FDA with certain basic information, such as the substance's identity and intended uses. To that end, the FDA must develop a strategy and timely process to prioritize assessment of the safety of existing GRAS substances in a more systematic manner.[18] This would include taking steps such as prioritizing food additives of greatest concern for reassessment, allocating sufficient resources to respond to citizen petitions in a timely manner, developing criteria for the circumstances under which the agency will reconsider the safety of a GRAS substance, and considering specific information collection criteria and processes from companies.[16]

Additionally, the FDA should strengthen the scientific rigor of its food safety assessment and review processes, including but not limited to the following recommendations:

- Expand the scope of recommended testing to cover new health effects, including cancer, endocrine-related, and neurobehavioral effects[21];
- Ensure adequate safety factors for those who are pregnant and breastfeeding as well as additional vulnerable populations, such as children[21];
- Consider cumulative and mixture effects from dietary sources, including other additives and contaminants[21];
- Address potential conflicts of interest and bias that arise within industry picked GRAS panels[15,16,18,21];
- Ensure transparency and public access to information on GRAS determinations[16,18,21]; and
- Develop strategies to periodically review products over time based on emerging testing techniques and the latest scientific evidence.[21]

However, even since the passage of the FAA, there has been concern that FDA staff would be overwhelmed by the volume of GRAS approval requests and not have the capacity to review all of the applications for proposed food additives; this is increasingly true today.[7] Since 2025, the FDA has lost nearly 3,500 employees, representing nearly 19 percent of its workforce with current budget proposals indicating future cuts to the agency's budget.[66] Currently, the FDA does not charge a fee to companies to review general food additives or safety submissions and their budget comes primarily from general appropriations to the agency.[67] A user fee program, similar to FDA's medical and device program, has been suggested as an approach to increase financial resources for

the program responsible within FDA.[67] There are a few challenges with this suggestion. First, it would require approval by Congress to create a new user fee. Additionally, if implemented, industry user fees have the potential to create serious conflicts of interest between companies paying the fees and the department responsible for regulating them.[68]

EXISTING AMA POLICY

AMA has existing policy on both food additives generally and some specific additives like trans fats and HFCS. Existing policy calls for increased regulation and scientific research on food additives broadly and HFCS specifically.[69,70] AMA policy H-150.998, "Food Additives," which was first adopted in 1977 and has been reaffirmed and/or modified several times, supports legislation that would amend the FAA to require "scientifically reproducible studies ... at dosage levels related to the amounts calculated as normal daily consumption for humans" as evidence of increased cancer risk before an additive is removed from the market.[71] Adopted Resolution 401-A-26 was appended to this policy and asked for AMA to advocate for the establishment of a joint task force comprising AMA representatives, FDA officials, U.S. Department of Agriculture (USDA) personnel, and relevant administration appointees to conduct a systematic review of food additives currently approved in the U.S. but banned or restricted in other nations and evaluate the health impacts.[69] Additionally, AMA also has policy on ultraprocessed foods, encouraging the reduced consumption of food and beverages with added sweeteners and support for nutrition labels that include information on added sugars.[72–74]

CONCLUSIONS

The federal regulatory framework for food additives in the U.S., particularly the GRAS exemption process, does not adequately ensure the safety of chemicals added to our food. With an estimated 10,000 food additives in our foods, compared to a few hundred in similarly developed countries, and evolving evidence showing negative health impacts from many additives previously considered safe, reform is clearly needed. While some states have passed legislation on this topic, your council recommends a national regulatory framework that ensures the safety of food additives and creates consistency and transparency across our food system. Considering the high level of public health and political attention on this issue, now is an ideal moment and opportunity for action to improve the current process for reviewing and approving food additives in the U.S.

RECOMMENDATIONS

Your Council on Science and Public Health recommends that the following recommendation be adopted, and the remainder of this report be filed.

1. That Policy H-150.998, "Food Additives" be amended by addition and deletion to read as follows:

Modernizing Food Additive~~s~~ Regulations

~~1. Our American Medical Association supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.~~

~~2.~~1. Our American Medical Association advocates for the establishment of an independent, ~~joint task force~~ ongoing scientific committee ~~comprising AMA representatives, FDA~~

~~officials, USDA personnel, independent academic scientists, and relevant administration appointees~~ whose responsibility will be to:

a. Conduct ~~a~~ regularly scheduled systematic reviews of food additives, including food colors, currently in use ~~approved~~ in the U.S. ~~but banned or restricted in other nations~~, prioritizing review of those that have been banned in U.S. states or in other countries and those with the most significant negative health impact;
b. Evaluate the scientific evidence regarding health impacts of these substances, considering emerging evidence and potential cumulative impacts on new classes of diseases, including but not limited to certain cancers, endocrine-related effects, and neurobehavioral effects; the cumulative impact of such additives with other ingredients; and potential enhanced effects on certain vulnerable populations, such as those who are pregnant or breastfeeding and children;
c. Develop a prioritized timeline for regulatory action on the most concerning additives;
d. Create transition pathways for food manufacturers to adopt safer alternatives; and
e. Engage the AMA and other interested members of the medical and scientific community throughout this process.

2. Our AMA supports:
   a. Comprehensive scientific research and safety testing for all food additives, demonstrating that they cause no statistically or clinically significant harm to human health at doses comparable to daily consumption patterns, prior to their review and approved by federal regulators.
   b. Updating the Food Additives Amendment to ensure the safety of food additives through more stringent regulatory oversight, including but not limited to requiring all new "generally recognized as safe" (GRAS) determinations to be submitted to the FDA for active review;
   c. The FDA having adequate resources and staff capacity to review GRAS determinations and do retroactive reviews of food additives that were previously deemed GRAS as new scientific evidence emerges; and
   d. Stronger criteria for making GRAS determinations, including improved transparency of evaluation methods, and forbidding conflicts of interest for those who serve on GRAS determination panels.

3. Our AMA will continue to monitor and support efforts to advance the implementation of more rigorous food additive legislation and regulations ~~policies~~ and provide ongoing ~~medical and scientific~~ guidance to help ensure reforms achieve meaningful public health improvements. This includes, but is not limited to, supporting adequate funding for medical and scientific research. (Modify Current Policy)

Fiscal note: Minimal

APPENDIX

Adopted State Legislation on Food Additives and Food Dyes

State	Details
Arizona	House Bill 2164 prohibits schools from providing "ultra processed food," which is defined as food containing: potassium bromate, propylparaben, titanium dioxide, brominated vegetable oil, Yellow 5, Yellow 6, Blue 1, Blue 2, Green 3, Red 3, and Red 40. Exceptions to this ban are parents/guardians providing their own student(s) with ultraprocessed food.[75] Effective date: Beginning of 2026-2027 school year
Arkansas	In 2025, the state adopted Act 622, the Make Arkansas Healthy Again Act, which bans the use of potassium bromate and propylparaben in food products made for human consumption in the state.[76] Effective date: January 1, 2028
California	In 2023, California passed AB-418: The California Food Safety Act, which will prohibit any food product manufactured, sold, delivered, distributed, held, or offered for sale in California from containing brominated vegetable oil, potassium bromate, propylparaben, or Red 3.[77] Effective Date: January 1, 2027 Additionally, in 2024, California passed AB-2316, which will remove foods from schools that contain the following dyes: Blue 1, Blue 2, Green 3, Red 40, Yellow 5, and Yellow 6. Under this law, food products containing the dyes may be sold as a part of a school event if the sale occurs off of school property or after the school day ends.[78] Effective Date: December 31, 2027
Delaware	Senate Bill 69, adopted in May 2025, prohibits a school district or charter school from selling or serving breakfast, lunch, or competitive food on campus during the school day (includes school nutrition programs, vending machines on campus, or served a la carte) that contains Red 40.[79] Effective Date: July 1, 2026
Louisiana	SB-14 prohibits public and nonpublic schools that receive state funding from serving food or beverages containing: Blue 1, Blue 2, Green 3, Red 3, Red 40, Yellow 5, Yellow 6, azodicarbonamide, butylated hydroxyanisole (BHA), butylated hydroxytoluene (BHT), potassium bromate, and propylparaben.[80] Effective Date: Beginning of 2028-2029 school year
Nebraska	LB-940 prohibits the following additives from being served in school meals: Blue 1, Blue 2, Green 3, Red 40, Yellow 5, and Yellow 6.[81] "The law specifically defines 'school meals' as a meal served 'pursuant to the federal Richard B. Russell National School Lunch Act . . . or the federal Child Nutrition Act of 1966,' and does not extend to 'any other food offered or made available to students.' Thus, this law does not apply to food in vending machines

	or meals served to students not participating in the two listed federal programs."[40] Effective Date: August 1, 2027
New Hampshire	NH SB577 prohibits public elementary or secondary schools from offering or making available to any student any food served as a part of a school meal or any competitive food that contains any of the following color additives: Blue 1, Blue 2, Green 3, Red 3, Red 40, Yellow 5, Yellow 6, Red 2, and Orange B.[82] Effective Date: January 1, 2028
Oregon	Oregon regulation ORS 616.350 gives the State Department of Agriculture authority to control, limit, or prohibit the use or presence of food additives to protect public and animal health. Overall, the law itself does not prohibit any specific food additives but rather empowers the state to issue rules that it deems will help keep food safe.[83]
Tennessee	SB-0476 dictates that schools are prohibited from selling, offering for sale, or providing to students on school property through the school nutrition program any food or beverage items which contain Red 40.[84] Effective Date: 2026-2027 school year SB-2423 expanded SB-0476 in that schools are prohibited from selling or providing to students through a school nutrition program the following additives: Red 40, Red 3, Yellow 5, Yellow 6, Blue 1, Blue 2, and Green 3. However, the ban does not extend to food or drinks that contain the dyes if the school contracted for that item prior to 08/01/2027.[85] Effective Date: August 1, 2027
Texas	89(R) SB-314 prohibits certain food additives from being included in free or reduced-price meals provided by school districts: brominated vegetable oil, potassium bromate, propylparaben, azodicarbonamide, butylated hydroxyanisole, Red 3, Red 40, Yellow 5, Yellow 6, Blue 1, Blue 2, Green 3, Citrus Red 3, Orange B, INS 150c/ammonia caramel (Class III), INS 150d/sulfite ammonia caramel (Class IV), titanium dioxide OR any additive that is substantially similar to an additive specified in Subdivisions 1-17. School districts or open-enrollment charter schools that receive a waiver under Section 7.056 are exempt.[86] Effective Date: 2026-2027 school year
Utah	HB-402, Food Additives in Schools, prohibits schools from selling, donating, offering, or serving food that contains: potassium bromate, propylparaben, Blue 1, Blue 2, Green 3, Red 3, Red 40, Yellow 5, or Yellow 6.[87] Exceptions include food provided by parents to their own students, food provided by teachers with parental permission, and items sold in vending machines or as concessions during school-sponsored events or activities; also, not applicable to a charter school or school district with 5,500 or fewer students. Effective Date: Beginning of 2026-2027 school year
Virginia	SB-1289 Public Elementary and Secondary Schools; Nutritional Standards for School Meals and Other Foods prohibits public elementary and secondary

	schools from offering or making available to any student any food served as a part of a school meal or any competitive food that contains any of the seven color additives listed in the bill: Blue 1, Blue 2, Green 3, Red 3, Red 40, Yellow 5, or Yellow 6.[88] Effective Date: July 1, 2027
West Virginia	HB-2354 Amended & reenacted § 16-7-2 and § 16-7-4 of the Code of West Virginia, 1931; and added new § 18-5D-3A. West Virginia adopted HB-2354, which bans butylated hydroxyanisole, propylparaben, Blue 1, Blue 2, Green 3, Red 3, Red 40, Yellow 5, and Yellow No. 6 in all food products sold in the state.[89] Effective Date: January 1, 2028 Additionally, Section §18-5D-3A prohibits the following additives from being permitted as an ingredient in any meal served in a school nutrition program as they are deemed to be unsafe: Red 3, Red 40, Yellow 5, Yellow 6, Blue 1, Blue 2, or Green 3.[89] Effective Date: August 1, 2025

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-I-26

Subject: Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing

Presented by: Tamaan Osbourne-Roberts MD, MBA, Chair

Referred to: Reference Committee K

At the 2025 Interim Meeting, the American Medical Association (AMA) House of Delegates referred Resolution 930, "Establishing Fire Risk Standards for Civilian and Non-Industrial Clothing." This resolution asked the following:

> That our American Medical Association study the flammability of and fire-resistant treatments for consumer clothing materials, and their potential public health benefits.
>
> That our AMA study the value of updated flammability risk standards that incorporate modern textile compositions and their associated fire risks.
>
> 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.

This resolution was introduced in response to recent incidents involving individuals being intentionally set on fire. Testimony on the resolution was mixed, with concerns about the safety of classes of chemicals used as flame retardant (FR) and calls for improved labeling and evaluation of potential dermatologic impacts. This report evaluates current flammability standards and labeling practices for consumer textiles with a particular focus on the safety and efficacy of FRs.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: "fire risk standards" AND "flammability risk standards." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

BACKGROUND

According to the International Association of Fire and Rescue Services (CTIF), in 2024, 40 countries reported 2.8 million fire cases, causing around 16,800 deaths and 46,000 injuries.[1] One study found that, in 2019, 23 percent of CTIF's fire cases were residential fires contributing to 84 percent of the reported fire deaths.[2] Residential fires are the most frequent type of fire in the United States (U.S.)s.[1,3,4] According to the U.S. Fire Administration, as of August there have been 1257 home fire fatalities in 2026.[3] In 2024, local fire departments responded to an estimated 1.38 million fires in the U.S. causing an estimated 3,920 deaths, 11,780 fire injuries, and costing roughly $19 billion.[5] The primary mechanisms of injury and death in fires are heat burns and inhalation of smoke and toxic gases (e.g., carbon monoxide, hydrogen cyanide, and phosgene) produced by

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incomplete combustion and burning of plastics and vinyl-based household materials.[6–8] The flammability of textiles is a major cause of burn injuries worldwide, and, among residential fire deaths in the U.S., upholstered furniture, bedding, and clothing are the leading items ignited first.[9,10] Most efforts to mitigate harm associated with fires focus on: (1) fire prevention, (2) early detection and control, and (3) delay or containment of fire spread. Reducing the flammability of textiles through the use of flame retardants (FRs) may be one important way to both prevent and delay fire. However, the development of safe FRs and FR standards for textiles and household items is both crucial and as the report will discuss, extremely challenging.[2]

DISCUSSION

FRs are a class of chemicals added to materials (e.g., furniture, electronics, textiles) to reduce flammability by disrupting the combustion process, either by postponing ignition, reducing the rate of heat release, or inhibiting the generation of flammable gases.[11] FRs reduce fire losses, fire injuries, and fire deaths by reducing the probability of serious fires, delaying rapid fire development, and reducing fire size, which increases the likelihood of escape and survival.[12] However, when burned, FRs can also produce toxic smoke.[7,8] FR treatment is often required for textiles, including clothing (e.g., fire fighter, military, and technical uniforms; sleepwear for children; and sport clothing) as well as transportation, interiors, and building textiles (e.g., carpets, upholstery, mattresses, curtains).[13-21]

Common FR application techniques include dip-coating, spray-coating, plasma treatment, sol-gel processes, and layer-by-layer assembly.[11,20,22-25] More than 175 different types of FRs exist, and they are classified as either reactive (i.e., covalently bound chemicals) or additive (i.e., chemicals mixed in with material).[11,26,27] The main classes of FRs are inorganic mineral based (i.e., aluminum and magnesium), organohalogen compounds (i.e., organochlorines, chlorinated paraffins, and organobromines), organophosphorus compounds (organophosphates), and halogenated compounds (i.e., bromine and chlorine) (See Appendix I).[11,23,28,29] Different FR additives vary in fire performance, including durability, the extent to which they are released to the environment, their subsequent bioavailability, and their toxicity.[12] Importantly, there is some overlap between organohalogen, organophosphorus, and halogenated compounds (See Appendix II).[30] These differences are driven largely by elemental composition, organic structure, and combustion conditions under which the fuel is decomposed.[12] Recent concerns over environmental and health impacts have driven development of eco-friendly FR options, but few if any of these eco-friendly options are currently scalable.[20,31,32]

History and Evolution of FR Use on Fabrics

In the 1950s and 1960s, advances in chemistry facilitated the implementation of successful and durable FR treatments for fibers and textiles. This, coupled with concern over flammability of textiles and apparel, prompted passage of the Flammable Fabrics Act (FFA) in 1953, and, since 1972, CPSC has set flammability standards.

The goal of the FFA is to keep dangerously flammable apparel and fabrics out of interstate commerce. To achieve this the statute outlines three flammability classes for fabrics (1) class 1 is normal flammability, acceptable for clothing; (2) class 2 is intermediate flammability, may be used for clothing; and (3) class 3 is rapid and intense burning, not acceptable for clothing. Flammability class is determined by the textile surface (plan vs raised) and the burn time of the fabric. The standards also include specific criteria (e.g., average char length and full specimen burn) for children's sleepwear, infant garments, and tight-fitting sleepwear as well as labels indicating size expressed in terms of months of age. Finally, the standard does not apply to hats, gloves, footwear,

and interlining fabrics and there are testing exemptions for plain fabrics weighing 2.6 ounces per square yard or more and all fabrics made entirely from or entirely from combination of the following fibers: acrylic, modacrylic, nylon, olefin, polyester, and wool. The testing exemptions were made based on evidence from years of testing in accordance with 16 CFR part 1610 that consistently demonstrated acceptable results in accordance with the standard.

Since the 1970s, FRs have been frequently added to synthetic materials to meet strict flammability standards.[33–35] Notably, the type of FR used has shifted over time. Brominated FRs (BFRs), which may include halogenated, organohalogen, and organophosphorus compounds that contain bromine, have historically been the most popular in the textile sector because they are inexpensive and bromine's high atomic weight and strong carbon-bromine bond reduces the total amount of FR required to reach the necessary levels of flame retardancy.[8] Yet, by the 1980s and 1990s, concerns over the potential health and environmental impacts of BFRs began to surface.[27,36] During the last 10 to 20 years, the use of many BFRs declined due to increased evidence of health and environmental impacts and consequent regulatory bans and voluntary action (See Appendix III).[8,30,36–38] In response, the use of organophosphate FRs (OPFRs) increased.[8,26,30,37] OPFRs have been shown to be effective FRs, and early evidence suggested they might be safer for the environment.[20,39] Yet, recently the potential environmental toxicity of selected OPFRs has also come under scrutiny, and in light of the lessons learned from BFRs, it is likely that they will also decline in the future.[8,30]

Evidence of Effectiveness of FRs

The evidence of effectiveness for the implementation of flammability standards for upholstered furniture, mattresses, bedding, and clothing is limited, inconsistent, and often based on correlation. Between 1980 and 2023, there was a 54 percent reduction in reported fires and total deaths from fires started by furniture, mattresses, bedding, and clothing decreased.[5] However, the rate of death per 1000 reported fires beginning with these items was nearly twice as high between 2019-2023 compared to 1980-1984.[10] Also, between 2014 and 2023 there was a 6 percent decrease in residential building fires, an 8 percent decrease in injuries from residential fires, but a 5 percent increase in deaths from residential fires.[4] Finally, data from the National Fire Incident Reporting System and the National Fire Protection Association's annual Fire Experience Survey show that between 2013 and 2017 upholstered furniture, mattresses, and bedding was involved in an average of 5 percent of home fires per year, but they resulted in an average of 36 percent of fire deaths per year.[40] This illustrates that fire starting with upholstered furniture, mattresses, and bedding – household items that fall under the FFA flammability standards and are often treated with FRs -- are relatively low-frequency, high-consequence fires.

Some researches posit that the lack of correlation between the existence of furniture and textile flammability regulations and fire death rates suggests that the reduction in fire deaths are largely due to other factors including other forms of fire prevention, delay and containment (e.g., building materials, building codes, sprinkler systems, fire extinguishers), early detection (e.g., smoke detectors and alarms), changes in smoking behaviors and locations, and decreases in open-source heating.[41] Notably, evidence from studies in the UK suggests that flame retardants increase smoke toxicity and other studies posit that the increased smoke toxicity from the burning of FRs explain why 50 percent of UK fire related casualties are due to smoke and toxic gas inhalation.[41–43] The total number of fires, fire deaths, and fire injuries have decreased since the implementation of flammability standards.[40] At face value this correlation suggests that flammability regulations and standards work. However, there have been simultaneous fire prevention, delay, containment, and detection efforts and current studies do a poor job of disentangling which fire prevention strategies are driving the changes in fire frequency, injury, and death. Moreover, a growing body of evidence

suggests the same FRs that can prevent or delay the spread of fires, may also make the smoke from that fire more toxic. This illustrates the need for more research on the effectiveness of FRs and other fire prevention and control strategies.

Evidence of Exposure

There is strong evidence that many BFRs (e.g., polychlorinated biphenyls, decabromodiphenyl (DecaBDE), and pentabromodiphenyl ethers (PentaBDE)) are persistent, bioaccumulative, and toxic in the environment and to animals and humans.[8,11,20,23,30,36–38,44–49] The evidence of bioaccumulation has also been observed worldwide.[46-50] Furthermore, evidence shows that some BFRs degrade into ecotoxicological congeners through exposure to UV light and microbiological agents.[8,51,55–59]

Starting in the early 2000s, many BFRs were banned or phased out in favor of OPFRs, which were expected to be less environmentally persistent and have a lower potential for widespread environmental distribution and exposure than BFRs.[11,30,60] However, evidence illustrates that OPFRs are easily discharged into the environment through volatilization, dissolution, and attrition, and multiple studies have detected OPFRs in water, air, dust, soil, sediment, and biota.[45,57-69] Multiple measurements show that the concentrations of many OPFRs have reached values that are orders of magnitude higher in air and water than BFRs at their peak.[14,30,70-77] Finally, OPFRs are more soluble than many BFRs and can persist in water, which gives them the ability to undergo long-range transport via waterborne routes.[30,76,80] Consequently, evidence suggests many OPFRs acts as persistent mobile organic compounds (PMOCs), which is concerning.[30,82,83] Evidence also shows that metabolites indicative of OPFR exposure are ubiquitous in human and animal samples.[84–93] Multiple studies found widespread presence of OPFR metabolites in urine, with the highest levels found in children as well as high levels in women compared to men.[82-84,86,90-93] Finally, an important consideration when evaluating evidence of OPFR exposure is the fact that the same chemical compounds used as OPFRs are both commonly used as plasticizers in consumer products and construction materials and also oxidation products of phosphites,[30,87,98–102] thereby suggesting their environmental ubiquity may not be solely attributable to their use as FRs.

What Are the Health Impacts of FRs?

Given that many BFRs have already been banned or phased out because of their health and environmental impacts, this section will focus on OPFRs. There is clear evidence of OPFRs and OPFR metabolites in humans and in the environment. There is also a small but growing body of evidence that adverse health effects from exposure to OPFRs may include endocrine, reproductive, developmental, neurotoxic, genotoxic, immunotoxic, and carcinogenic impacts.[49,102–104] However, the epidemiologic evidence of adverse health impacts in humans associated with these exposures is limited and/or attenuated.[102]

Endocrine, Reproductive, and Developmental Impacts. There is some evidence that OPFR metabolites act as endocrine disruptors.[49,105–109] Animal models illustrate that OPFR exposure is associated with adverse endocrine, reproductive, and developmental impacts, but human studies are limited.[99,110–115] A few small studies found that the presence of OPFR metabolites was associated with changes in sex hormones and decreases in semen quality in men, as well as increased total thyroxine, especially in women.[99,116,117] Also, a handful of small studies found negative health impacts associated with OPFR metabolite levels during pregnancy, including early pregnancy loss, sex-specific changes in birthweight and gestational length, as well as adverse health impacts in children, including reduced language, cognition, and working memory.[89,102,118–123] Finally, one study found that OPFR exposure early in life was associated with changes in adolescent bone

growth and strength.[124] Notably, these studies evaluated different OPFR metabolites, making generalization even more difficult. Early evidence suggests that exposure to OPFRs may be associated with adverse endocrine, reproductive, and developmental impacts. However, more robust epidemiological evidence is still needed.

Toxicity and Cancer. As a class, OPFRs have potential toxicity based on the Quick Chemical Assessment Tool (QCAT) and the U.S. Environmental Protection Agency (EPA). EPA categorized some of the OPFRs as high-priority compounds that critically need more toxicological studies.[30,125] However, the research on OPFR toxicity is limited. Animal and in vitro studies suggest exposure to OPFRs was associated with genotoxicity, developmental toxicity, neurotoxicity, immunotoxicity, and carcinogenesis.[36,51,109,114,126–135] In some cases, toxicity associated with exposure to OPFRs was comparable to the toxicity associated with BFRs.[30,133] However, human studies are extremely limited. One study suggests that higher concentrations of urinary OPFR metabolites are associated with increased DNA methylation aberrancies in sperm.[136] Also, one review found evidence suggestive of developmental neurotoxicity, including impaired cognitive function, hyperactivity, and externalizing behaviors, associated with exposure to OPFRs.[137] More research is needed to confirm the effects.

Skin Sensitization and Allergies. Given that FRs are frequently applied to textiles, there is some concern that exposure could have dermatological impacts. Some evidence suggests that OPFRs are dermally bioavailable from fabrics and that dermal exposure and absorption may occur.[138–141] However, there is limited evidence that exposure to OPFRs in textiles results in skin sensitization or other dermal impacts – one study has found evidence that house dust with OPFR metabolites is associated with children's allergic symptoms and eczema.[142] Ultimately, more research is needed to better understand dermal absorption of OPFRs and any corresponding dermal impacts.[143]

Legislation and Regulation in the U.S.

The Flammable Fabrics Act was passed in 1953, and, since 1972, the CPSC has set specific flammability standards.[34] These standards were updated with amendments in 2008 and 2023.[144,145] In 2017, the CPSC accepted a petition to ban a variety of products containing any member of the class of organohalogen FRs.[146] In response, the National Academies of Sciences, Engineering, and Medicine (NASEM) released a report outlining a potential plan for a hazard assessment in 2019; the CPSC issued manufacturer guidance and a consumer warning about organohalogens and began evaluating potential hazards associated with organohalogens as a class.[102,147] Additionally, the Toxic Substances Control Act (TSCA), which was passed in 1976 and amended in 2016, gives the EPA the authority to evaluate and regulate chemicals in commercial products and requires manufacturers to give safety information on chemicals used in coatings, textiles, and personal care items before they are introduced to the market. In 2004 and 2009, the EPA negotiated phaseouts of new production of polybrominated diphenyl ether (PBDE) and DecaBDE, respectively.[30,148] Finally, in 2024, the EPA determined that Tris(2-chloroethyl) phosphate (TCEP) posed an unreasonable risk of injury to human health and the environment, and, in 2026, EPA announced that it was advancing review of tetrabromobisphenol A (TBBPA).[149,150] States have also been active in enacting legislation banning or restricting products containing certain FRs sold within their borders. (See Appendix IV.) Some states, like California, have more stringent restraints on FR use, and at least 16 have introduced or adopted policy to eliminate toxic FRs from residential furniture, children's products, and mattresses.

International Regulation

There has also been significant international legislative and regulatory action around FRs. Initial concerns about the environmental and health impacts surfaced in Germany in 1986. Yet, it took nearly 20 years before the European Union (EU) banned the use of PentaBDE and octabromodiphenyl ethers (OctaBDE) in 2004.[8,16,30,151] In 2009, they were listed as persistent organic pollutants by the Stockholm Convention.[8,26,30,47] More FRs are being banned and phased out as research increases. In 2017, DecaBDE was added to the Stockholm Convention, followed by DecaBDE bans and phaseouts in many countries. (See Appendix IV).

CURRENT AMA POLICY

Our AMA currently has policy on fire prevention in public buildings, but there is no existing policy on FR textiles. (See Appendix V)

CONCLUSION

There is evidence that the use of FRs in clothing, upholstery, and other commercial textiles reduces flammability, but the evidence that FR use on textiles reduces injuries and death associated with fires is limited. More research is needed to better understand the safety and efficacy of FRs, particularly in comparison to other fire prevention and control interventions. First-generation BFRs have serious negative impacts on the environment and human health, and it took nearly 30 years to develop the evidence base to support their eventual bans and phaseouts. OPFRs have replaced BFRs, but their metabolites are ubiquitous in the environment and in humans. Evidence from animal and in vitro models suggests adverse health impacts, but there are too few human studies and those that do exist rely on small sample sizes, show weak effects, and are not generalizable. Despite the limited evidence on adverse health impacts in human studies, the lessons learned from BFRs suggest continued research, education, and proactive regulatory policies are merited. FR bans and phaseouts at the state, federal, and international level have helped reduce toxic FR exposure. However, these regulatory actions only prevent new FRs from entering the environment – many older products containing these FRs remain in use. Furthermore, the process of evaluating individual compounds is both time-consuming and insufficient, as it often leaves out other compounds in the same class. Future research on FRs should utilize a class-based approach to evaluation of health and environmental impacts and pursue eco-friendly alternatives.

RECOMMENDATIONS

Your Council on Science and Public Health recommends that the following be adopted and the remainder of this report be filed.

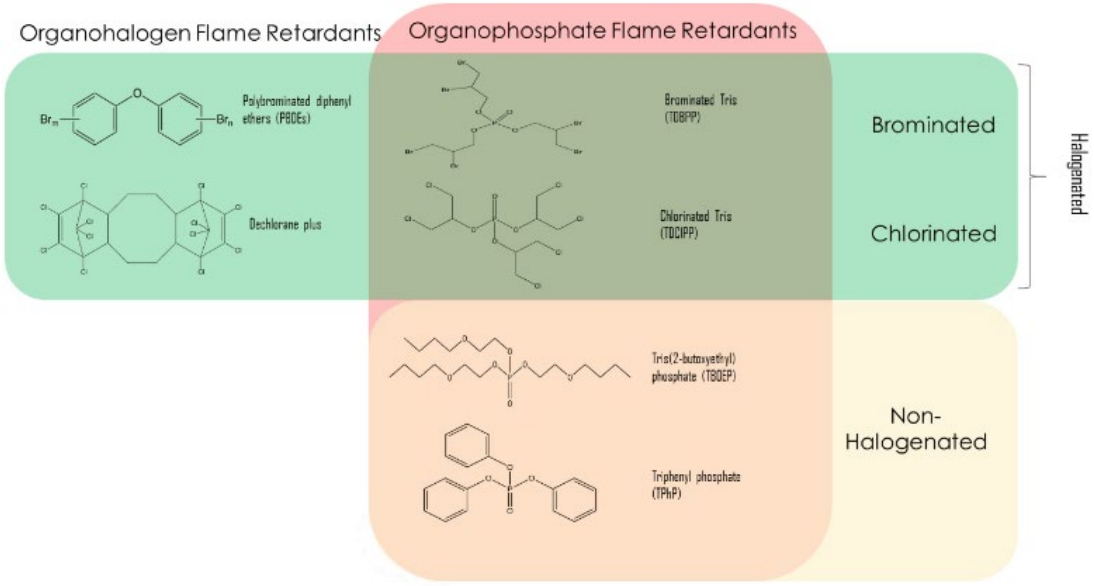
1. Our American Medical Association supports continued research on both the efficacy of flame retardants in reducing fire frequency, injuries, deaths, and other damages as well as the adverse health and environmental impacts of flame retardants, using a class-based approach when possible. (New HOD Policy)
2. Our AMA supports state and federal regulatory and legislative efforts to reduce exposure to toxic flame retardants, including clear and transparent flame retardant and flammability labeling practices. (New HOD Policy)
3. Our AMA supports efforts to raise awareness and improve public education of fire risks, fire safety, and the safety of flame retardants. (New HOD Policy)

Fiscal note: Minimal

APPENDIX I - Classification of Flame Retardants[27,36]

Flame Retardant Classes	**Examples**
Inorganic/Mineral	• Aluminum hydroxide (ATH), • Magnesium hydroxide (MDH), • Huntite and hydromagnesite, • Various hydrates, • Red phosphorus, and • Boron compounds, mostly borates.
Organohalogen compounds	• Decabromodiphenyl ether (DecaBDE), • Decabromodiphenyl ethane (a replacement for DecaBDE), • Polymeric brominated compounds such as brominated polystyrenes, brominated carbonate oligomers (BCOs), brominated epoxy oligomers (BEOs), • Tetrabromophthalic anhydride, • Tetrabromobisphenol A (TBBPA), and • Hexabromocyclododecane (HBCD).
Organophosphorus compounds	• Triphenyl phosphate (TPHP), • Resorcinol bis(diphenyl phosphate) (RDP), • Bisphenol A diphenyl phosphate (BADP), and • Tricresyl phosphate (TCP), • Phosphonates such as dimethyl methylphosphonate (DMMP), and • Phosphinates such as aluminum diethyl phosphinate.(ADP)
Halogenated phosphorus compounds	• Brominated: tris(2,3-dibromopropyl) phosphate, and • Chlorinated: tris(1,3-dichloro-2-propyl) phosphate (TDCPP) and tetrakis (2-chlorethyl) dichloroisopentyl diphosphate (V6)

APPENDIX II - Diagram of the General Structures of Flame Retardant Compounds and How the Classes are Related to One Another[30]



APPENDIX III – International and Federal Legislative and Regulatory Actions Concerning Flame Retardants[30]

International Regulation		
EC/ 2003/ Directive 2003/11/EC	Prohibits marketing or use of these PBDEs.	PentaBDE, OctaBDE
Canada/ 2008/ Polybrominated Diphenyl Ethers Regulations	These regulations prevent the manufacture of these PBDEs and restrict their use in Canada. Note: these regulations were subsequently repealed and replaced with the Prohibition of Certain Toxic Substances Regulations, 2012, to the same effect.	PentaBDE, OctaBDE
Stockholm Convention/ 2009/SC-4/18 and SC-4/14	Elimination of production, use, import, export by all countries party to the treaty, with exemptions for recycling of articles.	PentaBDE, OctaBDE
Canada/ 2010/ Canada Consumer Product Safety Act	Prohibits foam padded children's products with this flame retardant.	TCEP
EU/ 2014/ Commission Directive	Limits these flame retardants to 5 mg/kg in children's toys.	TCEP, TDCPP, TCIPP
EU/ 2015/ REACH Authorization List	Generally prohibits the use of this flame retardant.	TCEP
Canada/ 2016/ Regulations Amending the Prohibition of Certain Toxic Substances Regulations 2012	Adds DecaBDE to the list of prohibited PBDEs.	DecaBDE
Canada/ 2016/ Children's Sleepwear Regulations	Prohibits the use of these flame retardants in children's loose-fitting sleepwear.	Flame retardants with specific health hazards, including: oral toxicity, dermal sensitization, gene mutation, and tumorigenicity
Stockholm Convention/ 2017/ SC-8-10	Elimination of production, use, import, export by all countries party to the treaty, with exemptions for specific uses.	DecaBDE
Japan/ 2018/ Ministry of Economy, Trade and Industry	Prohibits the manufacture and use in Japan.	DecaBDE
EU/ 2018/ D059740/02	Prohibits the use of halogenated flame retardants in the enclosure or stand of covered electronic displays; requires that components containing flame retardants be labelled with a code to identify the flame retardant used.	Halogenated flame retardants prohibition; all flame retardants for labelling

United States Federal Legislation and Regulation		
US/ 2003/ phase out agreement	Agreement between US EPA and manufacturers to phase out manufacture and import by 2004.	PentaBDE, OctaBDE
US/ 2009/ phase out agreement	Agreement between US EPA and some manufacturers to phase out manufacture and import by 2013.	DecaBDE
US/ 2016/ Toxic Substances Control Act	US EPA is required to propose rules to reduce exposures to the extent practicable by June, 2019.	DecaBDE, IPTPP
US/ 2017/ Consumer Product Safety Commission	Initiated rulemaking to prohibit these flame retardants in children's products, furniture, mattresses, and electronics cases; issued guidance to manufacturers and consumers warning about health concerns of organohalogen flame retardants.	All halogenated OPFRs and all other additive, non-polymeric organohalogen flame retardants
US/ 2019/ Toxic Substances Control Act	These flame retardants proposed as high-priority chemicals which would undergo risk evaluation.	TCEP, TPHP

APPENDIX IV- State Regulation of Flame Retardants in Textiles[152]

State	Status	Year	Bill	Description
California	Adopted	2003	AB 302	Bans products containing more than 0.1 percent of the flame retardants PentaBDE or OctaBDE, by mass.
California	Adopted	2004	AB 2587	Moves up the effective date of a ban on the flame retardants PentaBDE and OctaBDE by a year and a half.
California	Adopted	2008	AB 1879	Establishes a process to identify, prioritize, and evaluate chemicals of concern in consumer products to determine how best to limit exposure or reduce the level of hazard, and establishes green chemistry challenge grants and a Green Ribbon Science Panel.
California	Adopted	2013	AB 127	Requires the state fire marshal to review flammability standards and chemical flame retardants and propose updated insulation flammability standards that maintain both overall building safety and occupant/firefighter protection.
California	Adopted	2014	SB 1019	Requires products to indicate if they contain added flame retardants and make information available online.
California	Adopted	2018	AB 2998	Restricts flame retardants in children's products, mattresses, and upholstered furniture.
California	Adopted	2023	A.B.267	Removes the requirement that all tents manufactured for sale in the state be flame retardant.
Georgia	Introduced	2025	H.B.9	Prohibits the sale, manufacture, and distribution of products containing specified chemical flame retardants, including bedding, carpeting, children's products, residential upholstered furniture, and window treatments.
Hawaii	Adopted	2004	HB 2013	Bans products containing more than 0.1 percent of the flame retardants PentaBDE or OctaBDE.
Illinois	Adopted	2005	HB 2572	Bans products containing more than 0.1 percent of the flame retardants PentaBDE or OctaBDE. Directs the Illinois EPA to review the health impacts of and alternatives available to decaBDE and submit a report to the Governor.
Maine	Adopted	2004	LD 1790	Bans products containing added brominated flame retardants.

Maine	Adopted	2006	EO 12	Authorizes the Department of Environmental Protection to submit legislation to phase out mercury batteries and improve mercury thermostat recovery. Creates one report assessing lead-free alternatives in consumer products and one on alternatives to the flame retardant DecaBDE. Underscores commitment to environmentally preferable procurement, including lead-free wheel weights and uniforms that don't require cleaning with perchloroethylene. Establishes Governor's Task Force to Promote Safer Chemicals in Consumer Products.
Maine	Adopted	2007	LD 1658	Clarifies earlier PBDE phaseout.
Maine	Adopted	2008	LD 2048	Identifies chemicals of high concern and requires reporting on usage and replacement with safer alternatives.
Maine	Adopted	2010	LD 1568	Prohibits the manufacture and sale of shipping pallets, or any product made from them, containing DecaBDE.
Maine	Adopted	2011	LD 1129	Selects up to 70 chemicals as Chemicals of High Concern based upon likely exposure to children or fetuses and uses this list to designate Priority Chemicals which will require reporting and disclosure when used in children's products.
Maine	Adopted	2017	LD 182	Bans the sale of residential upholstered furniture containing chemical flame retardants.
Maine	Adopted	2021	LD 1662	Amends the law restricting the sale of residential upholstered furniture treated with flame-retardant chemicals to align Maine's requirements with standards enacted in California. Effective January 1, 2022.
Maryland	Adopted	2005	HB 83	Bans products containing the flame retardants PentaDBE and OctaBDE. Requires the Department of the Environment to report DecaBDE in products and make recommendations regarding the use, sale, and disposal of products containing it.
Maryland	Adopted	2010	SB 556	Bans mattresses, residential upholstered furniture, and electronic equipment containing decaBDE by 2010.
Maryland	Adopted	2013	HB 99	Bans tris (2–chloroethyl) phosphate (TCEP) from children's products.
Maryland	Adopted	2014	HB 229	Bans kids' products containing the toxic flame retardant tris (1, 3-dichloro-2-propyl) (TDCPP).

Maryland	Adopted	2020	SB 0477	Prohibits sale of any juvenile product, mattress, upholstered furniture, or reupholstered furniture that contains more than 0.1 percent of a flame-retardant chemical by mass.
Massachusetts	Adopted	2021	H 4900	Bans 12 different types of flame retardants in the manufacture, sale, and distribution of bedding, carpeting, children's products, residential upholstered furniture, or window treatment.
Michigan	Adopted	2003	HB 4406	Bans products containing more than 0.1 percent of the flame retardant PentaBDE.
Michigan	Adopted	2004	SB 1458	Authorizes the department to establish a committee to determine the risk posed by the release of toxic flame retardants PBDEs, other than PentaBDE or OctaBDE, to human health and the environment.
Minnesota	Adopted	2007	SF 2096	Bans products containing the toxic flame retardants PentaBDE or OctaBDE. Requires review of the flame retardant decaBDE, looking at safer alternatives, fire safety, and any evidence regarding the potential harm to public health and the environment.
Minnesota	Adopted	2009	HF 2123	Generates a list of chemicals of high concern and priority chemicals, along with participation in Interstate Chemicals Clearinghouse.
Minnesota	Adopted	2015	SF 1215	Bans specified toxic flame retardants from children's products, mattresses, and residential upholstered furniture, and specifies that they not be replaced with chemicals that are carcinogens, endocrine disruptors, or otherwise cause developmental toxicity.
Minnesota	Adopted	2019	HF 359	Bans manufacture and sale of halogenated, phosphorus-based, nitrogen-based, and nanoscale flame retardants in residential upholstered furniture, children's products, and residential and business textiles. Prohibits the manufacture and sale of PFAS-containing firefighting foam.
Minnesota	Adopted	2024	S.F.4097	Omnibus bill. Includes a provision removing the requirement for tents to contain flame-resistant materials.
Nevada	Adopted	2021	AB 97	Prohibits the use of firefighting foam containing PFAS; establishes standards for the disposal of firefighting foam containing PFAS; establishes a working group to study issues related to PFAS and develop recommendations for state action; prohibits any flame-retardant organohalogenated

				chemical in the manufacture, sale, and distribution of children's products, upholstered residential furniture, residential textiles, business textiles, or mattresses (specifically exempts polymeric flame retardants).
New Hampshire	Adopted	2019	SB 193	Prohibits the manufacture and sale of upholstered furniture containing toxic flame retardants.
New York	Adopted	2004	S 7621	Prohibits the use of flame retardants PentaBDE and OctaBDE. Create a task force on flame retardant safety to review and report on relevant studies, risk assessments, findings, or rulings on decaBDE and its alternatives.
New York	Adopted	2011	A 6195	Enacts a first-in-the-nation ban on children's products containing the flame retardant TCEP.
New York	Adopted	2014	SB 3703	Bans toxic flame retardant TDCPP in children's products for kids three years of age and younger.
New York	Adopted	2019	A 6296	Requires manufacturers of children's products containing dangerous chemicals to notify the state and retailers; bans the sale of children's products containing dangerous chemicals.
New York	Adopted	2021	S 4630	Beginning January 1, 2024, prohibits the sale of any new upholstered furniture or mattress that contains any intentionally added flame retardants. Beginning January 1, 2023, prohibits a custom upholsterer from repairing upholstered furniture using replacement components that contain flame retardants. Beginning January 1, 2024, prohibits the sale of any electronic display that contains intentionally added organohalogen flame retardants.
Oregon	Adopted	2005	SB 962	Bans the toxic flame retardants PentaBDE and OctaBDE and recommend banning DecaBDE if safer alternatives are nationally available.
Oregon	Adopted	2009	SB 596	Phases out the toxic flame retardant DecaBDE from products bought and sold in the state.

Oregon	Adopted	2015	SB 478	The Oregon Toxic Free Kids Act (TFKA) establishes a list of high-priority chemicals of concern for children's products, posts the list online, requires manufacturer disclosure of these chemicals, and requires their eventual removal. Authorizes participation in the Interstate Chemicals Clearinghouse. Please note: The Oregon Health Authority (OHA) is in its final stages of implementing TFKA. The current final phase of rulemaking focuses on the exemptions manufacturers may seek if they are unable to completely phase out these toxic chemicals. OHA must finalize these rules in order for TFKA to be fully enforceable..
Rhode Island	Adopted	2006	HB 7917	Restricts the manufacturing or distribution of flame retardants containing PentaBDE or OctaBDE and requires study on decaBDE.
Rhode Island	Adopted	2017	H 5082	Prohibits the manufacture and sale of residential upholstered bedding and furniture containing toxic flame retardants.
Vermont	Adopted	2009	H 444	Bans the flame retardants OctaBDE and PentaBDE from all products and decaBDE from certain home products (mattresses and pads, residential furniture, televisions, and computers). Prohibits a manufacturer from replacing DecaBDE with a known or suspected carcinogen or a chemical identified by the U.S. EPA as causing birth defects, hormone disruption, or harm to reproduction or development.
Vermont	Adopted	2013	S 81	Bans the flame retardants OctaBDE and PentaBDE from all products, bans the sale of mattresses and furniture with DecaBDE, and bans TCEP TDCPP from children's products and furniture.
Washington	Adopted	2004	EO 04-01	Directs the Department of Ecology to move forward on phasing out the use of PBDEs.
Washington	Adopted	2007	HB 1024	Bans the sale of certain products containing the flame retardants PBDEs and mattresses containing DecaBDE and requires the state to study alternatives to them. Restricts the sale of televisions, computers, and residential upholstered furniture containing DecaBDE as a result of the Departments of Ecology finding that safer and technically feasible alternatives that meet fire safety standards are available.

Washington	Adopted	2016	HB 2545	Bans the sale of children's products and residential furniture containing toxic flame retardants TDCPP, TCEP, DecaBDE, HBCD, and additive TBBPA.
Washington	Adopted	2019	SB 5135	Directs the Department of Ecology to identify and take regulatory action on consumer products that are a significant source of chemicals that are a concern for sensitive populations and species. Prioritizes PCBs, PFAS, organohalogen flame retardants, phthalates, and phenolic compounds (BPA, APEs) for initial consideration.
Washington, D.C.	Adopted	2016	B21-0143	Prohibits the manufacture, sale, or distribution of any children's product or residential upholstered furniture containing carcinogenic flame retardants or chemicals known to be carcinogenic to humans.

APPENDIX V - Related Policy

H-10.989 Better Fire Prevention in Public Buildings
The AMA urges state public authorities to enact uniform fire protection codes in public buildings, for the risks such furnishings hold for the emission of toxic gases as well as intense heat, and at least in the case of new construction, the introduction of expanded sprinkler systems and fully automatic smoke detectors. [Res. 32, A-88Reaffirmed: Sunset Report, I-98Modified and Reaffirmed: CSAPH Rep. 2, A-08Modified: CSAPH Rep. 01, A-18]

H-10.966 Prevention of Fires Related to Cigarette Smoking
1. Our American Medical Association supports studies to determine the feasibility and practicality of establishing a standard for self-extinguishing cigarettes and requiring cigarette manufacturers to meet that standard.
2. Our AMA supports the concept of self-extinguishing cigarettes for the purpose of reducing **fire** related deaths, injuries and loss of property.
3. Our AMA reiterates its opposition to all smoking. [Sub. Res. 6, A-82Reaffirmed: CLRPD Rep. A, I-92Reaffirmed: CSA Rep. 8, A-03Reaffirmed: CSAPH Rep. 1, A-13Reaffirmed: CSAPH Rep. 08, A-23]

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-26)
Deprescribing in Clinical Practice
(Reference Committee K)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 921-I-25, "Prioritizing Deprescribing in Seniors," was referred by the House of Delegates. This report provides an overview of the goals, benefits, and barriers associated with deprescribing, as well as the current state of public perception, clinical research, and the guidelines and tools available to support its implementation in clinical practice.

METHODS. Literature searches were conducted in the PubMed database for English-language articles published between 2021 and 2026 using the search terms "deprescribing" and "medication optimization." Additional articles were identified by manual review of the references cited in these publications and from relevant government and expert stakeholder publications, as well as contemporary media reporting.

DISCUSSION. Deprescribing is a structured, patient-centered approach to medication optimization that seeks to ensure medications continue to provide more benefit than harm. As rates of polypharmacy increase, deprescribing has become an increasingly prominent area of research and clinical practice, particularly in older adults. Existing evidence suggests that deprescribing can safely reduce medication burden and may improve selected clinical and economic outcomes, although important limitations in the evidence base remain. A growing number of frameworks, guidelines, and decision support tools are available to support deprescribing, but challenges related to patient awareness, clinician training, and care coordination continue to pose barriers.

CONCLUSION. Deprescribing offers a systematic approach to evaluating and discontinuing medications when the potential risks for continuing outweigh the benefits. Key components of deprescribing include medication reconciliation, identification and assessment of medication risks in accordance with patient characteristics, shared decision-making; and physician-led team-based care. Additional research is needed to strengthen the evidence base, alongside further education for physicians and patients. Proposed changes to AMA policy include defining deprescribing and its key components, identifying barriers, and encouraging additional research and educational initiatives.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-I-26

Subject: Deprescribing in Clinical Practice

Presented by: Tamaan Osbourne-Roberts, MD, MBA, Chair

Referred to: Reference Committee K

At the 2025 Interim Meeting Resolution 921-I-25, "Prioritizing Deprescribing in Seniors," was referred by the House of Delegates and asked the following:

> 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.
>
> 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.
>
> That our AMA call for research and policy efforts to address barriers for implementation of deprescribing in routine medical care.
>
> That our AMA advocate for all insurers to reimburse deprescribing activities.
>
> 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.

This report provides an overview of the goals, benefits, and barriers associated with deprescribing, as well as the current state of public perception, clinical research, and the guidelines and tools available to support its implementation in clinical practice.

METHODS

Literature searches were conducted in the PubMed database for English-language articles published between 2021 and 2026 using the search terms "deprescribing" and "medication optimization." Additional articles were identified by manual review of the references cited in these publications and from relevant government and expert stakeholder publications, as well as contemporary media reporting.

BACKGROUND

The practice of discontinuing medications that appear to be creating more risk than benefit has long been a component of patient care, but only in the last couple of decades has this practice emerged as a formal area of research and clinical practice. The term "deprescribing" was introduced in the medical literature in a 2003 paper called "Deprescribing: Achieving Better Health Outcomes for Older People through Reducing Medications."[1] Since then, deprescribing has become part of the

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medical lexicon as a patient-centered, clinically supervised process aimed at reducing or stopping medications that may no longer be beneficial or could be causing more harm than benefit.[2] The primary goals of deprescribing are to improve patient outcomes, reduce the burden of unnecessary or potentially harmful medications, and enhance overall quality of life. Further, deprescribing helps to prevent prescribing cascades, whereby additional medications are prescribed to treat side effects of other medications, leading to increased risk of adverse events and polypharmacy. Polypharmacy is generally defined as the concurrent use of multiple medications, with five or more daily medications commonly used as a threshold.[3] While a high number of medications may indeed be necessary for some patients, polypharmacy may indicate to a physician that careful evaluation of the patient's medication list and potential consideration of deprescribing may be warranted in order to optimize the medication regimen and meet patient goals.

Deprescribing can be implemented in a wide variety of clinical situations but is particularly prevalent in the care of older adults. The Centers for Disease Control and Prevention (CDC) reports that medication use in older adults has been increasing over time: 43 percent of adults age 65 and older used five or more prescriptions in the past 30 days in 2017-2020 compared to 33 percent in 2001-2004 (see Figure 1).[4] However, this level of medication use may not be needed or desired in all cases. In a 2014 article, it was noted that nearly half of older adults take one or more medications that are not medically necessary, and that most express interest in reducing their medication burden.[5] A population-based survey found that 92 percent of Medicare beneficiaries reported being willing to stop one or more of their medications if their physician advised it was possible, and 67 percent specifically wanted to reduce the number of medications they were taking.[6] The combination of high rates of polypharmacy and considerable patient interest in reducing medications highlights the potential role of deprescribing in improving medication management, particularly among older adults.

In addition to polypharmacy, deprescribing is closely intertwined with several related concepts, including medication optimization, medication reconciliation, and potentially inappropriate medications (PIMs) (see Table 1).[7,8] Medication optimization is the broad process of ensuring that medication regimens are evidence-based, aligned with patient goals, and used in a manner that maximizes benefit while minimizing harm.[9,10] Medication optimization may involve adjusting medication use in a wide variety of ways, including initiating new therapies, adjusting doses, substituting one medication for another, or reducing or discontinuing medications that are no longer appropriate. This report focuses specifically on deprescribing as one strategy within the broader framework of medication optimization.

Central to the consideration of deprescribing is an accurate patient medication list, which helps ensure patient safety and is established through medication reconciliation, the systematic process of verifying and updating a patient's medication regimen.[11] Medication reconciliation often occurs during care transitions when medication regimens may change, such as at hospital admission, hospital discharge, or a patient's first visit with a new physician. During medication reconciliation, information – including medication name, dosage, frequency, and route of administration – is collected and compared across all available sources, such as the electronic health record (EHR), prescription drug monitoring programs, pharmacy records, direct communication with healthcare professionals, and discussions with patients and their caregivers or guardians. In addition to improving medication list accuracy, the reconciliation process can help physicians identify PIMs, broadly defined as medications for which evidence or expert consensus suggests that potential risks exist with medication use and often outweigh the clinical benefits in a particular patient population.[12]

After medication reconciliation has established an accurate medication list, deprescribing proceeds through a structured, patient-centered process (see Figure 2). Physicians and members of the healthcare team evaluate each medication's necessity, effectiveness, and risks; identify medications that may no longer be appropriate; and engage patients or caregivers in shared decision-making regarding possible dose reduction or discontinuation in appropriate circumstances. In conversations with patients or caregivers, physicians might choose to use language other than "deprescribing," such as "discontinuation," to increase understanding and accessibility. The physician might also coordinate with other members of the healthcare team, such as clinical pharmacists or other physicians. If this systematic process leads to a shared decision that one or more medications should be tapered or stopped, ongoing follow-up should include careful monitoring for withdrawal symptoms, recurrence or sequelae of the underlying condition, or indications that the medication should be resumed. Successful deprescribing requires ongoing shared decision-making with the patient or caregiver, and coordination among the care team to ensure medication regimens remain safe, effective, and aligned with patient objectives.

GOALS AND BENEFITS OF DEPRESCRIBING

As a threshold issue, the AMA strongly supports physicians making individualized clinical determinations. Decisions about a particular medication or treatment must rest in a shared decision-making process with the physician and patient. This process may include a decision to deprescribe through tapering or discontinuing a medication, or to maintain, add to, or otherwise change the medication regimen. Deprescribing is, therefore, one option in a physician's arsenal when optimizing a patient's medications.

With respect to deprescribing as a standalone practice, proponents note that the overarching goal of deprescribing is not to simply reduce the number of medications, but rather to improve patient outcomes and quality of life while maintaining patient trust, safety, and continuity of care. It may be appropriate to deprescribe when treatment goals have been met, adverse effects are causing unnecessary harm, a medication is not meeting the expected outcome, or a patient's preferences or clinical circumstances have changed.[13] Clinicians may also consider specific clinical or patient-centered components when deprescribing, such as reducing medication burden, improving adherence, lowering the risk of falls, preserving or improving cognitive function, and reducing the risk of hospitalization and death.[14] Lifestyle modifications may also be relevant to deprescribing decisions, as improvements in health status or disease management can alter the risk versus benefit profile of medication use. For example, significant decreases in blood sugar due to lifestyle changes by patients with type 2 diabetes may warrant adjusting medications to avoid hypoglycemia.[15] Additional factors that may warrant consideration of deprescribing include polypharmacy, multimorbidity, renal impairment, frailty, dementia, limited life expectancy, medication nonadherence, transitions between care settings, and prescriptions from multiple prescribers (see Table 2).[14]

One key target for deprescribing is addressing polypharmacy, which is particularly common in older adults and is associated with numerous negative outcomes.[16,17] Even after adjusting for disease burden, polypharmacy is associated with increased rates of adverse drug events[18] and medication nonadherence,[5] as well as increased risk of physical and cognitive impairment,[19] hospitalizations,[20] and mortality.[20–22] Furthermore, a study of older adults with cardiovascular disease found that polypharmacy was associated with almost double the total healthcare costs (198 percent) and nearly three times the pharmacy costs (287 percent) after adjusting for patient demographic and clinical factors.[23] Although residual confounding may contribute to these associations, as the same factors that increase disease burden may also increase the likelihood of polypharmacy, the available evidence suggests that polypharmacy is associated with substantial

clinical and economic burdens. Accordingly, deprescribing has emerged as a strategy to optimize medication use and reduce medication-related harms.

Existing studies on deprescribing and medication optimization consistently demonstrate reductions in the average number of prescribed medications without evidence of significant adverse clinical outcomes.[24–37] These findings hold true across a variety of settings, medication classes, and patient populations, suggesting that, when conducted in a structured and monitored manner, deprescribing can safely reduce medication burden. Several studies also report that deprescribing is associated with improved clinical outcomes, such as lower risks of rehospitalization, falls, and mortality.[24–37] For example, deprescribing benzodiazepines in older adults has been shown to reduce fall risk and improve cognitive and functional outcomes when medications are tapered gradually.[38,39] Some studies have also identified economic benefits associated with deprescribing, largely driven by reductions in unnecessary medication use and adverse drug reactions.[40–43] However, findings have not been consistent across interventions and patient populations, with many studies finding no association between deprescribing and clinical or economic outcomes.[24–37]
The evidence base for deprescribing remains limited by substantial heterogeneity in study interventions, patient populations, care settings, and outcome measures, making comparisons across studies challenging.[44,45] Furthermore, many studies have short follow-up periods (typically one year or less) and are underpowered to detect changes in clinical outcomes.[44,45] Additionally, many deprescribing studies have been conducted outside the U.S., particularly in Canada, Australia, and European countries.[46–53] While informative, these findings may not be fully generalizable to U.S. healthcare settings because of differences in payment structures, patient populations, prescribing patterns, and attitudes toward deprescribing.[54] Together, these limitations highlight the need for well-powered studies conducted in diverse U.S. settings to better understand the clinical and economic impacts of deprescribing.

ONGOING RESEARCH

Research on deprescribing and medication optimization has increased substantially over the last decade, though these topics appear to receive less funding than other areas of research.[7] To support early-stage research on deprescribing, the US Deprescribing Research Network (USDeN), which is funded by the National Institute on Aging, funds pilot and exploratory studies and provides small collaboration grants.[55] The goals of these programs are to support early research efforts that may develop into larger projects, support junior investigator development, and promote collaborations across the field.[56] As of June 1, 2026, ClinicalTrials.gov listed 181 ongoing clinical trials with the word “deprescribing” and 1,524 with the term “medication optimization.” Of these, 35 percent (64 deprescribing, 533 medication optimization) are based in the U.S. (see Figure 3).[57] These studies span a range of topics, including engaging patients, reducing healthcare costs, implementing deprescribing in real-world-settings, and measuring outcomes in patients with certain diagnoses, particularly dementia. Most trials are concentrated in primary care and long-term care settings and frequently target older adults with polypharmacy, with comparatively less attention to other populations or care transitions. Interventions vary widely, including clinician-led medication reviews, pharmacist-driven approaches, and electronic decision support tools, contributing to heterogeneity across studies. In addition, many of these studies may struggle with the same limitations as published research, such as non-standardized outcome measures and/or sample sizes that are underpowered to detect clinically meaningful differences in hospitalization or mortality.

DEPRESCRIBING FRAMEWORKS AND TOOLS

A variety of frameworks and tools are available to support physicians and patients throughout the deprescribing process. These resources range from broad deprescribing frameworks to more

targeted instruments that help identify PIMs, prioritize discontinuation strategies, and facilitate shared decision-making.[58] Importantly, validated tools can support not only decisions to reduce or discontinue medications but also determinations that a patient's current regimen remains appropriate. Ultimately, these guidelines and tools are intended to support individualized clinical decision-making that aligns with each patient's goals, preferences, and health needs. Although information and resources on billing for deprescribing services may be useful to members of the House of Delegates and other physicians, that topic falls outside the scope of this report. Instead, the resources discussed below provide information on the clinical implementation of deprescribing. Further information for physicians on deprescribing include the Drive to Deprescribe program,[59] which provides modules on deprescribing in long-term care and post-acute care settings, as well as USDeN[55] and deprescribing.org.[60]

Deprescribing Frameworks

Several deprescribing frameworks have been developed over the last couple of decades, many of which share concepts and processes. The deprescribing guide with perhaps the widest application is the CEASE protocol, which is a summary of several other guides and has been refined to a five-step protocol of[61–64]:

1. **C**onfirm current medicines through a comprehensive review (medication reconciliation);
2. **E**stimate risk of each medication, considering patient characteristics;
3. **A**ssess the usefulness of each medication in relation to its risk;
4. **S**ort the medications by discontinuation priority, taking patient preferences into consideration;
5. **E**liminate medication(s), if appropriate, by implementing a discontinuation regimen and monitoring patients closely.

The straightforward steps of CEASE are easy to follow and widely applicable. However, because CEASE is designed as a high-level framework, it may not fully capture all aspects of deprescribing, such as collaborating across care team members and developing or adjusting a tapering schedule if the risk of a medication outweighs its benefits. Although CEASE has been applied across a variety of clinical settings with positive results and has more evidence than other deprescribing frameworks, it still lacks controlled trials evaluating its impact on patient outcomes.[61]

Estimating and Assessing Medication Risk

Among the tools available to support deprescribing, evidence-based lists of PIMs are commonly used to flag high-risk medications (steps 2-3 of the CEASE protocol). The most prominent of these is the American Geriatrics Society (AGS) Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, which AGS has maintained and regularly updated since 2011. The most recent iteration (version 3) was released in 2023. The Beers Criteria provides recommendations on medications that are generally best avoided in adults aged 65 and older, both broadly and under specific clinical circumstances.[65] In addition to medication-specific recommendations (e.g., “avoid [medication] except for seizure treatment”), the criteria include the rationale for each recommendation and a rating of the quality of supporting evidence. The Beers Criteria is organized into five sections, which all apply to older adults:

1. Medications considered as potentially inappropriate;
2. Medications potentially inappropriate in patients with certain diseases or syndromes;
3. Medications to be used with caution;
4. Potentially inappropriate drug-drug interactions; and

5. Medications whose dosages should be adjusted based on renal function.

The Screening Tool of Older Persons' Potentially Inappropriate Prescriptions (STOPP) criteria is a similar tool to the Beers Criteria and is commonly used in European countries.[66] The STOPP criteria were expanded and updated in 2023 by a panel of 11 European physicians with expertise in geriatric pharmacotherapy.[66] Analyses comparing Beers and STOPP criteria have found that they have different strengths in detecting medication-related risks and may be most effective when used together.[67,68] Beers is organized by medication type and some conditions, while STOPP is organized by physiological systems, making the former useful for quick screening of PIMs, while the latter may allow for a more comprehensive review. Studies have found that STOPP criteria are often more sensitive in detecting PIMs, particularly in acutely ill patients, although Beers criteria may be more applicable in a U.S. setting because they better reflect U.S. drug availability.[67–69] STOPP also has accompanying criteria called the Screening Tool to Alert doctors to Right Treatment (START) that addresses potential prescribing omissions. Overall, both the AGS Beers Criteria and STOPP/START criteria can support deprescribing and medication optimization more broadly by identifying PIMs in older adults, but neither tool provides explicit guidance on how to carry out the deprescribing process nor addresses other patient populations. Physicians caring for other patient populations or seeking more detailed guidance may therefore need to rely on additional resources.

To supplement tools such as the Beers and STOPP/START criteria, numerous medication- and condition-specific deprescribing guidelines have been developed for commonly prescribed drugs and clinical conditions.[70–72] These guidelines vary considerably in format and terminology but often identify patient characteristics (e.g., age, sex, disease state, or clinical status) or clinical triggers (e.g., adverse drug reactions, remission, changes in health status, or patient preference) that may warrant reconsideration of continued medication use (see Table 3). For example, deprescribing may be particularly considered for populations that are more vulnerable to medication-related harm, including older adults, as well as children and adolescents, and pregnant, postpartum, breastfeeding, or pre-conception individuals.[13,73,74] These guidelines sometimes also include detailed guidance on how to implement a discontinuation regimen (step 5 of the CEASE protocol). For example, a guideline may recommend "reduce to 75 percent, 50 percent, and 25 percent of the original dose on a biweekly basis before stopping."[74] However, a scoping review found that 42 percent of assessed guidelines were lacking detailed recommendations for medication reduction or discontinuation.[74] As a result, clinicians frequently must synthesize information from multiple resources and apply substantial clinical judgment when translating deprescribing recommendations into individualized patient care.

Clinical Decision Support Tools

A critical step in the deprescribing process that is not addressed by Beers, STOPP/START, or medication-specific guidelines is the process of sorting patient medications by discontinuation priority, if appropriate (step 4 of the CEASE protocol). Clinical decision support tools have been developed to help with this process though, again, substantial physician judgment is still required. For example, MedStopper is a web-based decision aid developed by clinicians and researchers at the University of British Columbia to help physicians and patients make decisions about reducing or stopping medications.[75] Based on a patient's medication list and indications, Medstopper ranks drugs from most to least appropriate for discontinuation, based on expected symptom benefit, ability to prevent future illness, and risk of harm (see Figure 4). It also provides guidance on how to taper medications safely and lists possible symptoms to assess during the tapering process. While MedStopper may provide useful guidance for physicians, it lacks validation in controlled trials and does not account for individual patient circumstances beyond their medications and indications. Emerging tools incorporating augmented intelligence may further enhance

deprescribing efforts by personalizing recommendations based on patient-specific factors,[76] although evidence on their effectiveness, implementation, and potential risks remains limited, and careful evaluation will be needed as these tools evolve.

Overall, numerous tools are available to support deprescribing, but many lack robust validation and have not been systematically integrated into clinical practice, with the possible exception of Beers and STOPP/START criteria. Most tools are designed to help physicians identify deprescribing opportunities, whereas fewer provide practical guidance on prioritizing, implementing, and monitoring medication discontinuation in individual patients. As a result, use of multiple guidelines or tools alongside considerable clinical judgment remains necessary to translate general deprescribing principles into patient-specific decisions.

BARRIERS TO IMPLEMENTATION OF DEPRESCRIBING

There are a number of patient-, physician-, and system-level barriers that limit the uptake of deprescribing practices, even in situations where medication reduction or discontinuation may be in the best interest of the patient (see Table 4).[17,77–79] These barriers include limited patient awareness and physician training, a lack of role clarity, and a lack of interoperability that creates particular challenges during transitions of care and hinders necessary communication between physicians and pharmacists.

Patient Awareness of Deprescribing

One challenge to deprescribing is limited patient understanding, which may stem from both insufficient education and the poor quality of available educational materials. Patient resources on deprescribing primarily focus on the risks and benefits of common medications, such as statins, proton pump inhibitors, and antipsychotics, meaning that patients taking other medications may have limited access to relevant educational resources.[80] Additionally, a systematic review found that most patient-facing deprescribing resources are fact sheets, despite evidence that decision aids are more effective at improving patient understanding and facilitating shared decision-making.[81,82] Further, many resources exceed the average patient reading level and lack formal validation.[58,83] Consequently, patients may be less likely to initiate conversations about deprescribing due to lack of knowledge, even when they may be receptive to the topic if raised by their physician.

Physician Training on Deprescribing

Many physicians lack formal training in deprescribing and report limited confidence in initiating and managing these decisions in practice.[84] Medical education has traditionally emphasized diagnosis and the prescribing and monitoring of treatment, with comparatively less focus on medication optimization and the discontinuation of therapies when medically appropriate.[85] Although some specialties, such as geriatrics and psychiatry, may place greater emphasis on deprescribing principles, training in medical school and residency remains inconsistent.[86,87]

To address the challenge of initiating the deprescribing process, studies have identified effective approaches to deprescribing conversations with patients and caregivers. Key recommendations include using shared decision-making, introducing the topic gradually, communicating clearly about risks (including side effects) and benefits, and coordinating care among other members of the care team when applicable.[78,88] Notably, these recommendations are themselves frequently listed as barriers to deprescribing, showing the interwovenness of the challenges. Additionally, deprescribing may not be top of mind for physicians during appointments due to their many other responsibilities to their patients. Research has found that EHR-based alerts that prompt physicians

to evaluate medications for potential discontinuation and initiate deprescribing discussions have been shown to significantly increase deprescribing rates.[89] Together, these findings suggest that expanding education and practical training on deprescribing may increase physician confidence and support more consistent implementation of deprescribing when clinically appropriate.

Lack of Role Clarity

The shared nature of modern healthcare can create uncertainty regarding who is responsible for evaluating medications for potential deprescribing. There are often no clearly delineated roles for primary care physicians and specialists in this context, and physicians may hesitate to modify a treatment plan initiated by another clinician due to specialty practice boundaries, uncertainty regarding the original prescriber's rationale, or reluctance to interfere with another physician's care.[90] As a result, medications may accumulate over time without any single clinician comprehensively reviewing the patient's medication regimen and assuming responsibility for initiating a deprescribing discussion. Time constraints in clinical practice may further contribute to this hesitancy.

The involvement of additional healthcare professionals, including nurse practitioners, physician assistants, and clinical pharmacists, can further complicate communication and responsibility for medication management while also creating opportunities for collaboration.[91] For example, clinical pharmacists receive specialized training in medication review and optimization and can play an important role on a physician-led care team by identifying potential deprescribing opportunities and supporting implementation of deprescribing plans.

Liability concerns may also contribute to reluctance to deprescribe. Physicians may worry about potential legal risks if medication discontinuation results in symptom recurrence, disease progression, or another adverse outcome, particularly when the medication was prescribed by another clinician or is recommended by disease-specific clinical guidelines. These concerns may be amplified in fragmented care environments where responsibility for medication management is distributed across multiple clinicians, specialties, and health systems. Collectively, these factors can leave physicians uncertain about both their authority and responsibility to initiate deprescribing, creating an important barrier to medication optimization.

Transitions of Care

Transitions of care are a particularly challenging context for deprescribing because patient care is often fragmented across multiple healthcare professionals, locations, and health systems that lack interoperability.[92] As patients move between inpatient, outpatient, and specialty care settings, medication regimens often change rapidly, while communication and accountability for medication management may become less clear. Medications may be initiated, adjusted, or continued during an episode of care without a comprehensive reassessment of their ongoing need once acute treatment is completed. This can lead to both the continuation of unnecessary medications and uncertainty among clinicians about whether it is appropriate to discontinue medications started by another clinician. For example, formulary-based therapeutic substitution in one institution can result in therapeutic duplication in the next institution, unless mechanisms are in place to identify, and prevent harm from, potential therapeutic duplication. These challenges are often exacerbated by incomplete medication reconciliation, limited access to prior treatment rationale, and time constraints.[93,94] These dynamics underscore that transitions of care are both a crucial opportunity and a particularly difficult context in which to implement deprescribing, making coordination across the care team uniquely important.

Physician-Pharmacy Communication

Another challenge to deprescribing is communication between physicians and pharmacies. While healthcare systems have increasingly adopted electronic prescribing, medication discontinuation orders are not always transmitted directly from the EHR to the dispensing pharmacy. As a result, medications may continue to be dispensed through automatic refill programs even after a physician has decided to deprescribe them or change a dose, placing the patient at risk for a medication error.[95] This lack of interoperability means that effective deprescribing may require a more formal and intentional communication process than simply allowing a prescription to expire or choosing not to renew it. One approach to addressing this challenge is CancelRx, an e-prescribing functionality that electronically transmits medication discontinuation orders from the EHR to the pharmacy, helping to improve communication and reduce inappropriate medication dispensing.[96] While this program may aim to reduce medication errors from deprescribing, more information across various healthcare settings is needed to identify best practices for interoperability.

Together, these barriers highlight important gaps in the implementation of deprescribing in clinical practice. Challenges related to patient awareness, physician training, role clarity, transitions of care, and interoperability can limit opportunities to routinely evaluate and discontinue medications when appropriate. Addressing these barriers will likely require a combination of stronger evidence, improved education, clinical infrastructure, and clearer care team roles. Continued efforts in these areas may help support broader awareness and education about benefits and limitations of the integration of deprescribing into routine clinical practice.

THE RISE OF DEPRESCRIBING IN THE PUBLIC SPHERE

Accompanying growing clinical and research interest in medication optimization, deprescribing has become an increasingly prominent topic in public discourse. Major media outlets, including National Public Radio and The New York Times, have recently featured news stories and podcasts on the subject, while discussions have proliferated across social media and online forums.[97–101] These conversations have emerged in part in response to recent efforts by the U.S. Department of Health and Human Services (HHS) to decrease the use of certain prescribed medications, particularly psychiatric medications among children.[102] In response to perceived trends of overprescribing, HHS released a Dear Colleague Letter on May 4, 2026 emphasizing the importance of ensuring access to evidence-based nonpharmacological interventions for mental health conditions and noting that appropriate care may include medication review and, when clinically indicated, deprescribing.[13] The accompanying HHS action plan includes hosting educational webinars for prescribers, convening a Technical Expert Panel to inform the development of HHS clinical guidance on the appropriate use of psychiatric medications, providing grants for child-specific training for prescribers, and simplifying coverage.[102]

These efforts, while providing potentially useful information for physicians and patients, frequently conflate the concepts of overprescribing and deprescribing, which are necessarily distinct. Overprescribing refers to the practice of prescribing medications in excess or more often than necessary.[103] Despite a lack of evidence supporting broad claims of overprescribing, recent polling has shown that many parents view overprescribing of psychiatric medications as a threat to children's health.[104] However, current data suggest that rising prescription rates largely reflect the true prevalence of disease, improved recognition and diagnosis of psychiatric and other conditions, and greater access to needed treatment.[105–107]

Despite limited evidence supporting broad claims of overprescribing and substantial variation in individual patient circumstances, deprescribing has increasingly been positioned as a potential

solution. The academic and clinical approach to deprescribing focuses on reducing or discontinuing medications that were appropriate for a patient at one time but may no longer provide sufficient benefit relative to their risks, rather than avoiding the initiation of clinically indicated treatment. Deprescribing is therefore best understood as a strategy for optimizing medication use at the level of the individual patient, not as a means of reducing prescribing rates more broadly. This distinction is particularly important in psychiatric medicine, where stigma surrounding mental health conditions can already create barriers to accessing appropriate care, including clinically indicated medications. Further, psychiatric medications should not be misconstrued as the cause of the underlying conditions they are intended to treat.[107,108] Public messaging that presents deprescribing as a corrective to perceived overprescribing may discourage appropriate treatment or lead some individuals to discontinue medications without medical supervision, potentially resulting in symptom recurrence, withdrawal effects, or clinical deterioration.[109] While physicians should remain attentive to opportunities for medically appropriate deprescribing, decisions regarding medication discontinuation should be guided by individualized clinical judgment and the best interests of the patient rather than generalized assumptions regarding prescribing patterns or medication use. Ultimately, deprescribing should be viewed as a patient-centered strategy for medication optimization that rests in shared decision making and physician-led team-based care.

CURRENT AMA POLICY

The AMA does not have policy on deprescribing or medication optimization but does have policy related to polypharmacy, medication reconciliation, and team-based, individualized patient decision-making. Policy D-120.965, "Medication Reconciliation to Improve Patient Safety," supports systems being established to support physicians in medication reconciliation and recognizes that it is a multidisciplinary process. Policy D-120.928, "Reducing Polypharmacy as a Significant Contributor to Senior Morbidity," addresses the continuing problem of inaccuracies in medication reconciliation and supports patient education on the effects of medications and encourages physicians and ancillary staff to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications needed to optimize their health. Policy H-160.906, "Models/Guidelines for Medical Health Care Teams," states that physician leaders are focused on individualized patient care and the development of treatment plans and that care coordination is integral to the team's practice. This report and the recommendations included build on these policies to address deprescribing as an important component of clinical care.

CONCLUSION

Deprescribing has emerged as an increasingly recognized component of medication optimization and patient-centered care, particularly as rates of polypharmacy rise. Current evidence suggests that deprescribing can safely reduce medication burden and may improve selected clinical and economic outcomes when implemented through an individualized, structured, and supervised process. However, important evidence gaps remain, particularly regarding long-term outcomes and implementation in diverse U.S. healthcare settings.

Although a growing number of frameworks, guidelines, and decision support tools are available to support deprescribing, barriers related to patient awareness, clinician training, role clarity, and interoperability continue to limit broader adoption. As interest in deprescribing continues to expand among clinicians, policymakers, and the public, efforts to strengthen the evidence base and address implementation challenges will be critical. Ultimately, deprescribing should be viewed as a routine component of high-quality clinical care that seeks to ensure medications continue to provide more

benefit than harm. In response to these findings, we recommend that AMA policy define deprescribing and its key components, identify barriers, and encourage further research and educational initiatives.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted and the remainder of this report be filed:

1. Our American Medical Association recognizes that:
    a. Deprescribing is the planned, supervised process of medication dose reduction or discontinuation when a medication's continued use may no longer provide clinical benefit, may cause harm that exceeds the clinical benefit, or is misaligned with goals of care, particularly among older adults and during transitions of care.
    b. Deprescribing, as a component of medication optimization, includes medication reconciliation; identification and assessment of medication risks in accordance with patient characteristics; shared decision-making; and physician-led team-based care.
    c. Barriers to deprescribing include unclear professional roles; care fragmentation; and lack of clinical workflows and interoperability across healthcare entities. (New HOD Policy)

2. Our AMA encourages broader understanding of deprescribing through further research on clinical outcomes and best practices. (New HOD Policy)

3. Our AMA encourages educational initiatives on deprescribing for physicians, care teams, and patients. (New HOD Policy)

Fiscal Note: Minimal

APPENDIX - CITED POLICIES

Reducing Polypharmacy as a Significant Contributor to Senior Morbidity D-120.928

1. Our American Medical Association will work with other organizations e.g., AARP, other medical specialty societies, PhRMA, and pharmacists to educate patients about the significant effects of all medications and most supplements, and to encourage physicians to teach patients to bring all medications and supplements or accurate, updated lists including current dosage to each encounter.
2. Our AMA along with other appropriate organizations encourages physicians and ancillary staff if available to initiate discussions with patients on improving their medical care through the use of only the minimal number of medications (including prescribed or over-the-counter, including vitamins and supplements) needed to optimize their health.
3. Our AMA will work with other stakeholders and EHR vendors to address the continuing problem of inaccuracies in medication reconciliation and propagation of such inaccuracies in electronic health records.
4. Our AMA will work with other stakeholders and EHR vendors to include non-prescription medicines and supplements in medication lists and compatibility screens.

Medication Reconciliation to Improve Patient Safety D-120.965

1. Our American Medical Association supports medication reconciliation as a means to improve patient safety.
2. It is AMA policy that
   a. systems be established to support physicians in medication reconciliation, and
   b. medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting.
3. Our AMA
   a. recognizes that medication reconciliation is a multidisciplinary process; and
   b. supports education of physicians-in-training about the physician's role and responsibilities in medication reconciliation and management within a physician-led team in relevant clinical settings, to minimize medical errors and promote patient safety and quality of care.

Models/Guidelines for Medical Health care Teams H-160.906

1. Our AMA defines 'physician-led' in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

2. Our AMA supports the following elements that should be considered when planning a team-based care model according to the needs of each physician practice:

Patient-Centered:
a. The patient is an integral member of the team.
b. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.
c. Patient and family-centered care is prioritized by the team and approved by the physician team leader.
d. Team members are expected to adhere to agreed-upon practice protocols.
e. Improving health outcomes is emphasized by focusing on health as well as medical care.
f. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.
g. Safety protocols are developed and followed by all team members.

Teamwork:
h. Medical teams are led by physicians who have ultimate responsibility and authority to carry out final decisions about the composition of the team.
i. All practitioners commit to working in a team-based care model.
j. The number and variety of practitioners reflects the needs of the practice.
k. Practitioners are trained according to their unique function in the team.
l. Interdependence among team members is expected and relied upon.
m. Communication about patient care between team members is a routine practice.
n. Team members complete tasks according to agreed-upon protocols as directed by the physician leader.

Clinical Roles and Responsibilities:
o. Physician leaders are focused on individualized patient care and the development of treatment plans.
p. Non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.
q. Care coordination and case management are integral to the team's practice.
r. Population management monitors the cost and use of care, and includes registry development for most medical conditions.

Practice Management:
s. Electronic medical records are used to the fullest capacity.
t. Quality improvement processes are used and continuously evolve according to physician-led team-based practice assessments.
u. Data analytics include statistical and qualitative analysis on cost and utilization, and provide explanatory and predictive modeling.
v. Prior authorization and precertification processes are streamlined through the adoption of electronic transactions.

Figure 1. Use of prescription drugs in the past 30 days, by number of drugs taken and age group: United States, 2001-2004 to 2017-March 2020[110]

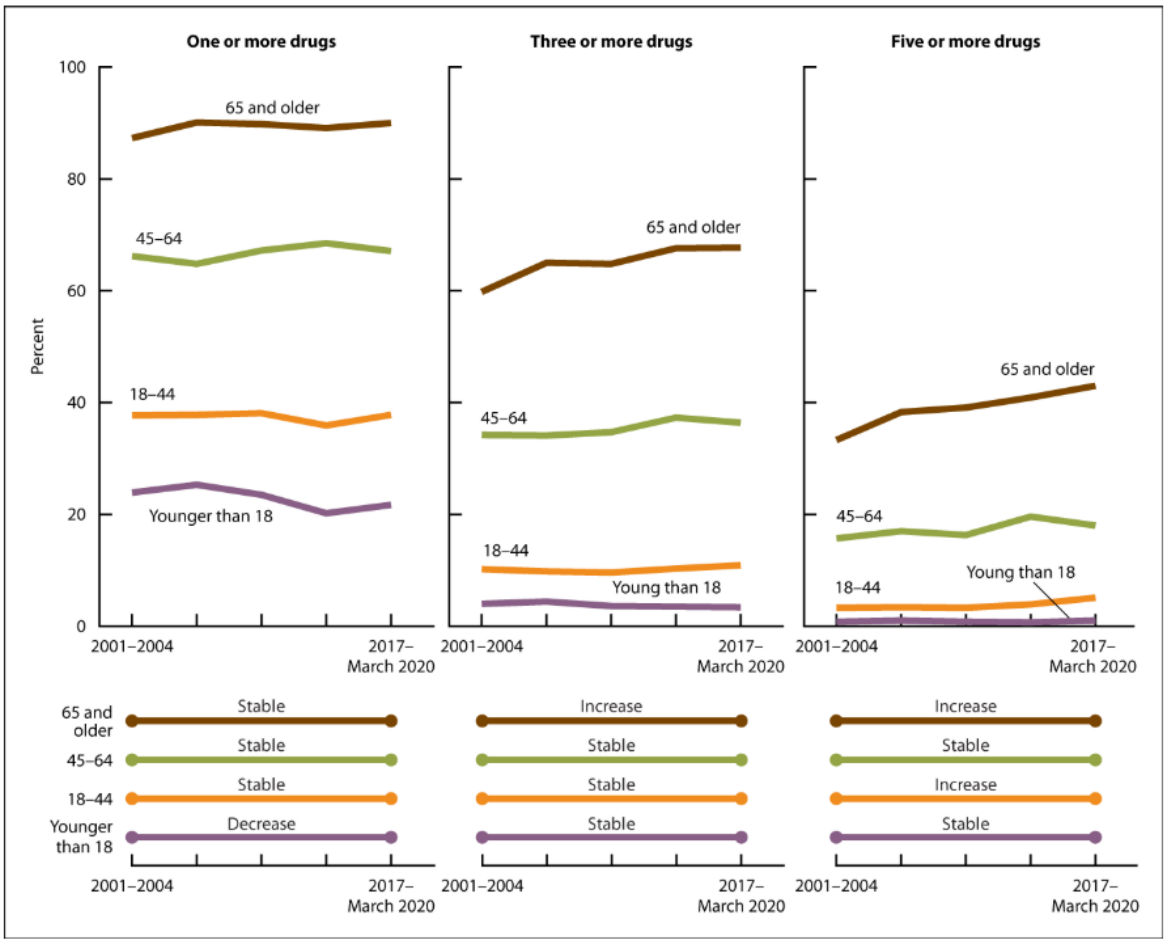
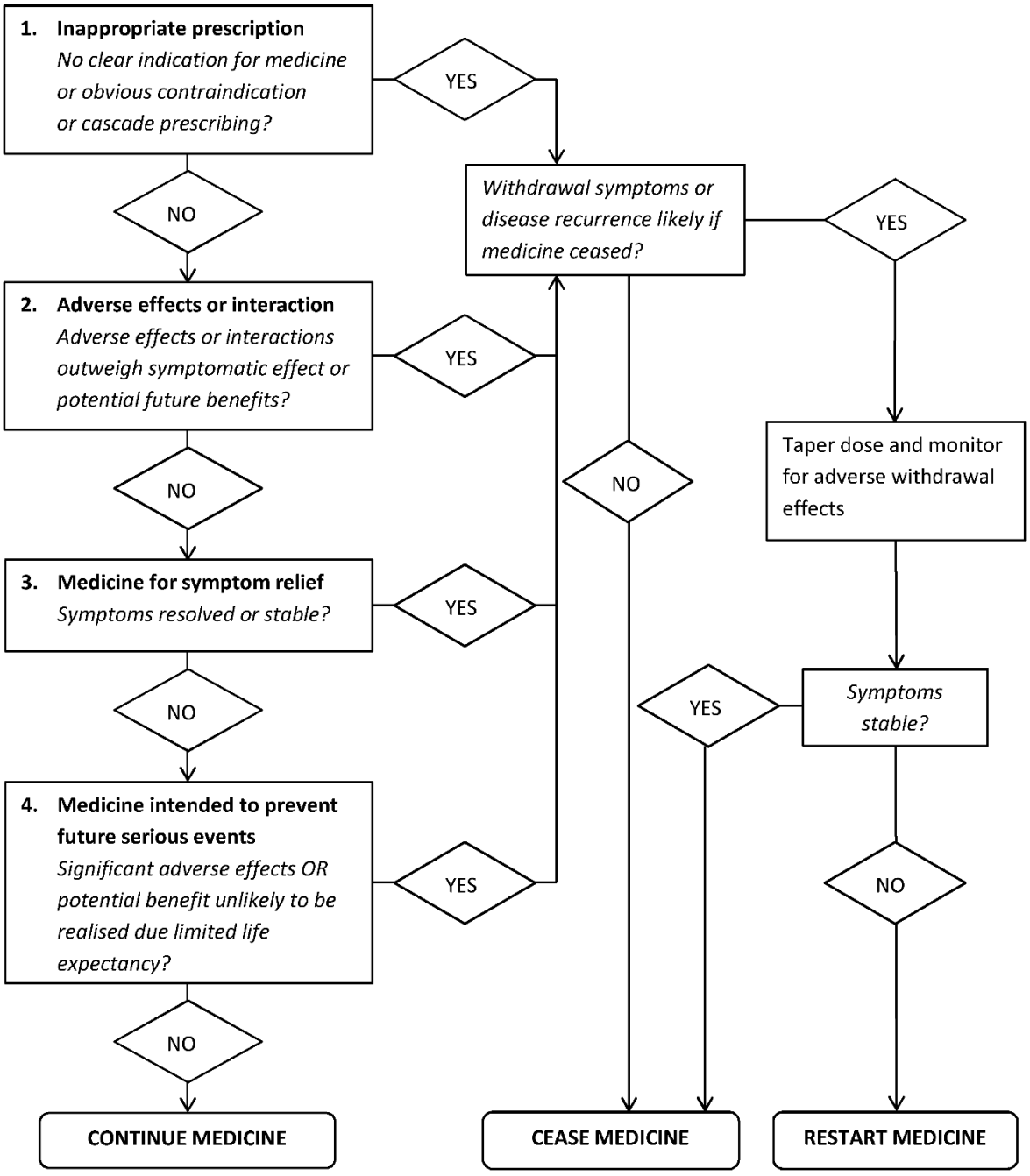


Table 1. Glossary

Term	Definition
Deprescribing	The planned, physician-supervised process of medication dose reduction or discontinuation when a medication's continued use may no longer be providing net clinical benefit or be causing harm.[2]
Medication reconciliation	The process of identifying the most accurate list of all medications that the patient is taking, including medication name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.[11]
Medication optimization	The process of ensuring that medication regimens are evidence based, aligned with patient goals, and used in a manner that maximizes benefit while minimizing harm.[9,10]
Polypharmacy	The concurrent use of multiple medications; a commonly accepted threshold is five or more medications daily.[111]
Potentially Inappropriate Medications	The use of a drug for which a clinical indication does not exist, or the use of an indicated drug in conditions where the risk outweighs the benefit.[12]

Figure 2. Deprescribing algorithm used in a study: "Deprescribing in Frail Older People: A Randomized Controlled Trial"[24, a]



[a] Figure is reproduced from Potter et al., 2016 and "licensed under Creative Commons Attribution 4.0 International."

Table 2. Special Populations or Patient Characteristics Wherein Deprescribing May Be Beneficial[a]

Special Population or Patient Circumstance	**Clinical Reasoning Supportive for Deprescribing**
Polypharmacy	Each additional medication increases the risk of medication-related problems; five or more medications daily is commonly used as a benchmark for polypharmacy.
Multimorbidity	Each additional chronic condition increases the risk of drug-disease interactions and likelihood of polypharmacy.
Renal impairment	Impaired renal function increases the risk of adverse drug events due to reduced drug clearance.
Multiple prescribers	Care delivered across multiple clinicians and settings increases the risk of unintended continuation or duplication of medications and subsequent adverse events or toxicity.
Transitions of care	Medication regimens frequently change during care transitions (e.g., hospital admission or discharge), increasing the risk of discrepancies, unintentional continuation, or inappropriate medications.
Medication nonadherence	Nonadherence may indicate that medications are burdensome, poorly tolerated, or misaligned with patient preferences.
Limited life expectancy, palliative care and hospice	Goals of care may shift, reducing the benefit of preventive medications and increasing the focus on symptom management.
Frailty and dementia	These populations have high rates of polypharmacy, potentially worsening or causing/worsening dementia or frailty, and may have changing goals of care and increased vulnerability to adverse effects.

[a] Adapted from Steinman and Reeve.[14]

Figure 3. Map of clinical trials with the word “deprescribing” on ClinicalTrials.gov as of June 1, 2026 [57,a]



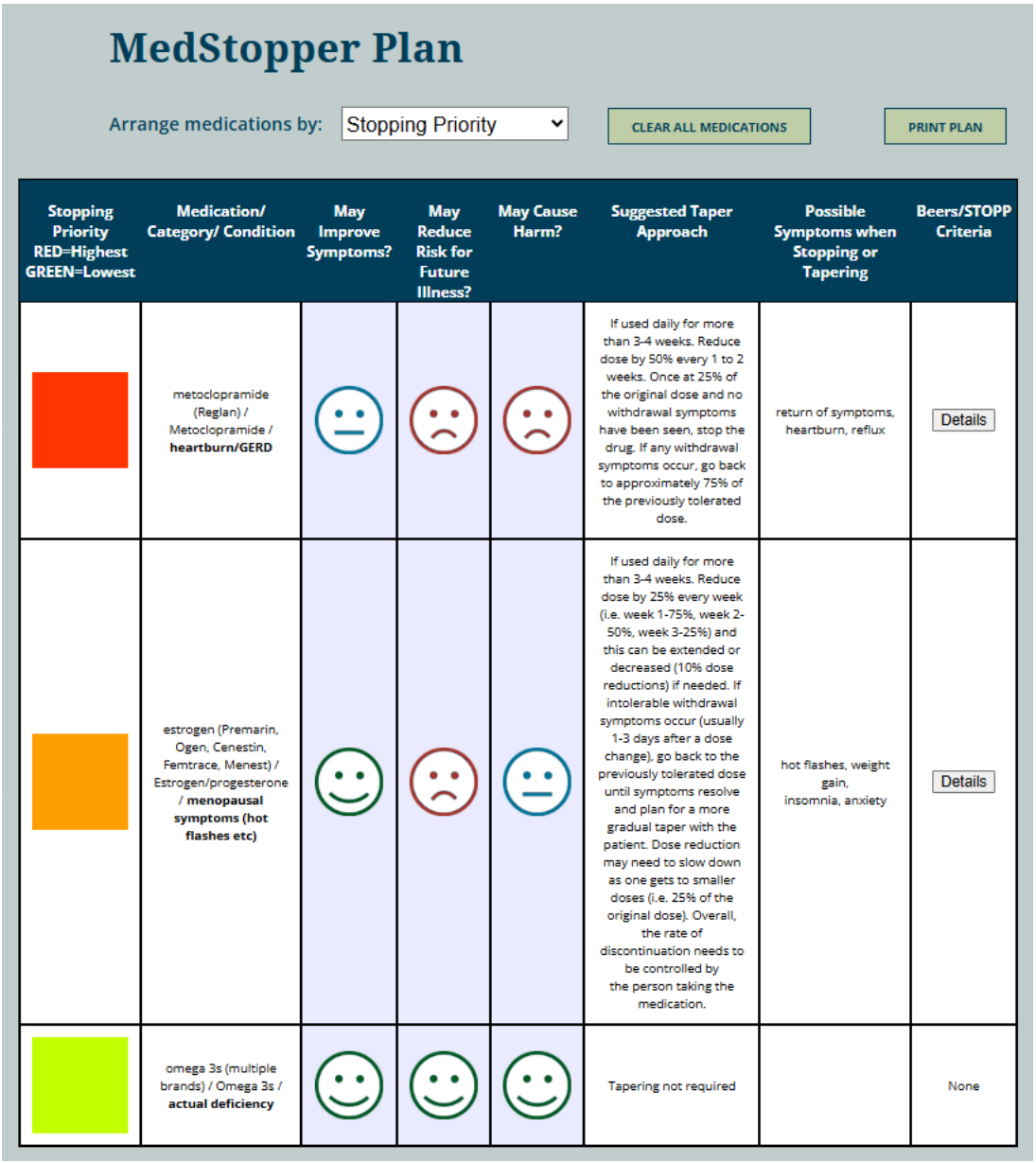
[a] In North America, 64 studies are based in the U.S. and 31 in Canada.
*Map is a screenshot from ClinicalTrials.gov.

Table 3. Content characteristics of clinical deprescribing recommendations[a]

Category	Number of Guidelines, n (%), total N = 80	Description	Example Quotes from Clinical Guidelines
Who	60 (75)	Population of interest, e.g., by age, sex, disease state, medication use, or clinical characteristics	"In adults aged 65 years and older…"; "In patients with Crohn's disease…"
What	89 (99)	Medication or medication class and/or the indication for the medication	"…antipsychotics for the treatment of insomnia"; "opioids for chronic non-cancer pain…"
When/Why	73 (91)	Specific time frame/duration or rationale for deprescribing, such as adverse drug reaction; remission; change in clinical parameters or health circumstances; treatment is no longer effective; patient preference; pre-conception, pregnancy, or breastfeeding	"an attempt to taper and withdraw the drug should be made within 4 months…"; "after a person has been seizure-free for 2 years…" "… the individual has severe or end-stage dementia"; "Tapering and discontinuing glucocorticoids is strongly recommended after inactive disease has been attained"
How – brief process	54 (68)	Some information about how to deprescribe but information was not comprehensive	"We recommend gradual tapering of opioids…" "Taper or terminate therapy"
How – detailed process	46 (58)	Detailed dose reduction plan; shared-decision making; preventing or managing withdrawal symptoms; monitoring or follow-up; recommending use of co-interventions; individualizing patient care	"Reduce to 75%, 50%, and 25% of the original dose on a biweekly basis before stopping"; "…a trial discontinuation, with close periodic monitoring (e.g. every 4 weeks)…"

[a] Adapted from Langford et al., 2024.[74] Licensed under Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license.

Figure 4. Example MedStopper plan showing three randomly selected medications. MedStopper orders the medications by discontinuation priority based on their likelihood to improve symptoms, reduce risk for future illness, and cause harm.[75]



MedStopper Plan

Arrange medications by: Stopping Priority | CLEAR ALL MEDICATIONS | PRINT PLAN

Stopping Priority RED=Highest GREEN=Lowest	Medication/ Category/ Condition	May Improve Symptoms?	May Reduce Risk for Future Illness?	May Cause Harm?	Suggested Taper Approach	Possible Symptoms when Stopping or Tapering	Beers/STOPP Criteria
	metoclopramide (Reglan) / Metoclopramide / **heartburn/GERD**				If used daily for more than 3-4 weeks. Reduce dose by 50% every 1 to 2 weeks. Once at 25% of the original dose and no withdrawal symptoms have been seen, stop the drug. If any withdrawal symptoms occur, go back to approximately 75% of the previously tolerated dose.	return of symptoms, heartburn, reflux	Details
	estrogen (Premarin, Ogen, Cenestin, Femtrace, Menest) / Estrogen/progesterone / **menopausal symptoms (hot flashes etc)**				If used daily for more than 3-4 weeks. Reduce dose by 25% every week (i.e. week 1-75%, week 2-50%, week 3-25%) and this can be extended or decreased (10% dose reductions) if needed. If intolerable withdrawal symptoms occur (usually 1-3 days after a dose change), go back to the previously tolerated dose until symptoms resolve and plan for a more gradual taper with the patient. Dose reduction may need to slow down as one gets to smaller doses (i.e. 25% of the original dose). Overall, the rate of discontinuation needs to be controlled by the person taking the medication.	hot flashes, weight gain, insomnia, anxiety	Details
	omega 3s (multiple brands) / Omega 3s / **actual deficiency**				Tapering not required		None

Table 4. Potential Barriers to Deprescribing[a]

Patient Barriers
Uncertainty of outcomes and fear of negative consequences of stopping a medication(s)
Poor access to deprescribing education
Difficulty in understanding medical jargon
Challenge of tapering and side effects/safety risks of immediately ceasing medications
Clinician Barriers
Lack of education/training on when and how to deprescribe specific medications
Uncertainty or professional concern around discontinuing a drug treatment that was initiated by another clinician
Lack of clarity on who should take the lead on deprescribing in team-based care models
Concern for patient safety and potential consequences of discontinuing drug treatments
Medical inertia when patient is not experiencing problems or has not reached treatment goals
Insufficient time or support; competing tasks
Legal risks and unintended consequences
System Barriers
A culture of prescribing medications and responding to patient concerns/symptoms
Lack of guidelines or scientific consensus for deprescribing
Fragmented care that includes multiple prescribing physicians for a single patient
Lack of shared decision-making tools

[a] Adapted from Hung et al., 2024.[18]

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 5-I-26

Subject: Battlefield Acupuncture

Presented by: Tamaan Osbourne-Roberts, MD, MBA, Chair

Referred to: Reference Committee K

Resolution 927-I-25, "Battlefield Acupuncture – An Educational Call to Arms," was referred by the House of Delegates (HOD) and asked the following:

> That our American Medical Association encourage greater awareness of and/or instruction in the use of battlefield acupuncture (BFA) 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.

BACKGROUND

BFA is a standardized auricular acupuncture technique developed in 2001 by Air Force physician Richard Niemtzow.[1] It should be noted that BFA is based on traditional Chinese acupuncture which has been used for centuries.[2] The protocol involves placement of semipermanent needles at five specific points in the external ear in a predetermined sequence.[1,3] Unlike traditional acupuncture, which commonly involves individualized point selection based on diagnosis and symptom presentation, BFA employs a fixed protocol designed to be easily taught and rapidly administered.[1,3] The technique was originally developed for military environments where rapid pain relief was desired in harsh settings and where conventional pharmacologic treatments might be unavailable, impractical, or associated with undesirable adverse effects.[1,4] Niemtzow subsequently worked with military and Veterans Health Administration (VHA) leaders to expand training opportunities in BFA, resulting in thousands of health professionals in the military and VHA health system receiving instruction.[4-6] The Department of Defense (DOD) and VHA jointly supported large-scale training initiatives aimed at increasing clinician familiarity with acupuncture-based pain management approaches.[4-6] Interest in BFA has increased substantially during the past two decades amid broader efforts to reduce opioid utilization and expand access to nonpharmacologic pain treatments.[4,8,9] Today, BFA is used in military treatment facilities, VHA programs, emergency departments, primary care clinics, rehabilitation settings, postoperative care programs, and selected specialty practices.[4,6,10]

METHODS

English language articles were selected from searches of PubMed and Google Scholar using the search terms "battlefield acupuncture," "acupuncture," "battlefield acupuncture" AND "armed services," and "pain management AND veterans." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by government agencies and applicable organizations will also be reviewed for relevant information.

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PROPOSED BIOLOGICAL MECHANISM

The precise mechanisms underlying BFA are not completely understood.[4,11] Current research suggests that the analgesic mechanism of BFA involves multidimensional biological effects. The core hypothesized mechanism can be summarized as follows: by stimulating specific acupoints in the ear (such as the cingulate gyrus, thalamus, and Shenmen acupoint), BFA activates central nervous system structures related to pain regulation. Auricular acupuncture is based on the theory that the external ear contains somatotopic representations corresponding to regions of the body.[1,11]

This hypothesis is further substantiated by the findings of functional magnetic resonance imaging (fMRI) studies, which have demonstrated that stimulation of these specific ear acupoints can modulate neural activity in the thalamus, cingulate gyrus, and sensory cortex.[3,12] In addition, these studies have shown that BFA can inhibit the transmission of nociceptive signals to the cerebral cortex, thereby leading to a swift alleviation of pain.[3,12] Concurrently, BFA may stimulate an immediate effect by promoting the transient release of neurotransmitters such as beta-endorphin and serotonin and by reducing the inflammatory response by regulating the secretion of anti-inflammatory cytokines such as IL-10.[13,14] Furthermore, the anatomical correlation between ear acupoints (such as the zero point and Shenmen) and the vagus nerve suggests that BFA may modulate the balance of the autonomic nervous system through afferent fibers of the vagus nerve, reduce sympathetic nerve excitability, and alleviate pain-related stress responses.[5]

SUMMARY OF EVIDENCE FROM SYSTEMIC REVIEWS

Systematic reviews provide the most comprehensive assessment of the evidence regarding BFA.[14-17] In a 2021 systematic review and meta-analysis of randomized controlled trials evaluating BFA for adult pain, Yang and colleagues identified nine eligible studies, five of which (344 participants) were included in pooled analyses.[14,18-24] Although several individual trials reported reductions in pain scores, the meta-analysis found no statistically significant improvement in pain intensity when BFA was compared with control interventions.[15] The authors concluded that the available evidence was limited by small sample sizes, study heterogeneity, and methodological weaknesses, preventing firm conclusions regarding effectiveness.[15]

Similarly, another systematic review and meta-analysis examining BFA in emergency settings concluded that although some studies demonstrated beneficial effects, the overall evidence was inconsistent and characterized by significant heterogeneity.[15,18,25-29] A more recent systematic review of 11 randomized controlled trials involving 1,232 participants found mixed evidence regarding the effectiveness of BFA.[17] Four studies reported significant reductions in pain scores, four found no difference compared with controls, and the remaining studies yielded inconsistent results.[15,16,19,21,22,24,30-35] Although the authors concluded that BFA appears safe and may offer benefits for acute pain management, they emphasized ongoing concerns regarding bias, protocol heterogeneity, limited blinding, and inadequate long-term follow-up.[17] Collectively, the systematic review literature suggests that BFA may offer short-term benefits for some patients but does not establish a consistent level of efficacy across acute and chronic pain conditions.[4,14-16]

EVIDENCE SUPPORTING BFA USE FOR ACUTE PAIN

Emergency Department Applications

Several studies have examined BFA in emergency department settings.[16,18,20,32,37] One study reported favorable outcomes among emergency department patients with acute low-back pain treated with BFA.[20] A randomized controlled trial comparing BFA with conventional

pharmacologic treatment for low-back pain found improvements in pain outcomes in certain patient groups.[32] In contrast, a study that evaluated BFA as an adjunctive treatment for abdominal pain, traumatic limb injuries, and low-back pain in emergency departments found no significant additional analgesic benefit.[15] Further, a systematic review focusing specifically on BFA in emergency department settings concluded that evidence remains mixed, with some studies demonstrating clinically meaningful improvements while others show little or no additional benefit beyond standard care.[18]

Perioperative and Procedural Pain

Several randomized trials have evaluated BFA in perioperative settings.[22,24,25,31,34,35] A study reported reductions in postpartum pain among women receiving BFA compared with controls.[25] Another study randomized veterans undergoing major surgery to receive either BFA or sham acupuncture and observed significantly lower postoperative opioid requirements, lower pain scores, and fewer opioid-related adverse effects among patients receiving BFA.[35] Studies involving adult tonsillectomy patients similarly reported improvements in postoperative pain outcomes.[22,31] However, other investigations have generated less favorable results. For example, a study reported no significant improvements in pain or quality of life following lower-extremity surgery.[24] More recently, a study found that adding BFA to standard physical therapy after shoulder surgery produced no significant additional benefit compared with physical therapy alone.[34] Thus, although perioperative studies provide some encouraging findings, results remain inconsistent.[24,25,34,35]

Further, several case reports and small studies suggest that BFA may reduce pain associated with medical procedures.[4] Published reports describe successful use during colonoscopy, abscess drainage, and other procedures when healthcare professionals sought nonpharmacologic alternatives for pain management.[4] Although these observations support feasibility, the current evidence remains preliminary and largely based on small sample sizes.[4]

EVIDENCE SUPPORTING BFA USE FOR CHRONIC PAIN

Evidence supporting BFA for chronic pain is less robust than evidence for acute pain.[17,18,38] A study reported pain improvements among patients receiving long-term opioid therapy who underwent BFA treatment.[38] The study observed favorable outcomes among veterans receiving BFA in individual and group settings.[39,40] Additional observational studies have reported improvements among veterans, cancer survivors, individuals with musculoskeletal pain, and patients with chronic migraine.[33,36,41,42] Pilot studies have also explored applications in tinnitus and other chronic symptom conditions.[12,19,42] Despite these encouraging observations, most chronic pain studies have important methodological limitations. Many lack adequate control (e.g. sham comparator) groups, include small sample sizes and/or are conducted within highly selected patient populations.[4,17,18] Consequently, although preliminary findings suggest possible benefit, current evidence is insufficient to conclude that BFA is an effective treatment for chronic pain generally.[17,18]

EFFECTIVENESS IN VHA SETTINGS

Much of the evidence regarding BFA originates from VHA facilities.[8,40,41,43–46] Multiple studies have demonstrated that veterans frequently report improvements in pain following treatment.[40,41,43] One large VHA evaluation involving more than 11,000 veterans documented favorable patient-reported responses following auricular acupuncture interventions delivered as part of routine clinical care.[43] Additional studies examining group visits and individual visits found that BFA can be efficiently integrated into clinical practice while providing a nonpharmacologic pain management option for veterans.[40,41]

The VHA has also studied clinician perspectives regarding BFA implementation.[8,9,47] Physicians and other healthcare professionals frequently report that patients appreciate having nonpharmacologic treatment options and that BFA can facilitate conversations regarding opioid reduction and holistic pain management.[9,47] Clinicians have identified advantages, including rapid administration, ease of training, low equipment costs, and broad applicability across clinical settings.[8,9,47,48]

SAFETY AND ADVERSE EVENTS

Safety is among the most consistent findings in the BFA literature.[4,15,18] Across randomized trials, observational studies, implementation projects, and systematic reviews, serious adverse events are uncommon.[15,17] Reported adverse effects are generally minor and self-limited and include localized discomfort, transient dizziness, mild bleeding, bruising, and irritation at insertion sites.[15,18] Rare complications have been reported, including migration of semipermanent needles into the external auditory canal.[49] Additional concerns include infection prevention, patient adherence to post-procedure instructions, and appropriate management of retained needles. Some studies have noted that the increasing use of semipermanent needles requires careful patient education and follow-up to minimize uncommon complications.[49,50] Overall, the available evidence suggests that BFA has a favorable safety profile when performed by appropriately trained healthcare professionals using proper technique and infection-control practices.[15,18]

TRAINING, IMPLEMENTATION, AND DISSEMINATION OF BFA

One of the principal advantages of BFA is its relative simplicity compared with traditional acupuncture.[3,5,6] Government-supported initiatives have trained thousands of physicians, physician assistants, nurse practitioners, nurses, physical therapists, and other health professionals.[5–7] Residency programs, continuing medical education courses, and military training programs have been developed to increase healthcare professional familiarity with the technique.[7,10,51] Implementation studies identify several advantages, including low equipment costs, rapid administration, favorable patient acceptance, and compatibility with existing clinical workflows.[9,47,51] However, barriers still remain. Clinicians frequently cite limited time, reimbursement challenges, scheduling difficulties, skepticism regarding evidence quality, and institutional support limitations.[51,52] Challenges associated with training and sustaining competency among healthcare professionals have also been described.[10]

EXISTING AMA POLICY

The AMA currently has no policy specifically related to BFA. AMA Policy H-270.974, "Acupuncture," states that nonphysician boards should not regulate the clinical practice of medicine. The AMA also has limited policy on nonpharmacological approaches to pain management.

CONCLUSION

BFA has emerged as a widely used nonpharmacologic approach to pain management within military and veterans' health systems, driven by interest in expanding treatment options beyond conventional pharmacologic therapies.[1,5–7] The available literature suggests that BFA is generally safe when administered by appropriately trained healthcare professionals and may provide short-term pain relief for some patients, particularly in acute and perioperative settings.[15,17,20,25,32,35,49] Its relative simplicity, low cost, ease of administration, and favorable safety profile have contributed to its adoption across a variety of clinical settings.[5,7,9] At the same time, important uncertainties

remain. Randomized controlled trials have produced inconsistent results, and systematic reviews have not demonstrated universally positive findings.[15–18,24,34]

This report highlights the challenges of interpreting the current evidence on BFA. While some randomized controlled trials and observational studies report reductions in pain scores and opioid use, most others demonstrate little or no benefit compared with control interventions or physical therapy.[4,11,15,17,38] Long-term outcomes, comparative effectiveness relative to other evidence-based nonpharmacologic interventions, and mechanisms of action are not fully understood.[11,17,18] Further, several studies have cautioned against widespread dissemination before stronger evidence becomes available and questions regarding long-term effectiveness, comparative effectiveness, and optimal patient selection are answered.[15,17,18,53,54] Although implementation success within military and veterans' health systems demonstrates feasibility and acceptability, the current literature suggests that BFA may have a role as a nonpharmacologic pain management modality capable of providing short-term pain relief in select patients.[8,9,51] However, important questions regarding its effectiveness, appropriate use, and long-term clinical effectiveness remain unanswered.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted and that the remainder of the report be filed.

1. Our AMA acknowledges Battlefield Acupuncture (BFA) as a nonpharmacologic pain management modality that may provide short-term pain relief in selected clinical circumstances when administered by appropriately trained healthcare professionals; and
2. Our AMA supports ongoing quality research regarding the efficacy, feasibility, and appropriate use of BFA as a nonpharmacologic approach to pain management. (New HOD Policy)

Fiscal Note: Minimal

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901
(I-26)

Introduced by: American Association of Public Health Physicians

Subject: The Establishment of Mandatory National Reporting of *Naegleria Fowleri* and Other Amebic Encephalitides

Referred to: Reference Committee K

Whereas, *Naegleria fowleri*, a thermophilic free-living amoeba, is a causative agent of primary amebic meningoencephalitis (PAM), characterized by extreme case fatality rates exceeding 97%, highlighting its public health significance[1,2]; and

Whereas, other free-living amoebae, such as *Acanthamoeba spp*. and *Balamuthia mandrillaris*, also result in severe and often fatal forms of amebic encephalitis, underscoring the urgent need for comprehensive surveillance[3,4]; and

Whereas, the increasing incidence of *Naegleria fowleri* infections, driven in part by climate change and rising water temperatures, necessitates prompt action to improve national health outcomes and create a standardized mechanism for data collection[5,6]; and

Whereas, only three states—Florida, Texas, and Louisiana—currently mandate reporting of *Naegleria fowleri* infections, leading to significant underreporting, lack of epidemiological data, and insufficient understanding of the true burden of disease nationwide[7]; and

Whereas, standardized data collection is crucial for accurate epidemiological case definitions and improved public health surveillance, facilitating better responses to emerging cases and outbreaks[8]; and

Whereas, the evolving distribution patterns of *Naegleria fowleri* and other amebic diseases, reflective of the sentinel impacts of climate change, highlight the critical need for a national reporting system that can adapt to shifting disease patterns[9]; and

Whereas, enhancing research initiatives on rapid diagnostics and investigational drugs is essential for improving patient outcomes and reducing mortality rates associated with *Naegleria fowleri* and related infections[10,11]; therefore be it

RESOLVED, that our American Medical Association supports the establishment of a mandatory national reporting system for *Naegleria fowleri* and other amebic encephalitides, empowering public health authorities to better monitor and respond to these diseases (New HOD Policy); and be it further

RESOLVED, that our AMA encourages all healthcare providers to report suspected or confirmed cases to relevant public health authorities, ensuring comprehensive data collection and knowledge-sharing (New HOD Policy); and be it further

RESOLVED, that our AMA supports research funding into rapid diagnostic tests and therapeutic options, facilitating timely clinical interventions in suspected cases of amebic encephalitis (New HOD Policy); and be it further

RESOLVED, that our AMA utilizes its leadership role to raise awareness among state affiliates and policy makers for the threat posed by *Naegleria fowleri* and other amebic infections amidst changing climate conditions. (New HOD Policy)

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

Received: 8/29/26

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RELEVANT AMA POLICY

H-440.824 Educating Clinicians and the Public About Amebic Meningoencephalitis Policy

1. Our American Medical Association supports CDC training and education efforts relating to Primary Amebic Meningoencephalitis (PAM).
2. Our AMA supports clinical guidelines and standards of care that promote rapid diagnosis and effective treatment of PAM.

D-440.922 Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems

1. Our American Medical Association will champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes.
2. Our AMA will develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress.
3. Our AMA will work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials.
4. Our AMA will advocate for
    a. consistent, sustainable funding to support our public health infrastructure.
    b. incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff.

c. public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health.
d. efforts to ensure equitable access to public health funding and programs.

H-440.825 Fund for Public Health Emergency Response
Our American Medical Association supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902
(I-26)

Introduced by: Illinois

Subject: Illegal Electronic Health Record Sharing and Patient Trust

Referred to: Reference Committee K

Whereas, health care providers are required to share patient records for treatment and continuity of care, and they cannot legally refuse to release records even if the requesting entity does not have rights to the records for fear of violating HIPAA, the federal law that protects patients' health information; and

Whereas, the United States Department for Health and Human Services has supported a network for sharing records, called the Trusted Exchange Framework and Common Agreement", or TEFCA, which is an honor-bound system, where "stranger danger" is felt to be a real concern that could undermine the entire model if health systems stop sharing records out of fear; and

Whereas, under the terms of TEFCA and other national health information exchanges, providers have to send a patient's records, without a fee, to any legitimate health care provider who requests them for the purpose of supporting a patient's treatment, but whether or not an entity is a legitimate health care provider has become a contentious question; and

Whereas, a recent court filing by the electronic health records company Epic Systems has shown that companies are posing as health providers to gain access to patient records through organizations that onboard other organizations to national networks so they can send and receive health records, and it has become apparent that entities posing as health care providers but were allegedly fronts for data sellers (of medical records) have been allowed access to medical records not for treatment; and

Whereas, these allegedly fraudulent entities have abused the "treatment" request pathway as a method of quickly and cost-effectively accessing patient records to review and summarize medical records and then providing those medical records to law firms; and

Whereas, the government has designated the Sequoia Project to do the vetting of organizations to see that they are legitimate health care providers, which many in the industry have felt has not been performing this function, nor Carequality, the privately run predecessor and main alternative to TECFA. This is evidenced by the fact that some 1,500 complaints have been lodged in the past 10 years, yet no information complaints have been acted upon in the 10 years since the policy was instituted; and

Whereas, the Assistant Secretary for Technology Policy (ASTP) deputy is aware of this problem with maintaining the privacy of medical records, and has been requested to do a centralized review and needs to say clearly what steps are being taken to ensure the integrity of the federal directory; therefore be it

RESOLVED, that our American Medical Association advocate for Congress to allocate appropriate funding for the Assistant Secretary for Technology Policy (ASTP), part of the U.S. Department of Health and Human Services, to be able to review and oversee the work of the Sequoia Project, the organization tasked by the government to oversee the vetting of companies to see that they are legitimate health care providers able to bill for medical services, and enact legal remedies and penalties against those organizations and companies seeking to obtain access to patient medical records not for direct patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA work to ensure that access to medical records for treatment is limited to those who are actually certified as providers of care, including hospital systems, home health care providers and ancillary care providers, and ensure that those who do not directly treat patients (i.e. lawyers and legal entities) do not have access to medical records via TEFCA, the Trusted Exchange Framework and Common Agreement, a network for sharing medical records for treatment, to assure the public of the safety of their records (New HOD Policy); and be it further

RESOLVED, that our AMA support exploring all options to both protect the privacy of medical records and at the same time balance the need for medical records sharing and interoperability of medical records systems. (New HOD Policy)

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

Received: 8/19/26

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1. https://www.statnews.com/2026/03/23/epic-systems-lawsuit-fraud-in-health-information-exchanges/

RELEVANT AMA POLICY

H-478.988 Data Ownership and Access to Clinical Data in Health Information Exchanges

1. Our American Medical Association:
    a. will continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE;
    b. will advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization;
    c. will advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data;
    d. will advocate that HIEs comply with all provisions of HIPAA in handling clinical data; and
    e. encourages physicians who experience problems accessing and using HIE data to inform the AMA about these issues.
2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures.
3. Our AMA will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice.
4. Our AMA will advocate that the direct and indirect costs of participating in health information exchanges should not discourage physician participation or undermine the economic viability of physician practices. (BOT Rep. 17, A-13 CMS Rep. 6, A-13 Reaffirmed: CMS Rep. 4, I-13 Reaffirmed: CEJA Rep. 05, A-23)

H-478.984 Prohibition of Clinical Data Blocking
Our American Medical Association will advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data to non-affiliated physicians who participate in the care of shared patients, thereby interfering with the provision of optimal, safe and timely care. (Res. 222, I-16 Reaffirmed: CMS Rep. 10, A-17 Reaffirmed: CMS Rep. 2, A-22)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903
(I-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

Subject: Improving Health Outcomes in Native Hawaiian Populations

Referred to: Reference Committee K

Whereas, Native Hawaiian adolescents experience disproportionately higher rates of suicidal ideation and attempts than their non-Native peers, including significantly higher suicide attempt rates than non-Hawaiian adolescents (12.9% vs 9.6%) even after adjustment for socioeconomic and psychiatric factors, with cultural affiliation, socioeconomic status, and psychiatric symptoms independently predicting this elevated risk[1,2]; and

Whereas, indigenous women in the United States experience disproportionately high rates of sexual violence compared with non-Indigenous women, with more than half reporting sexual violence during their lifetime[3]; and

Whereas, standard public health reporting frequently aggregates Asian American, Native Hawaiian, and Pacific Islander (AA/NHPI) data, obscuring the distinct and elevated risks of suicide and sexual violence faced by Native Hawaiian youth and women[2, 4-6]; and

Whereas, disaggregated analyses reveal that Native Hawaiian and multiethnic NHPI adolescents experience markedly higher suicidal ideation than monoethnic peers, and that this aggregation has historically led to their underrepresentation in prevention funding, programming, and research[2]; and

Whereas, state and national surveillance data confirm the severity of this disparity: 30.6% of Native Hawaiian/Pacific Islander students in Nevada reported past-year suicidal ideation and Native Hawaiian/Pacific Islander high school students nationally attempt suicide at rates approximately 61% higher than students overall[7]; and

Whereas, Native Hawaiian and Pacific Islander women and girls specifically experience disproportionate rates: in Hawai‘i, 12.7% of Native Hawaiian/Pacific Islander girls report being forced to have sex and 16.7% report unwanted sexual contact in the past year, while Native Hawaiian women report elevated lifetime intimate partner violence and IPV during or shortly before pregnancy[8-10]; and

Whereas, survivors and at-risk youth face barriers to care including stigma, cultural mistrust of institutions, and limited availability of culturally appropriate, trauma-informed services, even though culturally grounded, community-led prevention and intervention programs have been shown to improve engagement and outcomes[11,12]; and

Whereas, physicians and health systems play a critical role in screening for violence, providing trauma-informed care, and supporting culturally responsive suicide and violence prevention strategies that address health inequities among Indigenous populations, and improved data

disaggregation, culturally informed clinical approaches, and targeted public health programs may reduce these disparities and improve access to survivor- and youth-centered care for Native Hawaiians[13,14]; therefore be it

RESOLVED, that our American Medical Association amend Policy D-350.988, "American Indian / Alaska Native Adolescent Suicide," as follows;

> **American Indian / Alaska Native / Native Hawaiian Adolescent Suicide, D-350.988**
> Our American Medical Association will provide active testimony in Congress for suicide prevention and intervention resources to be directed towards American Indian/Alaska Native/Native Hawaiian communities. Our AMA will encourage significant funding to be allocated to research the causes, prevention, and intervention regarding American Indian/Alaska Native/Native Hawaiian adolescent suicide and make these findings widely available. Our AMA will lobby the Senate Committee on Indian Affairs on the important issue of American Indian/Alaska Native/Native Hawaiian adolescent suicide.

(Modify Current HOD Policy); and be it further

RESOLVED, that our American Medical Association amend Policy D-350.985, "Addressing Sexual Violence and Improving American Indian and Alaska Native Women's Health Outcomes," as follows:

> **Addressing Sexual Violence and Improving American Indian, Alaska Native, and Native Hawaiian Women's Health Outcomes D-350.985**
>
> 1. Our AMA advocates for mitigation of the critical issues of American Indian/Alaska Native/Native Hawaiian women's health that place Native women at increased risk for sexual violence, and encourages allocation of sufficient resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women.
> 2. Our AMA will collaborate with the Indian Health Service, Centers for Disease Control and Prevention (CDC), Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians and other health care professionals about the legal and cultural contexts of their American Indian, ~~and~~ Alaska Native, and Native Hawaiian female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population.
> 3. Our AMA will collaborate with the Indian Health Service, CDC, Tribal authorities, and community organizations to obtain or develop appropriate American Indian, ~~and~~ Alaska Native, and Native Hawaiian women's health materials for distribution to patients in the spirit of self-determination to improve responses to sexual violence and overall health outcomes.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

Preventing, Identifying and Treating Violence and Abuse E-8.10

All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse. To protect patients' well-being, physicians individually should: (a) Become familiar with: (i) how to detect violence or abuse, including cultural variations in response to abuse; (ii) community and health resources available to abused or vulnerable persons; (iii) public health measures that are effective in preventing violence and abuse; (iv) legal requirements for reporting violence or abuse. (b) Consider abuse as a possible factor in the presentation of medical complaints. (c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.[Issued: 2016]

Youth and Young Adult Suicide in the United States H-60.937

Our American Medical Association (1) recognizes child, youth and young adult suicide as a serious health concern in the US; (2) encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter child, youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources, (3) encourages efforts to provide children, youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk, (4) encourages continued research to better understand suicide risk and effective prevention efforts in children, youth and young adults, especially in higher risk sub-populations such as those with a history of childhood trauma and adversity, Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and children in the welfare system; (5) supports research to identify evidence-based universal and

targeted suicide prevention programs for implementation in middle schools and high schools, (6) will advocate at the state and national level for policies to prioritize children's, youth's, and young adult's mental, emotional, and behavioral health. [Res. 424, A-05Reaffirmed: CSAPH Rep. 1, A-15, Reaffirmed in lieu of: Res. 001, I-16Appended: CSAPH Rep. 3, A-21, Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21, Modified: Res. 419, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904
(I-26)

Introduced by: Medical Student Section

Subject: Regulation of Organ Transplant Open Offers

Referred to: Reference Committee K

Whereas, over 100000 patients are currently on organ transplant waiting lists across the United States, which order patients by allocation priority metrics based on need, distance from a major hospital, age, and other factors[1,2]; and

Whereas, organ procurement organizations increased their use of out-of-sequence allocation between 2019-2024 to up to 20% of all kidneys transplanted to minimize organ waiting time and maximize placements[1,3,4]; and

Whereas, these practices have come under heavy scrutiny for often leading to lower-needs patients, lower on the transplant list, receiving organs over patients higher on the same list[1,5]; and

Whereas, organs allocated via out-of-sequence allocation are less likely to be given to vulnerable and underserved populations, creating a situation of inequitable organ access[1,4,6,7]; and

Whereas, the federal Organ Procurement and Transplantation Network has only in the past year begun to address the inequities of out-of-sequence allocation[8]; and

Whereas, the complex equity issues underpinning out-of-sequence transplant organ allocations have not been explicitly previously addressed by the AMA[9-10]; therefore be it

RESOLVED, that our American Medical Association will support increased oversight and regulation of open offers and other out-of-sequence donor organ allocations (New HOD Policy); and be it further

RESOLVED, that our AMA support the creation of Organ Procurement and Transplantation Network (OPTN) policies for open offers and out-of-sequence deceased donor organ offers (New HOD Policy); and be it further

RESOLVED, that our AMA support OPTN/Health Resources and Services Administration-led evaluation and monitoring of open offer practices. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary. (Reaffirmed: CEJA Rep. 06, A-18)

Organ Transplant Equity for Persons with Disabilities D-370.980
Our American Medical Association supports: (a) Equitable inclusion of people with Intellectual and Developmental Disabilities (IDD) in eligibility for transplant surgery. (b) Individuals with IDD who can fulfill transplant center protocols having equal access to organ transplant services and protection from discrimination in rendering these services. (c) The goal of the Organ Procurement and Transplantation Network (OPTN) in adding disability status to their Nondiscrimination policy under the National Organ Transplant Act of 1984… (Res. 022, A-22).

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

Allocating Limited Health Care Resources Code of Medical Ethics 11.1.3
Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients, in keeping with the following criteria:
(a) Base allocation policies on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.
(b) Give first priority to those patients for whom treatment will avoid premature death or extremely poor outcomes, then to patients who will experience the greatest change in quality of life, when there are very substantial differences among patients who need access to the scarce resource(s).

(c) Use an objective, flexible, transparent mechanism to determine which patients will receive the resource(s) when there are not substantial differences among patients who need access to the scarce resource(s).
(d) Explain the applicable allocation policies or procedures to patients who are denied access to the scarce resource(s) and to the public. (Issued: 2016)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 905
(I-26)

Introduced by: Medical Student Section, American Academy of Pediatrics

Subject: Integrating Drowning Prevention Counseling and Resource Referral into Pediatric Preventive Care

Referred to: Reference Committee K

Whereas, drowning remains a leading cause of preventable injury death among young children, particularly in early childhood[1]; and

Whereas, evidence-based guidelines emphasize that pediatric drowning prevention requires multiple "layers of protection," as no single intervention is sufficient, with key strategies including context-appropriate measures such as 4-sided pool fencing, life jacket use, swim lessons, close supervision, and lifeguards[1]; and

Whereas, the American Academy of Pediatrics recommends anticipatory guidance on water safety during routine well-child visits, and evidence demonstrates that structured water safety education and increased drowning prevention counseling are associated with improved caregiver knowledge and engagement in preventive behaviors[1,2]; and

Whereas, unintentional drowning remains a significant and seasonally elevated cause of preventable injury-related death in the United States, with persistently high burden in recent years[3,4]; and

Whereas, structural and socioeconomic inequities contribute to disparities in access to water safety education and swim readiness resources, with higher drowning rates observed among Black and American Indian/Alaska Native children compared with other populations[1,4,5,6]; and

Whereas, standardizing brief, developmentally tailored water safety counseling and creating referral pathways to community resources improve caregiver knowledge and uptake of preventive measures[5,7]; and

Whereas, AMA Policy H-10.983 supports early water safety and water awareness programs, yet consistent integration of water safety anticipatory guidance into pediatric preventive care remains limited, despite evidence demonstrating that structured counseling approaches are effective in improving caregiver knowledge and preventive behaviors[2,8]; therefore be it

RESOLVED, that our American Medical Association amends Policy H-10.983 entitled Swimming Safety by addition and deletion to read as follows:

~~1. Our American Medical Association strongly supports barrier fencing and pool covers for residential pools, early water safety, and water awareness programs.~~

1. Our American Medical Association support evidence-based drowning prevention strategies consistent with national guidelines, including but not limited to four-sided isolation fencing, use of U.S. Coast Guard–approved life jackets, close and constant supervision, and avoidance of ineffective or non–evidence-based interventions

2. Our AMA encourages swimming pool manufacturers and pool chemical suppliers to distribute educational materials that promote swimming and water safety.
3. Our American Medical Association support public education efforts and anticipatory guidance by physicians on drowning prevention across the lifespan, including promotion of formal swim lessons, caregiver education, and targeted risk reduction for high-risk populations.
4. Our American Medical Association advocate for policies and community partnerships that expand access to water safety education, swim instruction, and drowning prevention resources, particularly in underserved and high-risk communities.
(Modify Current HOD Policy)

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

Date Received: 9/3/26

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RELEVANT AMA POLICY

Swimming Safety H-10.983

(1) Our American Medical Association strongly supports barrier fencing and pool covers for residential pools, early water safety, and water awareness programs. (2) Our AMA encourages swimming pool manufacturers and pool chemical suppliers to distribute educational materials that promote swimming and water safety

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906
(I-26)

Introduced by: Medical Student Section

Subject: Establishing Menstrual Products as a Standard of Inpatient Care

Referred to: Reference Committee K

Whereas, menstruation is a normal physiological process, and menstrual health is increasingly recognized as a health and human-rights issue that requires access to menstrual products, supportive environments, and appropriate disposal resources[1,2]; and

Whereas, the Centers for Disease Control and Prevention note that menstrual hygiene is important for health and comfort, including helping prevent infections like yeast infections and reducing discomfort during menstruation, needs that do not cease during hospitalization;[3] and

Whereas, about 1 in 5 individuals who menstruate experience heavy menstrual bleeding and can place patients at risk for anemia and other health impacts, and heavy bleeding may be worsened by anticoagulation—creating foreseeable inpatient need for sufficient menstrual products during acute illness;[4,5,20] and

Whereas, “period poverty” affects 1 in 4 teens and 1 in 3 adults in the United States and is associated with stigma, barriers to accessing products, and harmful coping strategies (e.g., prolonged use or makeshift substitutes), which can lead to negative health and psychosocial consequences;[6,7,8] and

Whereas, individuals experiencing homelessness report insufficient and inconsistent access to menstrual products, including gatekeeping distribution systems that provide limited quantities only upon request—illustrating how “ask-based” models can fail even when a supply exists;[9] and

Whereas, hospital-based quality improvement studies demonstrate that menstrual hygiene products are not routinely available as standard inpatient supplies, with the majority of healthcare staff reporting inadequate provision for patients and many individuals lacking immediate access to products when needed, indicating systemic gaps in hospital care;[19] and

Whereas, federal tax guidance recognizes menstrual care products as reimbursable/qualified medical expenses (including pads, tampons, liners, and cups), supporting the position that these products function as health-related supplies rather than discretionary consumer goods;[11,12] and

Whereas, hospital participation requirements and accreditation frameworks emphasize patient rights, privacy, dignity, and comfort; CMS interpretive guidance grounds privacy requirements in the patient’s right to “respect, dignity, and comfort,” and The Joint Commission includes a right to an environment that preserves respect and dignity;[13,14,15] and

Whereas, despite the absence of standardized national reporting, available studies and institutional reports consistently demonstrate that menstrual product provision is not universally

implemented across U.S. hospitals and is often inconsistent or dependent on staff discretion; and

Whereas, published hospital-focused quality-improvement and inpatient reports describe gaps in menstrual product provision (including not being supplied or being available only as "emergencies"), while also demonstrating that structured interventions can improve staff knowledge and product availability;[16,17] therefore be it

RESOLVED, that our American Medical Association advocate with relevant interested parties for implementation of menstrual hygiene product availability at no cost to hospitalized patients who menstruate. (Directive to Take Action)

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

Date Received: 9/3/26

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RELEVANT AMA POLICY

Considering Feminine Hygiene Products as Medical Necessities H-525.974
"Our American Medical Association encourages the Internal Revenue Service to classify feminine hygiene products as medical necessities…""Encourages the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers."
[Res. 218, A-18; Modified: Res. 209, I-21]

Increasing Access to Hygiene and Menstrual Products H-525.973
"Our AMA encourages public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students."
[Res. 209, I-21]

Tax Exemptions for Feminine Hygiene Products H-270.953
"Our AMA supports legislation to remove all sales tax on feminine hygiene products."
[Res. 215, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907
(I-26)

Introduced by: Medical Student Section, American College of Physicians, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Affirming Support for the National Institutes of Health Advisory Councils

Referred to: Reference Committee K

Whereas, the Department of Health and Human Services (HHS), including the National Institutes of Health (NIH) and the National Science Foundation (NSF), is a major source of funding for biomedical science and training of physicians, scientists, and physician scientists[1]; and

Whereas, the NIH is comprised of 21 institutes, of which all 21 institutes and 3 of its centers have their own advisory council, and the NSF is governed by the National Science Board and advised by 12 nonstatutory advisory committees[2-4]; and

Whereas, membership on these councils, boards, and committees has been decreasing because terms are ending without appropriate replacements, the dissolution of certain councils, committees, and boards, or the termination of the individuals serving on these councils, committees, and boards[2-4]; and

Whereas, the entirety of the National Science Board was fired this year, all NSF external advisory committees were dissolved, over half of the NIH Advisory Councils will lose all their members by the end of 2026, and only 9 institutes and centers have more than half of their allotted voting members[2-4]; and

Whereas, no grants can be funded without approval from the council; therefore, without voting members, no research funding can be disbursed to institutions across the United States, severely impacting physicians, physician-scientists, and patients[2,5]; and

Whereas, while the vetting of voting members is a lengthy process that is essential to mitigate conflicts of interest, maintain ethical standards, and ensure research funding allocation is scientifically sound and aligns with public interest, recent appointments to other HHS advisory councils, such as the CDC's Advisory Committee on Immunization Practices, have been rushed and have fully bypassed the vetting process[2,6]; and

Whereas, in determining which advisory council nominees will be terminated, White House staffers reportedly often screened candidates for involvement in diversity, equity, and inclusion initiatives or for harboring negative views of the federal government online[7,8]; therefore be it

RESOLVED, that our American Medical Association supports initiatives to ensure continuity and stability in scientific advisory councils, including the timely and appropriate replacement of members on NIH Advisory Councils and review panels, as well as other HHS agencies, with equally qualified members to prevent the delay, interruption, or cessation of HHS-funded research initiatives (New HOD Policy); and be it further

RESOLVED, that our AMA opposes the active removal of qualified scientists from NIH advisory councils and review panels, as well as qualified leaders in other HHS agencies, without documented proof of wrongdoing or misconduct in accordance with established federal or state legal statutes. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

NIH Grant Funding for Medical Research D-460.961

1. Our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and relevant stakeholders to oppose arbitrary and unilateral caps on indirect costs, including facilities and administrative reimbursements, in federal grants (including NIH grants and other governmental funding agencies) or any funding policy that restricts critical early-stage and independent research as well as grant-funded training programs.
2. Our AMA will work with the National Institutes of Health (NIH), other governmental funding agencies, and relevant stakeholders to protect the ability of research institutions to negotiate indirect cost rates to ensure the sustainability of federally funded biomedical research.
3. Our AMA will advocate for targeted reforms to streamline administrative and regulatory requirements in order to achieve sustainable cost reductions while preserving essential research infrastructure.

Opposing Unwarranted National Institutes of Health Research Institute Restructuring D-460.960

1. Our American Medical Association advocates for an independent NIH reorganization advisory commission composed of interested parties, including physicians, scientists, researchers, academics, and patient advocacy organizations, to ensure that any proposed restructuring of the NIH is guided by medical, scientific, and public health expertise and serves the best interests of patients and the scientific community
2. Our AMA advocates against reorganization or consolidation of the NIH when such action:
    a. lacks transparency or is implemented without meaningful input from the biomedical research and physician communities; and
    b. results in a reduction of funding that jeopardizes ongoing or long-term research through premature cancellation of grants, contracts, or programs essential to public health, biomedical innovation, or patient care.

3. Our AMA supports study of the short- and long-term impacts of federal biomedical research funding reductions, including medical innovation, the healthcare workforce, medical education, public health and local economies and communities.
4. Our AMA publicly opposes the reduction of research funding and funding opportunities from the NIH.

Funding of Biomedical, Translational, and Clinical Research H-460.926
Our AMA: (1) reaffirms its long-standing support for ample federal funding of medical research, including basic biomedical research, translational research, clinical research and clinical trials, health services research, outcomes research, and prevention research; and (2) encourages the National Institutes of Health, the Agency for Healthcare Research and Quality and other appropriate bodies to develop a mechanism for the continued funding of translational research.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908
(I-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

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

Referred to: Reference Committee K

Whereas, patients with sickle cell disease and other blood disorders such as transfusion-dependent thalassemia require regular, ongoing transfusion support, making access to safe, compatible blood an essential component of care[1,2]; and

Whereas, red blood cell alloimmunization is substantially more common in patients with sickle cell disease and increases the risk of hemolytic transfusion reactions while making identification of compatible red blood cell units more difficult[3]; and

Whereas, evidence shows that robust red blood cell phenotyping and transfusion of red blood cells with similar antigenic profiles leads to lower rates of erythrocyte alloimmunization in sickle cell disease and thalassemia spectrum disorders[4-8]; and

Whereas, insurance coverage for red blood cell molecular testing remains unpredictable, with some payers excluding routine pre-transfusion use, which may limit consistent access to recommended transfusion support for patients with sickle cell disease and other transfusion-dependent conditions[9,10]; and

Whereas, access to phenotype-matched blood for patients with sickle cell disease depends in part on the availability of racially and ethnically diverse blood donors, as compatible units are more often identified from donors of similar genetic background[11]; and

Whereas, despite efforts to recruit donors from diverse racial and ethnic backgrounds, there remains a large gap in both the recurrent donor pool and the availability of properly matched and phenotyped blood[12-13]; therefore be it

RESOLVED, that our American Medical Association supports expanding recruitment and retention of racially and ethnically diverse blood donors to improve access to phenotype-matched blood for high-needs patients, including those with sickle cell disease, while supporting scientifically based policies that ensure a safe national blood supply. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

H-50.977 - Blood Donor Recruitment

- Our AMA supports national efforts to recruit and retain blood donors to ensure a safe and sufficient blood supply.

H-370.974 - Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors

- Our AMA supports efforts to increase the number of all potential bone marrow donors registered in national bone marrow registries, especially minority donors, to improve the odds of successful HLA matching and bone marrow transplantation.

H-460.881 - Increasing Diversity in Stem Cell Biobanks and Disease Models

- Our AMA encourages research institutions and stakeholders to re-evaluate recruitment strategies and materials to encourage participation by underrepresented populations.
- Our AMA strongly encourages institutional biobanks to collect racially and ethnically diverse samples such that future induced pluripotent stem cell disease models better represent the population.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909
(I-26)

Introduced by: Medical Student Section, Texas

Subject: Public Emergency Alert Reporting Requirements on Private Platforms

Referred to: Reference Committee K

Whereas, mass casualty events, including natural disasters, are occurring with increasing frequency, underscoring the need to continually evaluate and strengthen existing public emergency alert systems, including mobile public alert and warning technologies[1]; and

Whereas, the loss of experienced operators and federal funding has led to failures in the timely utilization of integrated emergency warning systems, including at least 15 federally declared major disasters since 2016, during which officials in the most-harmed communities failed to send alerts over FEMA's Integrated Public Alert & Warning System (IPAWS), resulting in significant morbidity, mortality, and community losses[2-5]; and

Whereas, leading up to the catastrophic Texas floods that killed 78 people on July 4th, 2025, emergency alerts were delayed due to understaffing and federal funding cuts to the National Weather Service, or were posted later to private social media platforms including Facebook and X (formerly Twitter) and were inaccessible without a user account[5-8]; and

Whereas, social media platforms are increasingly used as real-time sources of emergency information and as a form of redundancy, thereby increasing the likelihood that individuals will see time-sensitive information during disasters; and

Whereas, emergency management agencies at the federal, state, and local levels increasingly use social media to disseminate preparedness, mitigation, and recovery information, as well as to communicate directly with the public, expanding beyond traditional one-way communication models[9]; and

Whereas, although social media platforms can facilitate rapid communication during emergencies, they introduce challenges related to message consistency and information verification, and emergency announcements are increasingly disseminated through private, account-restricted platforms that may require account creation, be subject to algorithmic filtering or content moderation, or experience outages[2,10-13]; and

Whereas, although social media platforms provide valuable tools for risk communication, evidence demonstrates they are not designed to function as primary emergency alert systems and are most effective when used in conjunction with traditional, universally accessible communication methods[12]; and

Whereas, social media platforms have raised public concern for restricting access to critical information or removing emergency-related content due to platform policies[14,15]; and

Whereas, the American Medical Association has historically supported policies that promote equitable access to health information, public health communication infrastructure, and digital

health equity, supporting advocacy for transparency and accessibility standards in systems that impact health outcomes[16-18]; therefore be it

RESOLVED that our American Medical Association encourages collaboration between public health agencies, emergency management systems, and private technology companies to improve the reliability, accessibility, and transparency of emergency information dissemination across both public alert systems and digital platforms. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

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

1. Our AMA supports government efforts to:
    a. coordinate and integrate federal medical and public health disaster response entities such as the Medical Reserve Corps, National Disaster Medical System, Public Health Services Commissioned Corps (PHSCC), as well as state-to-state sponsored Emergency Management Compact Systems, to strengthen health system infrastructure and surge capacity for catastrophic disasters (Incidents of National Significance) as defined by the Department of Homeland Security's (DHS) National Response Plan (NRP); and
    b. place all federal medical and public health disaster response assets (with the exception of the Department of Defense) under authority of the Secretary of the Department of Health and Human Services (DHHS) to prevent significant delays and ensure coordination during a catastrophic disaster (Incident of National Significance).
2. Our AMA will monitor progress in strengthening federal disaster medical and public health response capacity for deployment anywhere in the nation on short notice, and report back as appropriate. [BOT Rep. 3, A-07,Reaffirmed in lieu of Res. 218, I-15,Modified: CSAPH Rep. 01, A-25]

Emergency Preparedness D-130.974

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910
(I-26)

Introduced by: Underrepresented in Medicine Advocacy Section, American Association of Public Health Physicians, American Academy of Addiction Psychiatry

Subject: Consolidating and Modernizing AMA Policy on Alcohol Excise Taxation

Referred to: Reference Committee K

Whereas, the American Medical Association currently maintains two policies on alcohol taxation: H-30.939, "Increasing Taxes on Alcoholic Beverages," and H-30.932, "Increasing Taxes on Alcoholic Beverages"; and

Whereas, alcohol use is a leading preventable cause of death and contributes substantially to morbidity, mortality, and health care costs in the United States;[1-3] and

Whereas, extensive scientific evidence demonstrates that increases in alcohol excise taxes reduce alcohol consumption, alcohol-related harms, and associated health care costs and are the most cost-effective population-level interventions to reduce alcohol-related harm;[4-8] and

Whereas, alcohol-related harms are dose-dependent and include increased risks of cancer, liver disease, cardiovascular disease, violence, injury, and other adverse health outcomes, even at moderate levels of consumption;[9-12] and

Whereas, alcohol excise taxes have failed to keep pace with inflation in most jurisdictions, resulting in declining real tax rates and increasing affordability of alcoholic beverages over time;[13] and

Whereas, current alcohol excise tax structures often tax alcoholic beverages differently based on beverage type rather than ethanol content, resulting in inconsistent taxation of equivalent amounts of ethanol and reducing the public health effectiveness of alcohol pricing policies;[14-15] and

Whereas, the World Health Organization, Organisation for Economic Co-operation and Development, and other public health experts recommend volumetric (ethanol-based) taxation and complementary minimum unit pricing to reduce alcohol-related harm;[14-16] and

Whereas, dedicating a meaningful portion of alcohol tax revenues, where feasible, to prevention, treatment, recovery support, and other public health programs can improve health equity and public acceptability of alcohol tax policies; and

Whereas, the AMA has previously consolidated and modernized alcohol policy, including H-30.940, "Supporting Labeling and Dietary Guideline Clarity for Alcoholic Beverages," to reflect emerging scientific evidence and evolving public health priorities; and

Whereas, recent state-level legislative efforts demonstrate renewed momentum for alcohol excise tax reform and underscore the need for updated, evidence-based AMA policy;[17] therefore be it

RESOLVED, that our American Medical Association support increases in federal excise taxes on beer, wine, and distilled spirits, with a meaningful portion of new revenues, where feasible, dedicated to evidence-based prevention of alcohol-related harms, treatment and recovery services for alcohol use disorder, and public health and medical services in communities disproportionately affected by alcohol-related harm (New HOD Policy); and be it further

RESOLVED, that our AMA encourage increases in state and local excise taxes on alcoholic beverages, with a meaningful portion of new revenues, where feasible, reinvested in evidence-based alcohol prevention, treatment, recovery, and community health initiatives (New HOD Policy); and be it further

RESOLVED, that our AMA support coordinated state and local alcohol tax policies that increase the price and reduce the affordability of alcoholic beverages, particularly products with high ethanol content (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with other national and state organizations committed to reducing alcohol-related harm, including national medical specialty societies, public health associations, injury prevention groups, consumer health advocates, and medical alliance organizations (New HOD Policy); and be it further

RESOLVED, that our AMA, when state legislative efforts to increase alcohol taxes are unsuccessful, encourage state medical societies to consider ballot initiatives or other democratic mechanisms, where permitted by state law, to advance evidence-based alcohol tax policy (New HOD Policy); and be it further

RESOLVED, that our AMA affirm that alcohol excise taxes at the federal, state, and local levels should be based on the grams of ethanol in a beverage rather than its volume or type (e.g., beer, wine, or liquor), to ensure tax fairness, public health impact, and consistency with global recommendations (New HOD Policy); and be it further

RESOLVED, that our AMA support indexing alcohol excise taxes to inflation to preserve their real value and ensure sustained public health benefit over time (New HOD Policy); and be it further

RESOLVED, that our AMA support the use of complementary pricing policies, such as minimum unit pricing (MUP), to reduce the availability of inexpensive, high-alcohol-content beverages that disproportionately contribute to high-risk alcohol use (New HOD Policy); and be it further

RESOLVED, that our AMA oppose efforts by the alcohol industry to weaken or fragment alcohol tax policy through beverage-specific exemptions, preferential or disproportionately low tax rates, or promoting misleading narratives about economic harm (New HOD Policy); and be it further

RESOLVED, that our AMA recognize alcohol excise taxation as a cost-effective population-level strategy to reduce alcohol consumption and related morbidity, mortality, and social harms, improve health outcomes, and help offset the public costs attributable to alcohol use (New HOD Policy); and be it further

RESOLVED, that our AMA rescind policies H-30.939 and H-30.932. (Rescind HOD Policy)

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

Received: 09/14/2026

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RELEVANT AMA POLICY

Increasing Taxes on Alcoholic Beverages D-30.995
Our AMA will: (1) support increases in federal taxes on beer, wine, and liquor, with a substantial portion of the new revenues to be earmarked to the prevention of alcohol abuse and drunken driving, treatment of persons with alcohol use disorders or at-risk drinking patterns, and public health and medical programs that serve vulnerable populations; (2) encourage state and local increases in taxes on beer, wine, and liquor, with a substantial portion of the new revenues to be earmarked to the purposes noted above; (3) support, to the extent possible, state and local efforts to increase taxes on beer, wine, and liquor; (4) collaborate with other national organizations with an interest in this subject, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, Mothers Against Drunk Driving, and the AMA Alliance; and (5) when state legislative efforts to increase alcohol taxes are stymied, encourage state medical societies to give consideration to the use of ballot initiatives in the states that allow such initiatives.

Increasing Taxes on Alcoholic Beverages H-30.939
It is AMA policy that federal, state, and local tax rates on alcoholic beverages be based on the grams of ethanol present in the beverage, not on the fluid volume of beverages such as beer, wine, and distilled spirits.

Supporting Labeling and Dietary Guideline Clarity for Alcoholic Beverages H-30.940
1. Our AMA:
    a. supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol.
    b. supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors.

   c. urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels.
   d. urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.
2. Our AMA:
   a. expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol.
   b. recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant people, as well as the dangers of irresponsible use to all sectors of the populace).
   c. recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof).
3. Our AMA actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA
   a. supports federal and/or state oversight for all forms of alcohol advertising.
   b. supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse.
   c. opposes any form of advertising which links alcoholic products to agents of socialization in order to promote drinking.
   d. will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems.
   e. urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications.
   f. urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on school campuses and in advertising in school publications.
4. Our AMA:
   a. urges producers and distributors of alcoholic beverages to discontinue all advertising directed toward youth, including promotions on high school and college campuses.
   b. urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance).
   c. supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking.
   d. commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.
5. Our AMA supports federal and state legislation and regulations requiring standardized, front-of-package labeling on all alcoholic beverages that discloses:
   a. the number of standard drinks per container and aligns with current guidelines on alcohol consumption; and
   b. the best available science, including appropriate acknowledgment of alcohol’s causal link to cancer and the evidence that the risk of harm increases with greater alcohol consumption.
6. Our AMA supports legislation and regulations ensuring:
   a. alcohol labeling is presented with sufficient prominence, legibility, and design features, such as minimum font size, and color contrast, and optional pictorial elements, to enhance readability and support informed decision-making across populations; and
   b. clear, evidence-based point-of-sale warning signage in physical and digital retail environments where alcohol is sold.

7. Our AMA supports extending alcohol labeling requirements to “non-alcoholic” or “zero proof” beverages that are manufactured, packaged, or marketed in a manner similar to alcoholic beverages, to ensure consistent transparency regarding alcohol content.
8. Our AMA continues to strongly urge the Dietary Guidelines Advisory Committee to explicitly warn about the risks of alcohol consumption and its relationship to certain cancers and other diseases and affirm that there is no safe threshold for alcohol consumption.
9. Our AMA will submit a public comment in response to the Alcohol and Tobacco Tax and Trade Bureau’s proposed rule on Alcohol Facts Statements, calling for labeling standards that include standard drink information, health risk disclosures, consumer-centric design, and harmonization with federal dietary guidance and emerging public health evidence.
10. Our AMA supports research and evaluation initiatives to determine the impact of alcohol warning labels and signage on consumer knowledge and behavior, health outcomes, and alcohol sales patterns, with ongoing assessment to ensure future labeling interventions are evidence-informed and population-appropriate.
11. Our AMA advocates 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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912
(I-26)

Introduced by: American Academy of Ophthalmology

Subject: Reducing Medical Waste Through Electronic Instructions for Use (e-IFU) for Surgical and Medical Device Products

Referred to: Reference Committee K

Whereas, the global healthcare system accounts for creating 4.4% of global greenhouse gas emissions; and

Whereas, the World Health Organization has identified climate change as a leading threat to global health, with the National Academy of Medicine launching an Action Collaborative on Decarbonizing the U.S. Health Sector focused on the health care supply chain; and

Whereas, paper Instructions for Use (IFU) packaged with surgical instruments, implants, and medical devices across all surgical specialties generate substantial unnecessary paper, plastic, and packaging waste; and

Whereas, the IFUs are infrequently needed for reference in the operating room by trained surgical teams performing routine procedures; and

Whereas, in ophthalmology cataract surgery creates a significant carbon footprint, due to its high prevalence globally with one study estimated that a single cataract surgery creates 181.8 kg CO_2eq, which amounts to an estimated 728 million kg CO_2eq in the United States each year; and

Whereas, over 30 million cataract surgeries are performed globally each year, and analyses have shown that IFU booklets and device packaging account for a disproportionate share of total surgical waste relative to the devices they accompany; and

Whereas, the American Academy of Ophthalmology, the American Society of Cataract and Refractive Surgery, and the European Society of Cataract and Refractive Surgeons documented that transitioning from paper IFU to electronic IFU (e-IFU) would result in significant reductions in greenhouse gas emissions, paper waste; and

Whereas, the transition would also decrease manufacturing and shipping costs, and that 95% of manufacturers surveyed considered e-IFU an acceptable alternative to paper IFU; and

Whereas, electronic IFU offer meaningful advantages over paper IFU including real-time version control, searchability, enlarged display capability, multilingual accessibility, and ease of access prior to procedures; and

Whereas, the U.S. Federal Food, Drug, and Cosmetic Act already permit IFU for devices used in health care settings be made available solely by electronic means; and

Whereas, surveys demonstrate that ophthalmic surgeons and nurses overwhelmingly support reducing unnecessary operating room waste; and

Whereas, the primary barrier to broader e-IFU adoption is varying and inconsistent IFU requirements across countries, a barrier that coordinated regulatory action could meaningfully address; therefore be it

RESOLVED, that our American Medical Association encourage manufacturers of surgical and medical device products across all surgical specialties to replace paper Instructions for Use (IFU) with electronic Instructions for Use (e-IFU) when feasible, consistent with patient safety and applicable regulatory requirements (New HOD Policy); and be it further

RESOLVED, that our AMA advocate to the U.S. Food and Drug Administration and relevant federal agencies to clarify and expand the regulatory pathway under the Federal Food, Drug, and Cosmetic Act permitting e-IFU for surgical and medical device products, and to reduce inconsistent international IFU requirements that impede manufacturer adoption of e-IFU (Directive to Take Action); and be it further

RESOLVED, that our AMA share findings from published multisociety research on e-IFU with all AMA specialty sections and encourage interprofessional dialogue on sustainable device packaging practices, with the goal of developing a unified, cross-specialty position supporting e-IFU adoption across medicine. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9-15-26

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RELEVANT AMA POLICY

H-135.938 Global Climate Change and Human Health
Our AMA supports educating the medical community on the potential adverse public health effects of global climate change; encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability; supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. [CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

D-135.966 Declaring Climate Change a Public Health Crisis
Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. Our AMA will protect patients by advocating for policies that reduce U.S. greenhouse gas emissions and support rapid implementation of clean energy solutions. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. [Res. 420, A-22; Appended: CSAPH Rep. 02, I-22; Appended: BOT Rep. 11, I-24]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate
Our AMA supports advocacy for environmental sustainability in health care and climate-related health initiatives, including efforts to reduce the environmental footprint of health care delivery and the healthcare supply chain. [Res. 924, I-16; Reaffirmation I-19; Modified: Res. 415, A-24; Appended: Res 907, I-24; Appended: Res. 415, A-26]

H-135.973 Stewardship of the Environment
Our AMA supports physician education and stewardship of the environment, recognizing the relationship between environmental health and human health, and supports efforts to reduce waste, emissions, and environmental harm arising from health care activities. [CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16; Modified: Res. 414, A-24; Appended: Res. 420, A-25]

H-115.994 Prescription Product Labeling
Our AMA will advocate that the FDA work to establish a process whereby official labeling can be updated in a more expeditious fashion when new evidence becomes available, and that evidence-based standards can guide administration and usage. This policy supports the principle that product labeling -- including for medical devices -- should be modernized to reflect current evidence and best practices. [Sub. Res. 30, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 505, A-15; Reaffirmed: CSAPH Rep. 01, A-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

RESOLUTION 913 HAS BEEN WITHDRAWN

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-26)

Introduced by: Endocrine Society, American College of Obstetricians & Gynecologists, American Society for Reproductive Medicine, American Association of Clinical Endocrinology, Resident and Fellow Section

Subject: National Strategy to Close the Women's Health Gap

Referred to: Reference Committee K

Whereas, women make up more than half of the U.S. population, yet women's health research remains underfunded and clinical outcomes for women lag behind men[1]; and

Whereas, Congress took an important step in 1993 by requiring the inclusion of women in National Institutes of Health (NIH) funded clinical research through the NIH Revitalization Act. However, significant gaps remain in women's health research, clinical care, and implementation[2]; and

Whereas, NIH grant funding has steadily increased FY 2013–FY 2023 in both dollars spent and the number of projects funded. However, just 8.8% of NIH grant funding was directed towards women's health research during the same period[3]; and

Whereas, sex-specific research, as well as research into conditions that may differentially impact women (sex as a biological variable) continue to face funding gaps resulting in delayed diagnoses and poorer health outcomes for women[4]; and

Whereas, this underinvestment impacts women across the lifespan and health conditions, impacting the patient-physician relationship across specialties[5]; and

Whereas, the Society for Women's Health Research (SWHR), the American College of Obstetricians & Gynecologists (ACOG), and the Women First Research Coalition (WFRC) established a shared framework for a National Strategy to Close the Women's Health Gap,[6] calling for a federal investment in research and innovation, regulatory coordination and modernization, data and evidence infrastructure, bolstering the women's health clinical and research workforce, and for public awareness and education; and

Whereas, the national strategy proposes $7 billion for research and innovation, $1 billion for regulatory coordination and modernization, $4 billion for data and evidence infrastructure,$7 billion for bolstering the women's health clinical and research workforce, and $1 billion for public awareness and education for a total of $20 billion[7]; and

Whereas, Congress can help improve health outcomes for women, families, and communities while reducing long-term health care costs, strengthening the physician-scientist workforce, and advancing the nation's economic productivity; therefore be it

RESOLVED, that our American Medical Association endorse the national effort supported by over 50 medical organizations, national patient advocacy, and nonprofit organizations to make a

$20 billion, 10-year strategic commitment to close the women's health gap (New HOD Policy); and be it further

RESOLVED, that our AMA urge Congress to pass legislation that aligns with the national strategy to close the women's health gap (New HOD Policy); and be it further

RESOLVED, that our AMA address the urgent need for women's health research and adopt the national strategy in their federal policy priorities (Directive to Take Action); and be it further

RESOLVED, that our AMA amend H-525.988, Sex and Gender Differences in Medical Research by addition at the end as follows:

(10) supports strengthened coordination across the federal research agencies to inform our understanding of sex differences and women's health, including establishment of a women's health interdisciplinary fund; and

(11) advocates for a robust and sustained clinical and research workforce, including the creation and expansion of pathways to support early- and mid-career investigators within the women's health research workforce.

(Modify Current HOD Policy)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/16/26

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RELEVANT AMA POLICY

H-525.988 Sex and Gender Differences in Medical Research

Our AMA:

(1) reaffirms that gender and sex exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;

(2) affirms the need to include people of all sexes and gender identities and expressions in studies that involve the health of society at large and publicize its policies;

(3) supports increased funding into areas of women's health and sexual and gender minority health research;

(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minority communities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minority individuals from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;

(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and

(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minority individuals;

(7) supports the FDA’s requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women and sexual and gender minority populations;
(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender minority populations when those groups were not adequately represented in clinical trials; and
(9) supports and encourages the National Institutes of Health and other grant-making entities to fund post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women and sexual and gender minority populations in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events. [Res. 80, A-91Appended: CSA Rep. 4, I-00Modified: CSAPH Rep. 1, A-10Reaffirmed: CSAPH Rep. 05, A-16Modified: Res. 004, A-23Modified: CSAPH Rep. 04, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915
(I-26)

Introduced by: American Epilepsy Society, American Academy of Neurology

Subject: Ensuring Expert and Lived Experience Input in Federal National Health Plans

Referred to: Reference Committee K

Whereas, federal national health plans can coordinate research, clinical care, public health activities, services, and other federal efforts addressing complex diseases and health conditions; and

Whereas, the development and implementation of effective national health plans benefit from scientific expertise, clinical experience, and direct understanding of the needs and priorities of people affected by the diseases and conditions those plans are intended to address; and

Whereas, the National Alzheimer's Project Act established an Advisory Council on Alzheimer's Research, Care, and Services to advise the Secretary of Health and Human Services and inform the development and annual updating of the National Plan to Address Alzheimer's Disease; and

Whereas, the Alzheimer's Advisory Council includes non-federal representation from health care providers, researchers, patient advocates, caregivers, an individual diagnosed with Alzheimer's disease, and other relevant experts and organizations; and

Whereas, the Dr. Emmanuel Bilirakis and Honorable Jennifer Wexton National Plan to End Parkinson's Act established an Advisory Council on Parkinson's Research, Care, and Services to advise the Secretary of Health and Human Services, including on priority actions for the development and implementation of the National Plan to End Parkinson's; and

Whereas, the Parkinson's Advisory Council includes representation from people living with Parkinson's disease, a family caregiver, health care providers, biomedical researchers, physicians specializing in the treatment of Parkinson's disease and related conditions, nonprofit organizations, and relevant federal agencies; and

Whereas, Congress is currently considering the National Plan for Epilepsy Act, another bipartisan effort to improve federal coordination around a complex neurological condition, and the United States Senate unanimously passed S. 494 on August 4, 2026; and

Whereas, meaningful representation of physicians and other health care professionals, researchers, and people directly affected by a disease or condition can help ensure that federal national health plans reflect scientific evidence, clinical realities, and the needs and priorities of the populations they are intended to serve; therefore be it

RESOLVED, that our American Medical Association support meaningful representation of physicians and other health care professionals, researchers, and people with lived experience in the development, implementation, and evaluation of federal national plans addressing specific diseases and health conditions. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916
(I-26)

Introduced by:	American Psychiatric Association, National Medical Association, Underrepresented in Medicine Advocacy Section, American Academy of Child and Adolescent Psychiatry, American Academy of Addiction Psychiatry, American Association of Public Health Physicians, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, Resident and Fellow Section
Subject:	Opposition to Recreational Nicotine Products in Federal Correctional Facilities
Referred to:	Reference Committee K

Whereas, nicotine is a highly addictive substance, and nicotine pouches deliver nicotine through the oral mucosa and can produce nicotine dependence, cravings and withdrawal, as well as increased heart rate and blood pressure, nausea, dizziness, headache, and gastrointestinal symptoms, and oral irritation where the pouch repeatedly sits; and

Whereas, nicotine pouches can cause nicotine poisoning, particularly when multiple pouches are used or pouches are accidentally or intentionally ingested; and

Whereas, nicotine pouches are not Food and Drug Administration (FDA) approved for smoking-cessation medications or treatment of nicotine dependence; and

Whereas, in April 2006, the Federal Bureau of Prisons (FBOP) implemented evidence-based public health measures to reduce nicotine and tobacco-related disease within justice-involved populations by discontinuing the sale and use of smoked and smokeless tobacco products while continuing medically supervised tobacco cessation programs; and

Whereas, on May 15, 2026, FBOP issued Request for Information RFI_BOP_Nicotine_Pouches seeking vendors capable of supplying FDA-authorized nicotine pouch products for resale to incarcerated persons through the Bureau of Prisons Commissary Trust Fund at approximately 122 federal correctional institutions; and

Whereas, federal law prohibits the marketing of nicotine pouches subject to FDA tobacco-product jurisdiction, without authorization from the U.S. FDA, which may grant marketing authorization only when it determines that permitting the product to be marketed is appropriate for the protection of the public health; and

Whereas, on August 17, 2026, FBOP began selling a brand of nicotine pouches that did not appear on FDA's list of nicotine pouch products authorized for marketing in the United States; and

Whereas, FBOP policy limiting access to nicotine replacement products to physician-authorized smoking-cessation treatment, and the sale of recreational nicotine products represents a departure from that approach; and

Whereas, following questions regarding the regulatory status of the nicotine pouches being sold and consultation with the FDA, the FBOP suspended further purchasing and sales of the products on September 3, 2026, pending additional review; and

Whereas, incarcerated populations experience disproportionately high burdens of chronic disease, mental illness, substance use disorders, and tobacco dependence compared with the general population; and

Whereas, Black Americans, American Indian or Alaska Native persons, individuals with serious mental illness, and persons with substance use disorders are disproportionately represented in correctional settings and already experience significant disparities in nicotine and tobacco use, cardiovascular disease, pulmonary disease, and cancer outcomes; and

Whereas, although tobacco-free nicotine products do not expose users to the products of tobacco combustion, they are not risk-free, and while current evidence does not establish that nicotine pouches directly cause subsequent cigarette smoking, initiation of nicotine use among nicotine-naïve individuals may result in nicotine dependence and continued use of nicotine or other tobacco products; and

Whereas, correctional institutions provide a unique opportunity to initiate evidence-based tobacco dependence treatment because many individuals enter custody with limited access to preventive health care, making incarceration an important setting for reducing future morbidity and mortality rather than promoting or perpetuating nicotine dependence; and

Whereas, physicians have an ethical obligation to prevent disease, reduce exposure to addictive substances, and promote evidence-based treatment, and correctional health systems should prioritize prevention and treatment of nicotine dependence among populations already experiencing disproportionate burdens of cardiovascular disease, pulmonary disease, cancer, serious mental illness, and substance use disorders; therefore be it

RESOLVED, that our American Medical Association oppose the sale or distribution of recreational nicotine products within federal correctional facilities while supporting access to evidence-based, medically supervised treatment for tobacco and nicotine dependence (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the sale of any nicotine products that are not authorized FDA to be lawfully sold in the United States in correctional facilities (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the Federal Bureau of Prisons to evaluate and publicly report the health, fiscal, and health-equity impacts associated with the sale or proposed sale of recreational nicotine or tobacco products within federal correctional institutions (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the Federal Bureau of Prisons to provide evidence-based treatment for tobacco and nicotine dependence, including appropriate management of nicotine withdrawal (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that correctional health policies prioritize disease prevention, evidence-based tobacco dependence treatment, and long-term health outcomes over commissary revenue generated through the sale of recreational nicotine products. (Directive to Take Action)

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

Received: 9/16/26

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RELEVANT AMA POLICY

H-490.915 Tobacco Use in Prison Populations
Our AMA recognizes that anti-smoking policies applicable to the general population should apply equally to persons incarcerated in local jails, state prisons, and federal prisons; supports smoking cessation programs in correctional facilities; encourages physicians working in correctional settings to provide smoking cessation counseling; works through its representative to the National Commission on Correctional Health Care to make smoking cessation counseling a national standard for correctional medicine; supports smoke-free prison areas; and supports legislation banning smoking in prisons and jails. [CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24.]

H-490.917 Physician Responsibilities for Tobacco Cessation
Our AMA encourages physicians to use evidence-based clinical practice guidelines for treating tobacco dependence; supports physician counseling and treatment for tobacco dependence; encourages smoking cessation interventions at every patient encounter; supports collaborative approaches to identifying and treating tobacco dependence across all health care settings. [CSA Rep. 3, A-04; Appended: Res. 444, A-05; Reaffirmed: BOT Rep. 8, A-08; Reaffirmed in lieu of Res. 912, I-12; Reaffirmed: CSAPH Rep. 05, A-18.]

H-500.975 AMA Corporate Policies on Tobacco
Our AMA urges the federal government to reduce and control the use of tobacco and tobacco products; supports anti-tobacco health promotion; opposes tobacco industry influence on medicine and public health; and encourages tobacco-free public policy. [CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Reaffirmed: CSAPH Rep. 01, A-24]

Health Care While Incarcerated H-430.986
Our AMA supports linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 917
(I-26)

Introduced by:	American Academy of Dermatology, American Society for Dermatologic Surgery, American Contact Dermatitis Society, American College of Mohs Surgery, American Society of Dermatopathology, Society for Investigative Dermatology, Society for Pediatric Dermatology, American Society for Laser Medicine and Surgery, American Academy of Facial Plastic and Reconstructive Surgery, Maryland, District of Columbia, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Medical Student Section
Subject:	Modernizing Sunscreen Regulation to Advance Skin Cancer Prevention and Public Health
Referred to:	Reference Committee K

Whereas, skin cancer is the most common cancer in the United States, creating substantial morbidity, mortality, health care utilization, and economic burden, while ultraviolet radiation represents a major modifiable risk factor for melanoma and keratinocyte carcinomas; and

Whereas, comprehensive photoprotection, including regular use of broad-spectrum sunscreen, is an important component of evidence-based skin cancer prevention, and our American Medical Association already supports the development of sunscreens providing broad-spectrum protection against ultraviolet A (UVA) and ultraviolet B (UVB) radiation and public access to broad-spectrum sunscreen as part of a comprehensive skin cancer prevention strategy; and

Whereas, in June 2026, the U.S. Food and Drug Administration (FDA) approved the addition of bemotrizinol (BEMT), a high-molecular-weight, broad-spectrum, photostable ultraviolet filter with minimal systemic absorption and extensive international safety experience, to the over-the-counter sunscreen monograph, representing an important milestone in sunscreen innovation; and

Whereas; the approval of bemotrizinol, the first new sunscreen active ingredient added to the U.S. over-the -counter sunscreen monograph in more than two decades, demonstrates that rigorous scientific review and regulatory modernization can successfully expand consumer access while maintaining high standards for safety and effectiveness; and

Whereas, despite substantial advances in sunscreen technology internationally, until June 2026 FDA had not added a new sunscreen active ingredient to the over-the-counter sunscreen monograph since the late 1990s, limiting the range of ultraviolet filters available to U.S. consumers compared with those available in other countries; and

Whereas, Congress enacted the Sunscreen Innovation Act in 2014 to create an alternative pathway for review of sunscreen active ingredients, and subsequently modernized the broader over-the-counter drug review framework through section 505G of the Federal Food, Drug, and Cosmetic Act as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020, yet substantial regulatory barriers to sunscreen innovation persisted; and

Whereas, several sunscreen active ingredients have substantial histories of use outside the United States, and appropriately designed real-world evidence, observational data, international pharmacovigilance, published literature, and other scientifically valid evidence may provide important information regarding their safety, effectiveness, and performance in large and diverse populations; and

Whereas, FDA already recognizes real-world evidence as an important component of regulatory science and uses real-world data and evidence in regulatory decision-making across the lifecycle of medical products, including assessments of safety and effectiveness; and

Whereas, regulatory frameworks that appropriately incorporate high-quality real-world evidence and historical experience can complement traditional clinical studies while maintaining rigorous safety and effectiveness standards and potentially reducing unnecessary duplication of studies for products with substantial existing evidence; and

Whereas, for prospective sunscreen active ingredient applications federal sunscreen modernization efforts have recognized that appropriate non-animal testing methods, where accepted by FDA as scientifically valid, as an important component of a more efficient, contemporary evidentiary framework that maintains rigorous standards for safety and effectiveness; and

Whereas, the Supporting Accessible, Flexible, and Effective (SAFE) Sunscreen Standards Act, enacted in 2025, directs the Food and Drug Administration to modernize its review of sunscreen active ingredients by allowing appropriate consideration of real-world evidence, observational studies, and other scientifically valid evidence while preserving rigorous standards for safety and effectiveness; and

Whereas, the SAFE Sunscreen Standards Act further advances a modern regulatory framework that recognizes historical safety experience, promotes regulatory transparency and clearer evidentiary standards, and supports modern nonclinical testing methods to facilitate efficient evaluation of sunscreen active ingredients; and

Whereas, unnecessarily duplicative or uncertain regulatory requirements may discourage manufacturers from seeking U.S. authorization for sunscreen active ingredients with substantial international safety and effectiveness experience, limiting competition, product innovation, and consumer access; and

Whereas, access encompasses more than regulatory authorization, as consumers are more likely to use sunscreen consistently when products are affordable, cosmetically acceptable, appropriate for diverse skin types and tones, and available in formulations that patients are willing and able to use as recommended; and

Whereas, expanding the number of safe and effective sunscreen filters available to manufacturers may facilitate greater competition and innovation in broad-spectrum protection, formulation characteristics, tolerability, and cosmetic acceptability and thereby increase the range of evidence-based photoprotective options available to patients; and

Whereas, modernizing sunscreen regulation presents an opportunity to advance the shared goals of preventing cancer, reducing avoidable health care costs, supporting scientifically rigorous regulatory innovation, promoting competition, and improving access to effective preventive health products; therefore be it

RESOLVED, that our American Medical Association advocate for timely implementation of federal reforms modernizing United States Food and Drug Administration review of new sunscreen active ingredient applications, including appropriate consideration of real-world evidence, international safety and postmarket experience, and scientifically validated alternative testing methods as they become accepted for relevant over-the-counter topical drug safety endpoints, while maintaining rigorous standards for safety and effectiveness (Directive to Take Action); and be it further

RESOLVED, that our AMA support clear and efficient regulatory pathways and other policies that promote the development, evaluation, availability, and adoption of safe and effective broad-spectrum sunscreens in the United States (New HOD Policy); and be it further

RESOLVED, that our AMA support continued postmarket surveillance and real-world safety monitoring of newly approved sunscreen active ingredients as an integral component of a modernized regulatory framework. (New HOD Policy)

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

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RELEVANT AMA POLICY

H-55.972 Early Detection and Prevention of Skin Cancer

1. Our American Medical Association encourages all physicians to:
    a. perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday;

   b. examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer;
   c. urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and
   d. educate their patients concerning the correct way to perform skin self-examination.
2. Our AMA supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals.
3. Our AMA supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color.
4. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color. [CCB/CLRPD Rep. 3, A-14; Reaffirmed: CSAPH Rep. 0.1, A-24]

H-440.839 Protecting the Public from Dangers of Ultraviolet Radiation
1. Our AMA encourages physicians to counsel their patients on sun-protective behavior.

TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

SUNSCREENS. Our AMA supports: (a) the development of sunscreens that will protect the **skin** from a broad spectrum of ultraviolet radiation, including both UVA and UVB; and (b) the labeling of sunscreen products with a standardized ultraviolet (UV) logo, inclusive of ratings for UVA and UVB, so that consumers will know whether these products protect against both types of UV radiation. Terms such as low, medium, high and very high protection should be defined depending on standardized sun protection factor level.
2. Our AMA supports sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.
3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 403, A-14; Appended: Res. 404, A-19; Appended: Res. 905, I-19]

H-440.841 Permitting Sunscreen in Schools
1. Our AMA supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization.

2. Our AMA will work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs. [Res. 403, A-13; Appended: Res. 422, A-16]

H-100.980 Food and Drug Administration

1. Our American Medical Association policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible.
2. Our AMA:
    a. continues to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA;
    b. continues to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and
    c. continues to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively.
3. Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate. [Sub. Res. 548, A-92; BOT Rep. 32, A-95; BOT Rep. 18, A-96; Reaffirmed: BOT Rep. 7, I-01; Reaffirmation I-07; Reaffirmed: Sub. Res. 504, A-10; Reaffirmation A-15; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: CMS Rep. 07, A-18; Reaffirmation: A-23]

H-100.992 FDA

1. Our American Medical Association reaffirms its support for the principles that:
    a. an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute;
    b. this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and
    c. any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. Our AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. [Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20; Reaffirmation: A-23]

H-270.956 Evidence-Based Standard Requirement for Governmental Regulation

Our American Medical Association supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded. [BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 918
(I-26)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Strengthening the Radiation Protection Standard

Referred to: Reference Committee K

Whereas, our American Medical Association has a previous directive from 2024 policy regarding safely decommissioning of nuclear power plants that reads as follows:

That our American Medical Association advocate for strict limitations of aerosol, soil and/or water radionuclide releases in the decommissioning of US nuclear power plants in order to protect health, particularly that of local vulnerable populations; and

Whereas, for over 50 years, the scientific community has recognized that all radioactive elements produced in nuclear development including uranium mining, nuclear power plants, and nuclear weapons development can cause cancers in humans, including lung cancer, bone cancer, thyroid cancer, adult leukemia, and childhood leukemia[1]; and

Whereas, while high-dose exposures to these materials are the most highly carcinogenic, any exposure to radiation carries some risk of cancer; infants in utero and young children are especially vulnerable to even low doses of radiation[2]; and

Whereas, the scientific consensus is that every additional exposure to radiation adds to the total risk for genetic damage and thus increases risk for blood cancers like leukemia; increased radiation exposure results in increased incidence of these diseases in exposed populations; for solid cancers, such as lung cancer, bone cancer, and thyroid cancer, the risk for cancer from radiation is directly proportional to cumulative exposure[3]; and

Whereas, according to the National Academy of Sciences and EPA[4], there is no safe level of radiation exposure: the likelihood of cancer is proportional to the radiation dose, a linear relationship: smaller doses produce smaller risks and higher doses, larger risks, but there is no threshold below which there are no risk; this is known as the “linear no threshold” or LNT model[5] of radiation exposure risk; and

Whereas, the current administration is weakening and even eliminating many safety regulations regarding radioactive exposures: in May 2025, President Trump issued an executive order calling for weakening the radiation protection standard[6]; in January 2026, Department of Energy (DOE) removed the ALARA principle[7] from all DOE regulations (ALARA is the principle of protecting workers and the public by keeping emissions of radiation as low as reasonably achievable[8]) ; and in March of 2026, the Department of Energy acknowledged also having changed safety guidance that included deleting hundreds of pages of requirements, constituting two thirds of former safety guidelines, including weakening or eliminating rules regarding training guards, securing nuclear material, and protections against groundwater contamination[9]; and

Whereas, a weakened safety standard and these amended rules potentially threaten the health, safety, security, and environmental protection of occupational workers and surrounding communities adjacent to nuclear reactors, nuclear mining operations, and waste sites; and

Whereas, the NRC's current exposure limit for the general public is: total effective dose equivalent to individual members of the public from the licensed operation does not exceed 100 millirem in a year, exclusive of the dose contributions from background radiation[10]; NRC's current regulatory permissible dose (less stringent than EPA's) for the public of 100 millirem/year received over a lifetime results in approximately a cancer risk of 1 in 100, which is 100 to 10,000 times higher than the standard acceptable risk range for all other carcinogens[11]; and

Whereas, current public radiation exposure limits are 35 years old and worker limits, two thirds of a century old; and

Whereas, in 1991, despite a report from the National Academies of Science and Medicine noting substantially increased radiation risks per unit dose and calling for a strengthening of the radiation standard, the NRC did not tighten permissible exposures even though decades ago, NRC conceded its radiation limits produced risks higher than standard allowable risks[12]; and

Whereas, the former director of EPA's Office of Radiation and Indoor Air, Ramona Trovato, issued this statement in 1997: "To put it bluntly, radiation should not be treated as a privileged pollutant. You and I should not be exposed to higher risks from radiation sites than we should be from sites which had contained any other environmental pollutant;"[13] and

Whereas, in July 2025, the nuclear industry proposed weakening the radiation standard to 10 rem/year for occupational workers and 500 mrem/year for the general public[14]; the implications of this proposed weakening of the radiation standard could include abandoning cleanup at highly contaminated Superfund sites like Hanford, Los Alamos and Oak Ridge; voiding cleanup obligations for abandoned uranium mines on tribal lands such as the Navajo Nation; abandoning cleanup of former Manhattan Project contamination sites like Westlake, MO; and decommissioned nuclear plants would be able to leave much of their radioactive contamination onsite and/or discharge into waterways; and

Whereas, for active nuclear power plants, a weakened standard could eliminate most controls for routine radioactive releases into air, rivers, lakes, and oceans; and

Whereas, a weakened standard could result in the potential authorization of high level waste repositories even if projected doses from leakage far exceed current limits; and

Whereas, given the serious risks to health, particularly to women, children, and infants in the womb, and to the environment,[16] the radiation protection standard should be markedly strengthened, both for the public and occupational workers; therefore be it

RESOLVED, that our American Medical Association oppose efforts to weaken evidence-based U. S. radiation protection standards that relate to industrial use and disposal of radioactive materials and advocate for strengthening evidence-based standards and advocate for effective enforcement to better protect the health of both the general public and occupational workers. (New HOD Policy)

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

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RELEVANT AMA POLICY

H-455.994 Risks of Nuclear Energy and Low-Level Ionizing Radiation

1. Our American Medical Association supports the following policy on nuclear energy and low-level ionizing radiation. Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution.
2. Research on Health Effects of Low Level Radiation: There should be a continuing emphasis on research that is capable of determining more precisely the health effects of low level ionizing radiation.
3. Uranium Mill Tailings: Uranium mill tailings should be buried or otherwise covered.
4. Radioactive Waste Disposal: There should be acceleration of pilot projects to evaluate techniques for the disposal of high-level radioactive wastes. The decommissioning of nuclear reactors is a source of nuclear waste which requires accelerated technological investigation and planning.
5. Occupational Safety: The philosophy of maintaining exposures of workers at levels "as low as reasonably achievable (ALARA)" is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA.
6. Minimizing Exposures to Radiation: Each physician should attempt to minimize exposures of patients to ionizing radiation in accord with good medical practice.
7. Radiation Exposure Standards: The present standards for exposure of populations to ionizing radiation are adequate for the protection of the public.
8. Emergencies and Governmental Readiness: Government agencies at all levels should be prepared to respond to nuclear energy-related emergencies. There is need for improved public planning by the several federal agencies involved, including the Federal Emergency Management Agency (FEMA) and the agencies of state and local governments. Responsible officials should develop skills and undergo periodic retraining in order to be able to act appropriately during major radiation emergencies. Because emergency planning is a complex task involving aspects of health as well as problems related to utilities, state and local governments and the federal government (FEMA) would benefit from the cooperation of physicians and others in the health sciences.
9. Federal Radiation Emergency Planning Responsibilities: Federal groups such as the NRC and FEMA must work together closely to fulfill responsibilities in radiological emergency preparedness and in

crisis management. There is a need for NRC and FEMA to define better the roles of community hospitals and of physicians.

10. Reactor Operators and Radiation Inspectors: There is a need for better training of operating personnel with regard to prevention and management of untoward reactor operating conditions. Selection, training, and ongoing performance evaluation of operating personnel, and of radiation inspectors, are key elements in the safety of reactor workers and of the public. Physicians should help develop methods of selecting and evaluating personnel in the nuclear power industry.

11. Radiation Training for Physicians: Physicians should be prepared to answer the questions of their patients about ionizing radiation, especially if there is a radiation emergency. Each hospital should have adequately trained physicians and a plan and protocol for receiving and caring for radiation victims.

12. Radiation Education for the Public: Further education of the public about ionizing radiation is recommended.

13. Location of Nuclear Reactors: All nuclear reactors built in the future should be placed in areas of low population density; present reactors located in low density areas should be managed so that the populations surrounding them remain small.

14. Multiple Sources of Power Generation: AMA recommends the use of a diverse set of electricity generating methods and a continuing emphasis on the conservation of energy.

15. X-Ray Security Scanners:

1. Our AMA believes that as of June 2013, no data exist to suggest that individuals, including those who are especially sensitive to ionizing radiation, should avoid backscatter security scanners due to associated health risks.

2. Our AMA supports the adoption of routine inspection, maintenance, calibration, survey, and officer training procedures meant to ensure that backscatter security scanners operate as intended.

16. Our AMA supports continued authorization of federal radiation exposure compensation programs and expanded program eligibility to downwind individuals, communities, and tribes affected by the ongoing environmental harms of historic atomic weapons testing, including, but not limited to, residents of areas affected by the test of the first atomic bomb in New Mexico and uranium miners employed between 1942 through 1990.

CSA Rep. A, A-81 Reaffirmed: CLRPD Rep. F, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CSAPH Rep. 1, A-11 Appended: CSAPH Rep. 4, A-13 Modified: CSAPH Rep. 8, A-23 Modified: Res. 435, A-24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 919
(I-26)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Association for Geriatric Psychiatry

Subject: Protecting the Use of Evidence-Based Psychotropic Medications for the Treatment of Psychiatric Conditions

Referred to: Reference Committee K

Whereas, psychiatric disorders constitute a major public health burden and are associated with substantial morbidity, mortality, disability, family disruption, and economic costs; and

Whereas, evidence-based psychotropic medications remain a cornerstone of treatment for many psychiatric disorders, including depressive disorders, bipolar disorder, schizophrenia spectrum disorders, anxiety disorders, and attention-deficit/hyperactivity disorder; and

Whereas, multiple studies have found psychotropic medications to be underrepresented among individuals who die by suicide[1,2]; and

Whereas, despite substantial evidence supporting the effectiveness of psychopharmacologic treatment, misinformation and disinformation regarding psychiatric medications continues to circulate in public and social media forums; and

Whereas, such misinformation and disinformation may contribute to treatment avoidance, premature discontinuation of medication, and increased stigma toward evidence-based mental health care; and

Whereas, recent national discussions regarding psychotropic medication safety have underscored the need for accurate, evidence-based information about psychiatric treatment[3,4]; and

Whereas, leading national psychiatric organizations have emphasized the importance of ensuring that public policy and public education regarding psychotropic medications remain grounded in scientific evidence and clinical expertise[3]; and

Whereas, ensuring that the public has access to balanced, scientifically accurate information regarding the risks, benefits, alternatives, and appropriate monitoring of psychotropic treatments would advance mental health literacy, support shared decision-making, and help combat misinformation and disinformation regarding psychiatric care; therefore be it

RESOLVED, that our American Medical Association, in collaboration with relevant stakeholders, will support the development of educational materials that clearly articulate the benefits, safety, and effectiveness of appropriately used psychotropic medications and non-medication psychotherapeutic interventions, to counter misinformation and disinformation about their safety and effectiveness (Directive to Take Action); and be it further

RESOLVED, that our AMA will support physicians and other health care professionals in effectively communicating to patients, families, policymakers, and the media about the safety and effectiveness of appropriately used psychotropic medications and non-medication psychotherapeutic treatments. (New HOD Policy)

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

Received: 9/16/26

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3. American Psychiatric Association. *Joint Statement on Federal Concerns About Psychotropic Medication Safety.* March 21, 2025. Available at: APA Joint Statement.
4. Executive Order 14212. *Establishing the President's Make America Healthy Again Commission.* February 13, 2025. Available at: Executive Order 14212.

RELEVANT AMA POLICY

D-345.967 Protecting Access to Evidence-based Psychotropic Medication for the Treatment of Pediatric Mental Illness

1. Our American Medical Association opposes limitations on access to psychotropic medication as part of a comprehensive mental health treatment plan.
2. 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.

[Res. 929, I-25]

H-60.905 Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children

1. Our AMA objects to policies separating undocumented, immigrant parents or guardians from children.
2. Our AMA only supports the practice of administering psychotropic drugs to immigrant children when there has been evaluation by appropriate medical personnel, and with parental or guardian consent or court order except in the case of imminent danger to self or others.
3. Our AMA (a) supports education for immigration officials regarding increased risk of sexual assault and sexual trauma amongst unaccompanied minor immigrant children, as well as the emotional decompensation in this immigrant population due to these abuses and other traumas, and (b) encourages policies designed to decrease incidence of sexual assault, increase reporting and timely access to treatment services, and decrease stress and emotional trauma.

[Res. 003, I-18]

H-220.930 Regulatory Standards Should be Evidence-Based

1. Ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence.
2. Require that appropriate citations(s) from the peer reviewed scientific literature be appended to the documentation for every clinical standard imposed on health care institutions and providers.

[Res. 727, A-10; Reaffirmed: BOT Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21]

H-373.995 Government Interference in Patient Counseling

1. Our American Medical Association vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.

2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use their medical judgment as to the information or treatment that is in the best interest of their patients.

3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

[Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19]

H-270.956 Evidence-Based Standard Requirement for Governmental Regulation
Our American Medical Association supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded.
[BOT Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21]

D 440.914 Addressing Public Health Disinformation Disseminated by Health Professionals
1. Our American Medical Association will collaborate with relevant health professional societies and other stakeholders:
    a. On efforts to combat public health disinformation disseminated by health professionals in all forms of media.
    b. Address disinformation that undermines public health initiatives.
    c. Implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:

1. Maintaining our AMA as a trusted source of evidence-based information for physicians and patients.
2. Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.
3. Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
4. Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
5. Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.
6. Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
7. Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
8. Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.
9. Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions.

[Res. 411, I-21; Modified: BOT Rep. 15, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 920
(I-26)

Introduced by: LGBTQ+ Section, American College of Obstetricians and Gynecologists

Subject: Improving Protection for Patient Medical Records and Health Care

Referred to: Reference Committee K

Whereas, our AMA has long held that gender-affirming care is evidence-based, medically necessary care, and Policy H-185.927 commits our AMA to "opposing any criminal and legal penalties against patients seeking gender-affirming care, family members or guardians who support them, and health care facilities and clinicians who provide gender-affirming care," while Policy H-185.950 supports coverage of treatment for gender dysphoria as recommended by a patient's physician; and

Whereas, protected health information is increasingly being sought as an investigative tool against gender-affirming care: beginning in 2025 the U.S. Department of Justice served more than 20 subpoenas on hospitals, clinicians, and clinics providing such care to minors, demanding not only clinical and billing records but patient-identifying data including names, dates of birth, home addresses, and Social Security numbers[1]; and

Whereas, multiple federal district courts (including in Massachusetts, Washington, and Pennsylvania) have quashed these subpoenas as serving improper purposes rather than legitimate law-enforcement ends, and a coalition of 21 state attorneys general has opposed them as "an unjust attack on the privacy of transgender adolescents and a threat to effective healthcare," confirming both the reality of the threat and the vulnerability of patient records to it[2, 3]; and

Whereas, the confidentiality of medical records is a foundational ethical duty of the physician, and the credible prospect that a patient's PHI may be used to investigate or penalize them, their families, or their physicians deters patients from seeking care and chills clinicians from providing it, damaging the physician-patient relationship irrespective of any ultimate legal outcome; and

Whereas, existing federal privacy protections do not fill this gap: the 2024 HIPAA Privacy Rule to Support Reproductive Health Care Privacy was vacated nationwide in Purl v. U.S. Department of Health and Human Services (2025), and even while in effect it did not extend to gender-affirming care, leaving information about gender-affirming care without the targeted protection our AMA already seeks for reproductive health information, despite both facing the same category of politically motivated efforts to weaponize medical records[4]; therefore be it

RESOLVED, that our American Medical Association oppose governmental efforts to compel the disclosure of identifiable patient medical records from physicians or health care institutions when such efforts are primarily directed at investigating or deterring the provision of otherwise ethical, evidence-based medical care and lack a compelling patient safety or public health justification (New HOD Policy); and be it further

RESOLVED, that our AMA advocate that governmental requests for identifiable patient medical records in connection with investigations of clinical care be narrowly tailored, supported by an

individualized legal basis, and implemented in a manner that minimizes unnecessary intrusion into patient privacy and the patient-physician relationship (New HOD Policy); and be it further

RESOLVED, that our American Medical Association amend Policy D-315.966, "Improving Protection for Reproductive Health Information," by addition to read as follows:

1. Our American Medical Association supports legislation and regulations prohibiting the use or disclosure of protected health information (PHI) to conduct a criminal, civil, or administrative investigation into or to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health and gender-affirming care.
2. Our AMA advocates to ensure that the release of protected health information of a decedent to forensic pathologists be unimpeded by unnecessary administrative burdens. (Modify Current HOD Policy)

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

Received: 09/16/2026

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3. Attorney General Bonta Challenges U.S. DOJ's Continued Attempts to Subpoena Hospitals' Gender-Affirming Care Records. State of California - Department of Justice - Office of the Attorney GeneralDecember 4, 2025. Accessed September 16, 2026. https://oag.ca.gov/news/press-releases/attorney-general-bonta-challenges-us-doj%E2%80%99s-continued-attempts-subpoena-hospitals
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RELEVANT AMA POLICY

Clarification of Evidence-Based Gender-Affirming Care H-185.927
(1) Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
(2) Our AMA will work with state and specialty societies and other interested stakeholders to:
a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, gender-affirming care and patients who seek and/or receive such care, as well as their parents and guardians; and
d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
(3) Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.
[Res. 05, A-16 Modified: Res. 015, A-21 Modified: Res. 223, A-23 Appended: Res. 304, A-23 Reaffirmed: CSAPH Rep. 08, A-24 Reaffirmed: BOT Rep. 23, I-24]

Removing Financial Barriers to Care for Transgender Patients H-185.950
Our American Medical Association supports public and private health insurance coverage for evidence-based gender-affirming care as recommended by the patient's physician.
[Res. 122A-08 Modified: Res. 05, A-16 Reaffirmed: Res. 012, A-22 Modified: BOT Rep. 23, I-24]

Improving Protection for Reproductive Health Information D-315.966
1. Our American Medical Association supports legislation and regulations prohibiting the use or disclosure of protected health information (PHI) to conduct a 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.
2. Our AMA advocates to ensure that the release of protected health information of a decedent to forensic pathologists be unimpeded by unnecessary administrative burdens.
[Res. 007, I-25]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 921
(I-26)

Introduced by: LGBTQ+ Section

Subject: Transgender and Gender Diverse Cancer Research

Referred to: Reference Committee K

Whereas, data related to cancer incidence in transgender and gender diverse (TGD) patients are often limited[1]; and

Whereas, TGD patients have additional considerations related to non-hormonal cancers due to modifiable risk factors exacerbated by social determinants of health[2]; and

Whereas TGD patients currently undergoing gender-affirming hormone treatment have additional considerations related to hormonal cancers[3]; and

Whereas current inadequate Sexual Orientation and Gender Identity (SOGI) data collection standards for cancer studies result in underrepresentation for TGD patients[4, 5]**;** therefore be it

RESOLVED, that our American Medical Association support improved data collection for transgender/gender diverse patients by research bodies, while maintaining appropriate privacy protections (New HOD Policy); and be it further

RESOLVED, that our AMA support research to understand the correlations, risks and protective factors associated with hormone treatment and hormone-related cancer incidence as well as hormone treatment and non-hormone related cancer incidence for all individuals including transgender and gender diverse people (New HOD Policy); and be it further

RESOLVED, that our AMA support research regarding improved cancer detection and prevention measures for transgender and gender diverse people, taking care to consider the unique social determinants of health and systematic barriers experienced by transgender and gender diverse individuals. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 09/16/2026

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RELEVANT AMA POLICY

Improving Usability of Electronic Health Records (EHRs) for Transgender and Gender Diverse Patients H-65.929
Our American Medical Association supports the use of the term “chosen name” over “preferred name,” recognizing its importance to transgender and gender-diverse patients.
Our AMA acknowledges the evolving nature of language and engage appropriate collaborators to ensure the continued relevance and accuracy of terminology used across AMA resources and advocacy. [BOT Rep. 10, I-25]

Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training D-460.966
Our AMA will work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations. [Res. 02, I-19]

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Our AMA supports preservation and maintenance of federal and state public funding for physicians and institutions engaged in clinical care, research, and medical education regarding LGBTQ+ populations. [CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17 Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18; Reaffirmed: CSAPH Rep. 08, A-24; Appended: Res. 413, A-25]

Encouraging Research Into the Impact of Long-Term Administration of Hormone Replacement Therapy in Transgender Patients H-460.907
Our American Medical Association encourages research into the impact of long-term administration of hormone replacement therapy in transgender patients. [Res. 512, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Encouraging LGBTQ+ Representation in Medicine D-200.972
Our American Medical Association will advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity.
Our AMA encourages the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured.
Our AMA will work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities. [Res. 004, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 922
(I-26)

Introduced by: Resident and Fellow Section, Underrepresented in Medicine Advocacy Section

Subject: Eliminating Tax Barriers to Equitable Clinical Trial Participation

Referred to: Reference Committee K

Whereas, clinical trials are essential to advancing medical knowledge, improving patient outcomes, and ensuring equitable as well as timely access to innovative therapies[1-2]; and

Whereas, although clinical trial participants may receive modest financial compensation to help offset the burdens of participation, such as transportation, time away from work, childcare, and other incidental costs, the limited duration of a trial means this participation does not qualify as a regular or continuous activity for tax purposes and thus is not tax deductible as trade or business expenses[3-5]; and

Whereas, payments to clinical trial participants are generally modest (typically small, fixed stipends or expense reimbursements that offset the time, travel, childcare, and other incidental costs of participation) and are not designed to generate financial gain, serve as wages, or act as a primary source of income; rather their purpose is to ease the burden of participation and promote equitable enrollment, but these payments are currently treated as taxable income under the broad Internal Revenue Code definition of gross income as “all income from whatever source derived”[3-6]; and

Whereas, the classification of clinical trial compensation as taxable income creates an often-overlooked structural barrier to participation, particularly among historically marginalized populations, and may deter or prevent enrollment[3,5,7]; and

Whereas, prospective data demonstrate that patients with lower annual household income are significantly less likely to participate in cancer clinical trials, with those earning less than $50,000 annually having approximately 32% lower odds of participation compared to higher-income patients, highlighting the impact of financial barriers on equitable trial access[8]; and

Whereas, because clinical trial compensation is treated as reportable income, it poses disproportionate risks for low-income individuals and people who rely on public assistance such as Medicaid, Supplemental Security Income, and/or the Supplemental Nutrition Assistance Program, which have income-based eligibility thresholds, so even modest trial payments can reduce benefit amounts or jeopardize eligibility for essential benefits[5]; and

Whereas, existing federal policy provides only limited and narrowly defined income exclusions: the Ensuring Access to Clinical Trials Act of 2015 made permanent a $2,000-per-year exclusion for clinical trial compensation, but only applies to trials for rare diseases or conditions and only to the Medicaid and Supplemental Security Income programs, was never indexed to inflation, and does not address barriers for participants with more prevalent conditions or those relying on other means-tested benefits, which is insufficient to prevent loss of benefits or meaningfully mitigate participation barriers[5,9]; and

Whereas, financial disincentives, including taxation, contribute to persistent underrepresentation of historically marginalized populations in clinical trials, undermining the generalizability, equity, and scientific validity of clinical research[3,5,10]; and

Whereas, compensation for clinical trial participation is distinct from earned income and should be considered reimbursement or burden-offset support rather than taxable wages[3,4,5,11]; and

Whereas, the taxation of clinical trial-related compensation imposes a disproportionate financial burden on low- and middle-income individuals, thereby exacerbating existing inequities and serving as a structural barrier to equitable participation in clinical research[3,5,10,12]; therefore be it

RESOLVED, that our American Medical Association support exempting clinical trial participant compensation from taxable income and public assistance eligibility determinations, recognizing such payments as reimbursement rather than wages, to promote equitable participation in clinical research. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 09/16/26

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RELEVANT AMA POLICY

Supporting Diversity in Research H-460.875

1. Our American Medical Association supports the use of language interpreters and translators at no cost to individual physicians or practices in clinical trials and health research participation to promote equitable data collection and outcomes.

2. Our AMA encourages Institutional and Research Review Boards (IRBs) to develop and publish standardized guidelines for interpreter services to ensure appropriate enrollment and ongoing participation of clinical research participants with Limited English Proficiency and Deaf or Hard of Hearing people.

3. Our AMA encourages Institutional and Research Review Boards (IRBs) to develop and publish transparent guidelines for improving the diversity of research participants, including:
    a. that eligibility criteria be as inclusive as possible; and
    b. that written justification for exclusion be provided for review; and
    c. that additional accommodations for potential enrollees be considered.
4. Our AMA supports greater inclusion in clinical trials and health research of all peoples and groups that are underrepresented or excluded from such research to promote greater study generalization, health equity, and justice.
5. Our AMA supports community-centered engagement before, during, and after clinical trials and health research to foster and sustain public trust in medicine and science.
6. Our AMA encourages that all study protocols involving human research participants include appropriate funding to support the inclusion of underrepresented and excluded populations.

Increasing Diversity in Stem Cell Biobanks and Disease Models H-460.881
1. Our American Medical Association encourages research institutions and stakeholders to re-evaluate recruitment strategies and materials to encourage participation by underrepresented populations.
2. Our AMA strongly encourages institutional biobanks to collect racially and ethnically diverse samples such that future induced pluripotent stem cell disease models better represent the population.

Sex and Gender Differences in Medical Research H-525.988
Our AMA:
(1) reaffirms that gender and sex exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;
(2) affirms the need to include people of all sexes and gender identities and expressions in studies that involve the health of society at large and publicize its policies;
(3) supports increased funding into areas of women's health and sexual and gender minority health research;
(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minority communities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minority individuals from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;
(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative; and
(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minority individuals;
(7) supports the FDA’s requirement of actionable clinical trial diversity action plans from drug and device sponsors that include women and sexual and gender minority populations;
(8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing studies which evaluate the efficacy and safety of those products in women and sexual and gender minority populations when those groups were not adequately represented in clinical trials; and
(9) supports and encourages the National Institutes of Health and other grant-making entities to fund post-market research investigating pharmacodynamics and pharmacokinetics for generic drugs that did not adequately enroll women and sexual and gender minority populations in their clinical trials, prioritizing instances when those populations represent a significant portion of patients or reported adverse drug events.

Increasing Diversity in Stem Cell Biobanks and Disease Models H-460.881
1. Our American Medical Association encourages research institutions and stakeholders to re-evaluate recruitment strategies and materials to encourage participation by underrepresented populations.
2. Our AMA strongly encourages institutional biobanks to collect racially and ethnically diverse samples such that future induced pluripotent stem cell disease models better represent the population.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 923
(I-26)

Introduced by: Resident and Fellow Section, Underrepresented in Medicine Advocacy Section, Washington

Subject: Research the Community Health Impacts of Data Centers

Referred to: Reference Committee K

Whereas, data centers, also known as server farms, are large-scale industrial facilities that power augmented intelligence (AI), cloud services (email, storage), and applications, with more than 50% owned and operated by major corporations incl Amazon, Microsoft, and Google[1-3]; and

Whereas, there is growing bipartisan concern about the impacts of data centers on communities and the environment[4-8]; and

Whereas, data centers strain local electrical infrastructure that often utilize fossil fuels[1,8-11]; and

Whereas, data centers require substantial water resources for cooling and often depend on non-renewable energy generation, contributing to water scarcity, thermal pollution, and contamination in surrounding communities, particularly in water-stressed regions such as California, Arizona, and Texas[12-18]; and

Whereas, data centers, especially ones using non-renewable energy sources such as natural gas, diesel, and fossil fuels, contribute to local air pollution including particulate matter (PM) and nitrogen oxides, which are associated with increased incidence and exacerbation of respiratory diseases such as asthma[19-21]; and

Whereas, data centers may also contribute to soil and water contamination through fuel storage and generator systems, cooling water discharge, chemical use (e.g., biocides and corrosion inhibitors), and battery storage infrastructure, resulting in potential release of hydrocarbons, heavy metals, and other toxic substances that may impact groundwater, surface water, and surrounding ecosystems[22-30]; and

Whereas, data centers, through heating, ventilation, and air conditioning systems and diesel/gas generators, contribute to local noise pollution, often above the 85 dBA threshold considered harmful to hearing[1,3,31-33]; and

Whereas, data centers powered by fossil fuel sources, including natural gas turbines and diesel generators, emit fine particulate matter and nitrogen oxides that are associated with increased incidence and exacerbation of respiratory diseases such as asthma, and this burden falls disproportionately on communities of color, who live near EPA-regulated data centers in greater proportions than the national median and face levels of particulate matter, nitrogen dioxide, and diesel particulate matter above national averages[23,26,34-37]; therefore be it

RESOLVED, that our American Medical Association study and report on the public health impacts of data center development, including effects on air quality, water resources, soil contamination, energy infrastructure, noise exposure, and health equity. (Directive to Take Action)

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

Received: 09/16/2026

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RELEVANT AMA POLICY

Noise Pollution H-440.864
Our AMA recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure. [Sub. Res. 417, A-08; Reaffirmation A-16]

Pollution Control and Environmental Health H-135.996
Our AMA supports
1. efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and
2. its present activities in pollution control and improvement of environmental health.
[Sub. Res. 40 A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

AMA Position on Air Pollution H-135.998
Our AMA urges that:
1. Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.
2. Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.
3. Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.
4. Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

[BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19]

Air Pollution and Public Health H-135.941
Our AMA supports increased physician participation in regional and state decision-making regarding air pollution across the United States.
[Res. 408, A-08; Reaffirmed in lieu of Res. 509 A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Air Pollution and Public Health D-135.985
Our American Medical Association promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states. Our AMA will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies.
[Res. 408, A-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 01, A-24]

Declaring Climate Change a Public Health Crisis D-135.966
Our American Medical Association declares climate change a public health crisis that threatens the health and well-being of all individuals. Our AMA will protect patients by advocating for policies that:
- Limit global warming to no more than 1.5 degrees Celsius.
- Reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050.
- Support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge and making a commitment to lower its own greenhouse gas emissions.
Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
Our AMA supports the use of international, federal, regional, and state carbon pricing systems as an important tool to reduce global greenhouse gas emissions and achieve net-zero targets. Our AMA recommends that carbon dividends or energy subsidies for low-income households be a key component of any established carbon pricing system, to reduce the potential economic burden on households with lower incomes.
[Res. 420, A-22; Appended: CSAPH Rep. 02, I-22; Appended: BOT Rep. 11, I-24]

Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997
Our American Medical Association will advocate for the greater public and private funding for research into the environment causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease.
Our AMA asks the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues.
Our AMA encourages federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities.
Our AMA will lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
[Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19; Modified: Res. 415, A-23]

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969
Our American Medical Association, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.

[BOT Rep. 34, A-18; Reaffirmed: CSAPH Rep. 2, I-22]

Clean Air H-135.979
Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.
[Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Clean Air H-135.991
(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.
[BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-003; ReaffirmationI-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14; Modified: CSAPH Rep. 01, A-24]

Federal Clean Air Legislation H-135.984
1. Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health.
2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA's Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act.
[Res. 142, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 917, I-18]

Furthering Environmental Justice and Equity H-135.905
Our American Medical Association supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or those that have been impacted by other discriminatory development, loan servicing, and building practices with full participation by the community residents in these decisions.
Our AMA supports measures to protect frontline communities from the health harms of proximity to historical and current harmful industrial and mining operations, including fossil fuel extraction, refining and combustion, and large-scale agriculture, such as using the best available technology to reduce local pollution exposure, or health safety buffers from industrial operations.
Our AMA supports prioritizing greenspace access and tree canopy coverage for communities that received a "D" rating from the Home Owners' Loan Corporation, otherwise known as being "redlined," or that have been impacted by other discriminatory development and building practice, thereby protecting residents of these communities from displacement.
[Res. 416, A-24 → Modified: CSAPH Rep. 07, A-25]

EPA and Green House Gas Regulation H-135.934
1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.

2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification. [Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 924
(I-26)

Introduced by: Resident and Fellow Section

Subject: Ensuring Evidence-Based Nutrition Guidance in Public Health and Clinical Practice

Referred to: Reference Committee K

Whereas, the American Medical Association has adopted multiple policies supporting improved nutrition standards in schools, food assistance programs, and food labeling systems– including H-150.960, H-150.936, H-150.930, H-150.948, D-440.978, and D-150.978– which emphasize improving the nutritional quality of foods available to the public but rely substantially on federal nutrition standards and guidelines to define what constitutes healthy food, creating potential challenges for physicians and public health programs when those federal standards does not fully reflect the strongest or most current scientific evidence (H-150.960, H-150.936, H-150.930, H-150.948, D-440.978, D-150.978)[1]; and

Whereas, nutrition recommendations play an essential role in the prevention and management of chronic diseases including cardiovascular disease, diabetes, obesity, and other diet-related conditions, and therefore require careful evaluation of high-quality scientific evidence to guide clinical and public health decision-making[2-6]; and

Whereas, the development of dietary guidelines has historically relied on rigorous, multi-year structured evidence evaluation processes, including those conducted through the United States Department of Agriculture (USDA) Nutrition Evidence Systematic Review process and the Dietary Guidelines Advisory Committee, which synthesize rigorous nutrition science to inform public health recommendations[7-11]; and

Whereas, the USDA and U.S. Department of Health and Human Services appoint national experts to the Dietary Guidelines Advisory Committee, with extensive background checks for financial and ethical conflicts of interest, who then review nutrition science using rigorous protocol-driven methods and with input from other scientific organizations and public comment, with the aim of increasing public trust in U.S. nutrition policy[12-13]; and

Whereas**,** professional organizations such as the American Society for Nutrition and the Academy of Nutrition and Dietetics represent leading scientific and clinical communities dedicated to advancing nutrition research and translating scientific evidence into clinical and public health practice guidance[14-16]; and

Whereas, the 2025–2030 Dietary Guidelines for Americans (DGAs) introduced substantial departures from the rigorous processes and recommendations of the 2020-2025 and other prior DGAs, and from the 2025 Dietary Guidelines Advisory Committee Scientific Report, including rejection of most (30 of 56) recommendations from the Dietary Guidelines Advisory Committee, that prompted the creation of a separate report entitled “The Scientific Foundation for the Dietary Guidelines for Americans”[17-21]; and

Whereas, the new 2025–2030 DGAs encourage almost doubling protein intake from the existing Dietary Reference Intake of 0.8 grams of protein daily per kilogram of body weight to 1.2-1.6 g/kg, despite limited evidence that higher protein confers muscle or other health benefits in absence of regular strength training and concerns that excess dietary protein can be converted to fat by the liver, increasing visceral adiposity and diabetes risk[17,22-24]; and

Whereas, the new 2025-2030 DGAs rejected the Dietary Guidelines Advisory Committee recommendation to prioritize "plant-based" over "animal-based" protein sources due to established evidence base linking dietary patterns high in saturated fat and red meat with increased risk of cardiovascular disease, diabetes, and certain cancers, and instead, the DGAs promote higher intakes of animal-source proteins and full-fat dairy products[17,22,24]; and

Whereas, despite the aforementioned prior Dietary Guidelines Advisory Committee recommendation to prioritize "plant-based" over "animal-based" protein sources, the inverted food pyramid graphic that accompanies the new 2025–2030 DGAs visually promotes animal protein and saturated fat sources in the prominent upper-left position, while de-emphasizing legumes and nuts and leaving out soy, which is a major source of plant protein[17,25]; and

Whereas, the Physicians Committee for Responsible Medicine has filed a petition with the Offices of Inspector General for the Department of Health and Human Services and the U.S. Department of Agriculture requesting that the new 2025-2030 DGA be withdrawn and reissued due to concerns of industry influence[26]; and

Whereas, seven of the nine authors of the scientific report underlying the 2025-2030 DGA reported industry ties, including the Texas Beef Council, National Cattlemen's Beef Association, National Pork Board, National Dairy Council, and Atkins Nutritionals, which are organizations that would benefit from dietary guidelines that promote meat, dairy, and low-carbohydrate products)[27,28]; and

Whereas, the American College of Cardiology Nutrition & Lifestyle Work Group has published findings separating Evidence-Based 2025-2030 DGA Recommendations from other recommendations not supported by nutrition science[25]; and

Whereas, the Academy of Nutrition and Dietetics has also published a statement expressing concerns over the 2025-2030 DGAs' emphasis on butter, beef tallow, red meat, and full-fat dairy[29]; and

Whereas, the environmental implications and reduced carbon footprints of plant-forward versus animal-based diets are substantial, with modeling studies estimating that plant-based diets could reduce diet-related land use by 76%, diet-related greenhouse gas emissions by 49%, and water use by more than 10%[30,31]; and

Whereas, the DGAs influence numerous public programs—including school meal standards, nutrition assistance programs, military, and other institutional food procurement policies—which can affect the ability of physicians and other health professionals to provide consistent evidence-based nutrition counseling to patients and communities[1,29,32]; and

Whereas, physicians play an important role in communicating nutrition guidance to patients and the public and in countering health misinformation that may undermine evidence-based public health recommendations, and rely upon quality evidence-based dietary guidance to inform conversations with patients[1,22,33,34]; therefore be it

RESOLVED, that our American Medical Association advocates that nutrition recommendations used in clinical practice, state public health policy, and institutional nutrition programs be grounded in evidence-based science and informed by the scientific guidance (Directive to Take Action); and be it further

RESOLVED, that our AMA advocates for strengthened transparency, disclosure, and management of financial and non-financial conflicts of interest in the development of federal dietary guidelines and related scientific reports, including clear public reporting and exclusion of individuals with significant financial or industry-related conflicts of interest from decision-making roles. (Directive to Take Action)

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

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RELEVANT AMA POLICY

Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960

The AMA supports the position that primary and secondary schools should follow federal nutrition standards that replace foods in vending machines and snack bars, that are of low nutritional value and are high in fat, salt and/or sugar, including sugar-sweetened beverages, with healthier food and beverage choices that contribute to the nutritional needs of the students.

Support for Uniform, Evidence-Based Nutritional Rating System H-150.936

1. Our AMA supports the adoption and implementation of a uniform, nutritional food rating system in the US that meets, at a minimum, the following criteria: is evidence-based; has been developed without conflict of interest or food industry influence and with the primary goal being the advancement of public health; is capable of being comprehensive in scope, and potentially applicable to nearly all foods; allows for relative comparisons of many different foods; demonstrates the potential to positively influence consumers' purchasing habits; provides a rating scale that is simple, highly visible, and easy-to-understand and used by consumers at point of purchase; and is adaptable to aid in overall nutritional decision making.
2. Our AMA will advocate to the federal government - including responding to the Food and Drug Administration call for comments on use of front-of-package nutrition labeling and on shelf tags in retail stores - and in other national forums for the adoption of a uniform, evidence-based nutrition rating system that meets the above-referenced criteria.

National Nutritional Guidelines for Food Banks and Pantries H-150.930

Our AMA: (1) supports the use of existing national nutritional guidelines for food banks and food pantries and (2) will promote sustainable sourcing of healthier food options and the dissemination of user-friendly resources and education on healthier eating for food banks and food pantries.

Public Health Implications of US Food Subsidies H-150.915
Our AMA will study the public health implications of United States Food Subsidies, focusing on:
How these subsidies influence the affordability, availability, and consumption of various food types across different demographics.
Potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases.
Avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food.

Increasing Awareness of Nutrition Information and Ingredient Lists H-150.948
Our American Medical Association supports legislation or rules requiring restaurants, retail food establishments, and vending machine operators that have menu items common to multiple locations, as well as all school and workplace cafeterias, especially those located in health care facilities, to have available for public viewing ingredient lists, nutritional information, and standard nutrition labels for all menu items.

Culturally Responsive Dietary and Nutritional Guidelines D-440.978
1. Our AMA and its Minority Affairs Section will: (a) encourage the United States Department of Agriculture (USDA) to include culturally effective guidelines that include listing an array of ethnic staples and use of multicultural symbols to depict serving size in their Dietary Guidelines for Americans and Food Guide; (b) seek ways to assist physicians with applying the USDA Dietary Guidelines for Americans and MyPlate food guide in their practices as appropriate; (c) recognize that lactose intolerance is a common and normal condition among many Americans, especially African Americans, Asian Americans, and Native Americans, with a lower prevalence in whites, often manifesting in childhood; and (d) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care.
2. Our AMA will: (a) propose legislation that modifies the National School Lunch Act, 42 U.S.C. § 1758, so as to eliminate requirements that children produce documentation of a disability or a special medical or dietary need in order to receive an alternative to cow's milk; and (b) recommend that the U.S. Department of Agriculture and U.S. Department of Health and Human Services clearly indicate in the Dietary Guidelines for Americans and other federal nutrition guidelines that meat and dairy products are optional, based on an individual's dietary needs.

Sustainable Food D-150.978
1. Our American Medical Association supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality.
2. Our AMA supports sustained funding for evidence-based policies and programs to eliminate disparities in healthy food access, particularly for populations vulnerable to food insecurity, through measures such as tax incentive programs, community-level initiatives and federal legislation.
3. Our AMA will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

Reduction in Consumption of Processed Meats H-150.922
Our AMA supports: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for cardiovascular disease, type 2 diabetes, and cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption; and (4) educational programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives.

Food Environments and Challenges Accessing Healthy Food H-150.925
1. Our American Medical Association encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts.
2. Our AMA recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color.
3. Our AMA supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.
4. Our AMA will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options.

Food Additives H-150.998
1. Our American Medical Association supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market.
2. Our AMA advocates for the establishment of a joint task force comprising AMA representatives, FDA officials, USDA personnel, independent academic scientists, and relevant administration appointees to:
    a. Conduct a systematic review of food additives currently approved in the U.S. but banned or restricted in other nations
    b. Evaluate the scientific evidence regarding health impacts of these substances
    c. Develop a prioritized timeline for regulatory action on the most concerning additives
    d. Create transition pathways for food manufacturers to adopt safer alternatives.
3. Our AMA will monitor the implementation of any resulting food additive regulation policies and provide ongoing medical and scientific guidance to ensure reforms achieve meaningful public health improvements.

Public Health Implications of US Food Subsidies H-150.915
Our AMA will study the public health implications of United States Food Subsidies, focusing on:
1. How these subsidies influence the affordability, availability, and consumption of various food types across different demographics.
2. Potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases.
3. Avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 925
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers

Referred to: Reference Committee K

Whereas, the American Medical Association has longstanding policy opposing governmental interference in the physician-patient relationship and in the practice of medicine, including policies H-373.995, H-270.959, H-165.916, and H-5.989; and

Whereas, these policies should extend to governmental mandates requiring diagnostic testing that is not clinically indicated and/or that falls outside accepted standards of care; and

Whereas, government-mandated testing may create clinical and medicolegal concerns when it requires testing or follow-up outside the independent medical judgment of the physician and clinical team; and

Whereas, the U.S. Secretary of Defense has announced the implementation of a new screening program (starting on Wednesday, August 15, 2026) for testosterone deficiency among active duty servicemembers, stating that such screening is intended to enable troops to perform at their highest level; and

Whereas, the announced screening program would be conducted annually as part of required medical screenings for servicemembers aged 30 years and older, with servicemembers younger and 30 permitted to undergo testing on a voluntary basis, and with testosterone replacement therapy described as voluntary; and

Whereas, there may be clinical benefit to identifying asymptomatic men with low testosterone in appropriate circumstances; and

Whereas, testosterone testing is subject to biologic and analytic variability, and AMA policy H-260.963 recognizes the importance of educating clinicians regarding variability in testosterone assay accuracy; and

Whereas, broad screening may increase the risk of inappropriate self-treatment with unregulated supplements or hormones of uncertain safety, purity, quality, and efficacy; and

Whereas, patients and clinicians should be aware of frequent occurrences of both inaccurate herb labeling and of supplements containing active pharmaceuticals or other bioactive agents that are not identified on the label; and

Whereas, inappropriate testosterone use may result in adverse effects, including decreased sperm parameters, infertility, erythrocytosis/thrombotic risk, and unmasking subclinical prostate disease; and

Whereas, implementing an annual, mandatory diagnostic screening program across an entire eligible population—rather than testing directly by individualized clinical indication—carries substantial cost and resource implications, including downstream confirmatory testing, specialty referral, and long-term monitoring, without established evidence that population-wide mandatory screening is cost-effective compared to indication-based testing; therefore be it

RESOLVED, that our American Medical Association oppose mandatory, non-indication-based federal hormone screening programs, including policies requiring annual testosterone testing and affirms that hormone testing should be guided by individualized clinical judgment and evidence-based medical indications, rather than imposed through categorical or population-based mandates (New HOD Policy); and be it further

RESOLVED, that our AMA urge that proposals for federal testing of hormone levels (such as requiring annual testosterone testing of male active duty servicemembers aged 30 or older) should be evaluated for cost-effectiveness and resource stewardship, relative to indication-based clinical testing, including the downstream costs of confirmatory testing, specialty referral, and longitudinal monitoring, prior to implementation (New HOD Policy); and be it further

RESOLVED, that our AMA reaffirm policy H-260.963 and call for those principles to be applied to any federal hormone screening program, including the use of standardized, validated testosterone assays and clinician education on assay variability. (Reaffirm HOD Policy)

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

Received: 9/16/26

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RELEVANT AMA POLICY

Government Interference in Patient Counseling H-373.995

1. Our American Medical Association vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use their medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
    a. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
    b. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
    c. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
    d. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
    e. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
    f. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
    g. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Citation: Res. 201, A-11; Reaffirmed: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of: Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmed: A-19; Modified: Speakers Rep. 02, I-24

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our American Medical Association opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
    a. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
    b. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
    c. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
    d. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

Citation: Res. 523, A-06; Appended: Res. 706, A-13; Reaffirmed: Res. 250, A-22

Government Controlled Medicine H-165.916
Our AMA strongly reaffirms its unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care system to a government program with the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference.
Citation: Res. 141, I-93; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: A-97; Reaffirmed: I-00; Reaffirmed: A-02; Reaffirmed: I-07; Reaffirmed: A-09; Reaffirmed: I-09; Reaffirmed: CMS Rep. 01, A-19

Freedom of Communication Between Physicians and Patients H-5.989
It is the policy of our American Medical Association:
1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise their medical judgment as to what information or treatment is in the best interest of the patient.
2. working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship.
3. to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications.
4. to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients

Citation: Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13; Reaffirmed: CEJA Rep. 05, A-23; Modified: Speakers Rep. 02, I-24

Standardization of Testosterone Assays H-260.963
Our AMA: (1) supports efforts to standardize testosterone assays; (2) will work with the appropriate laboratory associations to increase use of analytic accuracy in testosterone assays; and (3) will work with other medical associations to educate clinicians about the variability of testosterone analytical accuracy.
Citation: Res. 921, I-10; Reaffirmed: CSAPH Rep. 01, A-20

Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing D-270.983
1. Our American Medical Association will ask the FDA to review the available evidence and other data on testosterone and submit updated recommendations, if warranted, to the DEA, for its consideration of the scheduling of testosterone-containing drug products.
2. Our AMA supports policies to remove barriers that delay or impede patient access to prescribed testosterone.
3. Our AMA will continue to work alongside our partner organizations to promote advocacy and physician education on testosterone prescribing.

Citation: Res. 519, A-23; Modified: CSAPH Rep. 08, A-24

Male Breast Cancer H-55.977
Our AMA:
1. recognizes that breast cancer is a condition that affects males as well as females;
2. recognizes that men who carry a known BRCA mutation, have a strong family history of cancer (especially male breast cancer), have a personal history of breast cancer, or have an altered estrogen-testosterone ratio are at increased risk of developing male breast cancer;
3. supports the utilization of heightened surveillance methods when indicated, and consideration of genetic testing when appropriate, in men who are at increased risk of developing breast cancer;
4. supports physician and patient education about the risks, signs, and symptoms of male breast cancer, and genetic consultation for males at increased risk and for their family members; and
5. supports Medicare and insurance coverage for male breast cancer surveillance and diagnostic methods, including clinical breast examination, mammography, genetic consultation, and genetic testing, when indicated.

Citation: CSAPH Rep. 2, A-09; Reaffirmed: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 926
(I-26)

Introduced by: New Jersey

Subject: Support for One Health Approaches to Protect Human, Animal, and Environmental Health

Referred to: Reference Committee K

Whereas, the One Health framework recognizes the interdependence of human, animal, and environmental health and promotes interdisciplinary collaboration among healthcare professionals, veterinarians, environmental scientists, public health agencies, and community partners; and

Whereas, emerging infectious diseases, antimicrobial resistance, vector-borne illnesses, climate-related health threats, environmental degradation, and biodiversity loss all demonstrate the need for coordinated, multisectoral approaches to prevention and response; and

Whereas, New Jersey is the first state to adopt by statute a One Health initiative which has established statewide One Health Task Force to advance interagency communication, data-sharing, research collaboration, and public engagement around cross-cutting health threats; and

Whereas, our American Medical Association has long supported evidence-based public health initiatives, preventive care, environmental health protections, and the strengthening of healthcare–public health partnerships including prior support for collaborations with veterinary medicine and for collaboration around zoonotic disease; and

Whereas, a One Health framework recognizes that health threats often arise from complex interactions beyond first-order zoonotic transmission, and that medical, veterinary, and environmental decisions are inseparable, such that pharmacologic and land-use choices made without ecological vigilance can reverberate through food systems and vector populations, ultimately impacting human maternal and child health (see case studies below); and

Whereas, recent and ongoing cuts to public health funding and data-sharing infrastructure have weakened surveillance, coordination, and response capacity for emerging zoonotic, environmental, and climate-related health threats, making it especially urgent for our AMA to articulate and advance a One Health approach that can help sustain integrated, cross-sector protections for patients and communities; and

Whereas, physicians and health systems are uniquely positioned to advocate for and participate in integrated responses to zoonotic disease surveillance, environmental monitoring, sustainable land use planning, and climate-resilient community health strategies; therefore be it

RESOLVED, that our American Medical Association, building on its prior study of the impact of zoonoses, will study the feasibility, structure, and potential impact of One Health initiatives that bring together medical, veterinary, environmental, academic, and community stakeholders to reduce shared health risks, with report back at A-27 (Directive to Take Action); and be it further

RESOLVED, that our AMA will assess opportunities and barriers to integrating One Health principles into medical education, residency training, and continuing medical education, including considerations of curricular feasibility, resource requirements, and measurable outcomes (Directive to Take Action); and be it further

RESOLVED, that our AMA develops model legislation for potential implementation of the One Health Initiative by states. (Directive to Take Action)

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

Received: 9/17/26

REFERENCES

1. See statutory language at N.J.S.A. 4:1-49, et seq.
2. https://www.who.int/health-topics/one-health#tab=tab_1
3. Case Study #1 In North America, the emergence of white-nose syndrome in bats has decimated local bat populations, removing a key natural predator of agricultural pests. As bat numbers collapsed, farmers in affected counties increased insecticide applications by roughly 31% to compensate, a shift associated with an approximately 8% rise in infant mortality, translating to more than 1,300 additional infant deaths in the United States between 2006 and 2017. Given established links between prenatal pesticide exposure and adverse pregnancy outcomes such as preterm birth, fetal growth restriction, and pregnancy loss, this chain of events illustrates how a fungal disease of bats can ultimately contribute to maternal and fetal complications through increased chemical exposures.
4. Bialek M, Ferranna M, Greenstone M. “Bats, Pesticides, and Infant Mortality.” (working paper; described in peer-reviewed outlets and under review). US bat decline triggered pesticide surge, 1,300 baby deaths
5.López-Hoffman L, Wiederholt R, Sansone C, et al. “Economic value of bats in agriculture: a review.” Annual Review of Ecology, Evolution, and Systematics. 2014;45: 239-259.
6.Reynolds HT, Ingersoll T, Barton HA. “Modelling the impact of white-nose syndrome on the population dynamics of the little brown bat.” Ecology. 2015;96(4): 1044-1054.
7. Woodruff TJ, Zota AR, Schwartz JM. “Environmental chemicals in pregnant women in the United States: NHANES 2003–2004.” Environmental Health Perspectives. 2011;119(6): 878-885.
8. Case Study #2 A parallel example comes from the Indian subcontinent, where widespread veterinary use of the nonsteroidal anti-inflammatory drug diclofenac in cattle led to catastrophic vulture declines exceeding 95% in some species. Vultures, highly efficient scavengers, had previously removed livestock carcasses rapidly; their loss left more carrion on the landscape, fueling a surge in feral dog populations and other scavengers. Dogs, in turn, are the primary vector for human rabies in India. Economic analyses attribute hundreds of thousands of excess human deaths over several years—driven by rabies and other sanitation-related infections—to this vulture collapse, with annual mortality damages estimated in the tens of billions of dollars.
9. Oaks JL, Gilbert M, Virani MZ, et al. “Diclofenac residues as the cause of vulture population decline in Pakistan.” Nature. 2004;427(6975): 630-633.
10. Green RE, Newton I, Shultz S, et al. “Diclofenac poisoning as a cause of vulture population declines across the Indian subcontinent.” Journal of Applied Ecology. 2004;41(5): 793-800.
11. Markandya A, Taylor T, Longo A, et al. “Counting the cost of vulture decline—An appraisal of the human health and other benefits of vultures in India.” Ecological Economics. 2008;67(2): 194–204.
12. Pain DJ, Bowden CGR, Cunningham AA, et al. “The race to prevent the extinction of South Asian vultures.” Bird Conservation International. 2008;18(S1): S30-S48.
13. Case Study #3 In the northeastern United States, declines in red foxes, linked to expansion of coyotes, reduced predation on small mammals that serve as key reservoirs for *Borrelia burgdorferi*, the agent of Lyme disease. A theoretical model and multi-state data suggest that reduced fox predation increased densities of infected nymphal ticks and Lyme disease risk, illustrating how changing predator communities can indirectly drive human vector-borne disease.
14. Levi T, Kilpatrick AM, Mangel M, Wilmers CC. Deer, predators, and the emergence of Lyme disease. Proc Natl Acad Sci U S A. 2012 Jul 3;109(27):10942-7.
15. Case Study #4 Studies in South Korea and South America indicate that higher predator species richness suppresses rodent reservoir populations and is associated with lower incidence of human hantavirus infections.
16. Spruill-Harrell B, Pérez-Umphrey A, Valdivieso-Torres L, Cao X, Owen RD, Jonsson CB. Impact of Predator Exclusion and Habitat on Seroprevalence of New World *Orthohantavirus* Harbored by Two Sympatric Rodents within the Interior Atlantic Forest. Viruses. 2021 Sep 29;13(10):1963.

RELEVANT AMA POLICY

AMA Policy Global Tracking System of Zoonotic Diseases D-440.940
Our AMA will work with the American Veterinary Medical Association and other relevant stakeholders to encourage the US Departments of Health and Human Services, Agriculture, Interior, and other appropriate federal and state agencies to take the lead in establishing a robust, coordinated, and effective global surveillance system of zoonotic diseases in humans and syndromic outbreaks in animals, thereby enhancing collaboration of human and animal health sectors and resulting in improved early detection and response. Policy Timeline Sub. Res. 519, A-10, Reaffirmed: CSAPH Rep. 04, A-19 Last Modified: 2019

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 927
(I-26)

Introduced by: New Jersey

Subject: Patient Safety and Clinical Authority in Deceased Organ Donation and Procurement

Referred to: Reference Committee K

Whereas, organ transplantation provides lifesaving and life-enhancing treatment for patients with end-stage organ disease, and a safe, ethical, and effective system of deceased organ donation and procurement is essential to patients awaiting transplantation; and

Whereas, recent federal oversight of organ donation and procurement has identified a concerning pattern of risk across organ procurement organizations involving inconsistent patient assessments, coordination of care, data collection, and lack of clarity regarding roles and responsibilities within the care team, prompting the Health Resources and Services Administration to direct the Organ Procurement and Transplantation Network to develop nationwide safety standards and policies to protect patients who may become organ donors; and

Whereas, AMA Code of Medical Ethics Opinion 6.1.2, “Organ Donation After Cardiac Death,” recognizes that efforts to increase the availability of organs for transplantation must be balanced against physicians’ duty to protect their individual patients and calls for appropriate clinical criteria, independence of decisions to withdraw life-sustaining treatment from decisions regarding organ donation, informed consent, and continued appropriate palliative care; and

Whereas, AMA Code of Medical Ethics Opinion 6.2.1, “Guidelines for Organ Transplantation from Deceased Donors,” provides that the physician’s primary concern must remain the well-being of the patient and calls for separation, to the greatest extent possible, between those providing end-of-life care and those retrieving or transplanting organs, exclusion of transplant team members from decisions to withdraw treatment or pronounce death, and determination of death by a physician not associated with the transplant team in accordance with accepted clinical and ethical standards; and

Whereas, the Organ Procurement and Transplantation Network is developing additional safeguards for donation after circulatory death, including proposed requirements for neurologic reassessment and processes to pause donation activities when changes in neurologic function, possible pain, or other patient-safety concerns arise; and

Whereas, as these national safeguards are developed and implemented, established principles of medical ethics provide an important foundation for ensuring that patients being evaluated for potential organ donation remain first and foremost patients, that clinical assessments and decisions regarding their care remain independent of organ procurement considerations, and that unresolved clinical concerns cannot be subordinated to the goal of organ procurement; and

Whereas, maintaining confidence among patients and families that potential donor status will not compromise patient care and that deceased organ donation and procurement are governed

by rigorous clinical and ethical safeguards is important to sustaining voluntary participation in organ donation; therefore be it

RESOLVED, that our American Medical Association advocate that national patient-safety standards governing deceased organ donation and procurement operationalize the primacy of the patient and the independence of clinical judgement by ensuring that:

1. clinical assessments and reassessments necessary for the care of the patient who is being evaluated for potential organ donation are conducted by appropriately qualified clinicians responsible for the patient's care, and remain that such assessments and reassessments shall be independent of organ procurement considerations; and
2. the respective roles, responsibilities, and clinical authority of the treating clinicians and the organ procurement personnel are clearly delineated, including authority for evaluating and resolving new or unresolved concerns regarding the patient's clinical condition or safety; and
3. when donation activities are paused because of new clinical findings, uncertainty regarding the patient's condition, or other patient-safety concerns, those donations activities shall not resume until the responsible treating clinicians have evaluated the concerns and determined that no unresolved clinical issue precludes continued progression through the donation pathway (Directive to Take Action); and be it further

RESOLVED, that our AMA actively engage with 1) the U.S. Department of Health and Human Services, including the Health Resources and Services Administration and the Centers for Medicare & Medicaid Services; 2) the Organ Procurement and Transplantation Network; and 3) the relevant physician, hospital, organ donation and transplantation, patient, and donor-family organizations. Such engagement shall be for the purpose of the development, implementation, and periodic review of national organ donation and procurement safety standards and advocacy for incorporation and maintenance of these safeguards. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/18/26

REFERENCES

1. HRSA, Strengthening Organ Donation and Procurement Safety — establishes the cross-OPO pattern of risk and nationwide policy response. https://www.hrsa.gov/optn/policies-bylaws/policy-issues/strengthening-organ-donation-and-procurement-safety HRSA/OPTN DCD Policy Proposal — establishes what reassessment and pause safeguards are currently being developed. https://www.hrsa.gov/sites/default/files/hrsa/optn/hrsa-directive-for-optn-dcd-policy-development-policy-proposal.pdf

2. HRSA Patient Safety Officer Directive, September 18, 2025 — establishes validated safety threats involving multiple OPOs. https://www.hrsa.gov/sites/default/files/hrsa/optn/9182025-letter-to-optn-re-patient-safety-officer-requirements.pdf

3. CMS QSO-26-05, March 11, 2026 — establishes existing federal duties of OPOs and donor hospitals and the continuing obligation to the patient. https://www.cms.gov/files/document/qso-26-05-opo-original-release-date-2026-03-11-pdf.pdf

4. HRSA January 2026 OPTN Modernization Update — establishes that broader national safety and quality standards are actively under development. https://www.hrsa.gov/optn-modernization/updates/january-2026?utm_source=chatgpt.com

RELEVANT AMA POLICY

1. Organ Donation After Cardiac Death 6.1.2
Increasing the supply of organs available for transplant serves the interests of patients and the public and is in keeping with physicians' ethical obligation to contribute to the health of the public and to support access to medical care. Physicians should support innovative approaches to increasing the supply of organs for transplantation but must balance this obligation with their duty to protect the interests of their individual patients.
Organ donation after cardiac death is one approach being undertaken to make greater numbers of transplantable organs available. In what is known as "controlled" donation after cardiac death, a patient who has decided to forgo life-sustaining treatment (or the patient's authorized surrogate when the patient lacks decision-making capacity) may be offered the opportunity to discontinue life support under conditions that would permit the patient to become an organ donor by allowing organs to be removed promptly after death is pronounced. Organ retrieval under this protocol thus differs from usual procedures for cadaveric donation when the patient has died as a result of catastrophic illness or injury.
Donation after cardiac death raises a number of special ethical concerns, including how and when death is declared, potential conflicts of interest for physicians in managing the withdrawal of life support for a patient whose organs are to be retrieved for transplantation, and the use of a surrogate decision maker.
In light of these concerns, physicians who participate in retrieving organs under a protocol of donation after cardiac death should observe the following safeguards:

(a) Promote the development of and adhere to clinical criteria for identifying prospective donors whose organs are reasonably likely to be suitable for transplantation.
(b) Promote the development of and adhere to clear and specific institutional policies governing donation after cardiac death.
(c) Avoid actual or perceived conflicts of interest by:

(i) ensuring that the health care professionals who provide care at the end of life are distinct from those who will participate in retrieving organs for transplant;
(ii) ensuring that no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.

(d) Ensure that the decision to withdraw life-sustaining treatment is made prior to and independent of any offer of opportunity to donate organs (unless organ donation is spontaneously broached by the patient or surrogate).
(e) Obtain informed consent for organ donation from the patient (or surrogate), including consent specifically to the use of interventions intended not to benefit the patient but to preserve organs in order to improve the opportunity for successful transplantation.
(f) Ensure that relevant standards for good clinical practice and palliative care are followed when implementing the decision to withdraw a life-sustaining intervention.

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

Guidelines for Organ Transplantation from Deceased Donors 6.2.1

Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physician's primary concern must be the well-being of the patient. However, organ transplantation is also unique in that it involves two patients, donor and recipient, both of whose interests must be protected. Concern for the patient should always take precedence over advancing scientific knowledge.

Physicians who participate in transplantation of organs from deceased donors should:

(a) Avoid actual or perceived conflicts of interest by ensuring that:
(i) to the greatest extent possible that the health care professionals who provide care at the end of life are not directly involved in retrieving or transplanting organs from the deceased donor. Physicians should

encourage health care institutions to distinguish the roles of health care professionals who solicit or coordinate organ transplantation from those who provide care at the time of death;
(ii) no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.
(b) Ensure that death is determined by a physician not associated with the transplant team and in accordance with accepted clinical and ethical standards.
(c) Ensure that transplant procedures are undertaken only by physicians who have the requisite medical knowledge and expertise and are carried out in adequately equipped medical facilities.
(d) Ensure that the prospective recipient (or the recipient's authorized surrogate if the individual lacks decision-making capacity) is fully informed about the procedure and has given voluntary consent in keeping with ethics guidance.
(e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment.
(f) Ensure that organs for transplantation are treated as a national, rather than a local or regional, resource.
(g) Refrain from placing transplant candidates on the waiting lists of multiple local transplant centers, but rather place candidates on a single waiting list for each type of organ.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 928
(I-26)

Introduced by:	California, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Emergency Medicine, Arizona, Guam and Washington
Subject:	Electric Bike and Scooter Safety, Regulation, and Enforcement
Referred to:	Reference Committee K

Whereas, the use of electric mobility devices, including e-bikes and scooters, is rapidly increasing across the country, with an estimated industry value of $35.7 billion in 2024; and

Whereas, these devices offer mobility benefit when used at appropriate speeds with safety equipment, but they pose growing safety risks; and

Whereas, electric bikes and scooters rarely require registration or licensing to operate; and

Whereas, the Consumer Product Safety Act, PL 107-319 defines two-or-three wheeled vehicles with fully operable pedals, an electric motor less than 750 watts, and maximum speed of under 20 mph as low-speed electric bicycles; and

Whereas, e-bikes are classified as Class I (pedal assistance required for motor support up to 20 mph), Class II (no pedal needed with motor support up to 20 mph) and Class III (pedal assistance required for motor support up to 28-mph); and

Whereas, the 2025 Mineta Transportation Institute report published multiple recommendations for improved education, infrastructure, regulation, and data collection in California; and

Whereas, California and other states have implemented evidence-based policies including age restrictions, universal helmet requirement for riders under 18, speed restrictions; and

Whereas, state and local laws governing electric mobility devices are inconsistent, including classification of e-bikes, varying in requirements for age, helmet use, speed and power limits, riding zones, and DUI regulation; and

Whereas, there is a strong need to expand the existing definitions of mopeds and motorcycles to include electric motors and regulate overpowered devices under the same frameworks. For example, in California, a moped is restricted to 30 mph, just 2 mph over a class 3 e-bike, and 4 horsepower; and

Whereas, injuries and fatalities from these devices are rising rapidly and more closely resemble those of motorcycle crashes, with the US Consumer Product Safety Commission reporting a 158 percent increase in related injuries between 2017 and 2023; and

Whereas, major medical organizations, including the American College of Surgeons, the American Academy of Orthopedic Surgeons, the American Association of Neurological

Surgeons, and the Congress of Neurological Surgeons have issued statements and articles on e-bike safety; therefore be it

RESOLVED, that our American Medical Association amend AMA policy D-10.989 by addition and deletion to read as follows:

1. Our American Medical Association recognizes electric bikes and scooters or micromobility injuries and deaths as a public health issue that would benefit from focused safety and injury prevention strategies.

~~1.~~ *2.* Our American Medical Association better defines and expands AMA policy to help improve safety for micromobility (e-bikes and e-scooters) usage by endorsing the following positions:

a. Helmets, certified by the US Consumer Safety Product Commission and rated for speed, should be worn for all and be mandatory for Class 3 e-bikes and all scooters;
b. Additional gear should include elbow pads, knee pads, wrist guards, closed-toe footwear and high-visibility or reflective gear for use at nighttime;
c. Headphones should be avoided during use;
d. E-scooters and Class 3 e-bikes should have a minimum age of 16 to operate;
e. Require education and training for Class 3 e-bikes;
f. Define where e-bikes can be ridden both on and off-road, including speed limits on shared paths and no operation allowed on sidewalks;
g. No distractions while operating;
h. No passengers while operating;
i. Regulate out-of-class products and anti-tampering; and
j. Training required to operate devices, including smooth and consistent braking at high speeds and basic traffic rules.

~~2.~~ 3. Our AMA advocates for standardized injury surveillance and reporting of micromobility-related injuries at the state and national level, including integration into existing trauma registries and public health reporting systems.

~~3.~~ 4. Our AMA encourages and advocates for accelerated research into the root causes of e-bike and e-scooter related injuries in the United States, with the goal of defining actionable best practices to prevent and/or minimize serious injury associated with operation of various classes of such vehicles, as well as the relevant demographics of the operators thereof (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA advocate for Congress to establish a task force to develop recommendations on how states should regulate e-bikes and e-scooters including:

- classification and labeling of electric bikes and scooters,
- licensing and registration requirements,
- age restrictions,
- universal helmet use,
- required rider safety education and public education
- motor power limits and maximum assistance-speed capabilities,
- night visibility requirements including lighting and reflectors
- braking performance;

- battery and electrical safety;
- safeguards against tampering or modification that allows a device to exceed its permitted class, power, or performance limits

This task force shall recommend minimum federal standards while allowing states to establish more stringent standards (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for roadway and transportation infrastructure improvements demonstrated to improve the safety of electric bike and scooter users, motorists, and pedestrians (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for parity of enforcement of safety regulations for electric bikes and scooters including citations and other enforcement actions. (Directive to Take Action)

Fiscal Note: Moderate – between $10,000 - $50,000

Received: 9/18/26

REFERENCES

1. Asha Weinstein Agrawal & Kevin Fang, Exploring Electric Bicycle Safety Performance Data and Policy Options for California, MINETA TRANSPORTATION INSTITUTE (December 2025), available at https://transweb.sjsu.edu/sites/default/files/2423-Agrawal-Electric-Bicycle-Safety-Data-Policy.pdf.
2. U.S. E-Bike Market Size & Share 2026-2035. Global Market Insights (March 2026). https://www.gminsights.com/industry-analysis/us-e-bike-market.
3. Asha Weinstein Agrawal & Kevin Fang, Exploring Electric Bicycle Safety Performance Data and Policy Options for California, MINETA TRANSPORTATION INSTITUTE (December 2025), available at https://transweb.sjsu.edu/sites/default/files/2423-Agrawal-Electric-Bicycle-Safety-Data-Policy.pdf.
4. Active Transportation and Micromobility, U.S. Department of Energy website at https://afdc.energy.gov/conserve/active-transportation.
5. CMA Sponsors Bill to Modernize E-Bike Safety Laws and Protect Kids, CALIFORNIA MEDICAL ASSOCIATION (February 20, 2026). https://www.cmadocs.org/newsroom/news/view/ArticleId/51133/Assemblymember-Lori-Wilson-introduces-CMA-sponsored-bill-to-modernize-e-bike-safety-laws-and-protect-kids.
6. AB. 2346. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202520260AB2346.
7. American Association of Neurological Surgeons, Joint Position Statement on Safety of Electric Bicycles and Scooters, March 2025, https://www.aans.org/wp-content/uploads/2025/04/CSNS-Position-Statement-on-EMobility-Safety-Final-033025.pdf.

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RELEVANT AMA POLICY

Supporting Regulations for More Stringent Safety Measures for Micromobility D-10.989

1. Our American Medical Association better defines and expands AMA policy to help improve safety for micromobility (e-bikes and e-scooters) usage by endorsing the following positions:
    a. Helmets, certified by the US Consumer Safety Product Commission and rated for speed, should be worn for all and be mandatory for Class 3 e-bikes and all scooters;
    b. Additional gear should include elbow pads, knee pads, wrist guards, closed-toe footwear and high-visibility or reflective gear for use at nighttime;
    c. Headphones should be avoided during use;
    d. E-scooters and Class 3 e-bikes should have a minimum age of 16 to operate;
    e. Require education and training for Class 3 e-bikes;
    f. Define where e-bikes can be ridden both on and off-road, including speed limits on shared paths and no operation allowed on sidewalks;
    g. No distractions while operating;
    h. No passengers while operating;
    i. Regulate out-of-class products and anti-tampering; and
    j. Training required to operate devices, including smooth and consistent braking at high speeds and basic traffic rules.

2. Our AMA advocates for standardized injury surveillance and reporting of micromobility-related injuries at the state and national level, including integration into existing trauma registries and public health reporting systems.
3. Our AMA encourages and advocates for accelerated research into the root causes of e-bike and e-scooter related injuries in the United States, with the goal of defining actionable best practices to prevent and/or minimize serious injury associated with operation of various classes of such vehicles, as well as the relevant demographics of the operators thereof.

H-15.960 Accident Prevention Motor Vehicle and Bicycle Safety
The AMA supports legislation that would make safety belt non-use by any occupants in automobiles and other enclosed motor vehicles a "primary offense" in all states; supports extension of motorcycle helmet laws to include motorized vehicles such as mopeds, scooters and all-terrain vehicles, and to cover all age groups; and supports legislation that would require helmet usage for riders of bicycles, including passengers.

H-10.964 Accident Prevention Helmets for Riders of Motorized and Non-motorized Cycles
General Helmet Use

1. Our American Medical Association encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling.
2. Our AMA encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior.
3. Our AMA encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles.
4. Our AMA urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety.
5. Our AMA advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use.
6. Our AMA encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.).
7. Our AMA supports the exploration of ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities.

Bicycles

1. Our AMA actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use.
2. Our AMA encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets.
3. Our AMA encourages the availability of helmets at the point of bicycle purchase.

Scooters

1. Our AMA recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents.
2. Our AMA encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight).
3. Our AMA urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale.

Motorcycles

1. Our AMA encourages physicians to be aware of motorcycle risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs.

2. Our AMA endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle.
3. Our AMA supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state.
4. Our AMA urges constituent societies to support the enactment or preservation of state motorcycle helmet laws.
5. Our AMA supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 929
(I-26)

Introduced by: American Association of Public Health Physicians

Subject: Strengthening Physician Education and Standardized Protocols for Human Rabies Post-Exposure Prophylaxis

Referred to: Reference Committee K

Whereas, rabies remains one of the deadliest zoonotic diseases known, carrying a case-fatality rate approaching 100% once clinical symptoms appear, yet it is nearly 100% preventable with prompt, appropriate Rabies Post-Exposure Prophylaxis (PEP)[1]; and

Whereas, the CDC issued a Health Alert Network (HAN) Advisory highlighting a sharp increase in reported human rabies exposures and a concurrent surge in post-exposure treatment management errors across emergency departments and primary care settings[1]; and

Whereas, physician errors in managing potential rabies exposures primarily stem from incorrect wound infiltration of Rabies Immune Globulin (RIG), improper timing or omission of rabies vaccine booster doses, unnecessary administration of PEP for non-exposure events leading to critical biologics shortages, and a lack of familiarity with localized animal vector epidemiology [1,2]; and

Whereas, existing AMA policy (e.g., Policy H-440.892, Bolstering Public Health Preparedness and Preparedness, and Policy H-440.825, Fund for Public Health Emergency Response) addresses broader infectious disease outbreaks, public health infrastructure, and emergency funding, yet fails to provide specific guidance, educational mandates, or standardized clinical decision-support protocols for zoonotic exposures like rabies; and

Whereas, the One Health paradigm, integrating human health, veterinary medicine, and environmental science, is essential for rapid vector identification, animal quarantine tracking, and preventing human rabies transmission[3]; therefore be it

RESOLVED, that our American Medical Association support clinician education on rabies exposure risk assessment, and proper administration of Rabies Post-Exposure Prophylaxis (PEP), including correct anatomical infiltration of Rabies Immune Globulin (RIG) (New HOD Policy); and be it further

RESOLVED, that our AMA support collaboration between the Centers for Disease Control and Prevention (CDC), state public health agencies, local health departments, and local, state and federal animal control agencies to improve real-time physician access to local zoonotic surveillance data and public health consultation in addition to decreasing exposure risks. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/21/26

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3. World Health Organization. Rabies. World Health Organization; 2024. Accessed September 19, 2026. https://www.who.int/news-room/fact-sheets/detail/rabies

RELEVANT AMA POLICY

H-440.892 Bolstering Public Health Preparedness

Our AMA: (1) supports the concept that enhancement of surveillance, response, and leadership capabilities of state and local public health agencies be specifically targeted as among our nation's highest priorities; (2) supports, in principle, the funding of research into the determinants of quality performance by public health agencies, including but not limited to the roles of Boards of Health and how they can most effectively help meet community needs for public health leadership, public health programming, and response to public health emergencies; (3) encourages hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery; (4) supports flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas; and (5) encourages health departments to develop public health messaging to provide education on unexpected infectious disease.

H-440.825 Fund for Public Health Emergency Response

Our American Medical Association supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 930
(I-26)

Introduced by: New York

Subject: Supporting the Use of Firearm Suppressors to Prevent Hearing Loss

Referred to: Reference Committee K

Whereas, firearm muzzle blast noise is a well-known cause of permanent hearing loss[1,2]; and

Whereas, the number of registered firearm suppressors in the United States has increased from 1.3 million in 2017 to 5.78 million in 2025[3]; and

Whereas, firearm suppressors are now legal for use in hunting or sport shooting in 42 states[4]; and

Whereas, the Academy of Doctors of Audiology supports improving access to suppressors[5]; and

Whereas, the Centers for Disease Control and Prevention states that the only potentially effective noise control method to reduce shooters' noise exposure from gunfire is through the use of suppressors[6]; and

Whereas, The American Academy of Otolaryngology-Head and Neck Surgery endorses the use of suppressors as an effective method of reducing the risk of hearing loss [7] and the New York State Society of Otolaryngology endorses the use of suppressors for hunting and recreational shooting to reduce preventable hearing loss[8]; therefore be it

RESOLVED, that our American Medical Association endorses the use of firearm suppressors in conjunction with conventional hearing protective measures for hearing preservation (New HOD Policy); and be it further

RESOLVED, that our AMA supports legislation decriminalizing the use of firearm suppressors during hunting, sports shooting, or on firing ranges for the purposes of reduction of hearing loss (New HOD Policy); and be it further

RESOLVED, that our AMA supports continued research on the subsequent effects of the use of firearm suppressors. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/22/26

REFERENCES

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3. National Shooting Sports Foundation, Firearm Suppressor Registrations Outpace Historic Figures, October 8, 2024. www.nssf.org/articles/firearm-suppressor-registrations-outpace-historic-figures/
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5. Heiman D, Czuhajewski S (Academy of Doctors of Audiology), Letter to Rep. J. Duncan and Sen. M. Crapo supporting the Hearing Protection Act, May 31, 2023. https://cdn.americansuppressorassociation.com/wp-content/uploads/2023/06/ADA-Support-Letter-Hearing-Protection-Act-2023_Upload.pdf
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7. American Academy of Otolaryngology-Head and Neck Surgery, www.entnet.org/resource/suppressors-for-hearing-preservation/
8. New York State Society of Otolaryngology, Policy Statement on Firearm Suppressors and Hearing Health, February 2026.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 931
(I-26)

Introduced by: Association for Clinical Oncology, American College of Rheumatology, American Society of Hematology, American Academy of Hospice and Palliative Medicine, American Society for Radiation Oncology

Subject: Allocation, Liability Protections, & Generic Drug Shortages

Referred to: Reference Committee K

Whereas, national shortages of essential generic injectable medications (including frontline chemotherapies such as carboplatin, cisplatin, ifosfamide, and methotrexate) have reached unprecedented levels, forcing clinicians to ration supplies, delay treatment cycles, reduce dosages, or substitute suboptimal alternative agents; and

Whereas, altering standard-of-care regimens in response to supply chain disruptions inflicts severe moral distress on clinicians and exposes practicing physicians to heightened medical liability and malpractice risk without statutory safe harbors for supply-driven triage decisions; and

Whereas, the underlying root cause of chronic generic sterile injectable shortages is a broken economic marketplace characterized by extreme price erosion for "penny drugs," where unsustainable reimbursement margins drive domestic manufacturers out of the market and undermine supply chain resilience; therefore be it

RESOLVED, that our American Medical Association advocate for resource allocation frameworks, alongside federal and state statutory liability protections (civil immunity safe harbors), for physicians forced to alter or triage care due to national drug shortages (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal market reforms for critical off-patent sterile injectables, including reimbursement price floors covering manufacturing costs plus operating margin, to address root economic drivers of generic drug shortages. (New HOD Policy)

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

Received: 9/22/26

REFERENCES

1. American Medical Association Council on Science and Public Health. CSAPH Report on Drug Shortages: Root Causes and Market Fragility. CSAPH Rep. 3, 2023.
2. American Society of Health-System Pharmacists (ASHP). National Drug Shortage Statistics and Chemotherapy Shortage Survey Findings. 2025–2026.
3. American Society of Clinical Oncology. Clinical Guidance on Rationing and Prioritizing Therapies During Systemic Chemotherapy Shortages. J Clin Oncol, 2023.
4. U.S. Department of Health and Human Services (HHS). White Paper on Preventing and Mitigating Generic Drug Shortages: Economic and Supply Chain Incentives. 2024.

RELEVANT AMA POLICY

H-100.956 National Drug Shortages: Our AMA considers drug shortages to be an urgent public health crisis. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base, increasing redundancy, and exploring measures designed to drive greater investment in production capacity for products that are in short supply. [CSAPH Rep. 2, A-11; Reaffirmed: A-23; Modified: I-23]

H-270.999 Medical Liability Reform: Our AMA continues to pursue federal and state tort reform, including statutory liability protections, affirmative defenses, and safe harbors for physicians acting in good faith under emergency conditions or severe supply disruptions beyond physician control.

H-110.988 Generic Drug Pricing and Market Resiliency: Our AMA supports market-based and regulatory incentives that sustain robust generic competition, oppose monopolistic practices, and encourage long-term manufacturing stability for critical medications.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 932
(I-26)

Introduced by: American Thoracic Society

Subject: Recognizing the Challenge of Tobacco use in the Era of Commercial E-Cigarettes and Nicotine Products

Referred to: Reference Committee K

Whereas, combustible cigarette smoking remains a major cause of preventable disease and death, and the greatest health risks from tobacco use are a result from exposure to toxicants generated by combustion; and

Whereas, nicotine is an addictive substance delivered by combustible cigarettes, e-cigarettes, nicotine pouches, and repeated nicotine exposure can result in dependence and withdrawal symptoms; and

Whereas, although e-cigarettes and smokeless nicotine products may expose users to fewer harmful substances than combustible cigarettes, e-cigarettes are not harmless and continued use often maintains nicotine dependence; and

Whereas, the U.S. Food and Drug Administration (FDA), through its Center for Drug Evaluation and Research, evaluates and approvals treatments of disease, including tobacco use disorder, while FDA's Center for Tobacco Products regulates and authorizes the sale of commercial tobacco and nicotine products, including e-cigarettes and electronic nicotine delivery systems, some of which continue to be commercially available without required FDA authorization, and current best practices for the treatment of tobacco use disorder, as reflected in guidance from the Office of the U.S. Surgeon General and the American Thoracic Society, support the use of FDA-approved cessation medications in conjunction with tobacco treatment counseling; and

Whereas, recent clinician-directed publications and education materials have recommended consideration of e-cigarettes in smoking cessation treatment, including a 2026 JAMA Special Communication, *Nicotine for E-Cigarettes for Cigarette Smoking Cessation: Recommendations to US-Based Clinicians*, which recommends that clinicians integrate e-cigarettes into discussion of evidence-based treatments for smoking cessation and provides guidance regarding their use for cigarette smoking cessation, despite e-cigarettes not being FDA-approved smoking cessation therapies; and

Whereas, the American Thoracic Society and the American College of Chest Physicians have expressed concern in response to these recommendations that greater caution is warranted regarding the potential role of e-cigarettes in smoking cessation and have emphasized the importance of increasing the use of effective FDA-approved treatments and promoting avoidance of unapproved inhaled aerosols; and

Whereas, the term "harm reduction" has no single definition and is used in varying ways across public health contexts, but is useful in understanding a loose framework for reducing harm to patient and the public in tobacco-related and other treatment scenarios; and

Whereas, physicians need evidence-based clinical guidance to treat patients who smoke combustible cigarettes, e-cigarettes or other commercial nicotine products, or are considering switching among nicotine products; and

Whereas, it is consistent with our American Medical Association policies H-495.972, “Electronic Cigarettes, Vaping, and Health,” H-495.988, “FDA Regulation of Tobacco Products,” and H-490.917, “Physician Responsibilities for Tobacco Cessation,” recognize the health risks and addictive potential of e-cigarettes and other nicotine products, promote FDA-approved smoking cessation tools and resources, and support the use of evidence-based clinical practice guidelines for the treatment of nicotine dependence; therefore be it

RESOLVED, that our American Medical Association remains consistent in its recommendations to follow evidence-based medicine and clinical guidelines and in doing so, does not endorse that physicians recommend or prescribe commercial e-cigarette devices for the purposes of tobacco cessation in adult and adolescent patients (New HOD Policy); and be it further

RESOLVED, that our AMA emphasizes the importance of developing clinical decision trees to support physicians who weigh the option of commercial nicotine products in the setting of tobacco use disorder (New HOD Policy); and be it further

RESOLVED that our AMA recommends against the use of the phrases "quit smoking" or "cessation" and instead recommends the use of the terms "transition", “switch”, or "conversion" to describe patients and research subjects who move off of combustible cigarettes and onto electronic cigarettes or commercial nicotine (New HOD Policy); and be it further

RESOLVED, that our AMA, based on the variable nicotine levels and toxicity profiles of commercial e-cigarettes and nicotine products, remains consistent with prior policy that physicians should continue to guide and counsel patients who have made the choice to use these products (New HOD Policy); and be it further

RESOLVED, that our AMA recognizes the chronic use of commercial nicotine products and e-cigarettes as nicotine dependence or addiction, and strongly recommends the use of clinical pathways and evidence-based treatment to support patients with nicotine dependence or addiction (New HOD Policy); and be it further

RESOLVED, that our AMA stands by the principles of harm reduction in individual patient care and in public health and recommends physicians provide non-punitive, non-judgmental information to adult patients who smoke when discussing commercial nicotine products and electronic cigarettes. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/22/26

REFERENCES

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2. American Thoracic Society and American College of Chest Physicians. Letter to the Editor regarding Nicotine E-Cigarettes for Cigarette Smoking Cessation: Recommendations to US-Based Clinicians. 2026.

RELEVANT AMA POLICY

Electronic Cigarettes, Vaping, and Health H-495.972
Our AMA urges physicians to educate themselves about electronic nicotine delivery systems, counsel patients regarding e-cigarette use, nicotine addiction, and the potential hazards of dual use, and recognize that questions about e-cigarettes may reflect a patient's desire to stop smoking. AMA policy encourages physicians to promote FDA-approved smoking-cessation tools and resources and recognizes nicotine-containing products as unsafe and potentially addictive for youth.
[CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19; Appended: Res. 428, A-19]

FDA Regulation of Tobacco Products H-495.988
Our AMA recognizes that e-cigarettes may contain fewer toxicants than combustible cigarettes but are not harmless and that complete cessation of tobacco and nicotine-related products is the goal. AMA policy recognizes tobacco products as delivery devices for addictive nicotine and supports continued FDA authority to regulate the manufacture, sale, distribution, and marketing of tobacco products.
[CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13; Modified: Speakers Rep., A-14; Appended: Res. 420, A-14; Reaffirmation A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed in lieu of Res. 412, A-19; Modified: CSAPH Rep. 03, A-19]

Physician Responsibilities for Tobacco Cessation H-490.917
Our AMA encourages physicians to use evidence-based practice guidelines for the treatment of patients with nicotine dependence and supports dissemination and implementation of clinical practice guidelines on smoking cessation. AMA policy also encourages physicians to routinely identify tobacco use, counsel patients to stop using tobacco, participate in cessation education, and take a leadership role in treating tobacco dependence.
[CSA Rep. 3, A-04; Appended: Res. 444, A-05; Reaffirmed: BOT Rep. 8, A-08; Reaffirmed in lieu of Res. 912, I-12; Reaffirmed: CSAPH Rep. 05, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 933
(I-26)

Introduced by: American Thoracic Society

Subject: Preventing Silicosis Associated with Engineered Stone Countertops

Referred to: Reference Committee K

Whereas, engineered stone has become the most popular countertop material in the United States; and

Whereas, engineered stone countertops can contain very high levels of crystalline silica, often exceeding 90%, and the cutting, shaping, sanding, grinding, and polishing of high-silica-content engineered stone can release high levels of respirable crystalline silica; and

Whereas, globally, there has been a documented increase in silicosis among countertop fabricators associated with exposure to respirable crystalline silica from high-silica-content engineered stone; and

Whereas, the State of California has documented a significant increase in silicosis among countertop fabricators associated with exposure to respirable crystalline silica while working with high-silica-content engineered stone; and

Whereas, even with the use of established engineering controls, such as wet methods, ventilation, and respiratory protection, hazardous exposures to respirable crystalline silica from high-silica-content engineered stone may persist; and

Whereas, the Occupational Safety and Health Administration has established a permissible exposure limit for respirable crystalline silica of 50 μg/m³ as an 8-hour time-weighted average and an action level of 25 μg/m³, yet hazardous exposures and cases of silicosis continue to be documented among countertop fabrication workers; and

Whereas, the American Thoracic Society workshop report, Silicosis in the Artificial Stone Countertop Industry, calls for higher-order prevention strategies, including the elimination or substitution of high-silica artificial stone; and

Whereas, commercially available countertop products containing less than 1% crystalline silica are available in the United States; and

Whereas, in response to high rates of silicosis among countertop fabrication workers, Australia implemented a prohibition in 2024 on the manufacture, supply, processing, and installation of engineered stone benchtops, panels, and slabs containing at least 1% crystalline silica; and

Whereas, in response to the documented increase in silicosis among countertop fabrication workers, California is pursuing emergency rulemaking to prohibit the fabrication of engineered stone countertops and similar products containing more than 1% crystalline silica; therefore be it

RESOLVED, that our American Medical Association support California's proposed emergency regulation to prohibit the fabrication of engineered stone countertops and similar products containing more than 1% crystalline silica (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the sale, installation, and use of high-silica-content engineered stone countertops across the United States (New HOD Policy); and be it further

RESOLVED, that our AMA recommends the industrial and commercial use of low-silica-content engineered stone products and other safer alternatives (New HOD Policy); and be it further

RESOLVED, that our AMA support the recommendations of the American Thoracic Society workshop report, Silicosis in the Artificial Stone Countertop Industry, including strengthening surveillance, improving access to screening and care, and advancing higher-order prevention strategies, including the elimination or substitution of high-silica engineered stone with lower-silica or other safer alternatives. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/22/26

REFERENCES

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RELEVANT AMA POLICY

Silicosis from Work with Engineered Stone D-365.994
Our AMA encourages physicians and other health professionals to report diagnosed or suspected cases of silicosis consistent with NIOSH guidance and supports preventive measures to reduce worker exposure to respirable crystalline silica. AMA policy also supports establishing silicosis registries, state compensation mechanisms for affected workers, and action by state medical associations to prevent silicosis and support recognition and compensation of workers with occupational disease.
[Res. 901, I-23]

Resolutions not for Consideration

003 Support for Completion of Medical Directives Before Elective Surgeries
004 Use of Live Animals in Medical Training
301 Missing Indigenous People Crisis in Medical Education
303 Transparent Visiting Rotation Fee Disclosure
307 Promoting Transparency on Fertility Healthcare Policies for Trainees
308 Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems
309 Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners
310 Disparities in Preliminary and Transitional Year GME Funding
911 Annual Alcohol Report and Comprehensive Review of AMA Alcohol Policy

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-26)

Introduced by: Minnesota

Subject: Support for Completion of Medical Directives Before Elective Surgeries

Referred to: Reference Committee on Ethics and Bylaws

Whereas, advance care planning (ACP) documentation before elective surgery remains persistently low, including among older adults undergoing high-risk procedures, despite its importance for aligning perioperative care with patient values and preferences[1,2]; and

Whereas, elective procedures and anesthesia may result in serious morbidity, mortality, or loss of decisional capacity, yet only 36.7% of U.S. adults have completed an advance directive and 70% of patients presenting for elective surgery lack one on file[3-5]; and

Whereas, ACP completion is uneven across patient populations, with disparities by sex, language preference, insurance status, race, and socioeconomic status[1,6-8]; and

Whereas, ACP discussions are often not initiated by surgical teams or tailored to surgery-specific risks, limiting opportunities to clarify patient goals before postoperative complications or decisional incapacity occur[1,2]; and

Whereas, completing advance directives before elective procedures can improve patient autonomy, reduce unwanted or non-goal-concordant care, decrease conflict and distress among families and clinicians, and may reduce health care costs[2,9]; and

Whereas, the American College of Surgeons Optimal Resources for Geriatric Surgery 2019 Standards section 5.2 requires that “code status and any existing advance directives must be reviewed preoperatively by the surgeon”, and for patients without such preferences documented should be “offered the opportunity to establish an advance directive”[10]; and

Whereas, the American College of Surgeons Optimal Resources for Geriatric Surgery 2019 Standards section 5.3 require all patients have a health care representative, surrogate, or proxy identified and clearly documented, and for those without, effort to identify one should be made[10]; and

Whereas, current American Medical Association policy encourages completion of advance directives and supports a national registry to facilitate availability of such documents, but policy does not provide details regarding advance care planning in the perioperative time; therefore be it

RESOLVED, that our American Medical Association support education and other evidence-based interventions aimed at improving completion of medical directives, at a minimum inclusive of a desired code status and healthcare power of attorney, prior to elective surgeries involving anesthesia or significant risk of harm that could render the patient incapacitated to make medical decisions. (New HOD Policy)

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

Received: 9/16/26

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1. Colley A, et al. Advance care planning documentation among older adults undergoing high-risk surgery. *JAMA Surgery*. 2022. doi:10.1001/jamasurg.2022.3687
2. Kalbfell E, et al. Advance directives and perioperative care for older adults. *JAMA Surgery*. 2021. doi:10.1001/jamasurg.2021.1521
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4. Yadav KN, et al. Approximately one in three US adults completes any type of advance directive for end-of-life care. *Health Affairs*. 2017. PMID:28679811
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RELEVANT AMA POLICY

H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

H-85.950 Support of a National Registry for Advance Directives

Our AMA will advocate for the development of model legislation and the establishment and maintenance of a national, no-charge, confidential and secure method for the storage and retrieval of advance directive documents by authorized agents.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-26)

Introduced by: Massachusetts

Subject: Use of Live Animals in Medical Training

Referred to: Reference Committee on Ethics and Bylaws

Whereas, while 97% of surveyed emergency medicine residency programs across the United States and Canada use only human-relevant training methods, some medical centers continue to use live animals.[1] Currently (as of 3/6/26), 272 programs use only nonanimal training methods and eight programs still use live animals;[2] and

Whereas, the use of live animals in medical student training in the United States (US) has ceased as of 2016;[3] and

Whereas, the AMA previously encouraged medical school faculty to consider using non-animal training methods;[4] and

Whereas, the use of animals for training residents has increasingly fallen out of favor as more technologically superior models have emerged; and

Whereas, the use of medical simulation in the training of residents has been proven to increase competency, reduce errors, and improve team-building;[5,6,7,8,9,10] and

Whereas, the shortened medical resident workweek necessitates easy access to training methods such as medical simulation, which can be employed without advance scheduling, animal acquisition, and veterinary staffing; and

Whereas, all surveyed pediatrics residency programs in the US and Canada exclusively use non-animal training methods;[11] therefore be it

RESOLVED, that our American Medical Association support the use of medical training that avoid the use of live animals. (New HOD Policy)

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

Received: 9/16/26

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RELEVANT AMA POLICY

Use of Animals in Medical Education H-295.957

The AMA has adopted the following guidelines on the use of animals in medical school curricula and continuing medical education courses: (1) Where appropriate, medical school faculty should consider using non-animal models in education activities; when animals are used in the curriculum, education goals should be clearly stipulated. (2) Each medical school should disseminate a policy statement to students before matriculation regarding their participation in educational experiences involving animals. (3) All educational experiences involving animals should have the approval of the institutional Animal Care and Use Committee. (4) Involved faculty should discuss with students the learning objectives of any educational experience that utilizes animals, and faculty should remain available throughout the laboratory exercise for advice and guidance on the conduct of the educational experience. (5) All educational experiences involving animals should be carried out in a humane manner without inflicting pain on the animal. This includes the appropriate use of anesthetic and analgesic drugs. (6) At the conclusion of study, animals should be euthanized in the manner described by the American Veterinary Medical Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

Subject: Missing Indigenous People Crisis in Medical Education

Referred to: Reference Committee C

Whereas, American Indian and Alaska Native women experience violence at rates significantly higher than other racial/ethnic groups, with studies indicating that more than 84% of AI/AN women experience violence in their lifetimes, and AI/AN women are murdered at rates more than ten times the national average in some regions[1]; and

Whereas, the Missing and Murdered Indigenous Persons (MMIP) crisis represents an ongoing epidemic of violence affecting American Indian and Alaska Native women, girls, Two-Spirit individuals, and men across urban and rural communities[2]; and

Whereas, fragmented criminal justice data systems, inadequate interagency coordination between federal, state, tribal, and local law enforcement, and jurisdictional complexities have created significant barriers to reporting, investigating, and resolving cases of missing or murdered Indigenous persons[3]; and

Whereas, the Bridging Agency Data Gaps and Ensuring Safety (BADGES) for Native Communities Act (S.390, 119th Congress) passed the United States Senate unanimously on December 15, 2025, and currently awaits consideration in the House of Representatives[4]; and

Whereas, the BADGES Act would require federal law enforcement agencies to report comprehensively on cases of missing or murdered Indigenous persons, establish grant programs to support coordination among tribal, state, and federal agencies, and mandate improved data sharing between the FBI's National Crime Information Center and the National Missing and Unidentified Persons System[3]; and

Whereas, Urban Indian Organizations are explicitly identified as eligible entities for the missing or murdered response coordination grant program established by this legislation, recognizing that urban Indigenous populations face heightened vulnerability to violence and trafficking[4]; and

Whereas, trauma-informed care practices that recognize historical trauma, cultural safety, and the intersection of racism and misogyny can position healthcare providers to intervene before tragic outcomes occur and support survivors with culturally appropriate resources[5–7]; and

Whereas, medical documentation of injuries and evidence of abuse can serve crucial roles in law enforcement investigations, criminal prosecutions, and child protection proceedings related to MMIP cases[7]; and

Whereas, the Not Invisible Act Commission Report of 2020 called for comprehensive federal action to address the crises of MMIP and human trafficking of Indigenous persons, and the bipartisan BADGES Act represents a direct legislative response to these recommendations[4]; and

Whereas, existing AMA-MSS Policy 350.039 partially addresses the MMIP crisis via supporting emergency alert systems, demonstrating the medical student community's ongoing commitment to this public health emergency; therefore be it

RESOLVED, that our American Medical Association will collaborate with the American Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to encourage medical schools to integrate education on the Missing and Murdered Indigenous Persons (MMIP) crisis, trauma-informed care for Indigenous populations, violence screening protocols, and recognition of human trafficking indicators into medical education curricula. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965
Our American Medical Association believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations.

Missing and Murdered Indigenous Persons H-350.938
Our American Medical Association supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on tribal reservations and elsewhere.

Missing Children Identification H-60.996
Our American Medical Association supports development of a means of identifying children.
Our AMA supports education of the public and parents on the fingerprinting and documentation of characteristic identifying marks as a matter of record, should it be necessary to assist officials in locating a missing child.

Commercial Exploitation and Human Trafficking of Minors H-60.912
Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-26)

Introduced by: Medical Student Section, American Academy of Ophthalmology, Resident and Fellow Section

Subject: Transparent Visiting Rotation Fee Disclosure

Referred to: Reference Committee C

Whereas, away rotations remain an important component of the residency application and admissions process[1,2]; and

Whereas, while students applying through the Visiting Student Learning Opportunities (VSLO) program pay a $15 fee for each individual program application, host institutions may directly charge visiting students additional fees before and after acceptance into an away rotation[3]; and

Whereas, AAMC survey data show that 25.6% of students reported spending more than $1,500 out of pocket on away rotations and 17.4% reported spending more than $2,500[1,2]; and

Whereas, reports continue to identify wide fee ranges, hidden fees, and differences in fees for MD and DO students[4-7]; and

Whereas, when mandatory visiting rotation fees are not publicly disclosed, students may be unable to compare the full cost of electives in advance, making budgeting, scheduling, and applying increasingly difficult[4-8]; therefore be it

RESOLVED, that our American Medical Association supports efforts to ensure transparent preapplication disclosure of all mandatory fees and expenses associated with visiting student rotations, including fees assessed through centralized application platforms and by host institutions, such that those fees and expenses are specific, well-defined, and available to applicants before application submission. (New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Date Received: 9/3/26

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RELEVANT AMA POLICY

H-295.876 Equal Fees for Osteopathic and Allopathic Medical Students
Our AMA: (1) discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training; (2) encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students; and (3) encourages the AAMC and ACGME to promote equitable access to clinical electives and equitable fees for visiting allopathic and osteopathic medical students. [Res. 809, I-05; Appended: CME Rep. 6, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 303, I-19; Modified: CME Rep. 5, I-21; Modified: CME Rep. 1, A-22]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt
Our AMA encourages medical schools to ensure that all medical student fees are earmarked for specific and well-defined purposes and to avoid charging overly broad or ill-defined fees; additionally, our AMA continues to monitor opportunities to reduce additional expense burden upon medical students. [CME Rep. 4, A-94; Reaffirmed: Sub. Res. 712, I-94; Modified: Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: Res. 301, A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: CME Rep. 02, A-19; Reaffirmed: Res. 310, I-22; Reaffirmed in lieu of: Res. 302, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-26)

Introduced by: Women Physicians Section, Resident and Fellow Section

Subject: Promoting Transparency on Fertility Healthcare Policies for Trainees

Referred to: Reference Committee C

Whereas, physicians have children later than non-physicians, face greater fertility challenges, and suffer from higher rates of age-related pregnancy complications,[1,2] the average entering age in medical school is now 24,[3] and as of 2024 data, more matriculants than ever were aged 30 or above, there is now a greater likelihood that residents will try to have children during their training periods; and

Whereas, at the same time, surgical specialties are seeking to increase female applicants, but medical students and residents report a lack of transparency or formal policies surrounding parental leaves, barriers due to workplace cultures, and hesitancy in asking about these policies[4]; and

Whereas, there have been significant strides in leave rights for resident trainees, such as the American Board of Medical Specialties (ABMS) Policy of Parental, Caregiver, and Medical Leave During Training in 2020,[5] yet significant variation exists on how residency programs may choose to implement these policies based on culture, program capacity, and specialty; and

Whereas, there have been significant strides in leave rights for resident trainees, such as the American Board of Medical Specialties (ABMS) Policy of Parental, Caregiver, and Medical Leave During Training in 2020,[5] yet significant variation exists on how residency programs may choose to implement these policies based on culture, program capacity, and specialty; and

Whereas, residents express a strong preference for transparent and standardized presentations of leave and fertility policies through objective methods, such as slide decks, brochures, or accessible web resources[6], while per a 2023 study, only 66% of top 50 ranked institutions with residency training displayed publicly available medical benefits and only 40% had publicly available fertility benefit information on their website[7]; and

Whereas, family planning and lifestyle considerations, including clear parental leave information, are among the most influential factors for medical students when selecting and ranking residency programs,[8] and the availability and transparency of these policies are increasingly critical in shaping residency decisions for applicants[9]; and

Whereas, the AMA's support for increased leave and fertility preservation or infertility policies via Resolution H-310.92 "Resident and Fellow Access to Fertility Preservation"[10]—by not including advocacy for disclosure of said policies—does not enhance an applicant's ability to discriminate across residency programs without risking harm to their applications in the residency process through potential discrimination; and

Whereas, specific advocacy toward transparency on leave and fertility policies has the potential to incentivize diversity in recruitment efforts, particularly across surgical specialties; and

Whereas, disclosure initiatives may incentivize programs to adopt stronger leave and/or fertility benefits to recruit a more diverse applicant pool and better manage potential disruptions to training; therefore be it

RESOLVED, that our American Medical Association amend existing policy H-310.902 "Resident and Fellow Access to Fertility Preservation" by addition:

1. Our American Medical Association encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs.
2. Our AMA encourages residency programs to disclose family planning and fertility health insurance policies
3. Our AMA supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

(Modify Current HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

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RELEVANT AMA POLICY

H-310.902 Resident and Fellow Access to Fertility Preservation

1. Our American Medical Association encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs.
2. Our AMA supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion. [Res. 302, A-22]

H-295.846 Increased Education and Access to Fertility Resources for U.S. Medical Students

1. Our American Medical Association will encourage interested parties to develop gender- and sexual minority-inclusive initiatives in medical education that raise awareness about:

    1. how peak child-bearing years correspond to the peak career-building years for many medical students and trainees;
    2. the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees;
    3. the high rate of infertility among medical students, trainees, and physicians; and
    4. various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs.
2. Our AMA will encourage interested parties to increase access to strategies by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage. [Res. 306, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(I-26)

Introduced by: Resident and Fellow Section

Subject: Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems

Referred to: Reference Committee C

Whereas, a 2025 NEJM review by Walensky and McCann examined challenges to the physician workforce, discussing GME funding mechanisms and the bottleneck created by limited federally funded residency positions;[1] and

Whereas, Medicare spent $16.2 billion on GME in 2020, and 15,000 new residency slots have been created in the past 20 years outside of federal funding, suggesting hospitals find economic value in resident training even without full federal support;[1] and

Whereas, the review also highlighted that the 2014 Institute of Medicine recommendations for GME reform (including pay-for-performance models) have seen little progress due to opposition from hospital associations that benefit from current funding structures;[1] and

Whereas, a 2025 JAMA Viewpoint by Frederick and colleagues offered their perspective on the financial pressures facing teaching hospitals amid rising resident unionization and it was noted that more than one-third of US hospitals are operating at negative margins, with hospital revenue failing to keep pace with inflation and Medicare physician payment rates falling by approximately 30% since 2001 (adjusted for inflation);[2] and

Whereas, concerns were raised in the Viewpoint including that as resident compensation costs rise through union negotiations, hospitals may find alternatives, such as advanced practice clinicians, more financially viable, potentially leading to program cuts;[2] and

Whereas, neither of these papers provides any meaningful change in the previous conclusion that the economic value residents create clearly exceeds the current level of resident compensation, with resident compensation being largely distorted due to a lack of effective market forces; and

Whereas, further characterization of this value, however, is difficult to meaningfully assess in greater granularity due to a lack of available data, a lack of comparability across specialties, and heterogeneity in training program structures and healthcare market economics, both within and across healthcare systems; and

Whereas, efforts to create such a standard that would allow for meaningful comparison universally across all programs are beyond the scope of the AMA, ACGME, or any identifiable agency or organization as it would require forcing a universal accounting standard far more stringent and prescriptive than GAAP or the existing tax code; therefore be it

RESOLVED, that our American Medical Association study the feasibility of quantifying the direct and indirect revenue generated by resident and fellow physicians for their sponsoring institution,

including the development of standardized methodologies for such estimation, and develop recommendations regarding whether and how such data should be transparently reported to training institutions, accrediting bodies, and the public. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

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2. Frederick PJ, Seshadri M, Zsiros E, McLean K. Reflections on Medical Trainee Unions and Health Care Systems. JAMA. 2025;333(12):1043-1044. doi:10.1001/jama.2025.14762.

RELEVANT AMA POLICY

Financing of Medical Education Programs D-305.973

1. Our American Medical Association will work with the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
    a. Ensure adequate Medicaid and Medicare funding for graduate medical education.
    b. Ensure adequate Disproportionate Share Hospital funding.
    c. Make the Medicare direct medical education per-**resident** cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions.
    d. Revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings.
    e. Stabilize funding for pediatric residency training in children's hospitals.
    f. Explore the possibility of extending full direct medical education per-**resident** payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need.
    g. Identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
    h. Act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose.
2. Our AMA will work with other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-26)

Introduced by: Resident and Fellow Section

Subject: Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners

Referred to: Reference Committee C

Whereas, "neurodivergence" refers to natural variations in human brain function, where individuals learn and process information differently and is an umbrella term that includes autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), dyslexia, and dyspraxia, as well as individuals without criteria for a formal clinical diagnosis. These differences can involve cognitive processing, social communication, executive functioning, and sensory perception, with an estimated 15-20% of the global population considered neurodivergent[1]; and

Whereas, neurodivergence may affect the way individuals engage with clinical environments. While medicine is a cognitively and sensorially demanding field, neurodivergence is not synonymous with "disability" or "impairment," and does not inherently restrict one's capability as a physician; and

Whereas, the cognitive and emotional demands of medicine require sustained attention, complex reasoning, rapid decision-making, and emotional regulation, leaving little space for cognitive variation. Neurodivergent learners must navigate hierarchical training systems, high-stakes clinical environments and interpersonal dynamics while maintaining patient safety and as a result, they frequently encounter disproportionate barriers that affect performance and success[2]; and

Whereas, school and workplace environments may exclude and stigmatize neurodivergent learners, as their actions are met with negative reactions and in order to avoid negative stigma, neurodivergent learners often hide their behaviors and personify 'neurotypical behaviors' which can lead to burnout, mental stress, and feeling disconnected from themselves[2]; and

Whereas, challenges faced by neurodivergent learners include written exams, which affect those with dyslexia, managing social situations, and planning independent self-study[4,5], and

Whereas, neurodiversity adds value to medical education and healthcare systems. Diverse workplaces perform better by incorporating a wider range of perspectives[5]; and

Whereas, in 2022 and 2023, 5.9% of residency-match registered learners self-reported a disability[6], and are required to have "reasonable accommodations" in Accreditation Council for Graduate Medical Education (ACGME) accredited training programs; and

Whereas, while the ACGME provides resources and guidance for programs to draft disability policies[7], there is no oversight of the outcome of these policies and institutions ultimately determine what constitutes reasonable accommodations, how accessible processes are, and whether these policies are publicly available[8,9]; and

Whereas, accommodations for disabilities may include wheelchair accessible space, scheduled breaks, flexible time for medical appointments, and a flexible jeopardy pool but while many institutions provide accommodations for trainees with disabilities, support is often fragmented across multiple offices, reflecting trainees' dual roles as learners and employees and this lack of coordination creates administrative burden, unclear accountability, and inconsistent access, underscoring the need for centralized, clearly defined systems; and

Whereas, unlike traditional disabilities, neurodivergence is not necessarily a medical diagnosis, complicating eligibility for accommodations and fear of stereotypes and stigma related to disability labels[10,11,12] may lead neurodivergent learners in medical training to avoid obtaining a diagnosis, disclosing their condition, and completing accommodation requests; and

Whereas, supporting neurodivergent learners in medical training requires shifting from reactive, individual accommodations, towards a proactive, inclusive training design and organizational culture and leadership are equally critical in shaping inclusive training environments[13]; and

Whereas, institution-wide efforts should include collaboration with neurodiverse trainees and allies, along with neurodiversity-inclusive hiring and visible role models to enhance representation and support career advancement[14]; and

Whereas, programs may also consider developing proactive consultation models, where trainees can engage with support services without requiring formal disability disclosure, thereby lowering the threshold for accessing assistance[15-16]; therefore be it

RESOLVED, that our American Medical Association support efforts to improve accessibility and transparency of accommodation processes for neurodivergent learners in medical training by:

(1) Encouraging residency and fellowship programs to provide clear guidance regarding procedures for requesting educational accommodations;

(2) Promoting faculty education and educational resources on teaching, supervising, and evaluating neurodivergent learners; and

(3) Encouraging collaboration between graduate medical education programs and institutional disability resource professionals and related specialists to support individualized accommodation planning for neurodivergent learners in medical training.

(New HOD Policy)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

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RELEVANT AMA POLICY

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990
1. Our American Medical Association urges that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing "organic" standards with "functional" standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.
2. Our AMA urges all medical schools and GME institutions to:
a. Make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services. b. Encourage students and trainees to avail themselves of any needed support services. c. Foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services[...]. [CME Rep. 2, I-21; Appended - BOT Action in response to referred for decision: Res. 314, A-21; Appended: Res. 302, I-23]

Advocacy for Physicians and Medical Students with Disabilities D-615.977
Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. [BOT Rep. 19, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(I-26)

Introduced by: Resident and Fellow Section

Subject: Disparities in Preliminary and Transitional Year GME Funding

Referred to: Reference Committee C

Whereas, the Association of American Medical Colleges (AAMC) notes that more medical school students and graduates are becoming unmatched[1]; and

Whereas, the number of medical school seats has outpaced the number of residency spots, which disadvantages osteopathic (DO) students and international medical graduates (IMGs). A significant number of unmatched students and physicians enter standalone Preliminary Year (PY) and Transitional Year (TY) programs to complete a PGY-1 intern year, which serve as opportunities to improve their clinical skills and network while re-entering the match; and

Whereas, PY programs contain a broad-based clinical PGY-1 year. A medical school graduate may match via the NRMP into a PY program alone or may simultaneously match into a specialized program to continue on to as a PGY-2; and

Whereas, several specialties require a PY program prior to entering into the specialized PGY-2 year (i.e. anesthesiology, dermatology, diagnostic and interventional radiology, neurology, physical medicine & rehabilitation, and radiation oncology). PY programs usually include Medicine-Preliminary, Surgery-Preliminary, and TY programs. OB/GYN-Preliminary and Pediatrics-Preliminary are rare; and

Whereas, TY programs are PY programs designed for unmatched medical school graduates[2] and TY programs provide multispecialty exposure including surgery and internal medicine to "enter a specialty where a thorough understanding of pathology, physiology and surgical procedures are necessary"[3]; and

Whereas, during each year spent in a TY program, participants can continue to enroll in NRMP and re-enter the match to join a residency program as a PGY-1; and

Whereas, Centers for Medicare & Medicaid Services (CMS) provides hospital funding for residents and fellows through Medicare. Graduate Medical Education (GME) funding for resident positions is determined by federal regulation CFR 42 § 413.79[4]; and

Whereas, direct GME (DGME) funding supports resident salary, benefits, and teaching costs, using the Initial Residency Period (IRP) to determine funding,[4] and IRP is the expected duration for a resident to complete their first primary specialty and become board certified[1]; and

Whereas, during the IRP, residents have 100% DGME funding. For all years after IRP, residents and fellows have 50% DGME funding[1]. Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency that advises the U.S. Congress on issues affecting the Medicare program; and

Whereas, MedPAC's 2001 report argues that the IRP should discourage "any unnecessary lengthening of training by individual residents and residency programs as well as multiple specialization and perpetual training."[6]; and

Whereas, MedPAC recognizes that the IRP-based federal funding may disadvantage certain applicants. Such applicants include Medicine-Preliminary interns, residents/fellow/attending physicians wanting to switch specialties, and residents/fellows who take an unexpectedly longer time to become board certified (e.g. extended leaves of absence)[6] and programs who consider these applicants will not receive full DGME funding; and

Whereas, given that programs have a funding incentive to minimize the number of years without full DGME years, programs may rank the Surgery-Preliminary applicant higher than the Medicine-Preliminary applicant for budgetary reasons. This is the primary regulatory mechanism that the original authors of RFS resolution 10 argue drives inequity and unmatched rates and as a result, system-level design - not trainee merit - financially drives opportunity and training continuity; therefore be it

RESOLVED, that our American Medical Association study the impact of current Initial Residency Period (IRP)-based GME funding policies on residency applicant selection, match outcomes, and career trajectories, including impacts on graduates of preliminary and transitional year programs and on populations disproportionately represented among unmatched applicants, such as international medical graduates (IMGs) and osteopathic (DO) graduates, and report back. (Directive to Take Action)

Fiscal Note: Minimal – less than $5,000

Received: 9/16/26

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RELEVANT AMA POLICY

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
    a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
    b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
    c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education

teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will:
    a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
    b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
    c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

1. It is AMA policy that:

A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.

B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.

C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.

D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.

E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.

F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.
I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

H-310.917 Securing Funding for Graduate Medical Education

1. Our AMA continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities).
2. Our AMA continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.
3. Our AMA encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs.
4. Our AMA encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

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

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation’s current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate

reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911
(I-26)

Introduced by: Underrepresented in Medicine Advocacy Section

Subject: Annual Alcohol Report and Comprehensive Review of AMA Alcohol Policy

Referred to: Reference Committee K

Whereas, alcohol remains a leading preventable cause of morbidity, mortality, injury, and health inequities in the United States, contributing substantially to chronic disease, cancer, mental illness, violence, motor vehicle crashes, and healthcare expenditures;[1-3] and

Whereas, the American Medical Association has adopted extensive policy related to alcohol prevention, treatment, impaired driving, youth access, advertising, and public health, yet these policies have developed over decades without a recurring mechanism to evaluate emerging evidence, monitor implementation, or identify gaps and opportunities for coordinated advocacy; and

Whereas, the AMA currently produces an Annual Tobacco Report that summarizes emerging scientific evidence, policy developments, litigation, regulatory activities, and AMA advocacy, providing the House of Delegates with an ongoing assessment of national tobacco control efforts and informing future policy priorities; therefore be it

RESOLVED, that our American Medical Association produce an Annual Alcohol Report that summarizes significant developments including, but not limited to, alcohol-related epidemiology, public health, clinical and policy evidence, federal and state policy, litigation, regulation, commercial practices, and AMA advocacy activities (Directive to Take Action); and be it further

RESOLVED, that our AMA conduct a comprehensive review of existing AMA alcohol policy and identify opportunities to modernize, strengthen, coordinate, and align our alcohol policy portfolio with current scientific evidence and evolving public health priorities, including evidence-based population-level prevention strategies, alcohol industry marketing and commercial practices, alcohol availability and affordability, and other policy interventions demonstrated to reduce alcohol-related harms. (Directive to Take Action)

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

Received: 09/14/26

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2. National Institute on Alcohol Abuse and Alcoholism. Alcohol's effects on health. National Institutes of Health. Accessed August 9, 2026. https://www.niaaa.nih.gov/alcohols-effects-health
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RELEVANT AMA POLICY

Annual Tobacco Report 2003 D-490.983

Our American Medical Association will continue to produce the Annual Tobacco Report.

Informational Reports

Report(s) of the Board of Trustees

02 American Medical Association Optimal Health Outcomes Annual Report
13 Enhancing the Work of the Center for Digital Health and AI
19 2026 AMA Advocacy Efforts
20 AMA Efforts on Medicare Payment Reform

Report(s) of the Speakers

02 Recommended Policy Reconciliations

REPORT OF THE BOARD OF TRUSTEES

BOT Report 02-I-26

Subject: American Medical Association Optimal Health Outcomes Annual Report

Presented by: Toluwalasé A. Ajayi, MD, Chair

BACKGROUND

At the 2018 Annual Meeting, the House of Delegates (HOD) adopted Policy D-180.981, directing our American Medical Association (AMA) to "develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements." The HOD provided additional guidance via Policy H-180.944: "Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity." HOD policy was followed by creation of the AMA Center for Health Equity (Center) in April 2019, the AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 (Plan) in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include "updates on [the AMA's] comprehensive diversity and inclusion strategy."

Towards the end of 2025, the AMA made the decision to strengthen its work in the pursuit of optimizing health outcomes; merging the Center for Health Equity (CHE) and the Improving Health Outcomes (IHO) business unit into the Center for Optimal Health Outcomes (COHO) with the goal of leveraging the talents of each of the units to support the US healthcare system in achieving optimal health for all.

At the 2026 Annual Meeting, the AMA Optimal Health Outcomes Annual Report (BOT Report 09-A-26) was referred with report back at the 2026 Interim Meeting requesting additional updates regarding the merger of CHE and IHO and the impact on the AMA's ability to accomplish its goals as outlined in existing HOD policy.

DISCUSSION

Impact of the CHE/IHO Merger

The CHE/IHO merger was a strategic decision by AMA management. The purpose of the CHE/IHO merger was to build on the momentum established by CHE to engage communities in addressing health disparities and leveraging IHO staff's clinical expertise, health system engagement, and community health organization partnerships. COHO maintains the same budget as CHE. While AMA management reduced staff with the CHE/IHO merger, this allowed COHO to achieve efficiencies while maintaining AMA's goal to advance health equity and improve health outcomes.

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The COHO team is a cross-functional workforce that bolsters AMA capabilities to support physicians, communities and organizations to close gaps and reduce health disparities. COHO is committed to taking measurable action and partnering to build and scale data-driven solutions to optimize health outcomes for everyone. COHO aims to do so by:

- Creating knowledge and generating evidence through research about what physicians need to know and do to improve patient health outcomes;
- Implementing physician-led solutions and contributing to what is effective in community health;
- Working with health care delivery systems and their affiliates to deliver and ensure access to high-quality medical care for patients; and
- Building strategic partnerships to advance policy that catalyzes change across health care on a local and national level.

The AMA is ultimately fulfilling the goals outlined in policy D-180.981, directing our AMA) to "develop an organizational unit, e.g., **a Center or its equivalent,** to facilitate, coordinate, initiate, and track AMA health equity activities" and instructing the "Board to provide an annual report to the House of Delegates regarding AMA's health equity activities and achievements" as well as in policy H-180.944 which not only defines health equity as optimal health for all, but instructs our AMA to "... [advocate] for health care access, research, and data collection; [promote] equity in care; [increase] health workforce diversity; [influence] determinants of health; and [voice and model] commitment to health equity." The creation of COHO allows for greater collaboration internally and externally, positioning AMA to take measurable action and build data-driven solutions to optimize health outcomes for all.

The following is a brief snapshot of some of COHO's work that is directly related to the HOD policies outlined above:

Overview of COHO Programs and Impacts of the CHE/IHO Merger

The following table demonstrates programs that were led by CHE and IHO, as well as the combined post-merger efforts that have resulted in greater operational efficiencies, expanded programs and enhanced overall impact.

Prior Unit Management	Program	Status	Summary of Developments
CHE	Medical Justice in Advocacy Fellowship (MJAF)	Expanded	• Expanded to 20 fellows • Expanding opportunities for MJAF alumni
CHE	Policy Analysis Tool	In Progress	• Tool to be platformed on the AMA website in 2027 • Training will be offered to AMA staff and members
CHE	Disability Advisory Group (DAG)	In Progress	• Caring for People with Disabilities series launched in May 2026

			• Supported improvements to accessibility at HOD and other AMA meetings • DAG approved for a 2-year term extension
CHE	Professional Societies Learning Network	In Progress	• Launched in June 2026 • This year's cohort includes 10 geographically-based societies and national/ specialty or subspecialty societies
Advocacy	Health Law Summer Internship and Fall Externship Program	In Progress	• Summer health law internship program previously overseen by Advocacy • Developing new connections with diverse groups to promote the internship • Established a new Health Law Fall Externship program beginning in Fall 2026
CHE/IHO	Community Health Impact Lab Micro Grants	Initiated	• $50k awards to 20 physician-led community health projects at local organizations • AMA will lead engagement with physician leaders and deepen insights into community health.
CHE/IHO	Release the Pressure (RTP) Campaign	Expanded	• Refresh of RTP's national media and communications campaign, including updated website content, social media outreach, and culturally relevant educational materials • Developing and disseminating community-based educational handouts and hypertension resources to new community partners • Expanding the number of in-person events to promote RTP across the country • Partnership with iHeart Radio to amplify RTP messaging across key markets.
IHO	Million Hearts	In Progress	• COHO aims to support capacity building • In partnership with Alliance Chicago, COHO is engaging 6 Health Center Control Networks, and supporting 24 different health centers (urban

			and rural) across 9 states to improve the quality of care in blood pressure control and cholesterol management.
IHO	AMA MAP™ Solutions	In Progress	• Helping health care organizations strengthen cardiovascular disease prevention through practical, evidence-based improvement strategies • 125 health care delivery organizations have implemented one or more AMA MAP™ Solutions, and 30 of those organizations have reported measurable impact.
IHO	Validated Blood Pressure Device Listing (VDL)	In Progress	• In 2026, 30 new devices, 7 of which are for pregnancy, have been added to the VDL • VDL continues to prioritize increasing the number of devices used during pregnancy and during the post-partum period.
CHE	Social Return on Investment	In Progress	• COHO staff continued to refine a methodology for quantifying the social return on investment in partnership with Kearney • Healthcare Anchor Network, invited COHO staff to present findings from this work at 2 convenings
IHO	GLP-1 RAs Research	In Progress	• COHO staff continued to explore the utilization and spending for GLP-1 RAs. • COHO is also studying the relationships of pairing behavioral and lifestyle medicine principles and practice with GLP-1 RAs and other anti-obesity Medications. • COHO's research was presented at the American College of Preventive Medicine.
IHO	Self-Measured Blood Pressure	In Progress	• COHO staff continued to examine the economic maternal and infant outcomes

	Return on Investment		of self-measured blood pressure (SMBP) monitoring
IHO	Maternal Health Pilot	Initiated	• The COHO team is collaborating with UMMC to pilot a Diabetes Prevention Program tailored for women with gestational diabetes in rural Mississippi.
CHE	Studies of Physician-Patient Dyads	In Progress	• COHO staff worked with Elevance Health to finish three major empirical studies of racial concordance
CHE	External Research Advisory Group	In Progress	• COHO staff continued to organize and meet with an external research advisory group. • Group includes 12 research leaders from across the health care ecosystem.

Overview of COHO Programs and Programs Post-Merger

Policy Development

Medical Justice in Advocacy Fellowship

The Medical Justice in Advocacy Fellowship (MJAF), created by the AMA and the Satcher Health Leadership Institute (SHLI) at Morehouse School of Medicine, will begin its fourth cohort in September 2026. This collaborative educational initiative aims to empower physician-led advocacy that advances optimal health for all people and communities and mobilize physicians to be part of the next generation of advocacy leaders, driving meaningful policy changes that produce optimal health outcomes in the communities they serve. With support of AMA leadership, the fourth cohort of the fellowship has doubled in size, expanding to 20 fellows. The fellowship curriculum, a fourteen-month engagement, includes both virtual learning sessions and in-person engagements. Additionally, COHO is continuing to develop opportunities for the 33 MJAF alumni to deepen their engagement and connection with each other and facilitate mentorship and learning with the new cohort of fellows. COHO is also investing in opportunities for the MJAF alumni to continue to build on the policy development, advocacy, and communication and scientific writing and publication skills they develop as fellows.

Policy Analysis Tool

The Policy Analysis Tool is intended for AMA staff and AMA physician members to support the development of inclusive policies that advance equitable health outcomes for all populations, particularly marginalized and minoritized communities. The tool will provide an interactive set of criteria and guiding questions to assess the potential health equity impact of policies, resulting in a more equity-oriented policy landscape. COHO is leading the adoption and implementation of this interactive tool to be platformed on the AMA website in 2027. Training will be offered to AMA staff and members to support inclusive policy development.

Health Workforce Diversity

The AMA is sponsoring the National Medical Fellowships (NMF) 80th Anniversary Homecoming Weekend in Chicago, October 1–4, 2026, with Dr. John Whyte serving as a Weekend Co-Chair. The partnership supports NMF's work to strengthen pathways into medicine through scholarships, mentorship, career development, and physician leadership. As part of the weekend, AMA will lead an educational session focused on how cross-sector partnerships can drive impactful community health programs, amplifying COHO's Live Health Chicago, West Side United, and the Atlanta Hypertension Initiative partnerships. In addition, AMA will host a brunch recognizing physician leadership, honoring Dr. Camille Clare, president of the American College of Obstetricians and Gynecologists. COHO is also supporting MedEd's sponsorship of the 2026 STEMM Pathways to Health Equity Symposium, further advancing efforts to build diverse STEMM and health-profession pipelines from campus to career. Together, these investments support the development of the next generation of diverse health professionals and leaders while strengthening partnerships that advance health equity.

Disability Advisory Group

The AMA Disability Advisory Group (DAG) was established by HOD policy to form an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities and promote and foster educational and training opportunities for AMA members and the medical community at large. The DAG has met regularly since its establishment in late 2024, with two active workgroups focused on Education and Workplace Inclusion & Accommodations. The Education Workgroup has contributed to the creation of foundational educational materials to address ableism in medicine. Most recently, COHO and the workgroup collaborated with the University of Colorado Anschutz School of Medicine to create the new AMA Ed Hub™ Caring for People with Disabilities series, which supports physicians and medical students in learning to improve health outcomes for people with disabilities. The initial education modules in the series launched on May 12, 2026, and additional content will be published throughout the year. The Workplace Inclusion & Accommodations Workgroup has contributed to extensive improvements to accessibility at HOD and other AMA meetings and will continue to work on developing tools and resources for physicians and students with disabilities to advocate for improvements in their local work environments. The DAG was approved for a 2-year term extension from 2027-2028.

Professional Societies Learning Network

The Professional Societies Learning Network (PSLN) (previously titled the Equitable Professional Societies Learning Network (EPSN)) is a program designed to support professional societies that are members of the AMA's Federation of Medicine in identifying gaps and improving health outcomes for the communities they serve by gaining deeper knowledge of social and structural drivers of health disparities and implementing interventions to address them. Through a series of six modules, which will include pre-work, live facilitated learning, and post-session technical support via office hours, staff and physician leaders from participating professional societies move beyond basic awareness to gain skills that allow them to actively engage with these issues in ways that foster system-level changes. The program launched in June 2026 and is designed to be flexible to support each participating society's individual goals for optimizing health outcomes in the communities they serve. This year's cohort includes the Society of Maternal-Fetal Medicine, the American Society of Hematology, the American Epilepsy Society, the American Academy of Neurology, and the American Psychiatric Association.

Policy Development Initiatives and Comment Letters

COHO leverages members of minoritized physician groups, community partners, and other stakeholders to draft comments for proposed rules, support letters for federal legislation, and responses to requests for information (RFIs) to support the AMA Advocacy business unit.

"Still at Risk" Initiative

The AMA has been working with the Preeclampsia Foundation on the "Still at Risk" postpartum hypertension awareness and action wristband initiative. This public-private partnership is focused on improving postpartum health outcomes through the creation, promotion, dissemination, and impact measurement of wristbands for postpartum women at risk of developing hypertension. The AMA has provided the Foundation with a letter of support and provided remarks during the launch of the initiative at the U.S. Department of Health and Human Services (HHS) National Conference on Women's Health.

TN-Meharry Medical College HBCU Wellness Project

The HBCU Wellness Project at Meharry Medical College is an intervention to promote health and modify risks for chronic diseases among individuals living in the surrounding communities while training undergraduate students interested in health professions. To date, this initiative has trained more than 1,000 students primarily from Fisk University, Lane College, LeMoyne-Owen College and additionally students from Tennessee State University, Austin Peay State University, Middle Tennessee State University, and the University of Tennessee at Chattanooga. The program's peer reviewed curriculum provides an intensive overview of essential research principles and frameworks, including human subjects protections, ethics, epidemiology, social determinants of health, institutional review board protocols, and other foundational topics that prepare students to research and address optimal health outcomes in resource-limited populations. The AMA is partnering with Meharry Medical College to provide $100,000 in funding to help recruit, train and engage students as well as strengthen the program's capacity to attend national conferences to further promote the work. Partnership in this initiative puts AMA at the forefront of providing education to and opportunities for students looking to deepen their research careers and contributions to health programming in local communities.

Memberships, Sponsorships, and Other Engagements

COHO is engaging the AMA with minoritized physician groups, community partners, and other stakeholders. COHO has worked to make AMA a member of the National Health Council, the National Rural Health Association, and the National Produce Prescription Collaborative. The AMA has also provided grants to several organizations to support professional development and promoting optimal health outcomes. COHO continues to seek opportunities to collaborate with and support organizations such as the National Medical Association, the National Hispanic Medical Association, the National Council of Asian Pacific Islander Physicians, the Association of American Indian Physicians, and GLMA.

Health Law Intern and Externship Program

COHO is working to develop a robust pipeline of highly qualified health law attorneys and lobbyists through the continuation of a summer health law program, previously overseen by Advocacy. COHO is maintaining existing relationships and developing new connections with a diverse group of law schools and professional organizations to promote the internship and full-time employment opportunities at the AMA.

Community Health

Community Health Impact Lab Micro Grants

The Community Health Impact Lab's micro grant initiative supports physician-led, community-centered initiatives that improve health outcomes—particularly for populations with demonstrated health needs. AMA awarded a total of $1 million in micro grants. Awards support a total of 20 physician-led community health projects at local organizations at $50,000 each. The projects are representative of 16 states and Washington, DC. Topics range from expanding access to preventive care and maternal health services to addressing mental health, nutrition, and chronic disease in diverse populations, including rural and indigenous populations, women, children, and other underserved or marginalized groups. During this inaugural micro grant cycle, AMA will lead engagement with physician leaders and deepen insights into community health.

Release the Pressure

Release the Pressure (RTP) is AMA's national hypertension awareness and engagement campaign focused on populations with high risk factors— combining patient education, community partnership, physician engagement, policy development and advocacy to improve heart health outcomes.

National Environmental Education Foundation (NEEF)

COHO is partnering with the National Environmental Education Foundation (NEEF) to administer the Veterans and Nature Grant Program to support veterans' health and well-being through nature-based experiences, education, and stewardship activities. The $125,000 grant supports community-based and veteran-serving organizations, including those serving under-resourced and rural communities, with the goal of increasing access to nature-based activities that promote physical health, mental well-being, social connection, and overall wellness. The program will also assess participation, reach, and early health and well-being outcomes to inform future programming.

West Side United

A coalition of healthcare systems, community organizations, and residents is working to close Chicago's West Side life expectancy gap through coordinated investments across health, education, economic vitality, and neighborhood improvement. The AMA has recommitted an additional investment of $3M over the next three years as an Anchor Mission Partner and continues to support local hiring, community events, and procurements. AMA has continued to offer $250K sponsorship to capacity building in local hiring, BP screening in the community, and workforce development, including Community Health Workers (CHW), care coordinators, and nursing. AMA's engagement and collaboration in this initiative continues to advance the knowledge and evidence on the impact of Social Return On Investment (SROI).

Live Healthy Chicago

The AMA continues to support Rush University Medical Center (and other organizations) in leading and advancing the Live Healthy Chicago (LHC) initiative. LHC is a civic initiative that brings together partners, programs, and resources from across the health care ecosystem to reduce cardiovascular disease (CVD) risk in 27 West and South Side neighborhoods where cardiovascular risk is nearly double the citywide rate and mortality from heart attacks and strokes is disproportionately high. This innovative initiative is offering primary care practices for the AMA

MAP™ Hypertension QI Program and implementation support to improve blood pressure control rates, deploying mobile community care teams, and launching a public health awareness campaign.

Atlanta Hypertension Initiative

The Atlanta Hypertension Initiative (AHI) brings together public health, health care, community, government, academia, and professional associations to address longstanding health outcome differences in hypertension control across metro Atlanta. Grounded in truth and accountability for disparate outcomes, AHI focuses on repair and healing through community partnership, continuous quality improvement, and shared capacity-building. Over the next five years, the initiative aims to improve blood pressure control for more than 500,000 adults. The initiative is utilizing the AMA MAP™ framework and AMA tools and resources, with support from COHO subject matter experts. COHO has supported the design and implementation of the AHI monthly QI webinars for all participating partners. COHO solutions are utilized to support the implementation and evidence-based practices and community engagement.

Million Hearts

AMA was awarded a multi-year Cooperative Agreement by the U.S. Centers for Disease Control and Prevention (CDC), Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health. As part of this Cooperative Agreement, COHO aims to support capacity building using implementation science principles, AMA MAP™ Framework, evidence-based quality improvement (QI) strategies, data-driven decision-making, and peer learning to improve blood pressure control and reduce heart attacks and strokes. Working in partnership with Alliance Chicago, COHO is engaging 6 Health Center Control Networks, and supporting 24 different health centers (urban and rural) across 9 states to improve the quality of care in blood pressure control and cholesterol management.

Health Systems Engagement

AMA MAP™ Solutions

This year, AMA MAP™ Solutions advanced the AMA's strategic priorities by helping health care organizations strengthen cardiovascular disease prevention through practical, evidence-based improvement strategies. These efforts also reinforce AMA leadership in practice of transformation, clinical quality, and physician support while helping organizations translate proven CVD strategies into measurable, sustained improvements for care teams and patients. To date, 125 health care delivery organizations have implemented one or more AMA MAP™ Solutions, and 30 of those organizations have reported measurable impact.

Validated Blood Pressure Device Listing (VDL)

The list of blood pressure measurement devices independently validated for clinical accuracy and meeting the VDL Criteria continues to expand. In 2026, 30 new devices, 7 of which are for pregnancy, have been added. The VDL continues to prioritize increasing the number of devices used during pregnancy and during the post-partum period.

Remote Area Monitoring (RAM)

Remote Area Medical (RAM), a nationally recognized nonprofit, delivers free, high-quality medical, dental, and vision care through pop-up clinics, mobile health units, and telehealth services in rural, under-resourced, and high-risk communities. COHO is collaborating with RAM on blood pressure monitor device donations and volunteering to advance the AMA's strategic priorities of

promoting health equity, improving access to care, expanding preventive screenings, and strengthening community-clinical linkages. RAM reaches individuals most affected by chronic disease and unmet health needs, including those who often forgo care due to cost barriers, competing life priorities or limited access to providers.

MIPS Adoption of Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes

AMA's electronic clinical quality measure (eCQM), *Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes*, has been adopted by CMS for use in MIPS. The 2026 measure description and specifications are available on the eCQI website. COHO is supporting organizations in implementing the measure for its inaugural reporting year in 2027 to help establish baseline performance. Additionally, COHO is gathering feedback from users on implementation challenges and developing a roadmap for future tools and resources to support its adoption.

Research and Evaluation

COHO is well-equipped to advance efforts to eliminate health disparities and improve health outcomes using quantitative, qualitative, econometric, social epidemiologic research methodologies and evaluation tools. COHO researchers work in close collaboration with AMA colleagues and with key external partners in health systems, community health organizations, and academic institutions. Findings are disseminated in peer-reviewed journal publications and presented at national conferences, which helps COHO establish an evidence base. This evidence supports the translation of research into policy and the development of innovative tools and products to mitigate inequities in care to improve health outcomes for all.

Healthcare Anchor Network / Social Return on Investment

COHO staff continued to refine a methodology for quantifying the social return on investment in partnership with Kearney associated with West Side United's social impact investing strategy. This work has drawn the interest of the Healthcare Anchor Network, who invited COHO staff to present findings from this work at their August convening in Chicago and at their October annual meeting in Denver. COHO staff has worked closely with West Side United on this work.

Glucagon-like peptide-1 receptor agonists (GLP-1 RAs)

COHO staff continued to explore research topics studying the utilization and spending for GLP-1 RAs. Using credible and timely data, the team continues to measure the accessibility, affordability, and safety of GLP-1 RAs, both in the overall population and among marginalized populations. They are also exploring how the relationships of pairing behavioral and lifestyle medicine principles and practice with GLP-1 RAs and other anti-obesity Medications. Data is extracted from multiple sources including Medicaid claims, pharmaceutical fills, and federally qualified health center networks. This work was presented at the American College of Preventive Medicine.

Self-Measured Blood Pressure Return on Investment

COHO staff continued research to examine the economic maternal and infant outcomes of self-measured blood pressure (SMBP) monitoring, which enables more frequent measurements and potentially earlier detection and management of hypertension (HTN) during pregnancy and the postpartum period for Medicaid beneficiaries. The work supports a targeted Medicaid coverage strategy that pairs SMBP with explicit protocols for reviewing elevated readings, confirming persistent hypertension, and initiating or intensifying treatment.

Maternal Health Pilot

The COHO team is collaborating with The University of Mississippi Medical Center (UMMC) to pilot a Diabetes Prevention Program tailored for women with gestational diabetes in rural Mississippi. The pilot will consist of three phases including (1) pre-implementation, (2) semi-structured interviews, and (3) implementation and evaluation. Collectively, the teams will work together to develop a lifestyle change program curriculum/guide tailored for this specific population, embed clinical workflows for providers, and enhance efforts to provide continuity of care post-partum via connections to local providers, telehealth or other modalities.

Elevance Health – Studies of Physician-Patient Dyads

COHO staff worked with research collaborators at Elevance Health to finish three major empirical studies of racial concordance using AMA's Physician Professional Data and Elevance Health's data on colorectal cancer screening, statin adherence among individuals with cardiovascular disease and diabetes care adherence. Each of the studies examined the importance of physician-patient concordance, while accounting for area-level social vulnerability and other relevant factors. These very large studies (the colorectal cancer analysis is based on over 5 million patient-year observations) are well positioned to make an impact on the literature on racial concordance, and ultimately all provide evidence of the importance of the clinical relationship.

External Research Advisory Group

COHO staff continued to organize and meet with an external research advisory group. The group includes twelve research leaders from across the health care ecosystem. Discussions center around strategy and feedback on COHO research projects.

Plans for Developing a New Strategy Under the Direction of New COHO Leadership

COHO is excited to welcome Denise Fair Razo, MBA, MPH as COHO's group vice president, effective August 3, 2026. Fair Razo brings to the AMA more than two decades of executive leadership experience spanning large-scale ambulatory care and healthcare organizations, public health and community partnerships. Most recently, she served as chief public health officer and chief operating officer of the City of Detroit Health Department, where she strengthened public health infrastructure and oversaw more than 40 programs spanning maternal and child health, immunizations, community health services, behavioral health, and environmental health. Under Fair Razo's leadership, COHO will develop and expand on data-driven solutions that improve health outcomes and build a healthier future for all.

CONCLUSION

While there have been staffing changes, the AMA remains committed to the pursuit of health equity and optimizing health outcomes for all populations. The creation of COHO allows for greater collaboration internally and externally, positioning AMA to take measurable action and build data-driven solutions to optimize health outcomes for all. COHO's cross-functional workforce bolsters AMA capabilities to support physicians, communities and organizations to close gaps and reduce health disparities. Under the direction of new COHO leadership, COHO will create a new short and long-term strategy guided by data-driven solutions that improve health outcomes and build a healthier future for all.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 13-I-26

Subject: Enhancing the Work of the Center for Digital Health and AI

Presented by: Toluwalasé A. Ajayi, MD, Chair

Policy G-615.998 Creation of an AMA Council with a Focus on Digital Health Technologies and AI, directed the American Medical Association (AMA) to establish a task force by the 2024 Interim Meeting focused on digital health, technology, informatics, and augmented/artificial intelligence (AI) with the potential to transition this task force to a new council and report back at the 2025 Annual Meeting on this transition.

Board of Trustees Report 25-A-25 amended the policy to direct the task force on AI, Digital Health, and Informatics to work toward an informed recommendation on the long-term model for House of Delegates (HOD) input with a report back at the 2026 Interim Meeting.

This report shares the work of the task force and presents the creation of a physician network of experts with representation from the HOD and all AMA members to provide guidance to the Center on Digital Health and AI. The network will also be available to provide other entities of the AMA, including the Board of Trustees and Councils with expertise as needed and requested.

BACKGROUND

Policy G-615.998 directed the AMA to establish a task force by the 2024 Interim Meeting focused on digital health, technology, informatics, and augmented/artificial intelligence, with the potential to transition the task force to a council. The task force was constituted before the 2024 Interim Meeting and first convened in February 2025. Over four meetings between February 2025 and January 2026, it progressed from defining its purpose and substantive priorities to evaluating the long-term governance structure for AMA leadership in these fields.

Task Force Selection and Composition

The founding charter authorized up to 22 members and established a deliberate, multi-source selection process. Members of the HOD could self-nominate through an application process; each of the AMA's seven councils nominated a liaison; and the Senior Management Group identified additional candidates with relevant expertise. Final membership was approved by the Chair of the AMA Board of Trustees. The resulting task force combined HOD members, representatives of every existing council, AMA Board members, and external physician and nonphysician experts serving as public or group members. This design gave the task force both a direct connection to the HOD and the technical breadth needed to address rapidly evolving issues.

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Inaugural Task Force Members

Member	Representation / selection source	Specialty or expertise
Adam Prater, MD, MPH	House of Delegates	Radiology
Carolyn Maureen Clancy, MD, MACP	House of Delegates	Internal medicine / Veterans Affairs
Christopher Libby, MD, MPH, FACEP	House of Delegates	Emergency medicine
David Aizuss, MD	AMA Board member; task force co-chair	Ophthalmology
Druv Bhagavan	House of Delegates	Medical student
Eric Langshur	Public member; Abundant Ventures	Nonphysician member
Gary R. Katz, MD, MBA, FACEP	Council on Long Range Planning and Development	Emergency medicine
Jerry P. Abraham, MD, MPH, CMQ	Council on Constitution and Bylaws	Family medicine
Lisa Dykstra	Public member; former CIO; CHIME	Nonphysician member
Lynn Jeffers, MD, MBA	AMA Board member	Plastic surgery
Mark Synovec, MD	House of Delegates	Pathology
Michael Suk, MD	AMA Board member; task force co-chair	Orthopaedic surgery
Padmini Ranasinghe, MD, MPH, FACP, FACPM	Council on Science and Public Health	General medicine
Rebecca Weintraub Brendel, MD, JD	Council on Ethical and Judicial Affairs	Psychiatry
Robyn Chatman, MD, MPH, FAAFP, CPHIMS, CHEP	House of Delegates	Family medicine / addiction medicine
Roxana Lupu, MD, MBA, FACP	Public/group member	Hospital medicine
Seema Sidhu, MD	Council on Medical Education	Obstetrics and gynecology
Steven L. Chen, MD, MBA	Council on Medical Service	Surgical oncology
Tom Lawry	Public member; Second Century Tech LLC	Nonphysician member
Tripti Kataria, MD, MPH, MBA, FASA	Council on Legislation	Anesthesiology
Vincent Liu, MD, MSc	Public/group member	Internal medicine

Evolution of the Task Force's Work

The task force intentionally separated its work into two related tracks. The first was substantive: to define the role and scope of AMA leadership in AI, digital health, and clinical informatics. The second was organizational: to determine what an enduring physician-led body should look like, including whether it should become a council, remain a task force, or take another form, and how it should interact with the newly established Center for Digital Health and AI.

On the substantive track, the task force identified five foundational areas for AMA leadership: health technology policy frameworks; liability and risk mitigation; physician education and upskilling; standards for responsible use in clinical environments; and governance for the integration of digital health and AI. It also emphasized evaluation frameworks, physician leadership in technology design and deployment, safe, transparent, and equitable adoption, coverage and pathways to payment, and stronger communication with the HOD.

On the organizational track, the task force considered an elected council, an appointed council, a standing task force, a standing advisory committee, and phased or hybrid approaches. It assessed the options against authority, continuity, agility, cost, access to specialized expertise, responsiveness to the HOD, and fit with the existing councils. The analysis demonstrated that AI, digital health, and informatics are not a discrete jurisdiction: they affect ethics, medical education, payment, legislation, public health, clinical workflow, and practice sustainability. The task force therefore concluded that the durable structure should coordinate expertise across councils and the AMA enterprise rather than duplicate or compete with existing council responsibilities.

DISCUSSION

The Center for Digital Health and AI

During 2025, the AMA established the Center for Digital Health and AI as the operational home for this work. The Center creates a business unit capable of commissioning research, building evaluation frameworks and educational resources, convening coalitions, and engaging technology developers, regulators, policymakers, health systems, and innovators. Its purpose is to help ensure that physicians shape technological change and that digital health and AI improve patient care, strengthen the patient-physician relationship, and earn public trust.

The Center is organized around four pillars:

- Policy and regulatory leadership: shaping benchmarks and policy frameworks for the safe and effective use of AI and digital health technologies.
- Clinical workflow integration: creating opportunities for physicians to shape tools so they fit clinical workflows and improve patient and clinician experience.
- Education and training: equipping physicians and health systems to evaluate, adopt, and use AI and digital health technologies effectively.
- Collaboration: building partnerships across technology, research, government, health care, and organized medicine to advance innovation aligned with patient needs.

The Center has already expanded the AMA's presence and physician support in this space through physician roundtables, the AI Evaluation Guide, an AI Specialty Collaborative involving more than 25 national specialty societies, policy and model-legislation work on AI-generated physician deepfakes, and a legislative framework addressing mental health chatbots. As the Center matures, its work may also include product development, standard-setting and validation, and additional partnerships and coalitions.

Role and Scope of the Network of Experts

The network of experts will be modeled after the Food and Drug Administration’s network of experts which is used to provide rapid access to expertise when it is needed to supplement existing knowledge and expertise across multiple Centers.

The Center does not make AMA policy and is not intended to replace the HOD. Policy authority remains with the HOD. The network of experts will make expansive physician leadership and expertise continuously available to the Center and other AMA entities seeking expert insights while preserving those governance boundaries. It will advise Center leadership, provide perspective on strategy, ethics, implementation, risk and liability, interface with existing councils and the Board, and elevate issues requiring HOD policy consideration, as well as other entities seeking expert insights on AI related issues.

This relationship addresses both dimensions of the task force's work. Substantively, the network of experts will provide a nexus of physician expertise across AI and digital health. Organizationally, it will connect that expertise to the Center's operational capacity, the existing councils' subject-matter jurisdictions, the Board's oversight, and the HOD's policy-making authority.

Conclusion

The Center for Digital Health and AI is constituting a network of experts to be used as advisors on all digital health and technology issues. All members of the House of Delegates and members of the AMA will have the opportunity to self-enroll as members of the network with a designation of specific expertise. The expertise of this network will be available to the Board of Trustees, the House of Delegates, and all AMA Councils as needed to provide expertise on all issues. This network of experts combines continuity, adaptability, cross-council coordination, and specialized expertise. This network of experts aligns with the original resolution that created the task force and further aligns with the direction of the task force.

In a field that is rapidly changing, having access to the expertise of more individuals will expand the Center's own reach and expertise. The self-enrollment process will allow the Center to harness the vast expertise of our members while not adding unnecessary meetings or obligations. The Center will be able to reach o as needed to experts for feedback, testimony, field testing, and myriad other issues. This model will allow the Center to have immediate access to expertise and will be able to convert guidance and expertise into operational work.

REPORT 19 OF THE BOARD OF TRUSTEES (I-26)
2026 AMA Advocacy Efforts

EXECUTIVE SUMMARY

This report is submitted for the information of the House of Delegates (HOD). Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the HOD at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on the American Medical Association's (AMA) most prominent advocacy activities for the year to date. (Note: This report focuses heavily on the first half of the year based on approval deadlines, so more recent developments may not be reflected.)

At the start of 2026, the AMA achieved several measurable, high-visibility wins that advance physician practice sustainability, defend physician-led care, and shape national healthcare policy. H.R. 7148, the "Consolidated Appropriations Act of 2026" included Medicare telehealth extensions; restoration of Alternative Payment Model (APM) incentives; virtual expansion of the Medicare Diabetes Prevention Program; Medicare Advantage provider directory accuracy reform; a five-year extension of Acute Hospital Care at Home; reauthorization of the "Dr. Lorna Breen Health Care Provider Protection Act;" Pharmacy Benefit Managers (PBM) reform; and two maternal health bills.

On Medicare payment, the chairs of the GOP and Democratic Doctors Caucuses—Reps. John Joyce, MD (R-PA), Greg Murphy, MD (R-NC) and Kim Schrier, MD (D-WA)—along with 23 original cosponsors, introduced the "Patients First Act" (H.R. 9693), a comprehensive, bipartisan proposal to reform the Medicare physician payment system. The legislation was developed over the past year through extensive consultation with the AMA and other physician organizations. The bill addresses all four of the core reforms organized medicine has sought for more than a decade: annual inflation-based payment updates, modernized budget neutrality policies, simplified and clinically relevant quality measurement, and expanded opportunities to participate in APMs. There are several more targeted Medicare payment reform bills under consideration as well.

The AMA is also lobbying extensively at the federal level and working with the Federation at the state level to attempt to mitigate any potential patient coverage losses due to implementation of H.R. 1, the "One Big Beautiful Bill Act" (OBBBA). Along with our lobbying efforts, the AMA is seeking to provide resources that can be used by physicians to directly help patients.

This report includes updates on these issues as well as prior authorization, augmented intelligence, physician wellness, reproductive health, and other key physician and patient advocacy topics.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 19-I-26

Subject: 2026 AMA Advocacy Efforts

Presented by: Toluwalaṣé A. Ajayi, MD, Chair

This report is submitted for the information of the House of Delegates (HOD). Policy G-640.005, "AMA Advocacy Analysis," calls on the Board of Trustees (the Board) to provide a report to the HOD at each Interim Meeting highlighting the year's advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The Board has prepared the following report to provide an update on the American Medical Association's (AMA) most prominent advocacy activities for the year to date. (Note: This report focuses heavily on the first half of the year based on approval deadlines, so more recent developments may not be reflected.)

DISCUSSION OF 2026 ADVOCACY EFFORTS

H.R. 7148, the "Consolidated Appropriations Act of 2026"- Enacted

At the federal level, 2026 started with the AMA producing measurable, high-visibility wins that advance physician practice sustainability, defend physician-led care, and shape national healthcare policy. The AMA was instrumental in securing bipartisan support for important physician and patient priorities in the federal budget deal enacted in February, H.R. 7148, the "Consolidated Appropriations Act of 2026." This legislative package included extensions and reforms in telehealth, value-based care, diabetes prevention, and efforts to tackle physician burnout. These illustrate AMA's ongoing influence on national health policy outcomes.

- Medicare telehealth extensions - Section 6209 extended Medicare telehealth flexibilities for two years, through Dec. 31, 2027. The AMA strongly supported this extension and continues to advocate for permanent authorization of Medicare telehealth flexibilities.
- Alternative payment model (APM) incentives restored - Section 6204 reinstated APM incentive payments at 3.1 percent for the 2026 performance year/2028 payment year. These provisions responded directly to AMA advocacy following the expiration of APM bonuses and the automatic Qualifying Participant (QP) threshold increase in 2025.
- Medicare Diabetes Prevention Program—virtual expansion - Section 6214 included the "PREVENT DIABETES Act," an AMA-endorsed policy expanding access to the Medicare Diabetes Prevention Program (MDPP). For the first time, CDC-recognized virtual diabetes prevention programs will be included in the MDPP expanded model on a trial basis from Jan. 1, 2026, through Dec. 31, 2029.
- Medicare Advantage provider directory accuracy reform - Section 6220 included the "Requiring Enhanced and Accurate Lists of (REAL) Health Provider Act," shaped by extensive AMA input. Medicare Advantage (MA) plans must maintain accurate, regularly updated provider directories and publicly report accuracy rates. It also includes Centers for Medicare & Medicaid Services (CMS) oversight, GAO evaluation, public reporting, and dedicated funding strengthen accountability and enforcement.

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- Five-year extension of Acute Hospital Care at Home - Section 6210 extended the Acute Hospital Care at Home (AHCaH) waiver for five years, through 2030. This preserved a proven, physician-led model delivering hospital-level care safely in the home.
- "Dr. Lorna Breen Health Care Provider Protection Act" reauthorization - Section 6508 reauthorized and expanded the Dr. Lorna Breen Health Care Provider Protection Act for five years, through FY 2030. The bill continued funding, mandates annual stigma-reduction campaigns, broadens grant eligibility to address administrative burden, and aligns grant periods with the authorization length.
- Pharmacy Benefit Managers (PBM) reform - The legislation included targeted pharmacy benefit manager reforms to enhance transparency, curb abusive Medicare drug rebate practices, and strengthen enforcement against anti-competitive behavior. These provisions represent tangible progress toward lowering prescription drug costs and improving fairness in the drug supply chain.
- Maternal health - The bill reauthorized the "PREEMIE Reauthorization Act" to expand federal research on preterm birth and improve outcomes for premature infants. It also reauthorized the "Preventing Maternal Deaths Act," increases authorized funding to $100 million annually through 2030, expanded the scope of state maternal mortality review committees, and directed federal agencies to more regularly disseminate best practices.

These eight provisions reflect multiple policy areas important to physicians and patients. They are the result of a tireless advocacy effort by the AMA that spanned several Congresses and included testimony, formal comment letters, legislative drafting input, coalition coordination, and sustained committee engagement. Each provision addresses a discrete policy issue; collectively, they represent measurable progress across several long-standing AMA advocacy priorities.

Medicare Payment Reform

The AMA and the Federation have a clear vision for fixing the nation's Medicare physician payment system. The AMA is calling on policymakers to reform the "Medicare Access and CHIP Reauthorization Act" (MACRA) along four key pillars:

- Annual payment updates tied to the Medicare Economic Index (MEI);
- Reforms to budget neutrality;
- Overhaul of the Merit-based Incentive Payment System (MIPS); and
- Modifications to alternative payment models.

The year began with Congress providing a hard-fought one-time 2.5 percent Medicare payment update for 2026 that was enacted in the "One Big Beautiful Bill Act" (H.R. 1) (OBBBA); however, Congress must act to address payment rates in future years. In line with our reform pillars, the AMA is advocating for:

- H.R. 6160, the "Strengthen Medicare for Patients and Providers Act," to provide physicians with a permanent inflationary update equivalent to the MEI, which has been reintroduced by Reps. Raul Ruiz, MD (D-CA), Gus Bilirakis (R-FL), Jimmy Panetta (D-CA), Ami Bera, MD (D-CA) and Kim Schrier, MD (D-WA).
- H.R. 8163, the "Provider Reimbursement Stability Act" which would make targeted improvements to the statute governing budget neutrality requirements within the Medicare Physician Fee Schedule. (In May, the bill passed the House Ways and Means Committee unanimously.) The Senate has introduced a companion bill (S. 5180) sponsored by Senators

John Boozman (R-AR), Peter Welch (D-VT), Roger Marshall, MD (R-KS), Angus King, (I-ME), Thom Tillis (R-NC), and Jeanne Shaheen (D-NH).

- H.R. 8622, the "Medicare Physician Data-driven Performance Payment System Act of 2026" which was introduced by Reps. Mariannette Miller-Meeks, MD (R-IA) and Herb Conaway, MD (D-NJ). This legislation would make key, targeted reforms to the MIPS program in hopes of making it more efficient, useful and fair for all participating physicians.

The AMA is still highly concerned about the Medicare payment efficiency adjustment promulgated by CMS in the 2026 Medicare Physician Fee Schedule, and we will continue to look for opportunities to modify this policy.

In a major development, on July 15, the chairs of the GOP and Democratic Doctors Caucuses—Reps. John Joyce, MD (R-PA), Greg Murphy, MD (R-NC) and Kim Schrier, MD (D-WA)—along with 23 original cosponsors, introduced the Patients First Act (H.R. 9693), a comprehensive, bipartisan proposal to reform the Medicare physician payment system. The legislation was developed over the past year through extensive consultation with the AMA and other physician organizations. The bill addresses all four of the core reforms organized medicine has sought for more than a decade: annual inflation-based payment updates, modernized budget neutrality policies, simplified and clinically relevant quality measurement, and expanded opportunities to participate in APMs.

Most importantly, the bill establishes a permanent annual payment update tied to the MEI, built into the baseline so that Medicare payment tracks growth in the actual costs of running a practice. The legislation also incorporates the budget neutrality reforms of the "Provider Reimbursement Stability Act" (H.R. 8163/S. 5180), raising the outdated $20 million threshold, correcting CMS utilization misestimates, and capping year-to-year conversion factor swings. In addition, the bill replaces MIPS with the new Patient Outcome Improvement National Tabulation System (POINTS); freezes the APM Qualifying Participant threshold at 50 percent; extends and increases the work Geographic Practice Cost Index (GPCI) floor benefiting rural areas and 34 entire states; and establishes a fully funded, five-year hybrid payment demonstration for independent primary care practices that is exempt from budget neutrality. On July 22, the AMA sent the sponsors a letter of support signed by AMA CEO John Whyte, MD, MPH, commending their bipartisan leadership in crafting this significant legislation and urging colleagues on both sides of the aisle to join as cosponsors.

Finally, the AMA has also kept pressure on Congress through our grassroots efforts including close to 2 million visitors to FixMedicareNow.org; over 758,000 direct contacts to Congress on Medicare Reform; over 12.3 million engagements with FixMedicareNow content; and 225+ earned media placements reaching an estimated audience of over 1+ billion.

For a more detailed look at this issue and the AMA's efforts, please see BOT Report 20-I-26, "AMA Efforts on Medicare Payment Reform."

Medicaid

When the OBBBA was enacted by Congress in 2025, it introduced sweeping funding cuts and policy changes to Medicaid, the Health Insurance Marketplace, Medicare physician payment and medical student loans. Over one year later, these changes have had a significant impact on many physicians and their patients' access to care. Throughout the OBBBA debate, the AMA was vocal about the potential harms to patients. Now, we are working on multiple fronts to protect patient

access to affordable coverage and ensure that states and advocates have the resources they need to help limit the law's impact.

The AMA is engaged in extensive advocacy relating to the implementation of new community engagement requirements (or "work requirements") in Medicaid. Prior to the issuance of an interim final rule (IFR) implementing the work requirements in June of 2026, the AMA engaged directly with CMS officials, including Dan Brillman, the Director of the Center for Medicaid and CHIP Services and the federal official responsible for implementing the OBBBA's Medicaid and CHIP provisions. In March, the AMA sent a letter to Director Brillman outlining the AMA's priorities for implementing work requirements (such as streamlined eligibility procedures to avoid procedural disenrollments and a comprehensive and flexible definition of "medical frailty" to ensure that patients are appropriately exempted from work requirements). In May, upon learning of reports that the forthcoming IFR would diverge from what CMS had been leading states and other stakeholders to expect in informal guidance, the AMA sent a letter to CMS, urging the agency to follow the approach it had been preparing states and stakeholders for and in particular to avoid making the medical frailty exemption standards too narrow. Unfortunately, the June IFR issued by CMS narrowly defines medical frailty and introduces numerous other extra-statutory elements (such as a requirement that individuals must be determined to be unable to comply with work requirements to receive a medical frailty exemption) that are expected to lead to high numbers of procedural disenrollments and an increased administrative burden for physician practices. Although the IFR is effective on July 31, 2026, without any additional action by CMS, the AMA submitted a comment letter describing the dire consequences of the approach taken by the IFR and recommending that CMS revise the rule to prevent significant harm to the Medicaid program. The AMA is also leading an amicus brief in support of a coalition of states that is seeking to enjoin the implementation of the IFR. Unfortunately, the trial court sided with the Administration. Finally, the AMA is working with the Federation on strategies to help physicians and patients navigate work requirement policies.

The AMA also sent a comment letter urging CMS to revise a proposed rule that would restrict state use of two payment mechanisms: state directed managed care payments and targeted practitioner fee-for-service payments. Like the work requirements IFR, this proposed rule exceeds what is mandated by Congress in the OBBBA, and threatens states' ability to operate their Medicaid programs efficiently and economically while ensuring an adequate provider network and high-quality care for beneficiaries, as required by statute. The AMA urged CMS to revise the rule so as to align with the requirements of the OBBBA, and emphasized that the mechanisms subject to restriction under the proposed rule are important tools for states to improve frequently inadequate reimbursement rates for Medicaid services.

Further, the AMA is providing individualized assistance to state medical associations as they collaborate with state health agencies to secure funding from the Rural Health Transformation Program (RHTP). The AMA was extremely active in shaping state applications for funding and continues to lead on RHTP issues.

The AMA is offering extensive educational efforts on the OBBBA's changes to Medicaid and CHIP, including webinars and other live learning opportunities and the creation of numerous resources covering topics from changes to Medicaid financing to exemptions from Medicaid work requirements. The AMA also produced a patient guide to new Medicaid work and community engagement rules which is intended as an educational resource for physician practices. States are now implementing OBBBA's policy changes, and the AMA continues to work closely with state and specialty medical associations to understand the state-specific impacts of OBBBA on patients and physicians and offer tailored solutions that respond to individual state needs. The AMA is also

assisting state medical associations with building tools and resources, including analyses, policy options, and other advocacy resources to support state advocacy. Further, the AMA is also convening Federation partners to share information and strategies as implementation continues and coordinating with state officials and national organizations to amplify physician perspectives.

Prior Authorization

Prior authorization is a remarkable frustration for physicians due to its excessive use by insurance companies to delay or deny patient care, and its use directly correlates with poorer healthcare outcomes. According to the most recent AMA research:

- Patient harm - More than one in four physicians (26 percent) reported that prior authorization has led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, or death.
- Poor outcomes - More than nine in 10 physicians (92 percent) reported that prior authorization has a negative impact on patient clinical outcomes.
- Delayed care - More than nine in 10 physicians (95 percent) reported that prior authorization delays access to necessary care.
- Disrupted care - More than three-fourths of physicians (79 percent) reported that patients abandon treatment due to authorization struggles with health insurers.
- Added burden - Physicians complete an average of 40 prior authorizations per week, and nearly one in three (32 percent) report that requests are often or always denied.
- Physician burnout - More than nine in 10 physicians (94 percent) say prior authorization contributes to burnout.
- Denial trend - Three-quarters of physicians (74 percent) report that denials have increased over the past five years, and six in 10 express concern that augmented intelligence (AI) may further increase denial rates.
- Diverted time and resources - Prior authorization consumes an average of 13 hours of physician and staff time each week, and two in five physicians (40 percent) employ staff dedicated exclusively to prior authorization tasks.
- Wasted health resources - More than four in five physicians (88 percent) report that prior authorization increases overall healthcare utilization, contributing to waste rather than savings. Physicians cite ineffective initial treatments (75 percent), additional office visits (73 percent), urgent or emergency care (47 percent), and hospitalizations (32 percent) as consequences of prior authorization requirements.

The House and Senate both reintroduced the "Improving Seniors' Timely Access to Care Act of 2025" (H.R. 3514/S. 1816). This bicameral, bipartisan legislation seeks to reform prior authorization in Medicare Advantage plans by improving transparency through public reporting of program metrics and streamlining the process using standard electronic transactions. The legislation has garnered tremendous bipartisan congressional support, specifically securing 70 Senate and 284 House cosponsors, and it passed the House Ways and Means Committee on July 15, 2026, and the House Energy and Commerce Committee on July 21, 2026.

Another piece of federal legislation introduced by Reps. John Joyce, MD (R-PA), Greg Murphy, MD (R-NC) and Kim Schrier, MD (D-WA), (the "Medicare Advantage Improvement Act" H.R. 8375/S. 4384) is a sweeping bipartisan bill that places major restrictions on the use of prior authorization within Medicare Advantage. The bill includes more stringent timeframes for MA plans to issue final PA decisions (no less than 24 hours for emergent, no less than 72 hours for all others), widespread transparency requirements, mandates for real-time PA decisions, prohibitions

on additional prior authorizations during ongoing treatment regimens, cuts to MA plans if they do not meet quality assurance standards, expansion of the star ratings program, codification of the two-midnight rule, and network adequacy standards. This legislation is currently cosponsored by six bipartisan cosponsors. The Senate companion bill was introduced on April 27th by Senators Roger Marshall, MD (R-KS) and Sheldon Whitehouse (D-RI).

There has again been a great deal of state activity on prior authorization. States that have passed prior authorization laws this year include: Alabama, Indiana, Iowa, Kentucky, Louisiana, New Mexico, New York, South Dakota, Utah, Virginia, and Washington. Reform themes include increased transparency, volume reduction, data reporting, automation, decreasing response times, and ensuring that licensed physicians are making the medical necessity determination (including in the context of AI). The AMA's model bill serves as the basis for many state laws, and we provide states with data, analysis, talking points, issue briefs, testimony and more to advance their efforts.

The AMA is also continuing our work with national policy making organizations to encourage national attention on the issue (e.g., the AMA was instrumental in the National Council of Insurance Legislators' (NCOIL's) recent adoption of a PA model bill and worked at the National Association of Insurance Commissioners (NAIC) on their recent PA white paper). This year, two NAIC committees are addressing the issue of prior authorization/utilization management, and we are already engaged there, including an upcoming presentation on prior authorization to the Health Innovations Workgroup in August.

Further, in response to growing concerns about the use of AI in PA and other utilization management processes, several states have recently enacted legislation to establish clearer safeguards, transparency requirements, and oversight mechanisms. These laws vary in scope but share a common emphasis: AI must not replace licensed clinicians in determining medical necessity, and AI tools must be deployed in a transparent, auditable, and nondiscriminatory manner. States that have adopted AI-related legislation in this space include Alabama, Arizona, California, Colorado, Illinois, Indiana, Iowa, Maryland, Minnesota, Nebraska, Texas, Utah, and Washington.

Reports have documented health plans using AI to deny, delay, or prematurely end coverage for medically necessary care, including post-acute and rehabilitation services, even when a physician recommends continued treatment. Patients may be forced to wait, navigate lengthy appeals, pay out of pocket, or forgo care. These harms necessitate enforceable federal safeguards requiring disclosure of AI use, independent validation and auditing, and individualized review of adverse decisions by a qualified physician. Health plans must be held accountable when AI coverage harms patients.

In addition to state legislative activity, national policymaking organizations are also advancing state AI regulatory efforts. For example, NAIC issued a model bulletin which reminds all insurance plans, including health insurance plans, that decisions or actions impacting consumers that were made or supported by AI tools must comply with applicable insurance laws and regulations. As of June 2026, 25 jurisdictions had adopted NAIC's model bulletin and four jurisdictions had adopted insurance-specific regulations or guidance.

Federal agencies have also begun to scrutinize the use of AI by health plans, though clear regulatory guidance is still emerging. In February 2024, CMS clarified that MA organizations may use AI and related technologies to assist in making coverage determinations, provided the tools do not override standards related to medical necessity or established MA plan coverage rules. In its final rule for Calendar Year 2026, CMS declined to adopt new AI-specific provisions for MA but

acknowledged the broad interest in AI and affirmed its intent to revisit the subject in future rulemaking. Finally, in January 2026, CMS launched a new model—the Wasteful and Inappropriate Service Reduction (WISeR) Model—a six-year pilot in six states that uses AI and third-party technology contractors to conduct prior authorization review for select Medicare services. The AMA raised serious concerns regarding the WISeR model when it was announced and has been continually working with CMMI to improve and refine the program to minimize patient care delays and physician practice burdens.

Federal legislation was recently introduced that would curb the use of AI by MA plans. H.R. 9734, the "Protecting Patients from Automated Denials Act," would require MA plans to provide their qualified physician reviewers' attestations to providers requesting PA, allow direct communication with the reviewing physician, disclose AI usage, retain all AI-related denial records for at least 10 years, and submit detailed reports to HHS every 90 days. The AMA strongly supports passage of this bill.

Scope of Practice

The best care and safest outcomes for patients depend on healthcare teams working together—with physicians in the lead. However, every year we see an increasing number of legislative efforts, especially at the state level, that try to inappropriately expand the scope of practice of non-physicians. This year is no different. The AMA Scope of Practice Partnership (SOPP), a coalition of 113 national, state and specialty medical and osteopathic associations, has been instrumental in defeating scope expansion bills across the U.S. Since 2007, the SOPP has awarded more than $5.7 million in grants to its members to fund advocacy tools and campaigns. In January, the AMA announced a commitment of $1 million annually to support the work of the SOPP, beginning in 2026. The SOPP has awarded 19 grants for 2026 to the following states: Arizona, California, Delaware, Georgia, Idaho, Illinois, Kentucky, Louisiana, Maryland (MedChi), Michigan, Missouri, Nebraska, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, South Carolina, and Tennessee. Of note, Arizona, Delaware, and Kentucky received grants for the 2025-2026 legislative sessions.

So far in 2026, the AMA, in collaboration with the SOPP, has successfully blocked over 70 proposed bills in 40 states that would have inappropriately expanded the scope of practice for physician assistants, optometrists, pharmacists and more. State efforts include:

- Idaho: With the help of a Scope of Practice Partnership (SOPP) grant, the Idaho Medical Association defeated physician assistant independent practice legislation and a bill that would have granted lay midwives broad authority to administer prescription drugs.
- Indiana: The Indiana State Medical Association delivered an important victory by defeating an advanced practice registered nurse independent practice bill.
- New Hampshire: The New Hampshire Medical Society scored a major win by securing a veto of an optometry surgery bill.
- Tennessee: Thanks to diligent advocacy and an SOPP grant, the Tennessee Medical Association was able to stop nurse practitioner and physician assistant independent practice bills, pharmacist test and treat legislation, and a psychologist prescribing bill.
- Washington: The Washington State Medical Association successfully defeated multiple scope bills this year including psychologist and naturopath prescribing legislation, as well as legislation that would have granted pharmacists the authority to diagnose and prescribe.

- West Virginia: The West Virginia State Medical Association successfully protected physician-led care by defeating physician assistant and nurse practitioner independent practice bills and a naturopath licensure bill.
- Wisconsin: With the help of an SOPP grant, the Wisconsin Medical Society secured a decisive win by defeating legislation that would have removed physician supervision of physician assistants and permitted them to change their title to "physician associate." It was also successful in defeating pharmacist and audiologist scope expansion legislation.

At the federal level, we achieved a major victory earlier this year with the passage of the "Consolidated Appropriations Act of 2026" which did not include the "Equitable Community Access to Pharmacist Services Act," (ECAPS) which would have expanded pharmacists' scope of practice. This bill is still a threat and under consideration, so the AMA will continue our opposition at each stage.

The AMA, through the Litigation Center, continued to be active in the courts supporting physicians on scope of practice issues.

- In June 2026, the Litigation Center, the Wisconsin Medical Society, the American Academy of Ophthalmology, and the Wisconsin Academy of Ophthalmology filed a lawsuit in Wisconsin state court seeking a declaratory judgment and injunction that would prohibit Wisconsin optometrists from performing laser eye surgery.
- In February 2026, the Litigation Center joined the California Medical Association in an amicus brief in the case *Palmer v. Bonta*, which involves a California statute prohibiting nonphysicians from publicly representing that they are "doctors." The case is pending in the federal Ninth Circuit Court of Appeals following a favorable decision in the district court.
- In November 2025, a West Virginia trial court struck down a West Virginia Optometry Board regulation, which had authorized state optometrists to perform eyelid surgery. The Litigation Center provided financial support for the case.

Physician Well-Being

Physicians, residents and medical students should be able to seek and receive care for mental health or substance use without fear of stigma and with full confidentiality protections. The AMA strongly urges all licensing boards, hospitals, health systems, liability carriers and credentialing bodies to remove from their applications inappropriate questions about mental health and treatment for a substance use disorder that create unnecessary barriers to care. Success on this issue has been due to a vibrant collaboration among the AMA, the Dr. Lorna Breen Heroes' Foundation, the Federation of State Medical Boards, the Federation of State Physician Health Programs, the National Association of Medical Staff Services, and all the other organizations that helped to make positive changes a reality.

Nearly 200 health systems have taken their commitment to physician well-being even further and earned recognition in the AMA Joy in Medicine® Health System Recognition Program.
As of May 2026, 44 state medical licensing boards and 3,300+ health systems, hospitals, medical centers, clinics and other care facilities have so far taken action to improve their licensing or credentialing applications and ensure that they are free from stigmatizing language and intrusive questions about past mental healthcare or substance use disorder treatment. This advocacy has benefitted more than 3.35 million physicians and other healthcare professionals. AMA advocacy and policy have been part of nearly every one of these efforts.

Shaping the Future of Digital Health and AI

In October of last year, the AMA announced the creation of the AMA Center for Digital Health and AI, a new endeavor that will put physicians at the center of shaping, guiding and implementing technologies transforming medicine. The Center for Digital Health and AI focuses on policy and regulatory leadership; clinical workflow integration; education and training; and collaboration and partnerships.

The AMA recently conducted a survey of physicians to capture the sentiment of practicing physicians regarding the increased usage of AI in healthcare, and the results are exciting, but also should serve as a bit of a warning to developers and regulators. Four in 10 physicians are equally excited and concerned about AI applications in healthcare and how it may impact the patient-physician relationship. About 70 percent recognize AI's potential to support diagnoses and improve workflow efficiency. Physicians' top concerns about AI are that if it is not designed and implemented correctly, it has enormous potential to negatively impact and, in fact undermine the patient-physician relationship.

In April, the AMA sent letters to key congressional caucuses focused on AI and digital health and pointed to growing concerns following reports of chatbots encouraging self-harm or suicide among vulnerable individuals. The issues were among those raised in prior congressional hearings that highlighted risks such as emotional reliance on AI, distorted perceptions of reality from prolonged use, and the absence of consistent safety standards.

In our message, we emphasized that AI tools have the potential to play a meaningful role in addressing gaps in mental healthcare access, particularly where cost and availability limit support. When designed responsibly, these technologies could help expand access to reliable information, identify early signs of mental health issues, and connect patients with appropriate care, while supporting clinicians and easing workforce shortages.

Responding to the escalating risk of AI-manipulated images, videos and audio that impersonate physicians, the AMA in April announced a new comprehensive policy framework to establish clear, enforceable protections for physicians against unauthorized AI-generated "deepfakes." In May, the AMA sent a letter of support to the House and Senate supporting the "NO FAKES Act," which would prohibit creation and dissemination of deepfakes of individuals and is partnering with interested stakeholders across several industries to urge passage. The AMA will continue to advocate for either broad or physician-specific deepfake protections.

The AMA continues to work with state medical associations and track state legislative efforts related to AI in healthcare, sharing issue briefs, data, and reviewing regulatory and legislative language to ensure it aligns with AMA Policy.

Vaccine Policy

In response to threats to undermine sound vaccine policy, the AMA announced in February that it is collaborating with the Vaccine Integrity Project and national medical specialty societies to launch an evidence-based review process to assess vaccine safety and effectiveness for the 2026–27 respiratory virus season. The review will focus on immunizations for influenza, COVID-19, and respiratory syncytial virus (RSV). The AMA has also been outspoken about other changes and potential changes to various vaccine protocols.

- The AMA issued a statement on changes to the childhood vaccine schedule.
- The AMA issued a statement on the Advisory Committee on Immunization Practices (ACIP) chair's comments on polio, routine vaccinations.
- The AMA further joined 130+ medical, nursing, public health and patient groups expressing deep concern regarding the significantly revised ACIP charter.
- The AMA issued a statement on the Executive Order directing CDC to assess the childhood vaccine schedule noting that there is no credible scientific evidence to support changing the current childhood vaccine schedule.
- The AMA joined a 2025 amicus brief (PDF) in the case of *AAP vs. Kennedy* calling for government recommendations regarding the COVID-19 vaccine to reflect the full body of medical evidence and to follow the statutory process for the provision of vaccine guidance.
- The AMA issued a statement on the federal court vaccine ruling calling it an important step toward protecting the health of Americans, particularly children.
- The AMA also issued a statement on August 10, 2026, in response to the Executive Order changing the childhood vaccine schedule. AMA President Willie Underwood III, MD, MSc, MPH stated in part, "Decisions about how and when vaccines are used should be driven by rigorous scientific evidence, patient safety, and independent medical and public health expertise. Altering a proven vaccination schedule without credible evidence risks weakening public confidence and putting children's health at risk."

Reproductive Health

The AMA remains deeply engaged in advocacy to protect access to reproductive healthcare and preserve the patient-physician relationship amid ongoing legislative and legal challenges. Across the states, the reproductive health policy landscape remains highly active. In August, the Massachusetts governor signed legislation removing restrictions on abortions after 24 weeks and replacing the prior framework with language allowing physicians to exercise their professional judgment. At the same time, harmful proposals continue to emerge: in 2026, eight states introduced bills explicitly criminalizing a pregnant individual for obtaining an abortion, though none have been enacted. States have also continued to legislate in related areas, including efforts to distinguish abortion care from pregnancy loss care, as reflected in South Dakota's newly enacted law excluding care for pregnancy loss from the definition of abortion.

States are also taking divergent approaches to medication abortion, shield laws, and broader reproductive rights protections. Several states introduced bills criminalizing the sale, purchase, or distribution of medication abortion; four have been enacted in Iowa, Mississippi, Oklahoma, and South Dakota. By contrast, Hawaii and Oregon expanded existing shield law protections in 2026, with Oregon's H.B. 4088 adding extradition protections and limiting information-sharing with federal officials regarding protected healthcare. Since Dobbs, ballot initiatives have remained a key avenue for protecting access to care. Voters in Idaho, Nevada, and Virginia are set to consider abortion-related measures in November 2026, while Missouri voters will consider whether to repeal the constitutional abortion protections adopted in 2024. A similar measure remains pending in Colorado. Protections for contraception have also advanced, with nine bills enacted across Georgia, Maryland, South Carolina, and Virginia, including Virginia's new right-to-contraception law.

Against this backdrop, the AMA has continued to prioritize reproductive health as a core advocacy issue and to devote significant resources to supporting physicians, trainees, and patients navigating abortion bans and restrictions. Through AMA-led work, informed by the Task Force to Preserve the Patient-Physician Relationship, the AMA has developed practical resources addressing legal

considerations, clinical care, practice management, medical education, physician well-being, and patient support. This includes the Reproductive Health Resource Navigator, a public-facing hub containing more than 300 resources for physicians navigating abortion bans and restrictions, including materials related to EMTALA, legal representation, and physician well-being. The AMA has also continued to advance operational and advocacy efforts to protect access to care, including research on the impact of abortion restrictions on the physician workforce; collaboration to expand legal assistance and state law guidance for physicians; support for institution-level guidance on pregnancy-related medical emergencies in restrictive states; and engagement with prosecutors to reduce the risk of criminalization for physicians providing medically necessary care. In addition, the AMA has supported residents and medical students affected by abortion bans through funding for out-of-state abortion training and resources addressing moral distress and learner well-being. Together, this work reflects the AMA's sustained commitment to reproductive health advocacy and its continued prioritization of policies and resources that protect patients, support physicians, and preserve evidence-based medical care.

Immigration Policy

Non-U.S. citizen international medical graduate (IMG) physicians, residents and fellows play a critical role in helping to alleviate the physician shortage by providing healthcare to many Americans, especially in communities in need as they tend to choose primary care specialties and work in areas of the country with higher rates of poverty. The AMA continues to push back on restrictions that hinder care provided by these physicians, residents, and fellows.

- On March 10, 2026, the AMA sent a letter to HHS concerning the U.S. Exchange Visitor Program.
- On April 13, 2026, the AMA sent a letter strongly supporting H.R. 7961, the "H-1Bs for Physicians and the Healthcare Workforce Act." This legislation would exempt physicians and healthcare workers involved in direct patient care from the $100,000 fee implemented by the Proclamation entitled, "Restriction on Entry of Certain Nonimmigrant Workers."
- On Feb. 27, 2026, the AMA sent a letter to the U.S. Department of Homeland Security and the U.S. Department of State urging the exemption of physicians from the partial and complete suspension of entry into the U.S., as indicated in Proclamation 10998 entitled "Restricting and Limiting the Entry of Foreign Nationals to Protect the Security of the United States."
- On April 15, 2026, the AMA signed onto a letter in support of the "H-1Bs for Physicians and the Healthcare Workforce Act" (H.R. 7961). This bipartisan legislation would exempt physicians and other health professionals from the $100,000 H-1B fee.
- On May 26, 2026, the AMA sent a letter commenting to the U.S. Department of Labor (DOL) on DOL Docket No. ETA-2026-0001: Improving Wage Protections for the Temporary and Permanent Employment of Certain Foreign Nationals in the United States. By significantly raising prevailing wage floors, the proposed rule would make it more difficult for many employers to sponsor H-1B physicians, especially in underserved areas.
- On June 1, 2026, the AMA sent a letter to the Department of State advocating for International Medical Graduates that have matched into accredited U.S. residency and fellowship training programs for the upcoming academic year to have their visa applications processed in a timely manner so that they can begin their residency training by July 1.
- On June 22, 2026, the AMA signed onto a letter regarding barriers preventing internationally-born physicians and international medical graduates (IMGs), including medical students, resident physicians, researchers, fellows, and practicing physicians, from entering the United States or remaining lawfully in the country to continue their training and practice.

Payer Issues

The AMA has been fighting Elevance's "Facility Administrative Policy" which disincentivizes hospitals if out-of-network physicians are used for non-emergent procedures. This is a clear attempt to circumvent the "No Surprises Act" (NSA). The AMA has engaged directly with Anthem on this policy and supported successful state legislative efforts in Indiana and Iowa. The AMA has also raised this problematic policy to federal lawmakers for their review. Advocacy is working closely with colleagues in our Litigation Center to explore options for litigation as well.

The AMA is also actively engaging members of Congress and their staff for enactment of "No Surprises Act Enforcement Act." One of our recent tools to keep the issue front and center was a sign-on letter to sponsors with every state medical association and dozens of specialties. While the NSA is working, it needs stronger enforcement around it.

Meanwhile, there have been significant regulatory wins on NSA implementation. The Departments of Health and Humans Services, Labor and the Treasury ("the Departments"), and the Office of Personnel Management recently issued the Independent Dispute Resolution Operations final rule. The proposed rule was published in November of 2023, and the AMA submitted detailed comments on the proposed rule in early January 2024. Broadly, the final rule is positive for physicians and looks to streamline the entire dispute process, require more information to be provided to physicians along the way, formalize the open negotiations process and create some accountability for plans to participate, and reduce the costs associated with participating in the process. It is worth noting a generally positive tone in the final rule toward physicians and other providers, and an attempt to recognize and address the asks and concerns the AMA and other physician groups brought to the Departments in our comments on the proposed rule. The final rule reflects many of the AMA's asks in our comments on the proposed rule including:

- Requires plans to use claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) on paper or electronic remittance advice in response to a claim for payment for healthcare items or services furnished by an entity with which it does not have a direct or indirect contractual relationship.
- Requires more information to be disclosed in the initial payment or notice of denial of payment.
- Streamlines the efficiency and increases the formality of the Open Negotiation process by placing the initiation and response in the federal IDR portal.
- Requires plans and issuers to register in a new Federal IDR portal so that their information is available to physicians and other parties.
- Allows for more flexibility in batching items or services into a single dispute, including extending the number of allowed line items from 25 to 50.
- Reduces the administrative fee from $115 to $15.
- Shortens the "cooling off period" for batched disputes from 90 business days to 30 business days.

Most recently, on July 17, 2026, the Departments issued guidance on the use of RARC as required in the new rules, requiring the use of specific RARC by January 1, 2027.

The AMA is also working to limit insurer downcoding practices, including and especially related to automated downcoding programs. The AMA authored model legislation, and 10 states introduced bills on this issue this year. Three states enacted new laws including Indiana, Illinois, and Virgina. Additionally, the Maryland Insurance Administration (MIA) recently determined that Cigna

improperly "downcoded" evaluation and management (E/M) claims submitted by physicians, reducing reimbursement levels in violation of Maryland's insurance statutes governing claim payment and processing. The MIA imposed an administrative penalty on Cigna and ordered that health plans stop the practice. The AMA is also working with congressional offices to see a federal bill introduced.

Maternal Health

As discussed earlier in the report, the AMA was very encouraged that H.R. 7148 was enacted and included the "PREEMIE Reauthorization Act." This section of H.R. 7148 will expand federal research on preterm birth and improve outcomes for premature infants. It also reauthorizes the "Preventing Maternal Deaths Act," increases authorized funding to $100 million annually through 2030, expands the scope of state maternal mortality review committees, and directs federal agencies to more regularly disseminate best practices.

The AMA is also pleased that CMS adopted AMA's recommendations in a proposed rule to update the Maternity Care Services code set. Beginning January 1, 2027, the CPT code set will be updated to comprehensively revise the maternity codes, reflecting modern obstetric practice. The new code set will provide much needed transparency for patients, and the increased granularity will improve the ability of physicians and researchers to better understand the drivers of maternal mortality. The AMA is not supportive of CMS' solicitation for comments on maintaining current coding through the creation of HCPCS G-codes. This proposal will unfortunately create confusion for care teams. The AMA is urging CMS to finalize the Maternity Care Services CPT code set without maintaining the historical global structure via HCPCS G-codes.

Other pieces of legislation that the AMA supports in this Congress related to maternal health include:

- On March 4, 2025, the AMA supported the Preeclampsia Foundation in the "Still at Risk" postpartum hypertension awareness and action wristband initiative. This public-private partnership is focused on improving postpartum health outcomes through the creation, promotion, dissemination, and impact measurement of wristbands for postpartum women at risk of developing hypertension.
- The AMA signed into two letters (Letter One; Letter Two) requesting level funding of $2 million to support the continued implementation of the Stillbirth Working Group's recommendations under the Office of the Secretary of Health and Human Services.
- On July 22, 2026, the bipartisan Rural Obstetrics Readiness Act (S. 380) advanced out of the Senate Health, Education, Labor, and Pensions (HELP) Committee with a 22-1 vote, moving to the full Senate floor. The AMA supports this important piece of legislation.

State Accelerator Grants

The AMA State Advocacy Accelerator Grant Program, initiated in January 2026, provides targeted, high-impact funding to state medical associations to help them "cross the finish line" on key state legislative and regulatory priorities. Modeled after the highly successful Scope of Practice Partnership (SOPP) grant program, this project will help state medical associations leverage national AMA expertise and resources at a pivotal moment in time for their specific state advocacy campaigns.

As of July 2026, 16 grants have been awarded totaling close to $600,000 in funding to cover issues aligned with AMA policy and state level priorities, including downcoding, out of network issues,

and prior authorization; physician wellness/creation of a physician health program; medical liability reform; and noncompete clause-related issues. States that have received a grant include Alaska, Georgia, Illinois, Iowa, Louisiana, Massachusetts, Michigan, Missouri, New Mexico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, and Wisconsin.

AMA ADVOCACY ONGOING UPDATES AND MEETINGS

The AMA offers several ways to stay up to date on our advocacy efforts, and we urge the HOD to avail themselves of all of them to stay informed and advance our grassroots efforts:

- Please sign up for AMA Advocacy Update a weekly newsletter that provides updates on AMA legislative, regulatory, and private sector efforts. We try to make sure all HOD members are on the email list, but if you are not receiving AMA Advocacy Update, please subscribe and encourage your colleagues to do so as well. Subscribers can read stories from previous editions here.
- Join the Physicians Grassroots Network for updates on AMA calls to action on federal legislative issues. And if you have connections with members of Congress, or are interested in developing one, the Very Influential Physician (VIP) program can help grow these relationships.
- Connect with the Physicians Grassroots Network on Facebook, X, and Instagram. Connect with the AMA on Facebook, X, Instagram, LinkedIn, TikTok, BlueSky and YouTube.

The AMA also encourages HOD members to attend the State Advocacy Summit and National Advocacy Conference. The 2027 State Advocacy Summit will take place on Jan. 7-9 at the Terranea Resort in Rancho Palos Verdes, California. The 2027 National Advocacy Conference will occur on Feb. 22-24 at the Mayflower Hotel in Washington, DC.

Finally, please consider contributing to AMPAC as another way to engage in AMA advocacy efforts.

CONCLUSION

The AMA continues to fight for physicians and patients on the most important healthcare issues. Along with the Federation, we have achieved important victories in the first half of 2026, but much work needs to be done. Grassroots involvement is key, and we urge the HOD to continue its important work in their home states and districts as our advocacy continues.

REPORT 20 OF THE BOARD OF TRUSTEES (I-26)
AMA Efforts on Medicare Payment Reform

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System," and amended Policy D-390.922, "Physician Payment Reform and Equity," together declaring Medicare physician payment reform an urgent priority and directing the Board of Trustees to report at each Annual and Interim Meeting on the progress of that work until a predictable, sustainable, and fair payment system is achieved. At the 2025 Annual Meeting the House further adopted Policy D-400.981, "Increasing Transparency of AMA Medicare Payment Reform Strategy," calling for regular reporting to members on advocacy barriers, strategy gaps, and recommendations for improvement. This report is responsive to those directives and covers activity for the year to date.

Physicians continue to face structural instability under the current Medicare payment system. The CY 2025 fee schedule finalized a 2.83 percent cut, and while Congress provided a temporary 2.5 percent update for 2026, that patch left the underlying flaws unresolved. Statutory Medicare Access and CHIP Reauthorization Act (MACRA) updates are not tied to inflation, and Medicare physician payment has declined approximately 33 percent since 2001 when adjusted for practice cost inflation. The pressure falls hardest on small, rural, and independent practices, where continued instability threatens access to care for the seniors and patients with disabilities they serve. Fixing this system remains one of the AMA's highest legislative priorities.

Since the previous report, that sustained work culminated in the July 15, 2026, introduction of the Patients First Act, H.R. 9693, comprehensive bipartisan legislation developed with extensive AMA consultation that reflects the AMA-developed Characteristics of a Rational Medicare Physician Payment System and addresses each of the four core reforms organized medicine has sought for more than a decade. Its introduction was preceded by momentum-building steps earlier in 2026, including unanimous Ways and Means approval of budget neutrality reform in H.R. 8163, introduction of targeted Merit-based Incentive Payment System (MIPS) reform in H.R. 8622, and a series of Energy and Commerce hearings at which the AMA testified. The AMA also engaged MedPAC as the Commission moved toward recommending a permanent update formula approximating the one established in Title I of the bill.

The AMA will continue to advance this work across its four advocacy pillars of legislative advocacy, regulatory advocacy, Federation engagement, and grassroots and public outreach, with its immediate priority the enactment of a permanent, Medicare Economic Index (MEI)-based payment update through H.R. 9693 and the securing of a positive physician payment update for 2027 as broader structural reforms advance. The AMA will continue to coordinate closely with state medical associations and national specialty societies to demonstrate unified physician support, sustain the Fix Medicare Now campaign and its grassroots networks to keep the issue before Congress and the public, and press Centers for Medicare & Medicaid Services (CMS), the Administration, and MedPAC to close the widening gap between physician payment and the cost of delivering care. The AMA will continue to report on this progress until a sustainable, fair, and effective Medicare physician payment system is achieved.

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 20-I-26

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Toluwalasé A. Ajayi, MD, Chair

At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-385.945, "Advocacy and Action for a Sustainable Medical Care System" and amended Policy D-390.922, "Physician Payment Reform and Equity." Together, they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of our AMA in achieving Medicare payment reform until a predictable, sustainable, fair physician payment system is achieved. In addition, the House adopted Policy D-400.981 "Increasing Transparency of AMA Medicare Payment Reform Strategy" at the Annual 2025 House of Delegates Meeting, which calls on the AMA to:

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

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

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

AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

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

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

- Automatic annual payment updates based on the Medicare Economic Index (MEI);
- Updated policies governing when and how budget neutrality adjustments are made;
- Simplified and clinically relevant policies under the Merit-based Incentive Payment System (MIPS); and

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- Greater opportunities for physician practices that want to transition to advanced alternative payment models (APMs).

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

Legislative Advocacy

Physicians continue to face significant financial instability under the current Medicare physician payment system. The calendar year (CY) 2025 Medicare Physician Fee Schedule finalized a 2.83 percent reduction in physician payment rates, continuing a pattern of recurring cuts that has persisted for several years. In response to sustained advocacy from the AMA, Federation partners, and the broader physician community, Congress included a provision in the One Big Beautiful Bill Act (OBBBA) providing a 2.5 percent Medicare physician update for 2026 to partially mitigate these reductions. While this action provided temporary relief, it addressed only a portion of the cut and did not resolve the structural flaws that continue to destabilize Medicare physician payment.

The AMA also remains concerned about the Medicare payment efficiency adjustment promulgated by CMS in the CY 2026 Medicare Physician Fee Schedule, which reduced work relative value units for most services and offset a portion of the update Congress provided. H.R. 7520, the "Efficiency Adjustment Delay Act," was introduced to delay implementation of the efficiency adjustment until January 1, 2030. However, the legislation faces significant headwinds: it is opposed by primary care organizations, lacks the support of the chairs or ranking members of the relevant committees of jurisdiction, and the Administration has communicated its opposition to House leadership. As a result, the legislation faces substantial obstacles to advancement in Congress. The AMA will continue to monitor the issue and look for alternative opportunities to address the impact of the efficiency adjustment on physician payment.

Beginning in 2026, statutory updates of 0.25 percent for most physicians and 0.75 percent for qualifying participants in advanced alternative payment models take effect under the Medicare Access and CHIP Reauthorization Act (MACRA), but these updates are not tied to inflation and fall far short of projected increases in practice costs. CMS estimates that the MEI, which measures changes in physician practice costs, will increase by 2.7 percent in 2026, further widening the gap between payment and the cost of delivering care. As a result, Medicare physician payments have effectively declined by approximately 33 percent since 2001 when adjusted for inflation in practice costs.

During this period, physician practices have experienced significant increases in expenses related to staffing, technology, regulatory compliance, and facility costs. This growing imbalance is placing increasing pressure on physician practices across the country. Small, rural, and independent

practices are particularly vulnerable to continued payment instability. When practices are forced to close, consolidate, or limit the number of Medicare patients they can treat, access to care is threatened for millions of seniors and patients with disabilities. Expanding the physician workforce alone will not solve these access challenges if newly trained physicians enter a Medicare system that remains financially unsustainable.

Fixing the broken Medicare physician payment system therefore remains one of the AMA's highest legislative priorities. The AMA continues to work closely with congressional leaders and Federation partners to move beyond the annual cycle of payment cuts and temporary patches and instead enact durable structural reforms that stabilize physician payment and support patient access to care. As detailed below, that sustained work culminated during this reporting period in the introduction of comprehensive, bipartisan reform legislation reflecting the AMA-developed framework—Characteristics of a Rational Medicare Physician Payment System.

Introduction of the "Patients First Act" (H.R. 9693)

On July 15, 2026, the bipartisan chairs of the GOP and Democratic Doctors Caucuses—Representatives John Joyce, MD (R-PA), Greg Murphy, MD (R-NC), and Kim Schrier, MD (D-WA)—introduced **H.R. 9693, the "Patients First Act,**" a comprehensive proposal to reform MACRA and the Medicare physician payment system. Over the past year, physician members of Congress met on a bipartisan basis to develop the legislation, consulting extensively with the AMA and other physician organizations throughout the drafting process. The resulting bill addresses each of the four core reforms—permanent inflation-based payment updates, modernized budget neutrality policies, simplified and clinically relevant quality measurement, and expanded opportunities for participation in alternative payment models—the AMA and organized medicine have sought for more than a decade and aligns squarely with the Characteristics of a Rational Medicare Physician Payment System. Introduction of the bill was preceded by several momentum-building developments earlier in 2026—including unanimous committee approval of budget neutrality reform legislation, introduction of targeted MIPS reform legislation, and a series of congressional hearings examining the physician payment system—described further below.

Title I of the legislation establishes, for the first time, a permanent annual Medicare physician payment update linked to the MEI and built into the baseline. Beginning in 2027, annual updates would be set at MEI minus 1 percentage point for most physicians and MEI minus 0.5 percentage points for Qualifying Participants in APMs, with a statutory floor of 25 percent of MEI ensuring the update remains positive even in low-inflation years. The practical impact is substantial: under current law, the cumulative update for most physicians from 2026 to 2036 would be essentially flat—just 0.03 percent—while under the Patients First Act it would grow by 7.7 percent, with a comparable improvement for physicians in APMs (5.1 percent under current law versus 13.1 percent under the bill). Title I also extends the 1.00 work geographic practice cost index (GPCI) floor through 2031 and increases it to 1.025, benefiting physicians in many rural areas, while providing a 2.0 percent work GPCI increase for all other localities. In addition, the bill establishes a five-year hybrid payment demonstration for independent primary care practices that is funded entirely with new money and explicitly exempt from budget neutrality, so it will not reduce payments for any other specialty.

Title II replaces MIPS, over a five-year transition, with the Patient Outcome Improvement National Tabulation System (POINTS), a quality measurement program driven by physicians and specialty societies rather than the government. POINTS sharply reduces maximum penalties—to 2 percent annually during the transition and 5 percent thereafter, down from the +/- 9 percent adjustments under MIPS—and eliminates the Promoting Interoperability category. A clinician-majority Quality

Care Reform Task Force will recommend all measures used in the program, with guaranteed representation for the relevant specialty and subspecialty societies. A new Care Efficiency category will, for the first time, give physicians credit for the Medicare savings they generate by preventing avoidable hospitalizations and complications of chronic disease. The bill also creates a bonus performance program reserved for independent physicians and small practices, prohibits penalties for any performance year in which physicians have not received timely quarterly feedback reports, and establishes a reporting pathway for clinician-led clinical data registries operated by physician professional societies.

Title III lowers barriers to APM participation by freezing the Qualifying Participant threshold at 50 percent for three years rather than the 75 percent required under MACRA, authorizing the Secretary to set lower thresholds, and requiring GAO and MedPAC reports on the barriers specialists face in joining APMs. Title IV incorporates the budget neutrality reforms of H.R. 8163, the "Provider Reimbursement Stability Act," discussed further below.

On the day of introduction, the AMA issued a national press release, attributable to AMA President Willie Underwood III, MD, MSc, MPH, commending the bipartisan leadership of the GOP and Democratic Doctors Caucuses for proposing solutions to stabilize physician payment and protect access to care. On July 22, 2026, the AMA transmitted a formal letter of support to the sponsors, urging members on both sides of the aisle to join as cosponsors and pledging to work closely with Congress to advance the bill through the legislative process. The AMA also distributed the legislative text, a section-by-section summary, a comparison of the bill to the Characteristics of a Rational Medicare Physician Payment System, and supporting payment analyses to state medical associations. Throughout the year, the AMA also conducted a series of in-person and virtual meetings with the Washington-based government affairs staff of national medical specialty societies, as well as individual meetings with specialty society staff, to discuss the developing legislation, address specialty-specific questions, and build support for reform. In addition, the AMA facilitated two virtual meetings with the bipartisan Doctors Caucus staff and the state medical associations: the first on March 26, 2026, when the Doctors Caucuses released an outline of their proposal, and the second on July 24, 2026, following introduction of the bill, to explain the legislation and answer questions.

Medicare Payment Reform: Budget Neutrality and H.R. 8163

The AMA continues to advocate for modernization of Medicare's budget neutrality requirements to prevent destabilizing payment reductions that occur when services are revalued or new services are added to the physician fee schedule. In May 2026, the AMA sent a letter of strong support for **H.R. 8163, "the Provider Reimbursement Stability Act,"** introduced by Representatives Greg Murphy, MD (R-NC) and Tom Suozzi (D-NY). The legislation raises the outdated $20 million budget neutrality threshold to $57.64 million in 2028 with regular indexing to the MEI thereafter; creates a correction process requiring CMS to reconcile utilization misestimates so physicians are no longer penalized indefinitely for estimation errors unrelated to the care they provide; requires regular updates to the direct cost inputs underlying practice expense values in consultation with physician specialty societies; and caps year-to-year conversion factor variance at 2.5 percent to prevent large, destabilizing swings in payment. H.R. 8163 was introduced with a strong contingent of members of the House committees of jurisdiction and has attracted 73 bipartisan cosponsors (49 Democrats and 24 Republicans). On May 21, 2026, the legislation passed the full House Ways and Means Committee unanimously by a vote of 44-0, demonstrating the breadth of bipartisan support for budget neutrality reform. These provisions were subsequently incorporated in their entirety as Title IV of the "Patients First Act." AMA advocacy staff also continue to work with a bipartisan group of Senators on companion budget neutrality reform legislation in the Senate.

Medicare Payment Reform: MIPS Reform and H.R. 8622

On April 30, 2026, Representatives Mariannette Miller-Meeks, MD (R-IA) and Herb Conaway, MD (D-NJ), two bipartisan physician leaders in the House, introduced **H.R. 8622, the "Medicare Physician Data-driven Performance Payment System Act of 2026,"** targeted legislation to reform MIPS developed with close AMA engagement. The GOP and Democratic Doctors Caucuses subsequently incorporated key elements of H.R. 8622 into their comprehensive Medicare reform package, the "Patients First Act," including the prohibition on CMS assessing penalties when it fails to provide timely quality feedback reports to practices and the reduction of the maximum penalty for practices unable to comply with reporting requirements from 9 percent to 2 percent. Together with the unanimous committee approval of H.R. 8163, the introduction of H.R. 8622 helped build the bipartisan momentum that culminated in the introduction of the "Patients First Act."

Energy and Commerce Hearings on Healthcare Affordability

The AMA also took advantage of a series of hearings conducted by the House Energy and Commerce Subcommittee on Health on healthcare affordability to further its Medicare physician payment reform agenda and set the stage for the comprehensive Medicare reform bill being developed by the Republican and Democratic physician caucuses with the AMA's assistance. For the first hearing in February 2026, on the health insurer landscape, the AMA shared its 2025 Update to Competition in Health Insurance: A Comprehensive Study of U.S. Markets with the Subcommittee and worked directly with subcommittee members to ensure that Medicare physician payment reform questions were asked at the hearing. This engagement led to the AMA being asked to testify at the second hearing, held on March 17, 2026, entitled Lowering Health Care Costs for All Americans: An Examination of the U.S. Provider Landscape. Then-AMA Board Chair David H. Aizuss, MD, testified on the AMA's behalf regarding the financial pressures facing physician practices and the need for Medicare physician payment reform. The March hearing set the stage for a third hearing in May focused specifically on examining the Medicare Physician Fee Schedule, MACRA, and opportunities for payment reform.

119th Congress AMA Advocacy Highlights

In early 2025, Representatives Greg Murphy, MD, (R-NC) and Jimmy Panetta (D-CA) introduced **H.R. 879, the "Medicare Patient Access and Practice Stabilization Act,"** bipartisan legislation designed to address the 2.83 percent Medicare physician payment cut that took effect on January 1, 2025, and to provide a positive payment update to help stabilize physician practices. The AMA worked closely with the bill sponsors and congressional physician leaders to support the legislation. More than 120 bipartisan House members cosponsored the legislation, and over 80 physician organizations, including all 50 state medical associations, joined a coalition letter urging Congress to act. Although H.R. 879 was not ultimately enacted as a standalone measure, the legislation played an important role in elevating Medicare physician payment reform as a priority issue for Congress and helped frame the policy debate that produced the "Patients First Act."

Alternative Payment Model (APM) Progress and H.R. 7148

H.R. 7148, the Consolidated Appropriations Act, 2026, included several important AMA-supported provisions restoring incentives for participation in advanced APMs. Specifically, the legislation reinstated APM incentive payments at 3.1 percent for the 2026 performance year (2028 payment year) and reduced the Qualifying Participant (QP) revenue threshold from 75 percent back to 50 percent for the same performance year. These changes help restore meaningful incentives for

physician participation in value-based care and reduce barriers that had limited participation following the expiration of the original APM bonus and the automatic increase in the QP threshold in 2025. The law also includes several Medicare extenders that expire at the end of 2026. As a result, Congress will again need to address key Medicare payment policies before year's end, creating an important legislative vehicle and opportunity for the AMA to continue advancing broader Medicare physician payment reforms, including the "Patients First Act" and efforts to secure a physician payment update for 2027.

National Advocacy Conference – February 2026

At the February 2026 National Advocacy Conference (NAC), the following lawmakers expressed the need for Medicare physician payment reform: Senator Peter Welch (D-VT) and Representatives Greg Murphy (R-NC), Kim Schrier (D-WA), Mariannette Miller-Meeks (R-IA), John Joyce (R-PA), Jill Tokuda (D-HI), and Steven Horsford (D-NV). More than 500 physician advocates attended NAC and participated in Capitol Hill meetings and distributed advocacy kits urging lawmakers to support legislation that:

- Provides annual inflationary updates tied to practice costs
- Reforms budget neutrality
- Improves MIPS
- Expands APM options

These reforms were framed as essential to preserving patient access to care by stabilizing physician practices and thereby ensuring America's seniors have timely access to high-quality care. Each of these four reforms is now embodied in the "Patients First Act."

Senate Legislation and H.R. 1

In April 2025, Senator Roger Marshall (R-KS) introduced the Senate companion bill, S. 1640. AMA advocacy staff were highly involved in drafting this legislation, ensuring it was responsive to the real-time 2025 Medicare cuts. Separately, H.R. 1, the OBBBA, initially included strong Medicare physician payment reform provisions, including a 75 percent MEI update for 2026 and a permanent annual update of 10 percent of MEI thereafter. The AMA advocacy team was instrumental in the development and inclusion of these House-passed Medicare provisions. These provisions passed the House of Representatives; however, the Senate scaled the proposal back to a temporary 2.5 percent update for 2026 with no permanent, inflation-adjusted fix. Still, the inclusion of any update represented forward movement and provided important momentum for the introduction of the "Patients First Act" in the 119th Congress.

Grassroots, Media, and Outreach

The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians Grassroots Network (PGN), Patients Action Network (PAN), and its Very Influential Physicians program. Op-eds have been placed in various publications from AMA leaders, as well as from "grass-tops" contacts in local newspapers. Digital advertisements are running targeted specifically to publications read on Capitol Hill, and media releases have been issued to highlight significant developments. The AMA has a dedicated Medicare payment reform web site, www.FixMedicareNow.org, which includes a range of AMA-developed advocacy resource material, updated payment graphics, a "Medicare basics" series of papers describing in plain language specific challenges presented by current Medicare payment policies and recommendations for reform, and also a link for patients and physicians to share their stories.

There is also an annual webinar for the PGN to help and encourage physicians to engage with their Members of Congress back home during the August recess.

Following the introduction of H.R. 9693, the AMA activated its grassroots networks with a national alert urging physicians and patients to contact their members of Congress and ask them to cosponsor the "Patients First Act," emphasizing that a more stable Medicare payment system will protect patients' access to care, particularly in small, rural, and independent practices.

Since its launch in the third quarter of 2023, the Fix Medicare Now campaign, in combination with engagement of the PGN and PAN, has generated the following results to date:

- 358,000,000+ media impressions
- 12,300,000+ engagements with Fix Medicare Now content
- 1,970,000+ FixMedicareNow.org site visitors
- 758,000+ contacts to Congress
- 61 PGN/PAN calls to action sent
- 225+ targeted earned media placements (op-eds, letters to the editor, and white papers) reaching an estimated audience of more than 1 billion
- 350+ third-party grass-tops communications delivered to key legislators by trusted in-district community members

Federation Engagement

The AMA continues to work closely with state medical associations and national medical specialty societies to build alignment around shared principles for Medicare physician payment reform. Through ongoing coordination with Federation partners, the AMA has strengthened advocacy efforts, reinforced consistent policy messaging, and demonstrated broad physician support for legislative solutions that stabilize Medicare physician payment and protect patient access to care.

Federation engagement has been central to building support for the "Patients First Act." Upon introduction, the AMA distributed the legislative text, section-by-section summary, and sponsors' press release to all state medical associations, followed by the AMA's letter of support and analyses comparing the bill to the Characteristics of a Rational Medicare Physician Payment System and to current law. The AMA also convened two national calls with the leadership and senior government affairs staff of state medical associations, each with direct participation from the bipartisan Doctors Caucus staff who drafted the bill—one held on March 26, 2026, when the Caucuses released their legislative outline and a second held on July 24, 2026, following the bill's introduction. The AMA continues its proactive outreach to national medical specialty societies to answer questions about the legislation, address specialty-specific considerations, and encourage formal endorsements, with the goal of demonstrating to Congress the unified support of the physician community. The AMA is committed to ensuring that all Federation partners—state medical associations and national medical specialty societies alike—receive timely access to AMA analyses, legislative materials, the weekly Advocacy Update, and direct engagement with AMA advocacy staff as reform efforts continue to advance.

Advocacy with MedPAC and Looking Forward

The AMA continues to engage with the Medicare Payment Advisory Commission (MedPAC) as it evaluates the adequacy of Medicare physician payment and develops recommendations to Congress. During its December 2025 meeting, MedPAC discussed a potential recommendation to update Medicare physician payment rates in 2027 by current law plus 0.5 percent, which would result in an update of approximately 1.25 percent for clinicians participating in advanced

alternative payment models and 0.75 percent for other physicians. However, the cost of providing care is expected to increase by approximately 2.1 percent, meaning that such a recommendation would allow the gap between physician payment and practice cost inflation to continue widening. In comments submitted following the meeting, the AMA urged MedPAC to recommend that Congress update physician payment in 2027 by the full increase in the MEI.

In its June 2026 report to Congress, MedPAC recommended increasing Medicare Physician Fee Schedule payment rates above current law, reflecting continued movement toward the AMA's position that physician payment must keep pace with the costs of providing care. In a briefing with reporters following the report's release, MedPAC Executive Director Paul Masi, MPP, reiterated the Commission's recommendation that fee-for-service Medicare move toward an annual physician payment update of approximately MEI minus 1 percent—the same permanent update formula established in Title I of the "Patients First Act." This alignment between the Commission's recommendations and H.R. 9693 provides important independent support for the central payment reform in the legislation as it advances through Congress.

The AMA also highlighted MedPAC data showing emerging access challenges for Medicare beneficiaries. In 2025, 29 percent of beneficiaries reported waiting six or more weeks to see a new primary care physician and 31 percent reported similar waits to see a new specialist. At the same time, growth in spending under the Medicare Physician Fee Schedule has remained modest compared to other components of Medicare Part B. The AMA will continue working with MedPAC to ensure that its recommendations to Congress reflect the growing gap between physician payment and practice cost inflation and the potential implications for patient access to care.

Call to Action

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

- Cosponsor and advance H.R. 9693, the "Patients First Act," which provides annual inflation-based updates, reforms budget neutrality, replaces MIPS with a clinician-driven quality program, and expands APM opportunities; and
- Enact a positive physician payment update for 2027 to keep pace with inflation as broader structural reforms advance.

Physician practices have lost 33 percent to inflation since 2001. Physician ownership of practices has also collapsed, dropping from 61 percent in 2001 to under 50 percent in 2016. This erosion threatens the viability of community-based care. Fixing this system will remove a major financial stressor for physicians, protect patient access, and stabilize our healthcare infrastructure. Ensuring regular, adequate payment updates is vital to practice sustainability, advancing value-based care models, and safeguarding access to care for Medicare beneficiaries—especially in rural and underserved communities, where practices treat four times as many Medicare patients as those in metropolitan areas. As physicians across the country continue to share their stories and advocate for reform, the introduction of comprehensive, bipartisan reform legislation demonstrates that our united efforts are breaking through the political and financial barriers that have hindered progress. The AMA will continue to fight tirelessly until a sustainable, fair, and effective Medicare physician payment system is achieved.

CONCLUSION

The AMA will continue to press Congress to address the structural flaws in the Medicare physician payment system and enact reforms that ensure stability for physician practices and protect patient access to care. The introduction of the "Patients First Act" represents meaningful progress toward that goal, reflecting years of sustained advocacy and the unified principles of the physician community; enactment, however, will require continued legislative action and engagement.

While the CBO has not yet scored the PFA, Congressional staff estimate that it could cost up to $150 billion over the next ten years. Given the limited days left in the Congressional calendar and the heated, upcoming mid-term elections, it is unlikely legislation of this magnitude can pass Congress and get signed into law this year. However, assuming the PFA garners significant bipartisan support in Congress and from outside stakeholders, it would be well-positioned to become the starting point in the 120th Congress. Further, the stronger the support for the PFA, the greater the leverage our Congressional champions will have to secure pieces of the bill in any end-of-year legislative package, such has a 2027 payment update, budget neutrality reforms, and APM bonus provisions.

The AMA will remain actively engaged with Congress, the Administration, and Federation partners to advance H.R. 9693 and related policies that stabilize Medicare physician payment, reduce administrative burden, and support physician participation in innovative care delivery models. Continued engagement from physicians across the Federation will remain essential as these efforts move forward.

REPORT OF THE SPEAKERS

Speakers' Report 2-I-26

Subject: Recommended Policy Reconciliations

Presented by: Lisa Bohman Egbert, MD, Speaker; and John H. Armstrong, MD, Vice Speaker

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Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," calls on your Speakers to "present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete."

Your Speakers present this report to update policies or portions thereof that are no longer relevant or were affected by actions taken at recent meetings by the House of Delegates. Suggestions on other policy statements that your Speakers might address should be sent to hod@ama-assn.org for possible action.

Changes effected by this Speakers' Report will not reset the sunset clock for the items partially rescinded, and all changes are implemented upon filing of this report.

RECOMMENDED RECONCILIATIONS

Accomplished directives to be rescinded

Policy Number	Title	Policy Language
D-600.952	AMA Bylaw Amendments Pursuant to AIPSC	Our American Medical Association will amend AMA Bylaws 2.12.2, 2.12.3.1, 5.2.4, 5.2.4.1, and 12.3 (now Bylaw 11.3) as follows: 2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on request of one third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall notify each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called. 2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

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		5.2.4 Notice of Meeting. Notice is given if delivered in person, by telephone, or any means of electronic communication approved by the Board of Trustees. Notice shall be deemed to be received upon delivery to the Trustee's contact information then appearing on the records of the AMA. 5.2.4.1 Waiver of Notice. Attendance at any meeting shall constitute a waiver of notice of such meeting, except where such attendance is for the express purpose of objecting to the transacting of any business because of a question as to the legality of the calling or convening of the meeting. 12.3 Articles of Incorporation. The Articles of Incorporation of the AMA may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved the amendment and provided it to each member of the House of Delegates at least 5 days, but not more than 60 days, prior to the meeting of the House of Delegates at which the amendment is to be considered.
D-600.955	Report of the Resolution Modernization Task Force Update	Our American Medical Association will amend the bylaws so that: 1. The resolution submission deadline be 45 days prior to the Opening Session of the House of Delegates with AMA Sections excluded from this deadline. 2. The definition of a late resolution shall be all resolutions submitted after the resolution submission deadline with AMA Sections excluded from the deadline and prior to the beginning of the Opening Session of the House of Delegates. 3. The definition of an emergency resolution shall be all resolutions submitted after the beginning of the Opening Session of the House of Delegates. 4. The term of committees of the House of Delegates shall commence upon their formation and shall conclude at the end of the meeting for which they were appointed, unless otherwise directed by the House of Delegates.
D-610.996	AMA Bylaws Nomination of Officers and Council Members	Our American Medical Association will amend AMA Bylaws 3.3, 6.8, 6.8.1 as follows: 3 Officers 3.3 Nominations. Nominations for President-Elect, Speaker and Vice Speaker, shall be made by a member of the House of Delegates at the opening session of the meeting at which elections take place. Nominations for all other officers, except for Secretary, the medical student trustee, and the public trustee, shall be made by a member of the House of Delegates at the opening session of the meeting at which elections take place. 6 Councils 6.8 Election – Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health 6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. The Chair of the Board of Trustees will present announced

		candidates, who shall be entered into nomination by the Speaker at the Opening session of the meeting at which elections take place. Nominations may also be made from the floor by a member of the House of Delegates at the opening session of the meeting at which elections take place.
G-600.959	Delegate Apportionment and Pending Members	Pending members will no longer be counted for delegate apportionment.
G-610.089	Directives on Nominations from Speakers Report 3	The language in Bylaw 6.8.1, "Nomination and Election" be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place.

Policies to be rescinded in part

Deletions are shown with strikethroughs. Given the length of some of the policies, only the affected portions are reproduced.

Policy Number	**Title**	**Policy Language**	
D-275.954(23)	Continuing Board Certification	23. Our AMA will encourage ~~the PCPI Foundation,~~ the ABMS~~,~~ and the Council of Medical Specialty Societies to work together toward utilizing ~~Consortium~~ performance measures in Part IV of CBC.	The PCPI and PCPI Foundation no longer exist. Therefore, all references to them have been removed.
D-450-978	~~PCPI;~~ Unfunded Performance Improvement Projects	Our AMA will: ~~(1) continue to promote the PCPI® as the leading resource for performance measures development and maintenance;~~ (1~~2~~) continue to advocate for appropriate implementation of performance measures; (2~~3~~) continue to encourage the testing and evaluation of ~~PCPI~~ performance measures by appropriate entities; (3~~4~~) continue to communicate organized medicine's strong objections to implementation of mandatory, unfunded performance improvement projects and offer our assistance to rectify deficiencies in these programs; (4~~5~~) continue to promote the AMA guidelines that provide operational boundaries that can be applied to specific components of pay-for-performance programs; and (5~~6~~) monitor the National Quality Forum, a merger of the National Quality Forum and the National Committee for Quality Health Care, to determine its current and future scope.	
H-450.939	Activities of the National Quality Forum	Our AMA will~~:~~ ~~(1) continue to advocate for the Physician Consortium for Performance Improvement as the measure developer for physician-level performance measurement; (2)~~ continue to monitor the National Quality Forum's (NQF) activities to ensure physician	

		representation and involvement in all activities and leadership.~~; and (3) oppose any efforts to expand the NQF's mission to include measure development or other actions that would effectively limit or eliminate the Physician Consortium for Performance Improvement's principal role in the measure development process.~~	
G-600.009(2)	CEJA and House of Delegates Collaboration	2. Consistent with Bylaw 2.13.1.1, the Speakers consider convening additional sessions of the Reference Committee on ~~Amendments to Constitution~~ Ethics and Bylaws when appropriate and feasible to accommodate CEJA business.	Updating policy using the new name for the reference committee.
G-600.054(1)	Procedures of the House of Delegates	1. Our AMA reaffirms that the current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure serves as our parliamentary authority.~~, including the~~ This includes the use of the motion to table and the motion to adopt in-lieu-of as defined by this authority~~, and treat amendments by substitution as first-order amendments~~.	Clarifies the use of the current edition of AIPSC and removes substitution which is not referenced in our parliamentary authority.

Policy clarification

Upon review of final HOD actions following the 2026 Annual Meeting, a discrepancy was found between existing policy language in H-160.891 and the language used to proffer amendments to the policy in Resolution 241 which were adopted. The proffered language in the resolution included text that was being amended that did not appear in the existing policy. Your Speakers have reviewed the discrepancies and provide the final language for clarification. PolicyFinder has been updated accordingly with the language as shown below.

H-160.891	Corporate Investors and Other Corporate Entities	1. Our AMA ~~encourages physicians who are contemplating corporate investor partnerships or corporate entity relationships, including those under "friendly" physician professional corporation (PC) arrangements with Management Service Organizations (MSOs), to consider the following guidelines:~~ supports policies that preserve physician ownership, governance, and independent medical judgment in physician practices and opposes corporate ownership or contractual arrangements that permit non-licensed entities to exercise control over the practice of medicine. Physicians and policymakers evaluating corporate investment in physician practices should consider the following guidelines: a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor/entity. b. Due diligence should be conducted that includes, at minimum, review of the corporate investor/entity's business model, strategic plan, leadership and governance, and culture. c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor/entity transactions.

		d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered. e. Physicians should consider whether and how corporate relationships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management. f. Physicians should consider the potential impact of corporate relationships on physician and practice employee satisfaction and future physician recruitment. g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate relationships, and application of restrictive covenants, including any changes in the scope or implementation of any current or proposed restrictive covenants based on the corporate relationship. h. Physicians should consider corporate procedures for medical staff representation on the board of directors and medical staff leadership selection as well as processes for resolution of conflict between medical staff leadership and the corporate entity. i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate relationships. j. Prior to entering into a relationship with a corporate entity, physicians and the corporate entity should explicitly identify the types of clinical and business decisions that should remain in the ultimate control of the physician, including but not limited to: i. Determining which diagnostic tests are appropriate; ii. Determining the need for referrals to, or consultation with another physician or licensed health professional; iii. Being responsible for the ultimate overall care of the patient, including treatment options available to the patient; iv. Determining how many patients a physician shall see in a given period of time or how many hours a physician should work; v. Determining the content of patient medical records; vi. Selecting, hiring, or firing physicians, other licensed health care professionals, and/or other medical staff based on clinical competency or proficiency; vii. Setting the parameters under which a physician or physician practice shall enter into contractual relationships with third-party entities; viii. Making decisions regarding coding and billing procedures for patient care services; and ix. Approving the selection of medical equipment and medical supplies. k. Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners. l. Clear protection and dispute resolution processes for physicians advocating on patient care and quality issues should be incorporated into an agreement between physicians and corporate entities. m. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection

		of faculty and trainees, as well as education and disciplinary issues related to these programs. n. Physician practices delivering medical care should be majority owned by licensed physicians who are actively practicing in the entity, and those licensed physicians must retain final authority over clinical decision making and over operational and administrative decisions that affect patient care, including clinical staffing, scope of services, clinical policies and standards, compensation structures tied to clinical services, coding and billing policies, payer contracting, and practice governance. o. Our AMA opposes stock transfer restriction agreements, "friendly PC" arrangements, succession rights, compelled sale provisions, management agreements, or other contractual mechanisms that permit non-licensed entities to exercise direct or de facto control over physician practices or over physicians' professional medical judgment. Physicians should review contractual provisions governing governance structures, compensation arrangements, and management responsibilities to ensure that such arrangements do not transfer control of clinical decision making, physician employment conditions affecting patient care, or other core professional functions to non-licensed entities. p. Our AMA supports clear disclosure of physician practice ownership, governance, management agreements, and contractual control rights so that physicians, patients, regulators, and policymakers can identify who holds financial and operational control over the practice entity 2. Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment. 3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians practicing in that specialty. 4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors/entities on the practice of medicine. 5. Our AMA supports meaningful physician representation in any corporate governance structure (e.g., seats on the board of directors, and/or other relevant leadership bodies) of any entity with which a physician practice, hospital, or other health care organization establishes a corporate relationship.