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REPORT OF THE BOARD OF TRUSTEES

BOT Report 03-I-26

Subject: Reduce Environmental Impact of Medical Journals

Presented by: Toluwalasé 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.

- 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.

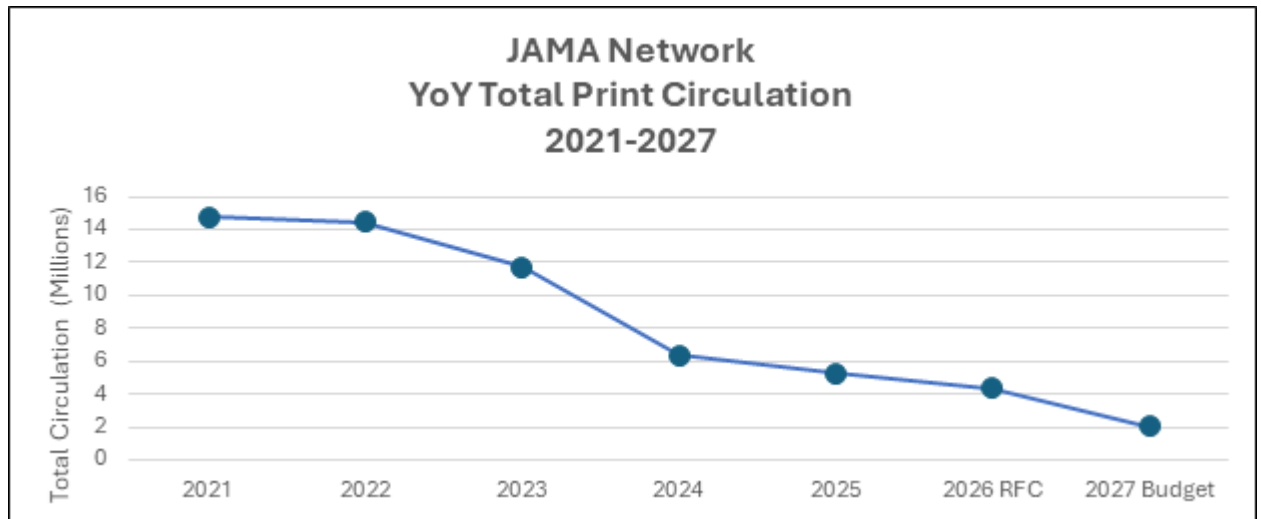
Print Frequency Reductions

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 - 2026 RFC/2027 Budget

Journal	Actual Totals					2026 vs 2021 Reduction	Projected Totals				Notes
	2021 Total	2022 Total	2023 Total	2024 Total	2025 Total		2026 RFC Total	2026 RFC vs 2021 Reduction	2027 Budget Total	2027 Budget vs 2021 Reduction	
JAMA	14,077,582	13,903,384	11,227,434	5,898,530	4,953,096	65% ↓	4,064,801	71% ↓	1,782,395	87% ↓	2027 JAMA Budget - 48 to 24 yearly issues
Pod	33,302	29,944	3,532	2,894	2,459	93% ↓	1,967	94% ↓	1,829	94% ↓	
De m	163,436	163,253	164,857	157,473	144,884	11% ↓	115,175	30% ↓	112,343	31% ↓	
Psych	48,613	5,395	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% ↓	
Ophthalm	124,044	119,641	114,067	105,489	2,784	98% ↓	1,191	99% ↓	990	99% ↓	
Ortho	24,228	16,921	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% ↓	
Disc	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	919	95% ↓	908	95% ↓	971	95% ↓	
Total	14,770,765	14,472,401	11,737,507	6,381,905	5,261,398	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

1 significantly. JAMA Network will work with our printer to identify and evaluate potential
2 alternatives, such as recycled paper or bamboo.

3
4 CONCLUSION

5
6 Because of the targeted efforts outlined above, print circulation has declined significantly across
7 the JAMA Network, and notably with *JAMA* as a Benefit of Membership. JAMA Network and
8 MMX continue to constantly evaluate how to limit print to those members who choose the format
9 as their preferred format for this member benefit. The resulting reductions in print circulation
10 reflect a deliberate transition away from costly, low-engagement mass distribution and toward a
11 more sustainable, member-directed, digital-first model, while still preserving limited print access
12 where it continues to provide value.

13
14 RECOMMENDATION

15
16 The Board of Trustees recommends that the following be adopted in lieu of Resolution 406-A-26
17 and the remainder of the report be filed:

18
19 Recommendation 1: That our AMA support continued efforts to reduce print circulation that
20 weigh the impact to membership and Publishing revenue models.

21
22 Recommendation 2: That our AMA continue the current practice during the member
23 onboarding process to require eligible members be asked to select their preferred delivery
24 format—print or digital—for their subscription.

25
26 Recommendation 3: That our AMA support JAMA Network undertaking a study to evaluate
27 options for climate friendly alternatives to the plastic packaging used for paper
28 journals including recycled paper, bamboo, and other options the printers may recommend.

29
30 (New HOD Policy)

31
32 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

1 This was followed by the chromosomal microarray, which allowed clinicians to analyze thousands
2 of genetic variants simultaneously, supporting a broader diagnostic approach for unexplained
3 phenotypes such as developmental delay.⁵ This broad approach was further accelerated by the
4 completion of the Human Genome Project in 2003, which enabled exome and whole-genome
5 sequencing assays that are now frequently used for precision oncology and diagnosis of rare
6 diseases.^{6–8} Although advances in testing technologies have led to distinctions between *genetic* and
7 *genomic* testing in research and clinical practice, these terms are often collectively referred to as
8 *genetic testing* in policy and public discourse. Accordingly, this report uses *genetic testing* to refer
9 to any laboratory testing of an individual's DNA for clinical purposes, unless otherwise specified.⁹

10
11 Genetic testing has become increasingly common in clinical practice over the past several decades
12 and is now used for a wide range of purposes beyond diagnosis, including predictive and pre-
13 symptomatic testing, carrier screening, and prenatal and newborn screening. Reflecting this
14 expanded role, genetic testing is now utilized across many medical specialties and is most
15 frequently ordered by obstetrician-gynecologists, oncologists (often for somatic tumor testing in
16 addition to hereditary cancer testing), and geneticists (Figure 1).¹⁰ A study of patients at Vanderbilt
17 University Medical Center found that the proportion of patients with genetic testing documented in
18 their electronic health records (EHRs) increased from 1.0 percent in 2002 to 6.1 percent in 2022.¹¹
19 The most commonly ordered tests in 2022 were multigene panels, followed by single-gene and
20 single-variant tests, whereas whole-genome sequencing remained relatively uncommon (Figure
21 2).¹¹

22
23 In contrast to many routine laboratory tests, genetic testing can generate identifiable data and reveal
24 information about biologically related family members. These considerations, together with the
25 ability of genetic testing to provide information about future disease risk, generate incidental
26 findings, and inform reproductive decision-making, have fueled ongoing debate regarding the
27 appropriate scope of informed consent and whether genetic testing should be subject to consent
28 requirements that differ from those used for other medical tests.^{1,12,13} For most medical tests, such
29 as ultrasounds or blood tests, physicians rely on ordinary informed consent and verbal agreement
30 from the patient. Under federal law, this typical process is permitted for genetic testing. However,
31 some states require the physician to obtain written informed consent from the patient before the
32 sample can be gathered for genetic testing.¹⁴ This process requires specific information to be
33 provided to the patient and, in some states, for genetic counseling to be offered. Once the sample is
34 collected, it is typically sent to a centralized laboratory for testing. The resulting genetic data are
35 then uploaded into the EHR, where they are accessible to other clinicians and, through patient
36 portals, to patients themselves (which is required under federal law). Genetic information may
37 remain in the medical record indefinitely and can potentially be reinterpreted as scientific
38 knowledge evolves.

39
40 The process for obtaining written informed consent, which varies by state and institution, can
41 create delays to care and increase administrative burden for clinicians and patients, while
42 simultaneously functioning to ensure patient comprehension of a complicated and consequential
43 test.^{14,15} The myriad of ethical and practical considerations are reflected in the numerous
44 workgroups, manuscripts, frameworks, and guidelines that have been developed over the last
45 several decades as technology has developed and genetic testing has been increasingly incorporated
46 into clinical care.^{15,16} While a full analysis of these considerations is outside the scope of this
47 report, the question of whether genetic information is sufficiently unique to warrant special
48 protections is integral to the development and application of informed consent policies for genetic
49 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

1 of certain insurance products may be an important consideration when deciding whether and when
2 to pursue testing. Physicians play a critical role in helping patients understand not only the
3 potential clinical benefits and limitations of testing, but also the possible privacy, insurance, and
4 family-related implications of obtaining genetic information.

5
6 Overall, federal law provides protections against discrimination on the basis of genetic information
7 but does not address informed consent for clinical genetic testing. At the same time, the limitations
8 of existing protections, particularly with respect to life, disability, and long-term care insurance,
9 illustrate why genetic testing may raise considerations that extend beyond immediate clinical
10 decision-making. These considerations reinforce the importance of physicians providing patients
11 with sufficient information and context to understand the potential benefits, limitations, and
12 consequences of testing before results are generated. Several states have enacted requirements
13 governing both the form and content of written informed consent, reflecting the view that genetic
14 testing may warrant additional safeguards beyond those applied to other medical tests.

15 16 *State Law*

17
18 Five states have written informed consent laws for clinical genetic testing: Massachusetts,²⁴
19 Michigan,²⁵ Nebraska,²⁶ New York,²⁷ and South Dakota (Table 1).²⁸ These laws were enacted
20 between 1994 and 2000, prior to both the completion of the Human Genome Project and the
21 enactment of GINA, at a time when genetic testing was largely limited to targeted analyses of
22 individual genes or mutations, was less frequent in clinical care (Figure 2), and protections against
23 genetic discrimination were more limited.¹⁴ These laws were intended to promote patient
24 autonomy, privacy, and informed decision-making regarding the use and disclosure of genetic
25 information.

26
27 In these states, written informed consent must be obtained before a specimen is collected, and the
28 required content of the consent document is prescribed by statute (Table 2). All five states require
29 disclosure of the nature and purpose of the test, the meaning of potential results, and information
30 regarding privacy and confidentiality. The scope of these requirements varies by state. In Michigan
31 and Nebraska, the requirements apply only to presymptomatic and predictive tests, whereas in
32 Massachusetts, New York, and South Dakota they apply more broadly to genetic testing, including
33 diagnostic testing. Massachusetts and New York also require that genetic counseling be offered,
34 and New York includes additional provisions governing disclosure and retention of genetic
35 information.

36
37 These state laws operate alongside federal protections such as GINA and reflect longstanding
38 efforts to address the unique ethical, privacy, and familial implications of genetic information.²⁹ At
39 the same time, advances in genomic technologies have changed both the scale and scope of genetic
40 testing since many of these laws were enacted. One analysis of state informed consent laws
41 observed that certain statutory definitions and disclosure requirements can be difficult to apply to
42 contemporary genomic testing, which often examines many genes simultaneously and may
43 generate a broader range of findings than earlier genetic tests.¹⁴ In addition, many of these laws
44 were developed during a period when genetic testing primarily focused on inherited (germline)
45 conditions, whereas contemporary clinical practice increasingly incorporates somatic tumor testing
46 and broader genomic analyses. As a result, healthcare systems, laboratories, and clinicians may
47 face challenges in translating statutory requirements developed for earlier forms of genetic testing
48 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

1 proposed a more individualized and flexible approach, leading to the development of conceptual
2 frameworks and decision aids that can be adapted to the clinical context and physician
3 judgment.^{37,38} As genetic technologies continue to evolve, ongoing work by clinicians, ethicists,
4 researchers, and professional organizations will likely play an important role in developing
5 practical guidance that balances patient autonomy, physician workflow, and the unique
6 considerations associated with genetic testing.

7 8 EXISTING AMA POLICY 9

10 Our AMA has extensive policy on numerous aspects of informed consent and clinical genetic
11 testing. These policies include the fundamentality of informed consent and suggest that physicians
12 document the informed consent conversation and the patient's (or surrogate's) decision in the
13 medical record in some manner (Code of Medical Ethics 2.1.1). When the patient/surrogate has
14 provided specific written consent, the consent form should be included in the record. Other AMA
15 policies support appropriate utilization of genetic testing, pre- and post-test counseling for patients
16 undergoing genetic testing, and physician preparedness in counseling patients or referring them to
17 qualified genetics specialists (H-480.944, "Improving Genetic Testing and Counseling Services"),
18 as well as guidance on topics the physician ordering a genetic test should discuss with the patient
19 (Code of Ethics 4.1.1, "Genetic Testing & Counseling"). In addition, AMA policy calls for
20 advocating for extending the consumer protections of GINA by adding long-term care, disability
21 insurance, and life insurance to the Act (D-315.970, "Consumer Genetic Testing and Privacy").
22 Collectively, current AMA policy emphasizes informed consent, patient privacy, appropriate use of
23 genetic testing and counseling, and protection against genetic discrimination.

24 25 CONCLUSION 26

27 As genetic testing has become increasingly integrated into clinical practice, questions regarding
28 informed consent and data sharing have grown in complexity. Written informed consent
29 requirements may help ensure that patients receive consistent information about the purpose, risks,
30 limitations, and potential implications of genetic testing, while also providing documentation and
31 guidance for clinicians. At the same time, these requirements may create administrative burdens,
32 introduce variability across jurisdictions, and contribute to delays in care, particularly as testing
33 technologies and clinical applications continue to evolve. The impact of these requirements may
34 differ depending on the clinical context, the type of genetic test being ordered, and the systems
35 used to implement consent procedures.

36
37 The ongoing debate surrounding genetic exceptionalism extends to requirements for informed
38 consent. The lack of consensus reflects a fundamental tension between promoting patient
39 understanding of potentially far-reaching information and minimizing unnecessary barriers to
40 testing and care. Existing federal and state laws, professional guidelines, and institutional policies
41 reflect differing views on how genetic information should be managed and what information
42 patients should receive before testing. As genetic testing becomes more commonplace across
43 medical specialties, continued evaluation of consent processes, implementation challenges, and
44 patient needs will be important to ensure that informed consent remains both meaningful and
45 practical in contemporary clinical care. Existing AMA policy upholds the importance of informed
46 consent in medical practice and recognizes the many considerations surrounding genetic testing.

1 RECOMMENDATION

2

3 The Board of Trustees recommends that the following policies D-315.970, “Consumer Genetic
4 Testing and Privacy,” H-480.944, “Improving Genetic Testing and Counseling Services,” Code of
5 Medical Ethics 2.1.1, “Informed Consent,” and Code of Medical Ethics 4.1.1, “Genetic Testing &
6 Counseling” be reaffirmed in lieu of Resolution 918-I-25 and that the remainder of the report be
7 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 2019¹⁰

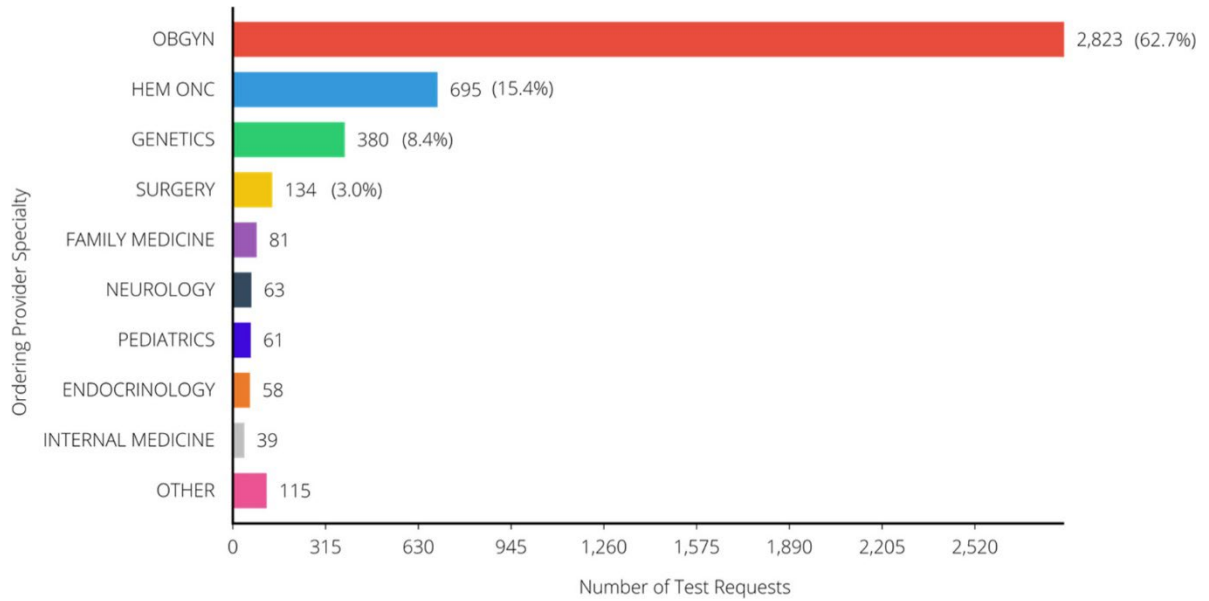


Figure 2. The cumulative number of clinical genetic tests ordered by year (2002, 2005, 2010, 2015, 2020, 2022) at Vanderbilt University Medical Center, stratified by test type¹¹

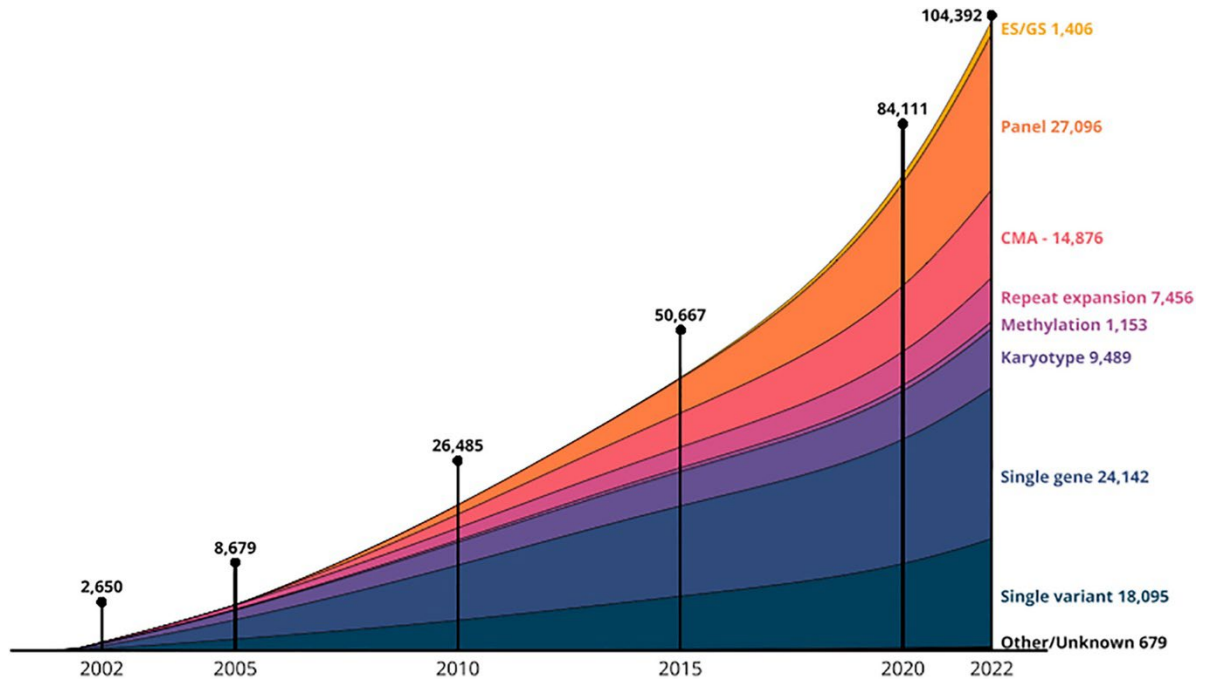


Table 1. Written informed consent for genetic testing in states with and without statutes

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: Toluwalasé 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

1 addition, TEFCA currently defines six specific exchange purposes for which EHI can be requested
2 or shared: treatment, payment, health care operations, public health, government benefits
3 determination, and individual access services.

4
5 The Sequoia Project² serves as the federally designated Recognized Coordinating Entity (RCE) for
6 TEFCA, managing the network's operational and oversight responsibilities. As the RCE, the
7 Sequoia Project develops, updates, implements, and maintains the Common Agreement, and is also
8 responsible for soliciting and reviewing applications from health information networks seeking
9 QHIN status and administering the QHIN designation and monitoring processes. In addition,
10 Sequoia engages with TEFCA stakeholders through routine public information sessions, ad hoc
11 presentations, and other channels.

12
13 The Centers for Medicare & Medicaid Services (CMS) Interoperability Framework³ is a voluntary,
14 federally-led initiative that serves as a blueprint for enabling secure health data exchange.
15 Organizations sign a pledge, agreeing to abide by an open, market-friendly set of guidelines
16 designed to accelerate real-time health data exchange. CMS Aligned Networks are the health
17 information networks, exchanges, and technology platforms that sign a pledge and voluntarily self-
18 attest to meeting framework criteria.

19
20 The Framework is intended to empower patients with easy access to their medical records without
21 added regulatory burdens by utilizing standardized, open technologies like Fast Healthcare
22 Interoperability Resources (FHIR) application programming interfaces (APIs) to seamlessly
23 connect patients, providers, and digital health applications. A foundational component of the
24 framework is strong digital identity and verifiable trust, which protects patient privacy while
25 breaking down institutional silos that may inhibit data exchange. Through shared infrastructure, the
26 framework enables patients to use authorized apps to view their records and navigate their care
27 without logging into multiple provider portals.

28
29 Many of the CMS Aligned Network entities are also QHINs under TEFCA, which expands the
30 reach and reliability for exchanging health records outside of traditional exchange partners. The
31 combination of the CMS Framework and Aligned Networks initiative helps fuel the growth of
32 digital innovations like conversational artificial intelligence (AI), paperless office visit check-ins
33 (the “Kill the Clipboard” initiative), and delivering real-time outcomes to patients.

34
35 Federal data privacy rules also shape what patient data can be shared and for what purposes. The
36 “Health Insurance Portability and Accountability Act” (HIPAA) Privacy Rule⁴ establishes national
37 standards to protect individuals’ medical records and protected health information (PHI) by
38 mandating that covered entities and business associates implement strict protocols to protect the
39 confidentiality and integrity of this data. The HIPAA Security Rule⁵ specifically requires these
40 organizations to apply appropriate administrative, physical, and technical safeguards for electronic
41 PHI. TEFCA and the CMS Interoperability Framework use HIPAA as the baseline privacy and
42 security apparatus undergirding their initiatives. Because federated data architectures query data
43 locally and return only aggregate or approved insights, they inherently align with HIPAA’s
44 minimum necessary standards by eliminating the need to pool massive amounts of vulnerable PHI
45 in a centralized repository.

46
47 TEFCA and the CMS Interoperability Framework combine to provide the foundational
48 infrastructure upon which future federated data sharing models can be built. TEFCA provides a
49 functional sharing model since federated data architecture capitalizes on patient data being
50 distributed across institutions, not in a central repository, and information only being shared
51 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

1 future federated research environments by making data more accessible and standardized at the
2 source.

3
4 Current centralized data models often limit large-scale research capabilities to well-resourced
5 institutions that can afford exorbitant access fees or have established prestige. Federated
6 architectures democratize clinical research by allowing smaller, less-resourced institutions to
7 participate in multi-center queries, thereby ensuring that patient populations from community
8 settings and diverse geographic areas are accurately represented in health systems research and
9 algorithmic training. Federated architectures also benefit well-resourced institutions as well as the
10 general community, as they allow access to data that likely would not have been easily available to
11 the individual institutions. Increased data democratization, enhanced data access, and mitigated
12 privacy risks support the utilization of federated data architecture.

13
14 The AMA continues to tout TEFCA data exchange and hold it up as an illustration of a successful
15 nationwide data exchange model. In recent public comment letters⁶ to federal government
16 agencies, we stated that we see TEFCA as a means to enable enhanced information exchange that
17 should remain as an option on the data exchange landscape. Our comments emphasized how
18 TEFCA, by standardizing health information exchange across many different networks, can help to
19 ensure nationwide network-to-network exchange of health information and simplify the work of
20 physicians and other clinicians by reducing the number of connections needed to send and receive
21 health information. We underscored TEFCA as a viable tool for exchanging data, and how it
22 should remain an option among the many means of data exchange currently available. Future
23 advocacy will focus on building on the successes of TEFCA and expanding the available exchange
24 purposes to include clinical research.

25 26 CONCLUSION

27
28 TEFCA and the CMS interoperability initiatives help address the fragmentation of the patient
29 journey across multiple providers and settings and are well-positioned to support a federated data
30 model that directs a robust nationwide clinical research program. With these two initiatives, our
31 nation is on track to achieve this goal.

32
33 As more physicians join TEFCA and the CMS Interoperability Framework, the volume of data
34 exchanged will only increase and further bolster their use and opportunities to expand clinical
35 research prospects. Federated data architectures support clinical research by minimizing
36 unnecessary data movement and maintaining data stewardship at originating institutions. They
37 support local governance by reducing the need for massive, centralized data repositories and
38 preserve patient trust through their structure and functions.

39
40 The strongest long-term architecture for a national healthcare research ecosystem is likely built on
41 TEFCA-enabled interoperability and CMS-driven FHIR standards. TEFCA provides the trust and
42 connectivity layer; CMS provides the policy and standards layer; together, they create conditions
43 where institutions can collaborate around large de-identified datasets without requiring widespread
44 centralization of PHI.

45
46 From a policy perspective, federated data architectures offer the best alignment with the goals of
47 interoperability, privacy, confidentiality, patient trust, ethical research, and precision medicine. The
48 principal remaining challenges are not technical, but organizational: governance harmonization,
49 adoption of common data models, patient consent management, sustainable funding, and incentives
50 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.

REFERENCES

¹ <https://healthit.gov/policy/tefca/>

² <https://rce.sequoiaproject.org/>

³ <https://www.cms.gov/health-technology-ecosystem/interoperability-framework>

⁴ <https://www.hhs.gov/hipaa/for-professionals/privacy/index.html>

⁵ <https://www.hhs.gov/hipaa/for-professionals/security/index.html>

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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.

REPORT OF THE BOARD OF TRUSTEES

BOT Report 12-I-26

Subject: Rethink the Medicare Annual Wellness Visit

Presented by: Toluwalasé 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

The Affordable Care Act (ACA) of 2010 established the AWP to give Medicare beneficiaries a recurring opportunity to assess their health risks and develop a personalized prevention plan without cost sharing. The AWP 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 AWP, provided that at least 12 months have passed since any IPPE, and may receive a subsequent AWP once every 12 months thereafter.

The ACA requires every AWP 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 AWP, and how frequently they must be furnished during subsequent AWP. Under existing regulations, the Centers for Medicare & Medicaid Services (CMS) currently requires AWP 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 AWP 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 AWP: 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 AWP were therefore derived from related office visit services, and they have never been informed by data on the resources required to furnish the AWP itself.

Table 1. Annual Wellness Visit Payment Amounts and Billing Patterns

HCCPS 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 AWW	\$174	60	54	Family medicine, 39%; 47% internal medicine, 31%; NPs/PAs, 25%	
G0439	Subsequent AWW	\$138	47	51	Family medicine, 41%; 54% internal medicine, 39%; NPs/PAs, 17%	

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 AWW codes accurately reflect the resources required to furnish these visits.

Physicians may provide services beyond the scope of the AWW 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 AWWs and 54 percent of subsequent AWWs.

Limitations of the Annual Wellness Visit

1. Beneficiary misunderstanding of the AWW's scope can lead to frustration and unexpected cost sharing.

Many Medicare beneficiaries [misunderstand](#) the purpose and scope of the AWW. A 2024 national survey of Medicare beneficiaries [illustrates](#) how pervasive this misunderstanding is: three in four respondents incorrectly indicated that the AWW 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 AWW covers.

This mismatch in expectations places physicians in a difficult position. If they remain within the scope of the AWW 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 AWW 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. AWWs 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 AWP in 2019. AWP 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 AWP 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 AWP, whereas those caring for larger shares of low-income, dual-eligible, rural, and medically complex beneficiaries furnish them less often. AWP 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 AWP'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 AWP, 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 AWP 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 AWP 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 AWP 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 AWP can undermine the central purpose of preventive medicine, which is not merely to identify and document risk, but to act on it.

4. The AWP 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 AWP are more likely to use certain preventive services. However, these associations do not establish that the AWP caused

the increase because beneficiaries who obtain AWWs 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 AWW 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: AWW 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 AWW confirm the harms the Cochrane review anticipated. In a [national study](#) of asymptomatic Medicare beneficiaries who received an AWW, 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 AWW, it almost certainly understates both the volume of unnecessary downstream care and the harms initiated during the visit.

5. The AWW is increasingly misaligned with today's longitudinal, team-based, and technology-enabled approach to preventive care.

The AWW 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 AWW, but also allow physicians to intervene promptly when blood pressure is uncontrolled—whether by adjusting

1 medications, scheduling an in-office visit for counseling, or urgently escalating care to prevent
2 serious complications.

3
4 Technology has also transformed one of the traditional functions of the preventive visit: identifying
5 which preventive services are due and reminding patients to obtain them. Electronic health record
6 (EHR)-based registries and clinical information systems can now continuously identify patients
7 with overdue preventive needs and trigger outreach when care is due, rather than waiting for an
8 annual visit to determine what each patient needs. Mailed fecal immunochemical testing (FIT)
9 programs demonstrate the potential of this approach. Practices can identify patients due for
10 colorectal cancer screening, send test kits directly to their homes, provide reminders, and arrange
11 diagnostic follow-up after an abnormal result. Randomized trials have found higher screening
12 completion with these programs than with usual care. In one [study](#) of rural Medicaid beneficiaries,
13 a mailed FIT and navigation program increased screening completion from 4.5 percent to 11.8
14 percent, demonstrating how technology-enabled, proactive outreach can reach patients who might
15 otherwise be missed by encounter-based preventive care.

16
17 Finally, the delivery of preventive care is increasingly shifting from a model in which physicians
18 personally perform and coordinate every service to one in which the physician leads a clinical team
19 whose members each contribute to the patient's preventive care needs according to their role and
20 expertise. The AMA is already helping practices put this approach into practice through its STEPS
21 Forward practice transformation [resources](#), which highlight practical models for implementing
22 physician-led, team-based care. In one such model, medical assistants trained as care coordinators
23 are assigned a panel of the physician's patients and, working under standing orders and physician-
24 directed protocols, engage those patients in chronic and preventive care throughout the year.
25 Coordinators proactively review panels for overdue screenings and other preventive needs, contact
26 patients to arrange services, track completion of testing and referrals, and escalate abnormal
27 findings or concerns to the physician. This distribution of work allows care teams to identify and
28 address preventive needs as they arise while preserving physician time for interpreting findings,
29 addressing complex medical needs, and engaging patients in shared decision making. Importantly,
30 team-based models have been [shown](#) to be particularly effective in smaller, resource-constrained
31 practices, which currently face the greatest challenges in delivering recommended preventive care.

32
33 The same principles can extend beyond individual practices to entire health systems, where shared
34 infrastructure can coordinate prevention across patient populations, specialties, and points of care.
35 Kaiser Permanente Southern California's Complete Care program, for example, [uses](#) EHR tools
36 and population registries to identify outstanding needs and distribute responsibilities across the care
37 team: pharmacists update medication lists; medical assistants and nurses review records for care
38 gaps, pend pre-visit orders, and provide patient education; and panel managers coordinate outreach
39 to patients requiring additional care. In designing the model, Kaiser also convened primary care
40 and specialist physicians to determine which preventive care gaps each specialty is best positioned
41 to address during its patient encounters and incorporated those activities into specialty workflows.
42 This has created additional opportunities to address patients' preventive needs every time they
43 interact with the health system. In its first six years, Kaiser's program improved performance
44 across 51 Healthcare Effectiveness Data and Information Set measures, including clinical outcomes
45 such as glycemic, blood pressure, and cholesterol control, by an average of 13 percent, compared
46 with a 5.5 percent improvement nationally.

47 48 RELEVANT AMA POLICY

49
50 *Individualized and evidence-based preventive care*

- 1 • [Policy H-425.984](#), “**Clinical Preventive Services**,” states that physicians should provide
2 preventive services appropriate to each patient’s age, gender, and individual and
3 environmental risk factors at every opportunity, including during episodic and acute care
4 visits. It further states that recommendations for clinical preventive services should be
5 based on outcomes research and effectiveness data and calls for additional funding to study
6 the outcomes, implementation, and public policy implications of these services.
- 7 • [Policy H-425.994](#), “**Medical Evaluations of Healthy Persons**,” supports periodic
8 evaluation of healthy individuals while emphasizing that the appropriate frequency and
9 content of those evaluations should reflect each patient’s age, socioeconomic status,
10 heredity, occupation, and other individual factors. It also calls for continued research on the
11 usefulness of tests intended to detect disease in asymptomatic populations.
- 12 • [Policy H-410.967](#), “**Clinical Preventive Services**,” recommends the U.S. Preventive
13 Services Task Force guidelines to clinicians and medical educators as one resource for
14 guiding preventive care, while clarifying that its recommendations should not replace
15 clinical judgment or individualized decision making. It also supports the development of
16 practice guidelines based on the best available evidence and continued collaboration
17 among expert groups and specialties.
- 18 • [Policy H-460.894](#), “**Value of Preventive Services**,” calls for organizations that issue
19 preventive service recommendations to incorporate specialty society input, use transparent
20 methods, rely on the best available evidence, provide enough specificity to inform cost-
21 effectiveness analyses, identify and de-prioritize services that lack evidentiary support or
22 are not cost-effective, and to address both primary and secondary prevention. It also
23 advocates for increased comparative-effectiveness research on secondary prevention.

24
25 *Longitudinal, coordinated, and team-based delivery*

- 26
27 • [Policy H-425.997](#), “**Preventive Services**,” supports policies and mechanisms that ensure
28 the continuity, coordination, and continuous availability of cost-effective preventive
29 services and states that any preventive service covered by public or private insurance
30 should be supported by evidence demonstrating improved outcomes or quality of life and
31 cost-effectiveness. The policy also emphasizes that preventive care should ideally be
32 coordinated by the patient’s physician.
- 33 • [Policy H-330.879](#), “**Providers and the Annual Wellness Visit**,” states that the AWP is
34 most appropriately furnished by a physician or a member of a physician-led healthcare
35 team. It also states that any clinician furnishing the AWP must enumerate all relevant
36 findings and make provisions for appropriate follow-up care. In addition, the policy calls
37 on CMS to give physicians a way to determine whether Medicare has paid for an AWP for
38 a patient within the preceding 12 months and to educate beneficiaries about scheduling
39 AWP with their primary care physicians.

40
41 *Coverage and financial incentives*

- 42
43 • [Policy H-185.954](#), “**Coverage for Certain Types of Well Care Examinations by Health**
44 **Insurers**,” supports regular evaluation of the benefits and cost-effectiveness of preventive-
45 service guidelines and encourages health insurers to offer policies that cover preventive
46 services.
- 47 • [Policy H-165.840](#), “**Preventive Medical Care Coverage for All**,” advocates for insurance
48 coverage of evidence-based preventive care and its delivery in all appropriate settings,
49 including primary care practices, specialty practices, workplaces, and community settings.
- 50 • [Policy H-425.987](#), “**Preventive Medicine Services**,” supports continued collaboration
51 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 AWW with a universal annual PE would perpetuate, rather than correct, the disproportionate use of preventive care by healthier and better-connected patients. Like AWWs, 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 AWW 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.

1 **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?

2
3 *Defining the goals of preventive care and measuring success*
4
5 This work should begin by defining the objectives of preventive care and the measures used to
6 evaluate its effectiveness. Specifically, experts should reach consensus on which outcomes
7 preventive interventions should be expected to influence—for example, whether effectiveness
8 should be assessed in terms of morbidity and mortality, functional status, quality of life, or other
9 outcomes—and the appropriate time horizon for assessing them. A stronger measurement
10 framework should also distinguish between process measures that assess whether recommended

1 preventive services were delivered and outcome measures that assess whether those services
2 achieved their intended effects. Clearly defined objectives, measures, and time horizons would
3 provide a consistent basis for evaluating preventive services and delivery models and generating
4 stronger evidence to inform policy and practice.

5
6 *Prioritizing preventive care interventions based on evidence and value*
7

8 Once the goals of preventive care are established, the next step should be to develop a framework
9 for determining which interventions warrant the greatest priority. Consistent with AMA policy, the
10 framework should consider the quality and quantity of the available evidence, the magnitude and
11 certainty of the expected clinical benefit, and the intervention's cost-effectiveness. It should also
12 account for potential harms and burdens, including false-positive findings, unnecessary
13 downstream care, and the time and resources required of patients and care teams. These
14 considerations would allow preventive interventions to be distinguished not simply by whether
15 evidence supports their use, but by the strength of that evidence and the value they are likely to
16 produce.

17
18 *Identifying patients with unmet needs and improving targeted outreach*
19

20 Despite decades of guidelines calling for preventive care to be targeted toward patients most likely
21 to benefit, the healthcare system still lacks reliable ways to identify those patients. Existing risk-
22 stratification models are designed to predict a disparate set of outcomes, often have limited
23 predictive accuracy, and frequently rely on inputs such as diagnosis codes that can be influenced by
24 documentation and coding practices. More fundamentally, even accurate prediction of an adverse
25 outcome does not establish whether preventive intervention can reduce that risk or which patients
26 are most likely to benefit.

27
28 Physicians should therefore establish a more rigorous, clinically useful approach to risk
29 stratification that identifies both patients at elevated risk and those most likely to benefit from
30 additional preventive attention. This should begin with determining which outcomes are most
31 important to predict and which factors most reliably predict them, while also assessing whether
32 identified risks are amenable to preventive intervention and which patients are most likely to
33 benefit. In selecting data for these assessments, experts should consider not only predictive value,
34 but also whether the information is reliable, verifiable, and resistant to manipulation.

35
36 This work should also consider how risk assessments should guide outreach and follow-up. The
37 appropriate intensity of outreach, mode of care, and frequency of follow-up may differ according to
38 the nature of the risk and the likelihood of benefit. For example, patients at higher risk or
39 substantially overdue for recommended preventive services may warrant more frequent care
40 coordination visits, in-person evaluation, and more intensive care team outreach, while others may
41 be appropriately managed through automated reminders, preventive care incorporated into routine
42 visits, or telehealth when an in-person encounter is not necessary.

43
44 Ultimately, this framework should be designed for integration into EHRs and other clinical systems
45 so that relevant data can be drawn automatically from the patient's record and used to identify
46 patients at elevated risk and those most likely to benefit from preventive intervention. These
47 systems could continuously update risk assessments as new clinical information becomes available,
48 prioritize patients for outreach, and prompt the care team when follow-up is warranted. Physicians
49 should be closely involved in their design to ensure that the new technologies integrate into clinical
50 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)

- 1 5. That our AMA, in collaboration with national medical specialty societies, explore
2 approaches to modernizing preventive care, including how to prioritize evidence-based
3 services according to individual patient needs, support longitudinal and physician-led
4 team-based care, and align payment and incentives with effective preventive care.
5 (Directive to Take Action)
- 6 6. That our AMA amend Policy H-425.997, “Preventive Services,” paragraph 3, as follows:
7
8 3. Our AMA believes that preventive care should ideally be coordinated by a patient's
9 physician, or, under the physician’s supervision, by members of the physician-led care
10 team. (Modify Current HOD Policy)
- 11
12 7. That our AMA amend Policy H-330.879, “Providers and the Annual Wellness Visit,”
13 paragraphs 2 and 3, as follows:
14
15 2. Our AMA supports that, at a minimum, any ~~clinician~~ physician or member of the
16 physician-led care team performing the AWW must enumerate all relevant findings from
17 the visit and make provisions for all appropriate follow-up care.
18 3. Our AMA supports that the Centers for Medicare & Medicaid Services (CMS) provide
19 a means for physicians, patients, and members of physician-led care teams to determine
20 whether or not Medicare has already paid for an AWW for a patient in the past 12 months.
21 (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.

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)

1 have at least one KSM that is solely manufactured in a single country (see Table 1).⁸ Transparency
 2 into these supply chains remains limited. The 2025 Senate report noted that the FDA relies heavily
 3 on manufacturer-reported data to track shortages and that the U.S. government has limited
 4 information about KSM supply chains, which are not readily reported.¹⁷ In response to the Senate
 5 report findings of concentrated manufacturing, unbalanced trade (see Figures 12 and 13), and
 6 limited transparency, the CLEAR LABELS Act of 2026 (Senate Bill 3788) was introduced. The
 7 Act would require manufacturers to identify the original source of finished drugs and their APIs on
 8 labels.²⁰ According to the sponsors, this Act would provide more information on potential supply
 9 chain vulnerabilities and increase transparency for patients, pharmacists, and healthcare
 10 professionals.²¹

11 *Challenge: Potential Global Disruptions to Supply Chains*

12
 13 Because the U.S. depends heavily on other countries for pharmaceuticals, global conflict can
 14 worsen drug shortages through disruptions to manufacturing, transportation, trade, and supply
 15 chains.²² As of the writing of this report, there are no data indicating whether the ongoing conflict
 16 in the Middle East has impacted the drug supply chain, but available manufacturing data indicate
 17 that several pharmaceutical products depend substantially on production capacity in the region.
 18 While just 0.3 percent of APIs and 0.6 percent of oral solid dose drugs come from the region, there
 19 are a handful of products that are substantially produced in the Middle East: 48 percent of
 20 amoxicillin oral suspension (Jordan), 73 percent of flumazenil API (Israel and Jordan), 48 percent
 21 of etomidate API (Jordan), and 24 percent of doxycycline hyclate capsules (Jordan).²³ More
 22 broadly, India uses the Red Sea corridor to transport pharmaceutical products to the U.S. and relies
 23 on the Strait of Hormuz to import 40 percent of its crude oil, which is used to create
 24 petrochemicals, a KSM for nearly all medications.^{24,25} Rising costs and transit times could arise
 25 from conflict and closures in these shipping corridors, potentially leading to drug shortages in the
 26 U.S. This is particularly relevant for generics, which are already produced on slim profit margins
 27 and account for about 90 percent of prescriptions in the U.S., nearly half of which are produced in
 28 India.²⁶

29
 30 It is not clear whether current conflicts in the Middle East will affect drug shortages in the U.S., but
 31 the situation warrants continued monitoring. Historically, military conflicts, as well as natural
 32 disasters and other geopolitical disruptions, have affected manufacturing operations, transportation
 33 networks, trade routes, and energy supplies, all of which can influence pharmaceutical production
 34 and distribution.²⁷⁻²⁹ Such disruptions may increase costs, lengthen transit times, and reduce
 35 production capacity, potentially increasing the risk of drug shortages. Given the increasingly global
 36 nature of pharmaceutical manufacturing and supply chains, visibility into potential disruptions may
 37 help policymakers, manufacturers, and regulators anticipate and respond to emerging supply
 38 challenges. Although FDA currently has limited visibility into many aspects of the global
 39 pharmaceutical supply chain, enhanced surveillance and supply-chain monitoring could improve
 40 the ability to identify vulnerabilities and support efforts to prevent or mitigate shortages.

41 FDA ACTIONS AND THEIR EFFECTS ON MEDICATION ACCESS

42
 43 The FDA plays a central role in shaping medication access through its regulatory, enforcement, and
 44 policy decisions and has undergone significant changes in recent years, as discussed in last year's
 45 report. The following examples illustrate how FDA policies in the last year have influenced drug
 46 availability, demand, and supply chains across multiple dimensions.
 47
 48

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

- 1 encouraging procurement from manufacturers that adopt AMTs and by supporting policies
2 that reward investments in modernized, resilient manufacturing infrastructure.
- 3 6. Promote Interagency Coordination and Sustain Cross Sector Collaboration: The Task
4 Force encourages CMS to work closely with partners across HHS, FDA, ASPR, and other
5 agencies to align policies, share insights, and harmonize data. Ongoing engagement with
6 industry, providers, and patient groups will help ensure that emerging solutions are
7 practical, scalable, and responsive to the real-world experiences of those directly impacted
8 by shortages.

9

10 Our AMA continues to monitor the use of buffer stocks as an effective strategy to mitigate drug
11 shortages and opposes the use of punitive fees for those who do not participate in buffer stocks.

12

13 *The Drug Shortage Prevention Act of 2025*

14

15 The Drug Shortage Prevention Act of 2025 was introduced in Congress in August 2025 and would
16 expand the drug shortage notification framework established by the CARES Act of 2020.⁵¹ Under
17 the CARES Act, manufacturers of certain critical drugs are required to provide HHS with at least
18 six months' advance notice of permanent discontinuance or manufacturing interruptions likely to
19 cause a meaningful supply disruption.¹³ The Drug Shortage Prevention Act of 2025 would further
20 require manufacturers to notify HHS of increased demand, export restrictions, and other
21 circumstances that could prevent a manufacturer from meeting U.S. demand, as well as provide
22 information on API sources, alternative suppliers, and expected interruption duration.
23 Manufacturers would also be required to disclose supplier names and production amounts twice a
24 year, rather than the current annual reporting requirement. In turn, HSS would be required to share
25 these manufacturer notices with appropriate organizations, including physician, health provider,
26 and patient organizations. Overall, this bill aims to increase transparency, take a preventive
27 approach to drug shortages, and strengthen the CARES Act, which, as discussed above, the FDA
28 cites as one factor contributing to its ability to mitigate and prevent drug shortages.¹²

29

30 DOMESTIC AND ALLIED MANUFACTURING

31

32 The current administration continues its interest in increasing domestic manufacturing of
33 pharmaceuticals. The FDA's 2027 budget proposal includes a legislative proposal that would allow
34 domestic generic drug manufacturers to submit FDA applications for marketing a generic drug one
35 month earlier than foreign manufacturers.⁵² This would increase the likelihood that a domestic
36 manufacturer qualifies for the 180-day generic market exclusivity, which typically provides
37 substantial profits. The FDA is also requesting funding to upgrade and establish new drug
38 manufacturing facilities in the U.S., as well as funding to expand resources for its foreign
39 inspection program to better oversee an increasingly globalized supply chain.

40

41 Tariffs have also played a significant role in the effort to increase domestic manufacturing. In April
42 2026, Proclamation 11020 was signed by the President, which establishes tariffs of up to 100
43 percent on imported patented pharmaceuticals and pharmaceutical ingredients.⁵³ No tariff is placed
44 on companies that are building drug manufacturing facilities in the U.S. and have signed a Most
45 Favored Nation (MFN) pricing deal, meaning the U.S. price must be no higher than that in
46 comparable foreign countries. A 20 percent tariff would apply to companies that do not have an
47 MFN deal but are building facilities in the U.S.; that tariff would increase to 100 percent in 2030.
48 Notably, at this point, generics and biosimilar drugs are exempt from these tariffs. Our AMA
49 supports legislative efforts aimed at mitigating the negative effects of tariffs on the healthcare
50 system, ensuring that patient care, medical supplies, and pharmaceuticals remain accessible and
51 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.

- 1 3. Our AMA will work with stakeholders to make sure essential medicines lists are data
2 driven and evidence based to satisfy priority health needs and provide predictability for
3 physicians and hospitals. (Modify Current Policy)
4
- 5 3. That Policy H-100.956, “National Drug Shortages” be amended by addition and deletion:
6
- 7 1. Our AMA urges the FDA and other appropriate agencies to develop a coordinated,
8 real-time data infrastructure by ~~to~~ requiring manufacturers and distributors to provide
9 greater transparency regarding the pharmaceutical product supply chain, including
10 production locations of drugs, any unpredicted changes in product supply and demand
11 such as import flow changes and pricing variability, and ~~provide~~ more detailed
12 information regarding the causes and anticipated duration of drug shortages. (Modify
13 Current Policy)
14
- 15 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, 2026⁷

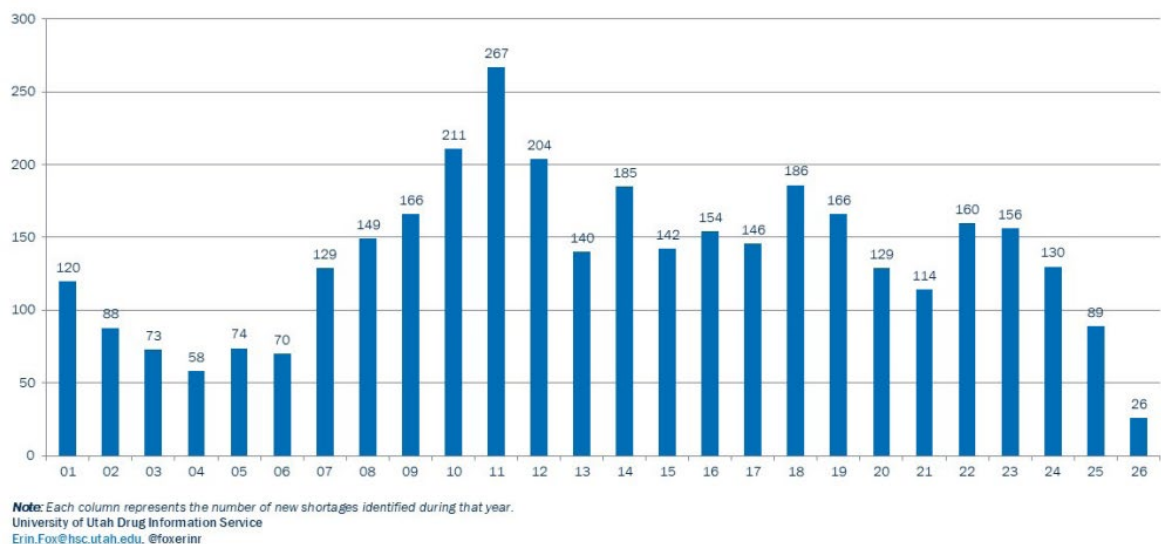
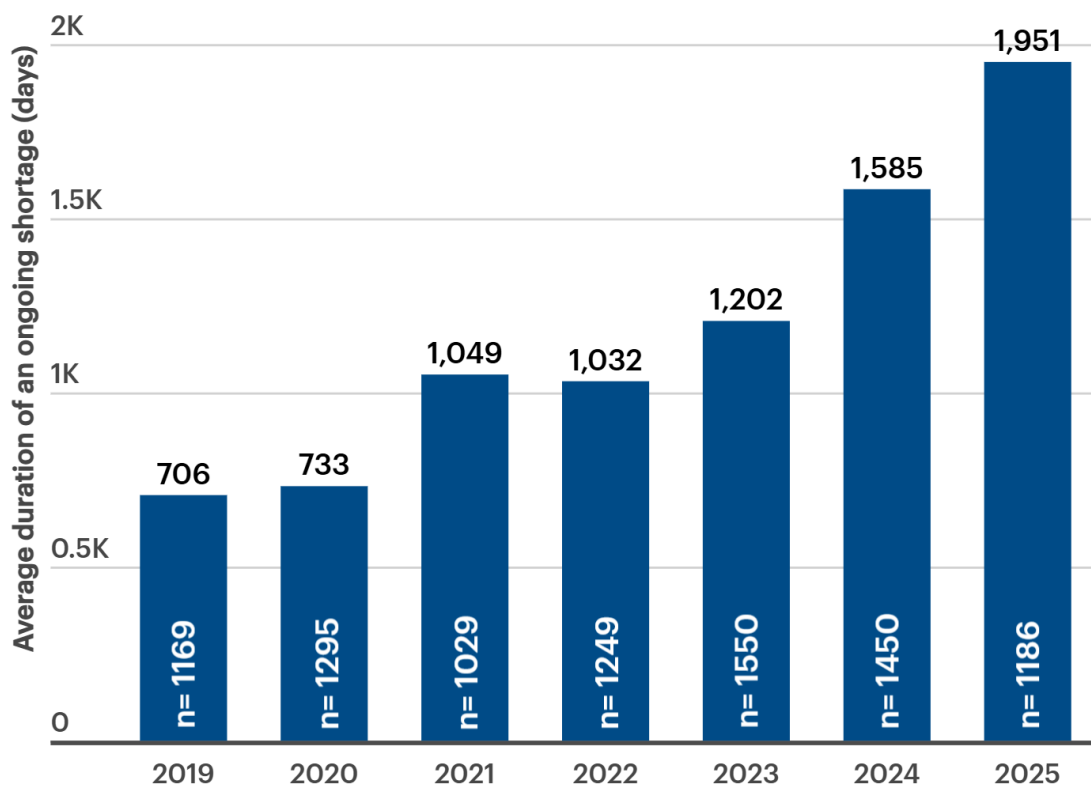


Figure 2. National Drug Shortages: Active Shortages by Quarter: 10 Year Trend⁷



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 2025⁸

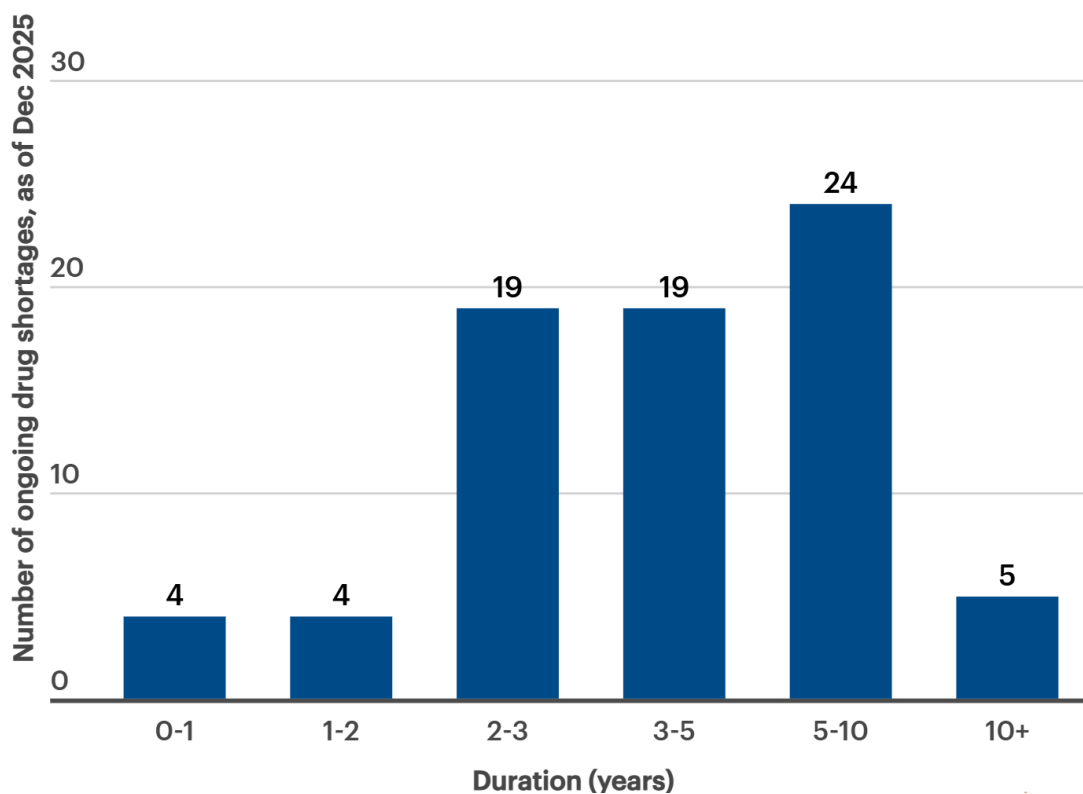
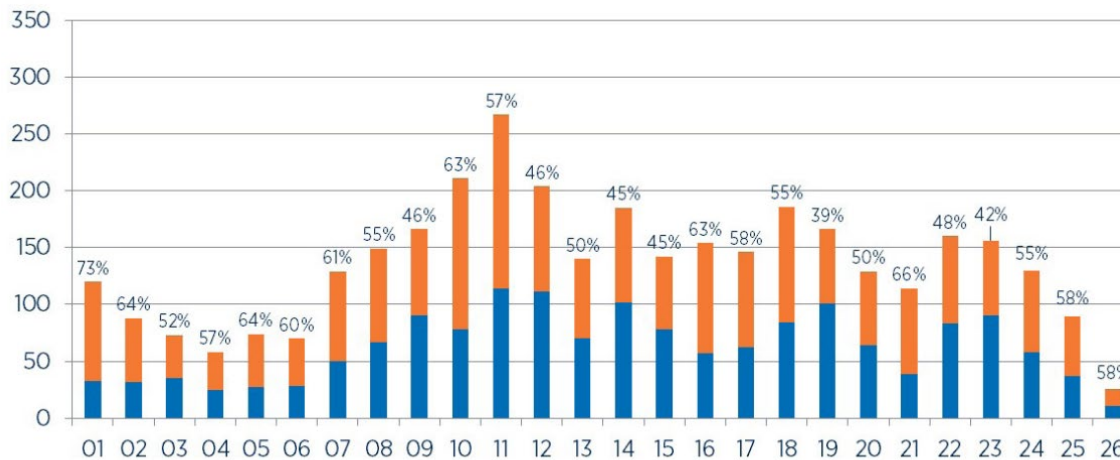


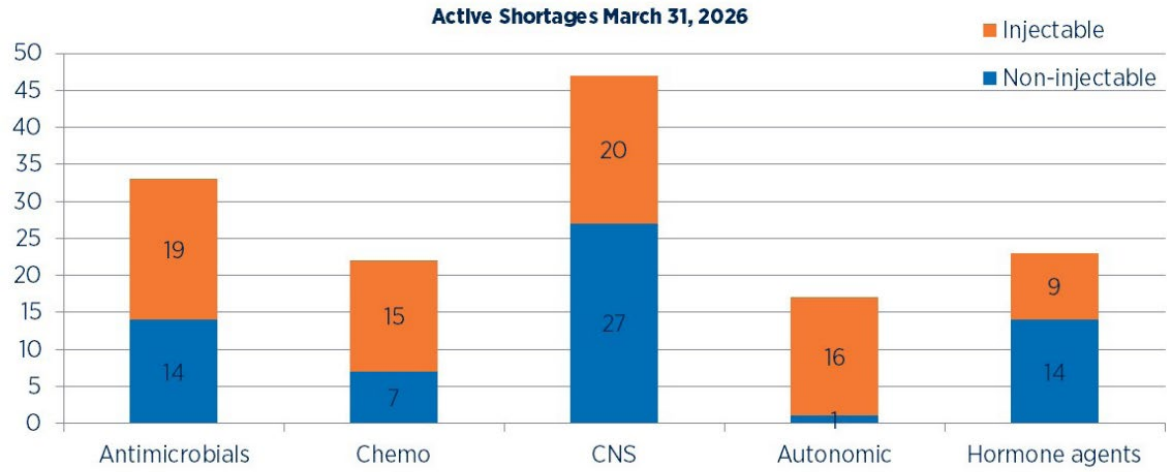
Figure 5. National New Drug Shortages by Year: January 2001 to March 2026, Percent Injectable^{7,a}



University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr

^a Injectables are shown in orange (top bar)

Figure 6. National Active Drug Shortages: Top 5 Drug Classes⁷



University of Utah Drug Information Service
Erin.Fox@hsc.utah.edu, @foxerinr

Figure 7. Top 10 Therapeutic Categories by Number of Drug Shortages⁸

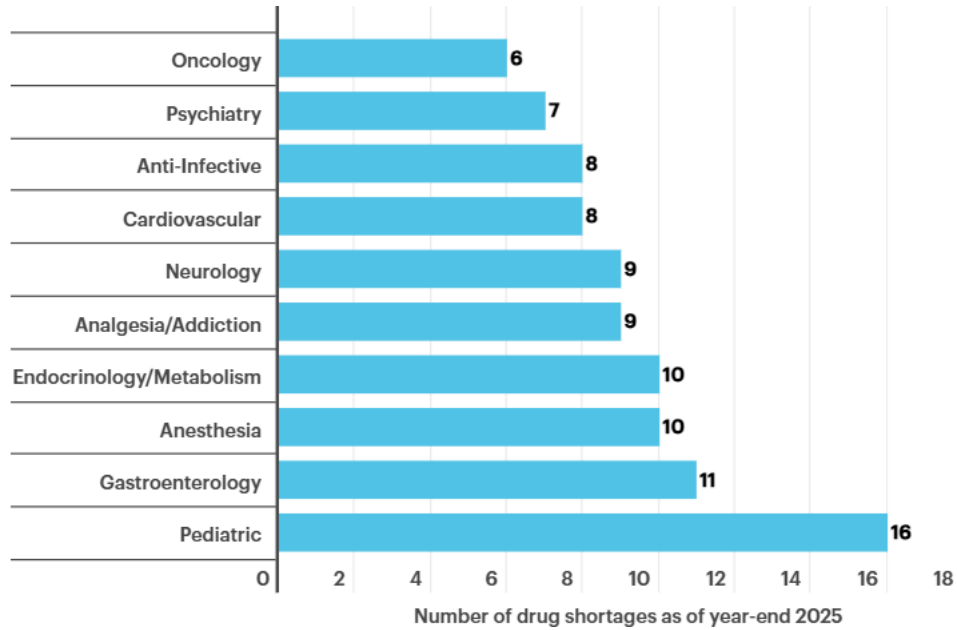


Figure 8. Reasons for Drug Shortages as Reported by Manufacturers⁷

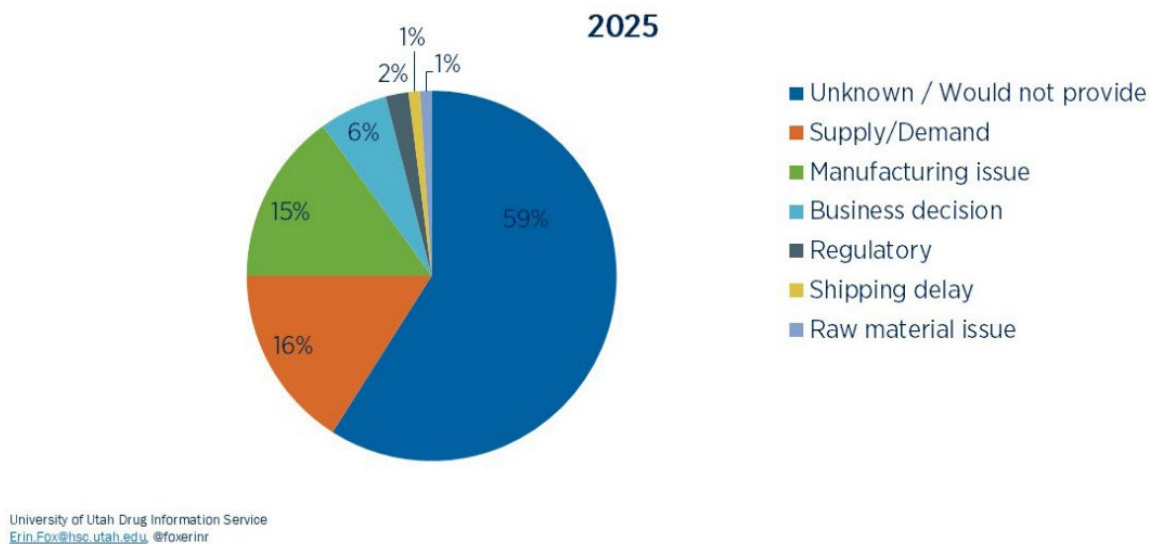


Figure 9. Common Drug Classes in Short Supply: 5 Year Trend⁷

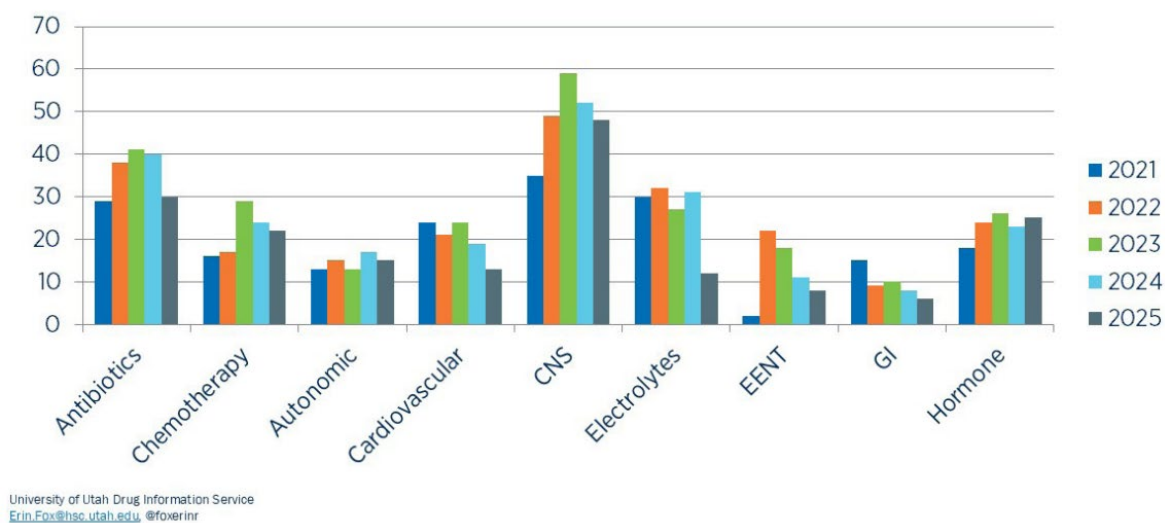
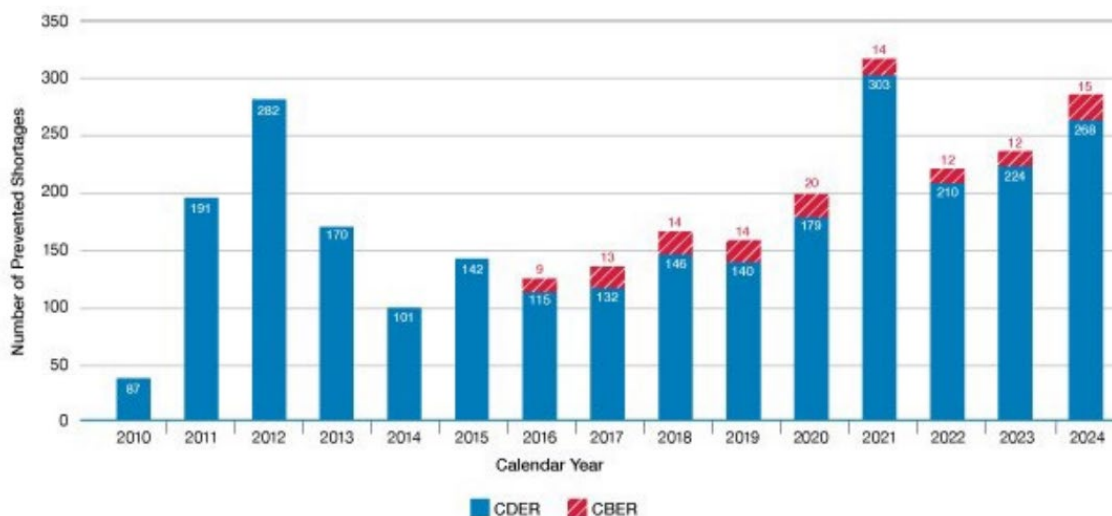
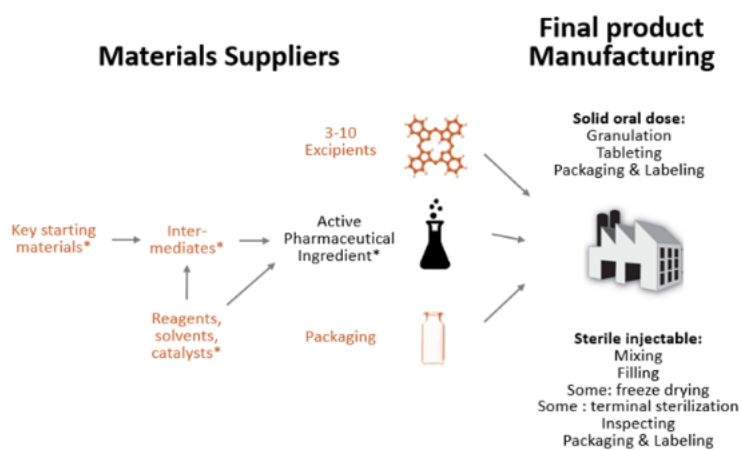


Figure 10. Number of Prevented Drug Shortages by the FDA Per Calendar Year, 2010-2024¹²**Figure 11. Typical drug supply chain for small molecule drugs⁵⁶**

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, 2000-2024¹⁵

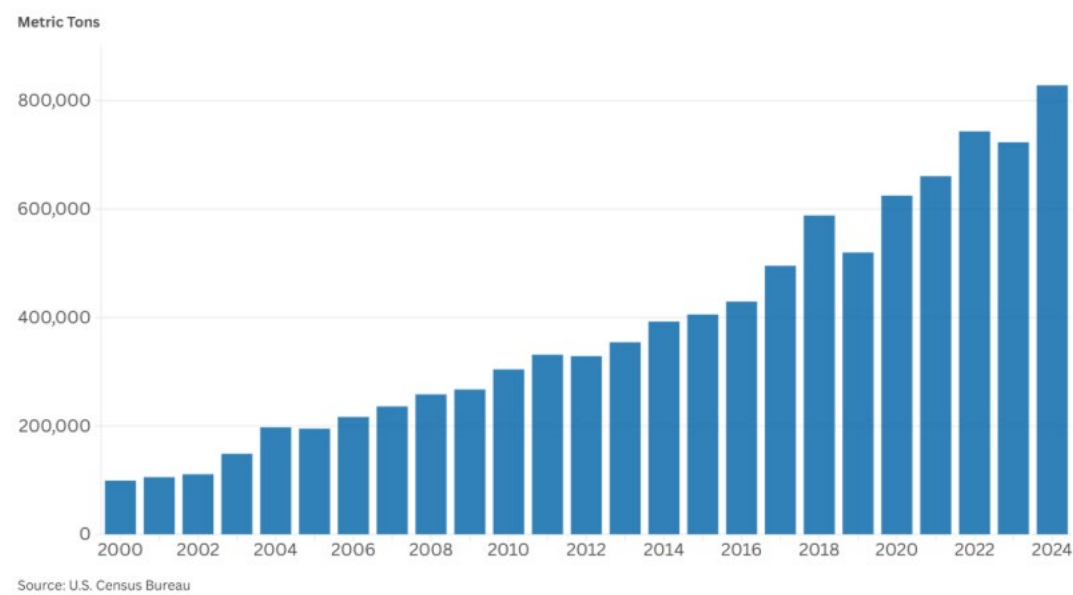


Figure 13. U.S. Pharmaceutical Trade Balance, 2000-2024¹⁵

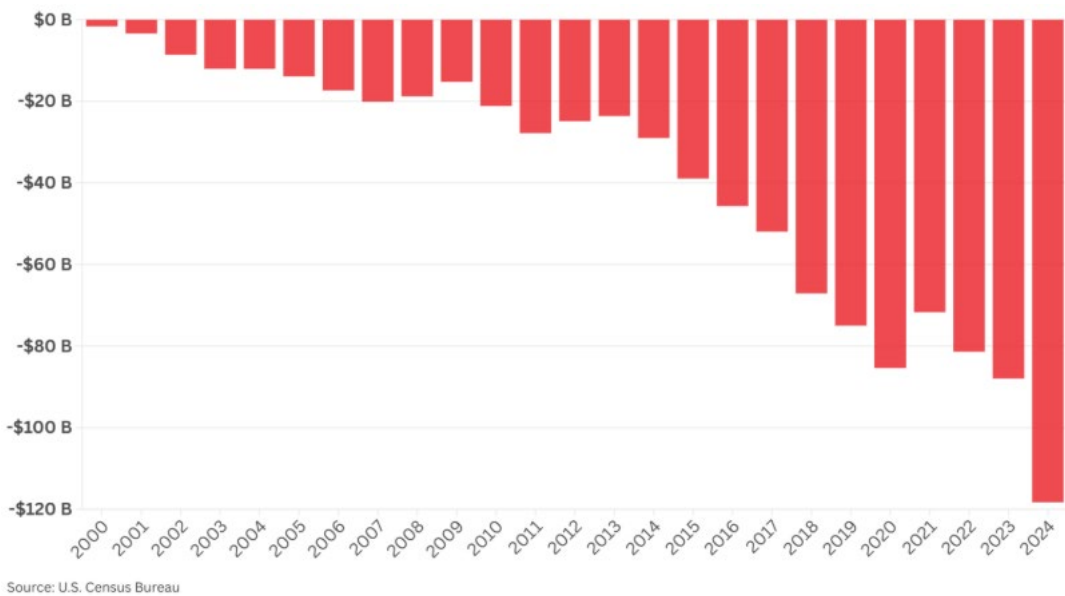


Figure 14. Estrogen-based hormone replacement therapy prescriptions per 1,000 women, by age group³⁴

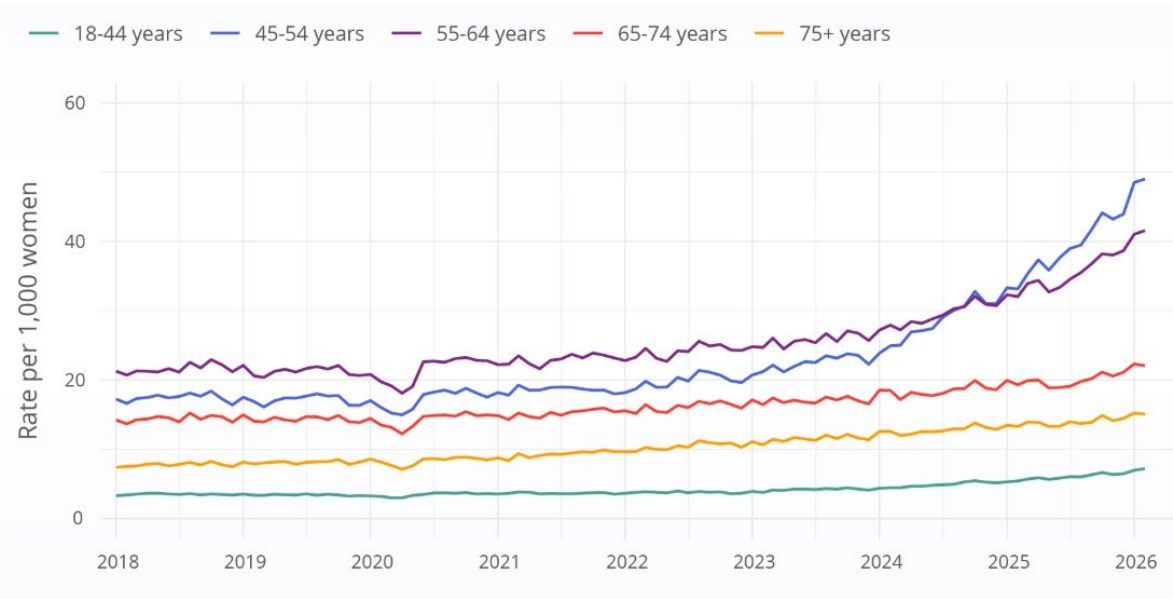
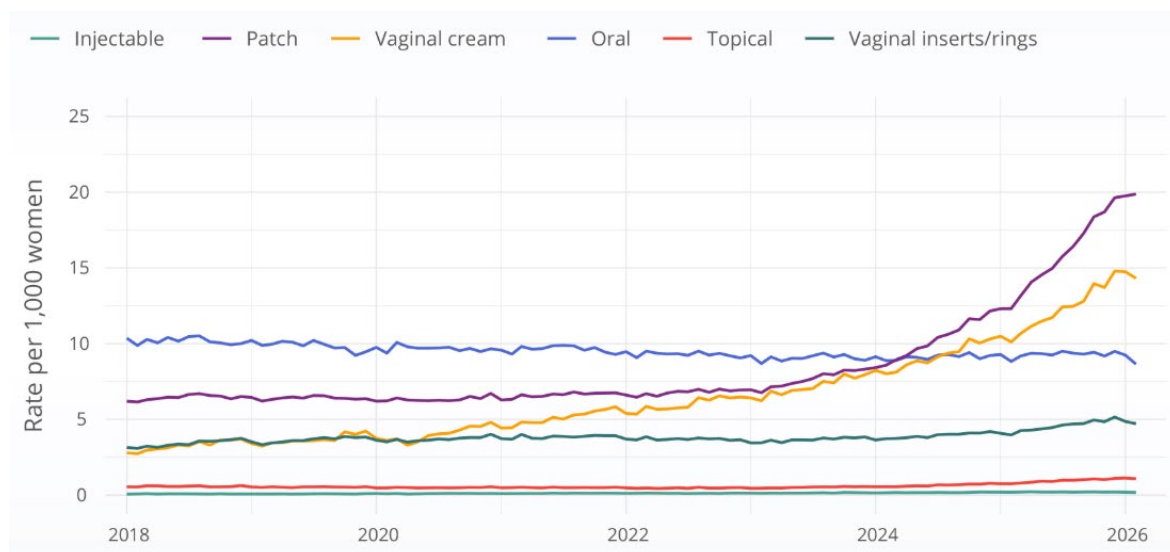


Figure 15. Estrogen-based hormone replacement therapy dispenses per 1,000 women by type³⁴**Table 1. Upstream KSM concentration among 2025 drug shortages (n=75)^a**

<u>Upstream KSM Indicator</u>	<u>Count of Shortage Drugs</u>	<u>Share of Shortage Drugs</u>
<u>At least one KSM solely manufactured in one country</u>	<u>33</u>	<u>44%</u>
<u>All KSMs solely manufactured in one country</u>	<u>6</u>	<u>8%</u>
<u>China is the primary KSM supplier (>50% market share)</u>	<u>26</u>	<u>35%</u>
<u>India is the primary KSM supplier (>50% market share)</u>	<u>18</u>	<u>24%</u>
<u>China or India is the primary KSM supplier</u>	<u>44</u>	<u>59%</u>

^a Adapted from USP 2025 Annual Drug Shortages Report⁸**Table 2. Seven synthetic peptides considered for inclusion on the 503A Bulks List by the Pharmacy Compounding Advisory Committee, July 23-24, 2026 meeting⁴²**

<u>Bulk Drug Substance^a</u>	<u>Uses Evaluated</u>
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.

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

1 This report provides a brief history of the current regulatory framework for food additives in the
2 U.S. and compares that to similar countries. A snapshot of state legislative activity on this topic is
3 also provided. It also includes a high-level summary of the available evidence on the health
4 impacts and safety concerns of some groups of synthetic food additives (as there are thousands),
5 notes where data are lacking and outlines opportunities for improving and strengthening
6 regulations to ensure and protect the health and well-being of Americans.

7 8 DISCUSSION

9 10 *The U.S. Regulatory Framework for Food Additives – A Brief History*

11
12 The regulatory framework for food safety was established over a century ago. In 1906, Congress
13 prohibited the introduction of adulterated or misbranded food and drugs into interstate commerce
14 with the Pure Food and Drugs Act.⁵ This was in response to widely publicized examples of
15 industry abuse and contamination of food, such as those presented in Upton Sinclair’s novel ‘The
16 Jungle,’ which told of the abuses of the meat packing industry.⁵

17
18 A few decades later, Congress updated the 1906 law with the passage of the Federal Food, Drug,
19 and Cosmetic Act (FDCA) in 1938.⁶ This foundational law authorized the FDA to oversee the
20 safety, manufacturing, and labeling of foods, drugs, medical devices, and cosmetics to protect the
21 public from adulterated or misbranded products.^{6,7} The passage of this law came from mounting
22 public concern over adulteration of consumer products, in particular a high-profile incident referred
23 to as the “Elixir Sulfanilamide” tragedy, in which a well-known medication, safe in tablet and
24 powder form, was dissolved in diethylene glycol and marketed without safety testing. The “Elixir
25 Sulfanilamide” incident resulted in as many as 100 deaths.⁶ With the passage of the FDCA in 1938,
26 the concept of premarket approval became law, but at this time it only applied to drugs and not
27 food ingredients.⁷

28
29 Following World War II, there was a growth in the use of synthetic chemicals in foods, including
30 artificial sweeteners and preservatives, and the mass production of processed foods.⁸ This led to
31 increased food safety concerns from the public and Congress. A Congressional report from the
32 early 1950s noted that there were about 700 known food additives in use but only about 430 were
33 known to be safe, and there were serious concerns about the lack of information on the long-term
34 risks of chemicals already being used in foods.⁵ As a result, Congress updated the FDCA with the
35 Food Additives Amendment (FAA) of 1958.^{5,7} The FAA gave the FDA the authority and
36 responsibility to require food manufacturers to provide safety assessments for all new food
37 additives, with some exceptions.⁹ Under the FAA, prior to market usage, a food additive
38 manufacturer is supposed to first seek approval from the FDA by submitting a food additive
39 petition, which needs to include evidence that the substance is safe for the ways in which it will be
40 used. Within this regulatory framework, regulators must show evidence of harm from the proposed
41 additive; otherwise it is considered safe.⁷

42
43 Exceptions to required safety assessments include substances that are “generally recognized as
44 safe,” known as GRAS. Based on the FAA, these include substances that were authorized prior to
45 1958, as well as dietary ingredients in dietary supplements and certain color additives and
46 pesticides that went through other premarket approval requirements.⁷ Originally, the GRAS
47 provision of the FAA was intended to permit substances commonly used in food at the time to
48 remain in the food supply (e.g., vinegar, salt, pepper) without companies having to prove safety,
49 thus reducing the administrative burden and preserving FDA’s finite resources to review such
50 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 manufacturers 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 Accountability 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

1 EU employ the precautionary principle, which essentially states that if there is any possible threat
2 to harm or safety, even if not fully understood, precautionary measures should be taken. The EU
3 also has an ongoing process for reviewing the state of the evidence on additives in order to assess
4 whether substances should be removed or daily allowable limits should be lowered.²⁹ Under this
5 program, the original scientific evaluation for approved food additives is reassessed periodically
6 and incorporates new data generated since the previous evaluation, which can result in a decision
7 of further regulatory action.

8
9 As a result, the U.S. food supply contains a significantly greater number of food additives, although
10 the exact number is unknown. While the FDA maintains a public database, Substances Added to
11 Food (formerly known as Everything Added to Foods in the U.S.) of about 3,900 substances, it is
12 estimated that there are more than 10,000 chemical additives in the U.S. food supply.^{30,31} In
13 contrast, the EU permits a little over 300 food additives.²⁹ All additives must be evaluated for
14 safety by the European Food Safety Authority (EFSA) and are searchable in the EU's Additives
15 Database.³² Canada also maintains a food additives database with 390 permitted food additives.³³
16 Notably, additives like Yellow Dye No. 5, butylated hydroxyanisole, and potassium bromate are
17 banned in Europe but allowed in the U.S.³⁴ Red Dye No. 3 was only recently banned in the U.S., 30
18 years after its European ban.^{35,36}

19 20 *State Legislation*

21
22 In addition to movement at the federal level, several states have passed legislation regulating food
23 additives, and many more are considering legislation restricting or banning food additives,
24 particularly food dyes, from food entirely or public school lunches specifically.³⁷ California
25 became the first state to pass such legislation in 2023, with the passage of the California Food
26 Safety Act, which banned four toxic chemicals from food sold, manufactured, or distributed in the
27 state.³⁸ In 2024, it also passed the California School Food Safety Act, which banned the food
28 additives Red Dye No. 40, Yellow Dye No. 5, Yellow Dye No. 6, Blue Dye No. 1, Blue Dye No. 2,
29 and Green Dye No. 3 from food served in public schools.³⁸ Texas also made headlines in summer
30 2025 when it passed legislation requiring consumer warning labeling on foods containing any of 44
31 chemical food ingredients.³⁹

32
33 In total, 156 food additive-related or food color-related bills have been introduced nationwide in
34 over half of states. However, only 20 bills have thus far been successfully enacted.³⁸ Adopted
35 legislation has most commonly focused on prohibiting a limited number of dyes and additives in
36 schools.⁴⁰ The measures that seem to be stalling are broad statewide prohibitions that attempt to
37 mirror the California Food Safety Act. Some possible reasons for the volume of pending legislation
38 are federal preemption issues and concern that too many different state laws will cause significant
39 issues for manufacturers and confuse consumers. See Appendix A for a list of states with enacted
40 legislation.

41 42 *Health and Safety Concerns*

43
44 Due to the ubiquitous nature of food additives in our current global food supply and without a
45 consistent system for measuring exposure, it is almost impossible to understand the true level of
46 risk for many food additives in our food supply. There is also a lack of data and research on the
47 cumulative impacts of these substances. These issues are of particular concern for young children,
48 who eat higher levels of processed foods, which in general contain higher levels of synthetic
49 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

1 There is a need for more rigorous evaluation of the long-term health effects of artificial sweeteners,
 2 especially regarding their interactions with the gut microbiota and metabolic pathways.

3
 4 Another health concern of noncaloric sweeteners is their potential association with increased
 5 cancer risk, for which the evidence is mixed and still evolving.⁵⁴ The FDA and the EFSA have
 6 generally concluded that noncaloric sweeteners are safe for consumption within established daily
 7 limits and do not show conclusive evidence of carcinogenicity in humans.^{48,55} These assessments
 8 are primarily based on animal studies and human epidemiological data that have failed to
 9 demonstrate strong, consistent links between typical consumption and cancer. However, newer
 10 research has cast doubt on these previous findings. The NutriNet-Santé cohort study from France
 11 found a modest but statistically significant association between higher intake of artificial
 12 sweeteners, particularly aspartame and acesulfame-K, and increased cancer risk, notably for breast
 13 and obesity-related cancers.⁴⁹ Similarly, the International Agency for Research on Cancer (IARC)
 14 classified aspartame as “possibly carcinogenic to humans” in 2023, reflecting limited evidence in
 15 humans and animals.⁵⁰ Despite these findings, most studies emphasize that the overall evidence is
 16 not yet strong enough for definitive conclusions, especially at normal dietary intakes.

17
 18 High Fructose Corn Syrup. High fructose corn syrup (HFCS) is a widely used sweetener in
 19 processed foods and beverages due to its affordability and shelf stability. HFCS can be found in
 20 sodas, sweetened cereals, condiments, sauces, and baked goods (to name a few). However,
 21 overconsumption of HFCS has been shown to contribute to several negative health outcomes,
 22 including insulin resistance, obesity, liver disorders, and diabetes.⁵⁶ HFCS contains a higher
 23 fraction of fructose compared to regular corn syrup and rapidly breaks down in the liver,
 24 encouraging fat production. This metabolic pathway can promote the accumulation of triglycerides,
 25 contributing to nonalcoholic fatty liver disease (NAFLD), obesity, and elevated blood lipids.⁵⁶
 26 Excessive intake of HFCS is also associated with insulin resistance, which is a precursor to type 2
 27 diabetes, as well as chronic inflammation and increased risk of cardiovascular diseases.^{57,58}

28
 29 Another important concern with HFCS is appetite regulation. Unlike glucose, the fructose in HFCS
 30 does not stimulate the release of insulin or the satiety hormone leptin, which means HFCS-
 31 containing foods and drinks may not trigger a sense of fullness.⁵⁹ This lack of satiety can lead to
 32 overconsumption, further fueling weight gain and its related health consequences. The health
 33 effects of HFCS are compounded when consumed in large amounts through a variety of highly
 34 processed goods, particularly in sugary beverages. A petition was submitted to the FDA in August
 35 2025 urging it to reevaluate the GRAS status of many refined carbohydrates, including HFCS, to
 36 limit population level exposure.⁶⁰

37
 38 Trans Fat. Trans fats, also known as trans-fatty acids, are unsaturated fats both found naturally in
 39 some animal products and, more commonly, produced industrially through the partial
 40 hydrogenation of vegetable oils.⁶¹ Industrially produced trans fats are found in many processed
 41 foods, including margarine, vegetable shortening, baked goods, and fried foods.⁶¹ Trans fats pose
 42 serious health risks and are associated with more than 278,000 deaths globally each year.^{61,62} High
 43 intake of trans fats has been associated with arterial blockage, increasing the risk of heart attacks,
 44 stroke, and coronary heart disease.⁶² Trans fats are particularly dangerous because they raise “bad”
 45 low-density lipoprotein (LDL) cholesterol while lowering “good” high-density lipoprotein (HDL)
 46 cholesterol in the blood.⁶³ This imbalance contributes significantly to the buildup of fatty deposits
 47 in arteries, increasing the risk for cardiovascular diseases.⁶⁴ Trans fat intake is also linked to a
 48 higher risk of developing type 2 diabetes and, according to some studies, may increase the risk for
 49 other health problems such as breast cancer, shortened pregnancy, preeclampsia, and certain
 50 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 effects²¹;
- Ensure adequate safety factors for those who are pregnant and breastfeeding as well as additional vulnerable populations, such as children²¹;
- Consider cumulative and mixture effects from dietary sources, including other additives and contaminants²¹;
- 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 Additives 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.).^{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

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.

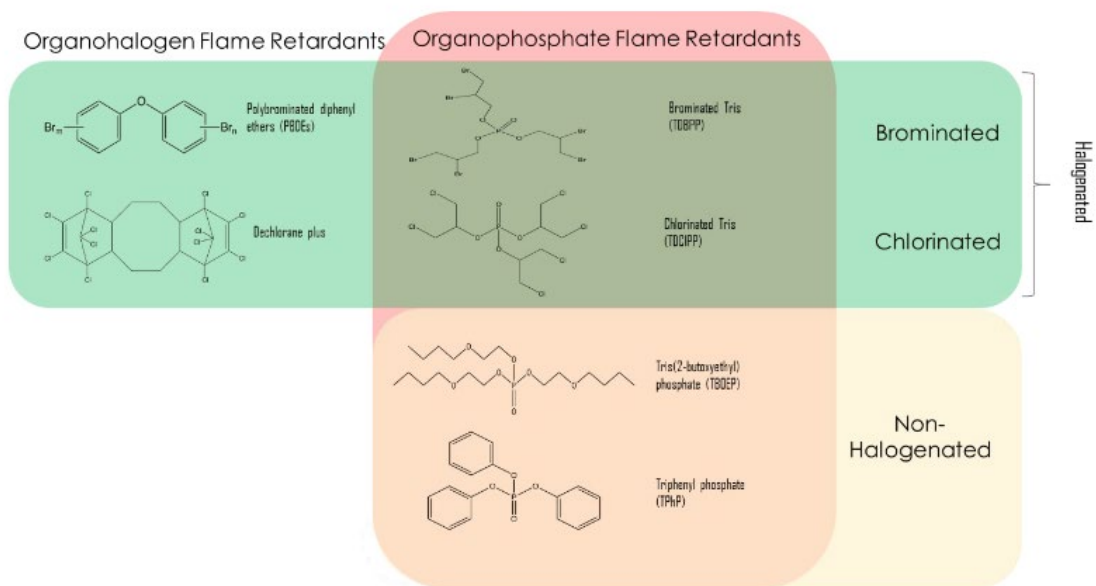
1. Our American Medical Association supports continued research on both the efficacy of flame retardants in reducing fire frequency, injuries, deaths, and other damages as well as the adverse health and environmental impacts of flame retardants, using a class-based approach when possible. (New HOD Policy)
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 Another³⁰



APPENDIX III – International and Federal Legislative and Regulatory Actions Concerning Flame Retardants³⁰

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 Textiles¹⁵²

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.

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

1 medical lexicon as a patient-centered, clinically supervised process aimed at reducing or stopping
2 medications that may no longer be beneficial or could be causing more harm than benefit.² The
3 primary goals of deprescribing are to improve patient outcomes, reduce the burden of unnecessary
4 or potentially harmful medications, and enhance overall quality of life. Further, deprescribing helps
5 to prevent prescribing cascades, whereby additional medications are prescribed to treat side effects
6 of other medications, leading to increased risk of adverse events and polypharmacy. Polypharmacy
7 is generally defined as the concurrent use of multiple medications, with five or more daily
8 medications commonly used as a threshold.³ While a high number of medications may indeed be
9 necessary for some patients, polypharmacy may indicate to a physician that careful evaluation of
10 the patient's medication list and potential consideration of deprescribing may be warranted in order
11 to optimize the medication regimen and meet patient goals.

12
13 Deprescribing can be implemented in a wide variety of clinical situations but is particularly
14 prevalent in the care of older adults. The Centers for Disease Control and Prevention (CDC) reports
15 that medication use in older adults has been increasing over time: 43 percent of adults age 65 and
16 older used five or more prescriptions in the past 30 days in 2017-2020 compared to 33 percent in
17 2001-2004 (see Figure 1).⁴ However, this level of medication use may not be needed or desired in
18 all cases. In a 2014 article, it was noted that nearly half of older adults take one or more
19 medications that are not medically necessary, and that most express interest in reducing their
20 medication burden.⁵ A population-based survey found that 92 percent of Medicare beneficiaries
21 reported being willing to stop one or more of their medications if their physician advised it was
22 possible, and 67 percent specifically wanted to reduce the number of medications they were
23 taking.⁶ The combination of high rates of polypharmacy and considerable patient interest in
24 reducing medications highlights the potential role of deprescribing in improving medication
25 management, particularly among older adults.

26
27 In addition to polypharmacy, deprescribing is closely intertwined with several related concepts,
28 including medication optimization, medication reconciliation, and potentially inappropriate
29 medications (PIMs) (see Table 1).^{7,8} Medication optimization is the broad process of ensuring that
30 medication regimens are evidence-based, aligned with patient goals, and used in a manner that
31 maximizes benefit while minimizing harm.^{9,10} Medication optimization may involve adjusting
32 medication use in a wide variety of ways, including initiating new therapies, adjusting doses,
33 substituting one medication for another, or reducing or discontinuing medications that are no
34 longer appropriate. This report focuses specifically on deprescribing as one strategy within the
35 broader framework of medication optimization.

36
37 Central to the consideration of deprescribing is an accurate patient medication list, which helps
38 ensure patient safety and is established through medication reconciliation, the systematic process of
39 verifying and updating a patient's medication regimen.¹¹ Medication reconciliation often occurs
40 during care transitions when medication regimens may change, such as at hospital admission,
41 hospital discharge, or a patient's first visit with a new physician. During medication reconciliation,
42 information – including medication name, dosage, frequency, and route of administration – is
43 collected and compared across all available sources, such as the electronic health record (EHR),
44 prescription drug monitoring programs, pharmacy records, direct communication with healthcare
45 professionals, and discussions with patients and their caregivers or guardians. In addition to
46 improving medication list accuracy, the reconciliation process can help physicians identify PIMs,
47 broadly defined as medications for which evidence or expert consensus suggests that potential risks
48 exist with medication use and often outweigh the clinical benefits in a particular patient
49 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 events¹⁸ 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 USDeN⁵⁵ and [deprescribing.org](https://www.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. Confirm current medicines through a comprehensive review (medication reconciliation);
2. Estimate risk of each medication, considering patient characteristics;
3. Assess the usefulness of each medication in relation to its risk;
4. Sort the medications by discontinuation priority, taking patient preferences into consideration;
5. Eliminate 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

1 to evaluate medications for potential discontinuation and initiate deprescribing discussions have
2 been shown to significantly increase deprescribing rates.⁸⁹ Together, these findings suggest that
3 expanding education and practical training on deprescribing may increase physician confidence and
4 support more consistent implementation of deprescribing when clinically appropriate.

5 6 *Lack of Role Clarity*

7
8 The shared nature of modern healthcare can create uncertainty regarding who is responsible for
9 evaluating medications for potential deprescribing. There are often no clearly delineated roles for
10 primary care physicians and specialists in this context, and physicians may hesitate to modify a
11 treatment plan initiated by another clinician due to specialty practice boundaries, uncertainty
12 regarding the original prescriber's rationale, or reluctance to interfere with another physician's
13 care.⁹⁰ As a result, medications may accumulate over time without any single clinician
14 comprehensively reviewing the patient's medication regimen and assuming responsibility for
15 initiating a deprescribing discussion. Time constraints in clinical practice may further contribute to
16 this hesitancy.

17
18 The involvement of additional healthcare professionals, including nurse practitioners, physician
19 assistants, and clinical pharmacists, can further complicate communication and responsibility for
20 medication management while also creating opportunities for collaboration.⁹¹ For example, clinical
21 pharmacists receive specialized training in medication review and optimization and can play an
22 important role on a physician-led care team by identifying potential deprescribing opportunities
23 and supporting implementation of deprescribing plans.

24
25 Liability concerns may also contribute to reluctance to deprescribe. Physicians may worry about
26 potential legal risks if medication discontinuation results in symptom recurrence, disease
27 progression, or another adverse outcome, particularly when the medication was prescribed by
28 another clinician or is recommended by disease-specific clinical guidelines. These concerns may be
29 amplified in fragmented care environments where responsibility for medication management is
30 distributed across multiple clinicians, specialties, and health systems. Collectively, these factors can
31 leave physicians uncertain about both their authority and responsibility to initiate deprescribing,
32 creating an important barrier to medication optimization.

33 34 *Transitions of Care*

35
36 Transitions of care are a particularly challenging context for deprescribing because patient care is
37 often fragmented across multiple healthcare professionals, locations, and health systems that lack
38 interoperability.⁹² As patients move between inpatient, outpatient, and specialty care settings,
39 medication regimens often change rapidly, while communication and accountability for medication
40 management may become less clear. Medications may be initiated, adjusted, or continued during
41 an episode of care without a comprehensive reassessment of their ongoing need once acute
42 treatment is completed. This can lead to both the continuation of unnecessary medications and
43 uncertainty among clinicians about whether it is appropriate to discontinue medications started by
44 another clinician. For example, formulary-based therapeutic substitution in one institution can
45 result in therapeutic duplication in the next institution, unless mechanisms are in place to identify,
46 and prevent harm from, potential therapeutic duplication. These challenges are often exacerbated
47 by incomplete medication reconciliation, limited access to prior treatment rationale, and time
48 constraints.^{93,94} These dynamics underscore that transitions of care are both a crucial opportunity
49 and a particularly difficult context in which to implement deprescribing, making coordination
50 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

1 solution. The academic and clinical approach to deprescribing focuses on reducing or discontinuing
2 medications that were appropriate for a patient at one time but may no longer provide sufficient
3 benefit relative to their risks, rather than avoiding the initiation of clinically indicated treatment.
4 Deprescribing is therefore best understood as a strategy for optimizing medication use at the level
5 of the individual patient, not as a means of reducing prescribing rates more broadly. This
6 distinction is particularly important in psychiatric medicine, where stigma surrounding mental
7 health conditions can already create barriers to accessing appropriate care, including clinically
8 indicated medications. Further, psychiatric medications should not be misconstrued as the cause of
9 the underlying conditions they are intended to treat.^{107,108} Public messaging that presents
10 deprescribing as a corrective to perceived overprescribing may discourage appropriate treatment or
11 lead some individuals to discontinue medications without medical supervision, potentially resulting
12 in symptom recurrence, withdrawal effects, or clinical deterioration.¹⁰⁹ While physicians should
13 remain attentive to opportunities for medically appropriate deprescribing, decisions regarding
14 medication discontinuation should be guided by individualized clinical judgment and the best
15 interests of the patient rather than generalized assumptions regarding prescribing patterns or
16 medication use. Ultimately, deprescribing should be viewed as a patient-centered strategy for
17 medication optimization that rests in shared decision making and physician-led team-based care.

18 19 CURRENT AMA POLICY

20
21 The AMA does not have policy on deprescribing or medication optimization but does have policy
22 related to polypharmacy, medication reconciliation, and team-based, individualized patient
23 decision-making. Policy D-120.965, “Medication Reconciliation to Improve Patient Safety,”
24 supports systems being established to support physicians in medication reconciliation and
25 recognizes that it is a multidisciplinary process. Policy D-120.928, “Reducing Polypharmacy as a
26 Significant Contributor to Senior Morbidity,” addresses the continuing problem of inaccuracies in
27 medication reconciliation and supports patient education on the effects of medications and
28 encourages physicians and ancillary staff to initiate discussions with patients on improving their
29 medical care through the use of only the minimal number of medications needed to optimize their
30 health. Policy H-160.906, “Models/Guidelines for Medical Health Care Teams,” states that
31 physician leaders are focused on individualized patient care and the development of treatment plans
32 and that care coordination is integral to the team’s practice. This report and the recommendations
33 included build on these policies to address deprescribing as an important component of clinical
34 care.

35 36 CONCLUSION

37
38 Deprescribing has emerged as an increasingly recognized component of medication optimization
39 and patient-centered care, particularly as rates of polypharmacy rise. Current evidence suggests that
40 deprescribing can safely reduce medication burden and may improve selected clinical and
41 economic outcomes when implemented through an individualized, structured, and supervised
42 process. However, important evidence gaps remain, particularly regarding long-term outcomes and
43 implementation in diverse U.S. healthcare settings.

44
45 Although a growing number of frameworks, guidelines, and decision support tools are available to
46 support deprescribing, barriers related to patient awareness, clinician training, role clarity, and
47 interoperability continue to limit broader adoption. As interest in deprescribing continues to expand
48 among clinicians, policymakers, and the public, efforts to strengthen the evidence base and address
49 implementation challenges will be critical. Ultimately, deprescribing should be viewed as a routine
50 component of high-quality clinical care that seeks to ensure medications continue to provide more

1 benefit than harm. In response to these findings, we recommend that AMA policy define
2 deprescribing and its key components, identify barriers, and encourage further research and
3 educational initiatives.

4 5 RECOMMENDATIONS

6
7 The Council on Science and Public Health recommends that the following be adopted and the
8 remainder of this report be filed:
9

- 10 1. Our American Medical Association recognizes that:
 - 11 a. Deprescribing is the planned, supervised process of medication dose reduction or
12 discontinuation when a medication's continued use may no longer provide clinical
13 benefit, may cause harm that exceeds the clinical benefit, or is misaligned with goals of
14 care, particularly among older adults and during transitions of care.
 - 15 b. Deprescribing, as a component of medication optimization, includes medication
16 reconciliation; identification and assessment of medication risks in accordance with
17 patient characteristics; shared decision-making; and physician-led team-based care.
 - 18 c. Barriers to deprescribing include unclear professional roles; care fragmentation; and
19 lack of clinical workflows and interoperability across healthcare entities. (New HOD
20 Policy)
- 21 2. Our AMA encourages broader understanding of deprescribing through further research on
22 clinical outcomes and best practices. (New HOD Policy)
- 23 3. Our AMA encourages educational initiatives on deprescribing for physicians, care teams,
24 and patients. (New HOD Policy)
- 25
- 26

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 2020¹¹⁰

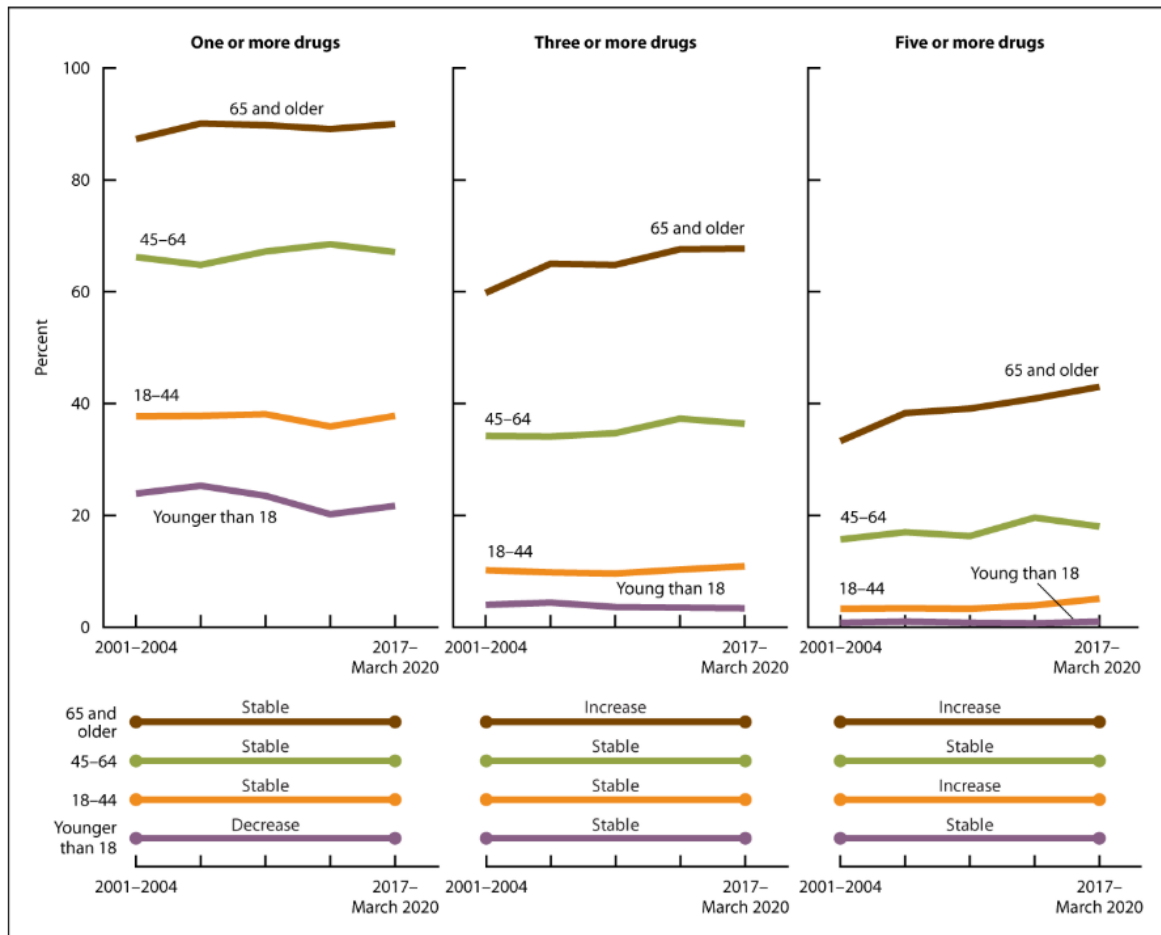
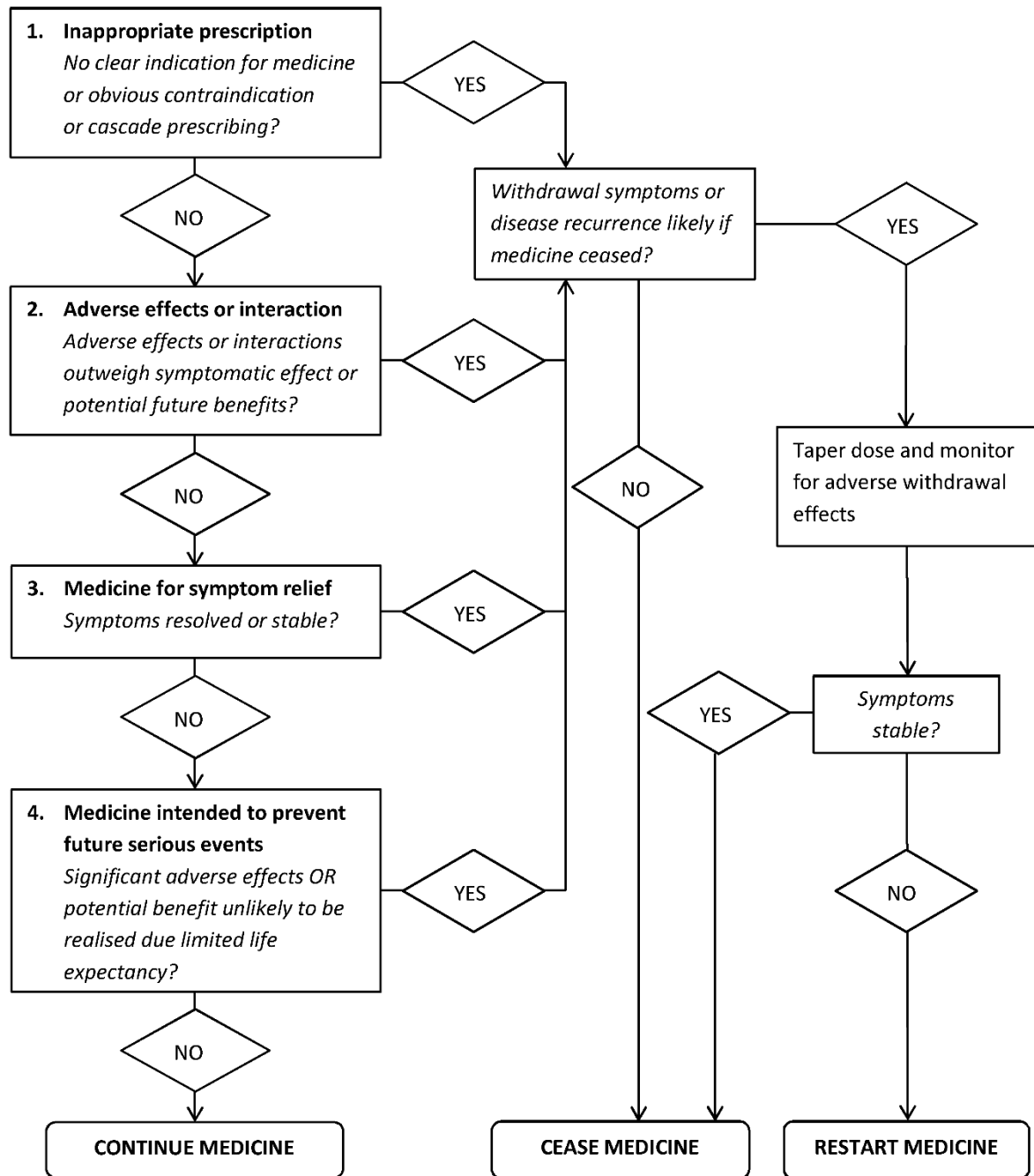


Table 1. Glossary

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.

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

1 remain. Randomized controlled trials have produced inconsistent results, and systematic reviews
2 have not demonstrated universally positive findings.^{15-18,24,34}

3
4 This report highlights the challenges of interpreting the current evidence on BFA. While some
5 randomized controlled trials and observational studies report reductions in pain scores and opioid
6 use, most others demonstrate little or no benefit compared with control interventions or physical
7 therapy.^{4,11,15,17,38} Long-term outcomes, comparative effectiveness relative to other evidence-based
8 nonpharmacologic interventions, and mechanisms of action are not fully understood.^{11,17,18} Further,
9 several studies have cautioned against widespread dissemination before stronger evidence becomes
10 available and questions regarding long-term effectiveness, comparative effectiveness, and optimal
11 patient selection are answered.^{15,17,18,53,54} Although implementation success within military and
12 veterans' health systems demonstrates feasibility and acceptability, the current literature suggests
13 that BFA may have a role as a nonpharmacologic pain management modality capable of providing
14 short-term pain relief in select patients.^{8,9,51} However, important questions regarding its
15 effectiveness, appropriate use, and long-term clinical effectiveness remain unanswered.

16 17 RECOMMENDATIONS

18
19 The Council on Science and Public Health recommends that the following be adopted and that the
20 remainder of the report be filed.

- 21
22 1. Our AMA acknowledges Battlefield Acupuncture (BFA) as a nonpharmacologic pain
23 management modality that may provide short-term pain relief in selected clinical
24 circumstances when administered by appropriately trained healthcare professionals; and
- 25 2. Our AMA supports ongoing quality research regarding the efficacy, feasibility, and
26 appropriate use of BFA as a nonpharmacologic approach to pain management. (New HOD
27 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 nationwide⁷; and

Whereas, standardized data collection is crucial for accurate epidemiological case definitions and improved public health surveillance, facilitating better responses to emerging cases and outbreaks⁸; 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 patterns⁹; 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

1 RESOLVED, that our AMA supports research funding into rapid diagnostic tests and therapeutic
 2 options, facilitating timely clinical interventions in suspected cases of amebic encephalitis (New
 3 HOD Policy); and be it further

4
 5 RESOLVED, that our AMA utilizes its leadership role to raise awareness among state affiliates
 6 and policy makers for the threat posed by *Naegleria fowleri* and other amebic infections amidst
 7 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

1 Whereas, health care providers are required to share patient records for treatment and
2 continuity of care, and they cannot legally refuse to release records even if the requesting entity
3 does not have rights to the records for fear of violating HIPAA, the federal law that protects
4 patients' health information; and

5
6 Whereas, the United States Department for Health and Human Services has supported a
7 network for sharing records, called the Trusted Exchange Framework and Common
8 Agreement", or TEFCA, which is an honor-bound system, where "stranger danger" is felt to be a
9 real concern that could undermine the entire model if health systems stop sharing records out of
10 fear; and

11
12 Whereas, under the terms of TEFCA and other national health information exchanges,
13 providers have to send a patient's records, without a fee, to any legitimate health care provider
14 who requests them for the purpose of supporting a patient's treatment, but whether or not an
15 entity is a legitimate health care provider has become a contentious question; and

16
17 Whereas, a recent court filing by the electronic health records company Epic Systems has
18 shown that companies are posing as health providers to gain access to patient records through
19 organizations that onboard other organizations to national networks so they can send and
20 receive health records, and it has become apparent that entities posing as health care providers
21 but were allegedly fronts for data sellers (of medical records) have been allowed access to
22 medical records not for treatment; and

23
24 Whereas, these allegedly fraudulent entities have abused the "treatment" request pathway as a
25 method of quickly and cost-effectively accessing patient records to review and summarize
26 medical records and then providing those medical records to law firms; and

27
28 Whereas, the government has designated the Sequoia Project to do the vetting of organizations
29 to see that they are legitimate health care providers, which many in the industry have felt has
30 not been performing this function, nor Carequality, the privately run predecessor and main
31 alternative to TECFA. This is evidenced by the fact that some 1,500 complaints have been
32 lodged in the past 10 years, yet no information complaints have been acted upon in the 10
33 years since the policy was instituted; and

34
35 Whereas, the Assistant Secretary for Technology Policy (ASTP) deputy is aware of this problem
36 with maintaining the privacy of medical records, and has been requested to do a centralized
37 review and needs to say clearly what steps are being taken to ensure the integrity of the federal
38 directory; therefore be it

1 RESOLVED, that our American Medical Association advocate for Congress to allocate
 2 appropriate funding for the Assistant Secretary for Technology Policy (ASTP), part of the U.S.
 3 Department of Health and Human Services, to be able to review and oversee the work of the
 4 Sequoia Project, the organization tasked by the government to oversee the vetting of
 5 companies to see that they are legitimate health care providers able to bill for medical services,
 6 and enact legal remedies and penalties against those organizations and companies seeking to
 7 obtain access to patient medical records not for direct patient care (Directive to Take Action);
 8 and be it further

10 RESOLVED, that our AMA work to ensure that access to medical records for treatment is
 11 limited to those who are actually certified as providers of care, including hospital systems, home
 12 health care providers and ancillary care providers, and ensure that those who do not directly
 13 treat patients (i.e. lawyers and legal entities) do not have access to medical records via TEFCA,
 14 the Trusted Exchange Framework and Common Agreement, a network for sharing medical
 15 records for treatment, to assure the public of the safety of their records (New HOD Policy); and
 16 be it further

18 RESOLVED, that our AMA support exploring all options to both protect the privacy of medical
 19 records and at the same time balance the need for medical records sharing and interoperability
 20 of medical records systems. (New HOD Policy)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 8/19/26

REFERENCES

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 lifetime³; 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 research²; 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 overall⁷; 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 pregnancy⁸⁻¹⁰; 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 allocation⁸; and

Whereas, the complex equity issues underpinning out-of-sequence transplant organ allocations have not been explicitly previously addressed by the AMA⁹⁻¹⁰; 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 childhood¹; 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 lifeguards¹; 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

1 Whereas, menstruation is a normal physiological process, and menstrual health is increasingly
2 recognized as a health and human-rights issue that requires access to menstrual products,
3 supportive environments, and appropriate disposal resources^{1,2}; and
4

5 Whereas, the Centers for Disease Control and Prevention note that menstrual hygiene is
6 important for health and comfort, including helping prevent infections like yeast infections and
7 reducing discomfort during menstruation, needs that do not cease during hospitalization;³ and
8

9 Whereas, about 1 in 5 individuals who menstruate experience heavy menstrual bleeding and
10 can place patients at risk for anemia and other health impacts, and heavy bleeding may be
11 worsened by anticoagulation—creating foreseeable inpatient need for sufficient menstrual
12 products during acute illness;^{4,5,20} and
13

14 Whereas, “period poverty” affects 1 in 4 teens and 1 in 3 adults in the United States and is
15 associated with stigma, barriers to accessing products, and harmful coping strategies (e.g.,
16 prolonged use or makeshift substitutes), which can lead to negative health and psychosocial
17 consequences;^{6,7,8} and
18

19 Whereas, individuals experiencing homelessness report insufficient and inconsistent access to
20 menstrual products, including gatekeeping distribution systems that provide limited quantities
21 only upon request—illustrating how “ask-based” models can fail even when a supply exists;⁹
22 and
23

24 Whereas, hospital-based quality improvement studies demonstrate that menstrual hygiene
25 products are not routinely available as standard inpatient supplies, with the majority of
26 healthcare staff reporting inadequate provision for patients and many individuals lacking
27 immediate access to products when needed, indicating systemic gaps in hospital care;¹⁹ and
28

29 Whereas, federal tax guidance recognizes menstrual care products as reimbursable/qualified
30 medical expenses (including pads, tampons, liners, and cups), supporting the position that
31 these products function as health-related supplies rather than discretionary consumer
32 goods;^{11,12} and
33

34 Whereas, hospital participation requirements and accreditation frameworks emphasize patient
35 rights, privacy, dignity, and comfort; CMS interpretive guidance grounds privacy requirements in
36 the patient’s right to “respect, dignity, and comfort,” and The Joint Commission includes a right
37 to an environment that preserves respect and dignity;^{13,14,15} and
38

39 Whereas, despite the absence of standardized national reporting, available studies and
40 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 scientists¹; 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 committees²⁻⁴; 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 boards²⁻⁴; 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 members²⁻⁴; 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

- 1 RESOLVED, that our AMA opposes the active removal of qualified scientists from NIH advisory
2 councils and review panels, as well as qualified leaders in other HHS agencies, without
3 documented proof of wrongdoing or misconduct in accordance with established federal or state
4 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

1 Whereas, patients with sickle cell disease and other blood disorders such as transfusion-
2 dependent thalassemia require regular, ongoing transfusion support, making access to safe,
3 compatible blood an essential component of care^{1,2}; and
4

5 Whereas, red blood cell alloimmunization is substantially more common in patients with sickle
6 cell disease and increases the risk of hemolytic transfusion reactions while making identification
7 of compatible red blood cell units more difficult³; and
8

9 Whereas, evidence shows that robust red blood cell phenotyping and transfusion of red blood
10 cells with similar antigenic profiles leads to lower rates of erythrocyte alloimmunization in sickle
11 cell disease and thalassemia spectrum disorders⁴⁻⁸; and
12

13 Whereas, insurance coverage for red blood cell molecular testing remains unpredictable, with
14 some payers excluding routine pre-transfusion use, which may limit consistent access to
15 recommended transfusion support for patients with sickle cell disease and other transfusion-
16 dependent conditions^{9,10}; and
17

18 Whereas, access to phenotype-matched blood for patients with sickle cell disease depends in
19 part on the availability of racially and ethnically diverse blood donors, as compatible units are
20 more often identified from donors of similar genetic background¹¹; and
21

22 Whereas, despite efforts to recruit donors from diverse racial and ethnic backgrounds, there
23 remains a large gap in both the recurrent donor pool and the availability of properly matched
24 and phenotyped blood¹²⁻¹³; therefore be it
25

26 RESOLVED, that our American Medical Association supports expanding recruitment and
27 retention of racially and ethnically diverse blood donors to improve access to phenotype-
28 matched blood for high-needs patients, including those with sickle cell disease, while supporting
29 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

1 Whereas, mass casualty events, including natural disasters, are occurring with increasing
2 frequency, underscoring the need to continually evaluate and strengthen existing public
3 emergency alert systems, including mobile public alert and warning technologies¹; and
4

5 Whereas, the loss of experienced operators and federal funding has led to failures in the timely
6 utilization of integrated emergency warning systems, including at least 15 federally declared
7 major disasters since 2016, during which officials in the most-harmed communities failed to
8 send alerts over FEMA's Integrated Public Alert & Warning System (IPAWS), resulting in
9 significant morbidity, mortality, and community losses²⁻⁵; and
10

11 Whereas, leading up to the catastrophic Texas floods that killed 78 people on July 4th, 2025,
12 emergency alerts were delayed due to understaffing and federal funding cuts to the National
13 Weather Service, or were posted later to private social media platforms including Facebook and
14 X (formerly Twitter) and were inaccessible without a user account⁵⁻⁸; and
15

16 Whereas, social media platforms are increasingly used as real-time sources of emergency
17 information and as a form of redundancy, thereby increasing the likelihood that individuals will
18 see time-sensitive information during disasters; and
19

20 Whereas, emergency management agencies at the federal, state, and local levels increasingly
21 use social media to disseminate preparedness, mitigation, and recovery information, as well as
22 to communicate directly with the public, expanding beyond traditional one-way communication
23 models⁹; and
24

25 Whereas, although social media platforms can facilitate rapid communication during
26 emergencies, they introduce challenges related to message consistency and information
27 verification, and emergency announcements are increasingly disseminated through private,
28 account-restricted platforms that may require account creation, be subject to algorithmic filtering
29 or content moderation, or experience outages^{2,10-13}; and
30

31 Whereas, although social media platforms provide valuable tools for risk communication,
32 evidence demonstrates they are not designed to function as primary emergency alert systems
33 and are most effective when used in conjunction with traditional, universally accessible
34 communication methods¹²; and
35

36 Whereas, social media platforms have raised public concern for restricting access to critical
37 information or removing emergency-related content due to platform policies^{14,15}; and
38

39 Whereas, the American Medical Association has historically supported policies that promote
40 equitable access to health information, public health communication infrastructure, and digital

1 health equity, supporting advocacy for transparency and accessibility standards in systems that
2 impact health outcomes¹⁶⁻¹⁸; therefore be it

3
4 RESOLVED that our American Medical Association encourages collaboration between public
5 health agencies, emergency management systems, and private technology companies to
6 improve the reliability, accessibility, and transparency of emergency information dissemination
7 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

1 RESOLVED, that our American Medical Association support increases in federal excise taxes
2 on beer, wine, and distilled spirits, with a meaningful portion of new revenues, where feasible,
3 dedicated to evidence-based prevention of alcohol-related harms, treatment and recovery
4 services for alcohol use disorder, and public health and medical services in communities
5 disproportionately affected by alcohol-related harm (New HOD Policy); and be it further
6

7 RESOLVED, that our AMA encourage increases in state and local excise taxes on alcoholic
8 beverages, with a meaningful portion of new revenues, where feasible, reinvested in evidence-
9 based alcohol prevention, treatment, recovery, and community health initiatives (New HOD
10 Policy); and be it further
11

12 RESOLVED, that our AMA support coordinated state and local alcohol tax policies that increase
13 the price and reduce the affordability of alcoholic beverages, particularly products with high
14 ethanol content (New HOD Policy); and be it further
15

16 RESOLVED, that our AMA collaborate with other national and state organizations committed to
17 reducing alcohol-related harm, including national medical specialty societies, public health
18 associations, injury prevention groups, consumer health advocates, and medical alliance
19 organizations (New HOD Policy); and be it further
20

21 RESOLVED, that our AMA, when state legislative efforts to increase alcohol taxes are
22 unsuccessful, encourage state medical societies to consider ballot initiatives or other democratic
23 mechanisms, where permitted by state law, to advance evidence-based alcohol tax policy (New
24 HOD Policy); and be it further
25

26 RESOLVED, that our AMA affirm that alcohol excise taxes at the federal, state, and local levels
27 should be based on the grams of ethanol in a beverage rather than its volume or type (e.g.,
28 beer, wine, or liquor), to ensure tax fairness, public health impact, and consistency with global
29 recommendations (New HOD Policy); and be it further
30

31 RESOLVED, that our AMA support indexing alcohol excise taxes to inflation to preserve their
32 real value and ensure sustained public health benefit over time (New HOD Policy); and be it
33 further
34

35 RESOLVED, that our AMA support the use of complementary pricing policies, such as minimum
36 unit pricing (MUP), to reduce the availability of inexpensive, high-alcohol-content beverages that
37 disproportionately contribute to high-risk alcohol use (New HOD Policy); and be it further
38

39 RESOLVED, that our AMA oppose efforts by the alcohol industry to weaken or fragment alcohol
40 tax policy through beverage-specific exemptions, preferential or disproportionately low tax rates,
41 or promoting misleading narratives about economic harm (New HOD Policy); and be it further
42

43 RESOLVED, that our AMA recognize alcohol excise taxation as a cost-effective population-level
44 strategy to reduce alcohol consumption and related morbidity, mortality, and social harms,
45 improve health outcomes, and help offset the public costs attributable to alcohol use (New HOD
46 Policy); and be it further
47

48 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

1 Whereas, the global healthcare system accounts for creating 4.4% of global greenhouse gas
2 emissions; and
3

4 Whereas, the World Health Organization has identified climate change as a leading threat to
5 global health, with the National Academy of Medicine launching an Action Collaborative on
6 Decarbonizing the U.S. Health Sector focused on the health care supply chain; and
7

8 Whereas, paper Instructions for Use (IFU) packaged with surgical instruments, implants, and
9 medical devices across all surgical specialties generate substantial unnecessary paper, plastic,
10 and packaging waste; and
11

12 Whereas, the IFUs are infrequently needed for reference in the operating room by trained
13 surgical teams performing routine procedures; and
14

15 Whereas, in ophthalmology cataract surgery creates a significant carbon footprint, due to its
16 high prevalence globally with one study estimated that a single cataract surgery creates
17 181.8 kg CO₂eq, which amounts to an estimated 728 million kg CO₂eq in the United States each
18 year; and
19

20 Whereas, over 30 million cataract surgeries are performed globally each year, and analyses
21 have shown that IFU booklets and device packaging account for a disproportionate share of
22 total surgical waste relative to the devices they accompany; and
23

24 Whereas, the American Academy of Ophthalmology, the American Society of Cataract and
25 Refractive Surgery, and the European Society of Cataract and Refractive Surgeons
26 documented that transitioning from paper IFU to electronic IFU (e-IFU) would result in significant
27 reductions in greenhouse gas emissions, paper waste; and
28

29 Whereas, the transition would also decrease manufacturing and shipping costs, and that 95% of
30 manufacturers surveyed considered e-IFU an acceptable alternative to paper IFU; and
31

32 Whereas, electronic IFU offer meaningful advantages over paper IFU including real-time version
33 control, searchability, enlarged display capability, multilingual accessibility, and ease of access
34 prior to procedures; and
35

36 Whereas, the U.S. Federal Food, Drug, and Cosmetic Act already permit IFU for devices used
37 in health care settings be made available solely by electronic means; and
38

39 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 men¹; 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 implementation²; 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 period³; 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 women⁴; and

Whereas, this underinvestment impacts women across the lifespan and health conditions, impacting the patient-physician relationship across specialties⁵; 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 billion⁷; 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

1 Whereas, federal national health plans can coordinate research, clinical care, public health
2 activities, services, and other federal efforts addressing complex diseases and health
3 conditions; and
4

5 Whereas, the development and implementation of effective national health plans benefit from
6 scientific expertise, clinical experience, and direct understanding of the needs and priorities of
7 people affected by the diseases and conditions those plans are intended to address; and
8

9 Whereas, the National Alzheimer's Project Act established an Advisory Council on Alzheimer's
10 Research, Care, and Services to advise the Secretary of Health and Human Services and
11 inform the development and annual updating of the National Plan to Address Alzheimer's
12 Disease; and
13

14 Whereas, the Alzheimer's Advisory Council includes non-federal representation from health
15 care providers, researchers, patient advocates, caregivers, an individual diagnosed with
16 Alzheimer's disease, and other relevant experts and organizations; and
17

18 Whereas, the Dr. Emmanuel Bilirakis and Honorable Jennifer Wexton National Plan to End
19 Parkinson's Act established an Advisory Council on Parkinson's Research, Care, and Services
20 to advise the Secretary of Health and Human Services, including on priority actions for the
21 development and implementation of the National Plan to End Parkinson's; and
22

23 Whereas, the Parkinson's Advisory Council includes representation from people living with
24 Parkinson's disease, a family caregiver, health care providers, biomedical researchers,
25 physicians specializing in the treatment of Parkinson's disease and related conditions, nonprofit
26 organizations, and relevant federal agencies; and
27

28 Whereas, Congress is currently considering the National Plan for Epilepsy Act, another
29 bipartisan effort to improve federal coordination around a complex neurological condition, and
30 the United States Senate unanimously passed S. 494 on August 4, 2026; and
31

32 Whereas, meaningful representation of physicians and other health care professionals,
33 researchers, and people directly affected by a disease or condition can help ensure that federal
34 national health plans reflect scientific evidence, clinical realities, and the needs and priorities of
35 the populations they are intended to serve; therefore be it
36

37 RESOLVED, that our American Medical Association support meaningful representation of
38 physicians and other health care professionals, researchers, and people with lived experience in
39 the development, implementation, and evaluation of federal national plans addressing specific
40 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

1 Whereas, nicotine is a highly addictive substance, and nicotine pouches deliver nicotine
2 through the oral mucosa and can produce nicotine dependence, cravings and withdrawal, as
3 well as increased heart rate and blood pressure, nausea, dizziness, headache, and
4 gastrointestinal symptoms, and oral irritation where the pouch repeatedly sits; and
5

6 Whereas, nicotine pouches can cause nicotine poisoning, particularly when multiple pouches
7 are used or pouches are accidentally or intentionally ingested; and
8

9 Whereas, nicotine pouches are not Food and Drug Administration (FDA) approved for smoking-
10 cessation medications or treatment of nicotine dependence; and
11

12 Whereas, in April 2006, the Federal Bureau of Prisons (FBOP) implemented evidence-based
13 public health measures to reduce nicotine and tobacco-related disease within justice-involved
14 populations by discontinuing the sale and use of smoked and smokeless tobacco products while
15 continuing medically supervised tobacco cessation programs; and
16

17 Whereas, on May 15, 2026, FBOP issued Request for Information RFI_BOP_Nicotine_Pouches
18 seeking vendors capable of supplying FDA-authorized nicotine pouch products for resale to
19 incarcerated persons through the Bureau of Prisons Commissary Trust Fund at approximately
20 122 federal correctional institutions; and
21

22 Whereas, federal law prohibits the marketing of nicotine pouches subject to FDA tobacco-
23 product jurisdiction, without authorization from the U.S. FDA, which may grant marketing
24 authorization only when it determines that permitting the product to be marketed is appropriate
25 for the protection of the public health; and
26

27 Whereas, on August 17, 2026, FBOP began selling a brand of nicotine pouches that did not
28 appear on FDA's list of nicotine pouch products authorized for marketing in the United States;
29 and
30

31 Whereas, FBOP policy limiting access to nicotine replacement products to physician-authorized
32 smoking-cessation treatment, and the sale of recreational nicotine products represents a
33 departure from that approach; and

1 Whereas, following questions regarding the regulatory status of the nicotine pouches being sold
2 and consultation with the FDA, the FBOP suspended further purchasing and sales of the
3 products on September 3, 2026, pending additional review; and
4

5 Whereas, incarcerated populations experience disproportionately high burdens of chronic
6 disease, mental illness, substance use disorders, and tobacco dependence compared with the
7 general population; and
8

9 Whereas, Black Americans, American Indian or Alaska Native persons, individuals with serious
10 mental illness, and persons with substance use disorders are disproportionately represented in
11 correctional settings and already experience significant disparities in nicotine and tobacco use,
12 cardiovascular disease, pulmonary disease, and cancer outcomes; and
13

14 Whereas, although tobacco-free nicotine products do not expose users to the products of
15 tobacco combustion, they are not risk-free, and while current evidence does not establish that
16 nicotine pouches directly cause subsequent cigarette smoking, initiation of nicotine use among
17 nicotine-naïve individuals may result in nicotine dependence and continued use of nicotine or
18 other tobacco products; and
19

20 Whereas, correctional institutions provide a unique opportunity to initiate evidence-based
21 tobacco dependence treatment because many individuals enter custody with limited access to
22 preventive health care, making incarceration an important setting for reducing future morbidity
23 and mortality rather than promoting or perpetuating nicotine dependence; and
24

25 Whereas, physicians have an ethical obligation to prevent disease, reduce exposure to
26 addictive substances, and promote evidence-based treatment, and correctional health systems
27 should prioritize prevention and treatment of nicotine dependence among populations already
28 experiencing disproportionate burdens of cardiovascular disease, pulmonary disease, cancer,
29 serious mental illness, and substance use disorders; therefore be it
30

31 RESOLVED, that our American Medical Association oppose the sale or distribution of
32 recreational nicotine products within federal correctional facilities while supporting access to
33 evidence-based, medically supervised treatment for tobacco and nicotine dependence (New
34 HOD Policy); and be it further
35

36 RESOLVED, that our AMA oppose the sale of any nicotine products that are not authorized
37 FDA to be lawfully sold in the United States in correctional facilities (New HOD Policy); and be it
38 further
39

40 RESOLVED, that our AMA encourage the Federal Bureau of Prisons to evaluate and publicly
41 report the health, fiscal, and health-equity impacts associated with the sale or proposed sale of
42 recreational nicotine or tobacco products within federal correctional institutions (New HOD
43 Policy); and be it further
44

45 RESOLVED, that our AMA advocate for the Federal Bureau of Prisons to provide evidence-
46 based treatment for tobacco and nicotine dependence, including appropriate management of
47 nicotine withdrawal (Directive to Take Action); and be it further
48

49 RESOLVED, that our AMA advocate that correctional health policies prioritize disease
50 prevention, evidence-based tobacco dependence treatment, and long-term health outcomes
51 over commissary revenue generated through the sale of recreational nicotine products.
52 (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

1 Whereas, skin cancer is the most common cancer in the United States, creating substantial
2 morbidity, mortality, health care utilization, and economic burden, while ultraviolet radiation
3 represents a major modifiable risk factor for melanoma and keratinocyte carcinomas; and
4

5 Whereas, comprehensive photoprotection, including regular use of broad-spectrum sunscreen,
6 is an important component of evidence-based skin cancer prevention, and our American
7 Medical Association already supports the development of sunscreens providing broad-spectrum
8 protection against ultraviolet A (UVA) and ultraviolet B (UVB) radiation and public access to
9 broad-spectrum sunscreen as part of a comprehensive skin cancer prevention strategy; and
10

11 Whereas, in June 2026, the U.S. Food and Drug Administration (FDA) approved the addition of
12 bemotrizinol (BEMT), a high-molecular-weight, broad-spectrum, photostable ultraviolet filter with
13 minimal systemic absorption and extensive international safety experience, to the over-the-
14 counter sunscreen monograph, representing an important milestone in sunscreen innovation;
15 and
16

17 Whereas; the approval of bemotrizinol, the first new sunscreen active ingredient added to the
18 U.S. over-the -counter sunscreen monograph in more than two decades, demonstrates that
19 rigorous scientific review and regulatory modernization can successfully expand consumer
20 access while maintaining high standards for safety and effectiveness; and
21

22 Whereas, despite substantial advances in sunscreen technology internationally, until June 2026
23 FDA had not added a new sunscreen active ingredient to the over-the-counter sunscreen
24 monograph since the late 1990s, limiting the range of ultraviolet filters available to U.S.
25 consumers compared with those available in other countries; and
26

27 Whereas, Congress enacted the Sunscreen Innovation Act in 2014 to create an alternative
28 pathway for review of sunscreen active ingredients, and subsequently modernized the broader
29 over-the-counter drug review framework through section 505G of the Federal Food, Drug, and
30 Cosmetic Act as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act of
31 2020, yet substantial regulatory barriers to sunscreen innovation persisted; and

1 Whereas, several sunscreen active ingredients have substantial histories of use outside the
2 United States, and appropriately designed real-world evidence, observational data, international
3 pharmacovigilance, published literature, and other scientifically valid evidence may provide
4 important information regarding their safety, effectiveness, and performance in large and
5 diverse populations; and
6

7 Whereas, FDA already recognizes real-world evidence as an important component of regulatory
8 science and uses real-world data and evidence in regulatory decision-making across the
9 lifecycle of medical products, including assessments of safety and effectiveness; and
10

11 Whereas, regulatory frameworks that appropriately incorporate high-quality real-world evidence
12 and historical experience can complement traditional clinical studies while maintaining rigorous
13 safety and effectiveness standards and potentially reducing unnecessary duplication of studies
14 for products with substantial existing evidence; and
15

16 Whereas, for prospective sunscreen active ingredient applications federal sunscreen
17 modernization efforts have recognized that appropriate non-animal testing methods, where
18 accepted by FDA as scientifically valid, as an important component of a more efficient,
19 contemporary evidentiary framework that maintains rigorous standards for safety and
20 effectiveness; and
21

22 Whereas, the Supporting Accessible, Flexible, and Effective (SAFE) Sunscreen Standards Act,
23 enacted in 2025, directs the Food and Drug Administration to modernize its review of sunscreen
24 active ingredients by allowing appropriate consideration of real-world evidence, observational
25 studies, and other scientifically valid evidence while preserving rigorous standards for safety
26 and effectiveness; and
27

28 Whereas, the SAFE Sunscreen Standards Act further advances a modern regulatory framework
29 that recognizes historical safety experience, promotes regulatory transparency and clearer
30 evidentiary standards, and supports modern nonclinical testing methods to facilitate efficient
31 evaluation of sunscreen active ingredients; and
32

33 Whereas, unnecessarily duplicative or uncertain regulatory requirements may discourage
34 manufacturers from seeking U.S. authorization for sunscreen active ingredients with substantial
35 international safety and effectiveness experience, limiting competition, product innovation, and
36 consumer access; and
37

38 Whereas, access encompasses more than regulatory authorization, as consumers are more
39 likely to use sunscreen consistently when products are affordable, cosmetically acceptable,
40 appropriate for diverse skin types and tones, and available in formulations that patients are
41 willing and able to use as recommended; and
42

43 Whereas, expanding the number of safe and effective sunscreen filters available to
44 manufacturers may facilitate greater competition and innovation in broad-spectrum protection,
45 formulation characteristics, tolerability, and cosmetic acceptability and thereby increase the
46 range of evidence-based photoprotective options available to patients; and
47

48 Whereas, modernizing sunscreen regulation presents an opportunity to advance the shared
49 goals of preventing cancer, reducing avoidable health care costs, supporting scientifically
50 rigorous regulatory innovation, promoting competition, and improving access to effective
51 preventive health products; therefore be it

1 RESOLVED, that our American Medical Association advocate for timely implementation of
2 federal reforms modernizing United States Food and Drug Administration review of new
3 sunscreen active ingredient applications, including appropriate consideration of real-world
4 evidence, international safety and postmarket experience, and scientifically validated alternative
5 testing methods as they become accepted for relevant over-the-counter topical drug safety
6 endpoints, while maintaining rigorous standards for safety and effectiveness (Directive to Take
7 Action); and be it further

8
9 RESOLVED, that our AMA support clear and efficient regulatory pathways and other policies
10 that promote the development, evaluation, availability, and adoption of safe and effective broad-
11 spectrum sunscreens in the United States (New HOD Policy); and be it further

12
13 RESOLVED, that our AMA support continued postmarket surveillance and real-world safety
14 monitoring of newly approved sunscreen active ingredients as an integral component of a
15 modernized regulatory framework. (New HOD Policy)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/16/26

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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 importance 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

1 Whereas, our American Medical Association has a previous directive from 2024 policy regarding
2 safely decommissioning of nuclear power plants that reads as follows:
3

4 That our American Medical Association advocate for strict limitations of aerosol, soil and/or
5 water radionuclide releases in the decommissioning of US nuclear power plants in order to
6 protect health, particularly that of local vulnerable populations; and
7

8 Whereas, for over 50 years, the scientific community has recognized that all radioactive
9 elements produced in nuclear development including uranium mining, nuclear power plants, and
10 nuclear weapons development can cause cancers in humans, including lung cancer, bone
11 cancer, thyroid cancer, adult leukemia, and childhood leukemia¹; and
12

13 Whereas, while high-dose exposures to these materials are the most highly carcinogenic, any
14 exposure to radiation carries some risk of cancer; infants in utero and young children are
15 especially vulnerable to even low doses of radiation²; and
16

17 Whereas, the scientific consensus is that every additional exposure to radiation adds to
18 the total risk for genetic damage and thus increases risk for blood cancers like leukemia;
19 increased radiation exposure results in increased incidence of these diseases in exposed
20 populations; for solid cancers, such as lung cancer, bone cancer, and thyroid cancer, the risk for
21 cancer from radiation is directly proportional to cumulative exposure³; and
22

23 Whereas, according to the National Academy of Sciences and EPA⁴, there is no safe level of
24 radiation exposure: the likelihood of cancer is proportional to the radiation dose, a linear
25 relationship: smaller doses produce smaller risks and higher doses, larger risks, but there is no
26 threshold below which there are no risk; this is known as the “linear no threshold” or LNT model⁵
27 of radiation exposure risk; and
28

29 Whereas, the current administration is weakening and even eliminating many safety regulations
30 regarding radioactive exposures: in May 2025, President Trump issued an executive order
31 calling for weakening the radiation protection standard⁶; in January 2026, Department of
32 Energy (DOE) removed the ALARA principle⁷ from all DOE regulations (ALARA is the principle
33 of protecting workers and the public by keeping emissions of radiation as low as reasonably
34 achievable⁸) ; and in March of 2026, the Department of Energy acknowledged also having
35 changed safety guidance that included deleting hundreds of pages of requirements, constituting
36 two thirds of former safety guidelines, including weakening or eliminating rules regarding
37 training guards, securing nuclear material, and protections against groundwater contamination⁹;
38 and

1 Whereas, a weakened safety standard and these amended rules potentially threaten the health,
2 safety, security, and environmental protection of occupational workers and surrounding
3 communities adjacent to nuclear reactors, nuclear mining operations, and waste sites; and
4

5 Whereas, the NRC's current exposure limit for the general public is: total effective dose
6 equivalent to individual members of the public from the licensed operation does not exceed 100
7 millirem in a year, exclusive of the dose contributions from background radiation¹⁰; NRC's
8 current regulatory permissible dose (less stringent than EPA's) for the public of 100
9 millirem/year received over a lifetime results in approximately a cancer risk of 1 in 100, which is
10 100 to 10,000 times higher than the standard acceptable risk range for all other carcinogens¹¹;
11 and
12

13 Whereas, current public radiation exposure limits are 35 years old and worker limits, two thirds
14 of a century old; and
15

16 Whereas, in 1991, despite a report from the National Academies of Science and Medicine
17 noting substantially increased radiation risks per unit dose and calling for a strengthening of the
18 radiation standard, the NRC did not tighten permissible exposures even though decades ago,
19 NRC conceded its radiation limits produced risks higher than standard allowable risks¹²; and
20

21 Whereas, the former director of EPA's Office of Radiation and Indoor Air, Ramona Trovato,
22 issued this statement in 1997: "To put it bluntly, radiation should not be treated as a privileged
23 pollutant. You and I should not be exposed to higher risks from radiation sites than we should
24 be from sites which had contained any other environmental pollutant;"¹³ and
25

26 Whereas, in July 2025, the nuclear industry proposed weakening the radiation standard to 10
27 rem/year for occupational workers and 500 mrem/year for the general public¹⁴; the implications
28 of this proposed weakening of the radiation standard could include abandoning cleanup at
29 highly contaminated Superfund sites like Hanford, Los Alamos and Oak Ridge; voiding cleanup
30 obligations for abandoned uranium mines on tribal lands such as the Navajo Nation;
31 abandoning cleanup of former Manhattan Project contamination sites like Westlake, MO; and
32 decommissioned nuclear plants would be able to leave much of their radioactive contamination
33 onsite and/or discharge into waterways; and
34

35 Whereas, for active nuclear power plants, a weakened standard could eliminate most controls
36 for routine radioactive releases into air, rivers, lakes, and oceans; and
37

38 Whereas, a weakened standard could result in the potential authorization of high level waste
39 repositories even if projected doses from leakage far exceed current limits; and
40

41 Whereas, given the serious risks to health, particularly to women, children, and infants in the
42 womb, and to the environment,¹⁶ the radiation protection standard should be markedly
43 strengthened, both for the public and occupational workers; therefore be it
44

45 RESOLVED, that our American Medical Association oppose efforts to weaken evidence-based
46 U. S. radiation protection standards that relate to industrial use and disposal of radioactive
47 materials and advocate for strengthening evidence-based standards and advocate for effective
48 enforcement to better protect the health of both the general public and occupational workers.
49 (New HOD Policy)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 9/16/26

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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

1 Whereas, psychiatric disorders constitute a major public health burden and are associated with
2 substantial morbidity, mortality, disability, family disruption, and economic costs; and
3

4 Whereas, evidence-based psychotropic medications remain a cornerstone of treatment for
5 many psychiatric disorders, including depressive disorders, bipolar disorder, schizophrenia
6 spectrum disorders, anxiety disorders, and attention-deficit/hyperactivity disorder; and
7

8 Whereas, multiple studies have found psychotropic medications to be underrepresented among
9 individuals who die by suicide^{1,2}; and
10

11 Whereas, despite substantial evidence supporting the effectiveness of psychopharmacologic
12 treatment, misinformation and disinformation regarding psychiatric medications continues to
13 circulate in public and social media forums; and
14

15 Whereas, such misinformation and disinformation may contribute to treatment avoidance,
16 premature discontinuation of medication, and increased stigma toward evidence-based mental
17 health care; and
18

19 Whereas, recent national discussions regarding psychotropic medication safety have
20 underscored the need for accurate, evidence-based information about psychiatric treatment^{3,4};
21 and
22

23 Whereas, leading national psychiatric organizations have emphasized the importance of
24 ensuring that public policy and public education regarding psychotropic medications remain
25 grounded in scientific evidence and clinical expertise³; and
26

27 Whereas, ensuring that the public has access to balanced, scientifically accurate information
28 regarding the risks, benefits, alternatives, and appropriate monitoring of psychotropic treatments
29 would advance mental health literacy, support shared decision-making, and help combat
30 misinformation and disinformation regarding psychiatric care; therefore be it
31

32 RESOLVED, that our American Medical Association, in collaboration with relevant stakeholders,
33 will support the development of educational materials that clearly articulate the benefits, safety,
34 and effectiveness of appropriately used psychotropic medications and non-medication
35 psychotherapeutic interventions, to counter misinformation and disinformation about their safety
36 and effectiveness (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA will support physicians and other health care professionals in
- 2 effectively communicating to patients, families, policymakers, and the media about the safety
- 3 and effectiveness of appropriately used psychotropic medications and non-medication
- 4 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

1 Whereas, our AMA has long held that gender-affirming care is evidence-based, medically
2 necessary care, and Policy H-185.927 commits our AMA to "opposing any criminal and legal
3 penalties against patients seeking gender-affirming care, family members or guardians who
4 support them, and health care facilities and clinicians who provide gender-affirming care," while
5 Policy H-185.950 supports coverage of treatment for gender dysphoria as recommended by a
6 patient's physician; and
7

8 Whereas, protected health information is increasingly being sought as an investigative tool
9 against gender-affirming care: beginning in 2025 the U.S. Department of Justice served more
10 than 20 subpoenas on hospitals, clinicians, and clinics providing such care to minors,
11 demanding not only clinical and billing records but patient-identifying data including names,
12 dates of birth, home addresses, and Social Security numbers¹; and
13

14 Whereas, multiple federal district courts (including in Massachusetts, Washington, and
15 Pennsylvania) have quashed these subpoenas as serving improper purposes rather than
16 legitimate law-enforcement ends, and a coalition of 21 state attorneys general has opposed
17 them as "an unjust attack on the privacy of transgender adolescents and a threat to effective
18 healthcare," confirming both the reality of the threat and the vulnerability of patient records to
19 it^{2, 3}; and
20

21 Whereas, the confidentiality of medical records is a foundational ethical duty of the physician,
22 and the credible prospect that a patient's PHI may be used to investigate or penalize them, their
23 families, or their physicians deters patients from seeking care and chills clinicians from providing
24 it, damaging the physician-patient relationship irrespective of any ultimate legal outcome; and
25

26 Whereas, existing federal privacy protections do not fill this gap: the 2024 HIPAA Privacy Rule
27 to Support Reproductive Health Care Privacy was vacated nationwide in *Purl v. U.S.*
28 Department of Health and Human Services (2025), and even while in effect it did not extend to
29 gender-affirming care, leaving information about gender-affirming care without the targeted
30 protection our AMA already seeks for reproductive health information, despite both facing the
31 same category of politically motivated efforts to weaponize medical records⁴; therefore be it
32

33 RESOLVED, that our American Medical Association oppose governmental efforts to compel the
34 disclosure of identifiable patient medical records from physicians or health care institutions
35 when such efforts are primarily directed at investigating or deterring the provision of otherwise
36 ethical, evidence-based medical care and lack a compelling patient safety or public health
37 justification (New HOD Policy); and be it further
38

39 RESOLVED, that our AMA advocate that governmental requests for identifiable patient medical
40 records in connection with investigations of clinical care be narrowly tailored, supported by an

1 individualized legal basis, and implemented in a manner that minimizes unnecessary intrusion
2 into patient privacy and the patient-physician relationship (New HOD Policy); and be it further
3

4 RESOLVED, that our American Medical Association amend Policy D-315.966, "Improving
5 Protection for Reproductive Health Information," by addition to read as follows:
6

- 7 1. Our American Medical Association supports legislation and regulations
8 prohibiting the use or disclosure of protected health information (PHI)
9 to conduct a criminal, civil, or administrative investigation into or to
10 impose criminal, civil, or administrative liability on any person for the
11 mere act of seeking, obtaining, providing, or facilitating reproductive
12 health and gender-affirming care.
- 13 2. Our AMA advocates to ensure that the release of protected health
14 information of a decedent to forensic pathologists be unimpeded by
15 unnecessary administrative burdens. (Modify Current HOD Policy)

Fiscal Note: Modest – between \$5,000 - \$10,000

Received: 09/16/2026

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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 limited¹; and

Whereas, TGD patients have additional considerations related to non-hormonal cancers due to modifiable risk factors exacerbated by social determinants of health²; and

Whereas TGD patients currently undergoing gender-affirming hormone treatment have additional considerations related to hormonal cancers³; 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

1 Whereas, clinical trials are essential to advancing medical knowledge, improving patient
2 outcomes, and ensuring equitable as well as timely access to innovative therapies¹⁻²; and
3

4 Whereas, although clinical trial participants may receive modest financial compensation to help
5 offset the burdens of participation, such as transportation, time away from work, childcare, and
6 other incidental costs, the limited duration of a trial means this participation does not qualify as a
7 regular or continuous activity for tax purposes and thus is not tax deductible as trade or
8 business expenses³⁻⁵; and
9

10 Whereas, payments to clinical trial participants are generally modest (typically small, fixed
11 stipends or expense reimbursements that offset the time, travel, childcare, and other incidental
12 costs of participation) and are not designed to generate financial gain, serve as wages, or act as
13 a primary source of income; rather their purpose is to ease the burden of participation and
14 promote equitable enrollment, but these payments are currently treated as taxable income
15 under the broad Internal Revenue Code definition of gross income as “all income from whatever
16 source derived”³⁻⁶; and
17

18 Whereas, the classification of clinical trial compensation as taxable income creates an often-
19 overlooked structural barrier to participation, particularly among historically marginalized
20 populations, and may deter or prevent enrollment^{3,5,7}; and
21

22 Whereas, prospective data demonstrate that patients with lower annual household income are
23 significantly less likely to participate in cancer clinical trials, with those earning less than
24 \$50,000 annually having approximately 32% lower odds of participation compared to higher-
25 income patients, highlighting the impact of financial barriers on equitable trial access⁸; and
26

27 Whereas, because clinical trial compensation is treated as reportable income, it poses
28 disproportionate risks for low-income individuals and people who rely on public assistance such
29 as Medicaid, Supplemental Security Income, and/or the Supplemental Nutrition Assistance
30 Program, which have income-based eligibility thresholds, so even modest trial payments can
31 reduce benefit amounts or jeopardize eligibility for essential benefits⁵; and
32

33 Whereas, existing federal policy provides only limited and narrowly defined income exclusions:
34 the Ensuring Access to Clinical Trials Act of 2015 made permanent a \$2,000-per-year exclusion
35 for clinical trial compensation, but only applies to trials for rare diseases or conditions and only
36 to the Medicaid and Supplemental Security Income programs, was never indexed to inflation,
37 and does not address barriers for participants with more prevalent conditions or those relying on
38 other means-tested benefits, which is insufficient to prevent loss of benefits or meaningfully
39 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 Google¹⁻³; and

Whereas, there is growing bipartisan concern about the impacts of data centers on communities and the environment⁴⁻⁸; 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 Texas¹²⁻¹⁸; 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 asthma¹⁹⁻²¹; 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 ecosystems²²⁻³⁰; 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

- 1 RESOLVED, that our American Medical Association study and report on the public health
2 impacts of data center development, including effects on air quality, water resources, soil
3 contamination, energy infrastructure, noise exposure, and health equity.
4 (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; Reaffirmation I-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-making²⁻⁶; 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 recommendations⁷⁻¹¹; 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 policy¹²⁻¹³; 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 guidance¹⁴⁻¹⁶; 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

1 Whereas, the new 2025–2030 DGAs encourage almost doubling protein intake from the existing
2 Dietary Reference Intake of 0.8 grams of protein daily per kilogram of body weight to 1.2–1.6
3 g/kg, despite limited evidence that higher protein confers muscle or other health benefits in
4 absence of regular strength training and concerns that excess dietary protein can be converted
5 to fat by the liver, increasing visceral adiposity and diabetes risk^{17,22–24}; and
6

7 Whereas, the new 2025–2030 DGAs rejected the Dietary Guidelines Advisory Committee
8 recommendation to prioritize “plant-based” over “animal-based” protein sources due to
9 established evidence base linking dietary patterns high in saturated fat and red meat with
10 increased risk of cardiovascular disease, diabetes, and certain cancers, and instead, the DGAs
11 promote higher intakes of animal-source proteins and full-fat dairy products^{17,22,24}; and
12

13 Whereas, despite the aforementioned prior Dietary Guidelines Advisory Committee
14 recommendation to prioritize “plant-based” over “animal-based” protein sources, the inverted
15 food pyramid graphic that accompanies the new 2025–2030 DGAs visually promotes animal
16 protein and saturated fat sources in the prominent upper-left position, while de-emphasizing
17 legumes and nuts and leaving out soy, which is a major source of plant protein^{17,25}; and
18

19 Whereas, the Physicians Committee for Responsible Medicine has filed a petition with the
20 Offices of Inspector General for the Department of Health and Human Services and the U.S.
21 Department of Agriculture requesting that the new 2025–2030 DGA be withdrawn and reissued
22 due to concerns of industry influence²⁶; and
23

24 Whereas, seven of the nine authors of the scientific report underlying the 2025–2030 DGA
25 reported industry ties, including the Texas Beef Council, National Cattlemen’s Beef Association,
26 National Pork Board, National Dairy Council, and Atkins Nutritionals, which are organizations
27 that would benefit from dietary guidelines that promote meat, dairy, and low-carbohydrate
28 products^{27,28}; and
29

30 Whereas, the American College of Cardiology Nutrition & Lifestyle Work Group has published
31 findings separating Evidence-Based 2025–2030 DGA Recommendations from other
32 recommendations not supported by nutrition science²⁵; and
33

34 Whereas, the Academy of Nutrition and Dietetics has also published a statement expressing
35 concerns over the 2025–2030 DGAs’ emphasis on butter, beef tallow, red meat, and full-fat
36 dairy²⁹; and
37

38 Whereas, the environmental implications and reduced carbon footprints of plant-forward versus
39 animal-based diets are substantial, with modeling studies estimating that plant-based diets
40 could reduce diet-related land use by 76%, diet-related greenhouse gas emissions by 49%, and
41 water use by more than 10%^{30,31}; and
42

43 Whereas, the DGAs influence numerous public programs—including school meal standards,
44 nutrition assistance programs, military, and other institutional food procurement policies—which
45 can affect the ability of physicians and other health professionals to provide consistent
46 evidence-based nutrition counseling to patients and communities^{1,29,32}; and
47

48 Whereas, physicians play an important role in communicating nutrition guidance to patients and
49 the public and in countering health misinformation that may undermine evidence-based public
50 health recommendations, and rely upon quality evidence-based dietary guidance to inform
51 conversations with patients^{1,22,33,34}; therefore be it

1 RESOLVED, that our American Medical Association advocates that nutrition recommendations
 2 used in clinical practice, state public health policy, and institutional nutrition programs be
 3 grounded in evidence-based science and informed by the scientific guidance (Directive to Take
 4 Action); and be it further

5
 6 RESOLVED, that our AMA advocates for strengthened transparency, disclosure, and
 7 management of financial and non-financial conflicts of interest in the development of federal
 8 dietary guidelines and related scientific reports, including clear public reporting and exclusion of
 9 individuals with significant financial or industry-related conflicts of interest from decision-making
 10 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

1 Whereas, the American Medical Association has longstanding policy opposing governmental
2 interference in the physician-patient relationship and in the practice of medicine, including
3 policies H-373.995, H-270.959, H-165.916, and H-5.989; and
4

5 Whereas, these policies should extend to governmental mandates requiring diagnostic testing
6 that is not clinically indicated and/or that falls outside accepted standards of care; and
7

8 Whereas, government-mandated testing may create clinical and medicolegal concerns when it
9 requires testing or follow-up outside the independent medical judgment of the physician and
10 clinical team; and
11

12 Whereas, the U.S. Secretary of Defense has announced the implementation of a new screening
13 program (starting on Wednesday, August 15, 2026) for testosterone deficiency among active
14 duty servicemembers, stating that such screening is intended to enable troops to perform at
15 their highest level; and
16

17 Whereas, the announced screening program would be conducted annually as part of required
18 medical screenings for servicemembers aged 30 years and older, with servicemembers younger
19 and 30 permitted to undergo testing on a voluntary basis, and with testosterone replacement
20 therapy described as voluntary; and
21

22 Whereas, there may be clinical benefit to identifying asymptomatic men with low testosterone in
23 appropriate circumstances; and
24

25 Whereas, testosterone testing is subject to biologic and analytic variability, and AMA policy H-
26 260.963 recognizes the importance of educating clinicians regarding variability in testosterone
27 assay accuracy; and
28

29 Whereas, broad screening may increase the risk of inappropriate self-treatment with
30 unregulated supplements or hormones of uncertain safety, purity, quality, and efficacy; and
31

32 Whereas, patients and clinicians should be aware of frequent occurrences of both inaccurate
33 herb labeling and of supplements containing active pharmaceuticals or other bioactive agents
34 that are not identified on the label; and
35

36 Whereas, inappropriate testosterone use may result in adverse effects, including decreased
37 sperm parameters, infertility, erythrocytosis/thrombotic risk, and unmasking subclinical prostate
38 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

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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

1 Whereas, the One Health framework recognizes the interdependence of human, animal, and
2 environmental health and promotes interdisciplinary collaboration among healthcare
3 professionals, veterinarians, environmental scientists, public health agencies, and community
4 partners; and
5

6 Whereas, emerging infectious diseases, antimicrobial resistance, vector-borne illnesses,
7 climate-related health threats, environmental degradation, and biodiversity loss all demonstrate
8 the need for coordinated, multisectoral approaches to prevention and response; and
9

10 Whereas, New Jersey is the first state to adopt by statute a One Health initiative which has
11 established statewide One Health Task Force to advance interagency communication, data-
12 sharing, research collaboration, and public engagement around cross-cutting health threats; and
13

14 Whereas, our American Medical Association has long supported evidence-based public health
15 initiatives, preventive care, environmental health protections, and the strengthening of
16 healthcare–public health partnerships including prior support for collaborations with veterinary
17 medicine and for collaboration around zoonotic disease; and
18

19 Whereas, a One Health framework recognizes that health threats often arise from complex
20 interactions beyond first-order zoonotic transmission, and that medical, veterinary, and
21 environmental decisions are inseparable, such that pharmacologic and land-use choices made
22 without ecological vigilance can reverberate through food systems and vector populations,
23 ultimately impacting human maternal and child health (see case studies below); and
24

25 Whereas, recent and ongoing cuts to public health funding and data-sharing infrastructure have
26 weakened surveillance, coordination, and response capacity for emerging zoonotic,
27 environmental, and climate-related health threats, making it especially urgent for our AMA to
28 articulate and advance a One Health approach that can help sustain integrated, cross-sector
29 protections for patients and communities; and
30

31 Whereas, physicians and health systems are uniquely positioned to advocate for and participate
32 in integrated responses to zoonotic disease surveillance, environmental monitoring, sustainable
33 land use planning, and climate-resilient community health strategies; therefore be it
34

35 RESOLVED, that our American Medical Association, building on its prior study of the impact of
36 zoonoses, will study the feasibility, structure, and potential impact of One Health initiatives that
37 bring together medical, veterinary, environmental, academic, and community stakeholders to
38 reduce shared health risks, with report back at A-27 (Directive to Take Action); and be it further

1 RESOLVED, that our AMA will assess opportunities and barriers to integrating One Health
2 principles into medical education, residency training, and continuing medical education,
3 including considerations of curricular feasibility, resource requirements, and measurable
4 outcomes (Directive to Take Action); and be it further

5
6 RESOLVED, that our AMA develops model legislation for potential implementation of the One
7 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

1 Whereas, organ transplantation provides lifesaving and life-enhancing treatment for patients
2 with end-stage organ disease, and a safe, ethical, and effective system of deceased organ
3 donation and procurement is essential to patients awaiting transplantation; and
4

5 Whereas, recent federal oversight of organ donation and procurement has identified a
6 concerning pattern of risk across organ procurement organizations involving inconsistent patient
7 assessments, coordination of care, data collection, and lack of clarity regarding roles and
8 responsibilities within the care team, prompting the Health Resources and Services
9 Administration to direct the Organ Procurement and Transplantation Network to develop
10 nationwide safety standards and policies to protect patients who may become organ donors;
11 and
12

13 Whereas, AMA Code of Medical Ethics Opinion 6.1.2, "Organ Donation After Cardiac Death,"
14 recognizes that efforts to increase the availability of organs for transplantation must be balanced
15 against physicians' duty to protect their individual patients and calls for appropriate clinical
16 criteria, independence of decisions to withdraw life-sustaining treatment from decisions
17 regarding organ donation, informed consent, and continued appropriate palliative care; and
18

19 Whereas, AMA Code of Medical Ethics Opinion 6.2.1, "Guidelines for Organ Transplantation
20 from Deceased Donors," provides that the physician's primary concern must remain the well-
21 being of the patient and calls for separation, to the greatest extent possible, between those
22 providing end-of-life care and those retrieving or transplanting organs, exclusion of transplant
23 team members from decisions to withdraw treatment or pronounce death, and determination of
24 death by a physician not associated with the transplant team in accordance with accepted
25 clinical and ethical standards; and
26

27 Whereas, the Organ Procurement and Transplantation Network is developing additional
28 safeguards for donation after circulatory death, including proposed requirements for neurologic
29 reassessment and processes to pause donation activities when changes in neurologic function,
30 possible pain, or other patient-safety concerns arise; and
31

32 Whereas, as these national safeguards are developed and implemented, established principles
33 of medical ethics provide an important foundation for ensuring that patients being evaluated for
34 potential organ donation remain first and foremost patients, that clinical assessments and
35 decisions regarding their care remain independent of organ procurement considerations, and
36 that unresolved clinical concerns cannot be subordinated to the goal of organ procurement; and
37

38 Whereas, maintaining confidence among patients and families that potential donor status will
39 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

1 Whereas, the use of electric mobility devices, including e-bikes and scooters, is rapidly
2 increasing across the country, with an estimated industry value of \$35.7 billion in 2024; and
3

4 Whereas, these devices offer mobility benefit when used at appropriate speeds with safety
5 equipment, but they pose growing safety risks; and
6

7 Whereas, electric bikes and scooters rarely require registration or licensing to operate; and
8

9 Whereas, the Consumer Product Safety Act, PL 107-319 defines two-or-three wheeled vehicles
10 with fully operable pedals, an electric motor less than 750 watts, and maximum speed of under
11 20 mph as low-speed electric bicycles; and
12

13 Whereas, e-bikes are classified as Class I (pedal assistance required for motor support up to 20
14 mph), Class II (no pedal needed with motor support up to 20 mph) and Class III (pedal
15 assistance required for motor support up to 28-mph); and
16

17 Whereas, the 2025 Mineta Transportation Institute report published multiple recommendations
18 for improved education, infrastructure, regulation, and data collection in California; and
19

20 Whereas, California and other states have implemented evidence-based policies including age
21 restrictions, universal helmet requirement for riders under 18, speed restrictions; and
22

23 Whereas, state and local laws governing electric mobility devices are inconsistent, including
24 classification of e-bikes, varying in requirements for age, helmet use, speed and power limits,
25 riding zones, and DUI regulation; and
26

27 Whereas, there is a strong need to expand the existing definitions of mopeds and motorcycles
28 to include electric motors and regulate overpowered devices under the same frameworks. For
29 example, in California, a moped is restricted to 30 mph, just 2 mph over a class 3 e-bike, and 4
30 horsepower; and
31

32 Whereas, injuries and fatalities from these devices are rising rapidly and more closely resemble
33 those of motorcycle crashes, with the US Consumer Product Safety Commission reporting a
34 158 percent increase in related injuries between 2017 and 2023; and
35

36 Whereas, major medical organizations, including the American College of Surgeons, the
37 American Academy of Orthopedic Surgeons, the American Association of Neurological

1 Surgeons, and the Congress of Neurological Surgeons have issued statements and articles on
2 e-bike safety; therefore be it

3
4 RESOLVED, that our American Medical Association amend AMA policy D-10.989 by addition
5 and deletion to read as follows:

6
7 1. Our American Medical Association recognizes electric bikes and scooters or
8 micromobility injuries and deaths as a public health issue that would benefit from
9 focused safety and injury prevention strategies.

10
11 ~~4.~~ 2. Our American Medical Association better defines and expands AMA policy to help
12 improve safety for micromobility (e-bikes and e-scooters) usage by endorsing the
13 following positions:

- 14 a. Helmets, certified by the US Consumer Safety Product Commission and
15 rated for speed, should be worn for all and be mandatory for Class 3 e-
16 bikes and all scooters;
- 17 b. Additional gear should include elbow pads, knee pads, wrist guards,
18 closed-toe footwear and high-visibility or reflective gear for use at
19 nighttime;
- 20 c. Headphones should be avoided during use;
- 21 d. E-scooters and Class 3 e-bikes should have a minimum age of 16 to
22 operate;
- 23 e. Require education and training for Class 3 e-bikes;
- 24 f. Define where e-bikes can be ridden both on and off-road, including speed
25 limits on shared paths and no operation allowed on sidewalks;
- 26 g. No distractions while operating;
- 27 h. No passengers while operating;
- 28 i. Regulate out-of-class products and anti-tampering; and
- 29 j. Training required to operate devices, including smooth and consistent
30 braking at high speeds and basic traffic rules.

31 ~~2.~~ 3. Our AMA advocates for standardized injury surveillance and reporting of
32 micromobility-related injuries at the state and national level, including integration into
33 existing trauma registries and public health reporting systems.

34 ~~3.~~ 4. Our AMA encourages and advocates for accelerated research into the root
35 causes of e-bike and e-scooter related injuries in the United States, with the goal of
36 defining actionable best practices to prevent and/or minimize serious injury associated
37 with operation of various classes of such vehicles, as well as the relevant demographics
38 of the operators thereof (Modify Current HOD Policy); and be it further
39

40 RESOLVED, that our AMA advocate for Congress to establish a task force to develop
41 recommendations on how states should regulate e-bikes and e-scooters including:
42

- 43 • classification and labeling of electric bikes and scooters,
- 44 • licensing and registration requirements,
- 45 • age restrictions,
- 46 • universal helmet use,
- 47 • required rider safety education and public education
- 48 • motor power limits and maximum assistance-speed capabilities,
- 49 • night visibility requirements including lighting and reflectors
- 50 • 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/conservation/active-transportation>.
5. CMA Sponsors Bill to Modernize E-Bike Safety Laws and Protect Kids, CALIFORNIA MEDICAL ASSOCIATION (February 20, 2026). <https://www.cmadoes.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.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>.

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 settings¹; 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 transmission³; 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

REFERENCES

1. Centers for Disease Control and Prevention. Nationwide increase in reported human rabies exposures and post-exposure prophylaxis errors. Centers for Disease Control and Prevention; September 10, 2026. CDC Health Alert Network Advisory HAN00533. Accessed September 19, 2026. <https://www.cdc.gov/han/php/notices/han00533.html>
2. Manning SE, Rupprecht CE, Fishbein D, et al; Advisory Committee on Immunization Practices. Human rabies prevention—United States, 2008: Recommendations of the Advisory Committee on Immunization Practices. MMWR Recomm Rep. 2008;57(RR-3):1-28.
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

1 Whereas, firearm muzzle blast noise is a well-known cause of permanent hearing loss^(1,2); and

2
3 Whereas, the number of registered firearm suppressors in the United States has increased from
4 1.3 million in 2017 to 5.78 million in 2025⁽³⁾; and

5
6 Whereas, firearm suppressors are now legal for use in hunting or sport shooting in 42 states⁽⁴⁾;
7 and

8
9 Whereas, the Academy of Doctors of Audiology supports improving access to suppressors⁽⁵⁾;
10 and

11
12 Whereas, the Centers for Disease Control and Prevention states that the only potentially
13 effective noise control method to reduce shooters' noise exposure from gunfire is through the
14 use of suppressors⁽⁶⁾; and

15
16 Whereas, The American Academy of Otolaryngology-Head and Neck Surgery endorses the use
17 of suppressors as an effective method of reducing the risk of hearing loss ⁽⁷⁾ and the New York
18 State Society of Otolaryngology endorses the use of suppressors for hunting and recreational
19 shooting to reduce preventable hearing loss⁽⁸⁾; therefore be it

20
21 RESOLVED, that our American Medical Association endorses the use of firearm suppressors in
22 conjunction with conventional hearing protective measures for hearing preservation (New HOD
23 Policy); and be it further

24
25 RESOLVED, that our AMA supports legislation decriminalizing the use of firearm suppressors
26 during hunting, sports shooting, or on firing ranges for the purposes of reduction of hearing loss
27 (New HOD Policy); and be it further

28
29 RESOLVED, that our AMA supports continued research on the subsequent effects of the use of
30 firearm suppressors. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/22/26

REFERENCES

1. National Institute on Deafness and Other Communication Disorders, Noise-Induced Hearing Loss, updated March 16, 2022.
www.nidcd.nih.gov/health/noise-induced-hearing-loss
2. Journal of the Acoustical Society of America, Auditory Changes Following Firearm Noise Exposure-A Review, March 17, 2022 (vol. 151, no. 3), pp. 1769-1791.
<https://pubs.aip.org/asa/jasa/article/151/3/1769/2838222/Auditory-changes-following-firearm-noise-exposure>
3. National Shooting Sports Foundation, Firearm Suppressor Registrations Outpace Historic Figures, October 8, 2024.
www.nssf.org/articles/firearm-suppressor-registrations-outpace-historic-figures/
4. American Suppressor Association,
<https://americansuppressorassociation.com/education/>
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
6. Brueck SE, Kardous CA, "Measurement of Exposure to Impulsive Noise at Indoor and Outdoor Firing Ranges During Tactical Training Exercises", Health Hazard Evaluation Report 2013-0124-3208, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, June 2014:14.
www.cdc.gov/niosh/hhe/reports/pdfs/2013-0124-3208.pdf
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

1 Whereas, combustible cigarette smoking remains a major cause of preventable disease and
2 death, and the greatest health risks from tobacco use are a result from exposure to toxicants
3 generated by combustion; and
4

5 Whereas, nicotine is an addictive substance delivered by combustible cigarettes, e-cigarettes,
6 nicotine pouches, and repeated nicotine exposure can result in dependence and withdrawal
7 symptoms; and
8

9 Whereas, although e-cigarettes and smokeless nicotine products may expose users to fewer
10 harmful substances than combustible cigarettes, e-cigarettes are not harmless and continued
11 use often maintains nicotine dependence; and
12

13 Whereas, the U.S. Food and Drug Administration (FDA), through its Center for Drug Evaluation
14 and Research, evaluates and approves treatments of disease, including tobacco use disorder,
15 while FDA's Center for Tobacco Products regulates and authorizes the sale of commercial
16 tobacco and nicotine products, including e-cigarettes and electronic nicotine delivery systems,
17 some of which continue to be commercially available without required FDA authorization, and
18 current best practices for the treatment of tobacco use disorder, as reflected in guidance from
19 the Office of the U.S. Surgeon General and the American Thoracic Society, support the use of
20 FDA-approved cessation medications in conjunction with tobacco treatment counseling; and
21

22 Whereas, recent clinician-directed publications and education materials have recommended
23 consideration of e-cigarettes in smoking cessation treatment, including a 2026 JAMA Special
24 Communication, *Nicotine for E-Cigarettes for Cigarette Smoking Cessation: Recommendations*
25 *to US-Based Clinicians*, which recommends that clinicians integrate e-cigarettes into discussion
26 of evidence-based treatments for smoking cessation and provides guidance regarding their use
27 for cigarette smoking cessation, despite e-cigarettes not being FDA-approved smoking
28 cessation therapies; and
29

30 Whereas, the American Thoracic Society and the American College of Chest Physicians have
31 expressed concern in response to these recommendations that greater caution is warranted
32 regarding the potential role of e-cigarettes in smoking cessation and have emphasized the
33 importance of increasing the use of effective FDA-approved treatments and promoting
34 avoidance of unapproved inhaled aerosols; and
35

36 Whereas, the term "harm reduction" has no single definition and is used in varying ways across
37 public health contexts, but is useful in understanding a loose framework for reducing harm to
38 patient and the public in tobacco-related and other treatment scenarios; and

1 Whereas, physicians need evidence-based clinical guidance to treat patients who smoke
2 combustible cigarettes, e-cigarettes or other commercial nicotine products, or are considering
3 switching among nicotine products; and
4

5 Whereas, it is consistent with our American Medical Association policies H-495.972, "Electronic
6 Cigarettes, Vaping, and Health," H-495.988, "FDA Regulation of Tobacco Products," and H-
7 490.917, "Physician Responsibilities for Tobacco Cessation," recognize the health risks and
8 addictive potential of e-cigarettes and other nicotine products, promote FDA-approved smoking
9 cessation tools and resources, and support the use of evidence-based clinical practice
10 guidelines for the treatment of nicotine dependence; therefore be it
11

12 RESOLVED, that our American Medical Association remains consistent in its recommendations
13 to follow evidence-based medicine and clinical guidelines and in doing so, does not endorse
14 that physicians recommend or prescribe commercial e-cigarette devices for the purposes of
15 tobacco cessation in adult and adolescent patients (New HOD Policy); and be it further
16

17 RESOLVED, that our AMA emphasizes the importance of developing clinical decision trees to
18 support physicians who weigh the option of commercial nicotine products in the setting of
19 tobacco use disorder (New HOD Policy); and be it further
20

21 RESOLVED that our AMA recommends against the use of the phrases "quit smoking" or
22 "cessation" and instead recommends the use of the terms "transition", "switch", or "conversion"
23 to describe patients and research subjects who move off of combustible cigarettes and onto
24 electronic cigarettes or commercial nicotine (New HOD Policy); and be it further
25

26 RESOLVED, that our AMA, based on the variable nicotine levels and toxicity profiles of
27 commercial e-cigarettes and nicotine products, remains consistent with prior policy that
28 physicians should continue to guide and counsel patients who have made the choice to use
29 these products (New HOD Policy); and be it further
30

31 RESOLVED, that our AMA recognizes the chronic use of commercial nicotine products and e-
32 cigarettes as nicotine dependence or addiction, and strongly recommends the use of clinical
33 pathways and evidence-based treatment to support patients with nicotine dependence or
34 addiction (New HOD Policy); and be it further
35

36 RESOLVED, that our AMA stands by the principles of harm reduction in individual patient care
37 and in public health and recommends physicians provide non-punitive, non-judgmental
38 information to adult patients who smoke when discussing commercial nicotine products and
39 electronic cigarettes. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/22/26

REFERENCES

1. Leavens ELS, Pebley K, Smith TT, et al. Nicotine E-Cigarettes for Cigarette Smoking Cessation: Recommendations to US-Based Clinicians. JAMA. 2026;336(9):783-790. doi:10.1001/jama.2026.13087.
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

1 Whereas, engineered stone has become the most popular countertop material in the United
2 States; and
3

4 Whereas, engineered stone countertops can contain very high levels of crystalline silica, often
5 exceeding 90%, and the cutting, shaping, sanding, grinding, and polishing of high-silica-content
6 engineered stone can release high levels of respirable crystalline silica; and
7

8 Whereas, globally, there has been a documented increase in silicosis among countertop
9 fabricators associated with exposure to respirable crystalline silica from high-silica-content
10 engineered stone; and
11

12 Whereas, the State of California has documented a significant increase in silicosis among
13 countertop fabricators associated with exposure to respirable crystalline silica while working with
14 high-silica-content engineered stone; and
15

16 Whereas, even with the use of established engineering controls, such as wet methods,
17 ventilation, and respiratory protection, hazardous exposures to respirable crystalline silica from
18 high-silica-content engineered stone may persist; and
19

20 Whereas, the Occupational Safety and Health Administration has established a permissible
21 exposure limit for respirable crystalline silica of 50 µg/m³ as an 8-hour time-weighted average
22 and an action level of 25 µg/m³, yet hazardous exposures and cases of silicosis continue to be
23 documented among countertop fabrication workers; and
24

25 Whereas, the American Thoracic Society workshop report, Silicosis in the Artificial Stone
26 Countertop Industry, calls for higher-order prevention strategies, including the elimination or
27 substitution of high-silica artificial stone; and
28

29 Whereas, commercially available countertop products containing less than 1% crystalline silica
30 are available in the United States; and
31

32 Whereas, in response to high rates of silicosis among countertop fabrication workers, Australia
33 implemented a prohibition in 2024 on the manufacture, supply, processing, and installation of
34 engineered stone benchtops, panels, and slabs containing at least 1% crystalline silica; and
35

36 Whereas, in response to the documented increase in silicosis among countertop fabrication
37 workers, California is pursuing emergency rulemaking to prohibit the fabrication of engineered
38 stone countertops and similar products containing more than 1% crystalline silica; therefore be it

1 RESOLVED, that our American Medical Association support California's proposed emergency
2 regulation to prohibit the fabrication of engineered stone countertops and similar products
3 containing more than 1% crystalline silica (New HOD Policy); and be it further
4

5 RESOLVED, that our AMA oppose the sale, installation, and use of high-silica-content
6 engineered stone countertops across the United States (New HOD Policy); and be it further
7

8 RESOLVED, that our AMA recommends the industrial and commercial use of low-silica-content
9 engineered stone products and other safer alternatives (New HOD Policy); and be it further
10

11 RESOLVED, that our AMA support the recommendations of the American Thoracic Society
12 workshop report, Silicosis in the Artificial Stone Countertop Industry, including strengthening
13 surveillance, improving access to screening and care, and advancing higher-order prevention
14 strategies, including the elimination or substitution of high-silica engineered stone with lower-
15 silica or other safer alternatives. (New HOD Policy)

Fiscal Note: Minimal – less than \$5,000

Received: 9/22/26

REFERENCES

1. Gandhi SA, Liu GY, Fazio JC, et al. Silicosis in the artificial stone countertop industry: An official American Thoracic Society workshop report. Ann Am Thorac Soc. Published online June 26, 2026. doi:10.1093/annalsats/aaog176.

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]