

Resolutions not for Consideration

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-26)

Introduced by: Minnesota

Subject: Support for Completion of Medical Directives Before Elective Surgeries

Referred to: Reference Committee on Ethics and Bylaws

1 Whereas, advance care planning (ACP) documentation before elective surgery remains
2 persistently low, including among older adults undergoing high-risk procedures, despite its
3 importance for aligning perioperative care with patient values and preferences^{1,2}; and
4

5 Whereas, elective procedures and anesthesia may result in serious morbidity, mortality, or loss
6 of decisional capacity, yet only 36.7% of U.S. adults have completed an advance directive and
7 70% of patients presenting for elective surgery lack one on file³⁻⁵; and
8

9 Whereas, ACP completion is uneven across patient populations, with disparities by sex,
10 language preference, insurance status, race, and socioeconomic status^{1,6-8}; and
11

12 Whereas, ACP discussions are often not initiated by surgical teams or tailored to surgery-
13 specific risks, limiting opportunities to clarify patient goals before postoperative complications or
14 decisional incapacity occur^{1,2}; and
15

16 Whereas, completing advance directives before elective procedures can improve patient
17 autonomy, reduce unwanted or non-goal-concordant care, decrease conflict and distress among
18 families and clinicians, and may reduce health care costs^{2,9}; and
19

20 Whereas, the American College of Surgeons Optimal Resources for Geriatric Surgery 2019
21 Standards section 5.2 requires that “code status and any existing advance directives must be
22 reviewed preoperatively by the surgeon”, and for patients without such preferences documented
23 should be “offered the opportunity to establish an advance directive”¹⁰; and
24

25 Whereas, the American College of Surgeons Optimal Resources for Geriatric Surgery 2019
26 Standards section 5.3 require all patients have a health care representative, surrogate, or proxy
27 identified and clearly documented, and for those without, effort to identify one should be made¹⁰;
28 and
29

30 Whereas, current American Medical Association policy encourages completion of advance
31 directives and supports a national registry to facilitate availability of such documents, but policy
32 does not provide details regarding advance care planning in the perioperative time; therefore be
33 it
34

35 RESOLVED, that our American Medical Association support education and other evidence-
36 based interventions aimed at improving completion of medical directives, at a minimum inclusive
37 of a desired code status and healthcare power of attorney, prior to elective surgeries involving
38 anesthesia or significant risk of harm that could render the patient incapacitated to make
39 medical decisions. (New HOD Policy)

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

Received: 9/16/26

REFERENCES

1. Colley A, et al. Advance care planning documentation among older adults undergoing high-risk surgery. *JAMA Surgery*. 2022. doi:10.1001/jamasurg.2022.3687
2. Kalbfell E, et al. Advance directives and perioperative care for older adults. *JAMA Surgery*. 2021. doi:10.1001/jamasurg.2021.1521
3. Mullen MG, et al. Risk of morbidity and mortality with elective procedures. *JAMA Surgery*. 2017. doi:10.1001/jamasurg.2017.0918
4. Yadav KN, et al. Approximately one in three US adults completes any type of advance directive for end-of-life care. *Health Affairs*. 2017. PMID:28679811
5. Sinha S, et al. Advance directive availability at preoperative visits for elective surgery. 2019. PMID:30604122
6. Tooba R, et al. Preoperative advance care planning intervention and advance directive completion. *Anesthesia & Analgesia*. 2023. doi:10.1213/ANE.0000000000006533
7. Izumi S, et al. Language-concordant and culturally sensitive advance care planning interventions. *PLOS ONE*. 2024. doi:10.1371/journal.pone.0301426
8. Sudore RL, et al. Effect of a patient-facing advance care planning intervention. *JAMA Internal Medicine*. 2018. doi:10.1001/jamainternmed.2018.4657
9. Bond WF, et al. Advance care planning and potential health care cost savings. *Journal of Palliative Medicine*. 2018. doi:10.1089/jpm.2017.0566
10. Coleman EA, et al. *Optimal Resources for Geriatric Surgery: 2019 Standards*. American College of Surgeons; 2019.

RELEVANT AMA POLICY

H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

H-85.950 Support of a National Registry for Advance Directives

Our AMA will advocate for the development of model legislation and the establishment and maintenance of a national, no-charge, confidential and secure method for the storage and retrieval of advance directive documents by authorized agents.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-26)

Introduced by: Massachusetts

Subject: Use of Live Animals in Medical Training

Referred to: Reference Committee on Ethics and Bylaws

1 Whereas, while 97% of surveyed emergency medicine residency programs across the United
2 States and Canada use only human-relevant training methods, some medical centers continue
3 to use live animals.¹ Currently (as of 3/6/26), 272 programs use only nonanimal training
4 methods and eight programs still use live animals;² and

5
6 Whereas, the use of live animals in medical student training in the United States (US) has
7 ceased as of 2016;³ and

8
9 Whereas, the AMA previously encouraged medical school faculty to consider using non-animal
10 training methods;⁴ and

11
12 Whereas, the use of animals for training residents has increasingly fallen out of favor as more
13 technologically superior models have emerged; and

14
15 Whereas, the use of medical simulation in the training of residents has been proven to increase
16 competency, reduce errors, and improve team-building;^{5,6,7,8,9,10} and

17
18 Whereas, the shortened medical resident workweek necessitates easy access to training
19 methods such as medical simulation, which can be employed without advance scheduling,
20 animal acquisition, and veterinary staffing; and

21
22 Whereas, all surveyed pediatrics residency programs in the US and Canada exclusively use
23 non-animal training methods;¹¹ therefore be it

24
25 RESOLVED, that our American Medical Association support the use of medical training that
26 avoid the use of live animals. (New HOD Policy)

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

Received: 9/16/26

REFERENCES

1. <https://www.pcrm.org/ethical-science/ethical-education-and-training/emergency-medicine-training>
2. <https://www.pcrm.org/ethical-science/ethical-education-and-training/survey-of-emergency-medicine-residencies>
3. Simkin D.J. (2017) The Death of Animals in Medical School. *New England Journal of Medicine*, 376(8):713–715.
4. AMA Policy. (2010) H-295.957 Use of Animals in Medical Education.
5. Shapiro M, et al. (2004) Simulation based teamwork training for emergency department staff: does it improve clinical team performance when added to an existing didactic teamwork curriculum? *Quality and Safety in Health Care*, 13:417–21
6. Lammers R. (2007) Simulation: the new teaching tool. *Annals of Emergency Medicine*, 49(4):506–7.
7. Wang E, et al. (2008) Developing technical expertise in emergency medicine—the role of simulation procedural skill acquisition. *Academic Emergency Medicine*, 15(11):1046–57
8. Youngblood P, et al. (2008) Design, development, and evaluation of an online virtual emergency department for training trauma teams. *Simulation in Healthcare*, 3(3):146–53.
9. Ten Eyck R. (2011) Simulation in Emergency Medicine Training. *Pediatric Emergency Care*, vol. 27, no. 4.
10. Iverson K., et al. (2015) Objective Comparison of Animal Training versus Artificial Simulation for Initial Cricothyroidotomy Training. *The American Surgeon*, vol. 81.
11. <https://www.pcrm.org/news/news-releases/all-surveyed-pediatric-residency-programs-us-and-canada-no-longer-use-animals>

RELEVANT AMA POLICY**Use of Animals in Medical Education H-295.957**

The AMA has adopted the following guidelines on the use of animals in medical school curricula and continuing medical education courses: (1) Where appropriate, medical school faculty should consider using non-animal models in education activities; when animals are used in the curriculum, education goals should be clearly stipulated. (2) Each medical school should disseminate a policy statement to students before matriculation regarding their participation in educational experiences involving animals. (3) All educational experiences involving animals should have the approval of the institutional Animal Care and Use Committee. (4) Involved faculty should discuss with students the learning objectives of any educational experience that utilizes animals, and faculty should remain available throughout the laboratory exercise for advice and guidance on the conduct of the educational experience. (5) All educational experiences involving animals should be carried out in a humane manner without inflicting pain on the animal. This includes the appropriate use of anesthetic and analgesic drugs. (6) At the conclusion of study, animals should be euthanized in the manner described by the American Veterinary Medical Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-26)

Introduced by: Medical Student Section, Underrepresented in Medicine Advocacy Section

Subject: Missing Indigenous People Crisis in Medical Education

Referred to: Reference Committee C

1 Whereas, American Indian and Alaska Native women experience violence at rates significantly
2 higher than other racial/ethnic groups, with studies indicating that more than 84% of AI/AN
3 women experience violence in their lifetimes, and AI/AN women are murdered at rates more
4 than ten times the national average in some regions¹; and

5
6 Whereas, the Missing and Murdered Indigenous Persons (MMIP) crisis represents an ongoing
7 epidemic of violence affecting American Indian and Alaska Native women, girls, Two-Spirit
8 individuals, and men across urban and rural communities²; and

9
10 Whereas, fragmented criminal justice data systems, inadequate interagency coordination
11 between federal, state, tribal, and local law enforcement, and jurisdictional complexities have
12 created significant barriers to reporting, investigating, and resolving cases of missing or
13 murdered Indigenous persons³; and

14
15 Whereas, the Bridging Agency Data Gaps and Ensuring Safety (BADGES) for Native
16 Communities Act (S.390, 119th Congress) passed the United States Senate unanimously on
17 December 15, 2025, and currently awaits consideration in the House of Representatives⁴; and

18
19 Whereas, the BADGES Act would require federal law enforcement agencies to report
20 comprehensively on cases of missing or murdered Indigenous persons, establish grant
21 programs to support coordination among tribal, state, and federal agencies, and mandate
22 improved data sharing between the FBI's National Crime Information Center and the National
23 Missing and Unidentified Persons System⁵; and

24
25 Whereas, Urban Indian Organizations are explicitly identified as eligible entities for the missing
26 or murdered response coordination grant program established by this legislation, recognizing
27 that urban Indigenous populations face heightened vulnerability to violence and trafficking⁶; and

28
29 Whereas, trauma-informed care practices that recognize historical trauma, cultural safety, and
30 the intersection of racism and misogyny can position healthcare providers to intervene before
31 tragic outcomes occur and support survivors with culturally appropriate resources⁵⁻⁷; and

32
33 Whereas, medical documentation of injuries and evidence of abuse can serve crucial roles in
34 law enforcement investigations, criminal prosecutions, and child protection proceedings related
35 to MMIP cases⁷; and

36
37 Whereas, the Not Invisible Act Commission Report of 2020 called for comprehensive federal
38 action to address the crises of MMIP and human trafficking of Indigenous persons, and the
39 bipartisan BADGES Act represents a direct legislative response to these recommendations⁴;
40 and

Whereas, existing AMA-MSS Policy 350.039 partially addresses the MMIP crisis via supporting emergency alert systems, demonstrating the medical student community's ongoing commitment to this public health emergency; therefore be it

RESOLVED, that our American Medical Association will collaborate with the American Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to encourage medical schools to integrate education on the Missing and Murdered Indigenous Persons (MMIP) crisis, trauma-informed care for Indigenous populations, violence screening protocols, and recognition of human trafficking indicators into medical education curricula. (New HOD Policy)

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

Date Received: 9/3/26

REFERENCES

1. Rosay AB. Violence Against American Indian and Alaska Native Women and Men: 2010 Findings from the National Intimate Partner and Sexual Violence Survey. National Institute of Justice Research Report. 2016. Available at: <https://nij.ojp.gov/library/publications/violence-against-american-indian-and-alaska-native-women-and-men>
2. Peters-Mosquera A, Bingham-Hendricks C, Woods C, Aronowitz T. The Role Nurses Can Play in Addressing and Preventing the Prevalence of Missing or Murdered Indigenous Women and Girls (MMIWG). J Transcult Nurs. 2023;34(6):431-442. doi:10.1177/10436596231198274
3. Congressional Budget Office. Cost Estimate: S. 390, BADGES for Native Communities Act. March 2025. Available at: <https://www.cbo.gov/publication/61715>
4. National Council of Urban Indian Health. NCUIH-Endorsed Bipartisan Legislation Aimed at Strengthening Tribal Public Safety Passes Senate. December 17, 2025. Available at: <https://ncuih.org/2025/12/17/ncuih-endorsed-bipartisan-legislation-aimed-at-strengthening-tribal-public-safety-passes-senate/>
5. Indian Health Service. Outlining the Intersection between Health Care and Missing and Murdered Indigenous People. IHS Blog, May 2024. Available at: <https://www.ihs.gov/newsroom/ihs-blog/may-2024-blogs/outlining-the-intersection-between-health-care-and-missing-and-murdered-indigenous-people/>
6. Tribal Health. 8 Ways Healthcare Can Support the Missing and Murdered Indigenous People Movement. April 28, 2025. Available at: <https://tribalhealth.com/mmip/>
7. Indian Health Service. American Indian and Alaska Native Patients & Medical Forensic Examination Considerations Guidebook. January 2025. Available at: https://www.ihs.gov/sites/forensichealthcare/themes/responsive2017/display_objects/documents/aianmfeconsiderationsguidebook012025.pdf

RELEVANT [AMA POLICY](#)

Family and Intimate Partner Violence H-515.965

Our American Medical Association believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations.

Missing and Murdered Indigenous Persons H-350.938

Our American Medical Association supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on tribal reservations and elsewhere.

Missing Children Identification H-60.996

Our American Medical Association supports development of a means of identifying children.

Our AMA supports education of the public and parents on the fingerprinting and documentation of characteristic identifying marks as a matter of record, should it be necessary to assist officials in locating a missing child.

Commercial Exploitation and Human Trafficking of Minors H-60.912

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-26)

Introduced by: Medical Student Section, American Academy of Ophthalmology, Resident and Fellow Section

Subject: Transparent Visiting Rotation Fee Disclosure

Referred to: Reference Committee C

Whereas, away rotations remain an important component of the residency application and admissions process^{1,2}; and

Whereas, while students applying through the Visiting Student Learning Opportunities (VSLO) program pay a \$15 fee for each individual program application, host institutions may directly charge visiting students additional fees before and after acceptance into an away rotation³; and

Whereas, AAMC survey data show that 25.6% of students reported spending more than \$1,500 out of pocket on away rotations and 17.4% reported spending more than \$2,500^{1,2}; and

Whereas, reports continue to identify wide fee ranges, hidden fees, and differences in fees for MD and DO students⁴⁻⁷; and

Whereas, when mandatory visiting rotation fees are not publicly disclosed, students may be unable to compare the full cost of electives in advance, making budgeting, scheduling, and applying increasingly difficult⁴⁻⁸; therefore be it

RESOLVED, that our American Medical Association supports efforts to ensure transparent preapplication disclosure of all mandatory fees and expenses associated with visiting student rotations, including fees assessed through centralized application platforms and by host institutions, such that those fees and expenses are specific, well-defined, and available to applicants before application submission. (New HOD Policy)

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

Date Received: 9/3/26

REFERENCES

1. Association of American Medical Colleges. Program by the numbers. AAMC. Accessed March 15, 2026. <https://students-residents.aamc.org/media/15621/download>
2. American Medical Association. Answering top medical student questions about away rotations. AMA. Published June 4, 2025. Accessed March 15, 2026. <https://www.ama-assn.org/medical-students/clinical-rotations/answering-top-medical-student-questions-about-away-rotations>
3. Association of American Medical Colleges. VSLO Frequently Asked Questions. AAMC. Accessed March 15, 2026. <https://students-residents.aamc.org/visiting-student-learning-opportunities/vslo-frequently-asked-questions>
4. Association of American Medical Colleges. The VSLO Program FAQs. AAMC. Accessed March 15, 2026. <https://www.aamc.org/services/vslo-institutions/vslo-program-faqs>
5. American Medical Association Council on Medical Education. Investigation of Existing Barriers for Osteopathic Medical Students Applying for Away Rotations. CME Report 5-N-21. 2021. Accessed March 15, 2026. <https://www.ama-assn.org/system/files/n21-cme05.pdf>
6. Modica A, Kazimierczak A, Klein BJ, White PB, Bitterman AD, Cohn RM. Revisiting differences in fourth-year orthopaedic away rotation opportunities and fees among allopathic and osteopathic medical students. JBJS Open Access. 2024;9(3):e24.00041. doi:10.2106/JBJS.OA.24.00041

7. Moza MM, Guarneri BD, Morrison L, Allgood L. Exploring the cost and access gap between osteopathic and allopathic medical students when applying for general surgery fourth-year away rotations. *Cureus*. 2025;17(3):e80402. doi:10.7759/cureus.80402
8. Bisch EJ, Sidhu AS, Ruiz de Luzuriaga A. Estimated financial costs of dermatology away rotations across U.S. metropolitan regions. *Journal of the American Academy of Dermatology*. Published online June 2026. doi:10.1016/j.jaad.2026.06.054

RELEVANT [AMA POLICY](#)

H-295.876 Equal Fees for Osteopathic and Allopathic Medical Students

Our AMA: (1) discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training; (2) encourages equitable access to and equitable fees for clinical electives for allopathic and osteopathic medical students; and (3) encourages the AAMC and ACGME to promote equitable access to clinical electives and equitable fees for visiting allopathic and osteopathic medical students. [Res. 809, I-05; Appended: CME Rep. 6, A-07; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 303, I-19; Modified: CME Rep. 5, I-21; Modified: CME Rep. 1, A-22]

H-305.925 Principles of and Actions to Address Medical Education Costs and Student Debt

Our AMA encourages medical schools to ensure that all medical student fees are earmarked for specific and well-defined purposes and to avoid charging overly broad or ill-defined fees; additionally, our AMA continues to monitor opportunities to reduce additional expense burden upon medical students. [CME Rep. 4, A-94; Reaffirmed: Sub. Res. 712, I-94; Modified: Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: Res. 301, A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: CME Rep. 02, A-19; Reaffirmed: Res. 310, I-22; Reaffirmed in lieu of: Res. 302, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-26)

Introduced by: Women Physicians Section, Resident and Fellow Section

Subject: Promoting Transparency on Fertility Healthcare Policies for Trainees

Referred to: Reference Committee C

1 Whereas, physicians have children later than non-physicians, face greater fertility challenges,
2 and suffer from higher rates of age-related pregnancy complications,^{1,2} the average entering
3 age in medical school is now 24,³ and as of 2024 data, more matriculants than ever were aged
4 30 or above, there is now a greater likelihood that residents will try to have children during their
5 training periods; and
6

7 Whereas, at the same time, surgical specialties are seeking to increase female applicants, but
8 medical students and residents report a lack of transparency or formal policies surrounding
9 parental leaves, barriers due to workplace cultures, and hesitancy in asking about these
10 policies⁴; and
11

12 Whereas, there have been significant strides in leave rights for resident trainees, such as the
13 American Board of Medical Specialties (ABMS) Policy of Parental, Caregiver, and Medical
14 Leave During Training in 2020,⁵ yet significant variation exists on how residency programs may
15 choose to implement these policies based on culture, program capacity, and specialty; and
16

17 Whereas, there have been significant strides in leave rights for resident trainees, such as the
18 American Board of Medical Specialties (ABMS) Policy of Parental, Caregiver, and Medical
19 Leave During Training in 2020,⁵ yet significant variation exists on how residency programs may
20 choose to implement these policies based on culture, program capacity, and specialty; and
21

22 Whereas, residents express a strong preference for transparent and standardized presentations
23 of leave and fertility policies through objective methods, such as slide decks, brochures, or
24 accessible web resources⁶, while per a 2023 study, only 66% of top 50 ranked institutions with
25 residency training displayed publicly available medical benefits and only 40% had publicly
26 available fertility benefit information on their website⁷; and
27

28 Whereas, family planning and lifestyle considerations, including clear parental leave information,
29 are among the most influential factors for medical students when selecting and ranking
30 residency programs,⁸ and the availability and transparency of these policies are increasingly
31 critical in shaping residency decisions for applicants⁹; and
32

33 Whereas, the AMA's support for increased leave and fertility preservation or infertility policies
34 via Resolution H-310.92 "Resident and Fellow Access to Fertility Preservation"¹⁰—by not
35 including advocacy for disclosure of said policies—does not enhance an applicant's ability to
36 discriminate across residency programs without risking harm to their applications in the
37 residency process through potential discrimination; and
38

39 Whereas, specific advocacy toward transparency on leave and fertility policies has the potential
40 to incentivize diversity in recruitment efforts, particularly across surgical specialties; and

Whereas, disclosure initiatives may incentivize programs to adopt stronger leave and/or fertility benefits to recruit a more diverse applicant pool and better manage potential disruptions to training; therefore be it

RESOLVED, that our American Medical Association amend existing policy H-310.902 “Resident and Fellow Access to Fertility Preservation” by addition:

1. Our American Medical Association encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs.
2. Our AMA encourages residency programs to disclose family planning and fertility health insurance policies
3. Our AMA supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion.

(Modify Current HOD Policy)

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

Received: 9/16/26

REFERENCES

1. Boyle P, By, Boyle P, Writer SS, 12 Dec. At medical schools, fewer apply but class sizes grow. AAMC. December 12, 2023. Accessed August 3, 2024. <https://www.aamc.org/news/medical-schools-fewer-apply-class-sizes-grow>. Click or tap here to enter text.
2. Ebernella Shirin Dason M. Medical students’ perspectives on family planning and impact on specialty choice. JAMA Surgery. February 1, 2024. Accessed August 3, 2024. <https://jamanetwork.com/journals/jamasurgery/fullarticle/2813027>.
3. Murphy B. Going directly from college to medical school: What it takes. American Medical Association. August 15, 2019. Accessed August 3, 2024. <https://www.ama-assn.org/medical-students/preparing-medical-school/going-directly-college-medical-school-what-it-takes>.
4. Samuel N, McQueen SA, Barnett RR, et al. Parenting and Childbearing in Neurosurgical Residency: Perspectives from the United States and Canada. J Surg Educ. 2023;80(4):572-580. doi:10.1016/j.jsurg.2023.01.004
5. American Board of Medical Specialties. ABMS Announces Progressive Leave Policy for Residents and Fellows. Accessed August 21, 2024. <https://www.abms.org/newsroom/abms-announces-progressive-leave-policy-for-residents-and-fellows/#policy>
6. Baniel CC, Qu V, Ponce SB, et al. Support: Survey of parental leave policies of radiation oncology programs and residency applicants. Advances in radiation oncology. March 1, 2023. Accessed August 24, 2024. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10130339/>.
7. Rasouli MA, Barrett F, Levy MS, et al. Publicly available information about fertility benefits for trainees at medical schools in the US. J Assist Reprod Genet. 2023;40(6):1313-1316. doi:10.1007/s10815-023-02849-1
8. Baniel CC, Qu V, Ponce SB, et al. SUPPORT: Survey of Parental Leave Policies of Radiation Oncology Programs and Residency Applicants. Adv Radiat Oncol. 2023;8(4):101207. Published 2023 Mar 1. doi:10.1016/j.adro.2023.101207
9. Kraus MB, Reynolds EG, Maloney JA, et al. Parental leave policy information during residency interviews. BMC medical education. December 18, 2021. Accessed August 24, 2024. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8684616/#CR6>.
10. Resident and Fellow Access to Fertility Preservation H-310.902. AMA Policy Finder. <https://policysearch.ama-assn.org/policyfinder/detail/fertility%20preservation?uri=%2FAMADoc%2FHOD.xml-H-310.902.xml>. Accessed June 3, 2026.

RELEVANT AMA POLICY

H-310.902 Resident and Fellow Access to Fertility Preservation

1. Our American Medical Association encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs.
2. Our AMA supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion. [Res. 302, A-22]

H-295.846 Increased Education and Access to Fertility Resources for U.S. Medical Students

1. Our American Medical Association will encourage interested parties to develop gender- and sexual minority-inclusive initiatives in medical education that raise awareness about:
 1. how peak child-bearing years correspond to the peak career-building years for many medical students and trainees;
 2. the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age in medical students and trainees;
 3. the high rate of infertility among medical students, trainees, and physicians; and
 4. various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs.
2. Our AMA will encourage interested parties to increase access to strategies by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage. [Res. 306, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(I-26)

Introduced by: Resident and Fellow Section

Subject: Update on Financial Transparency of the Revenue Generated by Trainees at Health Systems

Referred to: Reference Committee C

1 Whereas, a 2025 NEJM review by Walensky and McCann examined challenges to the
2 physician workforce, discussing GME funding mechanisms and the bottleneck created by
3 limited federally funded residency positions;¹ and
4

5 Whereas, Medicare spent \$16.2 billion on GME in 2020, and 15,000 new residency slots have
6 been created in the past 20 years outside of federal funding, suggesting hospitals find economic
7 value in resident training even without full federal support;¹ and
8

9 Whereas, the review also highlighted that the 2014 Institute of Medicine recommendations for
10 GME reform (including pay-for-performance models) have seen little progress due to opposition
11 from hospital associations that benefit from current funding structures;¹ and
12

13 Whereas, a 2025 JAMA Viewpoint by Frederick and colleagues offered their perspective on the
14 financial pressures facing teaching hospitals amid rising resident unionization and it was noted
15 that more than one-third of US hospitals are operating at negative margins, with hospital
16 revenue failing to keep pace with inflation and Medicare physician payment rates falling by
17 approximately 30% since 2001 (adjusted for inflation);² and
18

19 Whereas, concerns were raised in the Viewpoint including that as resident compensation costs
20 rise through union negotiations, hospitals may find alternatives, such as advanced practice
21 clinicians, more financially viable, potentially leading to program cuts;² and
22

23 Whereas, neither of these papers provides any meaningful change in the previous conclusion
24 that the economic value residents create clearly exceeds the current level of resident
25 compensation, with resident compensation being largely distorted due to a lack of effective
26 market forces; and
27

28 Whereas, further characterization of this value, however, is difficult to meaningfully assess in
29 greater granularity due to a lack of available data, a lack of comparability across specialties, and
30 heterogeneity in training program structures and healthcare market economics, both within and
31 across healthcare systems; and
32

33 Whereas, efforts to create such a standard that would allow for meaningful comparison
34 universally across all programs are beyond the scope of the AMA, ACGME, or any identifiable
35 agency or organization as it would require forcing a universal accounting standard far more
36 stringent and prescriptive than GAAP or the existing tax code; therefore be it
37

38 RESOLVED, that our American Medical Association study the feasibility of quantifying the direct
39 and indirect revenue generated by resident and fellow physicians for their sponsoring institution,

- 1 including the development of standardized methodologies for such estimation, and develop
- 2 recommendations regarding whether and how such data should be transparently reported to
- 3 training institutions, accrediting bodies, and the public. (Directive to Take Action)

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

Received: 9/16/26

REFERENCES

1. Walensky RP, McCann NC. Challenges to the Future of a Robust Physician Workforce in the United States. *N Engl J Med.* 2025;392(3):286-295. doi:10.1056/NEJMSr2412784.
2. Frederick PJ, Seshadri M, Zsiros E, McLean K. Reflections on Medical Trainee Unions and Health Care Systems. *JAMA.* 2025;333(12):1043-1044. doi:10.1001/jama.2025.14762.

RELEVANT AMA POLICY

Financing of Medical Education Programs D-305.973

1. Our American Medical Association will work with the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
 - a. Ensure adequate Medicaid and Medicare funding for graduate medical education.
 - b. Ensure adequate Disproportionate Share Hospital funding.
 - c. Make the Medicare direct medical education per-**resident** cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions.
 - d. Revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings.
 - e. Stabilize funding for pediatric residency training in children's hospitals.
 - f. Explore the possibility of extending full direct medical education per-**resident** payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need.
 - g. Identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
 - h. Act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose.
2. Our AMA will work with other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-26)

Introduced by: Resident and Fellow Section

Subject: Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners

Referred to: Reference Committee C

Whereas, “neurodivergence” refers to natural variations in human brain function, where individuals learn and process information differently and is an umbrella term that includes autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), dyslexia, and dyspraxia, as well as individuals without criteria for a formal clinical diagnosis. These differences can involve cognitive processing, social communication, executive functioning, and sensory perception, with an estimated 15-20% of the global population considered neurodivergent¹; and

Whereas, neurodivergence may affect the way individuals engage with clinical environments. While medicine is a cognitively and sensorially demanding field, neurodivergence is not synonymous with “disability” or “impairment,” and does not inherently restrict one’s capability as a physician; and

Whereas, the cognitive and emotional demands of medicine require sustained attention, complex reasoning, rapid decision-making, and emotional regulation, leaving little space for cognitive variation. Neurodivergent learners must navigate hierarchical training systems, high-stakes clinical environments and interpersonal dynamics while maintaining patient safety and as a result, they frequently encounter disproportionate barriers that affect performance and success²; and

Whereas, school and workplace environments may exclude and stigmatize neurodivergent learners, as their actions are met with negative reactions and in order to avoid negative stigma, neurodivergent learners often hide their behaviors and personify ‘neurotypical behaviors’ which can lead to burnout, mental stress, and feeling disconnected from themselves²; and

Whereas, challenges faced by neurodivergent learners include written exams, which affect those with dyslexia, managing social situations, and planning independent self-study^{4,5}; and

Whereas, neurodiversity adds value to medical education and healthcare systems. Diverse workplaces perform better by incorporating a wider range of perspectives⁵; and

Whereas, in 2022 and 2023, 5.9% of residency-match registered learners self-reported a disability⁶, and are required to have “reasonable accommodations” in Accreditation Council for Graduate Medical Education (ACGME) accredited training programs; and

Whereas, while the ACGME provides resources and guidance for programs to draft disability policies⁷, there is no oversight of the outcome of these policies and institutions ultimately determine what constitutes reasonable accommodations, how accessible processes are, and whether these policies are publicly available^{8,9}; and

Whereas, accommodations for disabilities may include wheelchair accessible space, scheduled breaks, flexible time for medical appointments, and a flexible jeopardy pool but while many institutions provide accommodations for trainees with disabilities, support is often fragmented across multiple offices, reflecting trainees' dual roles as learners and employees and this lack of coordination creates administrative burden, unclear accountability, and inconsistent access, underscoring the need for centralized, clearly defined systems; and

Whereas, unlike traditional disabilities, neurodivergence is not necessarily a medical diagnosis, complicating eligibility for accommodations and fear of stereotypes and stigma related to disability labels^{10,11,12} may lead neurodivergent learners in medical training to avoid obtaining a diagnosis, disclosing their condition, and completing accommodation requests; and

Whereas, supporting neurodivergent learners in medical training requires shifting from reactive, individual accommodations, towards a proactive, inclusive training design and organizational culture and leadership are equally critical in shaping inclusive training environments¹³; and

Whereas, institution-wide efforts should include collaboration with neurodiverse trainees and allies, along with neurodiversity-inclusive hiring and visible role models to enhance representation and support career advancement¹⁴; and

Whereas, programs may also consider developing proactive consultation models, where trainees can engage with support services without requiring formal disability disclosure, thereby lowering the threshold for accessing assistance¹⁵⁻¹⁶; therefore be it

RESOLVED, that our American Medical Association support efforts to improve accessibility and transparency of accommodation processes for neurodivergent learners in medical training by:

- (1) Encouraging residency and fellowship programs to provide clear guidance regarding procedures for requesting educational accommodations;
- (2) Promoting faculty education and educational resources on teaching, supervising, and evaluating neurodivergent learners; and
- (3) Encouraging collaboration between graduate medical education programs and institutional disability resource professionals and related specialists to support individualized accommodation planning for neurodivergent learners in medical training.

(New HOD Policy)

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

Received: 9/16/26

REFERENCES

1. Doyle N. Neurodiversity at work: a biopsychosocial model and the impact on working adults. *Br Med Bull*. 2020;135(1):108-125. doi:10.1093/bmb/ldaa021
2. Barel M, Javaid A. Supporting neurodiverse junior doctors: challenges, strategies, and policy implications for inclusive medical training. *Cureus*. 2026;18(3):e104746. doi:10.7759/cureus.104746
3. Thapar A, Rutter M, Cooper M. Neurodevelopmental disorders. *Lancet Psychiatry*. 2017;4:339-346. doi:10.1016/S2215-0366(16)30376-5
4. Hamilton LG, Petty S. Compassionate pedagogy for neurodiversity in higher education: a conceptual analysis. *Front Psychol*. 2023;14:1093290. doi:10.3389/fpsyg.2023.1093290
5. Hamilton RH, Williams ZJ, Brodtkin ES. Embracing neurodiversity in medicine—building a more inclusive physician workforce. *JAMA*. 2025;333(12):1030-1031. doi:10.1001/jama.2025.0094
6. Nguyen M, Meeks LM, Sheets ZC, et al. Outcomes of the main residency match for applicants with disability. *JAMA*. 2024;331(18):1590-1592. doi:10.1001/jama.2024.5000
7. ACGME. Disability Policy Toolkit. 2024. Accessed April 4, 2026. <https://dl.acgme.org/pages/disability-resource-hub-policy-toolkit>
8. Green E, Volpe KA. From policy to practice: building the disability inclusion infrastructure in graduate medical education. *Acad Med*. 2025;100(10S suppl 1):S184-S187. doi:10.1097/ACM.00000000000006127
9. Meeks LM, Taylor N, Case B, et al. The unexamined diversity: disability policies and practices in US graduate medical education programs. *J Grad Med Educ*. 2020;12(5):615-619. doi:10.4300/JGME-D-19-00940.1

10. Syharat CM, Hain A, Zaghi AE, Gabriel R, Berdanier CGP. Experiences of neurodivergent students in graduate STEM programs. *Front Psychol.* 2023;14:1149068. doi:10.3389/fpsyg.2023.1149068
11. Pereira-Lima K, Meeks LM, Ross KET, et al. Barriers to disclosure of disability and request for accommodations among first-year resident physicians in the US. *JAMA Netw Open.* 2023;6(5):e239981. doi:10.1001/jamanetworkopen.2023.9981
12. Rees S, Cohen D, Marfell N, Robling M. Doctors' decisions when disclosing their mental ill-health. *Occup Med (Lond).* 2019;69(4):258-265. doi:10.1093/occmed/kqz062
13. Belak T, Waddington K. What constitutes a compassionate university? In: Waddington K, ed. *Towards the Compassionate University: From Golden Thread to Global Impact.* Routledge; 2021:170-190.
14. Sarrett JC. Autism and accommodations in higher education: insights from the autism community. *J Autism Dev Disord.* 2018;48:679-693. doi:10.1007/s10803-017-3353-4
15. Kim SY, Crowley S. Understanding perceptions and experiences of autistic undergraduate students toward disability support offices of their higher education institutions. *Res Dev Disabil.* 2021;113:103943. doi:10.1016/j.ridd.2021.103943
16. Sulik J, Bahrami B, Deroy O. The diversity gap: when diversity matters for knowledge. *Perspect Psychol Sci.* 2022;17(3):752-767. doi:10.1177/17456916211006070

RELEVANT AMA POLICY

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990

1. Our American Medical Association urges that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing “organic” standards with “functional” standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.
2. Our AMA urges all medical schools and GME institutions to:
 - a. Make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services.
 - b. Encourage students and trainees to avail themselves of any needed support services.
 - c. Foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services[...]. [CME Rep. 2, I-21; Appended - BOT Action in response to referred for decision: Res. 314, A-21; Appended: Res. 302, I-23]

Advocacy for Physicians and Medical Students with Disabilities D-615.977

Our AMA will: (1) establish an advisory group composed of AMA members who themselves have a disability to ensure additional opportunities for including physicians and medical students with disabilities in all AMA activities; (2) promote and foster educational and training opportunities for AMA members and the medical community at large to better understand the role disabilities can play in the healthcare work environment, including cultivating a rich understanding of so-called invisible disabilities for which accommodations may not be immediately apparent; (3) develop and promote tools for physicians with disabilities to advocate for themselves in their own workplaces, including a deeper understanding of the legal options available to physicians and medical students to manage their own disability-related needs in the workplace; and (4) communicate to employers and medical staff leaders the importance of including within personnel policies and medical staff bylaws protections and reasonable accommodations for physicians and medical students with visible and invisible disabilities. [BOT Rep. 19, I-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(I-26)

Introduced by: Resident and Fellow Section

Subject: Disparities in Preliminary and Transitional Year GME Funding

Referred to: Reference Committee C

1 Whereas, the Association of American Medical Colleges (AAMC) notes that more medical
2 school students and graduates are becoming unmatched¹; and
3

4 Whereas, the number of medical school seats has outpaced the number of residency spots,
5 which disadvantages osteopathic (DO) students and international medical graduates (IMGs). A
6 significant number of unmatched students and physicians enter standalone Preliminary Year
7 (PY) and Transitional Year (TY) programs to complete a PGY-1 intern year, which serve as
8 opportunities to improve their clinical skills and network while re-entering the match; and
9

10 Whereas, PY programs contain a broad-based clinical PGY-1 year. A medical school graduate
11 may match via the NRMP into a PY program alone or may simultaneously match into a
12 specialized program to continue on to as a PGY-2; and
13

14 Whereas, several specialties require a PY program prior to entering into the specialized PGY-2
15 year (i.e. anesthesiology, dermatology, diagnostic and interventional radiology, neurology,
16 physical medicine & rehabilitation, and radiation oncology). PY programs usually include
17 Medicine-Preliminary, Surgery-Preliminary, and TY programs. OB/GYN-Preliminary and
18 Pediatrics-Preliminary are rare; and
19

20 Whereas, TY programs are PY programs designed for unmatched medical school graduates²
21 and TY programs provide multispecialty exposure including surgery and internal medicine to
22 "enter a specialty where a thorough understanding of pathology, physiology and surgical
23 procedures are necessary"³; and
24

25 Whereas, during each year spent in a TY program, participants can continue to enroll in NRMP
26 and re-enter the match to join a residency program as a PGY-1; and
27

28 Whereas, Centers for Medicare & Medicaid Services (CMS) provides hospital funding for
29 residents and fellows through Medicare. Graduate Medical Education (GME) funding for
30 resident positions is determined by federal regulation CFR 42 § 413.79⁴; and
31

32 Whereas, direct GME (DGME) funding supports resident salary, benefits, and teaching costs,
33 using the Initial Residency Period (IRP) to determine funding,⁴ and IRP is the expected duration
34 for a resident to complete their first primary specialty and become board certified¹; and
35

36 Whereas, during the IRP, residents have 100% DGME funding. For all years after IRP,
37 residents and fellows have 50% DGME funding¹. Medicare Payment Advisory Commission
38 (MedPAC) is an independent congressional agency that advises the U.S. Congress on issues
39 affecting the Medicare program; and

Whereas, MedPAC's 2001 report argues that the IRP should discourage "any unnecessary lengthening of training by individual residents and residency programs as well as multiple specialization and perpetual training."⁶; and

Whereas, MedPAC recognizes that the IRP-based federal funding may disadvantage certain applicants. Such applicants include Medicine-Preliminary interns, residents/fellow/attending physicians wanting to switch specialties, and residents/fellows who take an unexpectedly longer time to become board certified (e.g. extended leaves of absence)⁶ and programs who consider these applicants will not receive full DGME funding; and

Whereas, given that programs have a funding incentive to minimize the number of years without full DGME years, programs may rank the Surgery-Preliminary applicant higher than the Medicine-Preliminary applicant for budgetary reasons. This is the primary regulatory mechanism that the original authors of RFS resolution 10 argue drives inequity and unmatched rates and as a result, system-level design - not trainee merit - financially drives opportunity and training continuity; therefore be it

RESOLVED, that our American Medical Association study the impact of current Initial Residency Period (IRP)-based GME funding policies on residency applicant selection, match outcomes, and career trajectories, including impacts on graduates of preliminary and transitional year programs and on populations disproportionately represented among unmatched applicants, such as international medical graduates (IMGs) and osteopathic (DO) graduates, and report back. (Directive to Take Action)

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

Received: 9/16/26

REFERENCES

1. Association of American Medical Colleges. *Medicare payments for graduate medical education: what every medical student, resident, and advisor needs to know*. Published April 2025. Accessed April 4, 2026. <https://www.aamc.org/media/71701/download?attachment>
2. Gathright MM, Hankins J, Siddiqui MZ, Thrush CR, Atkinson T. A transitional year residency program provides innovative solutions for unmatched medical students. *J Grad Med Educ*. 2021;13(4):561-568. doi:10.4300/JGME-D-20-01231.1
3. American Medical Association. Transitional year programs with the most residency positions. Published February 26, 2026. Accessed April 4, 2026. <https://www.ama-assn.org/medical-students/preparing-residency/transitional-year-programs-most-residency-positions>
4. Electronic Code of Federal Regulations. Direct GME payments: determination of full-time equivalent residents. 42 CFR § 413.79. Accessed April 4, 2026. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-F/section-413.79>
5. Medicare Payment Advisory Commission. Treatment of the initial residency period in Medicare's direct graduate medical education payments. In: *Report to the Congress: Medicare payment policy*. Published March 2001. Accessed April 4, 2026. https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-mar01_entire_report-pdf/

RELEVANT AMA POLICY

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our American Medical Association will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA:
 - a. recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed.
 - b. will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda.
 - c. will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.

17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education

teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will:

- a. encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans.
- b. strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation.
- c. encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

35. Our American Medical Association will ask federal agencies that fund graduate medical education (including but not limited to the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Department of Defense, the Health Resources and Services Administration, and others) to issue an annual report detailing the quantity of total GME funding for each year including how Direct GME funds are allocated on a per resident or fellow basis, for the previous year.

H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs

1. It is AMA policy that:

- A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
- B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
- C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
- D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
- E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
- F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.

G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.

H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

I. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.

2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.

3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.

4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.

5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.

H-310.917 Securing Funding for Graduate Medical Education

1. Our AMA continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities).
2. Our AMA continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation.
3. Our AMA encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs.
4. Our AMA encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

H-200.949 Principles of and Actions to Address Primary Care Workforce

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate

reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911
(I-26)

Introduced by: Underrepresented in Medicine Advocacy Section

Subject: Annual Alcohol Report and Comprehensive Review of AMA Alcohol Policy

Referred to: Reference Committee K

1 Whereas, alcohol remains a leading preventable cause of morbidity, mortality, injury, and health
2 inequities in the United States, contributing substantially to chronic disease, cancer, mental
3 illness, violence, motor vehicle crashes, and healthcare expenditures;¹⁻³ and
4

5 Whereas, the American Medical Association has adopted extensive policy related to alcohol
6 prevention, treatment, impaired driving, youth access, advertising, and public health, yet these
7 policies have developed over decades without a recurring mechanism to evaluate emerging
8 evidence, monitor implementation, or identify gaps and opportunities for coordinated advocacy;
9 and
10

11 Whereas, the AMA currently produces an Annual Tobacco Report that summarizes emerging
12 scientific evidence, policy developments, litigation, regulatory activities, and AMA advocacy,
13 providing the House of Delegates with an ongoing assessment of national tobacco control
14 efforts and informing future policy priorities; therefore be it
15

16 RESOLVED, that our American Medical Association produce an Annual Alcohol Report that
17 summarizes significant developments including, but not limited to, alcohol-related epidemiology,
18 public health, clinical and policy evidence, federal and state policy, litigation, regulation,
19 commercial practices, and AMA advocacy activities (Directive to Take Action); and be it further
20

21 RESOLVED, that our AMA conduct a comprehensive review of existing AMA alcohol policy and
22 identify opportunities to modernize, strengthen, coordinate, and align our alcohol policy portfolio
23 with current scientific evidence and evolving public health priorities, including evidence-based
24 population-level prevention strategies, alcohol industry marketing and commercial practices,
25 alcohol availability and affordability, and other policy interventions demonstrated to reduce
26 alcohol-related harms. (Directive to Take Action)

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

Received: 09/14/26

REFERENCES

1. George S, Naimi TS, Keyes K, et al. Alcohol Intake and Health Study: No Protective Effect at Low Levels, With Mortality Increasing to 1 in 25 at 14 Drinks Per Week. *Journal of Studies on Alcohol and Drugs*. 2026;87(4):621-638. doi:10.15288/jsad.25-00435
2. National Institute on Alcohol Abuse and Alcoholism. Alcohol's effects on health. National Institutes of Health. Accessed August 9, 2026. <https://www.niaaa.nih.gov/alcohols-effects-health>
3. Centers for Disease Control and Prevention. Alcohol use. Accessed August 9, 2026. <https://www.cdc.gov/alcohol/index.html>

RELEVANT AMA POLICY

Annual Tobacco Report 2003 D-490.983

Our American Medical Association will continue to produce the Annual Tobacco Report.