2026 AMA Medical Student Section (MSS) Interim Meeting
Orlando, FL
November 5-6

Policy Materials

If you do not have the link to the MSS I-26 Assembly Microbrick and/or are not part of the I-26 Business Groupme and your Region Groupme. Please email amamedstudents@gmail.com.

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AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 001
(I-26)

Introduced by: Lucas Tang[1], Sanjay V. Neerukonda[2]

Affiliations: [1]Western University of Health Sciences COMP-NW
[2]McGovern Medical School at UTHealth

Subject: Disability Equity Standards for Clinical Augmented Intelligence

Sponsored by: (Leave Blank)

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, persons with disabilities represent approximately 16% of the global population and experience persistent healthcare disparities, including barriers to healthcare access, communication barriers, and inequities resulting from structural barriers within healthcare systems[1]; and

Whereas, augmented intelligence (AI) are increasingly being incorporated into clinical practice, including diagnostic decision support, risk prediction, clinical workflow optimization, imaging interpretation, and population health management[2]; and

Whereas, machine learning systems trained on historical healthcare data may reproduce or amplify existing healthcare disparities when datasets inadequately represent marginalized populations or when algorithmic performance is not evaluated across relevant patient groups[3,4]; and

Whereas, algorithmic bias in healthcare AI is well documented, and differences in training data, data quality, labeling practices, and model development have been found to produce unequal performance across patient populations, contributing to exacerbated healthcare disparities for people with disabilities[2,5,6]; and

Whereas, clinical algorithms have demonstrated biased outcomes, emphasizing the need for algorithmic auditing, transparency, explainability, and ongoing evaluation of augmented intelligence systems used in healthcare[7,8]; and

Whereas, current approaches to monitoring algorithmic discrimination frequently fail to identify harms specifically affecting people with disabilities because disability-related harms are highly individualized, heterogeneous, and often overlooked by aggregate statistical analyses, underscoring the need for disability-specific consideration during evaluation of artificial intelligence systems[9]; and

Whereas, studies evaluating clinical machine learning models have demonstrated that algorithm performance varies substantially across patient subgroups and that these disparities are frequently driven by characteristics of the underlying datasets, underscoring the importance of evaluating clinically people with disabilities during model validation rather than relying solely on aggregate performance metrics[10]; and

Whereas, disability-related information is frequently absent or inconsistently collected within healthcare datasets, limiting the ability to evaluate whether augmented intelligence systems perform equitably for patients with disabilities[1,11]; and

Whereas, current augmented intelligence fairness frameworks commonly evaluate disparities across race, ethnicity, sex, and socioeconomic status but less frequently evaluate disability-related algorithmic bias[12,13]; and

Whereas, despite existing AMA and MSS commitments to ethical augmented intelligence, health equity, transparency, and disability inclusion, no current AMA policy specifically addresses disability-specific algorithmic bias auditing, disability-stratified validation of clinical AI systems, or inclusion of disabled stakeholders in AI governance; and

Whereas, recent scholarship has concluded that improving representation of people with disabilities throughout AI development, validation, and governance is necessary to reduce algorithmic bias and promote equitable implementation of healthcare AI[3,4,14]; and

Whereas, scholars have argued that disability-inclusive artificial intelligence requires consideration of accessibility, participatory design, and health equity throughout the design, development, validation, and implementation of AI systems, rather than relying solely on post hoc assessments of algorithmic fairness[5]; and

Whereas, multidisciplinary experts have recommended that artificial intelligence systems be co-designed with individuals with disabilities and evaluated using inclusive design principles, recognizing that meaningful participation of people with lived experience improves accessibility, equity, and the performance of AI systems for diverse users[15]; and

Whereas, the disability rights principle of "Nothing About Us Without Us" recognizes that policies and technologies affecting persons with disabilities should be developed in meaningful partnership with people with disabilities, and recent guidance on disability-inclusive artificial intelligence similarly recommends involving persons with disabilities throughout the design, validation, implementation, and governance of AI systems to promote equitable and accessible outcomes[10]; therefore be it

RESOLVED, that our American Medical Association (AMA) partner with organizations representing people with disabilities to advocate for focused, disability-inclusive evaluation standards for augmented intelligence systems used in healthcare, including assessment of algorithmic performance across disability populations when clinically appropriate and methodologically valid.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Assessing the Intersection Between AI and Health Care H-480.931
Augmented Intelligence Development, Deployment, and Use in Health Care

1. General Governance
    1. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.
    2. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    3. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    4. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    5. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    6. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    7. Clinical decisions influenced by AI must be made with specified qualified human intervention points during the decision-making process. A qualified human is defined as a licensed physician with the necessary qualifications and training to independently provide the same medical service without the aid of AI. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a qualified human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
    8. Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.
    9. Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]
4. Generative Augmented Intelligence
    1. (...) Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed

datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
2. Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians and healthcare organizations should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
3. Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.
4. Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential. (...)

[BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25; Reaffirmed: Res. 505, A-26]

Augmented Intelligence in Health Care H-480.939
Our American Medical Association supports the use and payment of **augmented intelligence** (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of **care** and outcomes, improve population **health**, reduce overall costs for the **health care** system while increasing value, and support the professional satisfaction of physicians and the **health care** team. To that end our AMA will advocate that: …(1) Oversight and regulation of **health care** AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment….(7) Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate: (a) Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability. (b) Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are **in** the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and **in** their agreements with users. (c) **Health care** AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm…(9) There should be federal and state interagency collaboration with participation of the physician community and other stakeholders **in** order to advance the broader infrastructural capabilities and requirements necessary for AI solutions **in health care** to be sufficiently inclusive to benefit all patients, physicians, and other **health care** stakeholders. (New HOD Policy) [...]
[BOT Rep. 21, A-19; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 226, A-25]

Explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms D-480.954
1. To maximize the impact and trustworthiness of augmented intelligence and machine-learning (AI/ML) tools in clinical settings, our AMA recognizes that:
    1. Explainable AI with safety and efficacy data should be the expected form of AI tools for clinical applications, and exceptions should be rare and justified and require at minimum safety and efficacy data prior to their adoption or regulatory approval;
    2. To be considered "explainable," an AI device's explanation of how it arrived at its output must be interpretable and actionable by a qualified human. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer;
    3. Explainability should not be used as a substitute for other means of establishing safety and efficacy of AI tools, such as through randomized clinical trials; and
    4. Concerns of intellectual property (IP) infringement, when provided as rationale for not explaining how an AI device created its output, does not nullify a patient's right to transparency and autonomy in medical decision-making. While intellectual property

should be afforded a certain level of protection, concerns of infringement should not outweigh the need for explainability for AI with medical applications.

2. Our AMA will collaborate with experts and interested parties to develop and disseminate a list of definitions for key concepts related to medical AI and its oversight.

[CSAPH Rep. 08, A-25]

RELEVANT MSS POSITIONS

Machine Intelligence in Healthcare 480.034MSS
AMA-MSS (1) supports the use of machine intelligence as a complementary tool in making clinical decisions; (2) supports ethical, rapid development and deployment of machine intelligence research and machine learning techniques to improve clinical decision-making, including diagnosis, patient care, and health systems management;(3) supports partnerships with organizations actively developing machine intelligence and other appropriate groups to evaluate clinical outcomes, develop regulatory guidelines for the use of machine intelligence in healthcare, and ensure further developments will be beneficial to patients, physicians, and society; (4) encourages the education of medical students and physicians on the use of machine intelligence in healthcare; (5) supports increased utilization of the term "machine intelligence" rather than the term “artificial intelligence” when considering the use of computers to parse data, learn from it, and develop clinical guidelines or facilitate clinical decision-making. (MSS Res 37, I-17) (Jan 2025: Updated Position Section & Number to Technology: 480.032MSS from Television: 485.003MSS)

Improving Access to Telehealth for Those with Disabilities 90.009MSS
(1) AMA-MSS will ask the AMA to utilize virtual platforms that are accessible to all members, including those with hearing or visual impairment, by using resources such as closed- captioning, magnification, and screen readers;
(2) AMA-MSS will support policy ensuring technology companies produce telemedicine software/products that are accessible to persons with disabilities and in- line with the interpretation that ADA’s use of the phrase “public accommodation” is not limited to physical structures and may be extended to virtual spaces;
(3) AMA-MSS will ask the AMA to amend Policy D-90.992, Preserving Protections of the Americans with Disabilities Act of 1990, by addition as follows:

Preserving Protections of the Americans with Disabilities Act of 1990, D-90.992
1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability.
2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights.
3. Our AMA will develop educational tools and strategies to help physicians and institutions make their offices and telemedicine platforms more accessible to persons with disabilities, consistent with the Americans with Disabilities Act as well as any applicable state laws;
(4) AMA-MSS will ask the AMA to amend Policy H-90.971, Enhancing Accommodations for People with Disabilities by addition as follows:

Enhancing Accommodations for People with Disabilities, H-90.971
Our AMA encourages physicians to make their offices both physically and virtually accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.
(MSS Res 002, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 002
(I-26)

Introduced by: Jeffrey Gu[1], Sunnie Li[1]

Affiliations: [1] University of Virginia School of Medicine

Subject: Reforming Predispute Arbitration in Health Care

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, predispute binding arbitration agreements and class-action waivers are used in standardized patient-facing health care contracts, including health plan enrollment materials and health care service agreements[1,2]; and

Whereas, these provisions require patients to waive access to court, a jury trial, and ordinary judicial review for future disputes arising from contracted care[1,2]; and

Whereas, current 2026 Kaiser Permanente enrollment materials require California-region enrollees to sign an arbitration agreement covering claims related to plan membership, coverage, and delivery of services and expressly state that the enrollee gives up the right to a jury trial[3]; and

Whereas, in a 2024 survey, more than 99% of respondents who believed they had never entered an arbitration agreement likely had done so, and only 0.5% correctly understood the combined effect on rights to sue, obtain a jury trial, access public courts, join a class action, and appeal legal error[4]; and

Whereas, legal scholarship has observed that predispute arbitration clauses are frequently presented in standardized patient-intake contracts and that patients who decline may be required to forgo non-emergency treatment, raising concerns that such agreements may reflect unequal bargaining power rather than meaningful choice[5]; and

Whereas, recent litigation involving a Mississippi surgical clinic included testimony from clinic staff that patients were required to execute the arbitration agreement themselves and that the clinic would not treat a patient who refused to sign, further demonstrating that conditioning treatment on predispute arbitration remains a live concern outside the long-term care setting[6]; and

Whereas, Colorado prohibits providers from refusing medical care services solely because a patient refused to sign or rescinded such an agreement, and Illinois requires health care arbitration agreements to disclose that a patient cannot be required to sign in order to receive treatment[7,8]; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) already uses Medicare and Medicaid participation requirements to regulate predispute arbitration in long-term care facilities by prohibiting facilities from requiring an agreement as a condition of admission or continued care[9]; and

Whereas, in *Marmet Health Care Center, Inc. v. Brown*, the U.S. Supreme Court held that the Federal Arbitration Act preempted West Virginia's categorical rule prohibiting predispute arbitration of personal-injury and wrongful-death claims against nursing homes, demonstrating that state-level categorical restrictions may be displaced by federal law and supporting federal action to establish consistent patient protections[10]; and

Whereas, Congress recently reintroduced the Forced Arbitration Injustice Repeal Act, presenting an active federal advocacy opportunity relevant to patient-facing health care contracts[11]; and

Whereas, AMA Policy H-435.945 supports predispute binding arbitration agreed to by a patient and physician before non-emergent treatment as an effective method of conflict resolution, demonstrating that the ethical concern is not arbitration itself but whether agreement is voluntary and meaningfully informed[12]; and

Whereas, AMA policy supports voluntary patient-physician arbitration, opposes insurers requiring binding arbitration as a condition of physician network participation, and opposes mandatory predispute arbitration in prior-authorization disputes, but does not address institutional entities requiring patients to arbitrate as a condition of coverage, admission, or care[12–14]; therefore be it

RESOLVED, that our American Medical Association supports federal policies prohibiting any health care facility, health plan, or other corporate health care entity from requiring a patient to execute a predispute binding arbitration agreement or predispute class-action waiver as a condition of receiving health care services, admission, enrollment, or continued care; and be it further

RESOLVED, that our AMA affirms that predispute binding arbitration agreed to by patients and physicians before non-emergent treatment can be an ethical and effective method of conflict resolution, when the agreement is voluntary, separately presented from clinical consent, clearly discloses the rights waived, confirms patient understanding, provides for mutual selection of a neutral arbitrator and convenient venue, and permits a reasonable period for rescission.

Fiscal Note: TBD

Date Received: 09/06/2026

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7. Colo. Rev. Stat. § 13-64-403. Agreement for medical services—alternative arbitration procedures—right to rescind.
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9. 42 C.F.R. § 483.70(m). Binding arbitration agreements for long-term care facilities.

10. Marmet Health Care Center, Inc. v. Brown, 565 U.S. 530 (2012).
11. 119th Congress. H.R. 5350, Forced Arbitration Injustice Repeal Act of 2025, and S. 2799, Forced Arbitration Injustice Repeal Act. Introduced September 15, 2025.
12. American Medical Association. Policy H-435.945, Binding Arbitration. In: June Special House of Delegates Meeting Handbook Addendum. 2021.
13. American Medical Association House of Delegates. Board of Trustees Report 14-A-26, Binding Arbitration in Health Insurance Contracts. Adopted as amended, 2026 Annual Meeting.
14. American Medical Association. Directive D-320.974, Insurer Accountability When Prior Authorization Harms Patients.

RELEVANT AMA POLICY

Binding Arbitration H-435.945
Our AMA supports the utilization of pre-dispute binding arbitration that is agreed to by a patient and a physician prior to non-emergent treatment as an effective method of doctor-patient conflict resolution. [Res. 229, A-11]

Insurer Accountability When Prior Authorization Harms Patients D-320.974
Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts. [Res. 711, A-24]

Approaches to Increase Payer Accountability H-320.968
Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability. [CMS Rep. 08, A-17; Reaffirmed: Res. 125, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmed: CMS Rep. 4, A-21; Res. 727, A-22; CEJA Rep. 01, A-23]

RELEVANT MSS POSITIONS

Prior Authorization Reform 120.012MSS
AMA-MSS supports prescription prior authorization reform that prioritizes timely response guidelines, disclosure of medications requiring prior authorization to physicians, transparency in denial of prior authorization requests or rescission of authorization, portability of prior authorization, and exceptions for urgent care access, and increased legal accountability of insurers and other payers when prior authorization leads to patient harm, including but not limited to the prohibition of mandatory predispute arbitration and limitation on class action clauses in beneficiary contracts. [Amended: Res. OF068, I-23]

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS
AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; and supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. [MSS Res. 4, I-02; AMA Res. 108, A-03 Referred; Reaffirmed: MSS Rep. C, A-04; Reaffirmed: MSS GC Report B, I-09; Modified: GC Rep. A, I-16; Reaffirmed: MSS GC Report A, I-21]

Maintaining Insurance Coverage and Empowering State Choice 165.015MSS
AMA-MSS (1) supports an individual mandate for health insurance coverage; and (2) supports proposals for state-choice in federal health insurance reform only if they maintain the standards of insurance quality and reach set forward under the 2010 Patients Protection and Affordable Care Act. [MSS Res. 43, A-11]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 003
(I-26)

Introduced by: Lucas Tang[1], Elsa Chittet[2]

Affiliations: [1] Western University of Health Sciences COMP-NW
[2]University of Texas health Fort Worth

Subject: Ethical Standards for Consumer-Generated Health Data

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, consumer-generated health data (CGHD) provided by patients, including information collected from wearable devices, smartphone applications, home monitoring technologies, and direct-to-consumer testing platforms, has become increasingly available to patients and physicians as a potential source of health information;[1] and

Whereas, unlike physician-directed remote monitoring programs, consumer-generated health data may be collected independently by patients using consumer technologies that vary substantially in analytical validity, clinical validity, intended use, and data quality;[1,2] and

Whereas, consumer health technologies are frequently developed outside traditional clinical research and regulatory pathways, resulting in variability in measurement accuracy, validation standards, and applicability to diverse patient populations;[2] and

Whereas, physicians are increasingly expected to interpret and respond to patient-initiated consumer-generated health data despite limited evidence regarding its integration into routine clinical care and persistent challenges related to data quality, interoperability, workflow integration, and clinical relevance;[1,2] and

Whereas, inaccurate or misleading health data may contribute to unnecessary testing, inappropriate clinical decisions, patient anxiety, or inequitable care when physicians or patients interpret consumer-generated measurements without adequate clinical context;[1,2] and

Whereas, physicians have an ethical obligation to evaluate the reliability, relevance, and limitations of information used in clinical decision-making while respecting patient autonomy and incorporating patient-provided health information into the physician-patient relationship;[3] and

Whereas, current professional guidance emphasizes responsible use of digital health technologies but lacks specific standards addressing when consumer-generated health data should be documented in the medical record, how physicians should communicate limitations of such data, and what thresholds should guide clinical reliance on patient-generated information;[4] and

Whereas, the increasing use of consumer-generated health data in clinical care requires physicians and trainees to understand device validation, data quality, regulatory status, potential bias, clinical relevance, and appropriate interpretation, yet formal education in these areas remains inconsistent;[5,6] and

Whereas, study for the purpose of establishing clearer ethical guidance and education regarding the documentation, interpretation, communication of limitations and uncertainty, patient counseling, shared decision-making, and clinical use of CGHD would support patient safety, preserve physician judgment, and promote equitable integration of emerging health technologies into clinical practice;[1,2,6] therefore be it

RESOLVED, that our American Medical Association (AMA) study and report on the current use of patient-initiated consumer-generated health data, including data from wearable devices, home monitoring technologies, and direct-to-consumer health services, in clinical decision-making, and with attention to physician practices, ethical challenges, and barriers to implementation.

Fiscal Note: TBD

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RELEVANT AMA POLICY
H-480.939 Augmented Intelligence in Health Care

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
    a. clinical validation.
    b. alignment with clinical decision-making that is familiar to physicians.
    c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
    a. be informed by real world workflow and human-centered design principles.
    b. enable physicians to prepare for and transition to new care delivery models.

c. support effective communication and engagement between patients, physicians, and the health care team.
d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
e. seek end-user feedback to support iterative product improvement.

5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
    a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
    b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
    c. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
    d. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
    e. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
7. Our AMA, national medical specialty societies, and state medical associations:
    a. Identify areas of medical practice where AI systems would advance the quadruple aim.
    b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
    c. Outline new professional roles and capacities required to aid and guide health care AI systems.
    d. Develop practice guidelines for clinical applications of AI systems.
8. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
9. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it

[BOT Rep. 21, A-19 Reaffirmation: A-22 Reaffirmed: CSAPH Rep. 08, A-25 Reaffirmed: Res. 226, A-25]

H-480.943 Integration of Mobile Health Applications and Devices into Practice

1. Our American Medical Association supports the establishment of coverage, payment and financial incentive mechanisms to support the use of **mobile health** applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that:
    a. support the establishment or continuation of a valid patient-physician relationship;
    b. have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness;
    c. follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive **health** outcomes;
    d. support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication;
    e. support data portability and interoperability in order to promote care coordination through medical home and accountable care models;

f. abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app;
g. require that physicians and other **health** practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and
h. ensure that the delivery of any services via the app be consistent with state scope of practice laws.

2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages the **mobile** app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.
4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected **health** information.
5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets **Health** Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.
6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that they prescribe or recommends, and document the patient's understanding of such risks
7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.
8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

[CMS Rep. 06, I-16 Reaffirmation: A-17 Reaffirmation: A-23 Modified: Speakers Rep. 02, I-24]

H-478.981 Health Information Technology Principles
Effective HIT should:
1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will AMA utilize HIT **principles** to:
1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and **health** care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "**Information** Blocking."

Our AMA policy is that the cost of installing, maintaining, and upgrading **information technology** should be specifically acknowledged and addressed in reimbursement schedule
[BOT Rep. 19, A-18 Reaffirmation: A-19]

RELEVANT MSS POSITIONS
NONE

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 004
(I-26)

Introduced by: Samantha Josephson[1], Maria Dhinojwala[2]

Affiliations: [1] University of Central Florida College of Medicine
[2] Penn State College of Medicine

Subject: Secure Medication Storage for those Experiencing Homelessness

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, around 770,000 people experience homelessness nightly in the United States[1], and this population faces substantial barriers to accessing and managing medications, including lack of health insurance, requiring a fixed address, and challenges obtaining medications[2]; and

Whereas, people experiencing homelessness face numerous barriers to safely storing medications including but not limited to temperature-sensitive storage, protecting medications from loss or theft, and difficulty maintaining longer prescription quantities, creating particular challenges for medications such as insulin, biologics, PrEP, and psychiatric medications, increasing the risk of medication nonadherence and preventable disease progression[3-5]; and

Whereas, studies suggest there is a gap in infrastructure and resources for medication management among patients experiencing homelessness[6,7]; and

Whereas, access to secure medication storage has been identified as a strategy to reduce medication loss and barriers to medication adherence among people experiencing homelessness[4,8]; and

Whereas, existing interventions serving people experiencing homelessness, including Assertive Community Treatment,[9] Housing First,[10-11] medical respite programs,[12] and homeless-designated pharmacy services,[10] have improved medication adherence and health outcomes, but these interventions depend on eligibility, intensive multidisciplinary teams with small caseloads, program or housing availability, or temporary care settings, leaving limited strategies for safely storing medications in patients' current environments[9-12]; and

Whereas, secure and temperature-appropriate medication storage in shelters, clinics, pharmacies, and patients' current living environments has been identified as a promising strategy to reduce medication loss, theft, and barriers to medication adherence[4,8,10]; and

Whereas, decentralized medication access models, including smart lockers, vending machines, pharmacy kiosks, and community-based mobile medication delivery, have been implemented worldwide and have demonstrated potential to improve convenience, confidentiality, and medication adherence,[13-17] but evidence regarding the effectiveness and scalability of these models among people experiencing homelessness remains limited[4,8,10,13]; therefore be it

RESOLVED, that our American Medical Association support the development and implementation of evidence-based programs and infrastructure to address medication management barriers faced by patients experiencing homelessness, including but not limited to secure and accessible medication storage and temperature-controlled medication storage.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903:

1.Our American Medical Association supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services.

2.Our AMA recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless.

3.Our AMA recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis.

4.Our AMA supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance.
5.Our AMA recognizes the need for an effective, evidence-based national plan to eradicate **homelessness**.
6.Our AMA encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons.
7.Our AMA will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs.
8.Our AMA encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital.
9.Our AMA encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive **homelessness** policies and plans that address the healthcare and social needs of homeless patients. 1. Our AMA: a. supports laws protecting the civil and human rights of individuals experiencing **homelessness**, and b. opposes laws and policies that criminalize individuals experiencing **homelessness** for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available. 2. Our AMA recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods. 3. Our AMA: a. supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; b. supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and c. will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
10.Our AMA encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement. [Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22; Reaffirmed in lieu of: Res. 205, A-23; Modified: Res. 420, A-26]

Payment for Physicians who Practice Street Medicine H-160.886:

a.Our American Medical Association supports the development of **street medicine** programs to increase access to care **for** populations experiencing homelessness and reduce long- term costs.
b.Our AMA supports the implementation of Medicare and Medicaid **payment for street medicine** initiatives by advocating **for** necessary legislative and/or regulatory changes, including submission of a recommendation to the Centers **for** Medicaid & Medicaid Services asking that it establish a new place-of-service code to support **street medicine** practices **for** people eligible **for** Medicare and/or Medicaid, with "**street medicine**" defined, in keeping with the **Street Medicine** Institute, as "the provision of health care directly to people where they are living and sleeping on the streets." [Res. 117, A-23]

Drug Formularies and Therapeutic Interchange H-125.991:

It is the policy of the AMA:
(1) That the following terms be defined as indicated:
(a) Formulary: a compilation of drugs or **drug** products in a **drug** inventory list; open (unrestricted) **formularies** place no limits on which drugs are included whereas closed (restrictive) **formularies** allow only certain drugs on the list;
(b) Formulary system: a method whereby the medical staff of an institution, working through the pharmacy **and** therapeutics committee, evaluates, appraises, **and** selects from among the numerous available **drug** entities **and drug** products those that are considered most useful in patient care;
(c) Pharmacy & Therapeutics (P&T) Committee: an advisory committee of the medical staff that represents the official, organizational line of communication **and** liaison between the medical staff **and** the pharmacy department; its recommendations are subject to medical staff approval;
(d) **Therapeutic** alternates: **drug** products with different chemical structures but which are of the same pharmacological **and**/or **therapeutic** class, **and** usually can be expected to have similar **therapeutic** effects **and** adverse reaction profiles when administered to patients in therapeutically equivalent doses;
(e) **Therapeutic interchange**: authorized exchange of **therapeutic** alternates in accordance with previously established **and** approved written guidelines or protocols within a formulary system; **and**

(f) **Therapeutic** substitution: the act of dispensing a **therapeutic** alternate for the **drug** product prescribed without prior authorization of the prescriber.
(2) That our AMA reaffirms its opposition to **therapeutic** substitution (dispensing a **therapeutic** alternate without prior authorization) in any patient care setting.
(3) That **drug** formulary systems, including the practice of **therapeutic interchange**, are acceptable in inpatient hospital **and** other institutional settings that have an organized medical staff **and** a functioning Pharmacy **and** Therapeutics (P&T) Committee, provided they satisfy the following standards:
(a) The formulary system must:
(i) have the concurrence of the organized medical staff;
(ii) openly provide detailed methods **and** criteria for the selection **and** objective evaluation of all available pharmaceuticals;
(iii) have policies for the development, maintenance, approval **and** dissemination of the **drug** formulary **and** for continuous **and** comprehensive review of formulary drugs;
(iv) provide protocols for the procurement, storage, distribution, **and** safe use of formulary **and** non-formulary **drug** products;
(v) provide active surveillance mechanisms to regularly monitor both compliance with these standards **and** clinical outcomes where substitution has occurred, **and** to intercede where indicated;
(vi) have enough qualified medical staff, pharmacists, **and** other professionals to carry out these activities;
(vii)provide a mechanism to inform the prescriber in a timely manner of any substitutions, **and** that allows the prescriber to override the system when necessary for an individual patient without inappropriate administrative burden;
(viii) provide a mechanism to assure that patients/guardians are informed of any change from an existing outpatient prescription to a formulary substitute while hospitalized, **and** whether the prior medication or the substitute should be continued upon discharge from the hospital;
(ix) include policies that state that practitioners will not be penalized for prescribing non-formulary **drug** products that are medically necessary; **and**
(x) be in compliance with applicable state **and** federal statutes **and**/or state medical board requirements.
(b) The P&T Committee must:
(i) objectively evaluate the medical usefulness **and** cost of all available pharmaceuticals (reliance on practice guidelines developed by physician organizations is encouraged);
(ii) recommend for the formulary those **drug** products which are the most useful **and** cost-effective in patient care;
(iii) conduct **drug** utilization review (DUR) activities;
(iv) provide pharmaceutical information **and** education to the organization's (e.g., hospital) staff;
(v) analyze adverse results of **drug** therapy;
(vi) make recommendations to ensure safe **drug** use **and** storage; **and**
(vii) provide protocols for the timely procurement of non-formulary **drug** products when prescribed by a physician for the individualized care of a specific patient, when that decision is based on sound scientific evidence or expert medical judgment.
(c) The P&T Committee's recommendations must be approved by the medical staff;
(d) Within the **drug** formulary system, the P & T Committee shall recommend, **and** the medical staff must approve, all drugs that are subject to **therapeutic interchange**, as well as all processes or protocols for informing individual prescribing physicians; **and**
(e) The act of providing a **therapeutic** alternate that has not been recommended by the P&T Committee **and** approved by the medical staff is considered unauthorized **therapeutic** substitution **and** requires immediate prior consent by the prescriber; i.e., authorization for a new prescription.
(4) That **drug** formulary systems in any outpatient setting shall operate under a P&T Committee whose recommendations must have the approval of the medical staff or equivalent body, **and** must meet standards comparable to those listed above. In addition:
(a) That our AMA continues to insist that managed care **and** other health plans identify participating physicians as their "medical staff" **and** that they use such staff to oversee **and** approve plan **formularies**, as well as to oversee **and** participate on properly elected P&T Committees that develop **and** maintain plan **formularies**;
(b) That our AMA continues to insist that managed care **and** other health plans have well-defined processes for physicians to prescribe non-formulary drugs when medically indicated, that this process impose minimal administrative burdens, **and** that it include access to a formal appeals process for physicians **and** their patients; **and**
(c) That our AMA strongly recommends that the switching of **therapeutic** alternates in patients with chronic diseases who are stabilized on a **drug** therapy regimen be discouraged.

(5) That our AMA encourages mechanisms, such as incentive-based **formularies** with tiered co-pays, to allow greater choice **and** economic responsibility in **drug** selection, but urges managed care plans **and** other third party payers to not excessively shift costs to patients so they cannot afford necessary **drug** therapies. [BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20]

Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications H-95.932:

1.Our American Medical Association supports legislative, regulatory, **and** national advocacy efforts to increase access to affordable **naloxone and other safe and effective overdose reversal medications**, including but not limited to collaborative practice agreements with pharmacists **and** standing orders for pharmacies **and**, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, **and other** locations that do not restrict the route **of** administration for **naloxone and other safe and effective overdose reversal medications** delivery.
2.Our AMA supports efforts that enable law enforcement agencies to carry **and** administer **naloxone and other safe and effective overdose reversal medications** .
3.Our AMA encourages physicians to co-prescribe **naloxone and other safe and effective overdose reversal medications** to patients at risk **of overdose and**, where permitted by law, to the friends **and** family members **of** such patients.
4.Our AMA encourages private **and** public payers to include all forms **of naloxone and other safe and effective overdose reversal medications** on their preferred drug lists **and** formularies with minimal or no cost sharing.
5.Our AMA supports liability protections for physicians **and other** healthcare professionals **and** others who are authorized to prescribe, dispense **and**/or administer **naloxone and other safe and effective overdose reversal medications** pursuant to state law.
6.Our AMA supports efforts to encourage individuals who are authorized to administer **naloxone and other safe and effective overdose reversal medications** to receive appropriate education to enable them to do so effectively.
7.Our AMA encourages manufacturers or **other** qualified sponsors to pursue the application process for over the counter approval **of naloxone and other safe and effective overdose reversal medications** with the Food **and** Drug Administration.
8.Our AMA supports the widespread implementation **of** easily accessible **naloxone and other safe and effective overdose reversal medications** rescue stations (public **availability of naloxone and other safe and effective overdose reversal medications** through wall-mounted display/storage units that also include instructions) throughout the country following distribution **and** legislative edicts similar to those for Automated External Defibrillators.
9.Our AMA supports the legal access to **and** use **of naloxone and other safe and effective overdose reversal medications** in all public spaces regardless **of** whether the individual holds a prescription.
10.Our AMA supports efforts to increase the **availability**, delivery, possession **and** use **of** mail-order **overdose reversal medications**, including **naloxone**, to help prevent opioid-related **overdose**, especially in vulnerable populations, including but not limited to underserved communities **and** American Indian reservation populations.
11.Our AMA supports the expansion **of naloxone availability** through colocation **of** intranasal **naloxone** with AEDs in public locations. [BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21; Modified: Res. 505, A-23; Reaffirmed: BOT Rep. 11, A-24; Modified: Res. 512, A-24]

Prescription Drug Diversion, Misuse and Addiction H-95.945:

1.Our American Medical Association supports permanent authorization of **and** adequate funding for the National All Schedules **Prescription** Electronic Reporting (NASPER) program so that every state, district **and** territory of the US can have an operational **Prescription Drug** Monitoring Program (PDMP) for use of clinicians in all jurisdictions.
2.Our AMA considers PDMP data to be protected health information, **and** thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the

individual patient to release personal health information, **and** recommends that others recognize that PDMP data is health information.
3.Our AMA recommends that PDMP's be designed such that data is immediately available when clinicians query the database **and** are considering a decision to prescribe a controlled substance.
4.Our AMA recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries.
5.Our AMA recommneds that **prescription drug** monitoring program (PDMP) viewing access as a mainstay of appropriate **and** comprehensive medical training for clinical medical students **and** residents.
6.Our AMA will promote medical school **and** postgraduate training that incorporates curriculum topics focusing on pain medicine, **addiction** medicine, safe prescribing practices, safe medication storage **and** disposal practices, functional assessment of patients with chronic conditions, **and** the role of the prescriber in patient education regarding safe medication storage **and** disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of **prescription drug** diversion, **misuse**, **addiction and** overdose deaths. [Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16; Appended: Res. 241, A-23]

RELEVANT MSS POSITIONS

Eradicating Homelessness 440.048MSS:

AMA-MSS asked the AMA to: (1) support improving the health outcomes and decreasing the health care costs of treating the chronically homeless through housing first approaches; (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness; (3) to support the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs; (4) to recognize that stable housing promotes adherence to HIV treatment; (5) support access to stable housing; (6) to recognize and support the use of Street Medicine programs, and reimbursement by Medicaid and other public insurance for their maintenance; (7) support federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries; (8) include working with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance; (9) oppose measures that criminalize necessary means of living among homeless persons, including, but not limited to, sitting or sleeping in public spaces; (10) advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights; (11) recognize that among the homeless population, a lack of identification card serves as a barrier to accessing medical care as well as fundamental services that support healthy lifestyle; (12) support legislation and policy changes that aim to provide a streamlined and simplified application process for obtaining identification cards that facilitate accessibility to the homeless population; (13) promote legislation changes and policy initiatives focused on providing identification cards to homeless individuals without charge (MSS Res 33, A-14) (Amended by MSS Res. 602, A-25)

Amending H-160.903, Eradicating Homelessness, to Include Support for Street Medicine Programs and Reduce Evictions 160.043MSS:

AMA-MSS will ask the AMA to recognize and support the use of Street Medicine programs by amending policy H-160.903, Eradicating Homelessness via addition and deletion as follows:

H-160.903 – ERADICATING HOMELESSNESS

Our AMA: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy of services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) supports the use of street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;

(~~4~~5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(~~5~~6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(~~6~~7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost- effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
(~~7~~8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(~~8~~9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(~~9~~10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(~~10~~11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; and
(12) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries. (MSS Res. 32, I-21)
(MSS Res. 013, A-22, Adopt Substitute Resolution in Lieu of) (AMA Res. 205, Reaffirmed, A-23)

Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States 440.060MSS:

AMA-MSS will ask that our AMA amend policy H-160.903 by addition and deletion to read as follows:
Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and ~~(2)~~(3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness. (MSS Res 38, I-16) (AMA Res 208, A-17 Referred)

Medical Respite Care for Homeless Adults 440.079MSS:

AMA-MSS will ask the AMA to study funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons. (MSS Res 42, I-17) (AMA Res 416, A-18, Appended [H-160.903])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 005
(I-26)

Introduced by: Samantha Josephson[1], Sanjay V. Neerukonda[2]

Affiliations: [1] University of Central Florida College of Medicine
[2] McGovern Medical School at UTHealth

Subject: Supporting Children of Parents with Chronic Illness

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, in the context of parental chronic illness, caregiving capacity refers to a parent's ability to fulfill household and caregiving responsibilities without shifting these responsibilities onto dependent children[1]; and

Whereas, parental chronic illness affects a substantial proportion of US children, with an estimated 59.1% of children living with at least one adult with a chronic illness[2], and an estimated more than 5.4 million children caring for an adult family member who has a chronic illness[3]; and

Whereas, parental chronic illness is associated with disruptions in parental caregiving capacity and family functioning, including increased school absenteeism, shifts in family roles, and increased caregiving responsibilities among children, with greater parental chronic illness severity associated with increased risk of supervisory and physical neglect[1,4,5]; and

Whereas, these children of parents with chronic illnesses are also at a significantly greater risk of having mental health issues[6] and reduced quality of life compared to their peers[7]; and

Whereas, children affected by parental chronic illness may remain unidentified and unsupported within existing healthcare systems due to gaps in recognizing and addressing their support needs[8-12]; and

Whereas, adult healthcare providers do not routinely ask about dependent children and addressing the health-related needs of these children falls outside the traditional scope of adult medical care[8,9]; and

Whereas, parental chronic illness is not specifically identified as a screening target in any current American Academy of Pediatrics (AAP) guideline, periodicity schedule, or validated screening tool recommended for pediatric primary care[10-12]; and

Whereas, medical record systems are generally designed around the individual patient and may not routinely capture or facilitate identification of dependent children who could be affected by a parent's chronic illness[8,9]; and

Whereas, protective factors for these children include secure parent-child attachment, open communication about the parent's diagnosis, social support, and adaptive coping skills[10,13]; and

Whereas, these protective factors may buffer the effects of parental chronic illness by scaffolding emotional regulation, strengthening parent-child trust and family functioning, providing social and emotional support, and promoting adaptive responses to illness-related stress[8,10,13]; and

Whereas, these protective factors may be strengthened through timely recognition and intervention, with evidence suggesting that psychosocial interventions for children of parents with chronic illness, including cognitive behavioral therapy, psychoeducation, and school-based supports, improve psychological outcomes with longer intervention duration is associated with better outcomes[14-16]; and

Whereas, family-centered approaches that integrate psychosocial support into routine care and promote multidisciplinary collaboration may facilitate coordinated support and continuity of care for children and families affected by parental chronic illness[15]; and

Whereas, timely access to appropriate evidence-based interventions and supportive services depends on identifying children affected by parental chronic illness, yet no standardized process currently exists to systematically identify dependent children of chronically ill patients[8-10,15]; therefore be it

RESOLVED, that our AMA supports multidisciplinary coordination among physicians, behavioral health professionals, social workers, child life services, and other appropriate professionals to facilitate timely identification, referral, intervention, and care coordination for dependent children of parents with a chronic illness that affects caregiving capacity.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Principles of the Patient-Centered Medical Home H-160.919
1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows: *Principles. Personal Physician* - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care. *Physician Directed Medical Practice* - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. *Whole Person Orientation* - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.*Care is coordinated and/or integrated* across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. *Quality and safety* are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model. Patients and families participate in quality improvement activities at the practice level. *Enhanced access* to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff. *Payment* appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework: It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. It should support adoption and use of health information technology for quality improvement. It should support provision of enhanced communication access such as secure e-mail and telephone consultation. It should recognize the value of physician work associated with remote monitoring of clinical data using technology. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits). It should recognize case mix differences in the patient population being treated within the practice. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting. It should allow for additional payments for achieving measurable and continuous quality improvements.
2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.
3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.
4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home. [Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 03, I-18]

The Patient-Centered Medical Home H-160.918
Our AMA:
1. will urge **the** Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national **medical** specialty societies to design incentives to enhance care coordination among providers who provide **medical** care for patients outside **the medical home**;
2. will urge CMS to assist physician practices seeking to qualify for and sustain **medical home** status with financial and other resources;
3. will advocate that Medicare incentive payments associated with **the medical home** model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in **the** Medicare physician payment schedule;
4. will advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized **patient-centered** care recognizing that payer support is crucial to **the** long-term sustainability of delivery reform; and
5. encourages health agencies, health systems, and other stakeholders to support and assist **patient-centered medical home** transformation and maintenance efforts at levels that provide a stable platform for optimized **patient-centered** care. [CMS Rep. 8, A-09; Modified: CMS Rep. 03, I-18]

RELEVANT MSS POSITIONS
Support for Siblings of Chronically Ill Patients 60.033MSS
AMA-MSS asked AMA to support programs and resources that improve the mental health, physical health, and social support for pediatric siblings of chronically ill pediatric patients. (MSS Res 71, I-19) (AMA Res. 434, Adopted [H-60.899], A-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 006
(I-26)

Introduced by: Ciara Martinez[1]; Kenya Ochoa[2]

Affiliations: [1] University of Texas Medical Branch John Sealy School of Medicine; [2] UC San Diego School of Medicine

Subject: Coverage for Risk-Based Cervical Cancer Screening

Sponsored by:

Referred to: MSS Reference Committee

(TBA, Chair)

Whereas, immunosuppressed patients, including solid organ and hematopoietic stem cell transplant recipients and patients on immunosuppressive therapy for autoimmune diseases such as systemic lupus erythematosus, rheumatoid arthritis, and inflammatory bowel disease, face impaired viral clearance and a substantially elevated risk of cervical dysplasia and cancer[1,2]; and

Whereas, renal transplant recipients have more than twice the risk of developing high-grade cervical intraepithelial neoplasia compared to age-matched controls, and patients with rheumatoid arthritis have shown a nearly ten-fold increased standardized incidence ratio for cervical cancer[3]; and

Whereas, the American Society for Colposcopy and Cervical Pathology has published evidence-based screening recommendations directing that non-HIV immunosuppressed populations follow the same accelerated screening protocol established for patients living with HIV[1,3]; and

Whereas, a 2025 systematic review of clinical practice guidelines for anogenital cancer screening in immunosuppressed populations found that, while guidance for HIV-positive patients is well established, guidelines specific to transplant recipients and patients with autoimmune disease remain inconsistent and lower quality, with no consensus on screening frequency or method[4]; and

Whereas, even where risk-based screening guidance already exists, real-world adherence remains poor: a 2024 study of women with systemic lupus erythematosus found an overall cervical cancer screening adherence rate of only 61.5%, with the likelihood of completing screening decreasing by 41% during periods of active disease flare, precisely when immunosuppression and cervical cancer risk are highest[5]; and

Whereas, current Centers for Medicare & Medicaid Services and private payer coverage determinations for accelerated cervical cancer screening typically define “high-risk” status based on HIV infection alone, without accounting for the comparable or greater elevated risk

demonstrated in non-HIV immunosuppressed populations such as transplant recipients and patients on immunosuppressive therapy for autoimmune disease; and

Whereas, although Medicare allows physicians to request more frequent screening by documenting medical necessity on a case-by-case basis, this ad hoc process functions as a barrier rather than a guarantee of consistent access: only 58.5% of Medicare-enrolled female renal transplant recipients under 65 received cervical cancer screening within three years of transplantation, compared to nearly 80% of women in a general-population survey, and HPV co-testing remains capped at once every five years regardless of risk status, while private payer medical necessity criteria similarly reference general-population guidance[6,7,8]; and

Whereas, the Advisory Committee on Immunization Practices and multiple other expert bodies recommend a three-dose, rather than the standard two-dose, HPV vaccination schedule for immunocompromised patients due to attenuated immune response[9,10]; and

Whereas, vaccine uptake among solid organ transplant recipients remains critically low in practice: a 2025 study found that only 4.5% of solid organ transplant recipients transplanted since December 2009 had received any HPV vaccination, despite established guidance recommending it[11]; and

Whereas, existing AMA Policy H-460.894 encourages public and private payers to cover preventive services with multi-guideline consensus, and existing AMA Policy H-55.971 encourages the Centers for Medicare & Medicaid Services to ensure screening coverage reflects current evidence-based guidelines, but neither specifically addresses the under-inclusive definition of “high-risk” status used in current coverage determinations, nor documented gaps in physician awareness of risk-based screening and vaccination needs for non-HIV immunosuppressed adult patients; therefore be it

RESOLVED, that our AMA support expanding the definitions of “high-risk” used by the Centers for Medicare & Medicaid Services and private payers for cervical cancer screening coverage determinations to include non-HIV immunosuppressed patients, including solid organ and hematopoietic stem cell transplant recipients and patients on immunosuppressive therapy for autoimmune disease, so that these patients receive screening intervals, methods, and cost-sharing consistent with their demonstrated elevated risk; and be it further

RESOLVED, that our AMA support continuing medical education on the elevated cervical cancer risk faced by non-HIV immunosuppressed patients and on evidence-based, risk-appropriate approaches to their preventive screening and vaccination, given documented gaps in physician awareness and implementation.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Preventive Service Coverage Based on Multi-Specialty Consensus H-460.894
Encourages public and private payers to cover preventive services for which consensus has emerged in the recommendations of multiple guideline-making groups. Does not address the under-inclusive definition of “high-risk” currently used for cervical cancer screening coverage determinations.

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971
Encourages CMS to evaluate and review current cervical cancer screening policies to ensure coverage is consistent with current evidence-based guidelines. Does not specify that “high-risk” classifications should be expanded to include non-HIV immunosuppressing conditions.

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
Supports general HPV vaccination, routine HPV-related cancer screening, physician education, and adherence to ACIP and specialty society recommendations. Does not address the specific screening or education needs of non-HIV immunosuppressed adult patients.

RELEVANT MSS POSITIONS

Expansion of Medicaid Coverage of HPV Screening 290.011MSS
Supports self-sampling and primary HPV testing access. Does not address risk-based classification by immunosuppression status.
High Risk HPV Subtypes in Vulnerable Populations 350.038MSS
Addresses HPV subtype prevalence relevant to vaccine development. Does not address screening frequency or immunosuppression-specific vaccination guidance.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 007 (I-26)

Introduced by: Linwei Li, Sriya Gullapalli, Paul Kim

Affiliations: [1]UTRGV School of Medicine

Subject: Fair Allocation of Responsibility and Preservation of Clinical Judgment in AI Integration

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee

(TBA, Chair)

Whereas, AI systems are increasingly integrated into hospitals to support diagnosis, triage, and administrative efficiency[1], including in various specialties such as emergency medicine[2]; and

Whereas, AI systems now materially influence clinical decisions through imaging-based screening[3], automated prescription renewal[4], and FDA-authorized autonomous screening for diabetic retinopathy[5]; and

Whereas, although AI algorithms remain subject to training data biases[6,7] that diminish performance for underserved populations[8], AI-assisted tools are increasingly being adopted[9]; and

Whereas, as clinical efficiency and productivity are increasingly emphasized as markers of professional competence[10], performance evaluations and hiring criteria that reward AI adoption can effectively compel physicians to use AI systems regardless of individual clinical judgment, a form of functional compulsion that H-480.939's protection against penalizing *non-use* does not reach; and

Whereas, as AI systems assume a growing share of clinical decision-making, accountability has not followed, and the FDA's evolving Software as a Medical Device framework does not yet establish mechanisms for apportioning clinical liability between AI developers, deployers, and individual physicians[11]; and

Whereas, lawsuits seeking to hold AI developers accountable rarely succeed because courts generally treat clinical AI as decision-support that leaves final judgment with the physician as the ultimate arbiter[12]; and

Whereas, Article 12 and 19 of the EU AI Act require the manufacturers of AI systems to generate and keep an automatic log that is traceable over their lifetime in critical areas such as healthcare[13]; and

Whereas, AMA Policy H-480.939 Section 6 protects physicians from penalty only for declining to use AI systems, and no current AMA policy directly addresses how to protect physicians exercising the override capacity from consequences; and

Whereas, while many studies have shown AI-assisted tools with a superior outcome than physicians alone, the AI system integrated into the clinical system has shown a poorer performance, suggesting a potential efficacy-effectiveness gap that is difficult to prove due to HIPAA protection[14]; and

Whereas, the fundamental structure of medical practice aligns clinical decision-making authority with accountability, such that the physician who holds authority over a clinical decision also bears responsibility for its outcome, and this alignment serves as a core safeguard for patients; and

Whereas, when the party accountable to the patient is progressively stripped of the authority and autonomy to protect the patient, physicians are left to bear responsibility for decisions they cannot meaningfully control, and patients lose the safeguard that a responsible, empowered physician is meant to provide; and

Whereas, the adoption of AI systems with inappropriate apportioning of responsibility will eventually collapse the fundamental structure of medical practice systemically, which will ultimately harm the patients with no clearly accountable party to hold responsible, and therefore unable to obtain fair compensation through established avenues of medical malpractice; therefore be it

RESOLVED**,** that our AMA amend Policy H-480.939, Section 6 by addition and deletion as follows;

"6. Physicians should not be penalized if they do not use, or if they override, AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux, where the physician does so on the basis of good-faith, documented, patient-specific clinical judgement consistent with the applicable standard of care. Furthermore, our AMA opposes:

a. Policies by payers, hospitals, health systems, ~~or~~ governmental entities, or other entities that either mandate or functionally require use of health care AI systems as a condition of licensure, participation, payment, or coverage."

"7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:

a. Where a mandated or functionally required use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate or requirement must be assigned all applicable liability."

RESOLVED, that our AMA support that AI systems that support screening, diagnosis, and treatment in a clinical setting automatically generate, without requiring additional physician data entry, a brief summary of the system and version, the output provided, and whether the physician accepts or overrides that output; this summary will serve as a traceable document retained within or alongside the patient's medical record for no less than the applicable statute of limitations for medical liability claims; and be it further

RESOLVED, that our AMA support that responsibility for generating and retaining such documentation rest with the deploying institution and the system developer rather than with the individual physician and that our AMA support that failure to provide such documentation during a medical malpractice shall render the deploying institution partially liable.

Fiscal Note: TBD

Date Received: 09/06/2026

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Relevant AMA Policies

Search Terms: augmented intelligence, augmented intelligence liability, AI mandate, AI prior authorization

- H-480.939 Augmented Intelligence in Health Care
  - This is the policy with the greatest direct overlap. It already opposes certain mandatory uses of AI, states that physicians should not be penalized for non-use while standards and oversight remain unsettled, and supports assigning liability to the parties best positioned to identify and mitigate risk. It also assigns applicable liability to a mandating entity when a mandate prevents risk mitigation and requires developers of autonomous AI systems to accept liability arising directly from system failure or misdiagnosis. The now modified resolve 1 extends these protections from explicit mandates to functionally imposed use and to physician override.
- H-480.940 Augmented Intelligence in Health Care
  - Establishes a broad foundational framework for responsible AI development and implementation in healthcare. It supports meaningful physician involvement in AI design, validation, and deployment. It also supports clinically validated and user-centered systems, transparency and reproducibility, mitigation of bias and disparities, protection of privacy and data security, and education regarding AI's benefits and limitations. It also directs the AMA to explore legal issues, including liability, and advocate for appropriate professional and governmental oversight. The policy is relevant to the proposal's general concerns about physician authority, transparency, auditability, and AI-related liability, but it does not itself allocate liability or address explicit or functionally imposed AI mandates. This is addressed more directly in H-480.939.
- H-480.931 Assessing the Intersection Between AI and Health Care
  - Supports risk-based AI governance, human intervention points, and the ability of a qualified physician to intervene in or override AI output. It also states that institutions should not implement systems whose risks exceed their ability to mitigate and that AI should be integrated consistently with clinical workflow and physician oversight. These provisions support the clinical-judgment protections sought in Resolve 1 and relate to the documentation mechanism in now modified Resolves 2 and 3.
- D-480.956 Use of Augmented Intelligence for Prior Authorization
  - Supports legislative and regulatory oversight of payer use of AI, transparency and accountability for AI-informed denials, direct review by qualified clinicians, robust appeals, and safeguards against algorithmic discrimination. Relevant to reimbursement-linked pressure and preservation of individualized clinical judgment, but its scope is

limited to payer claims review and prior authorization rather than institutional or employment-related AI mandates.

- H-225.940 Augmented Intelligence and Organized Medical Staff
  - Recognizes that organized medical staff should be involved in selecting, developing, and implementing AI and digital-health tools used in hospital care. It supports physician participation in institutional AI governance, although it does not directly prohibit employment or productivity practices that functionally compel individual physicians to use AI. Most relevant to Resolves 1.
- D-480.952, Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence
  - Calls for disclosure when AI is used in clinical care, risk-based governance, clinically useful transparency, and lifecycle monitoring for safety, effectiveness, accuracy, and reliability. It relates to the documentation mechanism in now modified Resolves 2 and 3, although it does not require a retained per-encounter record.

Relevant MSS Positions:

Search Terms: augmented intelligence, AI development, machine intelligence, clinical autonomy

- 480.034MSS Machine Intelligence in Healthcare
  - Supports machine intelligence as a complementary tool in clinical decision-making, ethical development and deployment, evaluation of clinical outcomes, and development of regulatory guidelines. Its description of AI as complementary supports preservation of physician clinical judgment, but it does not address functional mandates, employment penalties, contractual liability transfer, or allocation of liability.
- 480.027MSS: Encouraging Collaboration Between Physicians and Industry in AI Development
  - Supports connecting physicians with AI developers and involving physicians early in AI design and testing. It is relevant to the proposal's broader concern that physicians should have meaningful input into systems that influence clinical care. However, it does not directly address physicians' ability to decline AI, institutional mandates, or liability.
- 480.029MSS Evaluating Clinical Outcomes of Mobile Health Technology
  - Supports evaluating the clinical effects of health technologies and recognizes the importance of maintaining clinical autonomy while reducing unnecessary workload. This is indirectly relevant to the resolution's concern that technology integration should support rather than undermine physician judgment, although it does not specifically address AI mandates or liability.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 008
(I-26)

Introduced by: Hannah Walker[1], Lauren Blaydon[2]

Affiliations: [1] Western Michigan University Homer Stryker M.D. School of Medicine
[2] UT Southwestern Medical School

Subject: Standardized Food Insecurity Screening and Referral

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, food insecurity is a household-level economic and social condition characterized by limited or uncertain access to adequate food, affecting 13.7% of U.S. households in 2024[1]; and

Whereas, food insecurity is associated with adverse health outcomes and may contribute to disparities in chronic disease, mental health, and overall health-related quality of life[2]; and

Whereas, food insecurity may not be readily apparent during routine healthcare encounters and validated brief screening instruments can identify food insecurity efficiently during healthcare encounters [3,4], including the two-item Hunger Vital Sign, which has demonstrated high sensitivity for identifying food insecurity when compared with longer validated household food-security assessments[5]; and

Whereas, the American Medical Association has recognized the importance of identifying and addressing social determinants of health and supports payment reform policies that incentivize screening for social determinants of health and referral to community support systems[4]; and

Whereas, the Centers for Medicare & Medicaid Services has finalized removal of Screening for Social Drivers of Health measures from several federal quality and value-based payment programs, including the Medicare Shared Savings Program APP Plus measure set[6] and the Hospital Outpatient Quality Reporting and Ambulatory Surgical Center Quality Reporting Programs[7], creating a timely opportunity for advocacy regarding standardized screening and referral for food insecurity within applicable federal programs; therefore be it

RESOLVED, that our American Medical Association advocate for federal policies and efforts to incorporate standardized, validated food insecurity screening instruments and appropriate referral to nutrition assistance and community resources into applicable federal healthcare quality and value-based payment programs; and be it further

RESOLVED, that our American Medical Association support federal healthcare quality programs that evaluate food insecurity screening and referral through measurable processes, including the proportion of patients screened, the proportion of patients with positive screens receiving appropriate referrals, and measures of documented follow-up efforts or closed-loop referral using electronic health record (EHR) systems and referral processes where feasible.

Fiscal Note: TBD

Date Received: 08/09/2026

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RELEVANT AMA POLICY

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
Our AMA (1) supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems, (2a) will advocate for data interoperability between physicians' practices, public health, vaccine registries, community-based organizations, and other related social care organizations to promote coordination across the spectrum of care, while maintaining appropriate patient privacy, (2b) adopts the position that electronic health records should integrate and display information on social determinants of health and social risk so that such information is actionable by physicians to intervene and mitigate the impacts of social factors on health outcomes, (3) acknowledges closed loop referral systems are a mechanism to address social determinants of health (SDOH) through a community-level, system approach that connects clinicians and the patients they serve to health care services and social support services, (4) supports the continued evaluation of closed loop referral systems in addressing SDOH and health-related social needs to identify best practices and improve health outcomes, (5) supports continued research to streamline the workflow processes and ensure two-way communication for closed loop referrals between health care systems and community-based organizations to address SDOH and health-related social needs. [BOT Rep. 39, A-18Reaffirmed: CMS Rep. 10, A-19Appended: Res. 440, A-22, Appended: CSAPH Rep. 02, A-24]

Food Environments and Challenges Accessing Healthy Food H-150.925
Our AMA (1) 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) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color, (3) 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) 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. [Res. 921, I-18Modified: Res. 417, A-21Appended: Res. 117, A-22]

Screening and Brief Interventions For Alcohol Problems H-30.942
Our AMA in conjunction with medical schools and appropriate specialty societies advocates curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol:

(a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine. [CSA Rep. 14, I-99Reaffirmation I-01Modified: CSAPH Rep. 1, A-11Reaffirmation: A-18]

RELEVANT MSS POSITIONS

Identifying and Addressing Food Insecurity and Food Deserts Nationwide 150.034MSS
AMA-MSS supports (1) research on the impact of factors influencing functional access to food including but not limited to gentrification, transportation, and crime rates on the development of food deserts; (2) the creation of new tools aimed at identifying food deserts taking into account cost of food in geographically accessible stores or modification of existing tools for identification of food deserts to include consideration of affordability in the establishment of accessibility of healthy food sources; and (3) current efforts by the United States Department of Agriculture in the incorporation of nutrition education programs focusing on sustainable food sourcing and the impact of healthy foods on overall well-being including but not limited to those involving school and community garden building and education on healthy eating habits.

Amendment to Food Environments and Challenges Accessing Healthy Food, H-150.925
Our AMA (1) 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; and (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) 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.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 010
(I-26)

Introduced by: Samyukta Karthik[1], Suraj Joshi[2], Jared Boyce[3], Kareena Chawla[4], Kara McBurnett[5]

Affiliations: [1] Pennsylvania State University - University Park Regional Campus
[2] Tufts School of Medicine
[3] University of Wisconsin School of Medicine and Public Health
[4] Nova Southeastern University Medical School
[5] Keck School of Medicine, University of Southern California

Subject: Electroconvulsive Therapy Access, Consent, and Public Education

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, Electroconvulsive therapy (ECT) is an established, evidence-based, and often life-saving treatment for severe depression, catatonia, and other serious psychiatric conditions[1]; and

Whereas, ECT has response rates of 60–80% and remission rates of 50–60% for treatment-resistant depression, thus barriers to timely access may prolong severe and potentially life-threatening psychiatric illness[2,3]; and

Whereas, ECT is uniquely indicated in situations requiring rapid clinical response, including malignant catatonia, severe suicidal depression, psychotic depression, and refusal of food or fluids, such that delays in treatment may result in significant morbidity or mortality[4]; and

Whereas, the most frequent complications of ECT are acute cardiopulmonary events, which occur in less than 1% of treatments[4]; and

Whereas, ECT has an estimated mortality of approximately 2.1 per 100,000 treatments, which is comparable to or lower than mortality rates for other minor surgical procedures requiring general anesthesia[2,]; and

Whereas, ECT is generally considered a safe, low-risk procedure[5,6]; and

Whereas, the Food and Drug Administration reclassified ECT devices in 2018 from Class III (high risk) to Class II (moderate risk with special controls) for severe unipolar or bipolar depression or catatonia in persons 13 years of age or older who are treatment-resistant or require a rapid response[7]; and

Whereas, currently, substantial variability among state regulations and no uniform federal guidelines governing equitable access to ECT, informed consent, procedural authorization, patient education, or the safe administration of ECT[8]; and

Whereas, surrogate decision-making statutes across all 50 states found that 25 states specifically prohibit surrogates from consenting to ECT, while only 8 states grant surrogates authority comparable to that available for general medical decisions, demonstrating that ECT is treated more restrictively than other medical procedures despite a comparable or more favorable risk profile[9]; and

Whereas, several states impose ECT-specific court-order or guardianship-hearing requirements not required for other procedures of comparable risk, including states such as Missouri, California, New York, and Texas, which mandates court order or full evidentiary hearing before a legal guardian may authorize ECT for an incompetent patient[8,10]; and

Whereas, such ECT-specific procedural requirements have been described as time-intensive and capable of rendering ECT inaccessible to patients with a limited treatment window[11]; and
Whereas, the American Psychiatric Association provides comprehensive guidance on informed consent for ECT, including discussion of anesthetic and neuromuscular blocking agent reactions, delayed seizures, manic symptoms, disorientation, memory loss, and re-review of consent when risks and benefits change or when transitioning from acute to maintenance treatment[11]; and

Whereas, AMA Code of Medical Ethics Opinion 2.1.2 establishes a surrogate decision-making framework based on substituted judgment or best interest that governs other high-stakes and irreversible medical interventions[12]; and

Whereas, imposing ECT-specific judicial requirements beyond this existing framework is duplicative rather than protective, as the same standards are deemed sufficient safeguards for procedures of comparable or greater risk; and

Whereas, persistent public stigma and misinformation about ECT, fueled in part by inaccurate media portrayals and limited public education, engender misconceptions about the safety and broader purpose of ECT[13,14]; and

Whereas, increasing numbers of states have enacted legislation restricting access to ECT, despite contrary evidence demonstrating ECT's safety and efficacy, which is likely to exacerbate existing disparities; and[15]

Whereas, educational interventions have proven effective in increasing both knowledge and positive perceptions of ECT, supporting evidence-based decision-making and countering stigma and misinformation[16,17]; therefore be it

RESOLVED, that our American Medical Association (AMA) opposes the imposition of consent or authorization requirements for ECT that are more restrictive than those required for other medical or surgical procedures of comparable risk, including requirements for legal guardianship or court order when a lawful surrogate decision-maker is available; and be it further

RESOLVED, that our AMA work with relevant organizations to develop and disseminate evidence-based educational materials on ECT for patients, families, legislators, and the public, including indications, risks and benefits, effectiveness, relevant consent processes, and usage in current clinical practice to counter stigma and misinformation that contribute to restrictive legislation.

Fiscal Note: None

Date Received: 8/9/2026

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Note: References 2/5, 10/13, 1/14, and 18/19 are duplicates. If consolidating to unique references, these pairs can be merged and the list renumbered accordingly.

RELEVANT AMA POLICY

H-345.990 Electroconvulsive Therapy

Our American Medical Association supports the use of **electroconvulsive therapy** as an effective treatment modality in selected patients, as outlined by the American Psychiatric Association.

2.1.2 Decisions for Adult Patients Who Lack Capacity

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf…

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 011
(I-26)

Introduced by: Clarissa Santiano BS[1], Madelyn Hartrim-Lowe BA BS[1], Joanna Marie Aguilar MS[2], Kiran Thirukonda BSA[3]

Affiliations:
1. Washington State University Elson S. Floyd College of Medicine
2. Georgetown University School of Medicine
3. Baylor College of Medicine

Subject: Advance Care Planning Inclusion in Domestic Refugee Health Screening

Sponsored by:

Referred to: MSS Reference Committee

Whereas, the United States Centers for Disease Control and Prevention recommends that newly arrived refugees receive a post-arrival domestic medical screening examination with objectives of improving refugee health and introducing refugees to the US healthcare system[1-3]; and

Whereas, existing domestic refugee health screening guidelines currently do not include any recommendations on conducting culturally-responsive conversations and education about advance care planning (ACP), despite AMA policy recognizing ACP as an important means of supporting patient self-determination and informed medical decision-making[4]; and

Whereas, ACP is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care, and standard ACP practices provide patients opportunities to learn about their rights during incapacitation in the US healthcare system, identify a healthcare proxy, increase the likelihood that treatment reflects their documented preferences, and reduce the ethical and legal complications that arise when a patient's wishes are unknown[5-6]; and

Whereas, studies show refugee ACP awareness is as low as 21% in the US, with only 6% having engaged in the process, though a majority express interest in discussing ACP with their physician once educated[7-8]; and

Whereas, low engagement in ACP among ethnic minorities in the U.S. has been found to be linked to a range of ethnicity-specific barriers and facilitators, a pattern likely compounded among refugees by resettlement-related stressors and differing cultural backgrounds, demonstrating a need for culturally responsive, rather than generic, approaches by providers[9]; and

Whereas, domestic refugee health screening appointments offered to all newly arrived refugees by the Office of Refugee Resettlement are optimal standardized early points of contact for ACP engagement as data suggests that many refugee patients, up to 31%, are lost to follow-up when given primary care referrals from their screening appointments[10-11];

Whereas, the aforementioned barriers to follow-up care are likely to worsen with termination of federal Medicaid funding eligibility for an estimated 1.4 million refugees starting October 2026 per State Health Official Letter #26-001 issued by the Centers for Medicare and Medicaid Services[12-13]; and

Whereas, policies requiring hospitals to ask about immigration status create barriers to healthcare access and ACP, exacerbating healthcare disparities and presenting ethical concerns — an argument for building ACP into the refugee screening exam, a resettlement-specific, protection-oriented setting rather than leaving it to be raised later in a general hospital context[14]; and

Whereas, recorded ACP decisions are of particular relevance in the refugee population, given that decision-making capabilities during incapacitation are otherwise, by default, relegated by state laws to spouses, parents, and adult children— individuals whose presence is highly variable based on the refugee immigration process and whose absence may create ethical and legal ambiguity in cases of refugee patient incapacitation where no other formally recorded healthcare proxy exists[1, 14]; and

Whereas, existing AMA policy H-140.845 supports ACP education and the use of advance directives and health care proxies, while H-350.957 recognizes the unique health needs of refugees and supports culturally-responsive policies and resources to address refugee health disparities, but neither specifically addresses offering culturally-responsive ACP education as part of domestic refugee medical screening nor any specific infrastructure to ensure ACP execution; therefore be it

RESOLVED, that our American Medical Association support the development and dissemination of a culturally-responsive, voluntary, trauma-informed, and linguistically appropriate advanced care planning component by the Centers for Disease Control and Prevention as part of its standardized national refugee screening guidelines for newly arrived refugees.

Fiscal note: TBD

Date received: 9/6/2026

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RELEVANT AMA POLICY

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845
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; … (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; … (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. [Reaffirmed: BOT Rep. 20, A-25Reaffirmed: BOT Rep. 12, A-26]

Addressing Immigrant Health Disparities H-350.957
Our AMA will: (1) recognize the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees; (2) urge federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocate for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocate for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. [Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19; Modified: BOT Rep. 08, I-24]

RELEVANT MSS POSITIONS

Refugee Health Care 250.020MSS
AMA-MSS asked the AMA to:
(1) recognize the unique health needs of refugees;
(2) encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees." [MSS Amended Res 4, A-09, AMA Res 804, I-09 [H-350.957]. Modified and Reaffirmed: MSS GC Rep A, I-14. Reaffirmed: MSS Res 30, A-18]

AMA-MSS Support of Advance Directives 140.007MSS
(2) AMA-MSS will ask the AMA to encourage physicians to discuss advance directives and organ donation with all patients, including young adults, as a part of the ongoing doctor-patient relationship…
(4) AMA-MSS will ask the AMA to support policies and legislation mandating physician reimbursement for time spent discussing advance directives with patients. (MSS Res 27, I-90, MSS Sub Res 59, I-98, MSS Res 20, I-09, MSS GC Rep A, I-06, MSS GC Rep I, I-84, Consolidated: MSS GC Rep F, I-10. Modified: MSS Res 04, I-16. Amended, MSS Res. 53, I-21. Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 012
(I-26)

Introduced by: Sreya Mandava[1], Sarah Jiang[1]

Affiliations: [1] University of Missouri-Kansas City

Subject: Mandating Public Disclosure of Private Equity Acquisitions

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, a “privately held” corporation is a corporation that issues shares of stock that are not traded on public stock exchanges, are subject to different disclosure and regulatory oversight than corporations that issue shares traded publicly, in markets such as the New York Stock Exchange and the NASDAQ , which may limit consumers’ access to information about their operations and policies, and are therefore inherently positioned to execute actions and policies that are less consumer-centric than are publicly-traded corporations[1–3] ; and

Whereas, one type of privately held corporation, “Private Equity” (PE) corporations, do not themselves produce goods or services, but instead, purchase other “privately held” corporations that do produce goods or services with the principal objective of generating profits that exceed those typically earned by publicly-traded corporations, placing the delivery of excellent goods and/or services as a secondary consideration[2,3]; and

Whereas, for a period greater than a decade, PE corporations have markedly increased their ownership share of health care entities which include an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan referenced from 42 U.S.C. § 18113(b)[4,5]; and

Whereas, this increasing PE ownership of health care entities has been associated with negative impacts on patients and health care workers as PE has pursued “monetizing” of the health care entities they purchase to maximize profits, a process which has resulted in a process associated with reductions in services, including maternity care, and workforce cuts that may require remaining employees to provide care with fewer staff members[6–12]; and

Whereas, This PE corporate behavior has had negative effects upon patients, such as but not limited to a 2.7% increase in 30-day post-operative mortality, higher charge-to-cost ratios, “significantly worse outcomes for Medicare patients”, 1.7% increase in nursing home mortality over a 12-year period, falls, new infections, and other harms during hospital stays, and increased complication rates despite a younger average patient population[8–12]; and

Whereas, The Hart-Scott-Rodino Antitrust Improvements Act mandates public disclosure of PE acquisitions of health care entities within 30 days only when PE health transactions of health care entities involve a purchase price that exceeds $133.9 million dollars[13]; and

Whereas, many PE health care entity acquisitions are made for purchase prices that are less than $133.9 million dollars, thus not triggering a requirement for public reporting, and are therefore not transparently revealed to health care consumers who are likely to be directly or indirectly harmed by PE acquisitions of such health care entities , and , increasing the time frame of reporting to the public while removing the minimal financial threshold will allow consumers reasonable time to make educated decisions or action plans regarding their access to healthcare[7,13,14] ; and

Whereas, there is increasing interest at the federal level to limit PE involvement and increase oversight of PE-owned healthcare facilities to prevent violation of anti-trust and monopoly laws[13,15]; and

Whereas, 14 states and 5 territories lack laws specifically protecting constituents from transactions that may adversely affect access to or quality of health care, while 48 states have general public notice statutes establishing eligibility requirements for outlets authorized to publish notices to the public, with Delaware and Alaska as exceptions[4,6,7,16]; and

Whereas, the laws of the various states differ markedly regarding disclosure timelines and the regulation of mergers and acquisitions in ways that may inadequately protect the interests of health care consumers, and reasonable standardization of disclosure timelines using the longest timeline currently implemented of 90 days would promote timely public access to information concerning such transactions; and[6,7,17]; be it therefore

RESOLVED, that our AMA advocate for legislation requiring that public disclosure and notification to the relevant state regulatory authorities be made at least 90 days prior to the consummation of any transaction, merger, acquisition, or restructuring by a private equity corporation that would transfer ownership, majority governance, or operational authority of a healthcare entity to another entity, and be it further

RESOLVED, that our AMA advocate that such disclosure be submitted to the appropriate federal regulatory authority and made publicly available to qualifying regional print and electronic news media outlets in each state affected by a private equity acquisition of a healthcare entity, provided that such outlets have readership, audience, or geographic-reach requirements, and be it further

RESOLVED, that our AMA supports the mandated preservation of essential services including emergency, inpatient, surgical, maternal, imaging, behavioral health, and any other services necessary to meet community needs upon acquisition, by requiring PE to create an escrow account to fund at least five years of anticipated operating expenses and capital expenses incurred by health care entities PE corporations newly acquire/merge/contract with, and be it further

RESOLVED, that our AMA supports mandates the reporting of patient quality and outcome metrics including but not limited to 90-day mortality post-discharge, patient reported outcomes measures (PROM), surgical mortality rates, central line-associated bloodstream infections

(CLABSI), catheter-associated urinary tract infections (CAUTI), and average length of stay (LOS) where applicable for 3 years after acquisition.

Fiscal Note: TBD

Date Received: 08/09/2026

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RELEVANT AMA POLICY

Strengthening Efforts Against Horizontal & Vertical Consolidation D-160.906
Our American Medical Association advocates to adequately resource competition policy authorities such as the Federal Trade Commission (FTC) and Department of Justice Antitrust Division to perform oversight of health care markets.

Impact of Integration and Consolidation on Patients and Physicians H-160.885
Our American Medical Association will continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor.
Our AMA will continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians.

Our AMA will support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions thatmay fall below the Federal Trade Commission (FTC)/Department of Justice review threshold.
Our AMA will encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns ofanticompetitive behavior.
Our AMA will encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals andphysician practices, with the FTC via their online submission form.

Hospital Merger Study H-215.969
It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: medical staff representation on the board of directors; clinical services to be offered by the institutions; process for approving and amending medical staff bylaws;selection of the medical staff officers, medical executive committee, and clinical department chairs; credentialing and recredentialing of physicians and limited licensed providers; quality improvement; utilization and peer review activities; presence of exclusive contracts for physician services and their impact on physicians' clinical privileges; conflict resolution mechanisms; the role, if any, of medical directors and physicians in joint ventures; control of medical staff funds; successor-in-interest rights; that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and Our AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

RELEVANT MSS POSITIONS
Supporting Efforts to Strengthen Competition in U.S. Healthcare Provider Markets 165.029MSS
AMA-MSS will ask the AMA to (1) oppose not-for-profit firm immunity from Federal Trade Commission competition policy enforcement in the healthcare sector, which represent the majority of U.S. hospitals; (2) advocate to adequately resource competition policy authorities such as the Federal Trade Commission and Department of Justice Antitrust Division to perform oversight of healthcare markets; (3) support lowering the transaction value threshold for merger reporting in healthcare sectors to ensure that vertical acquisitions in healthcare do not evade antitrust scrutiny; and (4) support healthcare-specific advocacy efforts which will strengthen antitrust enforcement in the healthcare sector through multiple mechanisms, including but not limited to a) Simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) Encouraging the FTC to leverage its authority to increase the frequency of challenges in consolidated healthcare markets.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 015
(I-26)

Introduced by: Sreya Mandava[1], Sarah Jiang[1]

Affiliations: [1] University of Missouri-Kansas City

Subject: Reducing healthcare monopolies and effects on healthcare delivery

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Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, mergers, acquisitions, and contracts (MACs) between healthcare systems or practices can lead to increase healthcare costs, reduce access for consumers, and create monopolies[1–4]; and

Whereas, as of 2025, hospital acquisition of physician practices can lead to a 14% average increase in service price, and horizontal hospital acquisition can lead to a 6-65% price increase1,2,5; and

Whereas, Mergers and acquisitions, especially by private equity leads to hospital closures, quality reductions, allows for monopoly creation, and hospital closures, with “nearly half of all metropolitan areas had only one or two hospital systems providing inpatient care”[1–4]; and

Whereas, there are a growing number of insurance companies that are acquiring healthcare facilities, which creates financial incentives to decrease access to care[1,2,5]; and

Whereas, 35/50 states in the country have differing laws that guide reporting of MACs with differing timelines and financial thresholds for reporting, with the longest period measuring 90 days prior to closing[3,4,6]; and

Whereas, there is a widespread desire for public dissemination of information regarding mergers, contracts, and acquisitions that do not meet the Hart-Scott-Rodino Antitrust Improvements Act which mandates public disclosure of PE acquisitions of health care entities within 30 days only when PE health transactions of health care entities involve a purchase price that exceeds $133.9 million dollars7,8; and

Whereas, the Herfindahl-Hirschman Index measures market concentration and competition among hospitals, health systems, or insurance companies used to establish antitrust guidelines[7,8]; and

Whereas, nearly half of all metropolitan areas were controlled by one or two healthcare systems in 2024, superseding the minimum HHI for a highly concentrated market to qualify as a monopoly[3]; and

Whereas, inconsistent or overly broad definitions of health care catchment areas may allow for intentional distortion or understate calculated market concentration, including Herfindahl-Hirschman Index values and market shares, potentially limiting regulatory review of antitrust violations and public reporting mandates[9,10]; and

Whereas, there is increasing interest at the federal level to limit and increase oversight of private equity involvement of healthcare facilities to prevent violation of anti-trust and monopoly laws[11,12]; be it therefore

RESOLVED, that our AMA supports federal and state regulation of healthcare delivery catchment area definitions to prevent intentional distortion of those boundaries that artificially reduces calculated HHI or combined market share.

Fiscal Note: TBD

Date Received: 08/09/2026

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RELEVANT AMA POLICY

Enter the top 3-5 most relevant AMA policies and top 3-5 most relevant MSS policies pertaining to your resolution, with the associated policy timeline (found at the bottom or end of the policy). You **do not** need to include all policies. If you are citing a lengthy policy, you may include only the paragraphs or clauses relevant to your resolution.

Health Care Entity Consolidation D-383.980

Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

Vertical Consolidation in Health Care – Markets or Monopolies D-160.908

(1)Our American Medical Association advocates against anticompetitive business practices that have the potential to adversely affect the physician patient relationship, to result in higher costs or decreased quality of care, or are not in the best interest of patients, the public and/or physicians. (2) Our AMA

supports efforts to increase transparency, review, and enforcement of laws with respect to vertical mergers that have the potential to negatively impact the health care industry. (3)Our AMA will work with all appropriate stakeholders to create model legislation to prohibit anticompetitive business practices within the health care sector.

Corporate Investors and Other Corporate Entities H-160.891
…(2)Our AMA supports improved transparency regarding corporate investments in and/or relationships to physician practices, subsidiaries and/or related organizations that interact with the physician group and/or patients of the physicians, and subsequent changes in health care prices, quality, access, utilization, and physician payment.(3)Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor relationships on patients and the physicians in practicing in that specialty.

RELEVANT MSS POSITIONS

Supporting Efforts to Strengthen Competition in U.S. Healthcare Provider Markets 165.029MSS
AMA-MSS will ask the AMA to (1) oppose not-for-profit firm immunity from Federal Trade Commission competition policy enforcement in the healthcare sector, which represent the majority of U.S. hospitals; (2) advocate to adequately resource competition policy authorities such as the Federal Trade Commission and Department of Justice Antitrust Division to perform oversight of healthcare markets; (3) support lowering the transaction value threshold for merger reporting in healthcare sectors to ensure that vertical acquisitions in healthcare do not evade antitrust scrutiny; and (4) support healthcare-specific advocacy efforts which will strengthen antitrust enforcement in the healthcare sector through multiple mechanisms, including but not limited to a) Simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) Encouraging the FTC to leverage its authority to increase the frequency of challenges in consolidated healthcare markets.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 016
(I-26)

Introduced by: Andrea Ramos[1]

Affiliations: University of Texas Rio Grande Valley School of Medicine[1]

Subject: Sudden Cardiac Arrest Preparedness in Primary Care Settings

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, out-of-hospital cardiac arrest (OHCA) remains a substantial public health burden, with 2024 Cardiac Arrest Registry to Enhance Survival (CARES) data demonstrating an incidence of approximately 78.7 EMS-treated OHCAs per 100,000 persons in covered U.S. populations and the 2026 American Heart Association Heart Disease and Stroke Statistics report that 18.3% of EMS-treated adult OHCAs presented with an initial shockable rhythm; these patients had a survival-to-hospital-discharge rate of 29.2%, compared with 10.5% overall[1]; and

Whereas, survival from cardiac arrest declines by approximately 7% to 10% for every minute that defibrillation is delayed, making immediate on-site access to an automated external defibrillator (AED) a critical, time-sensitive determinant of patient outcomes[2]; and

Whereas, cardiac arrest can occur in outpatient settings due to undiagnosed arrhythmias, cardiac ischemia, or acute decompensation in patients who present to primary care clinics appearing clinically stable, and a 15-year U.S. study of out-of-hospital cardiac arrests in ambulatory clinics found that defibrillator use before EMS arrival was associated with improved patient outcomes, supporting the importance of timely cardiac-arrest preparedness in outpatient settings[9]; and

Whereas, most state AED-placement laws commonly apply to specified settings including schools, gyms, dental offices, and other public facilities, while outpatient primary care practices are not uniformly subject to comparable AED-placement requirements[3]; and

Whereas, AMA Policy H-130.938, "Cardiopulmonary Resuscitation (CPR) and Defibrillators," already supports widespread AED placement, CPR and AED training, funding for AED acquisition, uniform state liability protections, and equitable targeted placement in communities with disproportionate rates of OHCA, and separately encourages K–12 schools to develop emergency action plans for sudden cardiac events, but does not explicitly extend comparable emergency-preparedness guidance to outpatient primary care settings[4]; and

Whereas, AMA Policy H-475.984, "Office-Based Surgery Regulation," establishes a risk-based precedent by requiring trained resuscitation personnel and appropriate resuscitative equipment for office-based procedures involving moderate sedation, deep sedation, or general anesthesia, demonstrating that our AMA already supports scaling emergency-preparedness expectations to the outpatient clinical setting[5]; and

Whereas, the Cardiac Arrest Survival Act of 2025 (H.R. 1466), currently pending before the House Committee on Energy and Commerce, would amend the Public Health Service Act to establish a nationally uniform baseline of civil liability protection for AED users, device owners, and premises managers, giving our AMA an active federal legislative vehicle through which to reinforce the uniform liability protections already called for in Policy H-130.938, and strengthening the case for extending that policy's broader preparedness framework to outpatient primary care settings[6]; and

Whereas, AED device acquisition alone can range from approximately $1,460 to $2,940 per unit as of 2026, with additional recurring costs for pad and battery replacement every two to five years and staff CPR/AED training, together representing a nontrivial expense for small, independent, rural, and safety-net primary care[7]; and

Whereas, public funding mechanisms have historically supported AED acquisition and training in rural communities, including HRSA's Rural Access to Emergency Devices Grant Program8, and current federal programs such as the USDA Community Facilities Direct Loan and Grant Program provide funding for equipment purchases for eligible rural health care facilities, including medical clinics[10], demonstrating precedent and existing mechanisms through which public funding can offset emergency-preparedness costs; and

Whereas, primary care practices can meaningfully improve readiness for sudden cardiac arrest through the development of emergency action plans, appropriate CPR and AED training, and AED access when feasible; therefore be it

RESOLVED, that our American Medical Association amend Policy H-130.938, "Cardiopulmonary Resuscitation (CPR) and Defibrillators," by addition:

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

1. Our American Medical Association supports publicizing the importance of teaching CPR, including the use of automated external defibrillation.
2. Our AMA strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs.
3. Our AMA encourages the American public to become trained in CPR and the use of automated external defibrillators.
4. Our AMA advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held.
5. Our AMA encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events.
6. Our AMA supports increasing government and industry funding for the purchase of automated external defibrillator devices.
7. Our AMA endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel.
8. Our AMA supports the development and use of universal connectivity for all defibrillators.

9. Our AMA supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use.
10. Our AMA will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications.
11. Our AMA urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators.
12. Our AMA supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.
13. Our AMA encourages the distribution of Automated External Defibrillators in an equitable manner through the development and utilization of targeted placement strategies in order to increase availability and decrease disparities in areas where disproportionate rates of out-of-hospital cardiac arrest episodes exist.
14. Our AMA supports efforts to improve preparedness for sudden cardiac arrest in outpatient primary care settings through the development of emergency action plans, appropriate CPR and AED training, and placement of automated external defibrillators in outpatient primary care settings when feasible, while advocating for public and/or private funding mechanisms that avoid imposing unfunded mandates on physician practices.

Fiscal Note: TBD

Date Received: 08/09/2026

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RELEVANT AMA POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938
Supports widespread AED placement (including K–12 schools), CPR/AED training and public awareness, public and private funding for AED acquisition and training, universal defibrillator connectivity, uniform state liability protections, and equitable targeted placement in communities with disproportionate OHCA rates. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 211, I-14; Modified: Res. 919, I-15; Appended: Res. 211, I-18; Modified: Res. 418, A-23]

Office-Based Surgery Regulation H-475.984
Requires emergency transfer arrangements, trained resuscitation personnel, BLS-trained staff, and appropriate resuscitative equipment for higher-risk office-based procedures — a risk-based

precedent for setting-specific emergency preparedness. [BOT Action in response to referred for decision BOT Rep. 23, A-03; Modified: CMS Rep. 4, A-13; Modified: CCB/CLRPD Rep. 1, A-23]

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945
States that all licensed physicians should be proficient in basic CPR and advanced cardiac life support to the extent appropriate for their clinical responsibilities. [CCB/CLRPD Rep. 3, A-14; Modified: CME Rep. 1, A-22]

Implementation of Automated External Defibrillators in High-School and College Sports Programs D-470.992
Supports state legislation and educational policies encouraging AEDs and trained personnel in high-school and college athletic programs, a setting-specific precedent for the proposed primary-care amendment. [Res. 421, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

Access to Emergency Services H-130.970
States that physicians and health care facilities have an ethical responsibility to provide needed emergency services. [CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep.07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 1, I-22]

RELEVANT MSS POSITIONS
130.002MSS: Use of Automatic External Defibrillators
Supports legislation increasing AED use, provided anticipated users receive CPR/AED training, devices are maintained per manufacturer guidance, EMS is activated following use, and AED locations are registered with local dispatch systems. (MSS Sub Res 12, A-98), (AMA Res 503, I-98 Referred), (BOT Rep 21, A-99 Adopted in Lieu of Res 503, I-98)

270.019MSS: Implementation of AEDs in High School and College Sports Programs
Supports state legislation or educational policy encouraging AED placement and trained personnel at participating high schools and colleges. (MSS Sub Res 5, I-07), (AMA Res 421, A-08 Adopted [D-470.992])

440.117MSS: Increasing the Availability of Automated External Defibrillators
Supports amending H-130.938 to encourage equitable AED distribution through targeted placement strategies in areas with disproportionate OHCA rates. (MSS Res. 029, A-22)

270.023MSS: Requiring Placement of AEDs in All Nursing Homes
Supports state legislation mandating AED placement in nursing homes as a condition of licensure — prior MSS support for setting-specific state AED requirements. (MSS Res 28, A-11), (Reaffirmed Existing Policy in Lieu of AMA Res 208, I-11)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 101
(I-26)

Introduced by: **Jeffrey Gu[1], Jessica Zeng[2]**

Affiliations: [1] University of Virginia School of Medicine
[2] Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C.

Subject: Medicare Coverage of Low-Vision Devices

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to:

Whereas, low vision is visual impairment that limits everyday activities despite ordinary eyeglasses, contact lenses, medication, or surgery, and rehabilitation seeks to maximize function, independence, and quality of life using remaining vision[1,3]; and

Whereas, the Centers for Disease Control and Prevention estimates that 7.15 million Americans had uncorrectable best-corrected visual-acuity loss in 2024, including 3.28 million aged 65 years or older, with prevalence rising from 4.54% at ages 65–84 to 12.38% at age 85 or older[2]; and

Whereas, the American Academy of Ophthalmology describes rehabilitation as part of the continuum from diagnosis and treatment through rehabilitation, with care determined by functional goals, visual deficits, and clinical complexity; and for purposes of this resolution, the full continuum includes individualized assessment and planning, medically necessary assistive technology, device fitting and training, skilled training in functional vision, independent living, and mobility, and appropriate follow-up, each provided as clinically indicated[3]; and

Whereas, low-vision assistive technologies range from optical magnifiers and telescopes to electronic devices providing magnification, contrast enhancement, optical-character recognition, text-to-speech, larger displays, or distance viewing, but exclude ordinary refractive eyewear and general-purpose electronics without medically necessary low-vision functions[3]; and

Whereas, a multicenter trial found that magnifiers improved reading ability by 0.61 logits and subsequent training added 0.44 logits, while LOVIT found that comprehensive rehabilitation improved reading, mobility, visual-information processing, visual-motor skills, and overall visual ability, and LOVIT II found therapist-supported rehabilitation more effective than devices alone, particularly for patients with greater impairment[7–9]; and

Whereas, suitable rehabilitation devices have a range of prices, from $539 for a handheld video magnifier to $3,699 for a larger-display system with distance viewing, but only coverage of the

least costly clinically appropriate device that meets a documented functional goal will be supported, with higher-cost technology covered when lower-cost options are inadequate[4–6]; and

Whereas, in LOVIT II, mean direct costs were $1,662 for device-based services and $1,788 for therapist-supported rehabilitation, which had greater visual improvement outcomes, demonstrating skilled rehabilitation comes at modest incremental clinical cost compared to devices alone[10]; and

Whereas, vision impairment threatens independent living by making shopping, financial tasks, cooking, and medication management more difficult, and adults aged 71 years or older with vision impairment had higher prevalences of falls (18.5% versus 14.1%) and fear of falling (38.4% versus 30.5%) than those without impairment[11,12]; and

Whereas, nonfatal falls among adults aged 65 years or older accounted for $80.0 billion in U.S. health care spending in 2020, mostly paid by Medicare, while severe vision loss among Medicare beneficiaries was associated with longer hospital stays, 22% higher odds of readmission, and 12% higher hospitalization and 90-day costs[13,14]; and

Whereas, Medicare covers qualifying rehabilitation therapy but does not permit low-vision specialists to bill as therapy professionals and denies low-vision aids billed under HCPCS codes V2600, V2610, and V2615[15];

Whereas, the Centers for Medicare & Medicaid Services tested services by physicians, occupational therapists, and certified vision-rehabilitation professionals, that demonstration did not create permanent nationwide coverage[15–17]; and

Whereas, H.R. 2045 and S. 2084 would cover physician-prescribed low-vision devices with reasonable limitations, and AMA policy supports access to low-vision aids, but neither the pending legislation nor existing AMA policy specifically addresses Medicare coverage of the complete continuum defined above[18–20]; therefore be it

RESOLVED, that our American Medical Association supports federal legislative and regulatory efforts to establish Medicare coverage of the full continuum of medically necessary comprehensive low-vision rehabilitation for beneficiaries with documented vision-related functional limitations.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Addressing the Need for Low Vision Aid Devices D-185.978

Our American Medical Association will work with interested national medical specialty societies and state medical associations to support insurance coverage for and increased access to low vision aids for patients with visual disabilities. [Res. 807, I-19]

Increasing Patient Access to Hearing, Dental and Vision Services D-185.972

Our AMA will: (1) promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia in later life, to physicians as well as to the public; (2) promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment or dementia and amenable to correction; (3) work with interested national medical specialty societies and state medical associations to encourage and promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services; and (4) work with interested national medical specialty societies and state medical associations to encourage and

promote research into vision and dental health and to increase patient access to vision and dental services. [Res. 113, A-22]

Eye Exams for the Elderly and Adults H-25.990
Our AMA encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients and adults who suffer from chronic systemic conditions that increase their likelihood of developing eye disease as well as a baseline eye examination for all adults aged 40 and above. [Res. 813, I-05; Modified: Res. 418, A-24]

RELEVANT MSS POSITIONS

180.021MSS Medicare Coverage of Dental, Vision, and Hearing Services
AMA-MSS supports Medicare coverage of routine eye examinations and visual aids, including eyeglasses and contact lenses. (MSS Res. 16, I-21), (AMA Res. 119, Alternate Resolution Adopted in Lieu of, A-22)

290.010MSS Support for Vision Screenings and Visual Aids for Adults Covered by Medicaid
AMA-MSS will ask the AMA to advocate that routine comprehensive vision exams and visual aids, including eyeglasses and contact lenses, be covered in all Medicaid and CHIP programs and any new public payers (MSS CEQM CGPH Rep. A, I-21), (AMA Res.102, Modified [D-185.972], A-24)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 102
(I-26)

Introduced by: Madelyn Hartrim-Lowe[1]

Affiliations: [1] Washington State University Elson S Floyd College of Medicine

Subject: Evaluating No Surprises Act Arbitration

Sponsored by:

Referred to: MSS Reference Committee

Whereas, the No Surprises Act (NSA), enacted in 2020 and implemented in 2022, established comprehensive federal protections against surprise medical billing for emergency services, air ambulance transport, and out-of-network care at in-network facilities[1,2]; and

Whereas, the NSA established the Independent Dispute Resolution (IDR) process using final-offer ("baseball") arbitration in which an arbiter must choose either the insurer's or the provider's payment offer with consideration of the qualifying payment amount (QPA), defined as the insurer's median in-network rate, alongside other factors to resolve payment disputes between insurers and out-of-network providers while removing patients from payment negotiations[2-4]; and

Whereas, implementation of the Independent Dispute Resolution process has proven substantially more complex than anticipated and subject to extensive litigation with high arbitration volume, administrative backlogs, and evolving federal regulations creating challenges for patients, physicians, insurers, and regulators[5-7]; and

Whereas, published analyses demonstrate considerable variation in Independent Dispute Resolution outcomes across specialties and services, raising questions regarding consistency, predictability, and the long-term sustainability of the current arbitration framework[8-9]; and

Whereas, investigators have raised concerns that aspects of the current final-offer ("baseball") arbitration model may create unintended incentives affecting reimbursement negotiations, provider and insurer behavior, and overall health care spending while preserving important protections against insurer underpayment[10-12]; and

Whereas, additional reports have identified emerging business models that may exploit NSA's framework by operating outside traditional hospital networks while leveraging the IDR process to obtain reimbursement rates far exceeding typical in-network payments[13-15]; and

Whereas, investigations have documented continued patient exposure to unexpected medical costs despite the NSA, including instances where insurers increase patient cost-sharing

amounts following IDR decisions or fail to comply with payment obligations after binding arbitration outcomes[16-17]; and

Whereas, the NSA's effects extend beyond out-of-network payments to influence in-network contract negotiations as the IDR process and QPA benchmarks alter the bargaining dynamics between physicians and insurers with potential spillover effects on in-network reimbursement rates across specialties[18]; and

Whereas, Congress, federal agencies, and health policy researchers continue to evaluate implementation of the No Surprises Act with multiple organizations calling for additional research regarding the long-term effects of the Independent Dispute Resolution process on patients, physicians, insurers, and health care markets[19-20,]; and

Whereas, existing AMA policy (D-285.957 and D-285.955) appropriately supports fair implementation of the No Surprises Act, timely insurer compliance with Independent Dispute Resolution decisions, and protection of patients from surprise medical bills, but fails to direct a comprehensive evaluation of NSA implementation on physician reimbursement, patient costs, and health system integrity[21-22]; and

Whereas, the AMA is actively supporting the No Surprises Enforcement Act (H.R. 4710/S. 2420) and has engaged in advocacy and litigation addressing implementation and insurer noncompliance; however, questions remain regarding whether incentives inherent to the statutory structure of the IDR process itself may contribute to unintended reimbursement patterns, strategic use of the IDR process, or increased payer- and system-level costs, warranting further evaluation to inform future AMA policy and advocacy[23-25]; therefore be it

RESOLVED, that our American Medical Association study whether the current implementation of the Independent Dispute Resolution process established under the No Surprises Act is effectively achieving the law's intended goals of protecting patients from unexpected medical costs while ensuring fair physician reimbursement, including, but not limited to, the effects of the current final-offer ("baseball") arbitration framework on physician reimbursement, patient financial protections, insurer behavior, administrative burden, and health care spending, and report its findings to the House of Delegates.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Addressing the Failed Implementation of the No Surprises Act Independent Dispute Resolution Process D-285.957

1. Our American Medical Association will advocate for the federal departments to immediately and correctly implement the fair and timely Independent Dispute Resolution (IDR) process as stipulated by the No Suprises Act including advocating specifically for the following:
    a. Specific requirements for insurers: Insurers must be required to make IDR loss payments directly to physicians, clarify IDR eligibility on explanation of benefit forms, and be prohibited from falsely claiming ineligibility due to network status or incorrect venue claims.
    b. Operational improvements in the IDR process: IDR entities must not close claims based on unverified insurer claims, an adequate number of IDR entities must be certified, and a structured timeline must be set for IDR entity selection and payment process. [Res. 253, A-24]

Out-of-Network Care H-285.904

1. Our American Medical Association adopts the following principles related to unanticipated out-of-network care:
    a) Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
    b) Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
    c) Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
    d) Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
    e) Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
    f) Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
    g) Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
    h) Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges. [Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22; Reaffirmed: CMS Rep. 3, I - 23; Reaffirmed: CMS Rep. 08, A-24; Reaffirmed: Res 818, I-25; Reaffirmed: Res 117, A-26]

Supporting Penalties on Insurers Who Fail to Pay Doctors D-285.955

Our American Medical Association advocates for passage of legislation that imposes penalties on insurers that fail to pay doctors within 30 days when doctors win for a claim brought to the federal Independent Dispute Resolution (IDR) process. [Res. 229, I-24]

RELEVANT MSS POSITIONS

130.007MSS Ground Ambulance Services and Surprise Billing

AMA-MSS will ask the AMA to oppose surprise billing practices for ground ambulance services. [MSS Res. 063, I-22; AMA Res. 207, Adopt as Amended, A-23]

155.013MSS Improving the External Appeals Process for Denied Claims

AMA-MSS will ask the AMA to (1) study supporting policies eliminating mandatory internal review requirements as a prerequisite for initiating independent external review of insurance claim denials; and (2) study supporting broadening patient access to independent external review of insurance claim denials, including by removing restrictive eligibility requirements that limit independent external review to cases involving medical judgment, surprise billing, retrospective coverage cancellation, or determinations of experimental treatment. [MSS Res. 122, A-26]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution XXX
(I-26)

Introduced by: **Marfy Abousifein**[1]

Affiliations: [1] Harvard Medical School

Subject: Addressing Financial Toxicity in Patient Care

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Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, out-of-pocket medical expenses, medical debt, and income loss can produce financial toxicity, defined as resulting material, psychological, behavioral, and clinical consequences, including treatment nonadherence or delays, forgoing recommended care or basic necessities, and downstream adverse health outcomes [1-6]; and

Whereas, rising patient cost sharing has imposed widespread financial hardship in the United States, with average deductibles in employer-sponsored plans reaching $1,886 in 2025, medical debt affecting approximately 18% of households, nearly one in five adults spending more than 10% of family income on out-of-pocket healthcare costs, and more than one in four experiencing financial burden or forgoing care because of cost [5,7-11]; and

Whereas, 12.5% of patients with eye disease report difficulty paying medical bills, and recent data in ocular melanoma demonstrate substantial increases in hospital charges to patients despite minimal increases in hospital costs and disparities in charges across patient populations and healthcare settings [17,32]; and

Whereas, studies across medical specialties demonstrate the prevalence of financial toxicity, with approximately 30% of oncology patients reporting delayed or forgone care because of cost, 12.6% of patients with atherosclerotic cardiovascular disease reporting cost-related medication nonadherence, and 41% of adults with diabetes reporting financial hardship from medical bills [2,6,16]; and

Whereas, financial toxicity is associated with clinically important outcomes, including twice the odds of medication nonadherence among patients experiencing financial burden, 15% higher all-cause mortality associated with cost-related medication nonadherence among patients with atherosclerotic cardiovascular disease, and 79% higher mortality among patients experiencing bankruptcy following a cancer diagnosis [2,12,13]; and

Whereas, financial toxicity is independently prognostic rather than a proxy for income or debt, as demonstrated by adjusted analyses showing that among breast cancer survivors perceived

financial toxicity was associated with recurrence or death (HR 1.42) and all-cause mortality (HR 1.74) regardless of objective socioeconomic status, a meta-analysis of more than 280,000 patients with hematologic malignancies found a pooled adjusted mortality hazard ratio of 1.57 (95% CI 1.29–1.91)[14,15]; and

Whereas, leading professional and health organizations, including the American Heart Association, American College of Cardiology, and American Society of Clinical Oncology, have recommended that clinicians discuss costs with patients and supported screening for financial toxicity using validated instruments, yet cost discussions are documented in fewer than 25% of patient encounters and most physicians report discomfort initiating such conversations [18-23,25]; and

Whereas, existing AMA policy, including H-373.990 (Patient Medical Debt) addresses medical debt management through payment plans, discounts, and collection protections, but does not recognize financial toxicity—which captures the downstream clinical consequences of financial strain, not cost alone— as a distinct clinical construct requiring validated screening, systematic measurement of its impact on health outcomes, or integration into clinical decision-making and medical education; and

Whereas, evidence-based interventions to address financial toxicity, when used to systematically screen patients and guide referral to financial counseling and assistance resources, reduced the development or worsening of financial difficulty (30.2% vs 39.0%, p=0.004), as well as copay and medication financial assistance programs associated with a 11-47% higher one-year medication persistence [26,27]; and

Whereas, financial toxicity remains insufficiently addressed as a clinical factor influencing patient outcomes, underscoring the role of physicians in recognizing financial toxicity when it may affect recommended care, incorporating patients' financial circumstances into patient-centered decision-making, and facilitating appropriate referral to available resources [28-31]; therefore be it

RESOLVED, that our American Medical Association supports evidence-based approaches to identifying financial toxicity when it may affect patients' ability to access or adhere to recommended care—including validated patient-reported screening instruments such as the Comprehensive Score for Financial Toxicity (COST), financial navigation programs, and screening integrated into the electronic health record with automated referral—and facilitating appropriate referral to available resources; and be it further

RESOLVED, that our AMA supports research on the prevalence, measurement, determinants, and clinical consequences of financial toxicity across medical specialties, disease states, and patient populations, including, when appropriate, incorporating financial toxicity outcomes into clinical research, quality improvement initiatives, and evaluations of healthcare delivery and patient outcomes; and be it further

Fiscal Note: TBD

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RELEVANT AMA POLICY

Patient Medical Debt H-373.990

1. Our American Medical Association encourages health care organizations to manage medical debt with patients directly, considering several options including but not limited to discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions.
2. Our AMA supports innovative efforts to address medical debt for patients, including sliding-scale, interest-free payment plans before collection or litigation activities and public and private efforts to eliminate medical debt, such as purchasing debt with the intent of cancellation.
3. Our AMA supports amending the Fair Debt Collection Practices Act to include hospitals and strengthen standards within the Act to provide clarity to patients about whether their insurance has been or will be billed, which would require itemized debt statements to be provided to patients, thereby increasing transparency, and prohibiting misleading representation in connection with debt collection.
4. Our AMA opposes wage garnishments and property liens being placed on low-wage patients due to outstanding medical debt at levels that would preclude payments for essential food and housing.
5. Our AMA supports patient education on medical debt that addresses dimensions such as:
    a. patient financing programs that may be offered by hospitals, physicians offices, and other non-physician provider offices;
    b. the ramifications of high interest rates associated with financing programs that may be offered by a hospital, physician's office, or other non-physician provider's office;
    c. potential financial aid available from a patient's hospital and/or physician's office; and
    d. methods to reduce high deductibles and cost-sharing.

[CMS Rep. 05, A-24]

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864

Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and

implementation of potential systems solutions for enhanced patient safety and improved patient outcomes. [Sub. Res. 301, A-13Reaffirmation I-15Reaffirmed in lieu of: Res. 307, A-17]

Improving Pharmaceutical Access and Affordability H-110.962
Our American Medical Association opposes Direct Member Reimbursement plans, where patients pay the full retail costs of a prescription drug that they may then be reimbursed for, due to their potential to expose patients to significant out-of-pocket costs. [Res. 801, I-23]

Improving Affordability in the Health Insurance Exchanges H-165.824
Our American Medical Association will:

a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections

Our AMA supports:

a. eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
b. increasing the generosity of premium tax credits.
c. expanding eligibility for cost-sharing reductions.
d. increasing the size of cost-sharing reductions.

RELEVANT MSS POSITIONS

155.010MSS Opposition to Debt Litigation Against Patients:
AMA-MSS will ask the AMA to encourage health care organizations to: (1) Manage medical debt with patients directly and consider several options, including assistance applying to coverage, discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before using third-party debt collectors, while avoiding those that harass debtors; (2) Consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to patients' well-being; and (3) Make multiple attempts to reach and negotiate with patients before proceeding with litigation against patients or any other punitive actions and reserve litigation for patients who are able, but unwilling to pay. (MSS Res. 26, I-21) (Reaffirmed: I-21)

155.002MSS Cost Containment:
AMA-MSS will ask the AMA to encourage medical schools and hospitals to orient medical students beginning in their clinical training and the house staff to the costs of laboratory tests and procedures (MSS Res 15, I-83 Referred) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

155.004MSS Advocating for Research on Physician-Initiated Conversations About Treatment Cost:

That our AMA (1) support the conduction of controlled studies to determine if conversations about cost with patients have any meaningful change on various measures of health outcomes, including but not limited to quality of treatment decisions, liability, and patient satisfaction; and (2) support studies to determine if physicians or health professionals are the appropriate party to initiate such conversations. (MSS Res 18, A-14) (Reaffirmed: MSS GC Rep A, I-19)

160.025MSS Poverty Screening as a Clinical Tool for Improving Health Outcomes: AMA-MSS will ask the AMA to (1) support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity; and (2) encourage the use of questionnaires to screen for social and economic risk factors in order to improve care plans, and direct patients to appropriate resources. (MSS Res 20, I-12) (Amended AMA Res 404, A-13 Adopted [H-160.909]) (Reaffirmed: MSS GC Report A, I-17) (Reaffirmed: MSS GC Report A, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution XXX
(I-26)

Introduced by:

Affiliations:

Subject: Minimizing Middlemen in Medicare and Medicaid

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Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, Medicare and Medicaid are publicly financed healthcare insurance programs that millions of Americans rely on, providing health coverage to older adults, individuals with disabilities, and low-income individuals, including children and pregnant persons; and

Whereas, Medicare Part C, also known as Medicare Advantage, allows private insurance companies to administer Medicare benefits using taxpayer funds through capitated payments from the federal government; and

Whereas, most state Medicaid programs contract private Managed Care Organizations (MCOs) to administer Medicaid benefits using taxpayer-funded capitation payments[1]; and

Whereas, Medicare Advantage plans and Medicaid MCOs are vehicles through which private insurers use taxpayer money as capital to generate profits, often at the expense of vulnerable populations[2]; and

Whereas, Medicare Advantage was found to cost the federal government approximately $84 billion more than it would to cover the same population with Traditional fee-for-service Medicare[3,4]; and

Whereas, patients on Medicare Advantage plans face restricted provider networks[5], delayed access to care due to prior authorizations[6], and poorer health outcomes compared to patients on Traditional Medicare Part-B[7]; and

Whereas, Medicare Advantage was found to cherry-pick healthy beneficiaries while providing lower-quality services, causing higher-need patients to switch to traditional Medicare at greater rates compared to other enrollees, ultimately generating an additional $41 billion in overpayments[8]; and

Whereas, on average, Medicare Advantage offerings gave private insurers a gross margin of $1,655 per patient - a much higher margin than in other private markets[9]; and

Whereas, administrative expenses are substantially higher under privatized Medicaid managed care, averaging 10%, than under state-administered Medicaid programs, which average 4%[10]; and

Whereas, studies show a 9.8% increase in cost burden to the state Medicaid program over four years in counties that mandated a transition to a Managed Care delivery of services[11]; and

Whereas, in 2012, Connecticut ended all Medicaid contracts with MCOs and moved to a managed fee-for-service model with direct state oversight and management[12,13]; and

Whereas, following this transition, the number of PCPs enrolled with the state Medicaid program increased, especially due to better support from the state in managing their own patient's care[13,14]; and

Whereas, Connecticut reported savings of approximately $400 million every year in administrative costs with this change, and reported saving taxpayers over $4 billion dollars since the program's implementation[14]; and

Whereas, Ohio centralized Medicaid pharmacy benefits under a Single Pharmacy Benefit Manager model in October 2022, improving transparency in pricing, accountability, and fairness in the Medicaid pharmacy benefit administration through standardizing dispensing fees, expanding the pharmacy network, and prohibiting practices like network steering, spread pricing, and post-payment clawbacks[15,16]; and

Whereas, since its installation, the Ohio Department of Medicaid has reported $333 million in administrative savings and $140 million in projected net savings during the first two years compared to expenditures under the previous managed care model[15,16]; and

Whereas, in 2003, Oklahoma terminated its fully-capitated Medicaid program, ending all contracts with private MCOs in favor of a publicly managed fee-for-service program run by the Oklahoma Health Care Authority (OHCA) known as SoonerCare[17,18]; and

Whereas, at the time of its operation, SoonerCare reported improved coverage for children, increased participation of PCPs and specialists in the program, reduced ER utilization and preventable hospitalizations, and program costs per member substantially below the national average[19]; and

Whereas, despite SoonerCare's success, Oklahoma opted to contract with private insurers again in 2021 to manage its newly introduced Medicaid expansion[20] in spite of opposition from various state medical associations including the Oklahoma State Medical Association, the Oklahoma Dental Association, the Oklahoma Osteopathic Association, the Oklahoma Society of Anesthesiologists, and Oklahoma Chapter American Academy of Pediatrics[21]; and

Whereas, since privatization, the OHCA has been placed under investigation by the Oklahoma Attorney General for potential fraud following multiple complaints from providers regarding payment delays, administrative barriers to claims processing, incorrect or inconsistent reimbursement determinations, and claim denials for medically necessary equipment[22,23]; and

Whereas, at A-26, the AMA House of Delegates adopted policy H-290.949, directing the AMA to study the impact of managed care on various state Medicaid programs due at A-27[24]; and

Whereas, recent cuts to the Medicaid program[25] are projected to place great financial strain on the healthcare system[26], necessitating measures to reduce administrative spending at the state level; and

Whereas, the removal of pernicious intermediaries in the administration of public healthcare programs will generate savings that could be redirected towards physician compensation; therefore be it

RESOLVED, our AMA-MSS opposes the use of taxpayer funds to contract private payors in the management of publicly funded healthcare systems, such as Medicare Advantage/Medicare Part-C or Medicaid Managed Care Organizations, and be it further

RESOLVED, our AMA-MSS supports policies that minimize the number and role of private intermediaries in the delivery of public health programs.

Fiscal Note: TBD

Date Received:

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RELEVANT AMA POLICY

Medicare Advantage Policies H-330.878
2. Our AMA will advocate:
for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients.
that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided. [Res. 116, A-17; Reaffirmation: I-18; Appended: Res. 809, I-22; Reaffirmed: Res. 219, I-25; Reaffirmed: Res. 222, A-26]

Study of Cost Implications of Medicaid Managed Care Organizations Compared with State-Administered Medicaid Programs H-290.949
Our American Medical Association will study and report back to the HOD at A-27 on Medicaid managed care organizations and state-administered Medicaid programs, including:
The comparative fiscal implications of programs administered through Medicaid managed care organizations versus those administered directly by states, including administrative costs, medical expenditures, and program oversight costs.
Whether Medicaid managed care arrangements result in net cost savings, increased costs, or cost neutrality compared with state-administered models.
The administrative impact of Medicaid managed care participation on physicians and health systems, including prior authorization requirements, network contracting, and claims administration.
Whether Medicaid managed care arrangements result in increased payments to physicians, including achievement of Medicare-to-Medicaid payment parity.
Whether Medicaid managed care impacts patient access to care, including in rural areas. [Res. 116, A-26]

Saving Traditional Medicare H-390.832
Our American Medical Association will continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion.
Our AMA will continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians.
Our AMA acknowledges that the term "Medicare Advantage" can be misleading, as it implies a superiority or enhanced value over traditional Medicare, which may not accurately reflect the nature and challenges of these plans. [Res, 216, I-23; Reaffirmed: Res. 219, I-25]

RELEVANT MSS POSITIONS

165.020MSS: National Single Payer Healthcare
AMA-MSS supports the implementation of a national single payer system. While our AMA-MSS shall prioritize its support of a federal single payer system, our AMA-MSS may continue to advocate for intermediate federal policy solutions including but not limited to a federal Medicare, Medicaid, or other public insurance option that abides by the guidelines for health systems reform in 165.019MSS and 165.024 MSS.
Our AMA-MSS asked the AMA to remove opposition to single payer from AMA policy, adopt a neutral stance on single payer healthcare reform, and instead evaluate single payer proposals by the extent to which they align with the AMA's policy on healthcare reform. (MSS Res 12, A-17) (MSS Res 40, I-17) (AMA Res 108, A-18, Referred), (CMS Report 2, A-19, Not Adopt), (Amended: MSS GC Report A, A-23), (MSS Res. 048, A-23), (AMA Res 818 from New England Delegation, I-23, Referred), (SD Report A, A-24)

180.031MSS: Corrections to the Medicare Part C Payment Structure
AMA-MSS support policies that reduce or eliminate overpayment of insurance companies under Medicare Part C including, but not limited to:
(1) Reforming risk adjustment models to use multiple years of diagnostic data as it pertains to assigning patients risk scores and/or determining payments granted to Medicare Part C plans;
(2) Altering the methodology for determining what diagnoses qualify for risk-adjustment to make it comparable between Medicare Part C and Traditional Medicare;
(3) Publicly reporting coding pattern differences between Medicare Part C plans and Traditional Medicare including subsequent contract-level risk adjustments;
(4) Reforming the benchmark payment rate system to reduce overall payment rates to insurers;
(5) Reforming the Quality Bonus Payment program to operate in a budget-neutral manner and concentrate on clinically important outcomes. (MSS Res. 115, A-24)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 110
(I-26)

Introduced by: Alexia Childress[1], Neha Sripathi[1], Jeffrey Gu[1], Komal Gandhi[2], Akhila Kunuthuru[3], Jocelyn Chow[4], Sarah Jiang[5], Daniel Kang[6], Kiran Thirukonda[7]

Affiliations: [1]University of Virginia School of Medicine, Region 6
[2]University of Maryland School of Medicine, Region 6
[3]Virginia Commonwealth University School of Medicine, Region 6
[4]Western University of Health Sciences College of Osteopathic Medicine, Region 1
[5]University of Missouri-Kansas City School of Medicine, Region 2
[6]Frank H. Netter MD School of Medicine at Quinnipiac University, Region 7
[7]Baylor College of Medicine, Region 3

Subject: FMAP Supplementation to Reflect Medicaid Population Need

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, Medicaid physician reimbursement rates averaged 71% of Medicare reimbursement rates in 2024, and only 74% of physicians accepting new patients reported accepting new Medicaid patients, compared with more than 95% accepting patients with private insurance[1,2]; and

Whereas, Medicaid covers approximately one in five Americans, yet enrollees experience significant barriers to accessing specialty care such as orthopedics, gastroenterology, neurology, psychiatry, dermatology, and cardiology, with nearly 60% of community health centers reporting difficulty obtaining new specialty visits for Medicaid patients[3,4]; and

Whereas, Medicaid is jointly financed through the Federal Medical Assistance Percentage (FMAP), which reimburses states for a share of qualifying Medicaid expenditures based principally on per-capita income, with rates ranging from 50% to 76.9% for states and 76% to 83% for U.S. territories, meaning that states ordinarily remain responsible for the corresponding nonfederal share of any increase in Medicaid physician payments[5]; and

Whereas, the FMAP formula, calculated as FMAPstate = 1 - (((Per capita $\text{income}_{\text{state}}$)^2/(Per capita $\text{income}_{\text{U.S.}}$)^2) * 0.45), has remained largely unchanged since 1965 and does not account for geographic variation in healthcare delivery costs or differences in the healthcare needs of Medicaid populations, such as disability and long-term acuity (associated with 72% of all Medicaid expenditures)[5-7,15]; and

Whereas, Congress demonstrated the feasibility of a fully federally financed Medicaid physician-payment floor through the Affordable Care Act's (ACA) 2013–2014 Primary Care Payment

Increase, which required payment at Medicare rates and provided a 100% FMAP for the incremental expenditure above each state's baseline payment[8]; and

Whereas, following expiration of that temporary fee increase, audit studies demonstrated that fee reductions compromised appointment availability to the same degree that fee increases improved it, with each $10 change corresponding to a 1.7% change in primary care appointment availability for new Medicaid patients ($p < 0.001$)[9]; and

Whereas, although the Centers for Medicare & Medicaid Services has taken regulatory steps to improve Medicaid access through community health integration in the 2024 Medicare Physician Fee Schedule and enabling state-directed value-based payments through CMS-2439-F, state-level access standards alone have shown little evidence of improving specialty access for Medicaid enrollees[10-11]; and

Whereas, Congress has demonstrated that enhanced federal matching can incentivize state Medicaid investment through the American Rescue Plan Act of 2021, which provided states newly adopting Medicaid expansion a five percentage-point increase in their regular FMAP for up to two years; the incentive is no longer available to states adopting expansion on or after January 1, 2026[12]; and

Whereas, in addition to recommending downturn-related assistance addressed in existing AMA policy (H-290.958), the U.S. Government Accountability Office (GAO) has also found that the per capita income-based model of FMAP is "a poor proxy for both the state's population in need of Medicaid services and the ability of a state to fund Medicaid" and has identified potential measures of state health care needs, geographic cost differences, and fiscal capacity that could improve on it[13,14]; and

Whereas, examples of these measures described by the GAO include age distribution, the prevalence of disability and complex health conditions, low-income population size, the number of children in foster care, Medicaid enrollment, and Medicaid health care utilization and spending[14]; and

Whereas, current AMA policy supports adequate physician payment and maintenance of federal funding for Medicaid expansion (H-290.965), continuation of the Affordable Care Act's Medicaid primary care payment increases beyond 2014 (D-290.977), payment parity with Medicare (H-385.921), AMA advocacy for federal legislation and regulations on Medicaid funding (H-290.963), FMAP increases for states during significant economic downturns (H-290.958), and increase of FMAP to 100% for medical services received through an Urban Indian Organization (D-350.987), but does not address structural reform to the FMAP formula; therefore be it

RESOLVED, that our American Medical Association supports federal legislation and regulatory action to supplement the per capita income-based Federal Medical Assistance Program formula in order to account for differences in Medicaid population need and geographically varying healthcare delivery costs.

RESOLVED, that our AMA study adjustments that can be made to the per capita income-based Federal Medical Assistance Program formula in order to better reflect the diversity of state healthcare needs, and support the incorporation of those adjustments into the formula.

Fiscal Note: TBD

Date Received:

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RELEVANT AMA POLICY

Affordable Care Act Medicaid Expansion H-290.965
Our AMA: …(6) supports adequate physician payment as an explicit objective of state Medicaid expansion programs; (7) supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care; (8) will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services; (10) supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016; and (11) supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists. [CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 122, A-22]

Pediatric Specialty Medicaid Reimbursement D-290.972
Our AMA: …(2) will advocate for payment parity with Medicare for the same or similar services provided to pediatric patients under Medicaid; and (5) will advocate for any demonstration projects undertaken to modernize Medicaid payment using value based payment models developed by the AMA and pediatric specialty societies be exempt from Medicaid demonstration project budget neutrality requirements. [Res. 249, A-24]

Medicaid Primary Care Payment Increases D-290.977
Our AMA: (1) advocates that the Affordable Care Act's Medicaid primary care payment increases for Evaluation and Management codes and vaccine administration codes include obstetricians and gynecologists as qualifying specialists, and support flexibility to achieve the best possible outcome; and (2) advocates for the Affordable Care Act's Medicaid primary care payment increases to continue past 2014 in a manner that does not negatively impact payment for any other physicians. [CMS Rep. 7, I-14; Reaffirmed in lieu of: Res. 807, I-18]

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
Our AMA: (6) supports an increase to the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) and encourages state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs. [Res. 233, A-13; Appended: Res. 229, A-14; Appended: Res. 812, I-23]

Medicaid Reform H-290.958
Our American Medical Association supports increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. [CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 4, I-21]

Health Care Access for Medicaid Patients H-385.921
Our American Medical Association supports policy that to increase and maintain access to health care for all, payment for physicians under Medicaid, TRICARE, and any other publicly funded insurance plan must be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay no less than 100 percent of RBRVS Medicare allowable. [Res. 103, A-07; Reaffirmed: CMS Rep. 2, I-08; Reaffirmation A-12; Reaffirmed: Res 132, A-14; Reaffirmed in lieu of Res. 808, I-14; Reaffirmation A-15; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: Res. 105, A-23; Modified: CMS Rep. 08, A-24; Reaffirmed: BOT Rep. 19, A-26]

Federal Medicaid Funding H-290.963
Our AMA will advocate that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on Medicaid funding. [CMS Rep. 09, A-17; Reaffirmed: CMS Rep. 05, I-17]

RELEVANT MSS POSITIONS

Improving Medicaid and CHIP Access and Affordability 290.012MSS
(1) AMA-MSS will ask the AMA to (1) oppose premiums, copayments, and other cost sharing methods for Medicaid and Children's Health Insurance Program (CHIP), including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries; (2) amend policy H-290.982 "Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured" by deletion as follows:
Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
~~(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;~~; and be it further and (3) encourage The Centers for Medicaid and Medicare Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums to Medicaid beneficiaries. (MSS Res. 037, A-23)

Health Coverage during States of Emergency 290.007MSS
(1) Our AMA-MSS supports increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue servicing Medicaid patients and cover rising enrollment. (MSS Res. 038, Nov. 2020)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 201
(I-26)

Introduced by: Andrew Norton[1], Joel Dumonsau[2], Pratik Thakur[3], Jeffrey Gu[4], Matthias Walters[5], Sarah Jiang[6]

Affiliations: [1]University of Wisconsin, [2]Creighton University School of Medicine, [3]Ohio State, [4]University of Virginia, [5]University of Nebraska Medical Center, [6]University of Missouri-Kansas City

Subject: Transparency of Elected Officials Health

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, elected officials are entrusted with essential governmental responsibilities, including legislative participation, voting, policymaking, and representation of their constituents, and physical or mental health conditions may, when sufficiently severe, temporarily or persistently impair the functional capacity necessary to carry out such responsibilities, with medical literature on presidential disability recognizing that even temporary impairment of judgment or decision-making ability may have significant consequences for governmental leadership and public affairs [1]; and,

Whereas, health-related hospitalizations, prolonged absences, and unexpected incapacity among elected officials have demonstrated the potential for illness to affect participation in governmental proceedings and can directly affect the development and implementation of health policy, the functioning of public health institutions, and governmental responses to public health emergencies, establishing a legitimate public health interest in continuity of governmental leadership and decision-making [2-5]; and,

Whereas, the disclosure of health information concerning political leaders has historically been inconsistent and governed largely by individualized and ad hoc decisions rather than uniform standards, with peer-reviewed analyses documenting repeated instances in which serious illnesses affecting national leaders were concealed or incompletely communicated and noting the absence of a consistent system for determining what health information relevant to an official's ability to discharge the duties of office should be made public [6]; and,

Whereas, inconsistent or unclear communication regarding an elected official's functional capacity may create uncertainty regarding the official's ability to exercise governmental authority and may undermine confidence in governmental institutions, while empirical research demonstrates that transparency can increase trust in government and that declining political trust is associated with less favorable evaluations of governmental institutions and reduced public support for government action [7]; and,

Whereas, governmental transparency is associated with public trust, and a July 2026 CNN/SSRS poll found that nearly two-thirds of Americans believe elected officials should publicly release medical information that may affect their ability to serve, demonstrating substantial public interest in health-related transparency when an official's capacity to perform the duties of office may be affected [8]; and,

Whereas, the development of clear, ethically grounded standards for health-related transparency among elected officials should be undertaken by appropriate governing bodies, informed by principles of medical ethics and public health, and, where appropriate, through collaboration with medical organizations, legislative bodies, ethics committees, and legal and constitutional experts [9-10]; and

Whereas, AMA Policy H-295.858 urges state medical boards to focus health-related inquiries on current functional impairment rather than a history of diagnosis or treatment, providing precedent for AMA advocacy to external governing bodies for function-based standards that balance legitimate public interests with confidentiality, access to care, and protection against stigma [11]; and

Whereas, adoption of ethically grounded, function-based standards for timely public communication when an elected official's health materially affects the ability to perform the essential duties of office would be expected to promote public trust in elected leadership, provide greater clarity regarding governmental authority and decision-making capacity, support continuity of governmental operations, reduce stigma associated with illness, disability, and treatment, including for mental health, and encourage elected officials to seek necessary and timely medical care without fear of unnecessary disclosure of private health information; therefore be it

RESOLVED, that our American Medical Association supports appropriate, function-based transparency when an elected official or other government officer's health materially limits the official's ability to perform the essential duties of office; and be it further

RESOLVED, that our AMA supports appropriate governing bodies in developing clear and ethically grounded standards for public communication regarding the health transparency of elected officials and government officers, balancing governmental accountability and continuity with medical privacy, individual autonomy, and protection from stigma.

Fiscal Note: TBD

Date Received: TBD

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RELEVANT AMA POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858

…Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety…Our AMA: encourages state medical boards to consider physical and mental conditions similarly; encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior…. [CME Rep. 01, I-26; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19; Reaffirmed: Res. 228, I-22; Modified: Res. 307, A-23]

RELEVANT MSS POSITIONS

N/A

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 204
I-26

Introduced by: Sunnie Li[1], Jeffrey Gu[2]

Affiliations: [1]University of Virginia School of Medicine
[2]University of Virginia School of Medicine

Subject: Ensuring Adequate Duration of Refugee Medical Assistance

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, Refugee Medical Assistance (RMA) provides temporary healthcare coverage to newly arrived refugees who are currently ineligible for Medicaid or other coverage, serving as a critical bridge during the resettlement period[1]; and

Whereas, many refugees experience delays in accessing Medicaid due to pending disability determinations, administrative processing timelines, and other barriers during resettlement, during which RMA is often their only source of coverage[2]; and

Whereas, the duration of RMA eligibility has changed repeatedly through federal administrative decisions, including a 2025 reduction from 12 months to four months, followed by a July 2026 notice restoring eligibility to eight months, creating ongoing uncertainty for patients, healthcare systems, and clinicians[3, 4]; and

Whereas, CDC guidance directs that the initial domestic medical screening for refugees may require up to three separate clinical visits and is only meant to cover the first 90 days after arrival, after which referrals for primary care, specialty follow-ups, and completion of immunization series routinely extend well beyond that window, such that a coverage period of only a few months is misaligned with the recommended screening and follow-up timeline[5]; and

Whereas, internal federal RMA data from October 2024 through March 2026 show that 84% of more than 578,000 medical service visits occurred at or after four months of eligibility, and that approximately 20% of RMA recipients receiving services carried a chronic condition such as hypertension, Type 2 diabetes, or HIV, such that premature loss of coverage risks disrupting treatment and delaying medically necessary care[2]; and

Whereas, when RMA coverage ends prematurely, the resulting costs of care shift onto state uncompensated care pools, community health centers, emergency departments, and local health systems, so extending the duration of coverage would relieve strain on these already stretched systems[2]; therefore be it

RESOLVED, that our American Medical Association supports federal policies establishing a minimum duration of Refugee Medical Assistance eligibility sufficient to allow for completion of recommended medical evaluations, establishment of longitudinal healthcare relationships, continuity of treatment, and successful transition to other sources of coverage; and be it further

RESOLVED, that our AMA supports ongoing evaluation by relevant federal agencies, including but not limited to the Office of Refugee Resettlement, of whether Refugee Medical Assistance duration continues to achieve these outcomes over time, with regular public reporting of deidentified, aggregate data to inform potential adjustment of the eligibility period.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Guiding Principles for the Healthcare of Migrant H-65.938

Our AMA (1) advocates for the development of adequate policies and / or legislation to address the healthcare needs of migrants and asylum seekers in cooperation with relevant legislators and stakeholders based on the following guiding principles, adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the "Colombo Statement."; (4) recognizes that the enhancement of migrants' health status relies on an equitable and non-discriminatory access to and coverage of health care and cross-border continuity of care at an affordable cost avoiding severe financial consequences for migrants, as well as for their families; (5) recognizes that investment in migrant health provides positive dividends compared to public health costs due to exclusion and neglect, and therefore underscore the need for financing mechanisms that mobilize different sectors of society, innovation, identification and sharing of good practices in this regard; (6) recognizes that the promotion of the physical and mental health of migrants as defined by the following select objectives from the World Health Organization's 72nd World Health Assembly, Global action plan on promoting the health of refugees and migrants, 2019-2023, is accomplished by…(b) improving the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems. [Res. 016, A-24]

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956

Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees. [Res. 006, A-17]

Addressing Immigrant Health Disparities H-350.957
Our AMA (1) recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees; (2) (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees; (3) calls for asylum seekers to receive medically-appropriate care, including vaccinations, in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin…(8) encourages provision of resources to assist people seeking asylum, including social and legal services. [Res. 804, I-09; Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19; Modified: BOT Rep. 08, I-24]

Public Health Care Benefits H-440.903
Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all lawfully present immigrants. [Res. 219, A-98; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12; Modified: CMS Rep. 1, A-22]

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition. [Res. 254, A-18; Reaffirmed: Res. 259, A-23]

RELEVANT MSS POSITIONS

Refugee Health Care 250.020MSS
AMA-MSS asked the AMA to (1) recognize the unique health needs of refugees; (2) encourage the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees. [MSS Amended Res 4, A-09; AMA Res 804, I-09; Modified and Reaffirmed: MSS GC Rep A, I-14; Reaffirmed: MSS Res 30, A-18]

Increasing Access to Healthcare Insurance for Refugees 250.028MSS
AMA-MSS (1) will ask the AMA to support state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, and to minimize gaps in health-care for refugees; (2) supports the efforts of federal and state government agencies to facilitate enrollment, or re-enrollment, of eligible refugees into Medicaid, CHIP or Refugee Assistance insurance plans. [MSS Res 05, I-16, First Resolve adopted, Second Resolve Referred; AMA Res 006, A-17 Adopted [H-350.956]; Reaffirmed: MSS CGPH Rep A, I-17, second resolve clause added]

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services 250.029MSS

AMA-MSS asked the AMA to oppose efforts to deter immigrants and their dependents from seeking healthcare or using public benefits for which they are eligible, including Medicaid, CHIP, WIC, and SNAP. [MSS Res 01, A-18; AMA Res. 254, A-18, Adopted [D-440.927]; Amended: MSS GC Report A, A-24]

ACA Subsidies for Undocumented Immigrants 270.057MSS

AMA-MSS asked the AMA to support federal and state efforts to provide subsidies for undocumented immigrants to purchase health insurance, including by extending eligibility for premium tax credits and cost-sharing reductions to purchase Affordable Care Act (ACA) plans. [MSS Res. 108, A-24]

Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants 440.105MSS

AMA-MSS will ask the AMA to amend D-440.985, Health Care Payment for Undocumented Persons by addition as follows: Health Care Payment for Undocumented Persons, D-440.985 Our AMA: (1) shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level; and (2) supports methods to increase health insurance access for undocumented immigrants, such as allowing them to purchase health insurance on the Affordable Care Act marketplaces. [MSS Res. 072, A-21]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 206
(I-26)

Introduced by: Michelle Trang[1]

Affiliations: [1] UTMB JSSOM

Subject: **Continuing Access to Personal Medical Supplies for ICE Detainees**

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, individuals detained by U.S. Immigration and Customs Enforcement (ICE) frequently rely on personal medical devices and supplies, including but not limited to: insulin pumps, continuous glucose monitors, CPAP/BiPAP machines, prosthetics, orthotics, mobility aids, hearing aids, ostomy supplies, and prescribed durable medical equipment to manage chronic and life-threatening conditions[1,2,11]; and

Whereas, abrupt separation from personally fitted or calibrated medical devices, which often cannot be replicated with generic replacements on short notice and can result in dangerous gaps in care, including loss of proper glycemic control, respiratory compromise, impaired mobility, and disruption of other medically necessary treatment[3,4,5]; and

Whereas, current ICE detention and removal procedures do not ensure that detainees are permitted to retain, access, or transport their own medical devices and supplies at the time of apprehension, during detention, or prior to deportation[5,67,9,10,12]; and

Whereas, the ICE Health Services Corps (IHSC) directly provides care to less than half of individuals in ICE custody, with the remainder receiving care through non-IHSC staffed facilities of variable capacity, creating inconsistent ability to furnish equivalent replacement devices in a clinically appropriate timeframe[8]; and

Whereas, our AMA has long-standing policy (H-430.986) supporting sustainable, evidence-based medical and behavioral health services for individuals in custody, and has previously called for increased transparency, accountability, and adequacy of medical care in immigration detention settings; and

Whereas, continuity of medical care during and after transitions in custody status is a recognized principle of our AMA's advocacy for incarcerated and detained populations, and

deportation without one's medical devices constitutes a foreseeable and preventable disruption in continuity of care; therefore be it

RESOLVED, that our American Medical Association support accessibility to personally prescribed, medically necessary devices and supplies by establishing a process that ensures these items are obtained and remain with the detainee throughout intake, transfer, and removal; and be it further

RESOLVED, that our AMA support policies against having detainees be deported without gaining access to medically necessary equipment that already existed in their possession prior to detention; and be it further

RESOLVED, that our AMA supports a mechanism whereby a detainee's family, caregiver, or legal representative may petition to have personally prescribed medical devices and supplies be delivered if the detainee is unable to procure their medically necessary items at the time of detention.

Fiscal Note: TBD

Date Received:

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Relevant AMA Policy

Care of Women and Children in Family Immigration Detention H-350.955

1. Our AMA recognizes the negative health consequences of the detention of families seeking safe haven.
2. Due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States.
3. Our AMA opposes the separation of parents from their children who are detained while seeking safe haven.
4. Our AMA will advocate for access to health care for women and children in immigration detention.
5. Our AMA will advocate for the preferential use of alternatives to detention programs that respect the human dignity of immigrants, migrants, and asylum seekers who are in the custody of federal agencies.
6. Our AMA advocates for the implementation of evidence-based, child-centered, and trauma-informed policies across all detention centers, ensuring detained minors have access to developmentally appropriate socioemotional care, including physical contact, and for all detained people, free, unfettered communication access including regular in-person communication, phone calls, and letters.
7. Our AMA supports efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers. [Res. 002, A-17; Appended: Res. 218, A-21; Reaffirmed: Res. 234, A-22; Appended: Res. 415, A-25]

Improving Medical Care in Immigrant Detention Centers D-350.983

1. Our American Medical Association will issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to:
    a. revise its medical standards governing the conditions of confinement at detention facilities to meet those set by the National Commission on Correctional Health Care;
    b. take necessary steps to achieve full compliance with these standards; and
    c. track complaints related to substandard healthcare quality.
2. Our AMA recommends the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care.
3. Our AMA advocates for access to health care for individuals in immigration detention. [Res. 017, A-17; Reaffirmed: Res. 252, A-26]

Mass Deportation as a Public Health Issue H-440.793

1. Our American Medical Association recognizes mass deportation of immigrants, asylum seekers, refugees, and others with or seeking an immigration benefit as a public health issue, and recognizes the long-term mental and physical health implications of deportation on individuals, families, and communities.
2. Our AMA opposes deportation of health care workers and medically vulnerable patients solely based on their documentation status.
3. Our AMA opposes the large-scale internment of individuals targeted for deportation efforts. [Res. 931, I-24; Reaffirmed: Res. 216; A-26; Reaffirmed: Res. 252, A-26]

Relevant MSS Positions:

Establishing Healthcare Monitoring and Accountability in ICE Detention Facilities 65.080MSS

RESOLVED, that our AMA support independent, transparent, unannounced inspections of all ICE detention facilities, with anti-retaliation protections for detainees and health staff who participate; and be it further

RESOLVED, that our AMA supports efforts to reform ICE's waiver system by requiring that all waivers include clear expiration dates, transparent public reporting, and standardized criteria that limit their use to cases of demonstrated necessity. (MSS CCR Report A, I-25)

Improving Medical Care in Immigration Detention Centers 350.016MSS

AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (MSS Res 22, A-17, Immediate Transmittal) (AMA Res 017, A-17 Adopted as Amended [D-350.983])

Supporting External Accountability for ICE and CBP 270.041MSS

AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 207
(I-26)

Introduced by: Alisa Gadkari[1*], Mahi Patel[1*],

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

Subject: Improving Access to Weight- and Size-Capable Diagnostic Imaging

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, standard computed tomography (CT) and magnetic resonance imaging (MRI) scanners are subject to manufacturer-specified table weight and bore diameter thresholds that may restrict imaging accessibility for patients whose body size exceeds these limitations[1]; and

Whereas, severe obesity affects approximately 10% of U.S. adults, representing a substantial population potentially affected by diagnostic equipment weight and size limitations[2]; and

Whereas, a national survey of United States emergency departments found that only 10% had large-capacity CT scanners and 8% had large-capacity MRI scanners, with availability even lower at rural (5%) and critical-access (3%) hospitals[3]; and

Whereas, recent literature demonstrates lower MRI utilization among patients with BMI greater than 50 kg/m² and documents cases in which diagnostic imaging was delayed because patient weight exceeded available scanner capacity, contributing to delayed diagnosis[4,5,6,7]; and

Whereas, despite advances in bariatric imaging technology and the growing prevalence of obesity nationally, no subsequent national study has assessed emergency department access to weight-inclusive CT and MRI equipment since 2008, leaving policymakers and physicians without updated data on the current severity of this access barrier[3]; and

Whereas, commercially available CT and MRI scanners can accommodate greater patient weights and dimensions than standard systems, demonstrating the technical feasibility of expanding weight- and size-capable imaging capacity[8,9,10,11,12,13]; and

Whereas, the U.S. Department of Justice acknowledged unresolved barriers regarding equipment weight capacity and deferred technical criteria to the U.S. Access Board, which stated that additional data are needed before specific standards can be established[14,15,16]; and

Whereas**,** rural hospitals face persistent financial constraints that may limit capital investment in medical equipment, underscoring the need for funding approaches that expand imaging capacity without exacerbating financial strain[17]; and

Whereas, existing provider-directory and health plan network-adequacy standards do not routinely identify the weight or dimensional capacity of individual imaging systems, therefore the presence of an in-network imaging facility may not ensure equipment that can physically accommodate every patient requiring imaging[18]; and

Whereas, health systems such as UCSF Health publicly disclose site-specific CT and MRI weight and dimensional limits to direct patients to appropriately sized equipment, yet current federal medical diagnostic equipment accessibility requirements do not require health care facilities nationwide to publicly report scanner-specific weight or bore limitations[19,14,16];and

Whereas, Centers for Medicare and Medicaid Services has incorporated Medicare Advantage provider information into Medicare Plan Finder and has previously included physical accessibility and accessible equipment in provider-directory guidance, providing a precedent for communicating equipment accessibility through referral tools[20,21,22]; and

Whereas, our AMA recognizes obesity as a disease (H-440.842), supports reducing obesity-related insurance bias and expanding coverage of obesity care (H-440.801), and calls for national collaboration to finance obesity research, prevention, and treatment (D-440.954); and

Whereas, despite this record of engagement, no provision within these policies, nor any other AMA or MSS policy, addresses the weight or bore capacity of diagnostic imaging equipment, dedicated funding mechanisms to expand weight-inclusive imaging capacity, or referral and directory infrastructure to help physicians and patients identify facilities equipped to accommodate patients of all sizes; therefore be it

RESOLVED, that our American Medical Association supports the inclusion of facility-specific diagnostic imaging capacity information, including weight and dimensional capacity, in physician- and patient-facing referral and directory tools to improve referral pathways and identify appropriately equipped imaging centers; and be it further

RESOLVED**,** that our AMA study existing evidence and potential policy and funding mechanisms to expand availability of weight- and size-inclusive diagnostic imaging equipment, including CT and MRI scanners with adequate weight and dimensional capacity, particularly in rural and safety-net settings.

Fiscal Note: TBD

Date Received: 03/15/2026

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RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842

Our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.[Res. 420, A-13; Reaffirmed: CSAPH Rep. 08, A-23]

Addressing Adult and Pediatric Obesity D-440.954

Our AMA:...(3)Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment. [BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22]

Advocacy Against Obesity-Related Bias by Insurance Providers H-440.801
Our AMA...(1A) Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria. (1C) Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status. (1D) Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes. (1E) Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change. (1F) Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies....[Res. 224, A-23; Appended: Res. 230, A-25]

RELEVANT MSS POSITIONS
N/A

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 209
(I-26)

Introduced by: Sheila De La Cruz, MPH[1]
Aaron Esterson[2],
Amanda Zuckerman[3]
Laura Hult[1]
Eva Eliftheriadis[4]
Sanya Dhama[5]

Affiliations: [1] Spencer Fox Eccles School of Medicine
[2] Touro University Nevada College of Osteopathic Medicine
[3] Loyola University Chicago Stritch School of Medicine
[4] Penn State College of Medicine
[5] University of California Riverside School of Medicine

Subject: Support for Developing Health System Guidance for Obstetric Care Continuity During Immigration-Related Disruptions

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, pregnancy requires consistent access to obstetric and perinatal care, and continuity of appropriate pregnancy-related care is essential for maternal and infant health outcomes[1]; and

Whereas, disruptions in continuity of care may interfere with follow-up visits, reduce healthcare utilization, and increase psychological stress among pregnant patients [1]; and

Whereas, delays in care are associated with increased risk and severity of negative maternal and fetal outcomes, including postpartum hemorrhage, eclampsia, and neonatal death[2,3]; and

Whereas, immigration-related disruptions refer to circumstances arising from immigration policies, enforcement activities, or immigration-related fears that may interrupt immigrants' ability to access or maintain continuity of healthcare, and may contribute to adverse pregnancy outcomes[4]; and

Whereas, noncitizen immigrant adults are disproportionately uninsured and more likely to delay or forego care, which may be compounded by xenophobia, racism, poverty, and exclusionary immigration policies[5]; and

Whereas, immigration enforcement policies, including those associated with U.S. Immigration and Customs Enforcement (ICE), may increase fears among patient populations and contribute to avoidance of medical and health facilities, further exacerbating healthcare disparities[6]; and

Whereas, studies have identified associations between immigrant status and certain adverse obstetric and perinatal outcomes, including emergency cesarean delivery, gestational diabetes mellitus, and small-for-gestational-age birth, underscoring the importance of access to appropriate resources and care[7,8]; and

Whereas, existing AMA policies recognize immigration status as a public health issue and affirm patients' rights to medical care regardless of immigration status, including care for pregnant patients in detention centers, but these policies do not address the continuity and coordination of obstetric and perinatal care following immigration-related disruptions in community settings; and

Whereas organizations like the American College of Obstetricians and Gynecologists (ACOG) encourage healthcare institutions to provide strong guidance and support for patients regarding disruptions to healthcare access as a result of immigration status, and that obstetrician-gynecologists should promote and support research and advocacy efforts to take an active role in improving healthcare access and quality patient experiences, regardless of immigration status[9]; and

Whereas; clinical guidance supports flexible accommodations such as telehealth for pregnant persons as an appropriate approach to expanding access to pregnancy-related care, with evidence demonstrating comparable maternal and neonatal outcomes for certain components of care[10]; and

Whereas clinical guidance identifies timely referral and care coordination, engagement of social workers and other support personnel, and secure and confidential transfer of medical records as important components of maintaining continuity of pregnancy-related care, particularly following transfers or release from custody[11]; therefore be it

RESOLVED, that our American Medical Association support efforts by healthcare institutions, detention facilities, and clinicians to facilitate continuity of obstetric and perinatal care in the setting of immigration-related disruptions in ways, including, but not limited to: flexible accessibility options for virtual and in-person appointments, timely care coordination between detention facilities and healthcare institutions, and confidential transfer of medical records at hospitals and public health centers.

Fiscal Note: TBD

Date Received:

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RELEVANT AMA POLICY

Care of Women and Children in Family Immigration Detention H-350.955

Our AMA: (1) recognizes the negative health consequences of the detention of families seeking safe haven; and (2) due to the negative health consequences of detention, our AMA opposes the expansion of family immigration detention in the United States; and (4) will advocate for access to health care for women and children in immigration detention. [Res. 002, A-17; Appended: Res. 218, A-21; Reaffirmed: Res. 234, A-22; Appended: Res. 415, A-25]

Immigration Status is a Public Health Issue D-350.975

Our AMA: (1) declares that immigration status is a public health issue that requires a comprehensive public health response and solution; (2) recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health; (3) will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population; (4) will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities. [Res. 904, I-22; Reaffirmed: Res. 210, A-23]

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA: (1) supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records, Medicaid, Children's Health Insurance Program (CHIP), or other health program data, including but not limited to Emergency Medicaid and related immigrant-specific programs, for immigration enforcement purposes; (2) supports efforts by interested parties to educate physicians, medical students, and patients about existing privacy protections to safeguard confidential health information, and to help ensure that this information reaches immigrant and mixed-status families. [Res. 018, A-17; Modified: Res. 229, I-25; Reaffirmed: Res. 216, A-26; Reaffirmed: Res. 252, A-26]

RELEVANT MSS POSITIONS

Supporting External Accountability for ICE and CBP 270.041MSS
AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19)

Patient and Physician Rights Regarding Immigration Status 350.015MSS
AMA-MSS will ask the AMA to support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (MSS Res 15, A-17, Immediate Transmittal), (AMA Res 018, A-17 Adopted [H-315.966], (Amended & Reaffirmed: MSS GC Report A, A-23)

Improving Medical Care in Immigration Detention Centers 350.016 MSS
AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (MSS Res 22, A-17, Immediate Transmittal) (AMA Res 017, A-17 Adopted as Amended [D-350.983])

Presence and Enforcement Actions of U.S. Immigration and Customs Enforcement (ICE) at Healthcare Facilities 350.022 MSS
AMA-MSS will ask the AMA to (1) advocate for and support legislative efforts to designate such healthcare facilities as sensitive locations; (2) work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourage healthcare facilities to

clearly demonstrate and promote their status as sensitive locations; and (4) oppose the presence of U.S. Immigrations and Customs Enforcement (ICE) at healthcare facilities. (MSS Res 43, I-17), (AMA Res 232, I-17, Adopted [D-160.921])

Promoting Child Welfare and Communication Rights in Immigration Detention 440.133 MSS

AMA-MSS will ask that our American Medical Association (1) advocate for the implementation of evidence-based, child-centered, and trauma-informed policies across all detention centers, ensuring detained minors have access to developmentally appropriate socioemotional care, including physical contact, and for all detained people, free, unfettered communication access including regular in-person communication, phone calls, and letters. and (2) support efforts to address and mitigate concerns and accusations of child abuse and neglect in detention centers. (MSS Res. 404, I-24)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 303
(I-26)

Introduced by: Declan Sawchuk[1], Sam Lieberman[1], Alison Ross[1]

Affiliations: [1]Geisinger College of Health Sciences School of Medicine

Subject: Augmented Intelligence Transparency in Medical Education

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, since ChatGPT was opened to the public in 2022, medical schools have been integrating generative augmented intelligence (AI) into classrooms and clinics[2]; and

Whereas, AI is being integrated into medical education through creation of personalized learning plans for students, image generation, learning materials, feedback, clinical communication training, and humanities-based exercises[5]; and

Whereas, our AMA is rewarding $1.1 million to 11 projects that promote precision education, which is a newer focus area of the organization that involves the usage of technology such as AI to personalize medical education for students[7]; and

Whereas, AI can generate material that is factually incorrect through poor AI prompt design, non-discrimination of low-quality information, and data gaps[3]; and

Whereas, the risk for error in AI generated material indicates the need for responsible AI usage through human oversight, information verification, and transparency[3]; and

Whereas, accountability through transparency of AI systems enables deep root-cause analysis when errors occur[1]; and

Whereas, AI transparency was an emerging topic of concern for both US courts and legislators in 2024[6]; and

Whereas, California passed AB3030, Healthcare Services: Artificial Intelligence, in 2024, which requires healthcare providers to disclose to patients AI usage in all communications[6]; and

Whereas, organizations such as the European Union (EU)[8] and the United Nations (UN)[3] established transparency as an ethical mandate for building accountability for AI usage; and

Whereas, our AMA supports AI transparency in scientific publications by journals in H-480.935 and as needed in the clinical setting by physicians and AI developers in H-480.931, but there is a gap in advocacy for AI transparency in the medical education setting; therefore be it

RESOLVED, that our American Medical Association amend Policy H-295.857, "Augmented Intelligence in Medical Education," by addition as follows

Augmented Intelligence in Medical Education, H-295.857

Our American Medical Association encourages:

a) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
b) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
c) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
d) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
e) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
f) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
g) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
h) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
i) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
j) close collaboration with and oversight by practicing physicians in the development of AI applications.
k) <u>institutions and programs to develop policies for instructors to promptly disclose to students the presence and extent of augmented intelligence usage in medical education curriculum including but not limited to generation of text, images, video, and audio in lectures, lecture materials, lecture assignments, and student feedback.</u>

[…]

Fiscal Note: TBD

Date Received:

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RELEVANT AMA POLICY

Augmented Intelligence in Medical Education H-295.857
(1) Our American Medical Association encourages (a) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards… (c) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes; (d) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules. [Res. 307, I-25]

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935
(1) Our American Medical Association will study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24. (2) Our AMA will work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice… (4) Our AMA will support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence. [Res. 247, A-23; Reaffirmed: Res. 226, A-25]

Assessing the Intersection Between AI and Health Care H-480.931
… (2) When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact **Medical** Decision Making at the Point of Care (a) Decisions regarding transparency and disclosure of the use of **AI** should be based upon a risk- and impact-based approach that considers the unique circumstance of **AI** and its use case. The need for transparency and disclosure is greater where the performance of an **AI**-enabled technology has a greater risk of causing harm to a patient. (i) **AI** disclosure should align and meet ethical standards or norms… (3) What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies (a) When **AI**-enabled systems and technologies are utilized in health care, the following information should be disclosed by the **AI** developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization [BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25; Reaffirmed: Res. 505, A-26]

RELEVANT MSS POSITIONS

Transparency in AI-Assisted Admissions 295.255MSS
AMA-MSS will ask the AMA to (1) study and report back on the ethical, equitable, and transparent use of augmented intelligence (AI) in medical school and residency application review processes, including potential standards for notice, disclosure, and explanation of AI involvement to applicants, including but not limited to, what stage AI is involved and to what extent; and (2) support approaches to promote fairness, accountability, and applicant due process, including access to human reevaluation and avenues to appeal or contest decisions influenced by such systems. [MSS Res. 319, A-26]

Augmented Intelligence Use in Assessment Development during Medial Education 295.254MSS
AMA-MSS will ask the AMA to support disclosure to students along the medical education continuum regarding the use of generative augmented intelligence (AI) in the development and evaluation of performance on assessments. [MSS Res. 316, A-26]

Generative Augmented Intelligence as a Threat to Scientific Publications 480.032MSS
AMA-MSS will ask the AMA to support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence. [MSS Res. 067, A-23]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 305
(I-26)

Introduced by: Andrew Norton[1], Sanjay V. Neerukonda[2], Megan Reilly[1], Joel Dumonsau[3], Ciara Martinez[4], Konrad Malik[5], Anish Kakarla[6], Maha Khan[7], Berit Lubben[8], Sarah Jiang[9], Eva Eleftheriadis[10]

Affiliations: [1] University of Wisconsin, [2] McGovern Medical School at UTHealth, [3] Creighton University School of Medicine, [4] University of Texas Medical Branch, [5] Chicago Medical School at RFUMS, [6] Midwestern University - Chicago, [7] Loyola University Chicago Stritch School of Medicine, [8] Mayo Clinic Alix School of Medicine, [9] University of Missouri-Kansas City, [10] Penn State College of Medicine

Subject: Inclusion of an "Advocacy, Policy, and Medical Organization Involvement" Section in Medical Career Applications

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, involvement in advocacy, policy, and organized medicine are core components of physician leadership and professional development and are often used in promotion considerations within academia[1]; and

Whereas, physicians are trusted sources of health information and play important roles in public health, advocacy, and civic engagement, and supporting medical-student participation in advocacy, health policy, and organized medicine promotes development of the leadership, communication, and systems-based skills necessary for physicians to serve patients and communities throughout their careers[2]; and

Whereas, a dedicated and standardized opportunity to describe meaningful advocacy, health policy, leadership, and organized medicine activities in residency, fellowship, and other physician career applications would improve recognition of these contributions and enable reviewers to consider them consistently as part of a holistic evaluation of applicants[2-5]; and

Whereas, medical students make meaningful scholarly and professional contributions through health policy, advocacy, and organized medicine, including the development of resolutions and policy proposals, legislative and regulatory advocacy, public comment, testimony, and other work that may not result in peer-reviewed publications[6]; and

Whereas, recent changes to residency applications limit individually reported scholarly work primarily to peer-reviewed products may reduce the visibility of these contributions and narrow the range of activities that residency programs are able to readily evaluate through an application such as inclusion of non-peer-reviewed publications like general magazines, trade journals, newspapers, government reports, books, website blogs, resolutions, policies, etc.[7-9]; and

Whereas, such changes may be inconsistent with ongoing efforts to advance holistic review in graduate medical education by encouraging residency programs to consider applicants' experiences, attributes, and contributions beyond traditional academic metrics; and

Whereas, residency application processes vary across specialties, with some specialties utilizing application systems or supplemental processes outside of ERAS (e.g., ResidencyCAS), creating a need for consistent recognition of meaningful advocacy, health policy, and organized medicine activities across residency application platforms; and

Whereas, AMA Policy recognizes physician engagement in organized medicine and legislative advocacy as an important component of professional activity, and the AMA encourages medical education institutions and academic medical centers to incorporate physician advocacy into faculty appointment, promotion, and tenure criteria and to develop best practices for recognizing advocacy through protected non-clinical effort and academic productivity models[10]; and

Whereas, the newly adopted policy did not extend the inclusion of organized medicine, policy, or advocacy involvement to medical trainees or other medical professionals[10]; and

Whereas, health advocacy is recognized in medical education literature as an important physician competency, and participation in advocacy and health policy activities can develop skills in leadership, communication, systems-level thinking, and addressing health disparities that are relevant throughout a physician's professional development[11]; and

Whereas, providing a dedicated and standardized section for advocacy, health policy, and medical organization involvement within residency, fellowship, and other physician career applications would make these activities more visible and consistently accessible to reviewers, thereby supporting meaningful consideration of these experiences as part of holistic applicant evaluation [12-13]; and

Whereas, advocacy, policy, and medical organization involvement is currently distributed across several ERAS experience types (including "Education/training," "Military service," "Professional organization," "Other extracurricular activity, club, hobby," "Research," "Teaching/mentoring," "Volunteer/service/advocacy," and "Work") which contributes to variation in how applicants categorize such experiences and subsequently how reviewers interpret them; and

Whereas, a number of residency programs across specialties have developed advocacy, health policy, and health equity pathways or distinction tracks, reflecting growing recognition of advocacy and organized medicine engagement as a meaningful area of professional development, and a standardized way for applicants to identify this experience within ERAS could help support connections between applicants and programs offering these pathways; and

Whereas, consolidating advocacy, policy, and medical organization involvement into a distinct section, rather than distributing it across several ERAS categories, will help applicants present a more complete picture of this work, especially within the existing ERAS limitations of a maximum of ten experiences, and could also help residency programs (particularly those with established advocacy pathways) more readily identify applicants whose experiences align with their program's mission and offerings; and

Whereas, medical students engaged in health policy and advocacy through the AMA Medical Student Section, state medical associations, and specialty societies have no dedicated

mechanism within ERAS to document this scholarly work other than general experience categories, which can result in it being omitted or diluted[14]; and

Whereas, collaboration among the American Medical Association, Association of American Medical Colleges, specialty societies, and organizations responsible for residency application platforms would help ensure that application systems appropriately recognize advocacy, health policy, organized medicine, and other scholarly and professional contributions; and

Whereas, recognition of trainee advocacy and organized medicine involvement in physician career applications aligns with AMA Policy recognizing advocacy as a component of professional activity and would encourage medical students and other trainees to participate in policy development, legislative and regulatory advocacy, and organized medicine [15]; therefore be it

RESOLVED, that our AMA advocates for residency, fellow, and other physician career applications to include an “Advocacy, Policy, and Medical Organization Involvement” section to describe experiences and honors (Directive to Take Action).

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

National Resident Matching Program Reform D-310.977

(…)(8) Our AMA will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the **residency** application process and allow both flexibility and standard rules for applicants…(19) Our AMA will work with appropriate stakeholders to study options for improving transparency in the resident application process. (20) Our AMA encourages the piloting of innovations to the **residency** application process with aims to reduce application numbers per applicant, focus applicants on programs with reciprocal interest, and maximize **residency** placement. With support from the medical education community, successful pilots should be expanded to enhance the standardized process. (21) Our AMA will continue to engage the National Resident Matching Program® (NRMP®) and other matching organizations on behalf of residents and medical students to further develop ongoing relationships, improve communications, and seek additional opportunities to collaborate including the submission of suitable nominees for their governing bodies as appropriate. [CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22; Modified: CME Rep. 02, A-24; Reaffirmed: CME Rep. 03, A-25]

Strategies for Enhancing Diversity in the Physician Workforce D-200.985
(...)(3) Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. (4) Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty…(9) Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities. [CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21; Modified: CME Rep. 02, I-22; Modified: Res. 320, A-23; Reaffirmed: CME Rep. 06, A-25]

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

1. Our AMA will encourage medical schools, medical honor societies, and residency/fellowship programs to work toward ethical, equitable, and transparent recruiting processes, which are made available to all applicants.
2. Our AMA will advocate for residency and fellowship programs to avoid using objective criteria available in the Electronic Residency Application Service (**ERAS**) application process as the sole determinant for deciding which applicants to offer interviews.
3. Our AMA will advocate to remove membership in medical honor societies as a mandated field of entry on the Electronic Residency Application Service (**ERAS**)—

thereby limiting its use as an automated screening mechanism—and encourage applicants to share this information within other aspects of the **ERAS** application.

4. Our AMA will advocate for and support innovation in the undergraduate medical education to graduate medical education transition, especially focusing on the efforts of the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize the residency/fellowship application and matching process and encourage the study of the impact of using filters in the Electronic Residency Application Service (**ERAS**) by program directors on the diversity of entrants into residency.
5. Our AMA will encourage caution among medical schools and residency/fellowship programs when utilizing novel online assessments for sampling personal characteristics for the purpose of admissions or selection and monitor use and validity of these tools.

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

Fellowship Application Reform D-310.958

(1) Our AMA will: (a) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training; and (b) continue to encourage all subspecialties to use the same application cycle and such application cycle should commence only in the final year of **residency** for programs of less than 5 years, or in the final 2 years of **residency** for programs of 5 years or longer.
(2) Our AMA will work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to evaluate the benefits and drawbacks for all interested parties.

[CME Rep. 5, A-09; Appended: Res. 303, A-18; Reaffirmed: CME Rep. 01, A-20]

RELEVANT MSS POSITIONS

Fairness in the National Resident Matching Program 295.069MSS

AMA-MSS will ask the AMA to remain committed to ensuring a fair residency selection process that works to accommodate students' best interests. (AMA Amended Res 332, I-95 Adopted)

The Residency Match Process 310.001MSS

The AMA-MSS recognizes the significant time, energy, and resources that are allocated to the residency match process and hereby supports the following principles to help improve the residency match process:

1. That the AMA-MSS will continue to work with other student, resident, and physician organizations to research and promote changes in the structure and/or the rules governing the Match so as to maximize the advantage to medical students and residents.

2. That the AMA-MSS supports efforts to encourage residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules.
3. That the AMA-MSS supports efforts to encourage the ACGME, the AOA, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.
4. That the AMA-MSS supports a change in the NBME policy to report examination scores as “pass-fail” only.
5. That the AMA-MSS encourages individual chapters to maintain a roster of students willing to host residency applicants when they visit their institution.
6. That the AMA-MSS will ask the AMA to work with the NRMP to keep transaction costs of the Match to reasonable levels, and ensure that fees charged for each program a medical student applies to be capped at a reasonable level that takes into account medical students’ budgeting constraints.
7. That the AMA-MSS will ask the AMA to support students, residents, and all appropriate organizations who work to ensure that any suspected violation of NRMP policy is addressed, publicized, and proper redress achieved, including the active promotion of NRMP complaint forms and other existing channels.
8. That the AMA-MSS will ask the AMA to urge the NRMP to allow students to opt out of the Match without penalty when there are extenuating circumstances, including but not limited to: unforeseen family emergencies such as illness that would require the individual to care for a family member; unforeseen physical or mental health problems that would impede the individual’s ability to participate in residency training and required military or foreign service duty.
9. That the AMA-MSS will ask the AMA to support the concept that programs should retain the ability to extend applicants positions outside the Match.
10. That the AMA-MSS will ask the AMA to support improvements to the structure of the Match program for efficient placement of unmatched students, as long as such alterations do not result in postponement of the traditional “Match Day” date in mid-March. (MSS GC Rep A, I-16)

Promoting Resident Involvement in Organized Medicine 310.021MSS

AMA-MSS encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and organized medicine conferences. (MSS Sub Res 13, I-97)

Overemphasis on Research in Trainee Selection 310.063MSS

AMA-MSS will ask that our American Medical Association support efforts and work with relevant parties to: Improve the holistic and equitable consideration of research, advocacy, service, teaching, mentorship, and other non-research domains in medical school and residency/fellowship selection; Reduce the emphasis on the quantity of research expectations for applicants; and Improve medical school and residency/fellowship application services to

allow applicants to comprehensively showcase the non-research domains that best align with their experiences and career goals. (MSS Res. 306, I-24) (Amended, MSS LR001, I-25)

Resources for Representation of Organized Medicine on Residency Applications and CVs 310.064MSS

AMA-MSS provide resources on how to cite resolutions and represent organized medicine involvement on CVs and residency application materials. (MSS ATF Report E, A-25)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 306
(A/I-XX)

Introduced by: Blancheneige Beohon[1], Katherine Yu[2], Kate Myers[3]

Affiliations: [1] University of Texas Medical Branch
[2] University of Iowa Roy J. & Lucille A. Carver College of Medicine
[3]The Anne Burnett Marion School of Medicine at Texas Christian University

Subject: Foundational Dermatologic Competencies in Medical Education

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, dermatologic conditions are frequently encountered by physicians outside of dermatology, particularly in primary care, pediatrics, and emergency medicine settings, making the ability to recognize and initially evaluate common skin conditions relevant to physicians across multiple specialties;[7] and

Whereas, undergraduate dermatology education varies among medical schools, and studies have identified gaps in medical students' preparedness and confidence in recognizing and managing common dermatologic conditions;[1,2] and

Whereas, educational interventions in dermatology have demonstrated improvements in medical students' diagnostic accuracy and ability to recognize common dermatologic conditions, supporting the effectiveness of focused dermatology education during undergraduate medical training;[2] and

Whereas, deficiencies in dermatologic education may be particularly consequential when evaluating patients with darker skin tones, with studies identifying disparities in medical student exposure to dermatologic disease across diverse skin tones and lower confidence or diagnostic performance when evaluating disease in skin of color;[3,4] and

Whereas, educational interventions incorporating dermatologic disease across diverse skin tones have demonstrated improvements in medical students' ability to recognize common dermatologic conditions in skin of color;[4] and

Whereas, recent implementation of an expanded dermatology curriculum at a U.S. medical school incorporated foundational skills including dermatologic terminology, skin-focused history and examination, clinical presentations, diagnosis, and treatment, demonstrating the feasibility of incorporating foundational dermatologic education into undergraduate medical training;[7] and

Whereas, the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and Accreditation Council for Graduate Medical Education jointly

established Foundational Competencies for Undergraduate Medical Education in 2024 to identify outcomes expected of medical students regardless of degree type or future specialty while preserving flexibility in how individual medical schools implement competency-based education;[6] and

Whereas, these Foundational Competencies establish broad outcomes for undergraduate medical education but do not identify specific foundational dermatologic knowledge and skills, while studies continue to demonstrate gaps in medical students' preparedness and confidence in recognizing and evaluating common dermatologic conditions; [1,2,6] and

Whereas, existing AMA Policy H-295.853, "Representation of Dermatological Pathologies in Varying Skin Tones," supports equitable representation of dermatologic disease across diverse skin tones in medical education but does not establish AMA policy supporting broader foundational dermatologic competencies for undergraduate medical students; therefore, be it

RESOLVED, that our American Medical Association support the development and adoption of evidence-informed foundational dermatologic competencies for undergraduate medical students in collaboration with appropriate medical education and specialty organizations (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the development, dissemination, and utilization of evidence-based educational resources in partnership with the appropriate organizations, such as medical education organizations and specialty societies, addressing foundational skills such as obtaining a focused dermatologic history, performing a focused skin examination, accurately describing skin lesions using standardized dermatologic terminology, recognizing common and time-sensitive dermatologic conditions across diverse skin tones, initiating appropriate initial evaluation and management when indicated, and recognizing when referral to dermatology is appropriate, to assist undergraduate medical education programs in achieving foundational dermatologic competencies while maintaining flexibility in curriculum design and implementation (Directive to Take Action).

Fiscal Note: TBD

Date Received: 08/09/2026

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RELEVANT AMA POLICY

Representation of Dermatological Pathologies in Varying Skin Tones H-295.853
Our American Medical Association encourages comprehensive, inclusive and equitable representation of a diverse range of skin tones in all dermatologic and other relevant medical educational resources for medical students, physicians, non-physician healthcare providers and patients. [Res. 505, I-21]

RELEVANT MSS POSITIONS

None identified.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 308
(I-26)

Introduced by: Emma Cook[1], Nicole Willing[2], Emma Green[2]

Affiliations: [1] Eastern Virginia Medical School at Old Dominion University
[2] Edward Via College of Osteopathic Medicine - Virginia Campus

Subject: Establishing Proactive Academic Support for Neurodivergent Medical Students

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

WHEREAS, Neurodivergence, including Attention-Deficit/Hyperactivity Disorder, autism, dyslexia, and other learning or processing differences, represents an important facet of diversity within undergraduate medical education and contributes distinct cognitive strengths, spatial reasoning abilities, and varied approaches to problem-solving in medicine[1,2]; and

WHEREAS, Neurodivergent medical students may encounter barriers related to executive functioning, sensory and information processing, communication, decisions surrounding disclosure, and transitions between classroom and clinical learning environments[3,4,5,6]; and

WHEREAS, Health professions education literature indicates that support for neurodivergent learners is not consistently available or implemented and may depend on the knowledge and preparation of individual educators, supervisors, and personnel involved in student support[4,5,6]; and

WHEREAS, Medical students with disabilities and neurodivergent trainees experience elevated risks of psychological distress, burnout, leave of absence, and attrition, while individualized academic support, mentorship, and structured transition planning may help qualified learners navigate educational barriers and persist in training[4,7,8]; and

WHEREAS, Neurodivergent learners report more supportive educational experiences when educators and clinical supervisors demonstrate neurodiversity awareness and provide informed, individualized support[4,5,6]; and

WHEREAS, Opportunities for specialized professional development in neurodiversity-informed educational strategies are not consistently available to personnel involved in academic support, accessibility, student learning, and clinical education[4,9]; and

WHEREAS, The Liaison Committee on Medical Education requires MD-granting medical schools to provide effective academic support services that facilitate students' professional development and graduation[10]; and

WHEREAS, the Commission on Osteopathic College Accreditation (COCA) requires that "[a] COM must provide academic counseling to assist all students in study skills, learning styles, learning resources, and other assistance for academic success" (Element 9.5, Academic Counseling [CORE])[11]; and

WHEREAS, existing AMA and AMA-MSS policies address disability accommodations, individualized disability assessment, technical standards, access to disability-related support services, and education and guidance for faculty and administrators, but do not establish a proactive, undergraduate medical education-specific framework for developing and disseminating voluntary, evidence-informed academic-support practices designed to support the learning needs of neurodivergent medical students in addition to the formal disability accommodation process[12,13,14,15]; and

WHEREAS, American Medical Association Resident and Fellow Section Report G, "Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners," supports transparent accommodation processes, faculty education, and collaboration with disability-resource professionals for neurodivergent residents and fellows, while the present proposal is complementary and focuses on proactive academic support within undergraduate medical education before learners require remediation or experience academic difficulty[16]; and

RESOLVED, That our American Medical Association collaborate with relevant national undergraduate medical education organizations, which may include the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as well as neurodivergent medical learners, disability-resource professionals, academic-support personnel, medical education experts, and other relevant stakeholders, to encourage the development and dissemination of voluntary, evidence-informed, and adaptable best practices for supporting neurodivergent medical students in undergraduate medical education; and be it further

RESOLVED, That our AMA encourage undergraduate medical education programs to consider proactive, strengths-based academic-support practices for neurodivergent medical students, which may include individualized academic coaching, peer mentorship, tailored support during transitions into clinical training, and neurodiversity-informed professional development for personnel involved in student support, provided that such practices complement rather than replace reasonable accommodations and disability-resource services.

Fiscal Note: TBD

Date Received:

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Relevant AMA Policies

- **Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990:** Supports addressing structural and cultural barriers encountered by medical students, residents, and fellows with disabilities, including access to qualified personnel knowledgeable about disability law, accommodations, and institutional 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:** Supports education regarding visible and invisible disabilities and promotes reasonable accommodations and institutional protections for physicians and medical students with disabilities. [BOT Rep. 19, I-21]
- **Advocacy for Physicians with Disabilities D-90.991:** Supports resources and education regarding the rights of physicians and physicians-in-training with disabilities, including access to reasonable accommodations and protection from disability-based discrimination. [Res. 617, A-19; Reaffirmed: CME Rep. 2, I-21; Modified: BOT Rep. 19, I-21]
- **Remediation Programs for Physicians D-295.325:** Supports early identification and remediation of conditions, including learning disabilities, that could contribute to later knowledge or skill deficits, and calls for LCME and ACGME standards encouraging medical education programs to address these needs. This policy recognizes learning differences but is framed primarily around remediation rather than proactive, strengths-based support. [CME Rep. 3, A-09; Reaffirmed: CME Rep. 01, A-19]
- **Caring for Neurodivergent Patients H-90.962:** Recognizes the diversity and personhood of neurodivergent individuals and supports collaboration with relevant stakeholders regarding programs and services for neurodivergent people. This policy is primarily patient-focused and does not directly address neurodivergent medical learners. [Res. 706, A-23; Appended: Res. 902, I-25]

Relevant MSS Policies

- **90.007MSS, Societal Discrepancies in the Disabled Population and Post-Secondary Disability Resource Center Utilization:** Supports education regarding disparities experienced by people with disabilities and the services available through postsecondary disability-resource centers. [MSS Res. 35, I-10; Reaffirmed: MSS GC Rep. D, I-15; Reaffirmed: MSS GC Rep. B, A-21]
- **295.201MSS, Standard Procedure for Accommodations in USMLE and NBME Exams:** Supports collaboration with medical licensing organizations to facilitate timely

accommodation applications and reduce excessive documentation, financial, and administrative burdens. [MSS Res. 11, I-19; Reaffirmed: MSS GC Report A, A-24]

- **295.211MSS, Improving Support and Access for Medical Students with Disabilities:** Supports transparent and accessible institutional policies for requesting and obtaining disability-related accommodations. [MSS CME Report B, I-19; Discharged by Delegate Report A, A-22; Amended: MSS GC Report A, A-24]
- **295.241MSS, Expanding Support for Medical Students and Physicians with Disabilities:** Supports prioritizing the input and leadership of individuals with lived experience of disability in disability-related policy and advocacy. [MSS CDA CME Report A, A-22]
- **310.055MSS, Improving Support and Assistance for Medical Students with Disabilities:** Supports individualized disability assessment and education for faculty and administrators regarding disability-inclusive communication, technical standards, assistive technology, and the competencies required of medical students and residents. [MSS Res. 33, A-18]

Related Previous Items and Reports

- **I-25 RFS Resolution 8, "Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners":** The resolution was referred after testimony supported its intent but raised concerns regarding wording, evidentiary support, and the need for further analysis.
- **A-26 RFS Report G, "Stronger Recognition and Promotion of Accommodations for Neurodivergent Learners":** Following referral of I-25 Resolution 8, the RFS developed language supporting transparent accommodation-request processes, education for faculty working with neurodivergent residents and fellows, and collaboration with disability-resource professionals to facilitate individualized accommodation planning in GME. The RFS Reference Committee recommended the report for adoption. It did not appear among the A-26 HOD Reference Committee A–G reports and should therefore be described as an RFS position rather than confirmed HOD policy.
- **Council on Medical Education Report 2, "A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities" (I-21):** Evaluated barriers affecting medical students and trainees with disabilities and informed AMA policy concerning accommodation procedures, technical standards, qualified institutional personnel, and disability-inclusive educational environments.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 309
(I-26)

Introduced by: Micah Char[1], Michelle Luh[1], Aaron Esterson[2]

Affiliations: [1]Kirk Kerkorian School of Medicine at UNLV
[2]Touro University Nevada College of Osteopathic Medicine

Subject: Support Privacy Protections for Resident and Fellow Physicians in Geolocation Tracking Applications

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, graduate medical education programs are responsible for monitoring compliance with clinical and educational work-hour requirements and maintaining learning environments that promote patient safety, physician well-being, and educational quality[1]; and

Whereas, real-time location technologies, including real-time location systems, electronic badges, Wi-Fi or Bluetooth-based systems, and mobile-device Global Positioning Systems (GPS), can feasibly be integrated into health care and graduate medical education settings for purposes such as clinical workflow, workplace safety, emergency response, and clinical and educational work-hour monitoring, underscoring the need for appropriate safeguards as these technologies are evaluated and adopted; and[1-6]; and

Whereas, published studies demonstrate that real-time location systems (RTLS) can generate granular, longitudinal records of trainee movement: a 2019 academic medical center study used RTLS to measure resident time and location, and a 2022 study collected 95,275 hours of observations from 43 internal medicine interns who wore infrared badges recording location and duration in patient rooms, hallways, and physician workrooms[2,3]; and

Whereas, a 2022 orthopedic residency study asked 22 residents to use an automated smartphone application that logged work hours through GPS coordinates; although residents found the application easier and less burdensome than self-reporting, they rated it as significantly more privacy-invasive[4]; and

Whereas, a separate application designed for medical staff used background GPS data to calculate work hours, sampled raw location at 10-minute intervals, and included 89 resident physicians, demonstrating the practical capacity of personal smartphones to generate recurring location records for trainees[5]; and

Whereas, GPS, geofencing, badge-based systems, and other real-time location technologies vary substantially in precision and scope, ranging from records of entry into or departure from a clinical facility to continuous geographic or room-level monitoring[5,7-12]; and

Whereas, requiring location monitoring through personally owned devices may permit the collection of information beyond clinical sites and scheduled duties because these devices routinely accompany resident and fellow physicians during their personal activities[7-12]; and

Whereas, geolocation information can reveal where individuals live and work and whether they visit health care facilities, places of worship, domestic violence shelters, and other sensitive locations[11,12]; and

Whereas, many resident physicians indicated that they have experienced intimidation, harassment, and discrimination during their training, in large part due to a perceived abuse of power, and proper informed consent, transparency and other protections are needed to protect against such an imbalance of power[13]; and

Whereas, state protections against location tracking remain limited and inconsistent, with many laws expressly exempting employer tracking conducted in connection with an employee's work[14]; and

Whereas, in absence of transparency and sufficient regulation of location tracking, sensitive location data might be sold by entities with access to the data, unknowingly to affected individuals[15]; and

Whereas, as real-time location technologies are evaluated and adopted in graduate medical education, standards promoting transparency, informed consent, data minimization, limitations on retention and disclosure, and other privacy protections are necessary to safeguard resident and fellow physicians[1,6,7-15]; therefore be it

RESOLVED, that our American Medical Association supports standards requiring transparency, informed consent, data minimization, limited retention, secure storage, resident and fellow physician access to and correction of their records, and protections against punitive or retaliatory use when GPS, geolocation, real-time location systems, or similar technologies are used to monitor resident and fellow physicians (New HOD Policy); and be it further

RESOLVED, that our AMA opposes the sale, licensing, commercialization, or disclosure of identifiable or reasonably linkable resident and fellow physician location data for purposes unrelated to patient care, workplace safety, graduate medical education administration, accreditation, or compliance with applicable law (New HOD Policy); and be it further

RESOLVED, that our AMA opposes requiring resident and fellow physicians to submit to continuous or off-duty location tracking as a condition of training, employment, or participation in clinical duties, except when temporarily necessary to respond to a specific and imminent patient or workplace safety emergency (New HOD Policy).

Fiscal Note: TBD

Date Received:

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RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

Resident/fellow physicians' bill of rights (F) Clinical and educational work hours that protect patient safety and facilitate resident well-being and education. With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME. (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. [CME Rep. 8, A-11, Appended: Res. 303, A-14, Reaffirmed: Res. 915, I-15, Appended: CME Rep. 04, A-16, Modified: CME Rep. 06, I-18, Appended: Res. 324, A-19, Modified: Res. 304, A-21, Modified: Res. 305, A-21, Modified: BOT Rep. 18, I-21, Reaffirmation: A-22, Reaffirmed in lieu of: Res. 307, I-22, Modified: CME Rep. 05, I-23, Reaffirmed: CME Rep. 02, A-24, Modified: Res. 304, I-24]

Resident/Fellow Clinical and Educational Work Hours H-310.907
Our American Medical Association adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training: (2) Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. (5) Our AMA encourages the ACGME to: (a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation. (b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits. [CME Rep. 5, A-14, Modified: CME Rep. 06, I-18, Reaffirmation: A-22)

Anti-Doxxing Data Privacy Protection H-80.990
(1)Our American Medical Association supports all physicians and medical students who experience doxxing, support nondiscrimination and privacy protection for employees, and availability of resources on doxxing (2) Our AMA will work with partners to support data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information for all physicians and medical students. [Res. 002, I-24]

RELEVANT MSS POSITIONS

Resident/Fellow Work and Learning Environment 310.030MSS
AMA-MSS supports the following general principles regarding resident/fellow duty hours to promote physician wellness: (1) Duty hours shall be defined as clinical and educational activities, clinical work done from home, and all moonlighting; (2) The total number of duty hours should not exceed 80 hours when averaged over a four-week period; (3) Trainees must be

scheduled for in-house call no more frequently than every-third-night, averaged over a four-week period; (4) Scheduled on-call assignments should not exceed 28 hours, with the last 4 hours being reserved for education, patient follow-up, and transfer of care; (5) Limits on duty hours must not adversely impact the organized educational activities of the residency program; (6) Scheduled time providing patient care services of limited or no educational value should be minimized; (7) Trainees must have at least one consecutive 24 hour duty-free period day every seven days, averaged over a four-week period; (8) Flexibility for residents to stay beyond their scheduled 28 hour limit to provide care for a single patient when important to patient care, educational, or humanistic needs, and that these hours count towards the weekly 80 hour limitation; (9) The Joint Commission should create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (10) The Joint Commission should establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; (11) The AMA Council on Legislation should serve as the coordinating body in the creation of legislative and regulatory options. [MSS Rep F, A-02, AMA Amended Res 321, A-02 Adopted H-310.907, Modified: CME Rep A, A-17]

Healthcare Provider Data Privacy Protection 480.036MSS

AMA-MSS (1) supports physicians and healthcare providers who experience doxxing, and support nondiscrimination and privacy protection for employees, and the availability of resources on doxxing; (2) supports data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information; and (3) supports institutions, employers, and state medical societies in providing legal resources and support to individuals affected by doxxing and prophylactically prevent doxxing through training and education on the issue. [MSS Res. 504, I-24]

Increased Cybersecurity Standards for Healthcare Entities 480.035MSS

AMA-MSS asked that our American Medical Association support the establishment of minimum cybersecurity standards, including, but not limited to, the use of multi-factor authentication, timely updates, and encryption for HIPAA covered entities. [MSS Res. 502, I-24, AMA Res. 510, A-25, Adopted as Amended H-478.974]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 310
(I-26)

Introduced by: Jared Boyce[1], Samyukta Karthik[2], Sanjay V. Neerukonda[3]

Affiliations: [1] University of Wisconsin School of Medicine and Public Health
[2] Pennsylvania State University - University Park Regional Campus
[4] McGovern Medical School at UTHealth

Subject: Developing Pathways for Medical School Transfers

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, in the first several decades after the Flexner Report was published, medical school curricula were standardized in a manner that permitted students to transfer schools with relative ease[1]; and,

Whereas, although there is no standardized curriculum to follow, all accredited U.S. allopathic and osteopathic medical schools must ensure their students learn core material as determined by their respective accrediting agencies and medical colleges[1]; and,

Whereas, accredited U.S. allopathic and osteopathic medical schools do not have a standardized or centralized process through which qualified students may transfer between institutions, resulting in highly variable eligibility requirements, timelines, and institutional practices[2]; and,

Whereas, medical students may require transfer to another accredited institution due to changes in personal, family, financial, disability-related, military, safety, or educational circumstances that cannot reasonably be accommodated at their current institution; and,

Whereas, mistreatment during medical school leads to student burnout, with 52.9% of students meeting criteria for distress and 22% having taken or considered a leave of absence to preserve their well-being, which may impact a student's ability to complete medical school[3]; and,

Whereas, students who experience frequent microaggressions are significantly more likely to consider transferring schools (14.5% vs. 4.7%) or withdrawing entirely from medical school (18.2% vs. 5.7%)[4]; and,

Whereas, students from historically marginalized backgrounds experience disproportionately higher rates of burnout and attrition, with attrition rates approximately 3.7 times higher than those of their peers[5,6,7,8]; and,

Whereas, among 14,126 medical students studied longitudinally, 22.9% experienced mistreatment by the beginning of their second year, and mistreatment was associated with significantly higher burnout, disengagement, and career regret at graduation in a dose-response fashion, demonstrating that institutional learning environments, not solely individual factors, drive student attrition[9]; and,

Whereas, despite these well-documented circumstances, few medical schools publicly provide comprehensive information regarding transfer eligibility, application requirements, timelines, or available positions, limiting students' ability to make informed decisions and access available opportunities; and

Whereas, inconsistent and incomplete public information regarding transfer opportunities forces students to navigate institution-specific requirements individually, increasing administrative burden and delaying access to educational environments better suited to their needs; and

Whereas, centralized resources such as the Medical School Admission Requirements (MSAR), Visiting Student Learning Opportunities (VSLO), AACOM Choose DO Explorer, and FREIDA demonstrate the value of providing applicants with standardized information across institutions[10,11,12,13]; and

Whereas**,** existing centralized resources for prospective medical students, such as the Medical School Admission Requirements (MSAR) and Choose DO Explorer, demonstrate established platforms through which standardized information regarding institutional transfer policies and opportunities could potentially be disseminated; and

Whereas, despite there being more than 93,000 MD students and 40,000 DO students in the United States, the nation faces a projected physician shortage of approximately 140,000 physicians by 2036[14,15,16]; and

Whereas, retaining students who would otherwise withdraw from medical education through reasonable transfer opportunities may strengthen the future physician workforce while preserving prior educational investment; and

Whereas, a formal medical school transfer process serves both the public interest and the physician workforce by creating an alternative pathway for students to continue their education at an institution better able to support their academic success and well-being; therefore, be it

RESOLVED, That our AMA supports increased transparency among accredited U.S. medical schools regarding transfer application policies, processes, and selection criteria.

Fiscal Note: None

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Resident and Fellow Physicians Seeking to Transfer GME Program H-310.900

(1) Our American Medical Association will encourage the development of a formal process for resident/fellow physicians to transfer to another graduate medical education program, without penalty, when an employment situation is not sustainable for a trainee and/or program. (2) Our AMA will investigate promoting the current capacity of FREIDA™; to post open positions and adding the ability for FREIDA™ to facilitate the process of residents and fellows who wish to transfer programs. [CME Rep. 05, I-23; Reaffirmed: CME Rep. 02, A-24]

Promoting Transparency in Medical Education and Access to Training H-295.860

…(2) Our AMA will work with the Accreditation Council for Graduate Medical Education and other appropriate stakeholders to support transparency within medical education, recommending that medical schools and graduate medical education training programs communicate with current and prospective medical students, residents and fellows how affiliations and mergers among health care organizations may impact health care delivery, medical education and training opportunities. (3) Our AMA will work with relevant parties to advocate for universal transparency of residency program eligibility requirements, including IMG eligibility and visa sponsorship policies, in electronic residency application systems and FREIDA™ to be published in a standardized, accessible format, to reduce unnecessary financial and emotional burdens on applicants. [Res. 319, A-15; Reaffirmed: CME Rep. 01, A-25; Appended: Res. 304, I-25]

RELEVANT MSS POSITIONS

None that apply to the scope of this resolution

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 311
(I-26)

Introduced by: Sanjay V. Neerukonda[1], Natasha Topolski[1], Druv Bhagavan[2]

Affiliations: [1] McGovern Medical School at UTHealth
[2] Washington University in St. Louis School of Medicine

Subject: Ensuring Flexible Testing Dates by the USMLE and Appropriate Stakeholder Engagement

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, the United States Medical Licensing Examination (USMLE) serves as the national pathway to physician licensure and plays a central role in medical student progression, residency applications, graduation timelines, and entry into the physician workforce; and

Whereas, the USMLE program announced that beginning in 2029, Step 1, Step 2 CK, and Step 3 examinations will transition from year-round administration to a Designated Testing Dates model with a combined total of approximately 45 testing days annually[1,2]; and

Whereas, the Step examination testing schedule is determined jointly by the Federation of State Medical Boards (FSMB), National Board of Medical Examiners (NBME), and the USMLE Composite Committee; and

Whereas, the current Step examination testing schedule offers examinations year-round excluding the first 14 days of January and major local holidays; and

Whereas, the proposed Designated Testing Dates model substantially reduces testing flexibility with the suggested calendar[3] offering only 17 dates for Step 1, 14 for Step 2 CK, and 14 for Step 3; and

Whereas, medical students rely on flexible testing windows to accommodate curricular differences, clinical rotations, research years, dual-degree programs, illness, disability accommodations, ensuring test day readiness, and other factors; and

Whereas, limiting testing windows may lead to substantially increased failure rates due to students feeling forced to take the exam when they are not ready, ill, or to meet academic milestone requirements for medical school; and

Whereas, during the COVID-19 pandemic, temporary closures and capacity restrictions at Prometric testing centers displaced approximately 17,000 USMLE examinees, resulted in widespread examination cancellations and rescheduling challenges, and prompted the USMLE

program to pursue supplemental and alternative testing options to expand examination capacity[4-6]; and

Whereas, the demonstrated consequences of constrained USMLE testing capacity underscore the importance of maintaining sufficient testing capacity, scheduling flexibility, and contingency mechanisms before implementing a substantial reduction in the number of available annual testing dates[4-6]; and

Whereas, the USMLE receives thousands of requests for test accommodations annually, with requests increasing substantially in recent years, and advises examinees to submit accommodation requests approximately 60 business days before their intended examination date to allow sufficient time for review and scheduling[7]; and

Whereas, medical students with disabilities experience disparities in access to USMLE Step 1 accommodations based on disability type, timing of diagnosis, and institutional access to specialized disability-resource professionals, demonstrating that the existing accommodation process may present additional barriers for examinees with disabilities[8]; and

Whereas, a reduction in the number of available USMLE testing dates may *disproportionately* affect examinees requiring accommodations, particularly those whose approved accommodations require additional testing time, additional breaks, or testing across multiple days, by limiting their ability to identify testing dates and locations that can accommodate their individualized needs; and

Whereas, delays in USMLE testing may disrupt medical students' academic progression, graduation planning, and transitions into residency and licensure[9]; therefore be it

RESOLVED, that our American Medical Association support:

a. a broad distribution of flexible testing dates throughout the year for each United States Medical Licensing Examination (USMLE) Step examination to accommodate diverse medical school and residency program curricula and unforeseen personal emergencies & circumstances, to ensure examinees can test when they are adequately prepared without undue stress; and
b. a defined emergency and hardship rescheduling process, distinct from the standard testing calendar, especially but not limited to when USMLE testing dates are limited in number or availability, to accommodate illness, disability-related needs, and unforeseen personal circumstances

(New HOD Policy); and be it further

RESOLVED, that our AMA support and encourage the USMLE program and its sponsoring organizations, the Federation of State Medical Boards and the National Board of Medical Examiners, with extensive involvement, review, and feedback by affected stakeholders, to comprehensively study, evaluate, and report, both prior to and following any implementation of the USMLE Designated Testing Dates model or any future alternative models:

a. The educational, logistical, financial, and workforce impacts, examination access, scheduling delays, travel burden, costs to examinees, residency application timelines, and
b. Differential impacts on students from historically marginalized or disadvantaged backgrounds, and

c. Assessment of its effects on medical students, residents, residency programs, and state medical licensing processes

(Directive to Take Action); and be it further

RESOLVED, that our AMA-MSS immediately forward this resolution to the I-26 House of Delegates Meeting.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Independent Regulation of Physician Licensing Exams D-295.939

(1) Our American Medical Association will continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system. (2) Our AMA will continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination. (3) Our AMA will continue to promote and disseminate the rules governing USMLE in its publications. (4) Our AMA will continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP). (5) Our AMA will work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). [CME Rep. 10, A-08; Modified: CME Rep. 01, A-18; Reaffirmation: A-22]

Reporting of Total Attempts of USMLE Step 1 and COMLEX-USA Level 1 Examinations H-295.841

(1) Our AMA encourages the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME) to continue evaluating barriers for students related to testing centers (e.g., rescheduling, cost, etc.). (2) Our AMA encourages medical schools to

assist examinees in scheduling of USMLE® and COMLEX-USA® exams and consider opportunities for flexibility. [CME Rep. 06, A-25]

Evaluate Barriers to Medical Education for Trainees with Disabilities D-90.990
…(3) Our AMA encourages the National Board of Medical Examiners (NBME), National Board of Osteopathic Medical Examiners (NBOME), and member boards of the American Board of Medical Specialties and the American Osteopathic Association to evaluate and enhance their processes for reviewing requests for accommodations from applicants with disabilities in order to reduce delays in completion of licensing and initial board certification examinations. This should include an assessment of the experience of those applicants and the development of a transparent communication process that keeps applicants informed about the expected timeline to address their requests. These processes should require neither proof of accommodation nor proof of poor academic performance prior to the time at which a need for accommodation was requested. (4) Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice. (5) Our AMA will collaborate with the NBME and the NBOME to facilitate a timely accommodations application. [CME Rep. 2, I-21; Appended - BOT Action in response to referred for decision: Res. 314, A-21; Appended: Res. 302, I-23]

Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools H-275.958
It is the policy of the AMA to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase. [Res. 289, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CME Rep. 01, A-20]

Proposed Single Examination for Licensure H-275.962
Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies. [CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17]

RELEVANT MSS POSITIONS
Future of the United States Medical Licensing Examination (USMLE) 295.188MSS
Examining Multi-Step Structure and Score Usage: AMA-MSS will ask that our AMA (1) work with the appropriate stakeholders to investigate the advantages, disadvantages, and practicality of combining the United States Medical Licensing Examination (USMLE) Step 1 and Step 2 Clinical Knowledge (CK) exams into a single licensure exam measuring both foundational

science and clinical knowledge competencies, and (2) work with the appropriate stakeholders to study alternate means of scoring United States Medical Licensing Examination (USMLE) exams. (MSS Res 21, I-16) (AMA Res 309, A-17 Adopted as Amended [appended to H-275.962 and H-275.953])

Standard Procedure for Accommodations in USMLE and NBME Exams 295.201MSS
AMA-MSS asked the AMA to: (1) collaborate with medical licensing organizations to facilitate a timely accommodations application process; and (2) in conjunction with the National Board of Medical Examiners, develop a plan to reduce the among of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities. (MSS Res. 11, I-19)

Support for Administration of USMLE and COMLEX Examinations by Home Institutions 295.222MSS
Our AMA-MSS supports the continued exploration of a permanent shift in the administration of USMLE and COMLEX examinations away from third-party testing sites and toward primary administration of home institutions with the supplementation of third party testing sites to accommodate test takers incapable of testing at home institutions. (MSS Res. 114, Nov. 2020)

USMLE Step 1 Timing 295.182MSS
AMA-MSS asked the AMA to ask the NBME to track USMLE Step 1 exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 exam performance. (MSS Res 20, A-14) (AMA Res 911, I-14 Adopted as Amended [D-275.958])

USMLE and COMLEX Exam Fee Burden 295.150MSS
AMA-MSS will study the actual costs of producing and administering the USMLE and COMLEX computer-based and clinical skills exams to determine the fairness and inherent burden of examination fees imposed on medical students. (MSS Res 4, A-10) (Amended and Reaffirmed: MSS GC Rep B, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 313
(I-26)

Introduced by: Ryan Borden[1], Rehet Chugh[2], Jocelyn Chow[3], Nidhi Lakshmanan[1], Gratiana Chen[1], Safia Iman[1]

Affiliations: [1] California Northstate University College of Medicine
[2] Burrell College of Osteopathic Medicine
[3] Western University of Health Sciences

Subject: Neurodiversity and Learning Differences in Medical Education

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, a systematic review of 29 studies from 17 countries encompassing 24,578 medical students reported widely variable rates of diagnosed attention-deficit/hyperactivity disorder (ADHD), possible ADHD, or ADHD symptoms, ranging from 1.7% by self-report to 38.9% using the Adult ADHD Self-Report Scale screener, and identified variation in assessment methods and a need for structured assessments and institutional support in medical education[1]; and

Whereas, medical students with ADHD have reported bullying and isolation by doctors and peers, alienation when unable to conform to expectations during clinical placements and examinations, and concerns regarding disclosure due to “weaponized professionalism,” which, in this context, refers to ADHD-related characteristics being inappropriately perceived as unprofessional despite likely having no true impact on medical-student performance or patient care[2]; and

Whereas, neurodivergence describes naturally occurring differences in how individuals perceive, process information, learn, communicate, and interact with the world; and neurodivergent medical students may have varied strengths and support needs, including students with ADHD, autism, and specific learning differences such as dyslexia, dysgraphia, dyscalculia, and dyspraxia[3]; and

Whereas, a scoping review of empirical research on neurodivergent students in undergraduate medical education identified limited evidence to guide educational practice, including limited research on assessment for students with autism, ADHD, or dyspraxia, and a need for greater attention to barriers and organizational support across clinical assessment settings for these students[3]; and

Whereas, a qualitative study of medical educators identified perceived gaps in educator preparedness and institutional support for teaching neurodivergent learners during clinical

placements, including barriers related to stigma, disclosure, and implementation of reasonable adjustments[4]; and

Whereas, a national modified Delphi consensus study identified limited guidance, inconsistent accommodation language, and variable institutional expertise as challenges to clinical-accommodation implementation in U.S. undergraduate medical education and developed consensus-based language for 75 clinical accommodations to improve clarity, consistency, and accessibility while allowing for individualized accommodation determinations[5]; and

Whereas, federal disability protections require covered postsecondary institutions to afford qualified students with disabilities equal opportunity to participate in educational programs through appropriate academic modifications, auxiliary aids, and services, while preserving applicable academic and technical standards[6,7]; and

Whereas, existing AMA policy supports disability-accommodation processes, functional technical standards, research on accommodation efficacy and safety in clinical programs, and supportive learning environments for trainees with disabilities, but does not specifically recognize neurodiversity or address equitable assessment practices across written, clinical-skills, and workplace-based assessments in undergraduate medical education[8,9]; and

Whereas, existing AMA-MSS policy supports individualized disability assessment, appropriate technical standards, and faculty and administrator guidance for students and trainees with disabilities, while its policy on USMLE and NBME accommodations focuses more on the application process for national licensing examinations rather than assessment practices within undergraduate medical education[10,11]; therefore be it

RESOLVED, that our AMA recognizes neurodiversity, including attention, learning, and communication differences, as a distinct category within existing disability and equity work in medical education (New HOD Policy); and be it further

RESOLVED, that our AMA supports efforts by medical schools and relevant medical education organizations to develop and implement evidence-informed, equitable assessment practices for neurodivergent medical students across written, clinical-skills, and workplace-based assessments, while preserving essential competencies and individualized accommodation processes (Directive to Take Action).

Fiscal Note: TBD

Date Received: 9/6/26

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RELEVANT AMA POLICY

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

(1) Our American Medical Association urges that all medical schools and graduate medical education (GME) institutions and programs create, review, and revise technical standards, concentrating on replacing "organic" standards with "functional" standards that emphasize abilities rather than limitations, and that those institutions also disseminate these standards and information on how to request accommodations for disabilities in a prominent and easily found location on their websites.
(2) Our AMA urges all medical schools and GME institutions to:
(a) make available to students and trainees a designated, qualified person or committee trained in the application of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, and available support services.
(b) encourage students and trainees to avail themselves of any needed support services.
(c) foster a supportive and inclusive environment where students and trainees with disabilities feel comfortable accessing support services.
(4) Our AMA encourages research and broad dissemination of results in the area of disabilities accommodation in the medical environment that includes: the efficacy of established accommodations; innovative accommodation models that either reduce barriers or provide educational approaches to facilitate the avoidance of barriers; impact of disabled learners and physicians on the delivery of health care to patients with disabilities; and research on the safety of established and potential accommodations for use in clinical programs and practice.
(8) Our AMA encourages the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM) and other relevant bodies to include questions on mistreatment based on disability, as defined by United States Americans with Disabilities Act, in their surveys including the AAMC Medical School Graduation Questionnaire.
(9) Our AMA encourages medical schools to cultivate learning environments that foster belonging for students with disabilities. [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]

Standardizing Coverage of Evidence-Based Treatments for Neurodivergent Individuals H-185.921

Our American Medical Association supports coverage and reimbursement for evidence-based treatments and services for neurodivergent individuals, including Autism Spectrum Disorder. [Res. 123, A-19; Modified: Res. 706, A-23]

RELEVANT MSS POSITIONS

Standard Procedure for Accommodations in USMLE and NBME Exams 295.201MSS

AMA-MSS asked the AMA to: (1) collaborate with medical licensing organizations to facilitate a timely accommodations application process; and (2) in conjunction with the National Board of Medical Examiners, develop a plan to reduce the among of proof required for approving accommodations to lower the burden of cost and time to medical students with disabilities. (MSS Res. 11, I-19)

Improving Support and Assistance for Medical Students with Disabilities 310.055MSS

AMA- MSS (1) supports the individualized assessment of disability, as required by current law, and discourages blanket prohibitions of assistive technology such as the use of American Sign Language (ASL) interpreters, Communication Access Realtime Translation (CART, sometimes referred to as real-time captioning) services, FM systems (devices that use FM frequencies to amplify sound), and trained intermediaries for students, residents, and clinicians with physical disabilities; and (2) supports the development of training and guidance for medical school faculty and administrators on: (a) communicating with and about persons with disabilities, (b) writing appropriate technical standards for applicants, medical students, and residents, and (c) identifying which technical standards are truly essential for all medical school graduates and residents by groups such as the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM). (MSS Res 33, A-18)

Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis 90.013MSS

AMA-MSS will ask (1) that our AMA supports research towards the evaluation and the development of interventions and programs for autistic individuals, (2) that our AMA work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism, and (3) that our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" by addition and deletion as follows:

Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder, H-185.921

Our AMA supports coverage and reimbursement for evidence-based ~~treatment of~~ services for Autism Spectrum Disorder ~~including, but not limited to, Applied Behavior Analysis Therapy.~~ (MSS Res. 012, A-22) (AMA Res. 706, Adopt as Amended, A-23)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 401
(I-26)

Introduced by: Jeffrey Gu[1]

Affiliations: [1] University of Virginia School of Medicine

Subject: Expanding FDA Mandatory Recall Authority for Human Drugs

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, ophthalmic drug products must be sterile and pose heightened safety risks because administration directly to the eye bypasses some of the body's natural defenses, allowing contamination to cause vision-threatening or life-threatening infection[1]; and

Whereas, a 2022-2023 multistate outbreak linked to contaminated artificial tears resulted in 81 patients with extensively drug-resistant Pseudomonas aeruginosa infection across 18 states, including 14 patients with vision loss, 4 patients requiring enucleation, and 4 deaths[2,3]; and

Whereas, a 2026 analysis of Food and Drug Administration enforcement reports identified 110 unique artificial-tear formulations recalled between 2014 and August 2025, including 65 for lack of sterility assurance and 25 for confirmed microbial contamination, and found that all identified recalls were voluntary and company initiated[4]; and

Whereas, the Food and Drug Administration already uses risk-based inspection, product sampling and testing, post-market monitoring, safety communications, and voluntary recall oversight for ophthalmic drugs, while existing AMA Policy H-120.958 supports FDA adverse-event reporting and medical-product safety activities, demonstrating that the remaining policy gap is not simply the existence of sterility, surveillance, or risk-communication programs[1,5]; and

Whereas, the Food and Drug Administration has mandatory recall authority for certain product categories but lacks such authority for most human drugs and therefore generally relies on manufacturers to initiate recalls, although FDA may pursue separate enforcement actions such as seizure or injunction when a manufacturer continues marketing a defective product[6,7]; and

Whereas, this limitation has produced real-world delays, as LightEyez Limited agreed in August 2023 to voluntarily recall contaminated ophthalmic drugs but subsequently ceased communication with FDA and had not initiated an FDA-coordinated recall when FDA issued its February 2024 warning letter requesting recall of affected sterile drug products[8]; and

Whereas, Congress has established mandatory recall frameworks for other FDA-regulated products, including food, for which FDA may order cessation of distribution when exposure presents a reasonable probability of serious adverse health consequences or death, demonstrating an existing federal model for mandatory product removal[9]; and

Whereas, the Food and Drug Administration has formally requested that Congress expand mandatory recall authority to all human and animal drugs, citing cases in which firms significantly delay or refuse requested voluntary recalls and concluding that mandatory authority would remove dangerous drugs more quickly and reduce consumer harm[10]; and

Whereas, existing AMA Policy H-150.954 specifically supports mandatory recall authority for certain dietary supplements, while AMA policies addressing human drugs support post-market surveillance, risk communication, and evidence-based FDA action without establishing support for mandatory recall authority for most human drugs, leaving a discrete policy gap[5,11,12]; and

Whereas, only Congress can expand the Food and Drug Administration's statutory recall authority for human drugs, and the AMA's established federal advocacy on drug safety and FDA oversight positions it to advocate for this national patient-safety change[5,10]; therefore be it

RESOLVED, that our American Medical Association support federal legislation granting the Food and Drug Administration mandatory recall authority for human drugs not already subject to such authority when the FDA determines that use or exposure presents a reasonable probability of serious adverse health consequences or death, including authority to order cessation of distribution and appropriate notification of affected parties.

Fiscal Note: TBD

Date Received: 08/03/2026

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RELEVANT AMA POLICY

Supporting Safe Medical Products as a Priority Public Health Initiative H-120.958
Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;

(2) continue participation in efforts to advance the science of safety in the medication use process, including work with the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's MedWatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, in an effort to improve patient safety; (5) participate in the work of the Healthy People 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy; and (6) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety. [Res. 416, A-99; Appended: Res. 504, I-01; Reaffirmation A-10; Modified: CSAPH Rep. 01, A-20; Modified: CSAPH Rep. 4, N-21; Modified: CSAPH Rep. 3, A-22]

Dietary Supplements and Herbal Remedies H-150.954
Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems. [Reaffirmed: Res. 510, A-24]

FDA H-100.992
Our AMA reaffirms its support for the principle that an FDA decision to approve a new drug, withdraw a drug's approval, or change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data fit for regulatory purpose, and/or postmarket incident reports as provided by statute. [Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20]

National Cosmetics Registry and Regulation H-440.855
Our AMA supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful. [BOT Action in response to referred for decision Res. 907, I-09; Reaffirmed in lieu of: Res. 502, A-17]

RELEVANT MSS POSITIONS

Reporting of Adverse Drug Events 100.009MSS
AMA-MSS supports physician education regarding voluntary adverse-drug-event reporting and investigation of barriers to reporting. [MSS Sub. Res. 19, I-09]

FDA Regulation of OTC Medication Advertising 105.002MSS
AMA-MSS supports increased federal oversight of over-the-counter medications in the context of advertising.

National Cosmetics Registry and Regulation 270.021MSS
AMA-MSS supports strengthened FDA authority to recall harmful cosmetics.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 402
(I-26)

Introduced by: Riya Kumar[1], Daniel Leonard[2], Noyonikaa Gupta[2], Sanjay V. Neerukonda[3], Kiran Thirukonda[4]

Affiliations:
[1] Drexel University College of Medicine
[2] Northeast Ohio Medical University
[3] McGovern Medical School at UTHealth
[4] Baylor College of Medicine

Subject: National Response to Xylazine-Associated Overdose, Wound Care, and Education

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, xylazine is a potent, non-opioid sedative, analgesic, and muscle relaxant strictly approved by the FDA for veterinary use in animals and not indicated in humans that has rapidly emerged as a major driver of overdose morbidity and mortality in the US; and

Whereas, while xylazine contributes to severe respiratory depression and hypotension, mimicking the physiologic effects of opioids such as heroin and fentanyl, it is nonresponsive to reversal of symptoms with naloxone due to its classification as a non-opioid sedative[1]; and

Whereas, xylazine causes ulcerative lesions that can progress to abscess, cellulitis, necrotic skin wounds, bone and tendon exposure, osteomyelitis, bacteremia, endocarditis, and autoamputation[2]; and

Whereas, the presence of xylazine in overdose fatalities increased from 0.36% of deaths in 2015 to 6.7% in 2020[3]; and

Whereas, the highest prevalence in overdose fatalities in 2020 was in Philadelphia, where xylazine was detected in 25.8% of overdose deaths, followed by Maryland (19.3%) and Connecticut (10.2%)[3]; and

Whereas, fentanyl-xylazine deaths increased from 99 in 2018 to 6,020 in 2023[4]; and

Whereas, illicitly manufactured fentanyl was identified in 98.4% of xylazine-involved overdose deaths, indicating a strong epidemiologic association between these substances[3]; and

Whereas, the U.S. Food and Drug Administration (FDA), in partnership with the Reagan-Udall Foundation for the FDA along with the White House Office of National Drug Control Policy, have officially designated fentanyl adulterated or associated with xylazine as an emerging threat to the United States[5,6]; and

Whereas, prior harm reduction studies evaluating drug-checking test strip distribution show high acceptability, increased risk awareness, safer drug-use practices, and reduced overdose incidence in high-risk populations[7]; and

Whereas, unlike fentanyl and other common causes of overdose, there are currently no national evidence-based clinical guidelines addressing the recognition, supportive management, wound evaluation, surgical referral, or withdrawal management of xylazine toxicity[8]; and

Whereas, since the TRANQ research act of 2023, more than half of states have passed, proposed, or implemented xylazine-related legislation or regulations, but federal actions have not yet translated into widespread clinical standardization or harm reduction infrastructure[9,10]; and

Whereas, the implementation of standardized clinical pathways to screen and treat non-xylazine opioid withdrawal has been shown to increase physician and provider confidence in recognizing overdose symptoms and increase their ability to provide timely and focused intervention for their patient populations[8]; and

Whereas, standardized wound care protocols, recognition of xylazine-associated sequelae, and medical education have been identified by the FDA to be necessary preventative and therapeutic strategies for reducing illicit use of xylazine and increasing access to evidence-based treatment[11]; therefore be it

RESOLVED, that our AMA recognize xylazine as an emerging national public health threat (New HOD Policy); and be it further

RESOLVED, that our AMA support the development and dissemination of evidence-based, standardized national clinical guidelines by professional organizations — including, but not limited to, the American Society of Addiction Medicine and the Infectious Diseases Society of America — for managing xylazine overdoses, limb salvage evaluation, and xylazine-associated wound care, including indications for specialty consultation and surgical intervention (Directive to Take Action).

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Supporting Harm Reduction H-95.900

Our American Medical Association supports (a) efforts to decriminalize the possession of non-prescribed buprenorphine for personal use by individuals who lack access to a physician for the treatment of opioid use disorder; (b) decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking; (c) additional study whether “safer smoking supplies” may be a potential harm reduction measure to reduce harms from the nation’s overdose and death epidemic. [BOT Rep. 18, A-24]

Prevention of Drug-Related Overdose D-95.987

Our AMA will (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug- related overdose; (b) support the development of adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose; (c) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose; (d) support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures; (e) advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies; (f) implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19; (g) support efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction. [Res. 526, A-06; Modified: Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18, Modified: Res. 506, I-21; Appended: Res. 221, A-23; Reaffirmation: A-23; Modified: Res. 505, A-23; Reaffirmed: BOT Rep. 18, A-24]

Calling for a Multifaceted Approach to the Illicit Fentanyl Crisis H-95.896

Our American Medical Association continues to (a) support public education and awareness about the rapidly evolving US illicit drug epidemic due to dangers of illegally made fentanyl and other toxic substances; (b) support efforts that respect human life and minimize harm by federal, state, and local government officials and agencies to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds; (c) monitor trends in polysubstance use, including the potential for drug checking technologies to assist public health officials in identifying how such technologies can lead to public health interventions, such as rapid deployment of naloxone and other overdose reversal agents; (d) encourage state medical associations and national medical specialty societies to support legislative and other

efforts to strengthen state 911 Good Samaritan Overdose statutory protection consistent with AMA policy. [Res. 202, I-24; Modified: BOT Rep. 01, I-25]

The Reduction of Medical and Public Health Consequences of Drug Use H-95.954
Our American Medical Association encourages (a) national policy-makers to pursue an approach to the problem of drug misuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (b) policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (c) the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (d) the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (e) a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (f) the ability of physicians to prescribe syringes and needles to patients who inject drugs in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; (g) state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. [CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 8, A-23]

RELEVANT MSS POSITIONS
95.009 MSS (Addressing Emerging Trends in Recreational Drug Abuse)
Our AMA-MSS supports (a) the appropriate agency to provide continuing medical education courses in emerging trends in recreational substance abuse; and (b) support the appropriate agency to disseminate current and accurate information regarding emerging trends in recreational substance abuse [MSS Res 16, A-14; Substitute AMA Res 901, I-14; Adopted with Change in Title [H-95.940]]

100.010MSS (Promoting Prevention of Fatal Opioid Overdose)
AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. [MSS Res 36, I-11]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution XXX
(A/I-XX)

Introduced by: Andrew Norton[1], Megan Reilly[1], Samyukta Karthik[2], Anish Kakarla[3], Allison Kelley[4], Berit Lubben[5], Sarah Jiang[6]

Affiliations: [1] University of Wisconsin, [2] Penn State - University Park, [3] Midwestern University - Chicago, [4] University of Colorado, [5] Mayo Clinic Alix School of Medicine, [6] University of Missouri-Kansas City

Subject: Improving Harm Reduction Strategies Though Free-of-Charge Drug-Checking Services and Materials

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, the United States' 1971 "War on Drugs" prioritized prohibition and criminalization, contributing to disproportionate harms in Black, Hispanic, and other marginalized communities, including incarceration, collateral barriers to housing, employment, and education, reduced access to treatment and harm-reduction services, infectious-disease transmission, and stigma that discourages care seeking [1-6]; and

Whereas, evidence demonstrates that criminalization of drug possession has little to no deterrent effect on drug use or prevalence, while contributing to adverse health outcomes, exacerbating health inequities, and exploiting the human rights of people who use drugs [7-10]; and

Whereas, the increasing reliance on synthetic drug manufacturing has enabled the rapid emergence, adulteration, and geographic spread of highly potent and novel substances (including illegally manufactured fentanyl, fentanyl analogs, nitazenes, xylazine, and other non-opioid sedatives) often in unpredictable combinations and without users' knowledge [11-12]; and

Whereas conventional public-health surveillance, toxicology testing, and mortality reporting may not identify such changes rapidly enough to provide timely warnings or guide overdose-prevention responses, there is a need for widely available, quality-assured drug-checking services that can identify harmful or unexpected substances, inform people who use drugs, and strengthen real-time public-health surveillance [11-13]; and

Whereas advanced drug screening with specialized equipment is better able to prevent overdose by providing the exact composition of a drug sample instead of only ruling out the presence of a single drug like fentanyl or xylazine test strips do [14]; and

Whereas, drug-checking services are harm-reduction interventions that provide people with timely information about fentanyl, xylazine, and other unexpected or harmful substances in the unregulated drug supply, supporting informed decisions to reduce overdose risk; and whereas expanded access to free, confidential, quality-assured drug checking should be supported

through sustainable funding and community-based distribution, while addressing barriers including equipment costs and laws that may classify drug-checking supplies as drug paraphernalia [3,15-20]; and

Whereas, despite their potential public-health benefits, drug-checking services remain unevenly available because of inadequate funding and organizational capacity, high equipment and operating costs, variable access to accurate and validated testing technologies, and legal and drug-paraphernalia barriers (including laws that clearly permit possession of drug-checking equipment in only 22 states and distribution in only 19 states) with 81% of drug-checking organizations identifying insufficient funding as the primary barrier to sustaining operations [21-22]; and

Whereas, legal ambiguity and criminalization under federal, state, and local drug-paraphernalia, controlled-substance, and possession laws may deter individuals and organizations from possessing, distributing, funding, operating, or using drug-checking equipment and services, thereby limiting access to potentially lifesaving harm-reduction tools; and governments at all levels should establish clear legal protections for individuals who possess or use drug-checking equipment and for public-health, community-based, and nongovernmental organizations that provide confidential or anonymous drug-checking services in good faith [23-24]; and

Whereas, integration of drug-checking services into community-based harm-reduction provides individualized information about emerging substances while creating low-barrier connections to overdose prevention, substance-use treatment, and other health and social services, thereby supporting health equity and reducing infectious-disease transmission among people who use drugs [25-29]; and

Whereas, drug-checking service delivery models have been successfully implemented across diverse U.S. settings, including Chicago's mobile drug-checking program using three complementary technologies at six outreach locations, demonstrating the feasibility of multi-technology drug checking integrated into existing harm reduction outreach [29]; and

Whereas, New York City, Rhode Island, and Michigan have each implemented or planned community-based drug-checking services embedded within syringe service programs, health departments, and harm reduction agencies, demonstrating that these programs can operate across varying state contexts and organizational structures [30-32]; and

Whereas, removing legal impediments, establishing sustainable infrastructure, and protecting participants from civil and criminal penalties are necessary to expand equitable access to validated drug-checking services through pharmacies, community health centers, harm reduction programs, and clinical settings [33-34]; and

Whereas, although existing AMA policy supports drug checking, advocates for funding and legal authorization at local, county, state, and national levels, and calls for continued monitoring of drug-checking efforts, it does not specifically address the development and expansion of free or low-cost, anonymous, community-accessible programs across governmental and nongovernmental service settings or the integration of quality-assured, multi-analyte testing with result interpretation, education, referral, and harm-reduction services [35]; and

Whereas, expanding free or low-cost, anonymous, community-accessible, and quality-assured drug-checking services through governmental and nongovernmental public-health, health care, pharmacy, harm-reduction, laboratory, and community partners would strengthen access to

timely information about an increasingly unpredictable drug supply; facilitate informed decision-making and connection to overdose-prevention, treatment, and other harm-reduction services; and support local public-health surveillance and overdose-prevention efforts; therefore be it

RESOLVED**,** that our AMA supports the development and expansion of free or low-cost, anonymous, community-accessible drug-checking programs operated by public-health agencies, pharmacies, community health centers, harm-reduction organizations, academic and clinical laboratories, and other nongovernmental community partners (Directive to Take Action); and be it further

RESOLVED**,** that our AMA supports the integration of quality-assured, multi-analyte drug-checking methods with appropriate result interpretation, education, referral, and harm-reduction services to enable individuals to make informed decisions and strengthen local overdose-prevention efforts (Directive to Take Action).

Fiscal Note: TBD

Date Received: TBD

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RELEVANT AMA POLICY

Drug Testing H-95.985

…Due to the limited specificity of the inexpensive and widely available non-instrumented devices such as point-of-care drug testing devices, acceptable clinical drug testing programs should include the ability to access highly specific, analytically acceptable confirmation techniques, which definitively establish the identities and quantities of drugs, in order to further analyze results from presumptive testing methodologies. Physicians should consider the value of data from non-confirmed preliminary test results, and should not make major clinical decisions without using confirmatory methods to provide assurance about the accuracy of the clinical data….

Prevention of Drug-Related Overdose D-95.987

Our American Medical Association: recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs. urges that community-based programs offering naloxone and other safe and effective overdose reversal medications and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area. encourages the education of health care workers and people who use drugs about the use

of naloxone and other safe and effective overdose reversal medications and other harm reduction measures in preventing opioid and other drug related overdose fatalities. will continue to monitor the progress of such initiatives and respond as appropriate. Our AMA will: advocate for the removal of fentanyl test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl or other adulterants from the legal definition of drug paraphernalia.

Supporting Harm Reduction H-95.900
Our American Medical Association supports efforts to decriminalize the possession of non-prescribed buprenorphine for personal use by individuals who lack access to a physician for the treatment of opioid use disorder. Our AMA supports decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking. Our AMA encourages additional study whether "safer smoking supplies" may be a potential harm reduction measure to reduce harms from the nation's overdose and death epidemic.

The Reduction of Medical and Public Health Consequences of Drug Use H-95.954
…Our AMA encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection…

In Support of a National Drug Checking Registry D-95.947
Our American Medical Association supports drug checking that provides real-world insight into the rapidly shifting drug supply, which helps reduce harm among people who use drugs, better inform clinicians, and enhance public health surveillance efforts. Our AMA advocates for funding and legal authorization to support drug checking services at the local, county, state, and national level. Our AMA will continue to monitor ongoing drug checking efforts.

RELEVANT MSS POSITIONS
95.000MSS Drug Abuse

- Inhalant Misuse
- Methamphetamine Misuse
- De-Scheduling Cannabis and its Derivatives
- Recognition of Addiction as Pathology, Not Criminality
- Comprehensive Evidence-Based Drug Treatment in Prisons
- Increased Advocacy for Needle Exchange Programs
- Cannabis and the Regulatory Void
- Addressing Emerging Trends in Recreational Drug Abuse
- Eliminating "Fail First" Policy in Addiction Treatment
- Supervised Injection Facilities as Harm Reduction to Address Opioid Crisis

- Access to Evidence-Based Care at Addiction Rehabilitation Facilities and Recovery Homes
- Support Expansion of Good Samaritan Laws
- Opposition to Lack of Evidence-Based Medicine in Drug Courts
- Opioid Treatment Programs Reporting to Prescription Monitoring Programs
- Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Drug Overdoses
- Use of Involuntary Outpatient Commitment
- Amend D-95.987, to Support Exempting Fentanyl Test Strips and other Drug Checking Technologies from Paraphernalia Laws
- Support Harm Reduction Efforts through Decriminalization of Possession on Non-Prescribed Buprenorphine
- Drug Policy Reform
- Supporting and Funding Sobering Centers
- Access to Naloxone for Vulnerable and Underserved Populations
- Addressing the Use of Mail-order Naloxone to Curb the Opioid Epidemic
- Supporting Further Study of Kratom
- Naloxone Alternative or Adjuncts to Combat Synthetic Opioid-Induced Respiratory Depression

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution XXX
(A/I-XX)

Introduced by: Andrew Norton[1], Emma Treco[1] , Matthias Walters [2], Mason Tuttle [3], Pratik Thakur [4], Lia Freed-Doerr [5], Eva Eleftheriadis [6], Sanya Dhama [7]

Affiliations: [1] University of Wisconsin, [2] University of Nebraska Medical Center, [3] Kansas City University, [4] Ohio State University, [5] University of Nevada - Reno, [6] Penn State College of Medicine, [7] UC Riverside SOM

Subject: Compliance and Restoration of Infectious Disease Surveillance Programs

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, the Trump administration's January 2025 termination of U.S. Agency for International Development (USAID) and its awards have disrupted or ended critical U.S. global-health programs, including the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), USAID's Neglected Tropical Diseases (NTD) Program, and USAID-supported global health and infectious disease response activities [1-6]; and

Whereas, the initial pause halted PEPFAR programming, 71% of identified USAID global-health awards related to HIV were reported as terminated, USAID-supported NTD activities in 24 African countries were disrupted (including 47 planned mass-drug-administration campaigns intended to reach approximately 142 million people), and 80% of identified USAID global-health awards were reported as terminated, which jeopardizes continuity of treatment, prevention, surveillance, and emergency-response capacity worldwide [1-6]; and

Whereas, the Foodborne Diseases Active Surveillance Network (FoodNet) is an active, population-based sentinel surveillance system monitoring *Campylobacter, Cyclospora, Listeria, Salmonella*, Shiga toxin-producing *E. coli, Shigella, Vibrio,* and *Yersinia* infections to improve public health practice and support reduction of foodborne illness[1]; and

Whereas, the data collected by FoodNet have been vital to identifying sources and outcomes of foodborne illnesses as well as reducing outbreaks through informing decisions for prevention resource allocation, as evidenced by the reduction of Shiga toxin-producing *E. coli*by 30% from 1996 to 2015[7-8]; and

Whereas, following FoodNet's recent reduction in required pathogen monitoring, outbreaks have occurred from pathogens no longer subject to required reporting by FoodNet, including a multi-state outbreak of Cyclospora in 2026 with reported illnesses reaching 11,458 and reported hospitalizations reaching 495 as of August 24, 2026[9-10]; and

Whereas, recent foodborne outbreaks continue to cause substantial morbidity and mortality, with the CDC coordinating 17 to 36 multi-state foodborne illness investigations each week through 2026, including outbreaks of *Listeria* and*Salmonella,* which led to over 50 hospitalizations and several deaths; and a 2025-2026 *E. coli* O157 outbreak linked to raw dairy products in which over half of reported illnesses were in children under five years old and one patient developed hemolytic uremic syndrome[10-13]; and

Whereas, recent reductions in U.S. support for global infectious disease programs have disrupted public health capacity, with the World Health Organization reporting that withdrawal of U.S. funding for NTD programs delayed 47 planned mass-treatment campaigns intended to reach 143 million people, while UNAIDS has reported international disruptions to HIV data collection and analysis and estimates that permanent discontinuation of U.S.-supported HIV treatment and prevention programs could result in an additional 6 million HIV infections and 4 million AIDS-related deaths between 2025 and 2029[14-17]; and

Whereas, public health surveillance systems are essential to the early detection of disease outbreaks, monitoring of disease trends, and identification of emerging public health threats, thereby enabling timely and evidence-based public health interventions[14]; and

Whereas, delays in surveillance can impede the timely investigation of disease outbreaks, including identification of affected populations and sources of transmission, and limit the ability of public health authorities to implement timely measures to control further spread[18-20]; and

Whereas, established federal public health surveillance programs have provided critical data for detecting and investigating foodborne illnesses and identifying emerging outbreaks, with reductions in such surveillance capacity risking gaps in disease detection and limiting timely public health response[21-22]; and

Whereas, restoration and expansion of the FoodNet and other programs should include sustained federal funding and technical support for mandatory, active, population-based monitoring of the eight aforementioned foodborne pathogens, as well as periodic evidence-based assessment of additional foodborne pathogens that are emerging public-health threats, in order to restore comprehensive trend monitoring, outbreak detection, and prevention capacity[23-25]; and

Whereas, the federal government should maintain and strengthen domestic infectious disease surveillance infrastructure through sustained appropriations, workforce development, laboratory capacity, interoperable electronic reporting systems, and timely sharing of complete surveillance data among public-health authorities, recognizing that effective national surveillance depends on coordinated reporting, investigation, and response capacity across these partners[26-28]; and

Whereas, the U.S. should support durable domestic and global infectious disease surveillance and response capacity through coordination among U.S. and international agencies/institutions, so that these entities are not required to independently absorb preventable gaps in surveillance, diagnostic, data-analysis, and outbreak-response capacity created by reductions in federal programs or reporting requirements [29-31]; and

Whereas, existing AMA policy recognizes the risk to the public, patients, and health care workers by transmissible and infectious diseases; encourages implementation of protections

against such, including advocacy for improved surveillance of certain transmissible diseases such as vector-borne diseases, HIV/AIDS, and blood-borne diseases; acknowledges disease surveillance and response capabilities of public health agencies to be “among our nation’s highest priorities”; and recognizes “the cost in human life of withdrawal of funding for USAID,” which is also involved in infectious disease surveillance; yet existing policy does not extend this recognition to specifically national and international infectious disease surveillance programs beyond support of continued surveillance by the CDC[32]**;** and

Whereas, the programs affected were impactful and would be beneficial to reinstate, including PEPFAR via USAID which has helped over 25 million lives affected by HIV/AIDS in more than 50 countries, and USAID’s continued support for tuberculosis control, global health security, malaria treatment and prevention, reproductive health, and nutrition programs, which if reinstated can continue helping vulnerable populations [33-35]; and

Whereas, reinstating NTD programs will help curtail preventable negative outcomes of these diseases on vulnerable populations and hence decrease socioeconomic disadvantages, thereby assisting in the accomplishment of the sustainable development goals[36-37]; and

Whereas, halting these programs has already had a cascade of negative effects, such as ineffective tracking of diseases, vital clinics and testing centers closing, medications expiring, and patients’ treatments and care rapidly stopping [38]; and

Whereas, restoring and expanding infectious disease surveillance would improve completeness, consistency, and representativeness of data used to determine disease burden, monitor changes in disease trends over time, evaluate the effectiveness of prevention measures, measure progress toward disease-prevention goals, identify disproportionately affected populations, and inform evidence-based public health policies, food-safety regulations, and clinical guidance; and

Whereas, effective disease surveillance serves as an early-warning system for outbreaks, supports the timely detection and investigation of emerging threats, and allows prevention and control measures to be initiated earlier, reducing the risk that outbreaks spread and preventable illness and death; therefore be it

RESOLVED, that our AMA advocates for the compliance and restoration of infectious disease surveillance programs (Directive to Take Action); and be it further

RESOLVED, that our AMA-MSS immediately forward this resolution to the HOD.

Fiscal Note: TBD

Date Received: 03/15/2026

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RELEVANT AMA POLICY

Bolstering Public Health Preparedness H-440.892

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.

Vector-Borne Diseases H-440.820

Due to the increasing threat and limited capacity to respond to vector-borne diseases, our AMA supports and will advocate for: (1) Improved surveillance for vector-borne diseases to better understand the geographic distribution of infectious vectors and where people are at risk; (2) The development and funding of comprehensive and coordinated vector-borne disease prevention and control programs at the federal, state and local level;

Next Generation Infectious Diseases Diagnostics H-440.834

Our American Medical Association supports strong federal efforts to stimulate early research and development of emerging rapid ID (infectious disease) diagnostic technologies through increased funding for appropriate agencies. Our AMA supports the reduction of regulatory barriers to allow for safe and effective emerging rapid diagnostic tests, particularly those that address unmet medical needs, to more rapidly reach laboratories for use in patient care. Our AMA supports improving the clinical integration of new diagnostic technologies into patient care through outcomes research that demonstrates the impact of diagnostics on patient care and outcomes, educational programs and clinical practice guidelines for health care providers on the appropriate use of diagnostics, and integration of diagnostic tests results into electronic medical

records. Our AMA supports efforts to overcome reimbursement barriers to ensure coverage of the cost of emerging diagnostics.

Restore Funding to USAID D-250.985

Our American Medical Association will make public statements regarding the cost in human life of withdrawal of funding for USAID. Our AMA will make public statements regarding the worldwide health risks associated with withdrawal of funding for treatment of infectious diseases such as Tuberculosis, HIV, Ebola, and others.

9.3.1 Physician Health & Wellness

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. To fulfill this responsibility individually, physicians should: (a) Maintain their own health and wellness by: (i) following healthy lifestyle habits; (ii) ensuring that they have a personal physician whose objectivity is not compromised.(b) Take appropriate action when their health or wellness is compromised, including: (i) engaging in honest assessment of their ability to continue practicing safely; (ii) taking measures to mitigate the problem; (iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease; (iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization H-440.831

AMA policy is that, in the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues or threatens the availability of the health care workforce, particularly a disease that has the potential to become epidemic or pandemic, including influenza, and for which there is an available, safe, and effective vaccine, physicians, health care workers (HCWs), and family caregivers who have direct patient care responsibilities or potential direct exposure have an obligation to accept immunization unless there is a recognized medical reason to not be immunized. In scenarios in which there is a documented medical contraindication to immunization of a physician or HCW, appropriate protective measures should be taken. Our AMA (a) encourages hospitals, health care systems, and health care providers to provide immunizations to HCWs against influenza and other highly transmissible diseases, at no cost to the employee, both for their own protection and to reduce the risk of infectious disease transmission to others; and (b) encourages health care institutions to develop mechanisms to maximize the rate of influenza immunization for HCWs, including the option of making immunization a condition of employment.

State Tracking of HIV/AIDS and Other Serious Infectious Diseases H-440.886
Our AMA encourages specific statutes be drafted that, while protecting to the greatest extent possible the confidentiality of patient information: (a) provide a method for warning unsuspecting sexual partners, needle-sharing partners, or other close contacts; (b) protect physicians from liability for failure to warn the unsuspecting third party; but (c) establish clear standards for when a physician should inform the public health authorities. Our AMA will assist states in their efforts to take whatever actions are necessary to allow blood banks and health departments to share information for the purpose of locating and informing persons who have any transmissible bloodborne disease.

Disease Prevention and Health Promotion in Correctional Institutions H-430.989
Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Global Climate Change and Human Health H-135.938
Our AMA supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

RELEVANT MSS POSITIONS
440.089MSS Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional Facilities
Our AMA-MSS will ask the AMA to: 1) collaborate with state medical societies to advocate for evidence-based public health measures to curb the spread of highly contagious pathogens in the setting of prisons and jails, including, but not limited to: a) universally available screening, testing, contact tracing, and medical care to staff and individuals that are incarcerated; b) Access to sanitizing equipment including, but not limited to, soap, hand sanitizer, and cleaning supplies; c) Humane and safe quarantine protocol for individuals that test positive for or are exposed to highly contagious respiratory pathogens; d) Adherence to use of personal protective equipment for incarcerated individuals and staff; and e) Expanded data reporting, including testing rates and demographic breakdown of highly contagious infectious disease cases and deaths; 2) support efforts to de-carcerate non-violent elderly and medically vulnerable individuals to mitigate the spread of highly contagious pathogens within correctional facilities and communities; and 3) support prioritizing COVID vaccine access for justice involved populations.

65.054MSS Opposing Use of Vulnerable Incarcerated People in Response to Public Health Emergencies of Infectious Disease Origin

AMA-MSS will ask that the AMA (1) opposes the use of forced or coercive labor practices for incarcerated populations and (2) supports that any labor performed by incarcerated individuals or other captive populations should include adequate workplace safety and fairness standards similar to those outside of carceral institutions and support their reintegration into the workforce after incarceration.

135.012MSS Toward Environmental Responsibility

AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 406
(I-26)

Introduced by: Katherine Neciosup[1]

Affiliations: [1] Russell and Glenda Gordy College of Osteopathic Medicine

Subject: Expanding Rural Access to Comprehensive Dermatologic Care

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, more than 60% of U.S. counties lack a practicing dermatologist, with some estimates as high as 68%, and fewer than 10% of dermatologists practice in rural areas despite these regions housing nearly 20% of the American population, leaving rural patients with a severe lack of access to care and long travel distances[1-3]; and

Whereas, this severe workforce shortage restricts access to comprehensive dermatologic specialty care, causing dangerous delays not only in cancer detection but also in the management of complex inflammatory diseases such as atopic dermatitis, autoimmune skin disorders, and persistent fungal infections which heavily burden rural communities[4]; and

Whereas, the severity of this specialty gap is supported by regional rural clinic data demonstrating that while dermatology accounts for 55% of all specialist referrals, only 20% of rural patients can successfully attend these appointments due to geographic and access barriers[4]; and

Whereas, the lack of broad specialty care leads to deadly delays in diagnosing high-risk conditions like melanoma, where early intervention and visual skin screenings are critical for survival, given that early detection of localized melanoma yields a five-year relative survival rate of over 99%[5-6]; and

Whereas, rural populations face an increased risk of skin cancer due to occupational UV exposure, poverty, lower rates of routine screening, and transportation barriers, leading to substantial delays in diagnosis and treatment[7]; and

Whereas, while evidence for routine population-wide skin cancer screening in asymptomatic adults remains inconclusive, targeted clinical evaluation and rapid triage of suspicious lesions are critical for high-risk rural populations facing disproportionate delays in care[3,8]; and

Whereas, teledermatology has demonstrated diagnostic sensitivity comparable to face-to-face specialist evaluations, successfully identifying malignant lesions and reducing the time to diagnosis by over 75% in underserved settings[3,9]; and

Whereas, community-based screening events and pop-up clinics successfully engage at-risk populations at the local level, providing immediate dermatologic access, identifying suspicious lesions, and delivering preventative education to underserved communities that would otherwise lack care[10]; and

Whereas, current AMA Policies H-200.949, D-440.922, H-465.994, and H-465.971 broadly support expanding mobile healthcare, addressing health inequities, rural health, and rural workforce challenges, but do not specifically address the severe workforce shortages and barriers unique to specialty dermatologic care[11-14]; and

Whereas, community-based screening events combined with teledermatology offer a sustainable, high-impact alternative that aligns with specialty priorities like workforce expansion and remote healthcare[3,9,10]; therefore be it

RESOLVED, that our AMA support legislative and regulatory efforts to expand access to comprehensive dermatologic specialty care in rural and underserved communities, utilizing strategies such as community-based care models and integrated teledermatology (Directive to Take Action).

Fiscal Note: TBD

Date Received: 09/05/2026

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RELEVANT AMA POLICY

Improving Rural Health H-465.994
Our AMA recognizes the need to address rural disparities in cancer screening and care; and supports the use of evidence-based teleconsultation models to improve rural access to cancer screening and specialty care services. [BOT Rep. 1, A-19; Reaffirmed: CMS Rep. 1, A-24]

Early Detection and Prevention of Skin Cancer H-55.972
Our AMA supports interventions aimed at the early detection and prevention of skin cancer, including public awareness, sun safety education, and physician-led clinical skin examinations. [Res. 414, A-19; Reaffirmed: CSAPH Rep. 3, A-24]

Rural Health Workforce Challenges H-465.971
Our AMA supports targeted funding for telehealth and the implementation of educational and loan-repayment programs that support practicing physicians and expand workforce infrastructure in rural settings. [CMS Rep. 5, I-23; Reaffirmed: A-26]

Coverage of and Payment for Telemedicine H-480.946
Our AMA defines telehealth and actively supports coverage, parity, and adequate payment models for medical services delivered via telemedicine that meet established standards of care. [BOT Rep. 2, A-96; Reaffirmed: CMS Rep. 1, I-19; Appended: CMS Rep. 8, A-21]

US Physician Shortage H-200.954
Our AMA supports comprehensive legislative and institutional initiatives to address rural health physician shortage and supports medical schools and residency programs in expanding training pathways focused on rural health service areas. [BOT Rep. T, I-19; Reaffirmed in lieu of Res. 305, A-24]

RELEVANT MSS POSITIONS
NONE

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 407
(I-26)

Introduced by: Katherine Neciosup[1]

Affiliations: [1] Russell and Glenda Gordy College of Osteopathic Medicine

Subject: Dermatologic Screenings for Unhoused Populations

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, populations with complex social needs, particularly individuals experiencing homelessness, face higher cancer incidence and mortality rates alongside substantial barriers to preventative healthcare services[1]; and

Whereas, unhoused individuals are disproportionately exposed to UV radiation due to a lack of reliable shelter and frequently lack access to early dermatologic care, significantly increasing their vulnerability to preventable malignancies[1-3]; and

Whereas, systemic healthcare barriers, such as lack of insurance, transportation, and stable communication, prevent individuals experiencing homelessness from seeking timely evaluation for suspicious skin lesions at traditional clinical sites[4]; and

Whereas, community-based outreach models, such as street medicine initiatives in Winston-Salem, North Carolina, and shelter-based free clinics in Salt Lake City, Utah, have demonstrated the feasibility and immense public health value of delivering targeted skin cancer outreach directly to unhoused populations[2,5]; and

Whereas, existing AMA Policies H-440.839 and H-55.972 support public sun safety education, free sunscreen dispensers, and skin cancer awareness, but do not provide dedicated mechanisms to integrate clinical dermatologic screening services into the safety-net and street medicine infrastructures utilized by unhoused populations[6,7]; therefore be it

RESOLVED, that our American Medical Association support legislative and regulatory efforts to integrate targeted dermatologic screenings into street medicine programs, Federally Qualified Health Centers (FQHCs), and safety-net clinics serving individuals experiencing homelessness.

Fiscal Note: TBD

Date Received: 09/06/2026

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7. American Medical Association. Early Detection and Prevention of Skin Cancer H-55.972.

RELEVANT AMA POLICY

Early Detection and Prevention of Skin Cancer H-55.972
Our AMA supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. [Res. 414, A-19; Reaffirmed: CSAPH Rep. 3, A-24]

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839
Our AMA supports shade structures in public space development; recognizes the importance of sun protection as a public health measure; and supports free public sunscreen programs. [Res. 408, A-18; Reaffirmed: CSAPH Rep. 1, I-22]

RELEVANT MSS POSITIONS

Public Education Announcements for Detection of Skin Cancer 440.012MSS
AMA-MSS supports public education initiatives regarding early detection of skin cancer as an essential public health measure. (MSS Res. 104, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 408
(I-26)

Introduced by: Michael Kaufmann[1], Phoenix Hollenbeck[1], Luke Reilly[1], Mark Baskharoun[2]

Affiliations: [1] Washington University School of Medicine in St Louis
[2] UT Southwestern School of Medicine

Subject: Expanding Federal Opportunities for Organ Donation Registration

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, over 103,000 individuals are currently on the national transplant waiting list and approximately 17 people die every day waiting for an organ[1]; and

Whereas, in fiscal year 2025, the Internal Revenue Service processed nearly 162.8 million individual income tax returns and the Department of State received more than 23.3 million passport applications, demonstrating that federal tax and passport processes provide opportunities to reach millions of individuals outside state motor-vehicle transactions[2,3]; and

Whereas, while 90% of U.S. adults express support for organ donation, only 54% to 60% are actively registered as donors[1]; and

Whereas, non-motor-vehicle government transactions have produced measurable donor registrations, with Michigan reporting 38,392 new registrations through income-tax forms, and New York voter-registration drives documenting 6,651 donor enrollments and a 27% enrollment yield[4,5]; and

Whereas, current organ donor registration pathways are overwhelmingly restricted to state Department of Motor Vehicles (DMV) interactions, leaving vast populations of unregistered potential donors unreached by existing procurement efforts[1]; and

Whereas, establishing additional registration opportunities within high-volume federal application processes (including, but not limited to passport applications, FAFSA applications, Social Security card enrollments, TSA precheck, and aviation licenses) presents an effective mechanism to expand donor outreach nationally; and

Whereas, expanding donor registration avenues across federal documentation infrastructure directly aligns with existing AMA policy supporting aggressive public education and broad recruitment initiatives to alleviate the organ shortage crisis; therefore be it

RESOLVED, that our American Medical Association support federal legislation and regulatory policies that expand organ donor registration opportunities to federal application processes including, but not limited to, passport applications, Social Security registration, TSA precheck, aviation licenses, and FAFSA applications.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Increasing Organ Donation H-370.971
Our American Medical Association recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care. [CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12 Reaffirmed: CEJA Rep. 4, A-22]

Organ Donation and Honoring Organ Donor Wishes H-370.998
1. Our American Medical Association continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members.
2. Our AMA, when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

[CSA Rep. D, I-80 CLRPD Rep. B, I-90 Amended: Res. 504, I-99 Reaffirmed: CSA Rep. 6, A-00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12 Reaffirmed: CEJA Rep. 4, A-22]

Organ Donor Recruitment H-370.995
Our American Medical Association supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following:
1. The need for organ donors.

2. The success rate for organ transplantation.
3. The medico-legal aspects of organ transplantation.
4. The integration of organ recruitment, preservation and transplantation.
5. The cost/reimbursement mechanisms for organ transplantation.
6. The ethical considerations of organ donor recruitment.

[Res. 32, A-82 Reaffirmed: CLRPD Rep. A, I-92 Reaffirmed: CSA Rep. 6, A-00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12 Reaffirmed: CEJA Rep. 4, A-22]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 409
(I-26)

Introduced by: Ellington D. McDaniels[1]

Affiliations: Howard University College of Medicine[1]

Subject: Addressing Commercially Driven Public Health Disinformation

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, in 2022, our American Medical Association (AMA) modified Policy D-440.914 "Addressing Public Health Disinformation Disseminated by Health Professionals," to combat public health disinformation, but this policy addresses disinformation spread almost exclusively by licensed health professionals, leaving unaddressed the actions of commercially incentivized, unlicensed individuals and entities; and

Whereas, licensed professionals leveraging their expert status account for only a small fraction of medical misinformation, while commercially incentivized non-physician actors leverage massive algorithmic reach on social media to disseminate unverified health claims, dangerous supplement regimens, and pseudoscientific advice for financial gain at the direct expense of public health, with recent research finding that the overwhelming majority of health and wellness influencers studied had a direct financial incentive tied to the content they produced[1]; and

Whereas, when unlicensed actors monetize their platforms through sponsorships, affiliate marketing, and corporate partnerships, the resulting promotional content constitutes "commercial speech," which the Federal Trade Commission (FTC) is empowered to regulate under Section 5 of the FTC Act and its Endorsement Guides requiring clear disclosure of material financial connections[2]; and

Whereas, our AMA maintains strict ethical advertising standards for physicians under Code of Medical Ethics Opinion 9.6.1 and for healthcare industries under Policy H-105.988, but restricting regulatory action strictly to licensed professionals allows commercial actors to profit from public health deception without any mechanism to hold them accountable; and

Whereas, while AMA Policy D-105.995 established a precedent for regulating monetized social media content by directing our AMA to lobby the FDA regarding paid endorsements of drugs and medical devices, yet left non-drug wellness claims and unregulated dietary supplement marketing for financial gain completely untouched, creating critical regulatory gaps; and

Whereas, Policy D-440.915 relies entirely on voluntary content moderation by private technology platforms, whereas expanding our AMA's framework to advocate for FTC enforcement against misleading commercial health speech targets the financial incentives behind health disinformation through statutory federal consumer protection authorities while preserving protected free speech; and

Whereas, the FTC presently possesses jurisdiction to penalize deceptive commercial speech and requires that paid endorsements and material connections be clearly disclosed to consumers, providing our AMA an existing federal regulatory avenue for advocacy that targets the commercial incentive for spreading health disinformation without infringing on protected free speech[3]; therefore be it

RESOLVED, that our AMA amend Policy D-440.914, "Addressing Public Health Disinformation Disseminated by Health Professionals," by addition to read as follows:

> Addressing Public Health Disinformation Disseminated by Health Professionals and Commercially Incentivized Entities D-440.914
> 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 and commercially incentivized individuals or entities 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 and commercially compensated actors 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-checkers 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.
> 10. Advocating to the Federal Trade Commission (FTC) and Food and Drug Administration (FDA) for the vigorous enforcement of existing consumer protection,

truth-in-advertising, and financial disclosure regulations against individuals or entities who receive material or financial compensation for knowingly propagating false, misleading, or unsubstantiated health claims.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914
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]

Medical and Public Health Misinformation Online D-440.915
(1) Our AMA encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified

health information. (2) Our AMA encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms. (3) Our AMA will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts. (4) Our AMA will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information. (5) Our AMA will work to educate both medical professionals and the public on the importance of scientific literacy and medical accuracy, the risks associated with healthcare misinformation, and the importance of continued advancement of evidence-based healthcare. [Res. 421, A-21; Reaffirmed: BOT Rep. 15, A-22; Reaffirmation: A-23; Modified: Res. 509, A-23; Appended: Res. 422, A-25]

Protecting Social Media Users by Updating FDA Guidelines D-105.995
Our AMA will lobby the Food and Drug Administration to: (1) update regulations to ensure closer regulation of paid endorsements of drugs or medical devices by individuals on social media; and (2) develop guidelines to ensure that compensated parties on social media websites provide information that includes the risks and benefits of specific drugs or medical devices and off-use prescribing in every related social media communication in a manner consistent with advertisement guidelines on traditional media forms. [Res. 209, I-15; Reaffirmed: BOT Rep. 09, A-25]

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988
(1) To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices. (2) That until such a ban is in place, our American Medical Association opposes product-claim DTCA that does not satisfy the following guidelines… (3) That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product… (7) That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public… (10) That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution… (12) That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary… (14) Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs. [BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99;

Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17; Reaffirmed in lieu of: Res. 112, A-19; Reaffirmed in lieu of: Res. 810, I-22; Reaffirmation: A-23]

RELEVANT MSS POSITIONS

Medical Misinformation in the Age of Social Media 440.106MSS
AMA-MSS will ask the AMA to: (1) encourage social media organizations to further strengthen their content moderation policies related to medical misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourage social media organizations to recognize the spread of medical misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) continue to support the dissemination of accurate medical information by public health organizations and health policy experts; (4) work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical information… (MSS Late Res. 02, A-21, Immediate Forward; HOD Res. 421, A-21, Adopt as amended, clause 6 Referred for Decision [X-XXX])

Addressing Medical Misinformation Online 440.122MSS
AMA-MSS will ask the AMA to amend policy D-440.915 by addition and deletion as follows:
Medical and Public Health Misinformation in the Age of Social Media Online D- 440.915
Our AMA: (1) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and (4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information. (MSS Res. 71, I-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 410
(I-26)

Introduced by: Lai Jiang[1], Mark Garmo[2]

Affiliations: [1] Western Michigan University Homer Stryker M.D. School of Medicine
[2] Wayne State University School of Medicine

Subject: Standardization of Medication Administration in K-12

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, approximately 35% of U.S. schools do not have a full-time school nurse while 6.3% had no access to a school nurse[1], contributing to gaps in medication administration and emergency response for students with chronic and acute health conditions[2]; and

Whereas, the National Association of School Nurses recommends a minimum ratio of one school nurse per 750 students[3], yet many states exceed this ratio significantly, with school districts serving larger proportions of rural students and students eligible for free or reduced-price meals experiencing significantly higher student-to-school-nurse ratios, limiting access to consistent school-based health services[4,5]; and

Whereas, students with conditions such as epilepsy, diabetes, asthma, and severe allergies require timely administration of medications including rescue seizure medications, insulin, glucagon, and epinephrine to safely attend school under federal protections including the Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act[6]; and

Whereas, inadequate staffing and inconsistent training of school personnel have been associated with missed medication doses, delayed emergency response, and preventable morbidity, disproportionately affecting students with medical complexity and disabilities[7]; and

Whereas, national survey reveals significant systemic inconsistencies in K-12 school medication administration, characterized by fragmented state delegation models where both required training hours and authorized training providers differ drastically by jurisdiction[8, 11]; and

Whereas, training requirements for unlicensed school personnel vary substantially according to the type and complexity of medication or procedure being administered, with state and local policies ranging from general medication administration training to task-specific training, competency verification, and additional requirements for emergency, specialized, or invasive procedures[8, 9, 10, 11]; and

Whereas, reductions in federal Medicaid funding threaten school health services and staffing, with Medicaid providing approximately $7.5 billion annually to K–12 education and 80% of surveyed school district leaders reporting that funding reductions would require downsizing specialized instructional support personnel, including school nurses, while disproportionately affecting students with disabilities and other students who rely on school-based health services[12, 13, 14];and

Whereas, given these persistent funding and staffing limitations, standardized, competency-based training incorporating simulation, periodic recertification, and skills assessment[15] for delegated, non-medically trained school personnel represents a complementary strategy to help bridge gaps in medication administration and emergency response while supporting, rather than replacing, adequate school nurse staffing[12, 14, 16]; therefore, be it

RESOLVED, that our American Medical Association encourage national medical societies to advocate federal minimum training standards for K–12 school personnel who administer medications, establishing a common baseline for required training content, instructional time, and competency verification across states, while allowing states to determine implementation; and be it further

RESOLVED, that our AMA support continued recertification of competency requirements for K–12 school personnel who administer medications—including maintenance medications for chronic conditions such as diabetes and asthma, time-critical emergency medications such as epinephrine, glucagon, and seizure rescue therapies, and medications requiring specialized or invasive administration—including regular review and updating of training modules and periodic skills assessments aligned with current evidence-based practices.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Providing Medical Services through School-Based Health Programs H-60.991
Our American Medical Association supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. [CSA Rep. D, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: Res. 412, A-05 Reaffirmed in lieu of Res. 908, I-12 Reaffirmed: CSAPH Rep. 1, A-22]

Childhood Anaphylactic Reactions D-60.976
Our American Medical Association will urge all schools, from preschool through 12th grade, to develop Medical Emergency Response Plans (MERP)…designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including…with using this equipment. [CSAPH Rep. 1, A-07 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmed: CSAPH Rep. 01, A-24]

Food Allergic Reactions in Schools and Airplanes H-440.884
Our AMA recommends that all schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use. [Res. 415, A-04 Reaffirmed: CSAPH Rep. 1, A-14 Reaffirmed: CSAPH Rep. 01, A-24]

School-Based and School-Linked Health Centers H-60.921
Our American Medical Association supports the implementation, maintenance, and equitable expansion of physician-led school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence. [CSAPH Rep. 1, A-15 Modified: Res. 116, A-22]

RELEVANT MSS POSITIONS

60.006MSS: First Aid Training For Child Daycare Workers
AMA-MSS supports certification of staff for emergency planning

60.038MSS: Reimbursement of School-Based Health Centers
"Our AMA supports the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence"

60.028MSS: Ensuring the Best In-School Care for Children with Sickle Cell Disease

AMA-MSS supports increasing training for medical professionals in schools for specific medical conditions such as sickle cell disease

440.117MSS: Increasing the Availability of Automated External Defibrillators
AMA-MSS supports development of school emergency action plan

150.042MSS: Counseling for Binge-Eating
AMA-MSS supports increasing training for medical professionals in schools for specific medical conditions such as binge eating

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 412
(I-26)

Introduced by: Micah Char[1], Michelle Luh[1], Aaron Esterson[2]

Affiliations: [1]Kirk Kerkorian School of Medicine at UNLV
[2]Touro University Nevada College of Osteopathic Medicine

Subject: Protecting Patients Who Rely on Electricity for Medically Necessary Care During Power Disruptions

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, patients receiving care at home may rely on electricity for medically necessary equipment and services, including ventilators, oxygen concentrators, home dialysis equipment, infusion and feeding pumps, power mobility devices, and refrigeration of medications[1]; and

Whereas, prolonged power outages can interrupt electrically powered medical equipment, dialysis, respiratory support, medication refrigeration, and other essential home-based health care services, placing patients who rely on electricity for medically necessary care at risk of preventable morbidity, emergency health care utilization, and loss of continuity of care[1-4]; and

Whereas, the U.S. Department of Health and Human Services (HHS) emPOWER Program identifies millions of Medicare beneficiaries who rely on electricity-dependent durable medical equipment or essential health care services and provides an existing framework for identifying populations at increased risk during power outages[5]; and

Whereas, electric utilities may intentionally interrupt electrical service through planned de-energization events, including public safety power shutoffs to prevent wildfire ignitions, which may interrupt electricity necessary for medically necessary care[6,7]; and

Whereas, some jurisdictions have established voluntary programs through which customers with medical needs may identify themselves to utilities and receive enhanced notification or other protections during planned power shutoffs, demonstrating the feasibility of targeted safeguards for medically vulnerable customers[6,8]; and

Whereas, current AMA policy Emergency Preparedness D-130.974 supports inclusive emergency alert systems, durable medical equipment, assistive technologies, and disability-specific disaster preparedness, but does not specifically address utility protections or continuity of electrical access for patients who rely on electricity for medically necessary care during planned utility shutoffs or prolonged power outages[9]; and

Whereas, current AMA policy Support for the Prevention of Eviction and the Termination of Life-Essential Utility Services During Public Health Emergencies D-440.920 supports preventing termination of life-essential utilities during public health emergencies, but does not address planned utility de-energization events or prolonged power outages occurring outside declared public health emergencies[10]; therefore be it

RESOLVED, that our American Medical Association supports federal and state policies and utility regulatory standards that protect medically necessary care for patients during planned utility shutoffs and prolonged power outages, including but not limited to voluntary programs for individuals or households to identify medically necessary electricity needs, timely and accessible advance notification when feasible, ongoing outage communication, appropriate protections for patient information; and be it further

RESOLVED, that our AMA supports policies that support continuity of medically necessary care for patients affected by prolonged power outages, including access to continuous backup power, charging resources, transportation, or alternative locations where medically necessary care can safely continue.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Emergency Preparedness D-130.974
(4) Our AMA supports increased federal and state funding for disability-specific disaster preparedness measures such as assistive technologies, durable medical equipment, mobility devices, and education programs in collaboration with relevant stakeholders. [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, Appended: Res. 923, I-25]

Support for the Prevention of Eviction and the Termination of Life-Essential Utility Services During Public Health Emergencies D-440.920

Our AMA will advocate for: (1) policies that prevent evictions during public health emergencies; and (2) prevention of termination of life-essential utilities during public health emergencies. [Res. 411, I-20]

Public Health Surveillance H-440.813
(3) Our AMA encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health. (4) Our AMA recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data. [CSAPH Rep. 1, I-19, Reaffirmed: Res. 219, A-21, Appended: Alt. Res. 402, A-21, Modified: CSAPH Rep. 2, I-21, Appended: Res. 413, A-26]

RELEVANT MSS POSITIONS

Enhancing Disaster Preparedness Mechanisms for People with Disabilities 90.015MSS
(1) AMA-MSS will ask our AMA, in coordination with relevant stakeholders, advocate for greater integration of inclusive emergency alert systems (e.g., visual, auditory, and haptic notifications) in emergency preparedness planning to ensure disaster response accessibility for people with disabilities; and (2) AMA-MSS will ask our AMA support increased federal and state funding for disability-specific disaster preparedness measures such as assistive technologies, durable medical equipment, mobility devices, and education programs for individuals with disabilities in collaboration with relevant stakeholders.[MSS Res. 434, A-25)

Adverse Impacts of Delaying the Implementation of Public Health Regulations 440.081MSS
AMA-MSS asked the AMA to support updates to the EPA's Risk Management Program Rule, such as the Chemical Disaster Rule, that prioritize chemical disaster prevention, emergency preparedness, and accessibility of safety information to the public.[MSS CGPH Rep A, I-18,
AMA Res 529, Adopted as Amended [D-440.925], Amended: MSS GC Report A, A-24]

Public Emergency Alert Reporting Requirements on Private Platforms 440.140MSS
AMA-MSS will ask that our AMA encourage collaboration between public health agencies, emergency management systems, and private technology companies to improve the reliability, accessibility, and transparency of emergency information dissemination across both public alert systems and digital platforms.[MSS CST Report A, A-26]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 413
(I-26)

Introduced by: Phoenix Hollenbeck[1], Michael Kaufmann[1], Luke Reilly[1], Mark Baskharoun[2]

Affiliations: [1]Washington University School of Medicine; [2]UT Southwestern

Subject: Expanding Donor Registration Through Wildlife and Professional Licensing Systems

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, more than 100,000 people in the United States are waiting for an organ transplant, while 93% of adults support organ donation but only 53% report being registered; among unregistered adults who want their organs donated, 66% report that they would register[1,2]; and

Whereas, organ donor registration remains concentrated at motor-vehicle offices, where 89% of registered respondents report enrolling, while hunting and fishing licensing represents another routine point of contact with state government, reaching 14.4 million hunters and 39.9 million anglers age 16 or older in the United States[2,3]; and

Whereas, Minnesota, Nebraska, and Iowa have established pathways for organ, eye, and tissue donor registration through wildlife-license transactions, with Minnesota recording 24,326 donor designations among 71,357 hunting and fishing license purchasers during the first seven months of its program and reporting minimal implementation challenges, while Iowa's Logan's Law similarly permits donor registration when obtaining hunting, fishing, or fur-harvester licenses[4–7]; and

Whereas, Indiana’s Department of Natural Resources and Professional Licensing Agency allow applicants to affirmatively register or skip the donor question and securely transmit donation decisions to the Indiana Donor Registry, with nearly 35,000 “yes” decisions recorded through wildlife licenses since 2021 and more than 125,000 through professional licensing since 2024, demonstrating the feasibility and reach of voluntary registration through varied licensing systems[8,9]; and

Whereas, existing American Medical Association policy supports organ donor recruitment, public education, informed choice, and efforts to increase donor registration, but does not specifically address donor registration through wildlife or professional licensing systems or provide an implementation model, while the AMA develops model legislation to advance policy priorities[10–14]; therefore be it

RESOLVED, that our American Medical Association support state laws and policies that offer eligible applicants a voluntary opportunity to register as organ, eye, and tissue donors when

applying for or renewing hunting, fishing, trapping, or comparable wildlife-related licenses or permits, or state-issued professional or occupational licenses, certifications, or registrations, with information sufficient to support an informed choice, no effect on an applicant's eligibility to obtain or renew a license if the applicant declines or skips the donor-registration question, and secure transmission of affirmative donor-designation data to the appropriate registry; and be it further

RESOLVED, that our AMA develop model state legislation, for use where administratively feasible, for voluntary organ, eye, and tissue donor registration through wildlife and professional licensing systems, in consultation in consultation with appropriate stakeholders.

Fiscal Note: TBD

Date Received:09/06/2026

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RELEVANT AMA POLICY

Organ Donor Recruitment H-370.996
Supports organ-donor recruitment, public and physician education, and state efforts to increase donor designation.

Methods to Increase the US Organ Donor Pool H-370.959
Supports evaluation of methods to increase organ donation and effective public information that enables well-informed consent.

Organ Donation Education H-370.984
Encourages states and organ procurement organizations to provide organ-donation educational materials through driver education and safety classes.

Organ Donation and Honoring Organ Donor Wishes H-370.998
Supports public education regarding organ donation, donor designation, and honoring documented donor wishes.

RELEVANT MSS POSITIONS

370.003MSS: Organ Donation and Transplantation
Supports efforts to identify ways to increase the organ donor pool.

370.012MSS: Organ Donation Education Programs in Driver Training Programs
Supports organ-donation education associated with driver licensure, providing precedent for incorporating organ-donation outreach into state licensing processes.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 416
(I-26)

Introduced by: Ashika Bakre[1], Kushi Kura[1], Sarah Lalani[2], Amanda Zuckerman[3], Sanya Dhama[4]

Affiliations: [1]Long School of Medicine, UT Health San Antonio
[2]Perelman School of Medicine, University of Pennsylvania
[3]Stritch School of Medicine, Loyola University Chicago
[4]University of California, Riverside School of Medicine

Subject: Health Insurance Navigation Literacy for Preventive Care

Sponsored by: FOR MSS STAFF USE ONLY. Leave blank on both First and Final Drafts.

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, few insured Americans fully understand their health plan mechanics, with only 4% to 14% able to correctly answer basic questions about health insurance concepts, and a validated national survey finding that lower health insurance literacy is concentrated among low-income, racial and ethnic minority, older, and previously uninsured populations who have the greatest healthcare needs[1]; and

Whereas, health insurance literacy—an individual's knowledge, skills, and confidence in selecting and using a health plan—is a distinct construct from general health literacy and remains persistently low, with national data showing that even among insured adults, large majorities cannot define terms such as "coinsurance," "provider networks," or "formularies"[2]; and

Whereas, patients receiving active outpatient care similarly demonstrate low health insurance literacy that is associated with financial hardship and delayed care[3]; and

Whereas, a systematic review of 21 studies encompassing 62,416 subjects found that 10 of 13 preventive care studies showed higher health insurance literacy was associated with greater use of primary care and preventive services, and 8 of 9 care-avoidance studies showed that lower health insurance literacy predicted delays in or avoidance of care[4]; and

Whereas, in a national study of insured adults, each 12-point increase in a Health Insurance Literacy Measure score was independently associated with greater use of preventive services and lower likelihood of delaying or forgoing preventive care due to cost, even after adjustment for general health literacy, numeracy, income, and education[1]; and

Whereas, the Affordable Care Act (ACA) requires most health plans to cover a defined set of preventive services without any cost-sharing, yet approximately 40% of preventive care

encounters in a recent national claims sample resulted in unexpected out-of-pocket costs, undermining the coverage guarantee and reinforcing cost-motivated care avoidance[5,6]; and

Whereas, public knowledge of which services are covered without cost-sharing remains poor, with survey respondents correctly answering only 38.6% of questions about existing ACA preventive coverage provisions, indicating that current disclosure mechanisms do not reliably connect enrollees to their eligible preventive benefits[7]; and

Whereas, structured patient navigation, defined as individualized assistance that identifies a patient's covered benefits, addresses informational and logistical barriers, and connects patients to eligible services, has high-strength evidence of increasing preventive care use, raising breast cancer screening rates by 13.8%, and raising cervical cancer screening rates by 15.6% in a meta-analysis of 42 randomized trials[8]; and

Whereas, patient navigation increased colorectal cancer screening uptake more than any other tested strategy in a network meta-analysis of over 400,000 participants, demonstrating that connecting patients to their covered benefits causally raises preventive service completion[9]; and

Whereas, a community-based randomized controlled trial of "Insuring Good Health"—a plain-language website and video series designed to build health insurance literacy in a low-income, racially and ethnically diverse population—significantly improved participants' beliefs about preventive care and their intention to seek help with insurance navigation, providing an example of a type of educational tool this resolution supports[10]; and

Whereas, the American Medical Association, the Agency for Healthcare Research and Quality, and the National Institutes of Health recommend that all patient-facing health materials be written at a fifth- to sixth-grade reading level to reach the widest possible population, yet the majority of patient-facing health materials exceed this reading level, and consumers consistently struggle to interpret the language and cost calculations in standard health plan summaries[11,12]; therefore be it

RESOLVED, that our American Medical Association support federal and state policies and efforts to improve patients' health insurance navigation literacy through educational initiatives, plain-language resource tools, and point-of-navigation communication strategies to increase the utilization of recommended, no-cost-sharing preventive care services; and be it further

RESOLVED, that our AMA support federal and state legislative and regulatory policies that encourage health insurance plans to provide accessible, plain-language navigational resources, defined as plan-specific, interactive decision-support tools that identify an enrollee's eligible no-cost-sharing preventive benefits and connect them to in-network sources of that care.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

Health Literacy H-160.931
AMA recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment; encourages development of literacy appropriate for distribution; encourages all third party payers to compensate physicians for formal patient education programs; and encourages allocation of federal and private funds for research on health literacy. [Res. 412, A-98; Reaffirmed: Res. 710, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

Explanation of Benefits H-190.994
AMA advocates for the health insurance industry to implement non-misleading, plain-language explanations of benefits that clearly convey coverage limits, patient financial responsibility, and claims determination rationale. [Sub. Res. 108, A-90; Reaffirmed: CMS Rep. 8, A-10; Reaffirmed: CMS Rep. 07, A-20]

Health Insurance Affordability H-165.828
AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. [CMS Rep. 8, A-15; Reaffirmed: CMS Rep. 03, A-21]

Patient Navigation Programs H-373.994
AMA recognizes patient navigators to help patients manage complex aspects of the health care system and supports the expansion and funding of patient navigation programs. [Res. 209, A-08; Reaffirmed: CSAPH Rep. 01, A-18]

RELEVANT MSS POSITIONS

155.003MSS Price Transparency in Healthcare
Supports the creation of educational resources from insurance providers to help patients and physicians understand health care costs, reduce economic strains, and promote informed healthcare usage. (MSS Res. 12, A-19)

170.001MSS Health Education & Preventive Care
Supports emphasis on preventive care in health education and advocates that medical care financing mechanisms should include coverage for preventive care and health education resources. (MSS Res. 04, I-18)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 417
(I-26)

Introduced by: Michelle Hama[1], Ammar Siddiqi[2]

Affiliations: [1] The University of Texas Southwestern Medical School
[2] University of California San Francisco School of Medicine

Subject: Standardized EHR Documentation of Non-Cigarette Tobacco Use

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, lung cancer is the deadliest cancer in the United States, causing 125,000 deaths annually, and low-dose computed tomography screening (LDCT) is an evidence-based screening tool that reduces lung cancer mortality among individuals at high risk[1]; and

Whereas, the current guidelines from the United States Preventive Services Task Force recommend that individuals aged 50 to 80 undergo annual LDCT screening for lung cancer if they currently smoke, have a documented 20-pack-year smoking history, or have quit smoking in the past 15 years, without accounting for non-cigarette tobacco products[1]; and

Whereas, non-cigarette tobacco products like water pipe tobacco and bidi tobacco tend to be used at higher rates within certain ethnic minority communities, including Arab American communities, compared with the general population, with an US Study showing rates of 12-15% of Arab Americans and research demonstrates that these products carry a risk of lung cancer comparable or exceeding that of cigarette smoking [2-5]; and

Whereas, research on pipe smoking demonstrates lung cancer risk that cannot be readily converted into a standardized cigarette pack-year measurement, necessitating specialized documentation; and

Whereas, electronic health record (EHR) systems offer limited structured options to document patients' use of culturally specific tobacco products, such as bidi and water pipe tobacco, and existing documentation of alternative tobacco products, such as electronic cigarettes, remains inconsistent even when dedicated fields within EHR exist, complicating providers' ability to comprehensively assess patients' full tobacco exposure accurately; and

Whereas, standardized documentation of non-cigarette and culturally specific forms of tobacco frequency, duration, cessation history, and dual or poly-product use in patients' EHR may close a significant gap in how patients' tobacco use and exposure are captured in clinical settings, enhancing equitable access to lung cancer risk assessment and allowing providers to better

understand the health impacts of non-cigarette tobacco use and how to properly counsel patients [6]; therefore, be it

RESOLVED, that our American Medical Association supports federal policies and national accreditation standards that require standardized documentation of patients' use of non-cigarette tobacco products, including beedi and water pipe tobacco, in EHR and clinic database systems, with structured questions and fields capturing product type, frequency of use, duration, and cessation history.

Fiscal Note: TBD

Date Received: 09/06/2026

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RELEVANT AMA POLICY

FDA Regulation of Tobacco Products H-495.988
1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal…. and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

Tobacco Product Labeling H-495.989
Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States… (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;"

RELEVANT MSS POSITIONS

505.013MSS — Amending Smoke-Free Environment Policies to Include E-Cigarettes

AMA-MSS asked the AMA to expand policies H- 490.913, Smoke-free Environments and Workplaces, and H-490.907, Tobacco Smoke Exposure of Children in Multi-Unit Housing, to include e-cigarettes and vape-free environments and workplaces.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 418
(I-26)

Introduced by: Jared Boyce[1], Samyukta Karthik[8], Emily Gitlin[2], Jeffrey Gu[3], Suraj Joshi[4], Hania Hashmi[5], Sharonya Battula[6], Sanya Dhama[7], Eva Eleftheriadis[8]

Affiliations: [1]University of Wisconsin School of Medicine and Public Health
[2] University of Michigan Medical School
[3] University of Virginia School of Medicine
[4] Tufts University School of Medicine
[5]PCOM South Georgia
[6]Vanderbilt University School of Medicine
[7]University of California, Riverside School of Medicine
[8] Penn State College of Medicine

Subject: Ensuring the Appropriate Placement of Children After Parental Deportation

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, 5.8 million U.S. households are home to at least one undocumented resident, 5.5 million children in these households were born in the U.S., and 1.8 million children live in a household with two undocumented parents[1]; and

Whereas, there are an estimated 145,000 U.S. citizen children with one parent in immigration detention, and more than 22,000 of these children have two parents in custody[2,3]; and

Whereas, approximately 36.5% of these children are <6 years old, 36.1% aged 6-12, and 27.4% aged 13-17[2]; and

Whereas, it would cost an estimated $116.5 billion to continue caring for and raising these US-born children[1]; and

Whereas, separation from a caregiver during critical developmental periods removes a child's primary stress buffer, inducing stress that impairs emotional co-regulation and physiologic functioning[4]; and

Whereas, U.S.-born Latino children ages 6-12 whose parents were detained or deported exhibited significantly greater post-traumatic stress symptoms, internalizing problems, suicidal ideation, and poorer overall functioning than peers without such exposure[5,6]; and

Whereas, U.S.-born adolescents who recently experienced parental deportation had significantly worse health status and more behavioral problems than adolescents in comparable families[7]; and

Whereas, among 190 children affected by parental arrest, detention, or deportation, over half cried frequently and one-third had concurrent sleep, eating, and crying disturbances persisting beyond nine months, worsening with longer separation[8]; and

Whereas, judicial precedent, federal child welfare law, and Immigration and Customs Enforcement (ICE) *Directive 11064.4* recognize parental rights in determining the placement of their children, but do not mandate safety screening of designated caregivers before placement[9,10,11]; and

Whereas, ICE does not always follow *Directive 11064.4*, particularly in cases where a final order of removal was issued, and the individual is deported rapidly[12,13]; and

Whereas, federal oversight has found that ICE does not consistently document detained parents' custody preferences or track whether children were placed with a designated caregiver, leaving no auditable record of placement decisions prior to removal[14,15]; and

Whereas, immigration enforcement-related parental separation is associated with increased foster care entry, and the absence of a standardized federal process has left families reliant on informal arrangements outside child welfare systems and states with fragmented caregiver designation mechanisms[13,16]; and

Whereas, such informal arrangements culminated in the murder of a child after his mother was deported[17]; and

Whereas, children held in ICE or contracted detention facilities have faced unsanitary conditions and inadequate access to medical care, food, and water, with a congressional investigation citing credible reports of human rights abuses[18]; and

Whereas, ICE data fields implemented in September 2025 on detained parents and their minor children do not capture the physical, developmental, behavioral, or mental-health outcomes of affected children[19]; and

Whereas, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and American Psychiatric Association have policies that recommend trauma evaluation and care coordination, and support expeditious reunification of children separated from their parents[20,21,22,23]; and

Whereas, current AMA policies address the health and well-being of children during deportation proceedings, but not after, nor the parent’s autonomy in deciding where their child is placed[24]; and

Whereas, the scale and severity of harm to U.S.-born children of deported parents stands in contrast to the absence of any federal process for honoring parental placement decisions, screening substitute caregivers, reporting these children's health outcomes, or connecting them to timely health and social services; therefore be it

RESOLVED, that our AMA-MSS supports the primary caregiver’s decision regarding the placement of a U.S.-born infant, child, and adolescent if that parent is being deported from the U.S.; and be it further

RESOLVED, that our AMA-MSS advocates for collaboration between the pertinent federal agencies and state legal and child welfare systems to screen all potential caregivers before rehousing the infant/child/adolescent of the primary caregiver being deported; and be it further

RESOLVED, that our AMA-MSS supports efforts to facilitate appropriate communication between deported parent(s) and the infant's, child's, or adolescent's new caregivers through secure, privacy-protecting mechanisms, consistent with applicable privacy laws and safeguards.

Fiscal Note: TBD

Date Received: 09/06/2026

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Relevant AMA Policies

Care of Women and Children in Family Immigration Detention H-350.955
AMA opposes the separation of families in detention centers
AMA recognizes the negative health consequences of detention centers
AMA advocates for healthcare access for women and children in detention centers

Consideration of the Health and Welfare of U.S. Minor Children in Deportation Proceedings Against Their Undocumented Parents D-60.966
AMA supports that the mental health, physical well-being, and welfare of US citizen minors should be taken into consideration when determining if parents should be detained / deported
AMA will work with local and state medical societies to address importance of considering health and welfare of US citizen minors in cases where parents of those minors are in danger of detention or deportation

Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children H-60.905
AMA objects to policies separating parents from children
AMA supports education of immigration officials regarding increased risk of sexual assault and sexual trauma

Relevant MSS Positions:

270.041MSS - Supporting External Accountability for ICE and CBP
AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19) (Reaffirmed: MSS Res. 031, A21)

65.076MSS - Reducing the Harmful Impacts of Immigration Status on Health
support deferral of deportation for people w/ disabilities and significantly limiting chronic illnesses
remove immigration enforcement from workplaces and employment considerations
support family reunification pathways for children and adult immigrants from other countries

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 420
(I-26)

Introduced by: Sarah Jiang[1], Sreya Mandava[1], Sanya Dhama[2]

Affiliations: [1]University of Missouri-Kansas City School of Medicine, [2]UC Riverside School of Medicine

Subject: Strengthening Maritime Biosecurity Against Novel Zoonotic Pathogens

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, emerging and re-emerging zoonotic infectious diseases pose an increasing global health threat because international travel can allow pathogens to cross national borders before outbreaks are fully recognized, creating the potential for substantial morbidity, mortality, and disruption across multiple public health jurisdictions[1-2]; and

Whereas, maritime travel creates distinct infectious-disease preparedness challenges because cruise and expedition vessels may carry large numbers of passengers and crew from multiple countries in enclosed or semi-enclosed environments, may operate far from advanced medical facilities, and may travel through several national jurisdictions during a single voyage, complicating timely diagnosis, isolation, reporting, and coordination of public health responses[3-4]; and

Whereas, the 2026 Andes virus outbreak associated with the expedition vessel *MV Hondius* demonstrated the potential for an emerging zoonotic pathogen to create a complex multinational maritime public health emergency, with the World Health Organization ultimately reporting 13 confirmed or probable cases and three deaths among passengers and crew and coordinating international contact-tracing and response activities after potentially exposed travelers had dispersed across multiple jurisdictions[5-6]; and

Whereas, previous outbreaks aboard passenger vessels, including COVID-19, influenza, norovirus, varicella, foodborne diseases, and Legionnaires' disease, further demonstrate that vessels can serve as settings for rapid infectious-disease transmission and can create complex challenges involving outbreak recognition, onboard clinical management, isolation, reporting, disembarkation, and post-voyage contact tracing[7-8]; and

Whereas, maritime infectious-disease emergencies may be particularly difficult to manage when the causative pathogen is novel or high-consequence because its transmissibility, incubation period, diagnostic requirements, or appropriate medical countermeasures may initially be uncertain, increasing the importance of adaptable preparedness systems capable of responding

to unusual disease clusters rather than protocols limited to routinely encountered maritime illnesses[9]; and

Whereas, national and international authorities already maintain important maritime infectious-disease requirements, including Centers for Disease Control and Prevention procedures for reporting illness and death aboard vessels and international public health requirements administered through the World Health Organization and national port-health authorities, demonstrating that an existing maritime public health infrastructure should be strengthened and harmonized rather than replaced by a separate system[10]; and

Whereas, however, existing maritime requirements may vary by jurisdiction and may primarily address general communicable-disease reporting and routine outbreak management rather than establishing consistent preparedness principles specifically designed for novel zoonotic and other high-consequence infectious diseases, creating an opportunity to strengthen coordination and preparedness across commercial cruise and expedition vessels[9]; and

Whereas, effective maritime infectious-disease preparedness requires collaboration among the governmental, international, and maritime organizations that possess responsibility for public health and vessel operations, including the Centers for Disease Control and Prevention, World Health Organization, International Maritime Organization, national public health authorities, maritime regulatory authorities, port authorities, and vessel operators, rather than placing responsibility for development or implementation of operational maritime systems upon a professional medical association[11]; and

Whereas, existing AMA policies, including Pandemic Preparedness H-440.847, Bolstering Public Health Preparedness H-440.892, and AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946, support robust infectious-disease preparedness, public health surveillance, funding, collaboration, and medical leadership during public health emergencies, but do not specifically address maritime biosecurity or preparedness for emerging infectious diseases aboard commercial cruise and expedition vessels; and

Whereas, the absence of maritime-specific AMA policy represents a distinct policy gap because general support for pandemic preparedness does not explicitly address the circumstances created when an emerging infectious-disease event occurs aboard an internationally operating vessel, where patients, clinicians, vessel operators, ports, and public health authorities may fall under different national and regulatory jurisdictions and where subsequent public health actions may need to continue across several countries after travelers disembark[9]; and

Whereas, such policy would complement rather than duplicate existing CDC and international maritime requirements by supporting the continued strengthening and harmonization of existing systems for emerging and high-consequence infectious threats, rather than directing the AMA to create, administer, or regulate surveillance, quarantine, evacuation, repatriation, or other maritime public health systems itself[12]; and

Whereas, a maritime-specific AMA advocacy principle could therefore provide physicians, public health authorities, and relevant maritime stakeholders with a clear professional position supporting coordinated preparedness for novel zoonotic and other high-consequence infectious diseases at sea while preserving the operational responsibilities of governmental agencies, international organizations, maritime regulators, and vessel operators[11]; therefore be it

RESOLVED, that our American Medical Association advocate that the Centers for Disease Control and Prevention and other relevant federal authorities to develop and periodically update evidence-based infectious-disease preparedness and response standards for commercial cruise and expedition vessels operating within or entering U.S. jurisdictions, with consideration of vessel size, trip itinerary, passenger and crew needs, onboard medical capabilities, and the risks posed by emerging, zoonotic, and other high-consequence infectious diseases; and be it further

RESOLVED, that our AMA advocate that such standards address voyage-specific risk assessment, infection prevention, timely disease detection and reporting, isolation and quarantine, diagnostic specimen collection and transfer, coordination with shoreside public health and health care systems, and continuity of care when disembarkation or medical evacuation is delayed or unavailable, and that relevant federal authorities incorporate these standards into applicable vessel inspection, reporting, preparedness practice, and compliance review.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Pandemic Preparedness H-440.847
Our AMA: (1) urges the Department of Health and Human Services Emergency Care

Coordination Center, in collaboration with the Centers for Disease Control and Prevention (CDC), state and local health departments, and their national organizations, to assess shortfalls in funding, staffing, supplies, vaccines, drugs, and data-management capacity needed to prepare for and respond to a pandemic or other serious public health emergency; (2) urges Congress and the Administration to ensure adequate funding and resources for federal, state, and local public health agencies to maintain and expand preparedness and response capacity; (3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and response to pandemics and other major public health emergencies; and (7) will monitor progress in developing contingency plans addressing future vaccine production or distribution problems and plans for responding to a pandemic in the United States. [CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21; Reaffirmed: CSAPH Rep. 1, I-22; Appended: Res. 924, I-22]

AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946
Our AMA: (1) provides leadership in coordinating efforts to improve medical and public health responses to terrorism and other disasters; (3) supports collaboration among federal agencies, state and local authorities, medical societies, health care organizations, and other stakeholders to ensure adequate resources, supplies, training, surge capacity, and communication for disaster response; (4) believes physicians should be alert to unexplained illness and death, understand disease-surveillance and control capabilities for unusual disease clusters, and understand procedures for collecting and reporting surveillance information; and (7) believes physicians and medical societies should participate directly with state, local, and national public health, law-enforcement, and emergency-management authorities in developing and implementing disaster preparedness and response protocols. [BOT Rep. 26, I-01; Reaffirmed: BOT Rep. 3, I-02; Modified: CSA Rep. 1, I-03; Reaffirmed: CME Rep. 1, I-11; Reaffirmation A-15]

Bolstering Public Health Preparedness H-440.892
Our AMA: (1) supports enhancement of the surveillance, response, and leadership capabilities of state and local public health agencies as a national priority; (3) encourages reporting of syndromic data to public health departments to facilitate surveillance, assess population disease risks, and support comprehensive mitigation, preparedness, response, and recovery planning; (4) supports flexible public health funding for unexpected infectious diseases to improve timely responses to emerging outbreaks and strengthen local public health infrastructure; and (5) encourages health departments to develop public health messaging regarding unexpected infectious diseases. [Sub. Res. 407, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 912, I-19]

Vector-Borne Diseases H-440.820
Our AMA supports and will advocate for local, state, and national research, education, reporting, and tracking of vector-borne diseases, including improved surveillance to better understand the geographic distribution of infectious vectors and populations at risk; enhanced reporting and tracking systems; education and training for health care professionals and the public regarding vector-borne disease risks and prevention; and research to develop new vaccines, diagnostics, and treatments for existing and emerging vector-borne diseases. [Res. 430, A-18; Modified: CSAPH Rep. 04, A-19]

HIV/AIDS Reporting, Confidentiality, and Notification H-20.915
Our AMA strongly recommends that states, territories, and the District of Columbia require confidential reporting of HIV infection to appropriate public health authorities and supports such reporting for public health surveillance, contact tracing, and partner notification, while

maintaining appropriate protections for the identity and confidentiality of individuals with HIV. [CSA Rep. 4, A-03; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17]

RELEVANT MSS POSITIONS

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional Facilities 440.089MSS
Our AMA-MSS will ask the AMA to: (1) collaborate with state medical societies to advocate for evidence-based public health measures to curb the spread of highly contagious pathogens in prisons and jails, including universally available screening, testing, contact tracing, and medical care; access to sanitizing equipment; humane and safe quarantine protocols; adherence to personal protective equipment use; and expanded data reporting; (2) support efforts to de-carcerate non-violent elderly and medically vulnerable individuals to mitigate the spread of highly contagious pathogens within correctional facilities and communities; and (3) support prioritizing COVID vaccine access for justice-involved populations. [(MSS Res. 005, Nov. 2020); (Combined with AMA Res. 404 and Adopted); I-20 (N-20)]

Opposing Use of Vulnerable Incarcerated People in Response to Public Health Emergencies of Infectious Disease Origin 65.054MSS
AMA-MSS will ask that the AMA (1) oppose the use of forced or coercive labor practices for incarcerated populations and (2) support that any labor performed by incarcerated individuals or other captive populations include adequate workplace safety and fairness standards similar to those outside of carceral institutions and support their reintegration into the workforce after incarceration. [(MSS CGPH CBH Report A, A-22); A-22]

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

Amending D-440.847, to Call for National Government and States to Maintain Personal Protective Equipment and Medical Supply Stockpiles 440.088MSS
Our AMA-MSS will ask the AMA to amend pandemic preparedness policy to urge assessment of shortfalls in funding, staffing, supplies, vaccines, drugs, and data-management capacity; ensure adequate resources for federal, state, and local public health preparedness; expand capacity to produce vaccines, antimicrobial drugs, medical supplies, and personal protective equipment; bolster state and local health department infrastructure; and encourage states to maintain medical and personal protective equipment stockpiles sufficient to respond to a pandemic or other major public health emergency. [(MSS Res. 004, Nov. 2020); (HOD Res. 415, A-21); I-20 (N-20)]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 421
(I-26)

Introduced by: Ammar D. Siddiqi[1], Nitin Reganti[2], Tara Young[1], Michelle Hama[2]

Affiliations: [1] University of California, San Francisco School of Medicine
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Subject: Improving Tobacco Care Provision in Behavioral Health Settings

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, the ~60 million individuals experiencing behavioral health conditions (i.e., mental illness and/or substance use disorders) in the US smoke cigarettes at rates up to 2-3 times higher than the general population, and consequently bear a disproportionate share of tobacco-related health burden[1-3]; and

Whereas, people experiencing behavioral health conditions consume ~40% of cigarettes, yet have historically faced substantial gaps in access to and receipt of evidence-based tobacco cessation treatment[4,5]; and

Whereas, tobacco-related illness is a major contributor to premature mortality among individuals served by behavioral health centers (i.e., mental health and substance abuse treatment facilities)[5,6]; and

Whereas, misconceptions persist in behavioral health settings that tobacco cessation may exacerbate psychiatric symptoms or jeopardize substance use recovery, despite substantial evidence demonstrating that tobacco cessation is associated with improved mental health and recovery outcomes, including reduced symptoms of depression and anxiety and greater likelihood of being in recovery from non-nicotine substance use[7-10]; and

Whereas, in 1993, The Joint Commission banned smoking in hospitals, but, following opposition from pro-tobacco and mental health advocacy groups, excluded inpatient behavioral health centers from this mandate on the wrongful basis that tobacco cessation worsened outcomes for mental health ailments[11-13]; and

Whereas, the Joint Commission's current Tobacco Treatment Measures fail to mandate tobacco treatment performance measures in both inpatient and outpatient behavioral health settings, despite rigorous research concluding that tobacco cessation significantly improves mental health outcomes[6,14-17]; and

Whereas, accreditation standards are an important driver of evidence-based clinical practice, and the historical exclusion of behavioral health centers from The Joint Commission's tobacco treatment performance measures limited the integration of systematic tobacco screening and treatment into behavioral health care; and

Whereas, behavioral health treatment settings have historically permitted tobacco use through designated smoking sites and the absence of tobacco-free workplace policies[18-20]; and

Whereas, evidence-based tobacco cessation interventions, including nicotine replacement therapy, cessation medications, and behavioral counseling, are effective for behavioral health patients[21,22]; and

Whereas, the failure to offer cessation treatment as a routine component of behavioral health care represents a significant gap in care and a missed opportunity to reduce preventable tobacco-related morbidity and mortality[23]; and

Whereas, behavioral health providers frequently report limited organizational support and a lack of resources for addressing tobacco use with their patients, contributing to inconsistent and inequitable access to cessation services[24,25]; and

Whereas, integrating evidence-based tobacco cessation services into behavioral health treatment can reduce the substantial health and economic burden of tobacco-related disease, which exceeds $300 billion nationally in direct healthcare expenditures and lost productivity[26.27]; and

Whereas, despite tobacco use disorder being classified as a substance-related and addictive disorder, coverage and reimbursement for tobacco dependence treatment are frequently administered through benefit structures distinct from those used for other substance use disorder treatments, which can limit providers' access to specialized behavioral health reimbursement mechanisms[28]; and

Whereas, numerous organizations have urged behavioral health centers to adopt tobacco-free policies and to treat tobacco use disorder with similar clinical urgency afforded to other substance use disorders[29]; therefore, be it

RESOLVED, that our American Medical Association supports that accrediting bodies overseeing behavioral health centers establish and enforce accreditation standards requiring tobacco-free policies for treatment facilities and on-site availability or direct referral pathways for evidence-based tobacco cessation pharmacotherapy and counseling as a condition of accreditation; and be it further

RESOLVED, that our AMA supports the elimination of policy and reimbursement structures that treat tobacco use disorder as categorically separate from other co-occurring substance use disorders in behavioral health treatment settings, including support for billing and coverage parity for tobacco cessation services delivered concurrently with psychiatric or substance use disorder treatment.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Health Insurance and Reimbursement for Tobacco Cessation and Counseling H-490.916
Our American Medical Association (a) continues to support development of an infrastructure for tobacco dependence treatment; (b) will work with the U.S. Public Health Service, particularly the Agency for Health Research and Quality, health insurers, and others to develop recommendations for third party payment for the treatment of nicotine addiction; (c) urges third party payers and governmental agencies involved in medical care to regard and treat nicotine addiction counseling and/or treatment by physicians as an important and legitimate medical service; (d) supports the ready availability of health insurance coverage and reimbursement for pharmacologic and behavioral treatment of nicotine dependence and smoking cessation efforts.

Our American Medical Association (a) requests Congress to provide matching funds for Medicaid coverage for evidence-based programs and Food and Drug Administration (FDA)-approved products that lead to smoking cessation; (b) seeks the requirement that state Medicaid programs, prepaid health plans, and insurance companies provide evidence-based approaches for smoking cessation and nicotine withdrawal, including FDA-approved pharmacotherapy, as part of their standard benefit packages. [CSA Rep. 3, A-04]

Physician Responsibilities for Tobacco Cessation H-490.917
Accordingly, our AMA (3) encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health; (4) (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; (iv) prohibiting all smoking in the office by patients, physicians, and office staff; and discouraging smoking in hospitals where they work (v) providing smoking cessation pamphlets in the waiting room; (vi) becoming aware of smoking cessation programs in the community and of their success rates and, where possible, referring patients to those programs; (b) supports the concept of smoking cessation programs for hospital inpatients conducted by appropriately trained personnel under the supervision of a physician; (5) (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs; (6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and (7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence. [CSA Rep. 3, A-04; Appended: Res. 444, A-05]

Smoke-Free America H-490.911
Our AMA makes the passage of legislation for a smoke-free America, that includes all public and workplaces and includes provisions for support of smoking cessation programs, a legislative priority for the AMA until such legislation is passed. [Res. 415, A-06]

RELEVANT MSS POSITIONS

Tobacco Cessation Counseling 490.015MSS
AMA-MSS will ask the AMA to: (1) urge third party payors and governmental agencies involved in medical care to regard and treat tobacco use disorder counseling and/or treatment by physicians as an important and legitimate medical service; and (2) work with the US Public Health Service, particularly the Agency for Health Care Policy and Research, health insurers, and others to develop recommendations for third party payment for the treatment of tobacco use disorder. [AMA Amended Res 411, I-92 Adopted [H-490.916]]

Providing Full Coverage for Smoking Cessation Treatments 490.027MSS
AMA-MSS (1) supports working with state and local medical societies to formally request that state lawmakers allocate at least the Centers for Disease Control and Prevention- recommended minimum amount of the state's Tobacco Settlement Fund award annually to tobacco cessation programs; and (2) recommends that third-party payers and government agencies involved in medical care offer full coverage for smoking cessation products to smokers seeking counseling for quitting. [MSS Res 38, I-11]

Smoke-free Workplaces 505.010MSS
AMA-MSS will ask the AMA to: (a) draft model legislation to eliminate smoking in public places and businesses; and (b) encourage individual medical students, residents, and physicians – as well as medical schools, hospitals, clinics, and physician practices – to endorse, support, and lobby for legislation to eliminate smoking in public places and businesses as a "workers right" issue. [MSS Res 1, I-02; amended: MSS Rep C, I-07]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 422
(I-26)

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Subject: Integrated Cardiometabolic and Mental Health Care

Sponsored by:

Referred to: MSS Reference Committee
(TBA, Chair)

Whereas, cardiometabolic conditions, including obesity, metabolic syndrome, diabetes mellitus, and cardiovascular disease, frequently co-occur with mental health conditions, including depressive disorders, anxiety disorders, and serious mental illness, and each may adversely affect the prevention, treatment, and management of the other[1,2]; and

Whereas, meta-analyses and large cohort studies demonstrate that depression and other common mental health conditions are independently associated with increased risk of incident coronary heart disease and adverse cardiovascular outcomes, while cardiovascular disease and cardiometabolic risk factors may increase the risk of depressive disorders, supporting a bidirectional relationship between cardiometabolic and mental health conditions[1,2,3]; and

Whereas, people with serious mental illness (SMI), including schizophrenia-spectrum disorders, bipolar disorder, and major depressive disorder, have a substantially higher prevalence of metabolic syndrome and cardiometabolic risk factors and significantly greater incidence of cardiovascular disease and cardiovascular-related mortality than the general population[4,5]; and

Whereas, people with serious mental illness experience premature mortality of approximately 15 to 20 years, often due to cardiovascular disease, and may experience disparities in cardiovascular risk assessment, prevention, and evidence-based treatment[5,6]; and

Whereas, conventional cardiovascular risk-assessment approaches may not adequately capture long-term cardiovascular risk in people with serious mental illness, and cardiometabolic monitoring, communication, and follow-up may be fragmented across mental health, primary care, and cardiovascular care settings[5,6,7]; and

Whereas, although care coordination and care-management interventions may reduce cardiovascular risk among people with serious mental illness, the evidence base for effective, scalable approaches to cardiometabolic risk assessment, prevention, treatment, communication, and follow-up across care settings remains limited[7,8,9]; and

Whereas, existing American Medical Association (AMA) policy supports access to and reimbursement for integrated medical, surgical, and psychiatric care; payment mechanisms and continuing professional development to advance physical and behavioral health integration; preventive evaluations tailored to individual risk factors; research on the relationship between obesity and mental health; and education on recognizing, diagnosing, and treating mental illness in patients with co-occurring general medical conditions[10-14]; and

Whereas, existing AMA policy does not explicitly recognize the bidirectional relationship between cardiometabolic and mental health conditions as an integrated public-health issue or specifically support research and evidence development on serious-mental-illness-informed cardiometabolic risk assessment and care coordination[10-14]; therefore be it

RESOLVED, that our American Medical Association recognizes the bidirectional relationship between cardiometabolic conditions and mental health conditions as an integrated public-health issue; and be it further

RESOLVED, that our AMA supports research and evidence development on cardiometabolic risk assessment, prevention, treatment, and care coordination for people with serious mental illness, including communication and follow-up across mental health, primary care, and cardiovascular care settings.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983
Our American Medical Association advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients. [Reaffirmed: CMS Rep. 6, I-18]

Integrating Physical and Behavioral Health Care H-385.915
Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings. [Reaffirmed: CMS Rep. 1, A-25]

Medical Evaluations of Healthy Persons H-425.994
The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease…(4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified…(5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. [Reaffirmed: CMS Rep. 03, I-17]

Awareness, Diagnosis and Treatment of Depression and Other Mental Illnesses H-345.984
(1) Our American Medical Association encourages: (a) medical schools, primary care residency programs, and other training programs, as appropriate, to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes…
(3) Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine, and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings… [Reaffirmed: Res. 425, A-22]

Clinical Utility of Measuring Body Mass Index, Body Composition, Adiposity, and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity H-440.866
Our AMA… (2) supports additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain... [Reaffirmed: CSAPH Rep. 08 A-23]

RELEVANT MSS POSITIONS

Obesity as a Chronic Disease 440.013MSS
AMA-MSS asked the AMA to: (1) recognize childhood and adult obesity as a major public health problem; and (2) work with other public and private organizations to develop ethical and evidence- based recommendations regarding education, prevention, and treatment of obesity. [Reaffirmed: MSS GC Report A, A-24]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 501
(I-26)

Introduced by: Patience Garrett[1], Sanjay V. Neerukonda[2]

Affiliations: [1]Oklahoma State University College of Osteopathic Medicine at the Cherokee Nation, [2]McGovern Medical School at UTHealth

Subject: Safeguarding FDA Oversight in Pharmaceutical Compounding

Referred to: MSS Reference Committee

Whereas, peptide therapeutics have an established role in medicine, with at least 85 peptides and polypeptides receiving U.S. Food and Drug Administration (FDA) approval for the treatment of diverse medical conditions[1]; and

Whereas, pharmaceutical compounding is the practice of combining, mixing, or altering ingredients to prepare a medication tailored to meet the individual clinical needs of a patient when an FDA-approved drug cannot appropriately meet those needs[2]; and

Whereas, pharmaceutical compounding serves an important medical need for patients who cannot be adequately treated with an FDA-approved drug, including patients requiring individualized formulations due to allergies, needing a different shape or form, or inability to use commercially available dosages[3]; and

Whereas, Section 503A of the Federal Food, Drug, and Cosmetic Act permits qualifying drug products compounded by licensed pharmacists or physicians pursuant to patient-specific prescriptions to be exempt from certain federal requirements, including FDA premarket approval, current good manufacturing practice requirements, and labeling with adequate directions for use, provided statutory conditions are met[4]; and

Whereas, Section 503B of the Federal Food, Drug, and Cosmetic Act establishes outsourcing facilities that may compound and distribute qualifying drug products without patient-specific prescriptions and without FDA premarket approval, provided statutory conditions are met, while requiring registration with and oversight by the FDA, compliance with current good manufacturing practice requirements, and other federal requirements[4]; and

Whereas, the Federal Food, Drug, and Cosmetic Act establishes FDA premarket review and approval requirements for new drugs, through which evidence supporting safety and effectiveness must be demonstrated prior to marketing[5]; and

Whereas, compounded drug products are not FDA-approved, and the FDA does not verify their safety, effectiveness, or quality prior to marketing[6]; and

Whereas, the use of unapproved synthetic peptide products is rapidly expanding in areas such as injury recovery and performance enhancement, alongside the emergence of a market for unapproved peptide compounds that have not undergone FDA premarket review[7]; and

Whereas, synthetic peptides are emerging as a new frontier in enhancement drug use in the United States, with substantial social media engagement surrounding injectable compounds

such as body protective compound-157 (BPC-157) and their purported muscle growth, recovery, and anti-aging benefits[8]; and

Whereas, existing AMA policy H-100.939 recommends that unapproved synthetic peptide products undergo FDA review and testing, but does not address the compounding pathways through which many unapproved synthetic peptide products currently reach individuals without undergoing such review; and

Whereas, the FDA has identified potential safety concerns associated with multiple bulk peptide substances nominated for use in compounding, including limited or absent human safety data and concerns related to immunogenicity, peptide-related impurities, and active pharmaceutical ingredient characterization[7]; and

Whereas, the FDA has identified instances in which compounding activities may put patients at risk or undermine the drug approval process, including false or misleading claims regarding the safety and effectiveness of compounded drugs that may incorrectly suggest the products have met FDA approval standards[9]; and

Whereas, preserving access to legitimate pharmaceutical compounding while ensuring that compounding exemptions do not function as an alternative pathway for the widespread prescribing, dispensing, distribution, or marketing of unapproved drug products is important to maintaining evidence-based prescribing and protecting patient safety; therefore be it

RESOLVED, that our American Medical Association supports federal regulatory and enforcement actions addressing the compounding, prescribing, dispensing, distribution, and marketing of unapproved peptide products; and be it further

RESOLVED, that our AMA oppose the use of U.S. Food and Drug Administration (FDA) compounding exemptions that enable widespread prescribing, dispensing, distribution, or marketing of unapproved synthetic peptide products as an alternative to FDA premarket review and approval when no legitimate compounding need exists.

Fiscal Note: TBD

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RELEVANT AMA POLICY

FDA Regulation of Unapproved Synthetic Peptides H-100.939
Our American Medical Association recommends that unapproved synthetic peptide products undergo FDA regulatory review, third-party testing, and demonstration of safety and efficacy through well-conducted clinical trials before marketing or clinical use. [Res. 516, A-26]

Pharmacy Compounding H-120.945
(5) Our AMA, 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. [BOT Action in response to referred for decision Res. 521, A-06; Revised: CSAPH Rep. 9, A-13; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed: CSAPH Rep. 01, A-26]

Ensuring the Safe and Appropriate Use of Compounded Medications D-120.949
1. Our American Medical Association will monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies.
2. Our AMA encourages the development of regulations that ensure safe compounding practices that meet patient and physician needs.
3. Our AMA will report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices.

[Sub. Res. 923, I-12; Reaffirmed: Res. 204, A-16; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed: CMS Rep. 01, A-26]

Appropriate Use of Compounded Medications in Medical Offices H-120.934
Our American Medical Association supports regulatory changes to improve access to:
1. The compounding and repackaging of manufactured FDA-approved drugs and substances usually prepared in the office-based setting; and
2. Purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded for the purpose of in-office use.

[Res. 207, A-15; Reaffirmed: CMS Rep. 04, A-16; Reaffirmed: Res. 204, A-16; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed: BOT Rep. 08, A-26]

Compounding D-120.931
Our American Medical Association will: (1) conduct a 50-state analysis of state law requirements governing in-office preparation of medications in physicians' offices, including which states have adopted USP Chapter 797 and how compounding is defined by state law; (2) advocate that the preparation of medications by a physician for administration to patients treated in the physician's office is the practice of medicine; and (3) will work with medical specialty societies to preserve a physician's ability to prepare medications in physicians' offices, and to be able to do so without being subject to unreasonable and burdensome equipment and process requirements by engaging with state policymakers (including but not limited to state legislatures, state medical boards, and state pharmacy boards) as well as accreditors. [BOT Action in response to referred for decision Res. 517, A-19]

RELEVANT MSS POSITIONS

None that apply to the scope of this resolution

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 502
(I-26)

Introduced by: Mitchell Nelson[1], Samyukta Karthik[2], Miaraha Humayan[3], Audrey Phan[4]

Affiliations: [1]Marshall University Joan C. Edwards School of Medicine, [2]Penn State-University Park, [3]University of Virginia School of Medicine, [4]Michigan State University College of Human Medicine

Subject: Data Center Transparency and Health Impact Mitigation

Referred to: MSS Reference Committee

Whereas, augmented intelligence (AI) is rapidly expanding across the country, increasing demands of large-scale computing infrastructure and accelerating construction of data centers throughout the United States[1]; and

Whereas, United States data centers consumed approximately 176 terawatt-hours of electricity in 2023, and their electricity consumption is projected to consume between 9.5% and 15.3% of national electric use by 2030, creating new challenges for electric-grid planning and reliability[2,3]; and

Whereas, AI's global water footprint is projected to reach 4.2-6.6 billion cubic meters annually by 2027, with many data centers located in water-stressed regions[4]; and,

Whereas, explosive growth in energy-intensive AI data centers is outstripping the pace of U.S. power grid interconnection and transmission expansion, with conventional project-led interconnection processes requiring 5 to 8 years and threatening grid reliability if not proactively managed[5]; and

Whereas, the North American Electricity Reliability Corporation has identified rapidly increasing electricity demand from large data centers as an emerging challenge for electric-grid planning and long term reliability[6]; and

Whereas, nearly one-half of the data centers are located in census tracts that have above-median environmental burdens as measured by the Centers for Disease Control and Prevention Environmental Justice Index[1]; and

Whereas, power outages are associated with increased emergency cardiovascular hospitalizations and respiratory hospitalizations among older adults, demonstrating that electricity reliability is directly linked to population health outcomes[7]; and

Whereas, recent large-scale electrical disturbances involving concentrated data center loads in Northern Virginia that impacted multiple states have demonstrated that concentrated computing infrastructure can potentially create regional reliability challenges[8]; and

Whereas, data center expansion represents a chronic, infrastructure-driven source of increased electricity and water demand that differs from climate-related utility disruption, warranting targeted advocacy to ensure continued access for essential health services; and

Whereas, existing reporting requirements are fragmented across jurisdictions and frequently rely on voluntary disclosures or proprietary utility information, limiting the ability of researchers, clinicians, and affected communities to evaluate cumulative health impacts; and

Whereas, proposed federal legislation would require assessment and standardized reporting of data-center energy and water use, greenhouse gas emissions, air and water pollution, electronic waste, noise, light, and other full-lifecycle environmental and public effects[9]; and

Whereas, the Data Center Transparency Act and Data Center Water and Energy Transparency Act of 2026 would require federal agencies to make aggregated data center energy, water, environmental, utility rate, and supply reliability information publicly available, demonstrating a current federal advocacy opportunity to ensure nonproprietary reporting is publically accessible[10]; and

Whereas, prior AMA policies supports reporting of emissions, water use, and electronic waste, current policy does not specifically address ensuring that these reports are free and publicly available; and

Whereas, physicians are among the most trusted sources of health information and play an essential role in educating patients and communities about environmental factors that may affect health[11]; and

Whereas, physicians and other healthcare professionals may increasingly receive questions from patients regarding the health implications of nearby data centers, yet few educational resources currently exist to support evidence-based patient counseling; and

Whereas, many primary care organizations like American Academy of Pediatrics and American Academy of Family Physicians already encourage anticipatory guidance frameworks for environmental health[12,13]; and

Whereas, the rapid expansion of AI data centers presents emerging public health, healthcare infrastructure, and community education challenges that are not fully addressed by existing AMA policy, creating a need for targeted advocacy promoting transparency, healthcare utility resilience, and anticipatory public health education; therefore be it

RESOLVED, that our American Medical Association – Medical Student Section advocate that reporting of emissions, water use, e-waste, and other public health impacts and ecological challenges from data centers, be publicly accessible at no cost; and be it further

RESOLVED, that our AMA-MSS support reliable public infrastructure, including electricity and water systems, to ensure consistent access for healthcare facilities and emergency services; and be it further

RESOLVED, that our AMA-MSS supports the creation of relevant community-centered and patient-centered education on the health and community impacts of nearby data centers.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Creation of an AMA Council with a Focus on Digital Health Technologies and AI G-615.998

1. Our American Medical Association will establish a task force by I-24 focused on digital health, technology, informatics, and **augmented**/artificial **intelligence** with the potential to transition this task force to a new council and report back A-25 on this transition.
2. Our AMA Task Force on AI, Digital Health, and Informatics will work toward an informed recommendation on the long-term model for HOD input with a report back at the 2026 Interim meeting.

[Res. 606, A-24; Appended: BOT Rep. 24, A-25]

Studying the Environmental Impact of Ambient Clinical Intelligence Use D-135.960

1. Our American Medical Association, in collaboration with state medical societies, will develop public health impact and ecological challenges posed by the growth of ambient clinical intelligence.
2. Our AMA supports efforts to require reporting of emissions, water use, and e-waste from data centers to allow for public health entities to anticipate care and coverage costs to affected populations.
3. Our AMA works with stakeholders to encourage state and federal legislatures to offer specific tax incentives to ambient clinical intelligence vendors to work toward using 100% sustainable energy sources.
4. Our AMA works with other industry healthcare associations to help establish clear guidelines on the responsible disposal of AI-enabled medical devices as well as AI purposed hardware.

[Res. 405, A-26]

Assessing the Intersection Between AI and Health Care H-480.931
Augmented Intelligence Development, Deployment, and Use in Health Care
General Governance

a. Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, transparent, and evidence-based.

b. Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.

c. Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.

d. AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.

e. Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce [See also **Augmented Intelligence** in Health Care H-480.939 at (1)]

f. AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.

… [BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25]

Stewardship of the Environment H-135.973

… 4. Our AMA supports enhancing the role of physicians and other scientists in environmental education. …

6. Our AMA encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes. …

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

20. Our AMA expects that health systems will provide transparency and avoid misleading the public regarding their greenhouse gas emissions, including but not limited to providing definitions used in the calculations of their net-zero emissions. …

[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]

Augmented Intelligence in Health Care H-480.939

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment. …

[BOT Rep. 21, A-19; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 226, A-25]

AMA Advocacy for Environmental Sustainability and Climate H-135.923

1. Our American Medical Association supports initiatives to promote environmental sustainability and other efforts to halt global climate change.
2. Our AMA will incorporate principles of environmental sustainability within its business operations.
3. Our AMA supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.
4. Our AMA supports a resilient, accountable health care system capable of delivering effective and equitable care in the face of changing health care demands due to climate change.
5. Our AMA encourages health care organizations to develop climate resilience plans, for the continuity of operations in an emergency, that take into account the needs of groups in their community that experience disproportionate risk of climate-related harm and ensure the necessary collaboration between different types of healthcare facilities.
6. Our AMA recognizes that climate resilience and mitigation efforts will be community-specific and supports physician engagement at the local level to promote community alliances for environmental justice and equity. …

[Res. 924, I-16; Reaffirmation: I-19; Modified: Res. 415, A-24; Appended: Res. 907, I-24; Appended: Res. 914, I-24; Appended: Res. 415, A-26]

RELEVANT MSS POSITIONS

480.037MSS Ensuring Environmental Sustainability in AI Applications
AMA-MSS support efforts to promote the responsible use of AI that mitigates the environmental impacts of AI infrastructure and use, including the consideration of:
(a) moratoria on the construction of new data centers without comprehensive assessments of their long-term environmental and socioeconomic impacts.
(b) opposition to tax incentives for technology companies engaged in these practices that shift infrastructure costs onto consumers and taxpayers.
(c) supporting the development of environmental regulations on AI infrastructure (including data centers), including independent assessments of energy sources, to limit excessive energy consumption, water use, noise pollution, and emissions.
(MSS Res. 508, A-25)

135.021MSS Environmental Contributors to Disease and Advocating for Environmental Justice
AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows:
Research into the Environmental Contributors to Disease and Advocating for Environmental Justice D-135.997
Our AMA will (1) advocate for the greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask 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; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.
(MSS Res. 019, A-21)

135.014MSS Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability

AMA-MSS (1) supports federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide;

(2) supports efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels; and

(3) support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions.

((MSS Res 23, A-17) (Modified: Res. 908, I-17 [H-135.949]) (Amended: MSS GC Report A, A-23))

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 504
(I-26)

Introduced by: Audrey R. Pham[1], Suraj Joshi[2]

Affiliations: [1] Michigan State University, College of Human Medicine
[2] Tufts University School of Medicine

Subject: Requiring Post-Trial Care for Implanted Neurodevices

Referred to: MSS Reference Committee

Whereas, Major Depressive Disorder (MDD) and Obsessive-Compulsive Disorder (OCD) are common disabling mental health conditions, with approximately 9% of U.S. adults suffering a major depressive episode in 2021[1] and OCD exhibiting a lifetime prevalence of 2.3%[2]; and

Whereas, approximately 65% of patients with MDD remain symptomatic despite multiple evidence-based treatment steps[5], and approximately one-half of patients with OCD fail to respond to first-line treatment[6], underscoring the need for effective alternatives for treatment-resistant psychiatric illnesses; and

Whereas, implanted neurotechnologies such as Deep Brain Stimulation (DBS) and Responsive Neurostimulation (RNS) are both increasingly used as investigational treatments for treatment-resistant MDD[3] and OCD[4]; and

Whereas, research participants in DBS/RNS studies may require long-term device programming, neurologic or psychiatric monitoring, battery or hardware replacement, management of adverse effects, and, in some cases, device revision or explantation, creating continuing clinical needs after a study concludes[7,8];and

Whereas, there is a distinctive post-trial dependency created by investigational neural technologies that remain implanted and require specialized technological and clinical infrastructure after the formal research relationship ends[8]; and

Whereas, these needs may additionally persist when research funding ends, an investigator leaves an institution, a manufacturer discontinues a device or proprietary platform, or a participant relocates[8,9]; and

Whereas, post-trial loss of device support may affect patients with severe psychiatric illness who have exhausted other treatment options[7,8]; and

Whereas, acute cessation or interruption of neurostimulation, including by unintended battery failure, has been shown to lead to rapid clinical deterioration[9,10,]; and

Whereas, neuroethics literature has identified persistent gaps in post-trial planning for implantable neural devices and has emphasized shared responsibilities among investigators, institutions, manufacturers, and funders[7,8]; and

Whereas, FDA Investigational Device Exemption (IDE) requirements address study approval, informed consent, monitoring, adverse-event reporting, device control, and sponsor and investigator responsibilities, but do not clearly establish comprehensive, adequately funded post-trial care for participants who remain implanted with investigational neurodevices[11,12,13]; and

Whereas, existing AMA policy addresses investigational device research, responsibility for safety and efficacy evaluation, and post-market surveillance[14], but does not assign prospective responsibility for post-trial care when a trial ends and an investigational device remains implanted; therefore be it

RESOLVED, that our American Medical Association supports requiring sponsors and research institutions conducting clinical investigations involving permanently implanted neurotechnologies to establish and disclose an adequately funded post-trial care plan before implantation; and be it further

RESOLVED, that our AMA supports requiring post-trial care plans to identify responsible parties for clinically necessary device programming, monitoring, maintenance, replacement, management of complications, revision, and explantation; and be it further

RESOLVED, that our AMA supports federal standards requiring contingency plans for ensuring continuity of care when a manufacturer, sponsor, proprietary platform, investigator, or implanting institution becomes unavailable or discontinues support.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Physician Involvement in Research E-7.1.1
Physician researchers share their responsibility for the ethical conduct of research with the institution that carries out research…Physicians who are involved in any role in research with human participants have an ethical obligation to ensure that participants' interests are protected and to safeguard participants' welfare, safety, and comfort…Demonstrate the same care and concern for the well-being of research participants that they would for patients to whom they provide clinical care in a therapeutic relationship. [Issued: 2016]

Informed Consent in Research E-7.1.2
Informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision…A valid consent process includes: Disclosing: (i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research;...(iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience;...(vi) the nature of the research plan and implications for the participant;...(vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician. [Issued: 2016]

Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices H-480.934
For a subset of higher risk devices receiving approval but have not completed clinical trials, time-limited approvals may be appropriate, after which the manufacturer may be required to provide post-market data to support full device approval. [CSAPH Rep. 02, A-23]

Medical Device Safety and Physician Responsibility H-480.972
The AMA supports: (1) the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research and clinical investigation and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration; and (2) conclusive study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations regarding safety of article surveillance and other potentially harmful electronic devices with respect to pacemaker use. [Res. 507, I-95, Res. 509, A-96, Appended Res. 504, A-99, Reaffirmed: CSAPH Rep. 1, A-09, Reaffirmed: CSAPH Rep. 01, A-19]

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988
DTCA for newly approved prescription drug or implantable medical device products [should] not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population… [BOT Rep. 38 and Sub. Res. 513, A-99, …, Reaffirmation: A-23]

RELEVANT MSS POSITIONS

Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices 270.040MSS
Our AMA-MSS asked the AMA to support:
A. the application of sound scientific and medical evidence of safety and efficacy derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or post-market incident reports as the basis for any FDA decision to approve, withdraw approval of, or change

indications for a medical device, analogous to evidence standards used for FDA decisions on medications;
B. FDA evaluation of evidence regarding device approval, in consultation with FDA Advisory Committees and expert extramural advisory bodies;
C. improvements to the Food and Drug Administration 510(k) exception to ensure the safety and efficacy of medical devices, including stricter guidelines for which devices qualify for 510(k);
D. mandates that all 510(k) devices demonstrate equivalent or improved safety and effectiveness compared to market devices for the same clinical purpose to;
E. stronger pre-market assurance and post-market surveillance requirements, including conditional approval until sufficient post-market data on safety can be collected;
F. timely completion of any confirmatory trials, especially for devices approved via expedited programs or based on surrogate endpoints or limited evidence; and
G. a public database of expedited device approvals, with related clinical trial and confirmatory trial data and all reported adverse events.
(MSS Res. 22, I-19) (MSS Res. 052, A-22, Substitute Resolution 052 be Adopted in Lieu of the Original) (Immediately forwarded to HOD, AMA Res. 523, Referred, A-22) (Consolidated 270.040MSS and 270.043MSS, MSS GC Report A, A-24)"

Reporting of Adverse Drug Events 100.009MSS
AMA-MSS will ask the AMA to (1) educate physicians about the distinction between adverse events and serious adverse events, as well as the importance of and ethical obligation to report serious adverse events; (2) work with relevant governmental agencies and private organizations to facilitate voluntary physician reporting of adverse drug and medical device events; and (3) encourage the FDA to investigate barriers to physician reporting of serious adverse events. (MSS Sub Res 19, I-09)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 507
(I-26)

Introduced by: Sarah Jiang[1], Sreya Mandava[1]

Affiliations: [1]University of Missouri-Kansas City School of Medicine

Subject: Protecting Biometric Voice Data in the use of AI Scribes

Referred to: MSS Reference Committee

Whereas, Ambient Clinical Intelligence (ACI) and other AI-enabled clinical documentation systems increasingly capture and process spoken clinical encounters to generate medical documentation and may use voice-derived identifiers to distinguish among patients, physicians, family members, interpreters, and others present during care[1]; and

Whereas, voice biometrics or voiceprints are derived from distinctive characteristics of an individual's voice and may be used to identify or reidentify that individual independently of the clinical information conveyed in the underlying recording[2]; and

Whereas, unlike passwords or other replaceable credentials, biometric characteristics are inherent to an individual and cannot readily be changed if compromised, making the unauthorized retention, disclosure, or misuse of voice biometric data a potentially persistent privacy and security risk[3]; and

Whereas, ambient clinical documentation systems may capture and process the voices and voice-derived biometric information of physicians, family members, caregivers, interpreters, and other individuals present during a clinical encounter who are not themselves receiving care and may have no direct relationship with, or awareness of, the collecting or processing of such information[4]; and

Whereas, consent to the use of audio or voice data for the primary purpose of generating documentation during a clinical encounter should be distinguished from consent to secondary uses of such data, including retaining recordings or voiceprints, developing commercial products, training or refining artificial intelligence models, or sharing, transferring, or otherwise using such data for purposes unrelated to the immediate provision of care[5]; and

Whereas, states have increasingly enacted privacy protections addressing biometric and consumer health data, including Washington's My Health My Data Act, reflecting growing recognition that health-related biometric information may present privacy risks requiring protections beyond those traditionally afforded to clinical records[6]; and

Whereas, variation among state laws governing biometric data processing, retention, consent, disclosure, and secondary use may result in inconsistent privacy protections for patients, physicians, and other individuals across jurisdictions, while AI developers, vendors, and health systems increasingly operate across state lines, underscoring the need for consistent national standards for the use of voice-derived biometric information in clinical care[7]; and

Whereas, although existing federal health privacy laws protect important categories of

identifiable health information, they do not establish a single, explicit framework governing all uses of voice-derived biometric data across the expanding clinical AI ecosystem, including retention of voiceprints, secondary AI model training, sale or transfer of biometric data, information captured from nonpatient individuals, and requirements for explicit opt-in consent[8-9]; and

Whereas, existing AMA policy, including H-480.931, H-480.940, D-480.952, and D-478.955, establishes broad principles supporting privacy, transparency, accountability, and appropriate data protections in the development and clinical use of augmented intelligence, but does not explicitly address the distinct privacy considerations associated with voiceprints, ambient audio, biometric data captured from nonpatient individuals, or secondary AI model training involving such data; and

Whereas, existing AMA AI and privacy policy does not explicitly establish whether an individual's authorization for AI-assisted clinical documentation also authorizes the subsequent use of that individual's identifiable audio recordings or voice biometric data to develop or train artificial intelligence models, leaving unresolved the distinct question of whether consent for a primary clinical purpose should constitute consent for a secondary AI-development purpose[10]; and

Whereas, meaningful authorization for secondary use of identifiable clinical audio or voice biometric data requires individuals to be able to distinguish the immediate use of such data for clinical documentation from subsequent uses for AI model development, training, or other purposes outside the clinical encounter[10]; and

Whereas, requiring authorization from every individual whose voice may be captured during a clinical encounter may create practical challenges involving minors, individuals with limited decision-making capacity, language barriers, interpreters, caregivers, and other necessary participants, underscoring the need for practical mechanisms for notification, exclusion, or deletion when secondary biometric use is not authorized[11]; and

Whereas, a health system's contractual authorization to deploy an AI-enabled clinical documentation system is distinct from an individual's authorization for secondary use of their identifiable voice data, and institutional adoption of such technology should not itself constitute individual authorization to use captured biometric data for AI model development or training[12]; and

Whereas, a consistent national AMA advocacy principle distinguishing authorization for clinical documentation from authorization for secondary AI training could guide physicians, health systems, state medical societies, regulators, and lawmakers as these technologies and state requirements continue to develop[13]; therefore be it

RESOLVED, that our American Medical Association support federal policies establishing that consent to the use of Ambient Clinical Intelligence or other AI-enabled documentation during clinical care does not itself constitute consent to the secondary use of identifiable audio recordings or voice biometric data for artificial intelligence model development or training, and requiring separate, informed authorization before such data are used for these secondary purposes; and be it further

RESOLVED, that our AMA support regulatory and technical standards for AI-enabled clinical documentation systems that require explicit, separate opt-in authorization before utilizing identifiable voice data for secondary AI model development, and mandate strict data

minimization protocols, including the deletion or de-identification of raw audio files following transcript verification and the implementation of safeguards to protect the privacy of non-consenting bystanders.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.939

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. Our AMA advocates that oversight and regulation of health care AI systems be based on risk of harm and benefit, including considerations of safety, efficacy, equity, transparency, and conditions of deployment; and that payment and coverage for health care AI systems be conditioned on compliance with appropriate federal and state laws and regulations, including those governing patient safety, efficacy, equity, truthful claims, privacy, and security. [BOT Rep. 21, A-19; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 226, A-25]

Ensuring Transparency and Accountability in Clinical Use of Augmented Intelligence D-480.952

Our AMA recognizes the need for clear disclosure to the healthcare provider whenever artificial intelligence is used in the delivery of clinical care to ensure the safe, transparent, and accountable use of AI-generated content in clinical and public-health settings. Our AMA advocates that entities developing or deploying AI systems in health care establish risk-based governance, implement relevant security measures and privacy protections, provide clinically

useful transparency, and implement risk-management approaches throughout the AI lifecycle to promote safety, effectiveness, accuracy, reliability, and ethical and regulatory alignment. [Res. 507, A-25]

Augmented Intelligence in Health Care H-480.940
Our AMA will promote the development of thoughtfully designed, high-quality, clinically validated health care AI that is transparent, addresses bias and health care disparities, and safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information. Our AMA will also explore the legal implications of health care AI and advocate for appropriate professional and governmental oversight for its safe, effective, and equitable use. [BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25]

Supporting Privacy in the Use of Artificial Intelligence Based Scribe Software D-478.955
Our American Medical Association will pursue federal regulation of artificial intelligence (AI) scribe technologies that protects clinician and patient privacy. [Res. 007, A-26]

RELEVANT MSS POSITIONS

Encouraging Collaboration between Physicians and Industry in AI Development 480.027MSS
AMA-MSS will ask the AMA to expand the Physician Innovation Network (PIN) by developing a network of advisors to connect physicians with artificial intelligence companies and researchers, including efforts to recruit and advise participants, conduct outreach, match physicians with relevant projects, and advance physician-centered artificial intelligence innovation. [(MSS Res. 121, Nov. 2020); I-20 (N-20); (AMA Res. 609, A-23, Referred)]

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 508
(I-26)

Introduced by: Sharon Zeldin[1], Shashank Madhu[2]

Affiliations: [1]Rutgers New Jersey Medical School
[2]University of Miami Miller School of Medicine

Subject: Opposition to Betting on Clinical Trials

Referred to: MSS Reference Committee

Whereas, clinical trials are the cornerstone of contemporary medicine and medical advancement in the United States and around the world[1]; and

Whereas, clinical trials have resulted in the approval of 46 new drugs in 2025[2]; and

Whereas, the United States pharmaceutical industry has generated half of all prescription drug sales globally and generated more than $800 billion dollars in revenue in 2024[3]; and

Whereas, clinical-trial results are among the most financially consequential events in drug development, and evidence shows that trial-outcome announcements produce statistically significant abnormal stock returns for sponsor companies, with the largest effects observed among smaller, early-stage biotechnology firms that have few or no marketed products[4]; and

Whereas, in July 2026 the prediction-market exchange Kalshi, in partnership with the data firm AppliedXL, launched contracts allowing the public to wager on the outcomes of Phase 3 clinical trials and U.S. Food and Drug Administration (FDA) regulatory decisions, with users placing hundreds of thousands of dollars in wagers within twenty-four hours of launch[5-7]; and

Whereas, prediction markets have expanded rapidly, with monthly trading volume across Commodity Futures Trading Commission (CFTC)-registered venues exceeding $25 billion in 2026, while the federal framework governing which event contracts may be listed remains unsettled and the subject of ongoing CFTC rulemaking[8-10]; and

Whereas, bioethicists, physicians, and clinical-trial researchers have warned that contracts tied to trial outcomes create meaningful risks of insider trading and manipulation as these trials involve many individuals who may hold non-public information; because such violations are typically detected only retrospectively, the integrity of a trial may already be compromised at the start of any investigations[6,7]; and

Whereas, even absent insider trading, a party with a financial or strategic interest in a trial's failure could place large wagers to influence the publicly displayed odds, potentially deterring patient enrollment or eroding confidence in an ongoing study, thereby creating a self-reinforcing dynamic that threatens data integrity[11,12]; and

Whereas, loss of financial backing can contribute to the premature termination of clinical trials, and survey evidence from healthcare professionals shows that premature termination causes emotional distress for participants and their families and creates significant challenges for

patient care and communication[13]; and

Whereas, Dr. Robert Califf, former Commissioner of the FDA, and other experts have characterized the introduction of betting markets into ongoing randomized trials as a breach of scientific conduct that threatens our already currently damaged public trust in medical research[14]; and

Whereas, Americans' confidence in science is lower than it was at the start of the COVID-19 pandemic in April 2020 and often split along partisan lines and amplified by underrepresented groups[15,16]; and

Whereas, banning prediction market and gambling involvement in clinical trials and FDA regulatory decisions will help safeguard the honest reporting of research findings, protect the integrity of clinical research and healthcare decisionmaking, and protect the health and welfare of trial participants[4,11-13]; therefore be it

RESOLVED, that our American Medical Association support banning prediction market contracts and related forms of gambling tied to clinical trials and health care-related regulatory decisions.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Internet Gambling H-275.939: Our AMA informs physicians and patients of the dangers of addiction associated with Internet gambling and supports prohibiting the availability of Internet gambling to children.

Gambling Disorder H-440.922: The AMA: (1) encourages physicians to advise their patients of the addictive potential of gambling; (2) encourages states which operate gambling programs to provide a fixed percentage of their revenue for education, prevention and treatment of gambling disorder; and (3) requests that states which operate gambling programs affix to all lottery tickets and display at all lottery counters a sign which states that gambling may become a gambling disorder and help is available through your local gambling hotline.

RELEVANT MSS POSITIONS

Addressing Public Health Risks of Online Sports Betting 440.138MSS: AMA-MSS will ask the AMA to (1) support efforts to establish federal consumer protections for online gambling, including sports betting and daily fantasy sports, to reduce harms associated with gambling disorder and other related behaviors; and (2) support epidemiological research to characterize the health impacts of online gambling, including sports betting and daily fantasy sports, with particular attention to adolescents, young adults, and other vulnerable populations.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 510
(I-26)

Introduced by: Ryan Borden[1], Jocelyn Chow[2]

Affiliations: [1] California Northstate University College of Medicine
[2] Western University of Health Sciences

Subject: Responsible Augmented Intelligence in Medical Education

Referred to: MSS Reference Committee

Whereas, augmented intelligence (AI) is increasingly being incorporated into medical education through teaching tools, assessment development, and clinical learning environments, creating new questions regarding appropriate use, learner protection, and educational oversight[1]; and

Whereas, a 2024 scoping review of curriculum frameworks and educational programs in AI for medical students, residents, and practicing physicians found that published AI education efforts remain heterogeneous and limited, with only 21 relevant papers identified and most describing local programs rather than broadly adopted standards[2]; and

Whereas, although AI may improve student engagement and educational outcomes, its use in medical education requires safeguards to protect learner privacy and data security, mitigate bias, and preserve the integrity of medical training[3]; and

Whereas, AI-generated content may include fabricated or inaccurate citations, underscoring the need for appropriate oversight and responsible use of AI in medical education[4]; and

Whereas, current AMA policy on Augmented Intelligence in Medical Education encourages accrediting and licensing bodies to study how AI should be addressed in standards, supports development of model AI learning objectives and curricular toolkits, and encourages stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias inherent in AI systems[5]; and

Whereas, current AMA policy states that health care AI should be ethical, equitable, responsible, accurate, transparent, and evidence-based, and supports bias mitigation, privacy protections, transparency, risk-based governance, and qualified human oversight[6,7]; and

Whereas, AMA-MSS policy has addressed augmented intelligence use in assessment development during medical education and transparency in AI-assisted admissions, demonstrating the need to further address learner privacy, responsible use in coursework, and safeguards for AI-assisted medical education assessment[9]; and

RESOLVED, that our American Medical Association supports clear guidance for the responsible use of augmented intelligence (AI) in medical education that addresses learner privacy and data security, appropriate use in coursework and assessment, transparency regarding AI use, protections against bias and misuse, and appropriate human oversight; and be it further

RESOLVED, that our AMA supports the development and implementation of standards for the use of AI in medical education assessment, in collaboration with relevant medical education, accreditation, licensing, and assessment stakeholders and with meaningful learner input, with attention to transparency, validity, fairness, bias mitigation, and appropriate physician oversight.

Fiscal Note: TBD

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RELEVANT AMA POLICY

Augmented Intelligence in Medical Education H-295.857
Our AMA encourages accrediting and licensing bodies to study how AI should be addressed in standards; encourages stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias in AI systems; will develop and disseminate model AI learning objectives and curricular toolkits; will collaborate with medical organizations to recognize AI literacy elements where appropriate; and will advocate for funding and faculty-development resources to implement and evaluate AI training initiatives.

Assessing the Intersection Between AI and Health Care H-480.931
Our AMA states that health care AI must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, transparent, and evidence-based; that national governance policies are needed; that AI systems should be developed and evaluated with a focus on mitigating bias and promoting equity; and that clinical decisions influenced by AI must include qualified human intervention points.

Ensuring Transparency and Accountability in Clinical Artificial Intelligence D-480.952
Our AMA recognizes the need for clear disclosure whenever AI is used in the delivery of care and advocates for risk-based governance, relevant security measures and privacy protections, clinically useful transparency, and risk-management approaches across the AI lifecycle.

Augmented Intelligence in Health Care H-480.940
As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.

RELEVANT MSS POSITIONS

295.254MSS - Augmented Intelligence Use in Assessment Development during Medical Education
AMA-MSS will ask the AMA to support disclosure to students along the medical education continuum regarding the use of generative augmented intelligence (AI) in the development and evaluation of performance on assessments. (MSS Res. 316, A-26)

295.255MSS - Transparency in AI-Assisted Admissions
AMA-MSS will ask the AMA to (1) study and report back on the ethical, equitable, and transparent use of augmented intelligence (AI) in medical school and residency application review processes, including potential standards for notice, disclosure, and explanation of AI involvement to applicants, including but not limited to, what stage AI is involved and to what extent; and (2) support approaches to promote fairness, accountability, and applicant due process, including access to human reevaluation and avenues to appeal or contest decisions influenced by such systems. (MSS Res. 319, A-26)

480.021MSS - Machine Intelligence and Data Science Literacy
AMA-MSS supports the development of core physician data science competency guidelines; and encourages medical schools to explore the implementation of more robust data science education. (MSS Res 36, A-18)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 601
(I-26)

Introduced by: Natasha Topolski[1], Sanjay V. Neerukonda[1], Druv Bhagavan[2]

Affiliations: [1] McGovern Medical School at UTHealth
[2] Washington University in St. Louis School of Medicine

Subject: Pilot of a Formal Policy Action Request Process and Tracking System

Referred to: MSS Reference Committee

Whereas, members often seek information regarding the status, progress, and outcomes of advocacy efforts undertaken pursuant to existing AMA policy but lack a centralized mechanism for tracking such activities or submitting such requests; and

Whereas, the American Medical Association (AMA) House of Delegates (HOD) routinely considers resolutions seeking action on issues for which existing AMA policy already provides direction; and

Whereas, our AMA's existing Follow-Up Report on Implementation of Resolutions and Report Recommendations tracks only newly adopted resolutions and report recommendations, with status updates limited to six-month and one-year checkpoints following adoption and does not provide a mechanism for members to request action on, or track the status of, existing AMA policy that predates or extends past this follow-up window[1]; and

Whereas, our AMA works to promote and implement its policies through a number of mechanisms, including via the legislative process, litigation, advocacy campaigns, recommendations to regulatory bodies, and more, and many of these processes may be prolonged past the timeline outlined in the Follow-Up Report on Implementation of Resolutions and Report Recommendations; and

Whereas, three years have passed since the adoption of A-23 Board of Trustees (BOT) Report 20, which was developed in response to Georgia Resolution 609 (A-22) and resolved that the AMA would continue “to invest in critical information technology and other appropriate infrastructure that allows for the tracking of past resolutions, existing policy, and supporting materials,” yet minimal improvements have been made to achieve these goals or updates on progress; and

Whereas, members currently have no formal mechanisms outside of the HOD resolution process to request updates, implementation, or enforcement of existing AMA policy; and
Whereas, in the absence of a formal mechanism, individual members seeking updates on existing AMA policy often resort to direct correspondence with the BOT, contributing to a volume of member emails that Board members and staff must field on an ad hoc basis outside of any formal tracking process; and

Whereas, in order to streamline and strengthen member requests, many sections have begun submitting memos to the BOT requesting action or updates on existing policy, a practice that

has led to inconsistency and confusion regarding process and lack of clarity on if and when these responses can be accessible or visible to the broader membership; and

Whereas, the development and submission of resolutions addressing topics already covered by existing AMA policy may consume valuable member, delegate, and staff resources that could otherwise be directed toward novel policy issues; and

Whereas, greater transparency regarding actions taken pursuant to adopted AMA policy would improve member understanding of the organization's advocacy, regulatory, and operational efforts; and

Whereas, organizations that maintain transparent systems for submitting and tracking member requests can enhance accountability, member engagement, and organizational responsiveness[2]; and

Whereas, providing a formal process for policy action requests would allow members to identify opportunities for implementation of and advocacy on existing policy without requiring the creation of duplicative policy or requests submitted via informal channels; and

Whereas, a publicly accessible tracking system or report providing a summary of each of the requests and responses could facilitate communication between AMA leadership, staff, and members regarding ongoing policy implementation efforts and their outcomes and decrease duplicative correspondence and requests submitted through informal channels; therefore be it

RESOLVED, that our American Medical Association develop a process for policy action requests that is membership-facing and accepts requests on a rolling basis, including a publicly accessible tracking system that reports when requests are received, actions taken, and outcomes achieved; and be it further

RESOLVED, that our AMA pilot a policy action request system and provide an informational report to the House of Delegates two years following implementation that summarizes the requests received, actions taken, outcomes achieved, and lessons learned.

Fiscal Note: TBD

Received: 09/06/2026

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RELEVANT AMA POLICY

Actions and Decisions by the AMA House and Policy Implementation G-600.071

1. AMA policy on House actions and decisions includes the following:
    a. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
    b. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by

means of a positive action of the House specifically intended to change that policy.

c. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

2. AMA policy on implementation of policy includes the following:
   a. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
   b. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
   c. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.
3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.
4. In urgent situations, the Board of Trustees will exercise its authority to take appropriate action. The Board shall make decisions that it deems to best represent the interests of patients, physicians, and to advocate for science and public health. The Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.
5. Our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustees advocacy and action.
6. Our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health.
7. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

[Res. 45, I-89; Res. 609, I-95; Res. 605, I-98; Reaffirmed: Sunset Report and Modified: BOT Rep. 15, A-00; Consolidated: CLRPD Rep. 3, I-01; Appended: BOT Rep. 19, A-04; Modified: CCB/CLRPD Rep. 1, A-12; Appended: Res. 618, A-19; Modified: Res. 602, A-25]

RELEVANT MSS POSITIONS

MSS Action Items 645.031MSS

1. Medical Student Section Action Items (MSSAIs) are formal, non-binding requests from MSS members for the MSS Governing Council to take action on issues that are currently supported by current MSS positions and AMA policy.
2. MSSAIs may be submitted at any time in accordance with procedures set by the MSS Governing Council.
3. The MSS Governing Council has the sole discretion on what, if any, actions are taken on behalf of the MSS in response to submitted MSSAIs
4. The MSS Governing Council shall review and provide a formal response to each MSSAI author on a reasonable timeframe determined by the MSS Governing Council. The Governing Council, at their discretion, may choose to provide further updates to the author and solicit additional information.
5. A list of all MSS Action Items received during the period between MSS national meetings , any actions taken by the MSS Governing Council in response, any resulting public AMA actions, and any subsequent advocacy impacts shall be made publicly available to MSS members at each business meeting of the MSS Assembly. Implementation status of MSSAIs shall be at the sole discretion of the MSS Governing Council.
6. The MSS Governing Council shall maintain archives of all MSSAIs and actions and shall make them available to any MSS member upon request, subject to the disclosure restrictions above.

(Amended GC Rep A, A-13) (Amended and Reaffirmed: MSS GC Rep A, I19) (Amended: Res. 027, A-21) (Amended: MSS GC Report B, A-23) (RTF Report, A-26)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 602
(I-26)

Introduced by: Andrew Norton[1], Samyukta Karthik[2], Matthias Walters[3], Sreya Mandava[4]

Affiliations: [1]University of Wisconsin, [2]Penn State-University Park, [3]University of Nebraska Medical Center, [4]University of Missouri-Kansas City

Subject: Biennial AMA-MSS Wide Survey

Referred to: MSS Reference Committee

Whereas, the MSS represents over 100,000 U.S. medical students, of which over 50,000 are active members of the Medical Student Section (MSS) at various levels [1-2]; and

Whereas, the MSS provides a mechanism for medical students to participate in organized medicine, develop policy, advocate for issues affecting medical education and public health, and contribute to the AMA's work on behalf of patients and physicians [3-4]; and

Whereas, existing approaches to identifying medical-student interests and perspectives, including town halls, committee and task-force surveys, informal feedback, and issue-specific outreach, may be limited to discrete topics, participation by limited number of individuals, and may not consistently capture the perspectives of the broader MSS membership; and,

Whereas, members who are highly engaged in MSS activities, members who are interested but participate intermittently, and members who are less engaged may have different priorities, experiences, barriers to participation, and preferences for MSS programming and communication; and

Whereas, decisions regarding organizational priorities, member engagement, and strategic planning are strengthened when informed by systematic and representative data rather than anecdotal feedback alone; and

Whereas, a section-wide survey could assess broad, generalizable areas of member experience, including engagement in organized medicine; barriers to participation; interest in advocacy, policy development, leadership, mentorship, research, and professional development; satisfaction with MSS programming and communication; and priorities for future MSS initiatives; and

Whereas, survey instruments that use clearly defined objectives, concise and understandable questions, appropriate response options, and pilot testing are more likely to generate interpretable data that can meaningfully inform organizational decision-making [5-6]; and

Whereas, survey fatigue and respondent burden can reduce participation and response quality, making it important to minimize unnecessary duplication, limit survey length, coordinate survey distribution, and select an interval that balances regular member input with feasibility [5-8]; and

Whereas, conducting a standardized section-wide survey every 2 years would provide regular opportunities for MSS members to share their perspectives while minimizing the burden associated with more frequent broad-based surveys; and

Whereas, a biennial survey could include questions that capture perspectives across the continuum of medical education, including preclinical students, clinical students, and students pursuing varied educational pathways, while allowing analysis by region, level of engagement, and other voluntary demographic or educational characteristics; and

Whereas, maintaining a consistent core set of survey questions across biennial survey cycles would enable comparison of aggregate member priorities, engagement barriers, and experiences over time, while allowing additional questions to address emerging issues and changing MSS strategic priorities; and

Whereas, accessible survey design (including mobile-compatible distribution, plain-language questions, voluntary participation, reasonable completion time, and coordinated outreach through MSS leadership) would promote broad participation and increase the likelihood that results reflect diverse MSS member perspectives [5-8]; and

Whereas, distribution of the survey to the entire MSS membership, with targeted and coordinated outreach through local campus sections, regional leadership, standing committees, task forces, and other MSS communication channels, would promote participation among members across class years, regions, and levels of prior MSS engagement; and

Whereas, regular analysis and reporting of member perspectives would enable the MSS Governing Council, regional leaders, committees, and task forces to make informed decisions while increasing transparency regarding how member feedback informs programming and advocacy; and

Whereas, development of a feasible and representative biennial MSS-wide survey requires consideration of survey content, administration, timing, methods to minimize survey fatigue, strategies to optimize participation across class years and regions, processes for analysis and dissemination of findings, and a timeline for implementation; and

Whereas, a biennial, section-wide survey designed to capture perspectives across training stages, regions, levels of MSS engagement, and areas of professional interest would provide comprehensive and actionable information on member priorities, needs, barriers to participation, and opportunities for improvement, thereby supporting data-informed strategic planning and alignment of future MSS programming, advocacy, and engagement efforts with the perspectives, prospects, and goals of the broader membership; therefore be it

RESOLVED**,** that our AMA-MSS create a group to develop a biennial section-wide survey and report back at A-27 with a survey, plan for distribution, and timeline for implementation.

Fiscal Note: TBD

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RELEVANT AMA POLICY

AMA Strategic Planning G-625.020

…Our AMA annual strategic planning cycle shall include the following dimensions:
Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process.
Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan…

AMA Goals, Roles, and Obligations G-625.011

Our American Medical Association reaffirms its goal to be the unified voice of the medical profession speaking for all physicians. Our AMA above all, affirms its role and obligations as a steward of our professional values, as well as the right and obligation of individual physicians to participate in the process.

RELEVANT MSS POSITIONS

N/A

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 603
(I-26)

Introduced by: Andrew Norton[1], Samyukta Karthik[2], Matthias Walters[3], Sreya Mandava[4]

Affiliations: [1]University of Wisconsin, [2]Penn State-University Park, [3]University of Nebraska Medical Center, [4]University of Missouri-Kansas City

Subject: Triennial AMA Wide Survey

Referred to: MSS Reference Committee

Whereas, the American Medical Association (AMA) represents more than 1 million physicians, residents, fellows, medical students, and other stakeholders and serves as a national physician organization with substantial influence on health care policy, medical education, professional standards, and public health [1-2]; and

Whereas, the AMA convenes a federation of more than 200 state and specialty medical societies, providing an important forum for physicians and trainees across specialties, career stages, practice settings, geographic regions, and communities to participate in organized medicine [3-4]; and

Whereas, the AMA's policy development, advocacy, strategic planning, and public-facing work may affect physicians, trainees, patients, and health systems nationally and internationally; and

Whereas, the AMA has historically used member surveys to identify member priorities, assess organizational direction, and inform strategic decision-making; and

Whereas, broad recurring member surveys may have been limited or discontinued because of administrative burden, cost, logistical challenges in survey administration and analysis, difficulties disseminating findings, and limitations of prior survey technologies and formats; and,

Whereas, the AMA currently receives member input through the House of Delegates, Board of Trustees, executive leadership, councils, committees, task forces, focus groups, member outreach, and other engagement mechanisms; and

Whereas, although these mechanisms provide valuable expertise and allow for substantive policy development and organizational governance, they may not consistently capture the perspectives, priorities, experiences, and concerns of the broader AMA membership, including members who are less engaged in formal AMA structures; and

Whereas, a comprehensive assessment of member perspectives would assist the AMA in evaluating alignment between its advocacy, strategic priorities, membership offerings, communications, and organizational direction and the needs and values of its members; and

Whereas, modern survey platforms, secure electronic data-collection methods, automated data-management systems, and emerging analytic tools may allow for more scalable, efficient, and cost-conscious survey administration, analysis, and reporting than were previously available; and

Whereas, a triennial AMA-wide membership survey would provide a regular and structured opportunity to collect broad member input while balancing the value of recurring data collection against response burden, administrative feasibility, and cost; and

Whereas, a triennial survey could assess broad and generalizable topics, including members' advocacy priorities; membership values; experiences with and barriers to AMA engagement; perceptions of AMA impact, relevance, and organizational direction; and opportunities to improve member programming, communication, education, and advocacy; and

Whereas, distributing a survey to the broad AMA membership and using targeted outreach across specialties, career stages, geographic regions, practice settings, and levels of prior AMA engagement would improve the opportunity to obtain more representative member input than may be available through House of Delegates structures alone; and

Whereas, conducting the survey every 3 years would align with the progression of an AMA President-elect to President and then Immediate Past President, enabling assessment of member perspectives and organizational priorities across a complete presidential leadership cycle; and

Whereas, use of concise and accessible survey design, clear communication of survey purpose and estimated completion time, appropriately timed reminders, and ethically appropriate participation incentives may improve response rates while minimizing survey fatigue; and

Whereas, formal analysis and reporting of aggregate survey findings to the Board of Trustees, House of Delegates, relevant councils, committees, staff, and the broader membership, as appropriate, would promote transparency, enable data-informed organizational planning, and allow the AMA to assess changes in aggregate member priorities and perceptions across survey cycles; and

Whereas, as a national physician organization whose advocacy priorities and public positions affect patients, physicians, trainees, and the health care system, the AMA requires broad and representative member input to ensure that its advocacy agenda reflects the needs, expertise, and priorities of the members it seeks to represent; and

Whereas, assessing membership values and opportunities for engagement would enable the AMA to identify barriers to participation, understand which programs, benefits, communications, and leadership opportunities members find most meaningful, and strengthen pathways for physicians and trainees across specialties, career stages, and geographic regions to participate in organized medicine; and

Whereas, regularly assessing member perceptions of the AMA's impact and organizational direction would provide an important measure of alignment between the AMA's strategic goals, advocacy, and member experience, thereby supporting transparent, data-informed planning and continuous improvement across the organization; therefore be it

RESOLVED**,** that our American Medical Association conduct a triennial survey of all AMA members that asks about advocacy priorities, membership values and opportunities to engage, and perceptions of AMA impact and direction, with a report back on the findings.

Fiscal Note: TBD

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RELEVANT AMA POLICY

AMA Strategic Planning G-625.020

…Our AMA annual strategic planning cycle shall include the following dimensions:
Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process.
Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan…

AMA Goals, Roles, and Obligations G-625.011

Our American Medical Association reaffirms its goal to be the unified voice of the medical profession speaking for all physicians. Our AMA above all, affirms its role and obligations as a steward of our professional values, as well as the right and obligation of individual physicians to participate in the process.

RELEVANT MSS POSITIONS

N/A

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution: 604
(I-26)

Introduced by: Natasha Topolski[1], Druv Bhagavan[2], Sanjay V. Neerukonda[1]

Affiliations: [1] McGovern Medical School at UTHealth
[2] Washington University in St. Louis School of Medicine

Subject: JAMA Student Editorial Positions & Special Issue for AMA Abstracts

Referred to: MSS Reference Committee

Whereas, ATF Report F (ATF-F-A-25-MSS) proposed the creation of a JAMA Network Journal for Medical Trainees specifically for publishing AMA abstracts and a JAMA Medical Student Editorial Fellowship program to expand meaningful scholarly and editorial opportunities for medical trainees[1]; and

Whereas, ATF Report F was adopted as amended, directing the MSS Governing Council and staff to continue informal discussions with JAMA leadership rather than immediately pursuing an external resolution through the AMA House of Delegates[2]; and

Whereas, the Governing Council's subsequent outreach to *JAMA*, as reported at A-26, was not successful, and the report recommended pausing active efforts while expressing support for future Governing Councils resuming the initiative when circumstances allowed with no formal MSS position or AMA policy[3]; and

Whereas, an effort at the A-26 MSS Assembly to extract and refer the underlying proposal to the House of Delegates was defeated, and the Assembly did not separately consider whether the underlying objective should be preserved as internal MSS position and therefore, the MSS did not have any internal policy position related to this ongoing effort[4]; and

Whereas, publication of poster abstracts in the official conference proceedings supplements of high-impact medical journals, such as the *Journal of Clinical Oncology, the Journal of the American College of Cardiology, Blood, Biological Psychiatry, Neurology,* and *Biophysical Journal,* is an industry standard that provides vital PubMed indexing and academic recognition for researchers[5–10]; and

Whereas, while the AMA has increased opportunities for students to present research through the AMA Poster Showcase and AMA Research Challenge, these works are not currently publicly or formally archived and indexed, and publishing them in a special issue would increase their visibility[11,12]; and

Whereas, *JAMA* previously offered a 4-week elective for third and fourth year US medical students, currently the *JAMA* Editorial Fellowship Program allows early career clinical or health services researchers within 5 years of their first faculty appointment to spend 10 months working remotely as part of the editorial team at JAMA and gain valuable skills in editorial decision-making, peer review, and professional science communication[13]; and

Whereas, integrating students into the editorial process of *JAMA* Network journals would provide valuable mentorship and professional development, cultivating future physician-scholars with expertise in medical writing, peer review, and publishing ethics; and

Whereas, other medical and scientific journals, including but not limited to the Radiological Society of North America journals and the Journal of the American Medical Informatics Association, have already established formal student editorial positions and calls have been made for medical journals broadly to adopt similar positions for medical students[14,15]; and

Whereas, in response to announced changes to ERAS that would limit the Scholarly Works category to peer-reviewed publications, the MSS urgently brought forward Resolution 312-I-25 at the HOD I-25 meeting, which was adopted as written, to address the resulting significant limitation on residency applicants' ability to showcase important scholarly and advocacy work, including resolutions, reports, and other advocacy materials[16–18]; and

Whereas, this resolution does not necessitate immediate action, establish a deadline, or mandate a particular outcome, but instead formally preserves this initiative as an ongoing MSS objective for pursuit when timing, resources, and organizational circumstances are favorable; therefore be it

RESOLVED, That AMA-MSS support fostering and exploring opportunities for medical trainees to engage with the *JAMA* Network, in collaboration with *JAMA* leadership and consistent with full editorial independence, including

a. Encouraging consideration of avenues to showcase AMA Research Challenge, Poster Showcase abstracts, advocacy materials, and other appropriate original content;
b. Exploring opportunities for compensated trainee involvement in editorial processes within existing *JAMA* Network journals, at the discretion of journal editors.

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RELEVANT AMA POLICY

AMA Publications G-630.090
Our American Medical Association policy on its publications includes the following:
1. JAMA and other AMA scientific journals should display a disclaimer in prominent print that the editorial views are not necessarily AMA policy.
2. Our AMA, in all of its publications and correspondence, will use the correct title for the medical specialist.
3. Our AMA recommends that medical journal articles using acronyms should have a small glossary of acronyms and phrases displayed prominently in the article.
4. The House of Delegates affirms that JAMA and The JAMA Network journals shall continue to have full editorial independence as set forth in the AMA Editorial Governance Plan.

Promoting the Equitable Evaluation of Non-Research Domains in Trainee Selection H-295.835
Our American Medical Association will support efforts and work with relevant parties to:
1. Improve the holistic and equitable consideration of research, advocacy, service, teaching, mentorship, and other non-research domains in medical school and residency/fellowship selection;
2. Reduce the emphasis on research expectations for applicants; and
3. Improve medical school and residency/fellowship application services to allow applicants to comprehensively showcase the non-research domains that best align with their experiences and career goals.

RELEVANT MSS POSITIONS

JAMA's Editorial Freedom 530.003MSS
AMA-MSS (1) opposes the introduction of empowerment of a review board that would compromise JAMA's editorial freedom and independence; and (2) supports the concept that the editors of JAMA must have full authority for determining the editorial content of the journal.