

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION (I-26)

Report of the MSS Reference Committee

Nicole Dawson and Samyukta Karthik, Chairs

RECOMMENDED FOR ADOPTION

1. Resolution 004 - Secure Medication Storage for those Experiencing Homelessness
2. Resolution 010 - Electroconvulsive Therapy Access, Consent, and Public Education
3. Resolution 101 - Medicare Coverage of Low-Vision Devices
4. Resolution 102 - Evaluating No Surprises Act Arbitration
5. Resolution 204 - Ensuring Adequate Duration of Refugee Medical Assistance
6. Resolution 309 - Support Privacy Protections for Resident and Fellow Physicians in Geolocation Tracking Applications
7. Resolution 310 - Developing Pathways for Medical School Transfers
8. Resolution 311 - Ensuring Flexible Testing Dates by the USMLE and Appropriate Stakeholder Engagement
9. Resolution 504 - Requiring Post-Trial Care for Implanted Neurodevices
10. Resolution 603 - Triennial AMA Wide Survey
11. CHEC Report A- Procedural Safeguards for Payer SIU Actions
12. SD Report A - Delegate Report: Policy Proceedings of the Annual 2026 House of Delegates Meeting

RECOMMENDED FOR ADOPTION AS AMENDED

13. Resolution 002 - Reforming Predispute Arbitration in Health Care
14. Resolution 106 - Minimizing Middlemen in Medicare and Medicaid
15. Resolution 110 - FMAP Supplementation to Reflect Medicaid Population Need
16. Resolution 207 - Improving Access to Weight- and Size-Capable Diagnostic Imaging
17. Resolution 409 - Addressing Commercially Driven Public Health Disinformation
18. Resolution 508 - Opposition to Betting on Clinical Trials
19. Resolution 601 - Pilot of a Formal Policy Action Request Process and Tracking System
20. Resolution 604 - JAMA Student Editorial Positions & Special Issue for AMA Abstracts
21. CPH/CHJ Report A - National Database for Civilian Injuries by Law Enforcement
22. CST Report A - "Right to Repair" for Hospital Equipment and Durable Medical Equipment

RECOMMENDED FOR ADOPTION IN LIEU OF

23. Resolution 016 - Sudden Cardiac Arrest Preparedness in Primary Care Settings

- 24. Resolution 408 - Expanding Opportunities for Federal Organ Donation Registration
- Resolution 413 - Expanding Donor Registration Through Wildlife and Professional Licensing Systems
- 25. Resolution 418 - Ensuring the Appropriate Placement of Children After Parental Deportation
- 26. Resolution 501 - Safeguarding FDA Oversight in Pharmaceutical Compounding
- 27. Resolution 602 - Biennial AMA-MSS Wide Survey
- 28. CME/CST Report A - Privacy and Protection of Trainee Educational Data in AI-Enabled Medical Education
- Resolution 303 - Augmented Intelligence Transparency in Medical Education
- Resolution 510 - Responsible Augmented Intelligence in Medical Education

RECOMMENDED FOR REFERRAL

- 29. Resolution 105 - Addressing Financial Toxicity in Patient Care
- 30. Resolution 401 - Expanding FDA Mandatory Recall Authority for Human Drugs

RECOMMENDED FOR NOT ADOPTION

- 31. Resolution 001 - Disability Equity Standards for Clinical Augmented Intelligence
- 32. Resolution 003 - Ethical Standards for Consumer-Generated Health Data
- 33. Resolution 005 - Supporting Children of Parents with Chronic Illness
- 34. Resolution 006 - Coverage for Risk-Based Cervical Cancer Screening
- 35. Resolution 007 - Fair Allocation of Responsibility and Preservation of Clinical Judgment in AI Integration
- 36. Resolution 008 - Standardized Food Insecurity Screening and Referral
- 37. Resolution 011 - Advance Care Planning Inclusion in Domestic Refugee Health Screening
- 38. Resolution 012 - Mandating Public Disclosure of Private Equity Acquisitions
- 39. Resolution 015 - Reducing Healthcare Monopolies and Effects on Healthcare Delivery
- 40. Resolution 201 - Transparency of Elected Officials Health
- 41. Resolution 206 - Continuing Access to Personal Medical Supplies for ICE Detainees
- 42. Resolution 209 - Support for Developing Health System Guidance for Obstetric Care Continuity During Immigration-Related Disruptions
- 43. Resolution 305 - Inclusion of an "Advocacy, Policy, and Medical Organization Involvement" Section in Medical Career Applications
- 44. Resolution 306 - Foundational Dermatologic Competencies in Medical Education
- 45. Resolution 308 - Establishing Proactive Academic Support for Neurodivergent Medical Students
- 46. Resolution 313 - Neurodiversity and Learning Differences in Medical Education
- 47. Resolution 402 - Xylazine-Associated Overdose, Wound Care, and Education
- 48. Resolution 403 - Improving Harm Reduction Strategies Through Free-of-Charge Drug-Checking Services and Materials
- 49. Resolution 404 - Compliance and Restoration of Infectious Disease Surveillance Programs
- 50. Resolution 406 - Expanding Rural Access to Comprehensive Dermatologic Care
- 51. Resolution 407 - Dermatologic Screenings for Unhoused Populations

- 1 52. Resolution 410 - Standardization of Medication Administration in K-12
- 2 53. Resolution 412 - Protecting Patients Who Rely on Electricity for Medically
- 3 Necessary Care During Power Disruptions
- 4 54. Resolution 416 - Health Insurance Navigation Literacy for Preventive Care
- 5 55. Resolution 417 - Standardized EHR Documentation of Non-Cigarette Tobacco
- 6 Use
- 7 56. Resolution 420 - Strengthening Maritime Biosecurity Against Novel Zoonotic
- 8 Pathogens
- 9 57. Resolution 421 - Improving Tobacco Care Provision in Behavioral Health
- 10 Settings
- 11 58. Resolution 422 - Integrated Cardiometabolic and Mental Health Care
- 12 59. Resolution 502 - Data Center Transparency and Health Impact Mitigation
- 13 60. Resolution 507 - Protecting Biometric Voice Data in the Use of AI Scribes
- 14 61. GC Report B - Annual Sunset & Consolidation Report
- 15 62. GC Report C - MSS Study of Assembly Representation

16 17 **RECOMMENDED FOR FILING**

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- 19 63. GC Report A - MSS Action Item Update Report
- 20 64. SCTF Report - Standing Committee Task Force Informational Report
- 21 65. IOPTF Report - Preliminary Report of Internal Operating Procedures Task Force
- 22

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 004 - SECURE MEDICATION STORAGE
FOR THOSE EXPERIENCING HOMELESSNESS

RECOMMENDATION:

Your Reference Committee recommends that Resolution
004 be adopted.

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.

VRC testimony was largely supportive. Your Reference Committee agrees with testimony that the resolution provides a novel and actionable addition to stand alongside H-160.903 (Eradicating Homelessness), which more generally supports plans to decrease healthcare barriers and understand the health needs of those experiencing homelessness.

Your Reference Committee acknowledges concerns that limited data exists establishing the efficacy of secure and accessible medication storage for people experiencing homelessness. The language of the Resolved ensures support for “evidence-based” programs and infrastructure, allowing flexibility to follow best practices as more data is generated that clearly delineates effective strategies. Your Reference Committee recommends Resolution 004 be adopted.

(2) RESOLUTION 010 - ELECTROCONVULSIVE THERAPY
ACCESS, CONSENT, AND PUBLIC EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution
010 be adopted.

RESOLVED, That our 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.

VRC testimony was mixed but with strong support. Your Reference Committee agrees with the testimony that the resolution is novel, feasible, and provides meaningful action

1 for the AMA. Some testimony expressed concerns with the specific language and the
2 removal of safeguards for patients who cannot speak for themselves. Nonetheless, your
3 Reference Committee believes that the authors have addressed this concern and further
4 believes that the current language is necessary to level the playing field between ECT
5 and procedures with comparable risk in a specific way that is not left open to
6 interpretation. Further, given that the authors have received support from AMA Staff on
7 the original language, your Reference Committee recommends Resolution 010 be
8 adopted.

9
10 (3) RESOLUTION 101 - MEDICARE COVERAGE OF LOW-
11 VISION DEVICES

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13 RECOMMENDATION:

14
15 Your Reference Committee recommends that Resolution
16 101 be adopted.

17
18 RESOLVED, that our American Medical Association supports federal legislative and
19 regulatory efforts to establish Medicare coverage of the full continuum of medically
20 necessary comprehensive low-vision rehabilitation for beneficiaries with documented
21 vision-related functional limitations.

22
23 VRC testimony was largely supportive. Your Reference Committee agrees with
24 testimony that the resolution provides a novel addition to existing AMA policy supportive
25 of insurance coverage for low vision devices, D-185.978. We read the Resolve clause as
26 specific and actionable, with feasible advocacy targets. Your Reference Committee
27 recommends Resolution 101 be adopted.

28
29 (4) RESOLUTION 102 - EVALUATING NO SURPRISES ACT
30 ARBITRATION

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32 RECOMMENDATION:

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34 Your Reference Committee recommends that Resolution
35 102 be adopted.

36
37 RESOLVED, that our American Medical Association study whether the current
38 implementation of the Independent Dispute Resolution process established under the No
39 Surprises Act is effectively achieving the law's intended goals of protecting patients from
40 unexpected medical costs while ensuring fair physician reimbursement, including, but
41 not limited to, the effects of the current final-offer ("baseball") arbitration framework on
42 physician reimbursement, patient financial protections, insurer behavior, administrative
43 burden, and health care spending, and report its findings to the House of Delegates.

44
45 VRC testimony was unanimously in support. Your Reference Committee agrees that this
46 resolution addresses a gap in current policy. Furthermore, we recognize the importance
47 of evaluating the efficacy of the Independent Dispute Resolution process given
48 increasing concerns raised by healthcare providers and specialty societies regarding
49 whether this process is beneficial for patients. Your Reference Committee recommends
50 Resolution 102 be adopted.

(5) RESOLUTION 204 - ENSURING ADEQUATE DURATION
OF REFUGEE MEDICAL ASSISTANCE

RECOMMENDATION:

Your Reference Committee recommends that Resolution
204 be adopted.

RESOLVED, that our AMA 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.

VRC was unanimously in support. Your Reference Committee agrees with testimony arguing that variation and decreases in refugee medical assistance eligibility and implementation periods compromises the ability of refugees to complete medical evaluations, care referrals, and initial continuity of treatment in a timely manner, and that establishing a minimum standard and evaluation mechanism for these outcomes would improve health outcomes among newly arrived refugees. Therefore, your Reference Committee recommends that Resolution 204 be adopted.

(6) RESOLUTION 309 - SUPPORT PRIVACY
PROTECTIONS FOR RESIDENT AND FELLOW
PHYSICIANS IN GEOLOCATION TRACKING
APPLICATIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution
309 be adopted.

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; 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; and be it further

RESOLVED, that our AMA opposes requiring resident and fellow physicians to submit to

1 continuous or off-duty location tracking as a condition of training, employment, or
2 participation in clinical duties, except when temporarily necessary to respond to a
3 specific and imminent patient or workplace safety emergency.

4
5 VRC testimony was largely in support, with one party in opposition, noting that it would
6 be more appropriate for this resolution to originate from the Resident and Fellow Section
7 (RFS), as it directly affects graduate medical education. While we hear this concern, with
8 the MSS only being one step away from the RFS, we believe it is within our purview to
9 advocate and raise awareness about this critical topic. Additionally, if this resolution
10 moves forward to HOD, our section could collaborate with RFS to achieve the best
11 possible outcome. Therefore, your Reference Committee recommends that Resolution
12 309 be adopted.

13
14 (7) RESOLUTION 310 - DEVELOPING PATHWAYS FOR
15 MEDICAL SCHOOL TRANSFERS

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17 RECOMMENDATION:

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19 Your Reference Committee recommends that Resolution
20 310 be adopted.

21
22 RESOLVED, That our AMA supports increased transparency among accredited U.S.
23 medical schools regarding transfer application policies, processes, and selection criteria.

24
25 VRC testimony was largely supportive, with opposing testimony citing concerns
26 regarding the scope and role the AMA would occupy in this space. Your Reference
27 Committee recognizes the importance of increasing the accessibility of institutional
28 policy surrounding transfers to ensure that students understand the process and have
29 the opportunity to prepare relevant materials for their individual circumstances. For these
30 reasons, your Reference Committee recommends that Resolution 310 be adopted.

31
32 (8) RESOLUTION 311 - ENSURING FLEXIBLE TESTING
33 DATES BY THE USMLE AND APPROPRIATE
34 STAKEHOLDER ENGAGEMENT

35
36 RECOMMENDATION:

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38 Your Reference Committee recommends that Resolution
39 311 be adopted.

40
41 RESOLVED, that our American Medical Association support:

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

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

- 7 a. The educational, logistical, financial, and workforce impacts, examination access,
8 scheduling delays, travel burden, costs to examinees, residency application
9 timelines, and
10 b. Differential impacts on students from historically marginalized or disadvantaged
11 backgrounds, and
12 c. Assessment of its effects on medical students, residents, residency programs, and
13 state medical licensing processes; and be it further
14

15 RESOLVED, that our AMA-MSS immediately forward this resolution to the I-26 House of
16 Delegates Meeting.
17

18 VRC testimony was largely in support with one testimony proffering amendments to
19 narrow the scope of this resolution and remove the immediate forward clause from this
20 resolution. Your Reference Committee agrees that the anticipated narrowing of USMLE
21 testing date availability will have drastic consequences on medical trainees nationwide
22 and that the AMA should have policy in place to push for greater stakeholder
23 involvement in future changes. Additionally, given the incredible timeliness of this
24 resolution, your Reference Committee feels that the immediate forward clause included
25 in the resolution is appropriate. As such, the Reference Committee recommends
26 Resolution 311 be adopted.
27

28 (9) RESOLUTION 504 - REQUIRING POST-TRIAL CARE
29 FOR IMPLANTED NEURODEVICES
30

31 RECOMMENDATION:
32

33 Your Reference Committee recommends that Resolution
34 504 be adopted.
35

36 RESOLVED, that our AMA supports requiring sponsors and research institutions
37 conducting clinical investigations involving permanently implanted neurotechnologies to
38 establish and disclose an adequately funded post-trial care plan before implantation; and
39 be it further
40

41 RESOLVED, that our AMA supports requiring post-trial care plans to identify responsible
42 parties for clinically necessary device programming, monitoring, maintenance,
43 replacement, management of complications, revision, and explantation; and be it further
44

45 RESOLVED, that our AMA supports federal standards requiring contingency plans for
46 ensuring continuity of care when a manufacturer, sponsor, proprietary platform,
47 investigator, or implanting institution becomes unavailable or discontinues support.
48

49 VRC testimony was strongly supportive with a relevant specialty society in support. Your
50 Reference Committee agrees with testimony that this resolution addresses a gap within

the current landscape of post-trial care for patients with implanted neurodevices, as they require additional monitoring. The Resolved clauses are actionable, and we believe they will be impactful for this underserved population due to current regulations, funding, and a lack of awareness and education on this issue. AMA advocacy will bring forward this issue and promote its visibility. Your Reference Committee recommends that Resolution 504 be adopted.

(10) RESOLUTION 603 - TRIENNIAL AMA WIDE SURVEY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 603 be adopted.

RESOLVED, that our AMA 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.

VRC testimony was mixed. Testimony weighed the value of a survey, the strategic concerns of this coming from the MSS vs another section in the AMA, and the importance of standard, recurrent feedback mechanisms. Your Reference Committee received late testimony aligning the national Council on Long Range Planning & Development with these asks and being in general support of this resolution. For these reasons, your Reference Committee recommends Resolution 603 be adopted.

(11) CHEC REPORT A - PROCEDURAL SAFEGUARDS FOR PAYER SIU ACTIONS

RECOMMENDATION:

Your Reference Committee recommends that the Recommendations in CHEC Report A be adopted and the remainder of the report be filed.

Your Committee on Health Economics and Coverage (CHEC) recommends that the following recommendations be adopted in lieu of Resolution 114 and the remainder of this report be filed:

1. That our American Medical Association supports federal policies extending continuity-of-care protections, including timely notice, transition assistance, and, where appropriate, temporary continued coverage under existing terms, to continuing care patients when provider removal or payment suspension based on Special Investigation Unit or other payment-integrity findings materially disrupts patient access before final adjudication, with exceptions for immediate threats to patient safety.
2. That our AMA supports policies requiring disclosure of recovery-linked compensation arrangements for SIU contractors and payment-integrity vendors and independent review of resulting recommendations that materially affect patient access to care.

1 VRC was unanimously in support. Your Reference Committee commends the authors of
2 this report for comprehensively expounding the evidence base behind payer Special
3 Investigation Unit structure and risks in threatening continuity of care through premature
4 termination of the physician-payer relationship during payment investigations. This report
5 refines the referred resolution by emphasizing adverse impacts on patients and requires
6 disclosure of SIU arrangements that may generate financial conflicts of interest, both of
7 which are feasible and novel. Therefore, your Reference Committee recommends CHEC
8 Report A be adopted.

9
10 (12) SD REPORT A - DELEGATE REPORT: POLICY
11 PROCEEDINGS OF THE ANNUAL 2026 HOUSE OF
12 DELEGATES MEETING

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14 RECOMMENDATION:

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16 Your Reference Committee recommends that the
17 Recommendations in SD Report A be adopted and the
18 remainder of the report be filed.

19
20 Your MSS Section Delegates recommend the adoption of the recommendations for MSS
21 positions outlined in Appendices A and B of this report and the remainder of the report
22 be filed.

23
24 VRC testimony was limited but in support. Your Reference Committee thanks the MSS
25 Section Delegates for the comprehensive review of policies passed at the 2026 Annual
26 Meeting of the House of Delegates. Your Reference Committee recommends SD Report
27 A be filed.
28

RECOMMENDED FOR ADOPTION AS AMENDED

(13) RESOLUTION 002 - REFORMING PREDISPUTE
ARBITRATION IN HEALTH CARE

RECOMMENDATION A:

Your Reference Committee recommends that the first
Resolve clause of Resolution 002 be amended by deletion:

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~~

RECOMMENDATION B:

Your Reference Committee recommends that the second
Resolve clause of Resolution 002 be deleted:

~~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.~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 002 be adopted as amended.

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.

1 VRC testimony was largely in support with amendments proffered. Broadly, this
2 resolution is novel and addresses a specific gap in policy with a specific federal target.
3 For the first Resolve clause, your Reference Committee agrees with testimony that
4 original language was not adequately covered in the Whereas clauses and evidence
5 base, and, therefore, recommend amending by deletion of "or predispute class action
6 waiver." For the second Resolve clause, we agree that the asks are covered by existing
7 policy, H-435.945 (Binding Arbitration), and therefore recommend striking the clause in
8 its entirety. Your Reference Committee recommends Resolution 002 be adopted as
9 amended.

10
11 (14) RESOLUTION 106 - MINIMIZING MIDDLEMEN IN
12 MEDICARE AND MEDICAID

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14 RECOMMENDATION A:

15
16 Your Reference Committee recommends that the first
17 Resolve clause of Resolution 106 be deleted:

18
19 ~~RESOLVED, our AMA-MSS opposes the use of taxpayer~~
20 ~~funds to contract private payors in the management of~~
21 ~~publicly funded healthcare systems, such as Medicare~~
22 ~~Advantage/Medicare Part C or Medicaid Managed Care~~
23 ~~Organizations, and be it further~~
24

25 RECOMMENDATION B:

26
27 Your Reference Committee recommends that the second
28 Resolve clause of Resolution 106 be amended by addition
29 and deletion:

30
31 RESOLVED, our AMA-MSS supports policies that
32 minimize the number and role of private payors
33 intermediaries in the management of publicly funded
34 healthcare systems, including but not limited to when
35 private payor involvement increases administrative costs,
36 reduces transparency, or impedes access to care delivery
37 of public health programs.
38

39 RECOMMENDATION C:

40
41 Your Reference Committee recommends that Resolution
42 106 be adopted as amended.

43
44 RESOLVED, our AMA-MSS opposes the use of taxpayer funds to contract private
45 payors in the management of publicly funded healthcare systems, such as Medicare
46 Advantage/Medicare Part-C or Medicaid Managed Care Organizations, and be it further
47

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

1 VRC testimony was mixed, with support testimony stating that internal policy would
2 strengthen MSS positioning on this topic and opposition testimony citing conflicts with
3 current policy and the upcoming report by the Council on Medical Service. While we
4 acknowledge the importance of the upcoming CMS report, we recognize the importance
5 of the ask of the second resolved clause as an internal MSS position and added
6 clarifying language. We recommend striking the first Resolved clause as we were not
7 presented with sufficient evidence to justify a stance of this strength at this time. There
8 were also concerns surrounding unintended effects if the MSS were to support such a
9 policy at this time. For the second Resolved, we recommend changing "intermediaries"
10 to "payers" to better clarify the role that our MSS wishes to limit. Lastly, we recommend
11 the addition of qualifying language to better delineate situations in which our MSS would
12 support the minimization of the role of private payors. For these reasons, your Reference
13 Committee recommends that Resolution 106 be adopted as amended.

14
15 (15) RESOLUTION 110 - FMAP SUPPLEMENTATION TO
16 REFLECT MEDICAID POPULATION NEED

17
18 RECOMMENDATION A:

19
20 Your Reference Committee recommends that the first
21 Resolve clause of Resolution 110 be deleted:

22
23 ~~RESOLVED, that our American Medical Association~~
24 ~~supports federal legislation and regulatory action to~~
25 ~~supplement the per capita income-based Federal Medical~~
26 ~~Assistance Program formula in order to account for~~
27 ~~differences in Medicaid population need and~~
28 ~~geographically varying healthcare delivery costs.~~

29
30 RECOMMENDATION B:

31
32 Your Reference Committee recommends that the second
33 Resolve clause of Resolution 110 be amended by addition
34 and deletion:

35
36 RESOLVED, that our ~~AMA~~ American Medical Association
37 study methods to supplement, or adjustments that can be
38 made, to the per capita income-based Federal Medical
39 Assistance Program Percentage formula in order to better
40 reflect the diversity of state healthcare needs, ~~and support~~
41 ~~the incorporation of those adjustments into the formula.~~

42
43 RECOMMENDATION C:

44
45 Your Reference Committee recommends that Resolution
46 110 be adopted as amended.

47
48 RESOLVED, that our American Medical Association supports federal legislation and
49 regulatory action to supplement the per capita income-based Federal Medical
50 Assistance Program formula in order to account for differences in Medicaid population
51 need and geographically varying healthcare delivery costs.

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

5
6 VRC testimony was largely in support. Your Reference Committee agrees with testimony
7 that there are still many barriers for the large proportion of Americans who rely on
8 Medicaid and reimbursements for physicians who care for these patients. However, your
9 Reference Committee agrees that there will be implementation concerns and that there
10 is insufficient evidence supporting the effectiveness of this proposed solution which may
11 be met with significant resistance. Given this, removing the first Resolve clause and
12 retaining the second Resolve clause, which asks for a study, should begin to address
13 these concerns. Your Reference Committee recommends Resolution 110 be adopted as
14 amended.

15
16 (16) RESOLUTION 207 - IMPROVING ACCESS TO WEIGHT-
17 AND SIZE-CAPABLE DIAGNOSTIC IMAGING

18
19 RECOMMENDATION A:

20
21 Your Reference Committee recommends that the second
22 Resolve clause of Resolution 207 be deleted:

23
24 ~~RESOLVED, that our AMA study existing evidence and~~
25 ~~potential policy and funding mechanisms to expand~~
26 ~~availability of weight- and size-inclusive diagnostic imaging~~
27 ~~equipment, including CT and MRI scanners with adequate~~
28 ~~weight and dimensional capacity, particularly in rural and~~
29 ~~safety-net settings.~~

30
31 RECOMMENDATION B:

32
33 Your Reference Committee recommends that Resolution
34 207 be adopted as amended.

35
36 RESOLVED, that our AMA supports the inclusion of facility-specific diagnostic imaging
37 capacity information, including weight and dimensional capacity, in physician- and
38 patient-facing referral and directory tools to improve referral pathways and identify
39 appropriately equipped imaging centers.

40
41 RESOLVED, that our AMA study existing evidence and potential policy and funding
42 mechanisms to expand availability of weight- and size-inclusive diagnostic imaging
43 equipment, including CT and MRI scanners with adequate weight and dimensional
44 capacity, particularly in rural and safety-net settings.

45
46 VRC testimony was largely in support, with several testifiers recommending
47 amendments to strike the second Resolved clause. Your Reference Committee agrees
48 that the first Resolved clause addresses a meaningful gap in access to diagnostic
49 imaging by improving the availability of facility-specific weight and dimensional capacity
50 information, providing a clear and actionable avenue for AMA advocacy. However, your

1 Reference Committee shares concerns that the second Resolved clause introduces a
2 broader study of equipment availability and funding mechanisms that extend beyond the
3 scope of the first Resolved clause. Furthermore, given the current limited existing
4 evidence base, your Reference Committee questions the feasibility and utility of such a
5 study in identifying actionable policy recommendations. We believe that retaining the first
6 Resolved clause would meaningfully advance equitable access to diagnostic imaging
7 without requiring additional study. Your Reference Committee recommends that
8 Resolution 207 be adopted as amended.

(17) RESOLUTION 409 - ADDRESSING COMMERCIALLY
DRIVEN PUBLIC HEALTH DISINFORMATION

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 409 be amended by addition and deletion:

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 incentivized individuals or entities 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.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 409 be adopted as amended.

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:

- d. On efforts to combat public health disinformation disseminated by health professionals in all forms of media.
- e. Address disinformation that undermines public health initiatives.
- f. 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

- 1 organizations to develop best practices around paywalls and preprints to
2 improve access to evidence-based information and analysis.
- 3 3. Addressing disinformation disseminated by health professionals and
4 commercially compensated actors via social media platforms and
5 addressing the monetization of spreading disinformation on social media
6 platforms.
- 7 4. Educating health professionals and the public on how to recognize
8 disinformation as well as how it spreads.
- 9 5. Considering the role of health professional societies in serving as
10 appropriate fact-checking entities for health-related information
11 disseminated by various media platforms.
- 12 6. Encouraging continuing education to be available for health professionals
13 who serve as fact-checkers to help prevent the dissemination of health-
14 related disinformation.
- 15 7. Ensuring licensing boards have the authority to take disciplinary action
16 against health professionals for spreading health-related disinformation
17 and affirms that all speech in which a health professional is utilizing their
18 credentials is professional conduct and can be scrutinized by their
19 licensing entity.
- 20 8. Ensuring specialty boards have the authority to take action against board
21 certification for health professionals spreading health-related
22 disinformation.
- 23 9. Encouraging state and local medical societies to engage in dispelling
24 disinformation in their jurisdictions.
- 25 10. Advocating to the Federal Trade Commission (FTC) and Food and Drug
26 Administration (FDA) for the vigorous enforcement of existing consumer
27 protection, truth-in-advertising, and financial disclosure regulations
28 against individuals or entities who receive material or financial
29 compensation for knowingly propagating false, misleading, or
30 unsubstantiated health claims.

31

32 VRC testimony was largely in favor. Most testifiers agreed that this was a novel and
33 actionable item. Those that opposed were concerned that this may be covered under
34 existing AMA policy. There were also concerns voiced regarding amending existing
35 policy, with some arguing that this could also be adopted in lieu of standalone policy to
36 avoid compromising current policy in the House of Delegates. Your Reference
37 Committee agrees that medical health misinformation is a very timely and widespread
38 issue and feels that amending current policy to expand our AMA's stance is appropriate
39 at this time. Additionally, amendments were proffered to standardize the terminology
40 used in the resolution and broaden the utilized language. Ultimately, your Reference
41 Committee recommends that Resolution 409 be adopted as amended.

(18) RESOLUTION 508 - OPPOSITION TO BETTING ON
CLINICAL TRIALS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 508 be amended by addition and deletion:

RESOLVED, That our ~~American Medical Association~~ AMA-MSS support banning prediction market contracts and related forms of gambling tied to clinical trials and health care-related regulatory decisions.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 508 be adopted as amended.

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.

VRC testimony was overall in support. Your Reference Committee agrees with testimony that this is a timely and relevant topic to address. Given that the New England Delegation is bringing forth Resolution 005 Opposing Trading on the Outcomes of Biomedical Research and Clinical Trials to this House of Delegates meeting, amending this language to be internal policy will enable your MSS Caucus to support this resolution at the meeting. Thus, your Reference Committee recommends Resolution 508 be adopted as amended.

(19) RESOLUTION 601 - PILOT OF A FORMAL POLICY
ACTION REQUEST PROCESS AND TRACKING
SYSTEM

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve clause of Resolution 601 be amended by addition and deletion:

RESOLVED, that our AMA develop a process for policy action requests that is membership-facing and accepts requests on a rolling basis, including a ~~publicly-accessible~~ tracking system accessible to AMA members that reports when requests are received, actions taken, and outcomes achieved; and be it further

1 RECOMMENDATION B:
2

3 Your Reference Committee recommends that Resolution
4 601 be adopted as amended.
5

6 RESOLVED, that our AMA develop a process for policy action requests that is
7 membership-facing and accepts requests on a rolling basis, including a publicly
8 accessible tracking system that reports when requests are received, actions taken, and
9 outcomes achieved; and be it further
10

11 RESOLVED, that our AMA pilot a policy action request system and provide an
12 informational report to the House of Delegates two years following implementation that
13 summarizes the requests received, actions taken, outcomes achieved, and lessons
14 learned.
15

16 VRC testimony was mixed, with testifiers recognizing the potential benefits of increased
17 transparency and accountability in AMA advocacy while raising concerns regarding
18 feasibility and resource allocation. Your Reference Committee agrees that limited
19 visibility into ongoing AMA advocacy efforts may contribute to duplicative resolutions and
20 inefficiencies within the House of Delegates. We believe that a formal policy action
21 request and tracking system would provide a novel, actionable mechanism for members
22 to request advocacy under existing policy, monitor progress, and better understand the
23 outcomes of AMA advocacy efforts. While your Reference Committee acknowledges
24 concerns regarding the financial and logistical resources required for implementation, we
25 believe that the proposed pilot approach and subsequent evaluation would allow the
26 AMA to assess feasibility, resource needs, and effectiveness before considering
27 permanent implementation. However, your Reference Committee agrees that making a
28 real-time resource detailing the specifics of ongoing AMA advocacy public carries risks,
29 especially on matters of current political controversy. We believe that the goal of the
30 resolution, to inform all AMA members and reduce the frequency of duplicative
31 resolutions, would substantially be met even with an AMA-member exclusive resource,
32 which would allow the AMA to include more detailed information which would be of
33 interest to AMA members considering personal advocacy while lowering the risk of
34 unintended consequences to the organization as a whole. We therefore support the
35 proposed amendment to limit this access to AMA members, preserving transparency,
36 and accountability while mitigating these concerns. Your Reference Committee
37 recommends that Resolution 601 be adopted as amended.

(20) RESOLUTION 604 - JAMA STUDENT EDITORIAL
POSITIONS & SPECIAL ISSUE FOR AMA ABSTRACTS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 604 be amended by addition:

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;
- c. Encouraging continued effort on behalf of the MSS Governing Council to cultivate a stronger relationship between MSS and JAMA and to re-trial these efforts every other year with subsequent MSS Governing Councils.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 604 be adopted as amended.

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.

VRC testimony was mixed. Your Reference Committee found this resolution to be timely given recent changes to the ERAS application highlighting peer-reviewed scholarly work. Your Reference Committee also recognizes that the language of this resolution has been carefully crafted to build upon rather than duplicate previous conversations between MSS and JAMA, without infringing upon JAMA's full editorial independence. Given prior efforts from former MSS Governing Councils to collaborate with JAMA, your Reference Committee favors the proposed addition of language enshrining the continuation of such efforts into MSS policy. Your Reference Committee recommends Resolution 604 be adopted as amended.

(21) CPH/CHJ REPORT A - NATIONAL DATABASE FOR
CIVILIAN INJURIES BY LAW ENFORCEMENT

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation in CPH/CHJ Report A be amended by deletion:

1. That our American Medical Association support federal legislation, regulations, programs, and policies that incentivize and facilitate reporting by state and local law enforcement agencies of law-enforcement-related civilian injuries and deaths, ~~including through federal funding mechanisms and technical assistance;~~

RECOMMENDATION B:

Your Reference Committee recommends that the second Recommendation in CPH/CHJ Report A be amended by addition and deletion:

2. That our AMA support ~~increased~~ federal coordination to improve the comparability data interoperability for of public-health data on law-enforcement-related civilian injuries and deaths across ~~relevant public health surveillance and law enforcement data collection reporting~~ systems, including through minimum national data standards ~~that facilitate cross-jurisdictional comparison and support of aggregate~~ public reporting, ~~while preserving the ability of states and other entities to exceed such standards based on local needs and maintaining with~~ appropriate safeguards for privacy, confidentiality, and data security; ~~and be it further;~~

RECOMMENDATION C:

Your Reference Committee recommends that the third Recommendation in CPH/CHJ Report A be deleted:

- ~~3. That our AMA support the harmonization and consistent implementation of standardized criteria for reporting law enforcement related civilian injuries across relevant surveillance systems, including refinement of such criteria as needed, and support improved clinical documentation and consistent use of applicable external cause codes for such injuries in health care settings.~~

1 RECOMMENDATION D:
2

3 Your Reference Committee recommends that the
4 Recommendations in CPH/CHJ Report A be adopted as
5 amended and the remainder of the report be filed.
6

7 Your Committee on Public Health (CPH) and Committee on Health Justice (CHJ)
8 recommend that the following be adopted in lieu of CPH Report B-A-26 and the
9 remainder of this report be filed:

10
11 1. That our American Medical Association support federal legislation, regulations,
12 programs, and policies that incentivize and facilitate reporting by state and local law
13 enforcement agencies of law-enforcement-related civilian injuries and deaths, including
14 through federal funding mechanisms and technical assistance;
15

16 2. That our AMA support increased federal coordination to improve data interoperability
17 for law-enforcement-related civilian injuries and deaths across relevant public health
18 surveillance and law-enforcement data-collection systems, including through minimum
19 national data standards that facilitate cross-jurisdictional comparison and support public
20 reporting, while preserving the ability of states and other entities to exceed such
21 standards based on local needs and maintaining appropriate safeguards for privacy,
22 confidentiality, and data security; and be it further
23

24 3. That our AMA support the harmonization and consistent implementation of
25 standardized criteria for reporting law-enforcement-related civilian injuries across
26 relevant surveillance systems, including refinement of such criteria as needed, and
27 support improved clinical documentation and consistent use of applicable external cause
28 codes for such injuries in health care settings.
29

30 VRC testimony was supportive, with testifiers recognizing the need to address
31 fragmented and incomplete reporting of civilian injuries and deaths involving law
32 enforcement. Your Reference Committee commends the authors for addressing the
33 concerns raised at the time of referral and providing a stronger evidentiary foundation for
34 improving public health surveillance and accountability. However, your Reference
35 Committee raised concerns regarding the feasibility and actionability of the second and
36 third Resolved clauses, particularly the AMA's role in establishing national data
37 interoperability standards, harmonizing reporting criteria across law enforcement
38 systems, and directing clinical documentation practices without sufficient supporting
39 evidence. While existing AMA policies H-440.813, H-145.969, and H-65.954 broadly
40 address public health surveillance and policing-related injuries, your Reference
41 Committee believes that targeted federal advocacy to improve reporting of law-
42 enforcement-related civilian injuries and deaths represents a meaningful extension of
43 these policies. We also discussed the importance of maintaining the AMA's focus on the
44 public health consequences of violence rather than prescribing operational requirements
45 for law enforcement agencies. Accordingly, your Reference Committee supports
46 consolidating the report into a more focused directive for improved reporting while
47 avoiding overly prescriptive or potentially duplicative requirements. Therefore, your
48 Reference Committee recommends that the recommendations in CPH/CHJ be adopted
49 as amended.

(22) CST REPORT A - "RIGHT TO REPAIR" FOR HOSPITAL
EQUIPMENT AND DURABLE MEDICAL EQUIPMENT

RECOMMENDATION A:

That the third Recommendation in CST Report A be
amended by addition and deletion:

3. That our AMA amends Policy H-185.912, "Expediting
Repairs for Power and Manual Wheelchairs," as follows:

Expediting Repairs for Power and Manual Wheelchairs, H-
185.912

1. Our American Medical Association supports health insurance coverage to eliminate barriers for patients to obtain wheelchair repair; ensure that repairs and services are safe, affordable, timely, and support mobility and independence for those who utilize power and manual wheelchairs; eliminate unnecessary paperwork and prior authorization requirements for basic repairs, including proof of continuous need; cover temporary rental of a substitute wheelchair when repairs require the primary wheelchair to be taken out of the home; and would include preventive maintenance and transporting the wheelchair between the patient's home and the repair facility.
2. Our AMA will identify procedures for obtaining changes to Medicare and other payers' current policies on repairing wheelchairs.
3. Our AMA supports suppliers of power and manual wheelchairs providing preventive maintenance and repair services for wheelchairs they supply to patients and permits consumers to perform ~~self-repairs as permitted by the manufacturer and when it does not void the warranty~~ via qualified third-party healthcare repair entities.

RECOMMENDATION B:

Your Reference Committee recommends that the recommendations in CST Report A be adopted as amended and the remainder of the report be filed.

Your Committee on Science and Technology (CST) recommends that MSS Resolution 502-A-26 be amended by addition and deletion as follows, and that the remainder of this report be filed:

1. That our AMA support federal and state legislation requiring medical device and durable medical equipment manufacturers to make available to healthcare facilities,

1 hospital-employed biomedical engineers and technicians, and independent service
2 organizations, on fair and reasonable terms: all documentation, parts, software, and
3 diagnostic tools necessary for the safe maintenance and repair of medical devices and
4 durable medical equipment; and be it further

5
6 2. That our AMA oppose the use of restrictive proprietary measures, including parts
7 pairing, software serialization, or digital locks, that limit device functionality or prevent
8 owners, hospital-employed biomedical engineers and technicians, and qualified third-
9 party technicians from installing functional replacement components in medical devices
10 and durable medical equipment for the purpose of repair and maintenance; and be it
11 further

12
13 3. That our AMA amends Policy H-185.912, "Expediting Repairs for Power and Manual
14 Wheelchairs," as follows:

15
16 Expediting Repairs for Power and Manual Wheelchairs, H-185.912

- 17
18 1. Our American Medical Association supports health insurance coverage to
19 eliminate barriers for patients to obtain wheelchair repair; ensure that repairs
20 and services are safe, affordable, timely, and support mobility and
21 independence for those who utilize power and manual wheelchairs; eliminate
22 unnecessary paperwork and prior authorization requirements for basic
23 repairs, including proof of continuous need; cover temporary rental of a
24 substitute wheelchair when repairs require the primary wheelchair to be taken
25 out of the home; and would include preventive maintenance and transporting
26 the wheelchair between the patient's home and the repair facility.
27 2. Our AMA will identify procedures for obtaining changes to Medicare and other
28 payers' current policies on repairing wheelchairs.
29 3. Our AMA supports suppliers of power and manual wheelchairs providing
30 preventive maintenance and repair services for wheelchairs they supply to
31 patients and permits consumers to perform self-repairs ~~as permitted by the~~
32 ~~manufacturer and when it does not void the warranty~~ via qualified healthcare
33 repair entities.
34

35 VRC testimony was unanimously supportive. Your Reference Committee thanks the
36 authorship for providing substantive evidence and agrees that the proposed
37 amendments within the report are more inclusive. For the amendments to existing policy,
38 we added clarifying language to avoid the apparent contradiction between the notion
39 of "self-repairs" and also allowing repairs by qualified entities. Therefore, we recommend
40 adopting as amended and filing of CST Report A.
41

RECOMMENDED FOR ADOPTION IN LIEU OF

(23) **RESOLUTION 016 - SUDDEN CARDIAC ARREST
PREPAREDNESS IN PRIMARY CARE SETTINGS**

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 016 be adopted in lieu of Resolution 016:

SUDDEN CARDIAC ARREST PREPAREDNESS IN OUT-OF-HOSPITAL HEALTH CARE SETTINGS

RESOLVED, That our American Medical Association supports efforts to improve preparedness for sudden cardiac arrest in out-of-hospital health care settings through the development of emergency action plans, appropriate CPR and AED training, and placement of automated external defibrillators in out-of-hospital health care settings when feasible and appropriate to the clinical setting, while advocating for public and/or private funding mechanisms that avoid imposing unfunded mandates on physician practices.

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

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

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

18
19 VRC testimony was mixed. Your Reference Committee supports the spirit of this
20 resolution as out of hospital cardiac arrest is a large public health issue. Testimony in
21 opposition referenced the relevance to the existing policy, feasibility, and verbiage of the
22 resolved clause. Your Reference Committee agrees that the existing policy is narrowed
23 to a specific setting that this amendment does not apply to. Thus, we recommend an
24 Adopt in Lieu as a stand alone policy instead. Furthermore, testimony included concerns
25 about the definition and narrow scope regarding primary care settings and thus
26 recommends an amendment to broaden this ask. Therefore, your Reference Committee
27 recommends that Alternate Resolution 016 be adopted in lieu of Resolution 016.

28
29 (24) RESOLUTION 408 - EXPANDING OPPORTUNITIES FOR
30 FEDERAL ORGAN DONATION REGISTRATION

31
32 RESOLUTION 413 - EXPANDING DONOR
33 REGISTRATION THROUGH WILDLIFE AND
34 PROFESSIONAL LICENSING SYSTEMS

35
36 RECOMMENDATION:

37
38 Your Reference Committee recommends that Alternate
39 Resolution 408 be adopted in lieu of Resolutions 408 and
40 413:

41
42 **EXPANDING OPPORTUNITIES FOR FEDERAL ORGAN**
43 **DONATION REGISTRATION**

44
45 RESOLVED, that our AMA-MSS study the possibilities for
46 expanding organ registration opportunities including:
47

- 1 1. Federal legislation and regulatory policies that expand
2 organ donor registration opportunities to federal
3 application processes including, but not limited to,
4 passport applications, Social Security registration, TSA
5 precheck, aviation licenses, and FAFSA applications.
6
- 7 2. State laws and policies that offer eligible applicants a
8 voluntary opportunity to register as organ, eye, and
9 tissue donors when applying for or renewing hunting,
10 fishing, trapping, or comparable wildlife-related
11 licenses or permits, or state-issued professional or
12 occupational licenses, certifications, or registrations,
13 with information sufficient to support an informed
14 choice, no effect on an applicant's eligibility to obtain or
15 renew a license if the applicant declines or skips the
16 donor-registration question, and secure transmission of
17 affirmative donor-designation data to the appropriate
18 registry; and
19
- 20 3. The development of model state legislation, for use
21 where administratively feasible, for voluntary organ,
22 eye, and tissue donor registration through wildlife and
23 professional licensing systems, in consultation with
24 appropriate stakeholders.
25

26 RESOLVED, that our AMA support federal legislation and regulatory policies that
27 expand organ donor registration opportunities to federal application processes including,
28 but not limited to, passport applications, Social Security registration, TSA precheck,
29 aviation licenses, and FAFSA applications.

30
31 VRC testimony for Resolutions 408 and 413 was largely supportive, with testifiers
32 recognizing the potential to expand voluntary organ, eye, and tissue donor registration
33 through additional federal and state application processes. Your Reference Committee
34 agrees that both resolutions present novel opportunities to increase donor registration
35 beyond traditional motor vehicle licensing systems and that their overlapping objectives
36 warrant a unified approach. However, your Reference Committee identified several
37 outstanding questions regarding the feasibility, jurisdictional authority, and
38 implementation of the proposed interventions. Specifically, because organ donor
39 registries are administered at the state level, we raised concerns regarding how
40 registration through federal applications would interface with existing state registries,
41 including the secure transmission and verification of donor designations. Similarly, state
42 licensing systems vary considerably in their administrative structures and regulatory
43 requirements, raising questions regarding the feasibility of standardized model
44 legislation and the appropriateness of directing AMA advocacy toward specific state
45 policies without further consultation with relevant stakeholders and state medical
46 societies. Your Reference Committee also considered the importance of ensuring
47 informed consent, protecting applicant information, and preventing donor registration
48 decisions from affecting eligibility for unrelated licenses or benefits.

1 Your Reference Committee considered adopting each resolution independently,
2 combining their proposed advocacy directives, and referring to the resolutions for further
3 study. While Resolution 413 presents a more immediately actionable state-level
4 approach, adopting either resolution without addressing these implementation questions
5 could prematurely commit the AMA to legislative strategies whose feasibility has not
6 been sufficiently established. Furthermore, advancing two substantially similar
7 resolutions through separate House of Delegates meetings could create duplicative
8 advocacy efforts without resolving their shared implementation challenges. Rather than
9 referring both resolutions independently or adopting potentially conflicting federal and
10 state directives, your Reference Committee believes that a unified MSS-led study would
11 preserve the merits of both proposals while allowing for a more comprehensive
12 evaluation of administrative feasibility, existing registration infrastructure, stakeholder
13 engagement, and opportunities for future advocacy. Such a study would also allow the
14 MSS to identify which approaches are most appropriate for federal advocacy, state
15 medical society collaboration, or model state legislation before requesting additional
16 AMA action. Therefore, your Reference Committee recommends that Alternate
17 Resolution 408 be adopted in lieu of Resolutions 408 and 413.

18
19 (25) RESOLUTION 418 - ENSURING THE APPROPRIATE
20 PLACEMENT OF CHILDREN AFTER PARENTAL
21 DEPORTATION

22
23 RECOMMENDATION:

24
25 Your Reference Committee recommends that Alternate
26 Resolution 418 be adopted in lieu of Resolution 418:

27
28 **ENSURING THE APPROPRIATE PLACEMENT OF**
29 **CHILDREN AFTER PARENTAL DEPORTATION**

30
31 RESOLVED, that our AMA-MSS support policies that
32 preserve the ability of parents or primary caregivers who
33 are detained or deported to participate in decisions
34 regarding their child's health and wellbeing, including
35 designation of an appropriate caregiver, consistent with the
36 child's safety and applicable law; and be it further

37
38 RESOLVED, that our AMA-MSS advocate for safe, timely,
39 culturally and linguistically appropriate, and trauma-
40 informed processes to ensure continuity of health care for
41 children experiencing immigration enforcement-related
42 separation from a parent or primary caregiver; and be it
43 further

44
45 RESOLVED, that our AMA-MSS support privacy-protective
46 mechanisms for secure communication between detained
47 or deported parents and designated caregivers to facilitate
48 continuity of care and health care decision-making.

1 RESOLVED, that our AMA-MSS supports the primary caregiver's decision regarding the
2 placement of a U.S.-born infant, child, and adolescent if that parent is being deported
3 from the U.S.; and be it further

4
5 RESOLVED, that our AMA-MSS advocates for collaboration between the pertinent
6 federal agencies and state legal and child welfare systems to screen all potential
7 caregivers before rehousing the infant/child/adolescent of the primary caregiver being
8 deported; and be it further

9
10 RESOLVED, that our AMA-MSS supports efforts to facilitate appropriate communication
11 between deported parent(s) and the infant's, child's, or adolescent's new caregivers
12 through secure, privacy-protecting mechanisms, consistent with applicable privacy laws
13 and safeguards.

14
15 VRC testimony was supportive of a few amendments proffered. Your Reference
16 Committee received late testimony with proffered amendments in order to align the
17 wording of the resolved clauses with an upcoming resolution submitted by UMAS. Given
18 UMAS support, and the ability to support this policy within the HOD, your Reference
19 Committee recommends that Alternate Resolution 418 be adopted in lieu of Resolution
20 418.

21
22 (26) RESOLUTION 501 - SAFEGUARDING FDA OVERSIGHT
23 IN PHARMACEUTICAL COMPOUNDING

24
25 RECOMMENDATION:

26
27 Your Reference Committee recommends that Alternate
28 Resolution 501 be adopted in lieu of Resolution 501:

29
30 **SAFEGUARDING FDA OVERSIGHT IN**
31 **PHARMACEUTICAL COMPOUNDING**

32
33 RESOLVED, that our American Medical Association
34 supports federal legislative and regulatory actions
35 addressing the misuse of Food and Drug Administration
36 (FDA) and other regulatory compounding exemptions that
37 enable compounding, prescribing, dispensing, distribution,
38 and marketing of unapproved synthetic peptide products
39 when such exemptions are not justified by identifiable
40 patient care needs.

41
42 RESOLVED, that our American Medical Association supports federal regulatory and
43 enforcement actions addressing the compounding, prescribing, dispensing, distribution,
44 and marketing of unapproved peptide products; and be it further

45
46 RESOLVED, that our American Medical Association oppose the use of U.S. Food and
47 Drug Administration (FDA) compounding exemptions that enable widespread
48 prescribing, dispensing, distribution, or marketing of unapproved synthetic peptide
49 products as an alternative to FDA premarket review and approval when no legitimate
50 compounding need exists.

VRC testimony was unanimously supportive, with testifiers recognizing the patient safety concerns associated with the misuse of pharmaceutical compounding exemptions to circumvent FDA premarket review and approval. Your Reference Committee agrees that this resolution addresses a novel gap in existing AMA policy by specifically targeting the misuse of compounding exemptions and building on prior policy addressing broad FDA oversight. However, your Reference Committee raised concerns that the original language, particularly the phrase “legitimate compounding need,” could be interpreted as opposing compounding exemptions more generally, potentially restricting access to medically necessary compounded medications. We considered amendments to broaden the resolution beyond synthetic peptides but determined that doing so could introduce unintended consequences for patients who rely on individualized compounded therapies. Your Reference Committee also discussed consolidating the two Resolved clauses to clarify the distinction between appropriate compounding practices and the misuse of regulatory exemptions, while preserving both legislative and regulatory advocacy opportunities. We believe that focusing on exemptions not justified by identifiable patient care needs more precisely targets the intended regulatory concern without unnecessarily restricting legitimate compounding. Therefore, your Reference Committee recommends that Alternate Resolution 501 be adopted in lieu of Resolution 501.

(27) RESOLUTION 602 - BIENNIAL AMA-MSS WIDE SURVEY

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 602 be adopted in lieu of Resolution 602:

BIENNIAL AMA-MSS WIDE SURVEY

RESOLVED, that our AMA-MSS study existing and novel member engagement and feedback mechanisms within our section to increase recruitment and engagement, assess section priorities, and foster sustained participation within advocacy spaces.

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.

VRC testimony was mixed. Proponent testimony argued for the importance of meaningfully capturing MSS advocacy priorities to inform future directions of our Section. Your Reference Committee also understands concern about the feasibility of implementation as well as the proposed time frame. The resolved clauses, as written, narrow the scope and possible work of the MSS on feedback and engagement efforts to a survey specifically. Additionally, as acknowledged on VRC, there are existing MSS mechanisms (including COLRP) who are suited to investigate possible avenues. Thus, your Reference Committee recommends Alternate Resolution 602 be adopted in lieu of Resolution 602.

(28) CME/CST REPORT A - PRIVACY AND PROTECTION OF
TRAINEE EDUCATIONAL DATA IN AI-ENABLED
MEDICAL EDUCATION

RESOLUTION 303 - AUGMENTED INTELLIGENCE
TRANSPARENCY IN MEDICAL EDUCATION

RESOLUTION 510 - RESPONSIBLE AUGMENTED
INTELLIGENCE IN MEDICAL EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that the Alternate
Recommendations in CME/CST Report A be adopted in
lieu of the Recommendations in CME/CST Report A and
Resolutions 303 and 510:

AI IN MEDICAL EDUCATION

RESOLVED, that our American Medical Association
supports institutional policies and regulatory frameworks
that address appropriate and transparent AI use in medical
educational curricula and coursework; and be it further

RESOLVED, that our AMA supports the application of
established data minimization standards to the collection,
retention, and secondary use of trainee data in AI-enabled
medical education systems to defend learner privacy and
data security; and be it further

RESOLVED, that our AMA supports that any AI-generated
output affecting a trainee's grading, remediation, or
academic progression remain subject to meaningful human
review.

Your Committees on Medical Education (CME) and Science and Technology (CST)
recommend that the following recommendations be adopted in lieu of Resolution 302-A-
26, and the remainder of this report be filed:

1. That our American Medical Association support institutional policies and regulatory frameworks that require transparent disclosure of, and informed consent for, the use of trainee-generated educational data, including its use as training data for artificial intelligence models, for any purpose beyond the original educational objective for which it was collected.
2. That our AMA define minimum trainee data in AI-enabled medical education as the smallest set of learner information necessary to accomplish a specific, defined educational objective, and support the application of established data minimization standards to the collection, retention, and secondary use of trainee data in AI-enabled medical education systems.

3. That our AMA work with relevant stakeholders, including accrediting bodies, medical education institutions, and medical students, residents, and fellows, to support the establishment of clear governance structures for defining "educational purposes" in AI-enabled medical education, and that any AI-generated output affecting a trainee's grading, remediation, or academic progression remain subject to meaningful human review.

VRC testimony for CME/CST Report A and Resolutions 303 and 510 was largely supportive, with testifiers recognizing the need for clearer standards governing AI use in medical education, particularly regarding transparency, learner privacy, data security, and human oversight. Your Reference Committee agrees that these proposals address important gaps in existing AMA policy and that their overlapping objectives are best addressed through a unified policy rather than three separate directives. Your Reference Committee considered proposed amendments and determined that a consolidated approach would strengthen actionability while preserving the distinct contributions of each proposal. Specifically, we incorporated Resolution 303's emphasis on transparent AI use in educational curricula and coursework, Resolution 510's protections for learner privacy and data security, and CME/CST Report A's recommendations regarding data minimization and meaningful human review of AI-generated decisions affecting academic progression. Your Reference Committee also discussed the feasibility of institutional implementation, the potentially restrictive implications of informed consent requirements, and ambiguity surrounding permissible secondary uses of trainee data. Accordingly, we favored flexible language supporting institutional policies and regulatory frameworks without imposing overly prescriptive requirements or unintentionally restricting legitimate educational and research activities. Your Reference Committee believes this consolidated language provides a more comprehensive, actionable foundation for AMA advocacy while avoiding duplicative or potentially conflicting policy. Therefore, your Reference Committee recommends that alternate language be adopted in lieu of the recommendations in CME/CST Report A and Resolutions 303 and 510.

RECOMMENDED FOR REFERRAL**(29) RESOLUTION 105 - ADDRESSING FINANCIAL TOXICITY IN PATIENT CARE****RECOMMENDATION:**

Your Reference Committee recommends that Resolution 105 be referred.

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.

VRC testimony was mixed, but many were in support with amendments. Your Reference Committee agrees with testimony that the issue of financial toxicity is novel and patient-centered but is currently not yet well-delineated or broadly applicable to various specialties outside of oncology. However, due to the heavy evidence base in oncology, we believe that this resolution could benefit from additional study to determine the best route of advocacy and actionability for this area. This resolution would also benefit from input from relevant stakeholders including Cancer Caucus. Therefore, your Reference Committee recommends that resolution 105 be referred for study.

Additional questions for those conducting the study to consider: Is there evidence regarding financial toxicity in specialties outside of oncology? If so, how widespread is it? Does this distinction of financial toxicity from broader concepts of financial insecurity, medical debt, and healthcare affordability identify clinical consequences or advocacy needs not adequately addressed by existing AMA policy? We additionally encourage consultation with relevant stakeholders and specialty societies to inform this evaluation.

(30) RESOLUTION 401 - EXPANDING FDA MANDATORY RECALL AUTHORITY FOR HUMAN DRUGS**RECOMMENDATION:**

Your Reference Committee recommends that Resolution 401 be referred.

RESOLVED, that our American Medical Association support federal legislation granting the Food and Drug Administration mandatory recall authority for human drugs not

1 already subject to such authority when the FDA determines that use or exposure
2 presents a reasonable probability of serious adverse health consequences or death,
3 including authority to order cessation of distribution and appropriate notification of
4 affected parties.

5
6 VRC testimony was mixed, with those in support stating that this resolution is novel,
7 actionable, and addresses a gap in current policy. Those in opposition cited concerns
8 with the narrow evidence base utilized to support the asks, and one testifier wrote on
9 behalf of a specialty society expressing concerns with expanding FDA regulatory
10 authority when other mechanisms already exist. Additionally, many testifiers
11 recommended a referral to study due to the limited evidence outlined in the Whereas
12 clauses. Your Reference Committee recognizes the issue brought forth by this
13 resolution; however, we believe that this resolution could be improved by a more robust
14 evidence base to support the asks of the Resolve clause. For these reasons, your
15 Reference Committee recommends that Resolution 401 be referred for study.
16

RECOMMENDED FOR NOT ADOPTION**(31) RESOLUTION 001 - DISABILITY EQUITY STANDARDS
FOR CLINICAL AUGMENTED INTELLIGENCE****RECOMMENDATION:**

Your Reference Committee recommends that Resolution
001 not be adopted.

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.

VRC testimony was mixed though largely in opposition. Your Reference Committee believes that though the asks in the author's resolved clauses identify language gap in policies H-480.931 (Assessing the Intersection Between AI and Health Care) and H-480.939 (Augmented Intelligence in Health Care), the asks of the authorship team are implicit under these two policies. Your Reference Committee expresses concern that if passed in HOD, this resolution runs the risk of undermining the aforementioned policies. Your Reference Committee believes that the intents of this resolution could be achieved through an MSS Action Item or Advocacy Referral. Your Reference Committee recommends Resolution 001 not be adopted.

**(32) RESOLUTION 003 - ETHICAL STANDARDS FOR
CONSUMER-GENERATED HEALTH DATA****RECOMMENDATION:**

Your Reference Committee recommends that Resolution
003 not be adopted.

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.

VRC testimony was largely in opposition. Your Reference Committee agrees with testimony that while this is an important issue to address especially with rapid change in technology, the resolved clause does not lay out a clear policy or advocacy target that would meaningfully address a gap in AMA action. Furthermore, testimony refers to existing policy H-480.943 and a recently published study "AMA Multi-Country Study on Consumable Wearable Data in Clinical Practice" that already addresses this topic. Your Reference Committee recommends Resolution 003 not be adopted.

(33) RESOLUTION 005 - SUPPORTING CHILDREN OF
PARENTS WITH CHRONIC ILLNESS

RECOMMENDATION:

Your Reference Committee recommends that Resolution
005 not be adopted.

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.

VRC was mixed. Your Reference Committee agrees with testimony highlighting the extent of this problem and implementation gap in screening for dependent children of chronic illness. However, we have many concerns regarding scope and actionability. This resolution does not clearly establish what criteria or kinds of chronic illness that would trigger screening, how caregiving capacity is assessed, how children are connected to resources, nor what specific standardized processes and frameworks this should occur under. Compelling testimony highlights concerns about privacy, excessive information disclosure, and stigmatization of families through revelation of a parent's diagnosis. Additionally, relevant specialty societies are in opposition to this language. While the proposal is novel, significant additional work is needed to clearly define its scope and implementation. Your Reference Committee recommends that Resolution 005 not be adopted.

(34) RESOLUTION 006 - COVERAGE FOR RISK-BASED
CERVICAL CANCER SCREENING

RECOMMENDATION:

Your Reference Committee recommends that Resolution
006 not be adopted.

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.

VRC testimony was largely in opposition. Your Reference Committee agrees with testimony that while this resolution addresses an important point of advocacy for

1 individuals with immunocompromising conditions, the asks of the resolution are
2 substantially accomplished with existing AMA Policy, including H-55.971, H-440.872 and
3 D-170.995. Your Reference Committee also agrees with testimony that different
4 immunocompromising conditions may warrant different screening practices, which are
5 not reflected in a one size fits all approach. We also note that current AMA Policy
6 supports USPSTF and 2025 ACIP guidelines for cervical cancer screening and
7 vaccination practices, with deference to triangulating specialty society guidelines, which
8 conflict with the asks of Resolution 006. Your Reference Committee recommends
9 Resolution 006 not be adopted.

10
11 (35) RESOLUTION 007 - FAIR ALLOCATION OF
12 RESPONSIBILITY AND PRESERVATION OF CLINICAL
13 JUDGMENT IN AI INTEGRATION

14
15 RECOMMENDATION:

16
17 Your Reference Committee recommends that Resolution
18 007 not be adopted.

19
20 RESOLVED, that our AMA amend Policy H-480.939, Section 6 by addition and deletion
21 as follows:

22
23 6. Physicians should not be penalized if they do not use, or if they override, AI systems
24 while regulatory oversight, standards, clinical validation, clinical usefulness, and
25 standards of care are in flux, where the physician does so on the basis of good-faith,
26 documented, patient-specific clinical judgement consistent with the applicable standard
27 of care. Furthermore, our AMA opposes:

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

31
32 7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best
33 positioned to know the AI system risks and best positioned to avert or mitigate harm do
34 so through design, development, validation, and implementation. Our AMA will further
35 advocate:

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

39
40 RESOLVED, that our AMA support that AI systems that support screening, diagnosis,
41 and treatment in a clinical setting automatically generate, without requiring additional
42 physician data entry, a brief summary of the system and version, the output provided,
43 and whether the physician accepts or overrides that output; this summary will serve as a
44 traceable document retained within or alongside the patient's medical record for no less
45 than the applicable statute of limitations for medical liability claims; and be it further

46
47 RESOLVED, that our AMA support that responsibility for generating and retaining such
48 documentation rest with the deploying institution and the system developer rather than
49 with the individual physician and that our AMA support that failure to provide such

1 documentation during a medical malpractice shall render the deploying institution
2 partially liable.

3
4 VRC Testimony was mixed. Your Reference Committee agrees that the increasing use
5 of generative AI in medical decision-making presents both opportunities for
6 advancements in clinical care but also risk of harm to physicians acting in patients' best
7 medical interest when using these tools in practice. Your Reference Committee agrees
8 with testimony that the second and third Resolve clauses are outside the scope of the
9 AMA, which has no ability to regulate the technical output of generative AI tools or the
10 legal definition of liability in any setting. Furthermore, Section 6(a) of H-480.939 already
11 provides broad support for policies which shift the burden of liability toward the entities
12 best positioned to understand a particular model's risks, and there is no clear federal
13 advocacy target which would not already be within the AMA's capabilities based on
14 current policy. Given existing policy, your Reference Committee believes this could be
15 better suited for an MSS Action Item or Advocacy Referral. Your Reference Committee
16 recommends that Resolution 007 not be adopted.

17
18 (36) RESOLUTION 008 - STANDARDIZED FOOD
19 INSECURITY SCREENING AND REFERRAL

20
21 RECOMMENDATION:

22
23 Your Reference Committee recommends that Resolution
24 008 not be adopted.

25
26 RESOLVED, that our American Medical Association advocate for federal policies and
27 efforts to incorporate standardized, validated food insecurity screening instruments and
28 appropriate referral to nutrition assistance and community resources into applicable
29 federal healthcare quality and value-based payment programs; and be it further

30
31 RESOLVED, that our American Medical Association support federal healthcare quality
32 programs that evaluate food insecurity screening and referral through measurable
33 processes, including the proportion of patients screened, the proportion of patients with
34 positive screens receiving appropriate referrals, and measures of documented follow-up
35 efforts or closed-loop referral using electronic health record (EHR) systems and referral
36 processes where feasible.

37
38 VRC testimony was mixed but largely in opposition. Your Reference Committee agrees
39 with the testimony that this resolution is largely covered under existing AMA policy,
40 namely H-160.896 (Expanding Access to Screening Tools for Social Determinants of
41 Health/Social Determinants of Health in Payment Models). While we appreciate the
42 authors' comment that food insecurity can be difficult to identify through broad social
43 determinant screening or brief questions and that this is a timely issue given CMS's
44 removal of Screening for Social Drivers of Health measures from several federal quality
45 and value-based payment programs, we believe this is better suited for alternative forms
46 of advocacy such as an MSS Action Item or Advocacy Referral. Your Reference
47 Committee recommends Resolution 008 not be adopted.

(37) RESOLUTION 011 - ADVANCE CARE PLANNING
INCLUSION IN DOMESTIC REFUGEE HEALTH
SCREENING

RECOMMENDATION:

Your Reference Committee recommends that Resolution
011 not be adopted.

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.

VRC testimony was mixed. Your Reference Committee agrees with the testimony that this resolution is largely covered by existing AMA policy H-140.845 (Encouraging the Use of Advance Directives and Health Care Powers of Attorney) and H-350.957 (Addressing Immigrant Health Disparities). Your Reference Committee agrees that this will not meaningfully alter AMA advocacy efforts, and has questionable feasibility given its specific tasking of the CDC with an operational mandate when current guidelines are not meant to provide comprehensive clinical guidance. Your Reference Committee recommends Resolution 011 not be adopted.

(38) RESOLUTION 012 - MANDATING PUBLIC DISCLOSURE
OF PRIVATE EQUITY ACQUISITIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution
012 not be adopted.

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

1 RESOLVED, That our AMA supports mandates the reporting of patient quality and
2 outcome metrics including but not limited to 90-day mortality postdischarge, patient
3 reported outcomes measures (PROM), surgical mortality rates, central line-associated
4 bloodstream infections (CLABSI), catheter-associated urinary tract infections (CAUTI),
5 and average length of stay (LOS) where applicable for 3 years after acquisition.
6

7 VRC testimony was mixed. Your Reference Committee agrees with testimony that the
8 resolution would provide novel ideas to stand alongside existing AMA policy. The matter
9 is timely, and increasing evidence points toward the mixed-to-harmful effects of common
10 private equity practices.
11

12 Your Reference Committee appreciates the amendments proposed by the MSS.
13 Concerns remain, including:
14

15 For the first Resolve clause: No delineation is made between the size of private equity
16 corporation that would require disclosure. What constitutes a "private equity corporation"
17 is unclear, and these firms can utilize a variety of practices that represent a large
18 spectrum of financial strategy. Not every state has a regulatory authority that a private
19 equity firm would publicly disclose to.
20

21 For the second Resolve clause: There is no appropriate federal regulatory authority in
22 existence for all private equity transactions, mergers, acquisitions, or restructures. Your
23 Reference Committee shares concerns previously outlined in review that requiring
24 disclosure to regional media is not feasible and possibly unconstitutional.
25

26 For the third Resolve clause: An escrow account able to fund five years of anticipated
27 operating expenses would deny PE financial strategies from ever being effective at
28 generating investor returns, and neutralize the entire industry within healthcare. While
29 there is an argument to be made for that reality, this is likely to encounter pushback if it
30 progressed to HOD.
31

32 For the fourth Resolve clause: The metrics outlined are prescriptive, and PE invests and
33 owns healthcare entities beyond the hospitals that may generate these types of metrics.
34 Your Reference Committee appreciates the amendments proposed, but does not believe
35 that these amendments resolve the concerns.
36

37 While Referral was considered by your Reference Committee, it is believed the
38 immensity of this topic, and its complexity, would not be reasonable for an MSS
39 Standing Committee to undertake in its current state. Your Reference Committee
40 recommends Resolution 012 not be adopted.
41

42 (39) RESOLUTION 015 - REDUCING HEALTHCARE
43 MONOPOLIES AND EFFECTS ON HEALTHCARE
44 DELIVERY
45

46 RECOMMENDATION:
47

48 Your Reference Committee recommends that Resolution
49 015 not be adopted.

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

4
5 VRC testimony was mixed. Your Reference Committee considered referral; however, we
6 noted that a study will not yield additional information as we currently have policy to
7 study monopolies within healthcare D-383.980. We agree with concerns regarding
8 reaffirmation of D-160.908 (Vertical Consolidation in Health Care, Markets or
9 Monopolies) and D-383.980 (Health Care Entity Consolidation). Amendments were
10 proffered, but your Reference Committee did not feel as though these fully addressed
11 the evidence base, novelty, and redundancy concerns. Therefore, your Reference
12 Committee recommends that Resolution 015 not be adopted.

13
14 (40) RESOLUTION 201 - TRANSPARENCY OF ELECTED
15 OFFICIALS HEALTH

16
17 RECOMMENDATION:

18
19 Your Reference Committee recommends that Resolution
20 201 not be adopted.

21
22 RESOLVED, that our AMA supports appropriate, function-based transparency when an
23 elected official or other government officer's health materially limits the official's ability to
24 perform the essential duties of office; and be it further

25
26 RESOLVED, that our AMA supports appropriate governing bodies in developing clear
27 and ethically grounded standards for public communication regarding the health
28 transparency of elected officials and government officers, balancing governmental
29 accountability and continuity with medical privacy, individual autonomy, and protection
30 from stigma.

31
32 VRC testimony was mixed. While your Reference Committee recognizes the importance
33 of governmental accountability and transparency regarding officials' ability to fulfill their
34 duties, we agree with testimony raising significant concerns regarding the scope,
35 feasibility, and ethical implications of this resolution. Specifically, the proposed language
36 does not clearly delineate which elected or appointed officials would be subject to these
37 standards, what constitutes a material limitation in functional capacity, or which
38 governing bodies would be responsible for developing and implementing such
39 standards. Additionally, your Reference Committee shares concerns regarding potential
40 conflicts with medical privacy and individual autonomy. Furthermore, your Reference
41 Committee is concerned that, as currently written, the proposed standards may conflict
42 with constitutional protections and established qualification procedures for elected
43 federal office, raising significant legal and practical barriers to implementation. While the
44 AMA may contribute valuable medical and ethical expertise to discussions of functional
45 capacity, establishing standards for disclosure and governmental accountability extends
46 beyond its primary scope of advocacy. Other AMA collaborators certainly influence
47 elected offices, and, potentially, these asks could be better achieved through partnership
48 with them. As written, your Reference Committee does not believe this policy is feasible
49 or appropriate for the AMA to undertake. Therefore, your Reference Committee
50 recommends Resolution 201 not be adopted.

(41) RESOLUTION 206 - CONTINUING ACCESS TO
PERSONAL MEDICAL SUPPLIES FOR ICE DETAINEES

RECOMMENDATION:

Your Reference Committee recommends that Resolution
206 not be adopted.

RESOLVED, that our AMA 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;

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;

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.

VRC testimony was mixed. Testimony was largely concerned about the overlap this resolution presents with existing policy as well as the feasibility. Your Reference Committee agrees that this resolution addresses important issues but is concerned about feasibility and redundancy.

Existing AMA policy, including D-350.983, H-350.957, and H-65.938, describes AMA stances on the care for those in immigration detention which does include the access to medical devices. These include but are not limited to "advocates for access to health care for individuals in immigration detention", "medically appropriate care", "health status relies on an equitable and non-discriminatory access to and coverage of health care". Having access to personal medical supplies is providing basic healthcare, and, thus, your Reference Committee interprets that these asks are currently covered. Given this, your Reference Committee recommends pursuing a MSS Action Item or Advocacy Referral to act in this space under existing policy. Your Reference Committee recommends Resolution 206 not be adopted.

(42) RESOLUTION 209 - SUPPORT FOR DEVELOPING
HEALTH SYSTEM GUIDANCE FOR OBSTETRIC CARE
CONTINUITY DURING IMMIGRATION-RELATED
DISRUPTIONS

RECOMMENDATION:

Your Reference Committee recommends that Resolution
209 not be adopted.

RESOLVED, that our American Medical Association support efforts by healthcare institutions, detention facilities, and clinicians to facilitate continuity of obstetric and

1 perinatal care in the setting of immigration-related disruptions in ways, including, but not
2 limited to: flexible accessibility options for virtual and in-person appointments, timely care
3 coordination between detention facilities and healthcare institutions, and confidential
4 transfer of medical records at hospitals and public health centers.

5
6 VRC testimony was mixed. Specialty society feedback was against external language,
7 and, thus, an amendment was proffered to make this internal policy. Your Reference
8 Committee agrees with testimony that the asks of this resolution are covered by existing
9 policy and are able to be advocated upon now, making internal policy unnecessary. This
10 could be pursued via MSS Action Item or Advocacy Referral. Your Reference Committee
11 recommends Resolution 209 not be adopted.

12
13 (43) RESOLUTION 305 - INCLUSION OF AN "ADVOCACY,
14 POLICY, AND MEDICAL ORGANIZATION
15 INVOLVEMENT" SECTION IN MEDICAL CAREER
16 APPLICATIONS

17
18 RECOMMENDATION:

19
20 Your Reference Committee recommends that Resolution
21 305 not be adopted.

22
23 RESOLVED, that our AMA advocates for residency, fellow, and other physician career
24 applications to include an "Advocacy, Policy, and Medical Organization Involvement"
25 section to describe experiences and honors.

26
27 VRC testimony was mixed. Although your Reference Committee believes that there are
28 important improvements to be made in consistently providing space to communicate
29 advocacy work in physician career application services, your Reference Committee
30 agrees with testimony that as currently written, advocating for a specific "Advocacy,
31 Policy, and Medical Organization Involvement" section across application services is too
32 prescriptive. Existing AMA and MSS policies 310.063MSS and H-295.835 advocate for
33 holistic review of applicants, and explicitly specifies non-research related activities. Your
34 Reference Committee interprets existing policy as sufficient to advocate in this space
35 now to request and/or raise concerns about the current state of residency application
36 services.

37
38 Your Reference Committee does not believe a study would provide solutions for the
39 underlying concerns with the resolution and would additionally be logistically challenging
40 given that the information required for such a report is not publicly available given the
41 variety of application services and the input given from various specialty educational
42 bodies and programs. For these reasons, your Reference Committee recommends
43 Resolution 305 not be adopted.

(44) RESOLUTION 306 - FOUNDATIONAL DERMATOLOGIC
COMPETENCIES IN MEDICAL EDUCATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution
306 not be adopted.

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

RESOLVED, that our AMA encourages 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.

VRC testimony was unanimously in opposition. We agree with testimony that the asks of this resolution largely overlap with existing policy, including H-295.853. This resolution is not likely to meaningfully advance the AMA's advocacy efforts in this area as the AMA does not dictate undergraduate medical education curricula. Furthermore, we received feedback from the relevant specialty society in opposition to this resolution with a variety of concerns. Therefore, your Reference Committee recommends Resolution 306 not be adopted.

(45) RESOLUTION 308 - ESTABLISHING PROACTIVE
ACADEMIC SUPPORT FOR NEURODIVERGENT
MEDICAL STUDENTS

RECOMMENDATION:

Your Reference Committee recommends Resolution 308
not be adopted.

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

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

8
9 VRC testimony was mixed with a majority in opposition. Your Reference Committee
10 agrees that neurodivergent students continue to face uneven barriers in education
11 settings, including pre-clerkship and clinical undergraduate medical education, and that
12 more effort is needed to address these inequalities to ensure appropriate access to
13 resources and criteria for evaluation and remediation. However, your Reference
14 Committee agreed with testimony that the asks of the resolution are substantially
15 covered by existing AMA policy, including D-615.977 and D-90.990, which address
16 disability education, accommodations, and institutional protections, and D-295.325 which
17 supports early identification and remediation for at-risk students. Furthermore, your
18 Reference Committee agrees with testimony that the language of the second Resolved
19 clause may be overly prescriptive and paradoxically reduce the potential for the AMA to
20 advocate for appropriate improvements to medical school procedures if such an
21 opportunity arose. Therefore, your Reference Committee recommends Resolution 308
22 not be adopted.

23
24 (46) RESOLUTION 313 - NEURODIVERSITY AND LEARNING
25 DIFFERENCES IN MEDICAL EDUCATION

26
27 RECOMMENDATION:

28
29 Your Reference Committee recommends that Resolution
30 313 not be adopted.

31
32 RESOLVED, That our AMA recognizes neurodiversity, including attention, learning, and
33 communication differences, as a distinct category within existing disability and equity
34 work in medical education; and be it further

35
36 RESOLVED, That our AMA supports efforts by medical schools and relevant medical
37 education organizations to develop and implement evidence-informed, equitable
38 assessment practices for neurodivergent medical students across written, clinical-skills,
39 and workplace-based assessments, while preserving essential competencies and
40 individualized accommodation processes.

41
42 Although VRC testimony was largely in support, your Reference Committee had
43 significant concerns regarding this resolution. We thank the authorship team for their
44 dedication in bringing awareness to medical students who may have different
45 educational support needs that are not currently recognized within existing disability and
46 equity frameworks in medical education. However, relevant stakeholders expressed
47 significant concerns regarding the specific use of the term "neurodivergent" and didn't
48 believe there was sufficient evidence to support neurodivergence being recognized as a
49 distinct category. Furthermore, we are unsure how the recognition of language of the

1 first Resolved clause will meaningfully advance advocacy in this space. Therefore, your
2 Reference Committee recommends that Resolution 313 not be adopted.

3
4 (47) RESOLUTION 402 - XYLAZINE-ASSOCIATED
5 OVERDOSE, WOUND CARE, AND EDUCATION

6
7 RECOMMENDATION:

8
9 Your Reference Committee recommends that Resolution
10 402 not be adopted.

11
12 RESOLVED, that our AMA recognize xylazine as an emerging national public health
13 threat; and be it further

14
15 RESOLVED, that our AMA support the development and dissemination of evidence-
16 based, standardized national clinical guidelines by professional organizations —
17 including, but not limited to, the American Society of Addiction Medicine and the
18 Infectious Diseases Society of America — for managing xylazine overdoses, limb
19 salvage evaluation, and xylazine-associated wound care, including indications for
20 specialty consultation and surgical intervention.

21
22 VRC testimony was largely in support. Your Reference Committee agrees that xylazine-
23 related health concerns are an emerging public health threat that is causing significant
24 harm to individuals and communities across the country. However, your Reference
25 Committee at large was concerned that the asks of this resolution can effectively be
26 covered in existing policy H-95.940, which is intentionally broad to allow for advocacy
27 regarding a variety of drug-related public health concerns. We also received testimony
28 from relevant stakeholders that this resolution would not meaningfully change AMA
29 advocacy. For these reasons, your Reference Committee recommends that Resolution
30 402 not be adopted.

31
32 (48) RESOLUTION 403 - IMPROVING HARM REDUCTION
33 STRATEGIES THROUGH FREE-OF-CHARGE DRUG-
34 CHECKING SERVICES AND MATERIALS

35
36 RECOMMENDATION:

37
38 Your Reference Committee recommends that Resolution
39 403 not be adopted.

40
41 RESOLVED, that our AMA supports the development and expansion of free or low-cost,
42 anonymous, community-accessible drug-checking programs operated by public-health
43 agencies, pharmacies, community health centers, harm-reduction organizations,
44 academic and clinical laboratories, and other nongovernmental community partners; and
45 be it further

46
47 RESOLVED, that our AMA supports the integration of quality-assured, multi-analyte
48 drug-checking methods with appropriate result interpretation, education, referral, and
49 harm-reduction services to enable individuals to make informed decisions and
50 strengthen local overdose-prevention efforts.

VRC testimony was largely in opposition, with testifiers believing that the asks of this resolution are extensively covered by multiple existing AMA policies: D-95.947, H-95.900, H-95.985, D-95.947, and D-95.950. Your Reference Committee also received testimony from relevant stakeholders citing similar concerns. We do not feel that adoption of this policy would meaningfully change AMA advocacy. For this reason, your Reference Committee recommends that Resolution 403 not be adopted.

(49) RESOLUTION 404 - COMPLIANCE AND RESTORATION
OF INFECTIOUS DISEASE SURVEILLANCE
PROGRAMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution
404 not be adopted.

RESOLVED, that our AMA advocates for the compliance and restoration of infectious disease surveillance programs; and be it further

RESOLVED, that our AMA-MSS immediately forward this resolution to the HOD.

VRC testimony was mixed. Supporters agreed that our AMA should build on our public health preparedness efforts by advocating explicitly for the restoration of infectious disease surveillance programs. Those in opposition felt that this resolution is largely covered in existing AMA policy. H-440.892, H-440.820, H-440.846, H-440.849, D-440.997, and D-250.985. Your Reference Committee agreed that the asks of this resolution can be effectively advocated for under existing AMA policy. Additionally, there were concerns that this language was very specific to the current political landscape and would not therefore be applicable beyond current events. Your Reference Committee recommends that Resolution 404 not be adopted.

(50) RESOLUTION 406 - EXPANDING RURAL ACCESS TO
COMPREHENSIVE DERMATOLOGIC CARE

RECOMMENDATION:

Your Reference Committee recommends that Resolution
406 not be adopted.

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.

VRC testimony was largely in opposition, with testifiers citing substantial overlap with existing AMA policies H-465.994, H-465.971, H-55.972, and H-480.946, which broadly support expanding access to specialty care, telehealth, and healthcare services in rural and underserved communities. While your Reference Committee recognizes the significant barriers to dermatologic care in rural populations, we agree with testimony that the proposed Resolved clause does not identify a sufficiently distinct policy gap or

1 actionable advocacy target beyond existing AMA policy. Furthermore, your Reference
2 Committee shares concerns raised by relevant specialty stakeholders regarding the
3 limited evidence supporting community-based screening models as an effective and
4 sustainable approach to expanding dermatologic access, particularly given
5 implementation costs and logistical barriers. Although the revised language broadens
6 the proposed strategies, these concerns remain, and your Reference Committee does
7 not believe that specialty-specific policy would meaningfully advance existing AMA
8 advocacy efforts and are concerned with progressing this resolution forward without
9 stakeholder support. We encourage the authors to pursue an MSS Action Item or
10 Advocacy Referral to advance this issue under current policy and in collaboration with
11 relevant specialty societies. Your Reference Committee recommends that Resolution
12 406 not be adopted.

13
14 (51) RESOLUTION 407 - DERMATOLOGIC SCREENINGS
15 FOR UNHOUSED POPULATIONS

16
17 RECOMMENDATION:

18
19 Your Reference Committee recommends that Resolution
20 407 not be adopted.

21
22 RESOLVED, that our American Medical Association support legislative and regulatory
23 efforts to integrate targeted dermatologic screenings into street medicine programs,
24 Federally Qualified Health Centers (FQHCs), and safety-net clinics serving individuals
25 experiencing homelessness.

26
27 VRC testimony was mixed, with supporters emphasizing the importance of expanding
28 preventive dermatologic care for individuals experiencing homelessness, while
29 opposition raised concerns regarding existing AMA policy, insufficient evidence, and
30 implementation feasibility. One testimony recommended a referral to study in order to
31 develop a more robust evidence base that would strengthen the asks of this resolution.
32 Your Reference Committee recognizes the disproportionate dermatologic health risks
33 faced by unhoused populations but agrees with testimony that existing AMA policies H-
34 440.839 and H-55.972 broadly address UV protection, skin cancer prevention, and early
35 detection. Furthermore, your Reference Committee shares concerns regarding the
36 limited evidence supporting routine dermatologic screening in the proposed settings,
37 particularly given the U.S. Preventive Services Task Force's conclusion that evidence is
38 insufficient to recommend routine skin cancer screening in asymptomatic adolescents
39 and adults. We also acknowledge concerns raised by relevant stakeholders regarding
40 policy redundancy and the financial and logistical challenges of implementing additional
41 screening services in street medicine programs, FQHCs, and safety-net clinics, which
42 often operate with limited resources. While your Reference Committee supports
43 improving dermatologic care for underserved populations, we do not believe the
44 resolution sufficiently establishes the evidence base, implementation mechanisms, or
45 distinct policy gap necessary to justify additional AMA advocacy. Therefore, your
46 Reference Committee recommends that Resolution 407 not be adopted.

1 (52) RESOLUTION 410 - STANDARDIZATION OF
2 MEDICATION ADMINISTRATION IN K-12

3
4 RECOMMENDATION:

5
6 Your Reference Committee recommends that Resolution
7 401 not be adopted.
8

9 RESOLVED, that our American Medical Association encourage national medical
10 societies to advocate federal minimum training standards for K–12 school personnel who
11 administer medications, establishing a common baseline for required training content,
12 instructional time, and competency verification across states, while allowing states to
13 determine implementation; and be it further

14
15 RESOLVED, that our AMA support continued recertification of competency requirements
16 for K–12 school personnel who administer medications—including maintenance
17 medications for chronic conditions such as diabetes and asthma, time-critical emergency
18 medications such as epinephrine, glucagon, and seizure rescue therapies, and
19 medications requiring specialized or invasive administration—including regular review
20 and updating of training modules and periodic skills assessments aligned with current
21 evidence-based practices.
22

23 VRC testimony was mixed, with those in favor of adoption arguing that this resolution
24 expands upon existing policy and is actionable alongside amendments to clarify the
25 scope and intent of the resolution and allow for broader advocacy. Calls for referral to
26 study included feasibility concerns and to further investigate the existing evidence to
27 substantiate the asks of the resolved clauses. Those in opposition cited feasibility
28 concerns, redundancy with existing AMA policy H-440.884, D-60.976, and H-60.991,
29 and concerns that this would be better advocated for at a state or local level. Your
30 Reference Committee agrees with the cited concerns regarding feasibility, actionability,
31 and redundancy. Additionally, we do not feel that there is sufficient existing evidence to
32 develop an effective report; therefore, we oppose referral to study at this time. For the
33 aforementioned reasons, your Reference Committee recommends that Resolution 410
34 not be adopted.
35

36 (53) RESOLUTION 412 - PROTECTING PATIENTS WHO
37 RELY ON ELECTRICITY FOR MEDICALLY NECESSARY
38 CARE DURING POWER DISRUPTIONS

39
40 RECOMMENDATION:

41
42 Your Reference Committee recommends that Resolution
43 412 not be adopted.
44

45 RESOLVED, That our American Medical Association supports federal and state policies
46 and utility regulatory standards that protect medically necessary care for patients during
47 planned utility shutoffs and prolonged power outages, including but not limited to
48 voluntary programs for individuals or households to identify medically necessary
49 electricity needs, timely and accessible advance notification when feasible, ongoing
50 outage communication, appropriate protections for patient information; and be it further

1 RESOLVED, That our AMA supports policies that support continuity of medically
2 necessary care for patients affected by prolonged power outages, including access to
3 continuous backup power, charging resources, transportation, or alternative locations
4 where medically necessary care can safely continue.

5
6 VRC testimony was mixed, with testifiers divided on whether the resolution's asks are
7 sufficiently addressed by existing AMA policies D-130.974 and D-440.920 and MSS
8 policy 90.015MSS, which broadly address emergency preparedness, medically
9 vulnerable populations, and access to life-essential utilities. While your Reference
10 Committee recognizes the importance of ensuring continuity of medically necessary care
11 during power disruptions, we agree with testimony raising concerns regarding the
12 feasibility, actionability, and scope of the proposed interventions. Specifically, utility
13 regulation and emergency response planning primarily fall under state and local
14 jurisdictions with utility regulatory bodies, limiting the AMA's ability to meaningfully
15 implement the proposed standards at the national level. Furthermore, the evidence
16 presented does not sufficiently establish gaps in existing utility notification and
17 emergency response programs, nor demonstrate that the proposed interventions would
18 meaningfully improve patient outcomes beyond current mechanisms. Although the
19 resolution addresses planned shutoffs and prolonged outages that may occur outside
20 declared emergencies, your Reference Committee does not believe that the authors
21 have sufficiently demonstrated a distinct policy gap warranting additional AMA action.
22 We encourage the authors to pursue collaboration with state medical societies and
23 relevant regulatory stakeholders to advance targeted advocacy. Your Reference
24 Committee recommends that Resolution 412 not be adopted.

25
26 (54) RESOLUTION 416 - HEALTH INSURANCE NAVIGATION
27 LITERACY FOR PREVENTIVE CARE

28
29 RECOMMENDATION:

30
31 Your Reference Committee recommends that Resolution
32 416 not be adopted.

33
34 RESOLVED, that our AMA support federal and state policies and efforts to improve
35 patients' health insurance navigation literacy through educational initiatives, plain-
36 language resource tools, and point-of-navigation communication strategies to increase
37 the utilization of recommended, no-cost-sharing preventive care services; and be it
38 further

39
40 RESOLVED, that our AMA support federal and state legislative and regulatory policies
41 that encourage health insurance plans to provide accessible, plain-language
42 navigational resources, defined as plan-specific, interactive decision-support tools that
43 identify an enrollee's eligible no-cost-sharing preventive benefits and connect them to in-
44 network sources of that care.

45
46 VRC testimony was mixed, with opposition citing substantial overlap with existing AMA
47 policies H-160.931, H-190.994, H-165.828, and H-373.994, which support health literacy
48 initiatives, plain-language insurance information, education regarding cost-sharing, and
49 patient navigation programs. While your Reference Committee recognizes the
50 importance of improving health insurance literacy to increase access to preventive care,

we agree with testimony that the proposed Resolved clauses are largely encompassed by existing policy and would not meaningfully expand AMA advocacy efforts. Furthermore, your Reference Committee shares concerns that the second Resolved clause is overly prescriptive in its support of plan-specific, interactive decision-support tools, particularly given the insufficient evidence presented to demonstrate that these specific interventions improve utilization of no-cost-sharing preventive services. Your Reference Committee believes that the authors' goals could be pursued through existing AMA policy, including through an MSS Action Item or Advocacy Referral. Your Reference Committee recommends that Resolution 416 not be adopted.

(55) RESOLUTION 417 - STANDARDIZED EHR
DOCUMENTATION OF NON-CIGARETTE TOBACCO
USE

RECOMMENDATION:

Your Reference Committee recommends that Resolution
417 not be adopted.

RESOLVED, that our AMA 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.

VRC testimony was mixed. Your Reference Committee recognizes supportive testimony highlighting that Resolution 417 would functionally facilitate the research of the implications of non-cigarette tobacco use on risk for lung cancer. However, your Reference Committee finds that the asks of this resolution as written are broadly accomplished under existing policies H-95.904, H-490.917, and H-495.988 addressing both the appropriate documentation of substance use history as well as its implementation within the Electronic Medical Record. Your Reference Committee considered referral for further study but ultimately determined that the proposed scope was too narrow, and that such a study might not adequately address the broader clinical and implementation of questions identified. We encourage the authors to further explore this issue in collaboration with relevant specialty societies and EHR stakeholders. Therefore, your Reference Committee recommends that Resolution 417 not be adopted.

(56) RESOLUTION 420 - STRENGTHENING MARITIME
BIOSECURITY AGAINST NOVEL ZONOTIC
PATHOGENS

RECOMMENDATION:

Your Reference Committee recommends that Resolution
420 not be adopted.

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.

VRC testimony was mixed. Your Reference Committee recognizes the unique challenges of infectious disease preparedness and response aboard maritime vessels, particularly regarding disease surveillance, isolation, and coordination with shoreside healthcare systems. However, we agree with testimony that the proposed asks are broadly encompassed by existing AMA policies D-440.940, H-440.847, H-10.974, and H-440.892, which address infectious disease preparedness, outbreak response, and public health coordination. Furthermore, your Reference Committee shares concerns regarding the feasibility and actionability of the proposed standards given the complex and overlapping domestic and international jurisdictions governing maritime vessels, particularly when vessels operate outside U.S. territorial waters. We also acknowledge concerns raised by AMA staff that the proposed language is overly prescriptive and extends beyond the AMA's appropriate role in establishing and enforcing maritime regulatory standards. While the resolution addresses an important public health concern, your Reference Committee does not believe that this additional policy would meaningfully expand existing AMA advocacy efforts. Your Reference Committee recommends that Resolution 420 not be adopted.

(57) RESOLUTION 421 - IMPROVING TOBACCO CARE
PROVISION IN BEHAVIORAL HEALTH SETTINGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 421 not be adopted.

RESOLVED, that our AMA 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.

1 VRC testimony was mixed, with a majority supporting the resolution's efforts to address
2 persistent disparities in tobacco cessation treatment within behavioral health settings.
3 Your Reference Committee recognizes the disproportionate burden of tobacco use
4 among individuals with behavioral health conditions and acknowledges the authors'
5 argument that accreditation requirements and reimbursement structures represent
6 potentially distinct barriers to integrating cessation services into behavioral health care.
7 However, we agree with testimony, including feedback from relevant specialty
8 stakeholders, that existing AMA policies H-490.916, H-490.917, H-490.913, H-490.911,
9 H-185.974, and H-345.983 broadly support tobacco dependence treatment across
10 clinical settings, smoke-free environments, and coverage for cessation services. Your
11 Reference Committee also raised concerns that conditioning accreditation on tobacco-
12 free facility policies could be overly prescriptive, potentially limiting individualized
13 treatment approaches and conflicting with harm reduction principles in certain behavioral
14 health settings. Regarding the second Resolved clause, we discussed whether
15 reimbursement disparities warrant more targeted advocacy but found insufficient
16 evidence establishing the specific inequities described or demonstrating that existing
17 policy cannot address them. Your Reference Committee considered adopting the
18 second Resolved clause independently and pursuing further study but ultimately
19 determined that its current language lacks sufficient clarity regarding the reimbursement
20 mechanisms and policy changes sought. While we recognize the importance of
21 improving tobacco cessation services in behavioral health settings, we do not believe the
22 proposed directives are sufficiently supported or distinct from existing policy to warrant
23 adoption. Therefore, your Reference Committee recommends that Resolution 421 not be
24 adopted.

25
26 (58) RESOLUTION 422 - INTEGRATED CARDIOMETABOLIC
27 AND MENTAL HEALTH CARE

28
29 RECOMMENDATION:

30
31 Your Reference Committee recommends that Resolution
32 422 not be adopted.

33
34 RESOLVED, That our AMA recognizes the bidirectional relationship between
35 cardiometabolic conditions and mental health conditions as an integrated public-health
36 issue; and be it further

37
38 RESOLVED, That our AMA supports research and evidence development on
39 cardiometabolic risk assessment, prevention, treatment, and care coordination for
40 people with serious mental illness, including communication and follow-up across mental
41 health, primary care, and cardiovascular care settings.

42
43 VRC testimony was largely in opposition. Your Reference Committee agrees with
44 concerns that the first and second resolved clauses may conflict in their asks, as well as
45 concerns that this is reaffirmation of H-425.994, H-440.866, H-345.983, and H-345.984.
46 Therefore, your Reference Committee recommends Resolution 422 not be adopted.

(59) RESOLUTION 502 - DATA CENTER TRANSPARENCY
AND HEALTH IMPACT MITIGATION

RECOMMENDATION:

Your Reference Committee recommends that Resolution
502 not be adopted.

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.

VRC testimony was mixed. Your Reference Committee agrees with supportive testimony highlighting the myriad of environmental and public infrastructural challenges posed by data center expansion in water- and electricity- stressed regions. While we recognize the potential novelty of the requirement that environmental reporting be freely accessible, opposing testimony compellingly identifies this resolution as broadly covered by existing policy addressing data center environmental reporting, healthcare infrastructure resilience, and environmental education: D-135.960, H-135.923, H-136.973. Additionally, the Council on Science and Public Health (CSAPH) is preparing a report for A-27 addressing this very issue. Therefore, your Reference Committee recommends that Resolution 502 not be adopted.

(60) RESOLUTION 507 - PROTECTING BIOMETRIC VOICE
DATA IN THE USE OF AI SCRIBES

RECOMMENDATION:

Your Reference Committee recommends that Resolution
507 not be adopted.

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

1 data minimization protocols, including the deletion or de-identification of raw audio files
2 following transcript verification and the implementation of safeguards to protect the
3 privacy of non-consenting bystanders.

4
5 VRC testimony was largely in opposition, with testifiers raising concerns regarding
6 substantial overlap with existing AMA policy. Your Reference Committee recognizes the
7 importance of protecting identifiable voice recordings and biometric data collected
8 through AI-enabled clinical documentation systems, particularly as these technologies
9 become increasingly integrated into clinical care. However, we agree with testimony that
10 existing AMA policies H-315.983, H-480.931, D-478.955, and H-480.940 broadly
11 address patient privacy, informed consent, data security, and appropriate oversight of
12 healthcare AI. Your Reference Committee specifically discussed whether the second
13 Resolved clause establishes a distinct policy gap regarding secondary use of voice data
14 for AI model training. While acknowledging the value of explicit authorization and data
15 minimization safeguards, we note that existing policy H-480.931 already addresses
16 disclosure of patient data use for ongoing AI model training, limiting the novelty of the
17 proposed directive. Furthermore, AMA advocacy staff indicated that the resolution
18 objectives are sufficiently supported by current policy. Although additional state and
19 federal advocacy opportunities remain, your Reference Committee believes these efforts
20 could be more effectively pursued through an MSS Action Item or Advocacy Referral
21 rather than establishing duplicative policy. Therefore, your Reference Committee
22 recommends that Resolution 507 not be adopted.

23
24 (61) GC REPORT B - ANNUAL SUNSET & CONSOLIDATION
25 REPORT

26
27 RECOMMENDATION:

28
29 Your Reference Committee recommends that the
30 recommendations in GC Report B not be adopted.

31
32 Your AMA-MSS Governing Council recommends that the following be adopted and the
33 remainder of the report by filed:

- 34
35 1. That the recommendations for retention, retention including amendments, and
36 consolidation actions specified in Appendix A and Appendix B of this report be
37 retained as official, active positions of the AMA-MSS or rescinded as indicated.
38
39 2. That the recommendations regarding MSS positions in Appendix A and Appendix B
40 of this report be adopted.
41
42 3. That our AMA-MSS amend 630.044MSS by addition and deletion as follows:

43
44 630.044MSS, "Sunset Mechanism for AMA-MSS Policy
45 AMA-MSS will establish and use a sunset review mechanism for AMA-MSS
46 positions with a ten-year time horizon whereby MSS positions that have not been
47 actively rescinded by the MSS Assembly are reviewed every ten years to
48 determine if they maintain relevance and considered for sunset, consolidation,
49 retention, or retention with amendments. The implementation of a sunset
50 mechanism for AMA-MSS policy shall follow the following procedures:

(1) review of positions will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial position recommendations being solicited from relevant Standing Committees as appropriate;

(2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset;

(3) position recommendations will be reported to the AMA-MSS Assembly at each Annual Meeting on the ten or nine and one-half year anniversary of a policy's adoption, with a brief rationale accompanying each recommendation;

(4) to gradually transition to the new timeline for sunset review, the 2025-2029 Sunset Reports only review policies last reaffirmed at the Annual Meeting five years prior (not the Interim Meeting 4.5 years prior), and then the 2030 Sunset Report will begin the new 10- and 9.5-year timeline, at which point this subclause will be automatically rescinded;

(5) a consent calendar format will be used by the Assembly in considering the positions encompassed within the report;

(6) the MSS Governing Council should recommend policies for consolidations of groups of related positions, whereby the report(s) are authored by the MSS Chair with recommendations solicited from relevant Standing Committees as appropriate;

(7) when MSS positions are reviewed via either the sunset or consolidation mechanisms, the result of any positions submitted to HOD and associated implementation actions will be reviewed and documented for archival purposes if not already characterized;

~~(8) in their report on the previous HOD's proceedings, the Section Delegates will recommend changes to any MSS positions that amend AMA Policy and were considered by HOD, in order to summarize the amendment's ask and simplify the language; and~~

~~(8) when an MSS position proposing an amendment to AMA policy has been considered by HOD, the Governing Council will consider whether the position should be summarized as a current MSS stance during sunset review; and~~

~~(9) any MSS positions written as "MSS will ask the AMA" will be automatically converted to past tense ("asked the AMA") after consideration by HOD as either a resolution or an amendment; and~~

~~(9) when an MSS position written as a request to the AMA is reviewed through the sunset mechanism, the Governing Council will consider whether its underlying position remains relevant and should be expressed as a current MSS stance; and~~

(10) any MSS position (or portion of a position) requesting an AMA or MSS study will automatically sunset after the study is completed by either the AMA or MSS or after consideration of the study request by HOD.

VRC testimony largely expressed significant concerns with both the specific decisions within the sunset report, as well as with the overall sunset review process. Some testifiers highlighted the absence of the major recommendations from the body of the report, which instead were consigned to a spreadsheet in the appendix, while others remarked on the organization of the spreadsheet itself, which made it difficult to understand the fate of individual policies. Still others pointed out inconsistencies in both the list of employable recommendation categories, as well as how they were applied in

the report. Concerns were also raised about the inconsistent adequacy of rationales for consequential decisions on amending, consolidating, or rescinding MSS positions, raising the question of whether approving sweeping changes to the MSS policy compendium through a consent calendar process is even appropriate.

Your Reference Committee additionally heard concerns regarding the overall sunset review process, noting that the process happens on a tight timeline for the Governing Council and Standing Committees. Your Reference Committee also acknowledges that the process was difficult for the Standing Committees as well, who were largely not made aware of the context for why the Sunset Report was referred, were not given a standardized process, received unclear instructions, and had no directions on standardized training for newer members.

In light of the aforementioned concerns with not only the substance of the report, but also the process behind its creation, your Reference Committee recognizes that a complete overhaul of the sunset review process would be the most appropriate recommendation. There was robust discussion on whether this would be best achieved through the adoption of an alternate resolution placing a pause on the sunset review process while calling for its study, or by recommending that this item not be adopted. Your Reference Committee ultimately chose the latter, as it would appropriately place the future direction of the process in the hands of the Assembly by allowing concerned members to author the exact justifications and parameters for a reimagination of the sunset process. For these reasons, your Reference Committee recommends that GC Report B not be adopted.

(62) GC REPORT C - MSS STUDY OF ASSEMBLY
REPRESENTATION

RECOMMENDATION:

Your Reference Committee recommends that the recommendations in GC Report C not be adopted.

Your MSS GC recommends that the following recommendations are adopted in lieu of Resolution 604-I-24 and the remainder of this report be filed:

1. That our AMA-MSS pursue revisions of AMA Bylaws to reflect the following amendments by addition and deletion to AMA MSS IOP 10.3.1.2:

Satellite Campuses. The AMA medical student members of an educational program (AMA Bylaw 1.1.1) that has more than one campus (a "satellite campus") may select one MSS Chapter Delegate and one Alternate MSS Chapter Delegate from each campus. A satellite campus is defined as an administrative campus separate from the central campus where a minimum of 20 members of the student body are assigned enrolled independently of the main campus for some portion of their instruction over a period of time not less than an 50% of the traditional 4 year medical school curriculum academic year. For students in combined or dual-degree programs (e.g., MD/PhD, MD/MPH, MD/JD), this calculation applies only to the traditional four-year medical education curriculum. MSS Chapter Delegates and

1 Alternate MSS Chapter Delegates credentialing under the satellite campus
2 provisions must, at the time of the meeting, reside at the campus they will represent.

- 3
4 2. That our AMA-MSS pursue revisions of AMA Bylaws to reflect the following
5 amendments by addition and deletion to AMA MSS IOP 7.3.3.1:

6
7 7.3.3.1 Representatives. The AMA medical student members of each educational
8 program as defined in Bylaw 1.1.1 may select one representative and one alternate
9 representative. An educational program as defined in Bylaw 1.1.1 that has a total
10 student population (excluding students at associated administrative satellite
11 campuses) greater than 999 799 may select one additional representative and one
12 additional alternate representative.

- 13
14 3. That our AMA-MSS ask the AMA to retain and expand existing funding opportunities
15 for MSS members, with enhanced support to chapters whose student population
16 allows for additional medical student delegates.

- 17
18 4. That our AMA-MSS establish standardized Campus Verification Process questions
19 to operationalize MSS IOPs 10.3.1.2 and 7.3.3.1, to be completed and certified by a
20 Dean or authorized institutional designee, to record institutional information including,
21 but not limited to campus structure, total enrollment, administrative enrollment status,
22 and curricular distribution.

- 23
24 5. That AMA-MSS staff responsible for credentialing maintain a centralized, accessible
25 database of verified campus structures and delegate configurations, and that any
26 elements of submitted verification forms requiring interpretive review be referred to
27 the MSS Governing Council for determination.

- 28
29 6. That the Campus Verification Process operate on a two-year re-verification cycle
30 requiring full resubmission of the Campus Verification Form to ensure continued
31 accuracy of campus designations under MSS Bylaw 10.3.1.2 and 7.3.3.1, or result in
32 inactive status of a campus chapter until verification is completed.

- 33
34 7. That campus chapters which become eligible for additional representation on the
35 basis of satellite campus status and/or sufficiently large enrolled student populations
36 be notified by AMA staff.

37
38 VRC testimony was mixed. Your Reference Committee appreciates the Governing
39 Council's continued efforts to address inconsistencies in Assembly representation and
40 recognizes the additional information and revisions incorporated since A-26. However,
41 compelling testimony and committee discussion identified several substantive concerns
42 that remain unresolved.

43
44 In particular, the report does not provide a comprehensive assessment of how the
45 proposed eligibility criteria and enrollment thresholds would affect representation across
46 individual campuses, institutions, and regions, including rural, geographically isolated,
47 and osteopathic medical schools. The proposed independent-enrollment and campus
48 residency requirements may inadvertently exclude legitimate regional campuses or
49 students participating in away rotations, while the rationale for the revised numerical
50 thresholds remains insufficiently substantiated.

1 Additionally, concerns persist regarding the feasibility of implementing a standardized
2 verification process across diverse medical school structures, the administrative burden
3 placed on institutions and chapters, and the potential consequences for students when
4 institutions fail to complete verification requirements. Your Reference Committee
5 believes these concerns warrant a more comprehensive evaluation of alternative
6 representation and delegate apportionment models rather than further modification of
7 the existing framework without sufficient supporting evidence.

8
9 Therefore, your Reference Committee recommends that GC Report C not be adopted.

10

RECOMMENDED FOR FILING

(63) GC REPORT A - MSS ACTION ITEM UPDATE REPORT

RECOMMENDATION:

Your Reference Committee recommends that GC Report A be filed.

GC Report A is an informational report.

VRC testimony was limited but in support. Your Reference Committee thanks the Governing Council for this report on MSSAIs and their current status. Your Reference Committee recommends GC Report A be filed.

(64) SCTF REPORT - MSS STANDING COMMITTEE
RESTRUCTURING: PROGRESS UPDATE

RECOMMENDATION:

Your Reference Committee recommends that the SCTF Report be filed.

The SCTF Report is an informational report.

VRC testimony was limited but supportive. We appreciated feedback positing additional questions for the Task Force to consider in their report, and we encourage authorship to do so. Your Reference Committee recommends that the SCTF Report be filed.

(65) IOPTF REPORT - PRELIMINARY REPORT OF THE I-26
INTERNAL OPERATING PROCEDURES TASK FORCE

RECOMMENDATION:

Your Reference Committee recommends that recommendations the IOPTF Report be filed.

The IOPTF Report is a preliminary and informational report. The finalized report with recommendations to amend the AMA-MSS Internal Operating Procedures will be presented at the A-27 Assembly meeting.

VRC testimony was limited but supportive of the Preliminary Report. Testifiers provided concerns that can be addressed in the Final Report. The Preliminary Report provides a transparent overview of the MSS's internal rules. Your Reference Committee recommends that the IOPTF Report be filed.