AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: (Assigned by HOD)
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Opposition to Mandatory Testosterone Testing for Active Duty Servicemembers

Referred to: Reference Committee (Assigned by HOD)

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

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

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

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

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

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

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

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

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

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

Whereas, implementing an annual, mandatory diagnostic screening program across an entire eligible population—rather than testing directly by individualized clinical indication—carries substantial cost and resource implications, including downstream confirmatory testing, specialty referral, and long-term monitoring, without established evidence that population-wide mandatory screening is cost-effective compared to indication-based testing; therefore be it

RESOLVED, that our American Medical Association oppose mandatory, non-indication-based federal hormone screening programs, including policies requiring annual testosterone testing and affirms that hormone testing should be guided by individualized clinical judgment and evidence-based medical indications, rather than imposed through categorical or population-based mandates (Directive to Take Action); and be it further

RESOLVED, that our AMA urge that proposals for federal testing of hormone levels (such as requiring annual testosterone testing of male active duty servicemembers aged 30 or older) should be evaluated for cost-effectiveness and resource stewardship, relative to indication-based clinical testing, including the downstream costs of confirmatory testing, specialty referral, and longitudinal monitoring, prior to implementation (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm policy H-260.963 and call for those principles to be applied to any federal hormone screening program, including the use of standardized, validated testosterone assays and clinician education on assay variability (Reaffirm HOD Policy).

Fiscal Note: (Assigned by HOD)

REFERENCES

1. “Hegseth announces new policy to test troops for low testosterone” at APnews.com, https://apnews.com/article/hegseth-pentagon-testosterone-testing-troops-47333bbf3af9e4cac432722332ff1383, 15 July 2026; accessed 7/18/26
2. AMA policy H-260.963: “Standardization of Testosterone Assays”
3. Qaseem A, Horwitch CA, Vijan S, Etxeandia-Ikobaltzeta I, Kansagara D; Clinical Guidelines Committee of the American College of Physicians; Forciea MA, Crandall C, Fitterman N, Hicks LA, Lin JS, Maroto M, McLean RM, Mustafa RA, Tufte J. Testosterone Treatment in Adult Men With Age-Related Low Testosterone: A Clinical Guideline From the American College of Physicians. *Ann Intern Med*. 2020 Jan 21;172(2):126-133. doi: 10.7326/M19-0882. Epub 2020 Jan 7. Erratum in: Ann Intern Med. 2023 Apr;176(4):584. doi: 10.7326/L23-0043. PMID: 31905405. https://pubmed.ncbi.nlm.nih.gov/31905405/
4. Dobs AS, Campbell KJ. An Individualized Approach to Managing Testosterone Therapy in the Primary Care Setting. *Int J Gen Med*. 2022 Oct 7;15:7719-7733. doi: 10.2147/IJGM.S364189. PMID: 36238539; PMCID: PMC9552794, at https://pubmed.ncbi.nlm.nih.gov/36238539/

RELEVANT AMA POLICY

Government Interference in Patient Counseling H-373.995

1. Our American Medical Association vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use their medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
    a. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
    b. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
    c. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
    d. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
    e. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
    f. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
    g. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Citation: Res. 201, A-11; Reaffirmed: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of: Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmed: A-19; Modified: Speakers Rep. 02, I-24

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our American Medical Association opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
    a. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
    b. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
    c. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
    d. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

Citation: Res. 523, A-06; Appended: Res. 706, A-13; Reaffirmed: Res. 250, A-22

Government Controlled Medicine H-165.916

Our AMA strongly reaffirms its unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care system to a government program with the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference.

Citation: Res. 141, I-93; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: A-97; Reaffirmed: I-00; Reaffirmed: A-02; Reaffirmed: I-07; Reaffirmed: A-09; Reaffirmed: I-09; Reaffirmed: CMS Rep. 01, A-19

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of our American Medical Association:

1. to strongly condemn any interference by the government or other third parties that causes a physician to compromise their medical judgment as to what information or treatment is in the best interest of the patient.
2. working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship.
3. to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications.
4. to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients

Citation: Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13; Reaffirmed: CEJA Rep. 05, A-23; Modified: Speakers Rep. 02, I-24

Standardization of Testosterone Assays H-260.963

Our AMA: (1) supports efforts to standardize testosterone assays; (2) will work with the appropriate laboratory associations to increase use of analytic accuracy in testosterone assays; and (3) will work with other medical associations to educate clinicians about the variability of testosterone analytical accuracy.

Citation: Res. 921, I-10; Reaffirmed: CSAPH Rep. 01, A-20

Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing D-270.983

1. Our American Medical Association will ask the FDA to review the available evidence and other data on testosterone and submit updated recommendations, if warranted, to the DEA, for its consideration of the scheduling of testosterone-containing drug products.
2. Our AMA supports policies to remove barriers that delay or impede patient access to prescribed testosterone.
3. Our AMA will continue to work alongside our partner organizations to promote advocacy and physician education on testosterone prescribing.

Citation: Res. 519, A-23; Modified: CSAPH Rep. 08, A-24

Male Breast Cancer H-55.977

Our AMA:

1. recognizes that breast cancer is a condition that affects males as well as females;
2. recognizes that men who carry a known BRCA mutation, have a strong family history of cancer (especially male breast cancer), have a personal history of breast cancer, or have an altered estrogen-testosterone ratio are at increased risk of developing male breast cancer;
3. supports the utilization of heightened surveillance methods when indicated, and consideration of genetic testing when appropriate, in men who are at increased risk of developing breast cancer;
4. supports physician and patient education about the risks, signs, and symptoms of male breast cancer, and genetic consultation for males at increased risk and for their family members; and
5. supports Medicare and insurance coverage for male breast cancer surveillance and diagnostic methods, including clinical breast examination, mammography, genetic consultation, and genetic testing, when indicated.

Citation: CSAPH Rep. 2, A-09; Reaffirmed: CSAPH Rep. 01, A-19