2025 Annual American Medical Association House of Delegates Meeting Summary

This is a brief summary of the 2025 annual AMA HOD meeting that ran from June 6th to June 11th, 2025, in Chicago. Approximately 80% of the 729 delegates attended the meeting. There was a lot of excitement and high energy overall, but with great security oversight.

This meeting is organized first into caucuses, which are made up of organ systems from subspecialty societies, and the other half of delegates are from state associations. ASE currently has two delegates (Dr Rahko and I), which allows us considerable latitude in leveraging the services of AMA on many topics that are of importance to us.

At the assembly, there is first the collection of resolutions that may be sent in by any delegate from either state associations or subspecialty societies for consideration. The reference committee's function is much like congressional hearings, where each resolution is presented by its advocate to a committee, and anybody who is attending the hearings can stand up and comment upon it. Controversial topics take a long period of discussion. These resolutions are then worked through by the reference committee and are recommended for adoption, non-adoption, or rewritten, revised, or consolidated with multiple resolutions. The reference committees also hear reports from various societies of the AMA, usually on topics that were reported at previous meetings.

The cardiovascular medicine caucus gives us an opportunity to directly meet delegates from ACC, other subspecialties such as SCAI, ASNC, HRS, SCCT, SCMR etc. This gives us a good cross-section of how other organizations are viewing these issues. There is also a subspecialties service (SSS) caucus, which encompasses all subspecialty societies that meet multiple times throughout the meetings, and they give you another cross-sectional flavor as to what other subspecialty societies are interested in and concerned about. Dr Rahko and I attend these meetings as delegates of the house, supported by Katherine Stark, who is the Director of Advocacy from ASE. Dr Rahko could not attend this meeting as he was feeling unwell.

There were a limited number of resolutions pertinent to the cardiology community broadly and to ASE in particular. There were many interesting and important resolutions that were discussed. I will provide a summary of the meeting below:

Dr Bobby Mukkamala, the new 180th President of AMA, who is an ENT surgeon and father of two, outlined the reasons why physicians fight on behalf of their patients and their profession. He discussed the privilege and responsibility that come with being a physician. He shared his recent diagnosis of a brain tumor for which he underwent surgery at the Mayo Clinic, which was able to remove 90% of his tumor. He is currently on an isocitrate dehydrogenase inhibitor to prevent regrowth. He called for Medicare physician payment reform, addressed ways to combat the increasingly dire physician shortage, as well as physician burnout, and addressed the scope of practice. This was a very personal

speech filled with passion, clarity, and empathy coming from a "tumor wisdom"- a space for reflections on everything from clinical empathy to spiritual humility.

This was followed by elections for the various positions to serve the AMA. Meeting of reference committees as follows:

- Reference Committee on Ethics & Bylaws, which covers the **AMA constitution, bylaws and medical ethics matters**
- Reference Committee A which covers **Medical Service**
- Reference Committee B, which covers **Legislation**
- Reference Committee C, which covers **Medical education**
- Reference Committee D, which covers **Public Health**
- Reference Committee E, which covers **Science and Technology**
- Reference Committee F, which covers **Finance**.
- Reference Committee G, which covers **Medical practice**

1. **Reference committee on Ethics and Bylaws:**

BOT report 18-Physician Assisted suicide: AMA has been urged to oppose (1) Civil or criminal legal action against physicians and health professionals who legally engage in physician-assisted suicide at a patient's request and with their informed consent. (2) Civil or criminal legal action against patients who engage or attempt to engage in physician-assisted suicide.

BOT report 26- There is general agreement within the medical profession that more needs to be done to reduce burnout and improve physician well-being. Because individual personal health information and biological data can provide valuable insights into physical and mental health, the collection and use of such data offer potential avenues to support the well-being of healthcare professionals, including the early identification of burnout and the development of evidence- based prevention strategies. The Internet of Things (IoT), which, in relation to health data, refers to a network of connected medical devices, such as wearable sensors that continuously capture various health metrics, including heart rate, blood pressure, sleep levels, and blood glucose levels, and transmit this information wirelessly in real time to a health care platform, has made it easier than ever to collect and monitor personal health information and has been promoted as a potential tool for combating physician burnout. Many physicians already use such wearable technologies as tools for self-monitoring and behavioral modification to promote well-being. However, while the collection and use of physicians' personal health information may help to identify and reduce burnout, doing so also poses serious concerns regarding efficacy, privacy, ethical data collection, and accountability.

CEJA report 02: Supporting efforts to strengthen medical staff through collective action and/or unionization. Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and wellbeing. Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and wellbeing, and/or institutional culture that negatively affect patient care. Physicians should refrain from collective action that could jeopardize the health of patients or compromise patient care. This is referred for adoption.

2. **Reference committee F:**

BOT report 24 deals with the Creation of an AMA Council with a Focus on Digital Health Technologies and AI. While the AMA has internal staff focused on supporting physicians with optimizing existing technology and preparing for the future of health care technology, the AMA currently does not have an advisory body that is dedicated to guiding the success of technology adoption. With the volume of resolutions around the topic of technology over the last few years, the HOD called for the creation of a task force focused on digital health technologies, AI, and clinical informatics.

3. **Reference Committee G:**

Resolution 708 which advocated against prior authorization for in-person visits with physician was adopted.

Resolution 714 recommends a study into the root cause analysis of the causes of the decline of private medical practices. The delegates urged AMA to study and report back on the root cause of the decline in private practice, to include consideration of at least the following factors: 1. The declining inflation-adjusted Medicare rates 2. Stark laws, which allow hospitals, but not private physicians, to self-refer 3. The development of insurance plans that have no out-of-network benefits 4. The permitted consolidation of insurers and hospitals 5. Hospital-insurer agreements with minimal in-network 21 fee requirement and other conditions, such as the requirement for high hospital technical fees 6. Increased government influence by insurers and hospitals, and decreased influence by doctors 7. Inadequate formal education on the business of medicine 8. Educational debt of early career physicians 9. Evolving lifestyle preferences of early career physicians. 10. Overhead costs such as HER, personnel, and administrative costs. 11. Provider- based facility fees are charged by hospital employers but not by private practitioners.

4. **Reference committee G**:

BOT report 6 deals with Transparency and Accountability of Hospitals and Hospital Systems. This report highlighted persistent barriers that prevent physicians from reporting patient care concerns or seeking recourse when subjected to a bad-faith peer review process. It identified interests that often prompt the initiation of bad-faith peer reviews, including retaliation for raising patient care concerns, efforts to limit competition, and racism. The report also outlined existing mechanisms for physicians to report concerns about their health system or hospital employer, as well as relevant AMA policies and resources. It recommended reaffirming these policies and urged the AMA to (1) support and facilitate transparent reporting of final physician complaints against hospitals through publicly accessible channels (e.g., the Joint Commission Quality Check reports), and (2) develop educational materials to help physicians recognize a bad-faith peer review and navigate the peer review process.

5. **Reference committee C:**

Resolution 301 deals with examining ABMS processes for new board recommendations. ACC section council spoke to an alternate resolution 301 be adopted in lieu of Resolution 301 to read as follows: Asked AMA to study and define principles for recognizing board certifying bodies which offer appropriate assessment of physician competence in balance with patient safety and promoting professional self-regulation, with report back to the HOD at annual 2026. This was supported by the Council of Medical Education and others.

Resolution 701 deals with Electronic Health Records Contract Termination. AMA has asked EHR vendors to provide physician practices with a minimum 180-day notification of contract termination without cause, and also that AMA petition the CMS and the Office of the National Coordinator for Health Information Technology (ONC) to mandate that EHR vendors provide a minimum 180-day notification of contract termination without cause to physician practices.

There was an **emergency resolution 1001 that was in response to the action of the Secretary of HHS in abolishing the vaccine advisory committee to the CDC. This advocates for the following: Advisory Committee on Immunization Practices (ACIP) is a public body; and a federal advisory committee that develops evidence-based recommendations on the use of vaccines in the civilian population in the United States; and the Centers for Disease Control and Prevention sets the U.S. adult and childhood immunization schedule based on recommendations of ACIP; and vaccines recommended by the CDC must be covered under preventive services mandate of the Affordable Care Act (ACA); and, ACIP is comprised of medical experts from several fields of medicine as well as public members; and ACIP decisions are evidenced-based and informed by input from stakeholders and subject matter experts; and conflicts of interest are always declared and open for review; and the most recent decision by Secretary Kennedy to fundamentally alter the structure and membership of ACIP is without appropriate due process or rationale whereas, vaccines have been proven to dramatically reduce hospitalization and death; and the public must have confidence in the science and process of vaccine recommendations; and it is imperative for recommendations to be made without political interference.

6. Reference committee B

Resolution 201 deals with the Inclusion of DICOM Imaging in Federal Interoperability Standards. AMA has been asked to support the addition of DICOM imaging to federal interoperability standards, namely the United States Core Data for Interoperability (USCDI), to promote sandardized, interoperable image sharing across healthcare systems and advocate for policies and regulations requiring EHR and imaging archive system vendors to support the secure, efficient, and interoperable exchange of DICOM imaging data between healthcare entities (and regulations requiring EHR and imaging archive system vendors to support the secure, efficient, and interoperable exchange of DICOM imaging data between healthcare entities.

Resolution 233 deals with increasing the transparency of the AMA Medicare payment reform strategy. This specifically asked AMA to provide a summary of findings and actionable recommendations from both internal and external advocacy consultants regarding Medicare payment reform. This report is to focus on barriers identified, gaps in the current strategy, and specific recommendations for improving and accelerating advocacy efforts, and share the reports at both Interim and Annual Meetings, and more frequently as legislative dynamics dictate.

Resolution 238 was about preserving accreditation standards on Diversity, Equity, and Inclusion, which had significant testimony and was recommended for adoption.

Resolution 230 deals with expanding the advocacy of private insurance coverage of anti-obesity medications. There was a lot of testimony regarding this.

7. **Reference Committee A**

Resolution 120 discussed Medigap, preexisting conditions, and Medicare coverage education to cover both Medicare Advantage and Medicare fee-for-service coverage, and for the elimination of Medigap insurers' ability to deny coverage.

Resolution 121 opposed the pharmacy benefit manager's spread pricing.

CMS report 2 urges reconsideration of AMA policy on the Affordable Care Act eligibility firewall. There was a lot of testimony in favor of this.

CMS report 6 is to do with prescription medication price negotiation. It urges AMA to support efforts to ensure that patients have affordable access to medications, encourage all payers, both public and private, in efforts to establish a reasonable and affordable cap on patient out-of-pocket prescription drug spending in a manner that does not increase patient premiums which supports efforts to ensure drug prices are affordable to patients and increase PBM transparency and regulation.

8. **Reference committee E**

Council on Science and Public Health Report 5 is about screening for Image Manipulation in Research Publications. AMA supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs; supports the promotion, through AMA publications and other vehicles, of a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, encourages multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior and support the promotion of discussions on the peer review process and the role of the physician investigator. AMA supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proven guilty of scientific misconduct. AMA supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals. AMA will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms. AMA supports policies requiring authors to disclose the use of generative artificial/augmented intelligence programs to best allow content to be reviewed for intentional and unintentional scientific misrepresentation. AMA supports efforts to disseminate accurate and valid research findings and to combat research and publication fraud in the face of rapidly advancing technology. This was recommended for adoption.

Resolution 519 is about the framework to convey evidence-based medicine in AI tools used in clinical decision-making. This resolution asks AMA to collaborate with stakeholders, including physicians, academic institutions, and industry leaders, to create a report with recommendations for how AI tools used in clinical decision support convey transparency in the quality of medical evidence and the grading of medical evidence to physicians and advanced care practitioners so clinical recommendations can be accurately verified and validated.

CSAPH report 8 discussed the explainability of Artificial/Augmented Intelligence and Machine Learning Algorithms to maximize the impact and trustworthiness. Claims that an algorithm is explainable should be adjudicated only by independent third parties, such as regulatory agencies or appropriate specialty societies, rather than by declaration from its developer. Explainability should not be used as a substitute for other means of establishing the safety and efficacy of AI tools, such as through randomized clinical trials.

Resolution 510 deals with improving cybersecurity standards for healthcare facilities. It recommends that AMA support the establishment of minimum cybersecurity standards, including, but not limited to, the use of multi-factor authentication, timely updates, and encryption for HIPAA- covered entities, designed to support a risk-based approach with security-by-design principles that are subject to periodic review and updating.

Conclusion

In summary, there was a huge volume of resolutions presented, but the vast majority of them did not have a direct impact on ASE, cardiovascular disease, or medical imaging. However, resolutions CSAPH report 8 and resolution 519 deal with AI in medicine and will be important to us. Resolution 301 deals with asking for a study from the BOT regarding the denial of the new ABCVM board by ABMS. We will be following these resolutions intently at the interim AMA 2025 meeting as well as the annual 2026 meeting and will provide updates accordingly.

Again, it was our pleasure to serve ASE by attending the annual AMA 2025 meeting. Not only do we have the ability to interact on issues directly, but it is also vital to maintain our delegate status so that society can maintain all the advantages, particularly at the RUC committee, where we can have direct access and not have to go through associations such as ACC. We also want to particularly acknowledge Katherine Stark, who has made multiple important contacts with AMA personnel and other subspecialty societies that are invaluable to ASE. She is very knowledgeable about policy and is well-respected.

Please feel free to contact us if you have questions or need additional information. Katherine Stark has all of the details if you so desire to explore any of these substantial reports or resolutions.

Sincerely,
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