

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**61st INTERIM MEETING****Honolulu, Hawaii****November 10–13, 2007****CALL TO ORDER AND MISCELLANEOUS BUSINESS**

CALL TO ORDER: The House of Delegates convened its 61st Interim Meeting at 3:00 p.m. on Saturday, November 10, in the Kalakaua Ballroom of the Hawaii Convention Center, Honolulu, Jeremy A. Lazarus, MD, Speaker of the House of Delegates, presiding. The Sunday session, November 11, Monday session, November 12, and Tuesday session, November 13, also convened in the Kalakaua Ballroom.

INVOCATION: The invocation was delivered on Saturday, November 10 by Kalani Brady, MD, an AMA member and native Hawaiian who spoke in that tongue.

DISTINGUISHED SERVICE AWARD: Richard Allen, MD, was presented with the AMA Distinguished Service Award for his efforts on behalf of the profession. Dr. Allen has been president of the Oregon Medical Association and the Colorado Medical Society and has served as a delegate for both the Oregon Medical Association and the American College of Obstetricians and Gynecologists. He was a member of the AMA Council on Medical Education from 1995–2004, serving as chair 2000–2001. Dr. Allen has distinguished himself in regard to graduate and post-graduate medical education and has been instrumental in working to improve medical education. Dr. Allen's name is synonymous with high quality, practical medical education and continuing medical education. He has taught obstetrics and gynecology since 1969 and is recognized by peers and students alike as an excellent instructor.

DR. WILLIAM BEAUMONT AWARD IN MEDICINE: Kristin Melissa Bell, MD, was awarded the William Beaumont Award in Medicine in recognition of her work at the San Diego VA Medical Center, where she serves as a staff physician specializing in pain management. Her work, which includes developing an innovative acupuncture clinic designed to treat veterans with chronic pain, has earned her recognition from patients and colleagues alike. Dr. Bell is also an assistant clinical professor of medicine at the University of California at San Diego School of Medicine. In 2005 she developed and implemented a new behavioral medicine curriculum for third-year medical students, which involves interactive learning in a small group environment.

MEDICAL EXECUTIVE LIFETIME ACHIEVEMENT AWARD: Medical Executive Lifetime Achievement Awards were presented to William T. Applegate, Richard King and Robert Seehusen. Mr. Applegate has dedicated his career to the medical profession. He has been with the Kentucky Medical Association for 39 years, serving as the executive vice president for the last 11. He is regarded by his colleagues as a hardworking, trustworthy and effective leader, and the physicians of Kentucky have the highest regard and esteem for him.

Mr. King concluded his career with the Indiana State Medical Association in 2005, leaving a legacy of leadership and advocacy on behalf of the medical profession. His work there affected not only the professional lives of Indiana's physicians but also the health and well-being of the citizens of Indiana.

Mr. Seehusen is the chief executive officer of the Idaho Medical Association where he has sought to ensure quality patient care and good representation for physicians, despite the challenges of working in a state with a few population centers spread across a large geographic area. Under his leadership, the Idaho Medical Association has successfully dealt with issues such as scope of practice and Medicaid reimbursement.

MEDICAL EXECUTIVE MERITORIOUS ACHIEVEMENT AWARD: Two people were named recipients of the Medical Executive Meritorious Achievement Award. The first was Arthur Ellenberger who has worked in organized medicine since 1952 when he became the first executive director of the Essex County Medical Society; ten years later he was named the first executive director of the New Jersey Chapter of the American College of Surgeons. He still holds both positions. His leadership and commitment to New Jersey physicians have made him a legend in his home state.

The second was Scott Hunt, executive director of The Endocrine Society since 1988. In that time, the organization has grown from a purely academic society into one representing the needs and interests of practicing physicians,

clinical scientists and academicians, and it is routinely cited for excellence. Mr. Hunt is a frequent speaker and consultant to other professional societies on association management issues.

AMA FOUNDATION AWARD FOR HEALTH EDUCATION: Dileep Bal, MD, was recognized with the 2007 AMA Foundation Award for Health Education for his longtime efforts to educate people around the world on the harms caused by tobacco as well as his public health leadership. His contributions are numerous, and he has served as national president of the American Cancer Society and co-chair of the 2006 World Conference on Tobacco OR Health. He has also been the principal investigator on major cancer prevention and control projects for the National Cancer Institute and Centers for Disease Control and Prevention. Dr. Bal's many articles on cancer prevention and control and on tobacco use have helped train public health officials internationally to prevent and control tobacco use.

ISAAC HAYS, MD, AND JOHN BELL, MD, AWARD FOR LEADERSHIP IN MEDICAL ETHICS AND PROFESSIONALISM: Paul Stuart Appelbaum, MD, was awarded the Hays-Bell Award for Leadership in Medical Ethics in recognition of his unquestioned dedication to the principles of medical ethics and his thoughtful and articulate advocacy on behalf of patients and the medical profession. Dr. Appelbaum is a board-certified, practicing psychiatrist and a former president of the American Psychiatric Association who began working in the field of medical ethics as a resident. In the years since he has helped to define the ethical parameters of medical practice, and over his career he has made major contributions to the practice of informed consent and the assessment of decisional capacity, as well as to the ethics of general and forensic psychiatry.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Louis Kraus, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, November 10, 492 out of 555 delegates (88.6%) had been accredited, thus constituting a quorum; on Sunday, November 11, 507 (91.2%) were present; on Monday, November 12, 518 (93.3%) were present; and on Tuesday, November 13, 519 (93.5%) were present.

RULES REPORT, Saturday, November 10

HOUSE ACTION: ADOPTED

1. House Security

Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly badged will be permitted to attend.

2. Credentials

The registration record of the Committee on Rules and Credentials shall constitute the official roll call at each meeting of the House.

3. Order of Business

The order of business as published in the Handbook shall be the official order of business for all sessions of the House of Delegates. This may be varied by the Speaker if, in his judgment, it will expedite the business of the House, subject to any objection sustained by the House.

4. Privilege of the Floor

The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.

5. Procedures of the House of Delegates

The June 2005 edition of the "Procedures of the House of Delegates" shall be the official method of procedure in handling and conducting the business before the AMA House of Delegates.

6. Limitation on Debate

There will be a 3-minute limitation on debate per presentation subject to the Speaker, who may waive the rule for just cause.

7. Conflict of Interest

Members of the House of Delegates who have a substantial financial interest in a commercial enterprise, which interest will be materially affected by a matter before the House of Delegates, must publicly disclose that interest before testifying at a reference committee on the matter or speaking on the floor of the House of Delegates on the matter.

8. Conduct of Business by the House of Delegates

Each member of the House of Delegates, and the AMA Officers and Board of Trustees resolutely affirm a commitment to be courteous, respectful and collegial in the conduct of House of Delegate actions, characteristics which should exemplify the members of our respected and learned profession.

SUPPLEMENTARY REPORT, Sunday, November 11

HOUSE ACTION: LATE RESOLUTION 1001 (611) ACCEPTED

EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 702, 703, 706, 708, 712, 720, 803, 807, 810, 812, 901, 908, 910, 916 AND 918

RESOLUTIONS 709, 714, 715, 808, 816, 905, 911 AND 912 EXTRACTED AND REFERRED TO APPROPRIATE REFERENCE COMMITTEES

The Committee on Rules and Credentials met Saturday, November 10, 2007 to discuss Late Resolution 1001. Sponsors of Late Resolutions are informed of the time the Committee on Rules and Credentials meets to consider Late Resolutions, 8:30 a.m. on Saturday, and the opportunity to present for the Committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting. Sponsors of Late Resolution 1001 appeared to discuss their resolution.

LATE RESOLUTION

Recommended for Acceptance

1. Late Resolution 1001 - Appreciation by Nevada Physicians of the American Medical Association Support in Opposition to UnitedHealth Group Merger Proposal
Submitted by Nevada Delegation

REAFFIRMATION RESOLUTIONS

The Speakers asked the Committee on Rules and Credentials to review the recommendations for placing resolutions introduced at this meeting of the House of Delegates on the Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed remain active policies within the AMA policy database and therefore are part of the body of policy that can be used in setting the AMA's agenda. It also resets the "sunset clock," so such policies will remain viable for 10 years from the date of reaffirmation. The Committee recommends that current policy be reaffirmed in lieu of the following resolutions (current policy and AMA activities are listed in the Appendix to this report):

1. Resolution 702 - Support for Increased Regulation in Tissue Procurement
2. Resolution 703 - Encouragement of Medicaid Funding for 17P Progesterone for High Risk Pregnancies
3. Resolution 706 - Medicare Reimbursement
4. Resolution 708 - Health Care Disparity and the Patient-Physician Relationship
5. Resolution 712 - Delayed Implementation of Ambulatory Surgery Center Payment Rate
6. Resolution 720 - Access to Quality Health Care
7. Resolution 803 - Childhood Obesity
8. Resolution 807 - Same Day Procedures
9. Resolution 810 - CO₂ Emissions
10. Resolution 812 - Antibiotic Drug Resistance
11. Resolution 901 - Medical Student Loan Repayment
12. Resolution 908 - Revision of Medicare Funding and Approval of Graduate Medical Education Slots
13. Resolution 910 - Healthcare Integrity and Protection Data Bank
14. Resolution 916 - State Children's Health Insurance Program (SCHIP)
15. Resolution 918 - Prohibition of the Use of FDA-Approved Drugs and Medical Devices Off-Label

APPENDIX - POLICIES REAFFIRMED AND RELEVANT CURRENT ACTIVITIES

1. Resolution 702 - Support for Increased Regulation in Tissue Procurement
 - D-370.995 Anatomical Gifts
 - D-140.986 Use of Anatomical Gifts in Medical Research and Education
 - H-370.988 Regulation of Tissue Banking
2. Resolution 703 - Encouragement of Medicaid Funding for 17P Progesterone for High Risk Pregnancies
 - H-290.993 Coverage of Drugs by Medicaid
 - H-420.972 Prenatal Services to Prevent Low Birthweight Infants
 - H-425.976 Preconception Care
3. Resolution 706 - Medicare Reimbursement
 - H-400.952 Consolidation of Medicare Fee Schedule Areas
 - H-400.972 Physician Payment Reform
 - H-390.945 Legal Action to Resolve Medicare Reimbursement Disparities
 - D-400.989 Equal Pay for Equal Work
 - D-390.987 Medicare Payment For Critical Care Services
 - H-400.988 Medicare Reimbursement, Geographical Differences
4. Resolution 708 - Health Care Disparity and the Patient-Physician Relationship
 - H-165.846 Adequacy of Health Insurance Coverage Options
 - H-180.961 Defining Levels of Health Insurance Coverage
 - H-165.847 Comprehensive Health System Reform
 - H-330.898 Long-Term Funding of Medicare
 - H-165.855 Medical Care for Patients with Low Incomes
 - H-180.973 The "Hassle Factor"
 - H-165.888 Evaluating Health System Reform Proposals
 - H-240.966 Reimbursement to Physicians and Hospitals for Government Mandated Services
5. Resolution 712 - Delayed Implementation of Ambulatory Surgery Center Payment Rate
 - H-240.993 Discontinuance of Federal Funding for Ambulatory Care Centers
 - H-185.960 Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans
 - H-70.991 Coding and Payment for Patient Management in Ambulatory Settings and Skilled Nursing Facilities
 - H-425.992 Coverage of Preventive Medical Services by Medicare
 - September 14, 2007 AMA comment letter re: Medicare Program: Proposed Changes to the Ambulatory Surgical Center Payment System and CY 2008 Payment Rates, "The payment rates in the final rule will be published as part of the 2008 OPPS/ASC final rule later this year. We are pleased that the final rule will create a four-year transition period for implementing the revised rates. Four years, as opposed to the initially proposed two-year transition period will provide ASCs with more adequate time to adjust to the new program."

6. Resolution 720 - Access to Quality Health Care
 - H-165.847 Comprehensive Health System Reform
 - H-165.904 Universal Health Coverage
 - D-165.953 Crisis Commission on the State of Health Care in America
7. Resolution 803 - Childhood Obesity
 - H-170.984 Healthy Living Behaviors
 - H-170.999 Health Instruction and Physical Education in Schools
 - D-60.990 Exercise and Healthy Eating for Children
 - D-440.971 Recommendations for Physician & Community Collaboration on the Management of Obesity
 - The AMA Division of Medicine and Public Health is actively engaged in ongoing efforts to address childhood obesity. Most recently the AMA along with the Centers for Disease Control and Prevention and the Maternal and Child Health Bureau funded an Expert Committee to update national recommendations for the assessment, prevention, and treatment of child and adolescent overweight and obesity. The Committee consisted of 15 national organizations who were key stakeholders in pediatric obesity. They released their recommendations in early 2007 (attached). An overview paper along with the papers containing the review of the scientific literature will be published in a supplement to Pediatrics in December, 2007.
8. Resolution 807 - Same Day Procedures
 - D-70.982 Fair Payment for Separate Services
 - D-400.999 Non- Medicare Use of the RBRVS
 - H-385.944 Insurance Company Denial of Payment for Office Visit and Invasive Procedure Done on the Same Day
 - D-70.974 Reimbursement for Evaluation and Management Visit Performed on the Same Day as a Preventive Visit
 - H-70.962 Changes in the Bundling of Medical Services by Managed Care Plans
9. Resolution 810 - CO₂ Emissions
 - H-135.949 Support of Clean Air and Power Plant Emissions Act
 - H-135.984 Federal Clean Air Legislation
 - H-135.999 Federal Programs
 - H-135.979 Clean Air
 - In addition, the AMA Council on Science and Public Health is preparing a report for the 2008 Annual Meeting in response to referred Resolution 409 (A-07) which will address the issues raised in Resolution 810.
10. Resolution 812 - Antibiotic Drug Resistance
 - H-100.973 Combating Antimicrobial Resistance through Education
 - D-100.998 Combating Antibiotic Resistance Via Physician Action and Education: AMA Activities
 - D-100.995 Antimicrobial Use and Resistance
11. Resolution 901 – Medical Student Loan Repayment
 - H-305.928 Proposed Revisions to AMA Policy on Medical Student Debt
12. Resolution 908 – Revision of Medicare Funding and Approval of Graduate Medical Education Slots
 - D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education
 - D-310.971 The Residency Physician Shortage Reduction Act of 2007
 - H-305.935 Policy Options for Support of Graduate Medical Education
 - H-305.929 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs
 - H-200.955 Revisions to AMA Policy on the Physician Workforce
 - D-305.973 Proposed Revisions to AMA Policy on the Financing of Medical Education Programs
 - D-200.991 The Physician Workforce: Recommendations for Policy Implementation
 - AMA/medical specialty society sign-on letter to Acting Administrator Leslie Norwalk urging the Centers for Medicare and Medicaid Services to rescind a May 2007 proposed rule that seeks to

eliminate federal financial participation matching funds associated with Medicaid graduate medical education payments, June 22, 2007.

- AMA letter to Representatives Castor, Porter and Meek supporting H.R. 1093, the “Resident Physician Shortage Reduction Act of 2007,” to expand the number of Medicare-supported physician residency training positions in states with a shortage of residents, March 8, 2007.
- AMA letter to Senate Majority Leader Reid and Senator Nelson supporting S. 588, the “Resident Physician Shortage Reduction Act of 2007,” to expand the number of Medicare-supported physician residency training positions in states with a shortage of residents, February 23, 2007.

13. Resolution 910 – Healthcare Integrity and Protection Data Bank

- H-175.976 Physician Protections in Fraud Data Bank Program
- H-175.982 Due Process for Physicians

14. Resolution 916 – State Children’s Health Insurance Program (SCHIP)

- H-165.888 Evaluating Health System Reform Proposals
- H-165.985 Opposition to Nationalized Health Care
- H-165.916 Government Controlled Medicine

15. Resolution 918 – Prohibition of the Use of FDA-Approved Drugs and Medical Devices Off-Label

- H-120.988 Patient Access to Treatments Prescribed by Their Physicians
- H-100.980 Food and Drug Administration
- H-100.992 FDA
- AMA letter to Senator Kennedy and Representatives Dingell, Barton, and Deal expressing the AMA’s opposition to certain provisions of H.R. 2900, “Food and Drug Administration Amendments of 2007,” including those that would significantly expand the FDA’s authority to restrict use and distribution of drugs without establishing a meaningful standard to evaluate whether such restrictions are warranted, July 23, 2007.
- AMA letter to House Energy and Commerce Health Subcommittee Chairman Pallone expressing concern about expanding FDA authority prohibiting off-label prescribing, June 14, 2007.

SUPPLEMENTARY REPORT, Monday, November 12

HOUSE ACTION: LATE RESOLUTION 1002 NOT ACCEPTED

The Committee on Rules and Credentials met Monday November 12, 2007, to discuss Late Resolution 1002. The sponsor appeared before the Committee to explain why the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

LATE RESOLUTION

Recommended for Acceptance

1. Late Resolution 1002 - AMA Model Agreements with Advanced Practice Nurses
Submitted by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations

CLOSING REPORT, Tuesday, November 13

HOUSE ACTION: ADOPTED

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Lazarus, and the Vice Speaker, Doctor Gurman, for the outstanding manner in which they have assisted our deliberations by their fair and impartial conduct of the House of Delegates and to commend the members of the House for their cooperation in expediting the business before us.

Your Committee wishes at this time to offer the following Resolution:

Whereas, The Interim Meeting of the House of Delegates of the American Medical Association has been convened in Honolulu, Hawaii, during the period of November 10–13, 2007; and

Whereas, This Interim Meeting of the House of Delegates has been most profitable and enjoyable from the viewpoint of policy deliberations and fellowship; and

Whereas, The City of Honolulu has extended to the members attending this meeting the utmost hospitality and friendliness; therefore be it

RESOLVED, That expressions of deep appreciation be made to the AMA Board of Trustees for arranging this meeting, to the management of the Hilton Hawaiian Village and the Hawaii Convention Center, to the City of Honolulu, to the members of the Alliance who always contribute so substantially to our meetings, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Interim Meeting of the House of Delegates.

APPROVAL OF MINUTES: The Proceedings of the 156th Annual Meeting of the House of Delegates, held in Chicago, Illinois, June 23–27, 2007, were approved.

REMARKS OF THE EXECUTIVE VICE PRESIDENT: The following remarks were presented by Michael D. Maves, MD, MBA, Executive Vice President of the American Medical Association, on Saturday, November 10:

Good afternoon and welcome to Hawaii. Before we begin I would like to take this opportunity to introduce two important new members of the AMA senior management team: First I would like to introduce Ms. Marietta Parenti, our new Senior Vice President and Chief Marketing Officer. Marietta brings an extensive portfolio of experience in marketing, ranging not only from productive time in the agency world, but also a resume of increasing responsibility at a variety of corporations, capped by her tenure as the Chief Marketing officer of the Rehabilitation Institute of Chicago. Second, Ms. Colleen Lawler has been named our new Vice President for Membership. She comes to us following a distinguished career at the American Academy of Family Physicians where she headed their membership department. I know you will join me in welcoming them to the American Medical Association and helping them in their first time at the House of Delegates.

Recently, the Board of Trustees asked me to review and elaborate on my vision for the American Medical Association. I, along with the senior management team took some time this summer and put together our vision for the AMA. This presentation is meant to challenge and push all of us to think critically about where we are and where we would like and need to go. The Board received this in September, and I shared portions of this template with state and specialty executives. Now I want to challenge you to reflect on our effort and the implications this might have for all of us in the future.

Let's go back to my beginning. Six years ago, I stood before the House of Delegates and described a very straightforward vision for the association: an AMA responsible for its actions; an AMA with sufficient resources; an AMA physicians want to join; and an AMA as the voice of medicine.

Now we could stop right here and simply say the more things change, the more they stay the same, because this vision still applies. But, things have changed and what I'd like to do today is talk through with you how our experience over the last six years, along with lots of change in the environment in which we live and work influences how we pursue this vision.

The time line chronicles the efforts and significant milestones in the evolution of the AMA from 2001 to the present time. Six months after my initial presentation of the vision, we began the year-long "Organization of Organizations" process. Following this project, we re-engaged McKinsey & Company to do an in-depth, systematic review of membership and business processes that occupied the next 18 months.

In January 2005, my executive team made up of new and existing members of senior management was complete. This team included Bernie Hengesbaugh, Gary Epstein, Dr. Modena Wilson, Rich Deem, Jon Ekdahl, Dr. Cathy DeAngelis, Bob Musacchio, Denise Hagerty and Maria Maher. For the past three years, we have been focused on

the execution of the McKinsey recommendations through the three pillars of advocacy, involvement and communication: brand and streamline the AMA agenda; seek involvement of members; enhance member benefits; and upgrade relationships with state and specialty societies.

So where does this bring us today? With regard to the first element of my vision, we have embraced the responsibility that comes with our position in the public. My personal commitment to continued vigilance is as strong as ever. Your Board and staff have engaged in continuing development activities, such as participation in a program at Northwestern University's Kellogg School of Management that focused on critical elements of corporate responsibility. Our high standards for medical ethics and professionalism provide us with the code we need to follow.

Second, our strategic, disciplined management of the business operations has led to a period of unprecedented growth in profitability and reserves. This secure financial base allows us the flexibility to pursue public policy initiatives and other programs. However, our robust financial health has also drawn criticism from some in organized medicine accusing us of becoming "fat cats" and losing our focus on rank and file physicians. Nothing could be further from the truth. In fact, our financial success will allow the AMA to engage in significant public policy initiatives such as the for the Voice for the Uninsured Campaign that you will hear about from Dr. Peter Carmel in Reference Committee F tomorrow and other activities.

But, let's be clear that our AMA's continued financial stability depends on the sustained performance of both our business services and membership acquisition and retention. The annual operating cost of AMA as an association, including advocacy, professional standards, and governance support is about \$130 million, while funds from membership account for \$37 million, business operations \$112 million and investment income \$11 million.

We need to ensure the sustainability of both membership and business operations, for the association would not exist without either. Therefore, we need to not only continue to explore new business opportunities, but also manage our resources effectively. And we also need to solve our membership challenge which brings me to my next element.

The continuing decline in our membership challenges us to critically assess our membership offerings and literally redefine our membership value proposition. You may be surprised to learn that most physicians have been a member of the AMA at one time or another. That's the good news. The bad news is that it's well known in business that it's more difficult to re-attract former customers than it is to win new customers and the 30 plus year decline in our membership rolls bears this out.

Now, we have made some progress. In my first year with the association we lost 17,000 members and by April 2005, with an aggressive marketing effort, we had more or less stabilized our membership. But what we're doing now is simply "managing the decline" which is not a strategy I want to continue and I don't think you do either. I've recently been visiting some state society executives to discuss our mutual challenges. This has been one of the best activities I've undertaken in my tenure and it's also given me much to think about. I asked one executive about why his society didn't participate in the recent examination of the Partnership for Growth Membership Task Force. His reply was, "We saw that all you were going to deal with was invoices, mailings and collections. These are small ideas and we don't deal with small membership ideas and you shouldn't either". Our value proposition needs to bring us members who stay members.

So I have asked our staff to think differently about membership and to undertake a reassessment of our membership value proposition considering fundamental questions like: What are the real benefits of membership? What could they be? And then, armed with that market-driven information, I have asked them to generate big ideas that address physician needs today and well into the future.

Our challenges of membership acquisition and retention have also put us at a crossroads in our ability to be effective as the voice of medicine. There are at least three components we need to examine: 1) voice of whom? 2) voice with whom? and 3) voice for what?

We claim to represent all physicians, some 800,000 in practice today, but we can count only a fraction of those doctors as members. I don't think we do as good of a job of as we could communicating to our members and I'm sure we don't reach many of the US practicing physicians. On the other hand I have physicians who are not members, but feel they get great value from our business products and services. In our membership model, how do we account for these doctors?

Does our decision-making process and governance processes help or hurt our efforts? I think this is a question we need to seriously address. Our governance must focus on the big issues that are of greatest concern to physicians. We touched on this in the “org of org” process, but we really never got to the heart of the matter. Our membership and House of Delegates must reflect the demographics of physicians in practice. Something needs to be done. Again, in my meetings with state society execs they say they are having increasing trouble attracting community physicians into active membership and leadership roles. And without that input, we may find ourselves increasingly irrelevant. To achieve our vision of the AMA as the Voice of Medicine, we need to come to terms with relationships among AMA, states and specialties

Together we are stronger, but what are the areas of commonality that bind us together? What are the distractions that cause fractures in that relationship? What role does or can the HOD play in this process?

Frequently we will discuss or debate an item within the House of Delegates only to have no one abide by the decision. Are we going to hang together or hang separately? We meet in the House of Delegates as a body twice a year, but are we really listening to one another? Are we committed to a single voice?

Let me try to elaborate. Our traditional alignment with the state societies was nearly complete. However, change is constant. Pressures on state medical societies and the AMA are altering these relationships so that (without assigning a value judgment) we are trending apart with state societies focused on local and national advocacy, grassroots activities, physician recruiting and immediate service requirements. The Litigation Center, Advocacy Resource Center and participation in governance are still areas we do together. And states are still the testing ground for novel solutions to problems such as medical liability reform.

On the other hand, while the AMA and specialty societies historically have had less interaction, we now have an important and deepening agenda around areas such as CPT, RUC, SOPP, FDA drug safety and national advocacy. How does the AMA fit into these changing organizational dynamics, changing physician practice patterns, changing physician demographics and the ever increasing mission requirements of organized medicine? A challenge indeed.

Finally, we also need to ask ourselves, year in and year out, whether we are effectively using the levers for change that are available to us. Consider our AMA agenda as a series of boxes cutting across internal departments, geographic and specialty societies. Push elements are instruments to change the world in which physicians practice – pass a law, obtain a judgment, stop a regulation. Pull elements provide physicians with tools to be effective in the world in which they live – professional guidelines, ethics, practice management, continuing education.

We need to use both levers to be effective and to be relevant to the argument. What the balance of these levers has been in the past, where push tools may have predominated, may not be right for the future where recent success has emphasized the power of pull technology. In fact, we will advance our profession only by using both push and pull. So what does all this mean? Let me reiterate, my vision for the AMA is unchanged and steady, but as you have seen, our challenges have changed dramatically. First, let us continue to be not only an AMA responsible for our actions, but also an AMA relevant to the dialogue of health care in this country. Second, we will continually evaluate optimal scenarios for business growth. This is the core of the viability of our AMA and critical to its future. Third, we will secure a compelling value proposition for the AMA. Small changes are not the solution. To quote Daniel Burnham, the architect who led the rebuilding of Chicago after the great fire said: “Make no little plans. They have no magic to stir men’s blood and probably will themselves not be realized. Make big plans; aim high in hope and work, remembering that a noble, logical diagram once recorded will not die.”

Finally, if we are to remain the voice of medicine, we need to honestly engage one another about our strengths and weaknesses. We need to achieve alignment within organized medicine and to use all of the tools, both push and pull, to help physicians and patients in a meaningful and achievable way. I for one can hardly wait to get started. Have a great meeting.

REMARKS OF THE CHAIR OF THE AMPAC BOARD: The following remarks were offered by John B. Neeld, Jr., MD, Chair of AMPAC:

Thank you, Mr. Speaker. I'm an anesthesiologist from Atlanta, and it is my privilege to serve as the current Chair of the AMPAC Board.

I here this afternoon to ask that each member of this House of Delegates join AMPAC, medicine's voice in the nation's capital. When we next gather for an Interim Meeting in Orlando a year from now, we will have elected a new president and a new Congress, and when that Congress begins its work in 2009, health care reform will be the number one domestic policy issue. Unfortunately, the influence of AMPAC and, hence, of American medicine, is fading due to two things; decreased participation by physicians and increasing competition from other PACs.

For example, in 1992, when we elected the Congress that defeated the Clinton health care plan, AMPAC was the number three PAC in the nation. Last year, the 2006 election cycle, we had fallen to number 33. We can do better, and we absolutely must do better if we are to have the political strength in Washington to defend our ability to practice medicine and to properly care for our patients.

Now, last year at the Interim Meeting, the Florida delegation offered a resolution that called for AMPAC to increase its membership and to increase its fund raising. Responding to that resolution, the Board of the AMA hired a consultant in PACs to assist us, and he examined AMPAC and many other major national PACs. We learned much from that study. I will share only one fact with you that was very compelling to me.

According to the consultant of the 200 largest PACs, the average contribution was \$350 annually. To AMPAC, the average contribution was \$61. That will not get the job done in Washington when you recall that only 11.2 percent of the members of the Federation are actually AMPAC members.

As I said, we must do better. The AMPAC Board has raised for 2008 the minimum dues level from \$50 to \$100 as we have created a new premium level of membership, the AMPAC Capitol Club Gold at the \$1,000 level. That is the highest level of commitment to advocacy for American medicine at the present time.

Now, every one of us in this room is a leader. Every one of us is accustomed over the years to set examples for other physicians. Despite this, only 59 percent of the House of Delegate members are members of AMPAC. Only 14 percent of us are members of the current Capitol Club.

Now for the good news. At this meeting I am happy to tell you that 100 percent of the AMPAC Board of Directors, 100 percent of the AMA Board of Directors, 18 of my anesthesiology colleagues from the Section Council, and almost all of the Council on Legislation have already joined for 2008 at the Capitol Club Gold level. We are off to a great start for the 2008 election cycle.

My request, if you will, my ask, as they say in Washington, of each of you is that you personally commit to not leaving this island until you have joined AMPAC at some level, hopefully one of the Capitol Club levels. Together we are stronger is absolutely true in the area of advocacy, and we do need to be much stronger in the next election.

Thank you for your attention. I will see you at the AMPAC booth.

ADDRESS OF THE PRESIDENT: The following address was presented by Ronald M. Davis, MD, President of the American Medical Association, on Saturday, November 10:

Shall We Dance?

Aloha, and mahalo nui loa; thank you very much. I hope you're all enjoying our location. I know I am. The beauty of these islands is simply unsurpassed. And the people are so warm and friendly. I think I feel healthier just breathing in the air here, or smelling the flowers. I wish we could write prescriptions for that.

Another reason why I have a deep affection for Hawaii is because my very first AMA meeting was here, back in December 1979. Also, my father was stationed here during World War II, from 1942 to 1945.

Hawaii is still a crucial strategic location in the world. Did you know that this is the only place with all five US armed services on one small island? Soldiers at Schofield Barracks, sailors at Pearl Harbor, airmen at Hickam Air Force Base, Marines at Kaneohe Bay, and the Coast Guard patrolling the waters as well?

Wherever they are, and whenever they served, I want to acknowledge all those who put themselves in harm's way to protect our freedom, and this country, and a way of life that embraces peace and friendship among all people. And that includes the selfless physicians here with us from the Defense Department and the Veterans Administration.

My brother returned from Iraq two months ago, and like others returning from the front lines, he's going through a challenging transition. As physicians, we'll be dealing for years to come with highly visible physical injuries suffered by service members returning from Iraq and Afghanistan, and also post-traumatic stress disorders and other emotional wounds that afflict our returning troops. Let's be ready for them. They deserve it.

Getting back to my father, who passed away in 1997, he was in the 113th Radio Intelligence Corps, just a few miles from here. And in his free time, believe it or not, he taught ballroom dancing to his fellow GIs.

Watching a film clip a few weeks ago of him teaching dancing in Hawaii got me thinking about the dancing we do at the AMA, and the partners with whom we dance. We engage in a very special form of dancing. It's not the Hula. It's not Tahitian dancing. It's not nearly as pretty, or graceful, or enjoyable to watch. Sometimes it's more like a limbo at a luau.

Thirty years ago, a Rhodes Scholar named Eric Redman wrote about "The Dance of Legislation." That was actually the title of his book, about the drafting and passage of legislation to establish the National Health Service Corps. The NHSC, through scholarship and loan repayment programs, has recruited more than 27,000 health professionals to deliver primary care in underserved communities.

Many of you have no doubt read "The Dance of Legislation." Redman published an updated version of it a few years ago. This dance is one of both triumph and frustration, and includes some strange moves and countermoves. But most of all, it involves one hell of a lot of work. And it's a very slow dance. Legislative change usually occurs incrementally rather than revolutionarily.

Take a look at the State Children's Health Insurance Program, or SCHIP. The original legislation passed 10 years ago, but with a 10-year sunset. This year, Congress passes a bill to reauthorize the program, but it's vetoed by President Bush, and the House fails to override his veto. So now we have a new bill, stewing in the most partisan environment I've ever seen. Yet it's over something that we, the members of the House of Delegates of the AMA, had no problem with last summer. We were virtually all on board when we adopted our position. It's clearly in the best interests of everyone.

I've been disappointed in hearing a lot of uninformed criticisms of the SCHIP legislation. Let's separate fact from fiction.

Myth No. 1 is that the SCHIP compromise is a major step toward "government-run, socialized" health care. In fact, SCHIP is a public-private partnership, with 77 percent of kids in the program getting their coverage through private health plans. Let me ask you this: if the SCHIP legislation is socialized medicine, why is Senator Orrin Hatch supporting it?

Myth No. 2 is that the SCHIP compromise vastly expands program eligibility. In fact, there is no provision in the bill to expand income eligibility for children, and the compromise will limit program eligibility more than current law.

Myth No. 3 is that the SCHIP compromise bill will cover illegal immigrants. In fact, the SCHIP bill does not change current law prohibiting coverage for illegal immigrants. Health coverage is only available for US citizens and legal immigrants who have been in the United States for at least five years.

Myth No. 4 is that the SCHIP legislation will cover adults. In fact, the bill phases out non-pregnant adults from the program.

I don't know about you, but I can no longer stomach rollercoaster rides. So let's get SCHIP off Washington's rollercoaster, so children from low-income families will have secure and reliable access to health care.

* * *

The first version of the SCHIP legislation in the House included Medicare physician payment reform. Unfortunately, the Medicare provisions were not included in legislation passed by the Senate, and did not make it into subsequent compromise bills. So now it's likely we'll be dancing with that one all the way to December, down to the wire, once again. Recent Congresses seem to want to wait until a crisis occurs, or until the last possible moment before it would almost assuredly occur, before taking definitive action. And this pathetic yearly tourniquet approach to the SGR cuts is a perfect example of management by crisis.

We in medicine know a lot about crises through our work in disaster preparedness. We plan for, and respond to, terrorism, tsunamis, hurricanes, and many other mass-casualty events.

The latest are the fires in southern California, which were on everyone's minds when I was at the California Medical Association's annual meeting in Los Angeles a few weeks ago. Our hearts go out to our colleagues and their patients who have been affected by the fires, and we've offered assistance through our AMA Center for Public Health Preparedness and Disaster Response.

Speaking of fires, I share a birthday with the late Red Adair. You'll remember that he was the world-famous oil field fire fighter, who successfully battled more than 2,000 fires in oil and natural gas wells. Adair's well control company, which continues its work today, divides its services into three categories: prevention, response, and restoration. Let's apply those approaches to the looming SGR disaster.

Let's begin with prevention. Prevention involves safety inspections. We've already done safety inspections, and we already see weak points in our system of care for seniors. According to the Medicare Payment Advisory Commission, or MedPAC, about a quarter of seniors seeking a new primary care physician are already having difficulty in finding one to take care of them. Prevention also includes conducting a risk assessment. We've done that too. And we see huge risks if Medicare cuts go through as projected.

According to our MemberConnect survey, if the 10 percent cut goes through in January, almost a third of physicians will reduce the number of new Medicare patients they accept, and almost 30 percent will stop accepting new Medicare patients altogether. Even more disturbing is that almost a third of physicians will reduce the number of established Medicare patients in their practice, if the 2008 cut goes through. And another eight percent will stop seeing any Medicare patients in their practice.

And ladies and gentlemen, 10 days after Halloween, this is not the type of scare I want. Before the US Capitol becomes a haunted house, Congress needs to listen to MedPAC, its own advisory committee, and scrap the SGR. Listen to MedPAC, and tie physician payment to the Medicare Economic Index, the government's own index for the costs of running a physician practice.

A few years ago, the Congressional Budget Office estimated that a permanent SGR fix would cost \$90 billion. Now the CBO says that deep-sixing the SGR in favor of the MEI will cost us \$262 billion. As Congress continues to kick the can down the road, effective remedies become more and more costly. But Congress seems to ignore the benefits of preventing an SGR disaster. It seems willing to rely on disaster response and restoration.

Well, we need to tell Congress that if this imminent melt-down occurs, response and restoration will be slow and repairing the damage will be expensive, and may ultimately fail. If physicians across the country are forced out of the Medicare program and lose trust in the program, they may become wholly resistant to any last-ditch effort by the federal government to respond to the crisis, and to restore the program to "business as usual." Unless Congress has a "Medicare Red Adair" to put out brush fires in every one of the 3,066 counties in the United States, a lot of seniors are going to get burned.

I'm pleased that my own senator, Debbie Stabenow, is showing leadership on this issue. You'll recall that she spoke at our National Advocacy Conference in February, wearing her AMA purple. Two days ago, she spoke passionately about the SGR problem on the floor of the Senate. She called on Congress to "pass legislation this year that provides physicians with two years of positive Medicare payment updates in a way that does not add to the cost of eliminating the SGR."

Senator Stabenow endorsed a repeal of the SGR and the establishment of "a Medicare physician payment system that will provide stable, positive payment updates to preserve Medicare beneficiaries' access to high-quality care for

the long-term.” She said, “It defies common sense to think that payment rates that are lower today than they were six years ago will be enough to maintain the access to care that our seniors need.”

Many physicians have told me that they doubt Congress will solve this problem unless a melt-down actually occurs. Thus, some have suggested that we acquiesce to the 10 percent cut for 2008; just let it go through, they say, so Congress will see that our concerns and predictions are not a poker-style bluff. A few have even suggested to me a physician boycott of the Medicare program. Well, boycotts raise serious legal and ethical issues. But I know where those suggestions come from. Many or most physicians are mad as hell and are in no mood to take it any longer. Lest you have any doubt, there’s as much anger on this stage as there is on the floor of this House and in physician offices across this country. So let me highlight several courses of action that are available to physicians.

First, we can do what TV news anchor Howard Beale suggested in that 1976 movie “Network”—get up out of your chairs, go to the window, open it, and stick your head out, and yell, “I’m as mad as hell, and I’m not going to take this anymore!” Unfortunately we don’t have any windows in this room, so you’ll have to save your best Halloween scream for later.

For our second course of action, we must continue, and intensify, our advocacy efforts, talking to our Congressmen, and our patients, and the media, about the looming melt-down.

And third, we must remind physicians, in the face of these huge cuts, that they may wish to review their Medicare participation options. As explained in the fact sheet that’s available on the tables at the back of this room, physicians who wish to change their current Medicare participation or non-participation status for next year, must do so between November 15th and December 31st.

They have three options: One, they may sign a PAR agreement and accept Medicare’s allowed charge as payment in full for all of their Medicare patients. Or, two, they may elect to be a non-PAR physician, which permits them to make assignment decisions on a case-by-case basis and to bill patients 9.25 percent above the PAR-approved payment rates. Or, three, they may become private contracting physicians, agreeing to bill patients directly and to forego any payments from Medicare to their patients or themselves.

* * *

For folks who are fatigued by these endless machinations in policy, Eric Redman explains our current reality: “the dance of legislation never really ends, and a law may [even] intensify rather than terminate the perpetual struggle over policy.” At the AMA, it’s our job to continue this dance until the music stops. Fortunately, we’ve had some nice recent victories in the smaller dance contests, such as getting the Department of Education to extend eligibility for deferring repayment of student loans, so that medical student and resident debt burdens don’t get worse than they already are. Yet that, too, is a short-term fix. We still need a long-term legislative solution to that problem.

Have you seen either of the current reality television shows, “So You Think You Can Dance” or “Dancing with the Stars”? To win these competitions, you need to be more than just the best dancer. There’s song selection. There’s how well you’re trained by a randomly chosen choreographer. And there’s your popularity with the viewers, who vote off the contestants. Thus, winning the dance contest involves talent, training, and a tendency to be liked.

Well, physicians have a lot of talent. Are we’re certainly well trained. And I’d like to think we’re popular among our patients. So we must show Congress that we’re in this for the long haul. We aim to win our dance marathon, and not get voted off.

Now, to accomplish this, I believe the key is to always keep patients as our main focus, and to ensure that their access to care is the basic harmonic running through everything we do, which is why we’ve been pushing so hard to be the Voice for the Uninsured. I’m very proud of our campaign. We’ve joined forces with some of the most influential groups in America. And we’ve joined forces with our patients. What we’re doing, we’ve done before, but never with as much strategic and tactical focus.

So this is probably a good time to show you one of our 30-second spots. These will go national in January. And those of you in Iowa, South Carolina, and New Hampshire have most likely already seen it. I’d really like to thank the medical societies of those states for their superb partnership with us on this campaign. When I was out on the road for four days last week in Iowa, I personally heard several sad stories about the devastating impact that lack of insurance can have on people who experience serious illness or injury.

I heard something else, too. Leaders of the Iowa Medical Society and I met with Gov. Chet Culver for an hour, to talk about covering the uninsured, Medicare physician payment reform, and a few other important issues. Moments after we walked into his office, the Governor mentioned that he had seen our AMA billboards about covering the uninsured all over the place. I'm glad the Governor saw our signs because for two days before our meeting with him, I was out driving our mobile billboard around the state capitol in Des Moines.

So we need to do whatever it takes to get the message out in this campaign, to important decision-makers but also to our patients and to voters, to convince them to consider this issue when they decide which presidential candidate to support. Politicians everywhere, but especially in Congress, need to be told by us that we're going to do our damndest to win these contests; that we're going to lead the charge to provide the best health care for all Americans, but especially the most vulnerable: our children, the elderly, and the uninsured.

* * *

As we work toward covering all Americans, we need to remind our patients, and all citizens, that they play a critically important role in determining how healthy they are and how long they will live. More than one-third of all deaths in this country are due to four unhealthy lifestyles: tobacco use, alcohol abuse, poor diet, and physical inactivity.

That's why I'm very pleased that earlier this week, our AMA and the American College of Sports Medicine launched a new initiative to assist physicians in helping their patients get more physical activity. The theme of the campaign is "Exercise is Medicine," and we encourage you to prescribe exercise for all of your patients. Please check out the campaign website at www.exerciseismedicine.org.

Incidentally, one way to get exercise is through dancing. In fact, the state of West Virginia is combating the epidemic of youth obesity by placing the videogame "Dance Dance Revolution" in all 765 public schools in the Mountain State.

* * *

I sometimes wish I had inherited my father's dancing skills. I did not. But when we do the "Dance of Legislation," whether for SCHIP or Medicare or another important issue, it really doesn't matter if we occasionally step on our partner's toes. It might even prove a point. What matters is, when the music stops, who wins the dance?

I hope you get the chance to catch the evening show at the Hilton Hawaiian Village or out at the Polynesian Cultural Center. You'll be amazed at all the dancing. And the climax is a dancer who juggles flaming torches. It's like combining Red Adair with Fred Astaire.

Sometimes, we have to juggle a little fire in our dance. That just comes with the territory. And when we have partners, we're not always going to be in sync. And we may have to switch partners when we find one who has better moves. And we may need to stay on the dance floor longer than we thought we should.

So bring your Dr. Scholl's because we need to fight for physicians everywhere. We need to prevail for patients everywhere. And we need to win, not to get a trophy, but because it's the right thing to do. There is no one in this country who has more expertise in health care than we do. So in this dance, we need to take the lead.

REMARKS OF THE PRESIDENT OF THE AMA ALLIANCE: The following comments were presented by Dianne Fenyk, President of the AMA Alliance, on Saturday, November 10:

Friends and family, how nice to be together in beautiful Hawaii. I am delighted to be here and to have this opportunity. I would like to post two questions. As President of the AMA Alliance, I want to ask you, first, if the reasons that you became a physician are the same reasons you remain a physician despite a challenging health care system? There may be several reasons, but I bet two of them are the same for all of you, your sincere desire to help people and the personal support and balance you receive from your family to pursue your life's work.

This leads to my second question. Your family supports the work that you do in your leadership role in medicine. How do you recognize your family members as contributors to the family medicine for the support they provide and the balance they bring to your life as a physician? I have an answer to this one. The AMA Alliance is primarily a

physician and physician spouse network. While we are together in Hawaii, please add yourself and your spouse to the AMA Alliance network of medical families. Show your support for the volunteer work that we do to promote better health in America. We have made it easy for you. Just take a moment sometime this weekend to stop by the Alliance booth. You will see what we are up to in combating tobacco use among children as part of the AMA and AMA Alliance “Screen Out” project. Add your voice by signing the petition directed to the nation’s big six movie producers and Motion Picture Association of America. Add your name, please.

We have prepared a special certificate for you to use to say thanks to your spouse for supporting your life’s work in the family of medicine, and if you would like to gift yourself, we would welcome your membership, too. You’ll find the petition, the certificate and a few surprises at our Alliance booth. You will find me and other Alliance members hosting the booth, and if we have stepped away, please leave your card, and we will get back to you.

Thank you for attention this afternoon and for all that you are doing on behalf of the family of medicine. I will see you later at the AMA Alliance booth. Thank you.

REPORT OF THE PRESIDENT OF THE AMA FOUNDATION: The following remarks were presented by Barbara A. Payne Rockett, MD, President of the AMA Foundation, on Saturday, November 10:

I’d like to take the opportunity to thank all of you who have given thoughtful and vital contributions to our Foundation. You made a significant impact on the health care community this year.

I’d also like to tell you we have a wonderful staff working for us, and I’d like to thank them. We were fortunate to have Maria Maher as our interim director, and she deserves thanks as well. We welcome our new Executive Director, Stephen Churchill. He’s here in the front row. When you see him, please say hello and welcome him, as well.

We are very grateful to AMA Alliance for the support they have given us over the years and they are well represented on our Board of Directors. I’d like to say that our Speaker of the House, Dr. Jeremy Lazarus, has served as the Chair of our Uniting for the Future of Medicine campaign and thank you, Jeremy. I would be remiss if I didn’t thank my husband, Fran, for the support he gave me and also the Foundation over the years. Thank you very much. I was told in a meeting I forgot him before, so I can’t do that again.

We helped physicians in Georgia rebuild their practices in the wake of devastating tornadoes. We distributed approximately \$500,000 to struggling and deserving medical students. Most notably we debuted our new program, Healthy Communities—Healthy America. We awarded \$225,000 to very worthy, physician-led free clinics. Our exciting new partnership with Pfizer will allow us to dramatically increase the number of awards in 2008.

These programs need your support to continue. I am challenging each of you to make a contribution to the best of your ability to the AMA Foundation this year so that we can say a hundred percent of the doctors in the House of Delegates have supported our Foundation. Please join me in supporting your AMA Foundation. Thank you very much.

REPORT OF THE AMPAC BOARD OF DIRECTORS: The following report was submitted by John B. Neeld, Jr., MD, Chair of AMPAC:

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding AMPAC’s activities. Since its creation nearly 50 years ago, AMPAC has been an innovative leader in political involvement. As the oldest non-labor union political action committee in the United States, AMPAC has a proud history of working in concert with the state medical political action committees to elect federal officeholders who support the legislative agenda of the American Medical Association.

POLITICAL ACTION

This year has been busy preparing for the 2008 election cycle with campaign contributions, an in-kind polling program, and special elections. Earlier this year Wyoming lost one of its senators, Craig Thomas (R), to a battle with leukemia. Wyoming state law allowed for the governor to appoint his replacement, and in June, John Barrasso, a physician and AMA member, was chosen to serve until the next regular election. Dr. Barrasso—a graduate of

AMPAC's Campaign School program—will face an election in November 2008 to serve the remainder of the late Senator Thomas' term, which expires in 2012.

It's important that organized medicine has an AMA member in the US Senate and to assist Senator Barrasso in his election efforts, AMPAC commissioned an in-kind poll on his behalf to learn more about the attitudes of the voters in Wyoming and what's important to them. The results have been delivered to the Senator, which should be very helpful in his campaign.

For the 2007-2008 election cycle, AMPAC has started to make a limited number of campaign contributions to representatives and senators in leadership positions, champions of organized medicine and key committee members. Working with our colleagues in the state medical societies, we continue to cultivate relationships developed over the years and work to build new ones in a dynamic political environment.

With that in mind, AMPAC is currently in discussions with our Federation PAC colleagues, considering preliminary recommendations for campaign contributions for the remainder of the election cycle. AMPAC's Congressional Review Committee will meet near the end of January to finalize the contribution budget for 2008.

POLITICAL EDUCATION PROGRAMS

In 2008, AMPAC will once again host the Candidate Workshop and Campaign School to help AMA members become more effective advocates for medicine. The Candidate Workshop, to be held February 29-March 2, is ideal for those considering a run for public office. The Campaign School, to be held April 9-13, is an intensive hands-on seminar that trains participants as campaign experts. Both programs will be held in the Washington, DC area. Enrollment is open to AMA members, their spouses and immediate family members, and Federation staff. AMPAC, through its Political Education Fund, covers lodging, meals, tuition and course materials, a significant benefit to AMA members. Information and applications are available at the AMPAC booth.

AMPAC will co-host a Regional Campaign and Grassroots Seminar with the Medical Society of New Jersey on December 7-8, 2007. This program provides grounding in the basics of political campaigning and grassroots lobbying to help physicians get involved in the political process. If your state is interested in co-hosting one of these programs, please stop by the AMPAC booth for more information.

AMPAC MEMBERSHIP

Overall, AMPAC membership at the close of October was 29,860 compared to 37,672 in 2006. Total AMPAC receipts collected through the end of October are \$2,105,248 compared to \$2,550,048. The decline in both AMPAC membership and revenue is associated with the drop in transmittals from states that are no longer acting as collecting agents.

Thirty-three state PACs are collecting agents for AMPAC and through the end of October 17,976 members have been transmitted to AMPAC compared to 19,245 in 2006 for a 7 percent decrease. Receipts from state PACs are also behind with receipts totaling \$937,171 compared to \$1,027,133 in 2006 for a 9 percent decrease of \$89,962. Four states have exceeded their goal of achieving 20 percent participation from their membership. Congratulations to Hawaii (24.1%), Iowa (22.4%), Mississippi (58.6%) and Missouri (20.7%).

AMPAC direct membership through October is 6,972 members, compared to 7,333 at the same time in 2006. AMPAC direct receipts are currently running behind with contributions totaling \$907,936 compared with \$967,137 in 2006, for a 6 percent decrease. However, a mailing went out to direct members in mid-October, and responses to this mailing should bring 2007 direct memberships up to last year's levels.

AMPAC's Capitol Club surpassed 500 members this year and there are currently 585 members through the end of October. This represents a 29 percent increase over this same time last year of 454 members, and also surpasses last year's final number of 474 Capitol Club members. Furthermore, AMPAC is introducing a new major donor level during the Interim meeting, Capitol Club Gold. This new level is \$1,000 annually and will provide exclusive member benefits. Promotion of AMPAC's Capitol Club Gold will begin during the Interim meeting for 2008 memberships and AMA members can join at the AMPAC booth. This newly created donor level will provide AMPAC with additional resources that are needed to ensure the AMA's advocacy agenda is furthered on Capitol Hill.

I strongly encourage every individual who serves in an AMA leadership position to lead by example by contributing to AMPAC and becoming a member of AMPAC's Capitol Club Gold. Your support will not only protect the future of our profession, but it gives us a powerful and collective voice as we continue our fight on behalf of medicine's agenda.

CONCLUSION

On behalf of the AMPAC Board of Directors, I'd like to thank all of our members for their continued involvement in political and grassroots activities. Your AMPAC membership is an investment in the future of your practice, your profession, and your patients. Through this support and leadership we have a positive impact on public policy decisions that are beneficial to our patients and our profession. Just as we have a responsibility to care for our patients, we also have a duty to our profession to assure that the interests of medicine are properly represented in the halls of Congress.

RECOGNITION OF RETIRING MEMBERS OF THE HOUSE OF DELEGATES AND RETIRING MEDICAL EXECUTIVES: The following delegates, alternate delegates and medical executives were recognized by the House of Delegates as serving at their last meeting of the House (listed alphabetically by state and specialty society):

Arizona
Philip E. Keen, MD

California
Daniel Borenstein, MD
Vincent Gualtieri, MD
Stephen Hansen, MD
Judith Mates, MD

Idaho
Robert K. Seehusen

Indiana
Ralph W. Stewart, MD

Iowa
William McMillan, MD
Bryan Pechous, MD
Siroos Shirazi, MD

Kentucky
William T. Applegate

Massachusetts
Virginia T. Latham, MD
Eugenia Marcus, MD

Michigan
Dorothy M. Kahkonen, MD

Nebraska
Sandy Johnson

New York
Ann C. Cea, MD
Patricia A. Randall, MD

North Carolina
H. David Bruton, MD

Oklahoma
Gary Stroebel, MD

Pennsylvania
Richard D. Baltz, MD
Kelly J. Caverzagie, MD
Meg E. Gibson, MD
Mary J. Hudak, MD
Angelica L. Kloos, MD
George J. Koenig, DO
Gerald P. Tracy, MD

Washington
Steven C. Arendt, MD

American Academy of Pediatrics
Calvin Sia, MD

American College of Rheumatology
Melvin C. Britton, MD

American College of Surgeons
Thomas V. Whalen, MD

American Society for Reproductive Medicine
Kamran Moghissi, MD

American Urological Association
Robert Stackpole, MD

College of American Pathologists
E. Randy Eckert, MD

REFERENCE COMMITTEE MEMBERS

Reference Committee on Amendments to Constitution and Bylaws

Jane C.K. Fitch, MD, American Society of Anesthesiologists, Chair
 Keith Adams, MD, Pennsylvania
 John Burge, MD, Arkansas
 Diana Fite, MD, Texas
 Adam Ostendorf, Regional Medical Student
 M. Eugene Sherman, MD, Colorado

Reference Committee F (AMA Finance and Governance)

Alan M. Harvey, MD, Massachusetts, Chair
 Steven C. Arendt, MD, Washington
 Nancy J. Auer, MD, American College of Emergency Physicians
 Lisa Egbert, MD, Ohio*
 David C. Fleeger, MD, Texas*
 Frank J. Indihar, MD, Minnesota
 Gary D. Thal, MD, MBA, American Society of Anesthesiologists

Reference Committee J (Advocacy in the Public Sector)

Liana Puscas, MD, American Academy of Otolaryngology-Head and Neck Surgery, Chair
 John S. Antalis, MD, Georgia*
 Kathleen Blake, MD, New Mexico*
 Veronica Dowling, MD, Arizona
 Jesse M. Ehrenfeld, MD, Resident and Fellow Section
 Scott Karlan, MD, American Society of General Surgeons
 Charles J. Rainey, MD, Wisconsin*

Reference Committee K (Advocacy in the Private Sector)

M. Leroy Sprang, MD, Illinois, Chair
 Robyn F. Chatman, MD, Ohio*
 Virgil H. Crowder, Jr., MD, Tennessee
 Willarda Virginia Edwards, MD, Maryland
 Hillary D. Johnson, MD, PhD, New York
 John D. Longwell, Jr., MD, California*
 Nancy L. Mueller, MD, New Jersey*

Reference Committee L (Legislative Advocacy)

E. Coy Irvin, Jr., MD, Florida Medical Association, Chair
 Patricia L. Austin, MD, California Medical Association
 Suvas Ghelabhai Desai, MD, American Association of Physicians of Indian Origin
 Julia V. Johnson, MD, American Society for Reproductive Medicine
 Richard Pieters, Jr., MD, Massachusetts Medical Society*
 Nestor Ramirez-Lopez, MD, Illinois State Medical Society
 Samuel Wann, MD, American College of Cardiology

Committee on Rules and Credentials

Louis Kraus, MD, American Academy of Child and Adolescent Psychiatry, Chair
 Blanton Bessinger, MD, MBA, Minnesota*
 K. Barton Farris, MD, Louisiana
 Candace E. Keller, MD, American Society of Anesthesiologists*
 Thomas Shieh, MD, Guam
 Mark S. Wurzel, MD, Wyoming

Tellers

S. William Clark, III, MD, Georgia, Chief Teller

Assistant House Tellers

Michael C. Brunner, MD, Radiological Society of North America*
 Mary Carpenter, MD, South Dakota*
 Richard H. Esham, MD, Alabama*
 John J. Ingram, III, MD, Tennessee*
 Deborah Y. Smart, MD, American Academy of Insurance Medicine*
 David D. Teuscher, MD, Texas *

* - Alternate Delegate

