AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

153RD ANNUAL MEETING
CHICAGO, ILLINOIS
June 12-16, 2004

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 153rd Annual Meeting at 3:00 p.m. on Saturday, June 12, in the Grand Ballroom of the Hyatt Regency Chicago, Nancy H. Nielsen, MD, PhD, Speaker of the House of Delegates, presiding. The Sunday session, June 13, Monday session, June 14, Tuesday session, June 15, and Wednesday session, June 16, also convened in the Grand Ballroom.

INVOCATION: Rabbi Herman Schaalman, Rabbi Emeritus of Emanuel Congregation, Chicago, delivered the following invocation on Saturday, June 12:

An ancient text tells us that two groups of sages engaged in a debate for a period of two years over the question as to whether God should have created the human species altogether or not. Perhaps to their own surprise, they came to the conclusion that it would have been better for God not to have created humans, but then quickly added, as long as we are here, let us be meticulous in our actions.

Our God, this is a challenge thrown out to all of us, but in particular to those of us who deal with our fellow human beings in pain and distress, how meticulous our actions need to be, with what care and understanding and sensitivity we need to approach them and deal with their problems.

We understand how sacred is the opportunity given to us and deeply appreciate this great opportunity given to this particular group of human beings, skilled in their own great work, to bring healing and hope and reassurance. How grateful we are not only to meet with one another, but, here again, to reconfirm our own deepest commitments to this sacred value, which we not only represent, but on the basis of which we act and live with those who need us so badly.

For all this, our God, we give you our thanks and ask that your presence be manifest here in our convocation so that through what we say and what we think and what we do, there will come into this, your world, a ray of hope, of reassurance, yea of blessing. To this end, be with us and bless us. Amen.

CREDENTIALS: The Convention Committee on Rules and Credentials reported that on Saturday, June 12, 478 out of 528 delegates (90.5 percent) had been accredited, thus constituting a quorum; on Sunday, June 13, 501 out of 528 delegates (94.9 percent) were present; on Monday, June 14, 522 out of 528 delegates (98.9 percent) were present; on Tuesday, June 15, 522 out of 530 delegates (98.5 percent); and on Wednesday, June 16, 525 out of 530 delegates (99.1 percent) were present. (On Monday, two additional national medical specialty societies were granted representation in the House of Delegates.)

REPORTS OF THE CONVENTION COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Alan M. Harvey, MD, Chair:

Saturday, June 12

HOUSE ACTION: ADOPTED

Your Committee on Rules and Credentials recommends that:

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 Convention 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 2004 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. The June 2004 edition has been revised to reflect the AMA's change in parliamentary authority from Davis' Rules of Order to the current edition of The Standard Code of Parliamentary Procedure. It has also been revised to reflect updated policy (H-600.061 and H-600.062, AMA Policy Database) on fiscal notes on reports and resolutions, and to update the names and topic areas of reference committees of the House. Finally, the provision for the motion to recall, which is not in The Standard Code, and which can be accomplished by the motion to reconsider, has been deleted.

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. Nominations and Elections

The House will receive nominations for President-Elect, Speaker, Vice Speaker, Trustees, and Council Members on Saturday afternoon, June 12. Speeches will be limited to candidates for Officers and Trustees with no seconding speeches permitted. The order will be selected by lottery.

The Association's 2004 annual election balloting shall be held Tuesday, June 15, between the hours of 7:30 a.m. and 8:45 a.m. as specified in Sections 3.40 and 6.90 of the Bylaws, and the following procedures shall be adopted:

Accredited Delegates may vote any time between 7:30 a.m. and 8:45 a.m. by reporting to the Polls in the Columbus K-L Room of the Hyatt Regency Chicago. The Convention Committee on Rules and Credentials will certify each Delegate and give him/her an "authority to vote" slip. The slip will then be handed to an election company technician, who will direct the voter to a voting machine and provide any assistance that is requested.

The announcement and confirmation of the election results will be called for as soon as possible and appropriate.

In instances where there is only one nominee for an office, a majority vote without ballot shall elect on Saturday.

8. Conflict of Interest

   Members of the House of Delegates who have a substantial financial interest in 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.

Supplementary Report, Sunday, June 13

HOUSE ACTION: LATE RESOLUTIONS 1002 (12), 1004 (133) AND 1005 (235) ACCEPTED

LATE RESOLUTIONS 1001 AND 1003 NOT ACCEPTED

EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 3, 101, 102, 104, 107, 108, 110, 112, 113, 115, 121, 126, 129, 203, 205, 209, 218, 219, 226, 227, 228, 230, 419, 429, 433, 434, 437, 525, 531, 535, 705, 706, 713, 719, 720, 722, 726 AND 727

RESOLUTIONS 105, 106, 127, 128, 208, 217, 220, 314, 317, 518, 520, 709 AND 715 EXTRACTED AND REFERRED TO APPROPRIATE REFERENCE COMMITTEES

The Committee on Rules and Credentials met Saturday, June 12, 2004 to discuss Late Resolutions 1001 through 1005. Sponsors of Late Resolutions that are received prior to a week before the opening of the House of Delegates are informed of the time the Committee on Rules and Credentials meets to consider Late Resolutions, 10:00 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 Resolutions 1001 through 1005 appeared to discuss their resolutions.

LATE RESOLUTIONS

Because of the number of Late Resolutions, your Committee is including its recommendations on a consent calendar based upon whether or not the resolution met the criteria for consideration as a Late Resolution.

Consent Calendar

Recommended for Acceptance:

1. Late Resolution 1002 - Humane Treatment of Prisoners and Detainees
   Submitted by American College of Physicians

2. Late Resolution 1004 - New DRG for Severe Sepsis
   Submitted by Society of Critical Care Medicine

3. Late Resolution 1005 - Physician Ownership and Referral for Imaging Services
   Submitted by American College of Cardiology, American College of Physicians, American Urological Association, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Gastroenterological Association, American Academy of Orthopaedic Surgeons, American College of Obstetricians and Gynecologists, and American Medical Group Association

Recommended Not Be Accepted:

4. Late Resolution 1001 - Identification of Expert Witnesses in AMA Publications
   Submitted by Florida Delegation

5. Late Resolution 1003 - Medical Liability Reform - Call for National "White Coat Rally"
   Submitted by Connecticut 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 data 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 3 - Guidelines for Preservation and Transfer of Patient Records of a Deceased or Retired Practitioner
2. Resolution 101 - Implant Reimbursement for Medicare and Other Insurers in Ambulatory Surgery Centers
3. Resolution 102 - Mandate Insurance Coverage for Comprehensive Contraceptive Services
4. Resolution 104 - Voluntary Enrollment of Vulnerable Patients in Managed Care Programs
5. Resolution 105 - Ensuring Choice in the Health Insurance Market
6. Resolution 106 - The Economic Impact on Physician Reimbursements of the Shifting of Inpatient Medicare Part A Services to Outpatient Medicare Part B Services
7. Resolution 107 - Ending Discrimination against Contraception
8. Resolution 108 - Uninsured Hospital Charges
9. Resolution 110 - Resource-Based Relative Value Scale Revisited
10. Resolution 112 - 72-Hour Hospital Admission Rule for Transfer to an Alternate Level of Care
11. Resolution 113 - Elimination of Financial Caps for Medicare Beneficiaries in Need of Outpatient Physical Therapy, Speech Therapy and/or Occupational Therapy
12. Resolution 115 - Agency to Buy Drugs at Bulk Rate
13. Resolution 121 - Tax Deductions for Private Health Insurance by Individuals--Acute Care and Long-Term Care
14. Resolution 126 - Fee-Waived Medical Licensure for Volunteer Physicians
15. Resolution 127 - CMS Rule Regarding Route of Administration of Drugs
16. Resolution 128 - The Promotion of Public Health Through AMA Health System Review
17. Resolution 129 - Medicare Prescription Drug Coverage and Therapeutic Substitutions
18. Resolution 203 - Model State Execution Statutes to Exclude Health Professionals
19. Resolution 205 - Durable Medical Equipment (DME) for Medicare Recipients
20. Resolution 208 - DEA Number
21. Resolution 209 - Freedom of Choice in Malpractice Coverage Limits
22. Resolution 217 - DEA Number
23. Resolution 218 - Denigration of Physicians by Government
24. Resolution 219 - Antitrust Relief
25. Resolution 220 - Moving Drug Costs Out of Medicare Part B
26. Resolution 226 - Professional Liability Insurance Expense Pass Through
27. Resolution 227 - Physician Administrative Fees (was Resolution 124)
28. Resolution 228 - Administrative Surcharges (was Resolution 125)
29. Resolution 230 - Alternative Dispute Mechanisms
30. Resolution 314 - Accreditation Council for Graduate Medical Education Accredited Programs Not to Discriminate Based on Medical School of Graduation
31. Resolution 317 - Discrimination in Residency Selection
32. Resolution 419 - Seat Restraints for Vehicles Transporting Schoolchildren
33. Resolution 429 - Secondhand Smoke
34. Resolution 433 - Smoking Age
35. Resolution 434 - Combating Obesity in Children
36. Resolution 437 - AMA Policy Regarding Tobacco Use in Prison and Jail Populations
37. Resolution 518 - Herbal Products and Drug Interactions
38. Resolution 520 - Regulation of Media-Based Drug Sales without Good Faith Medical Examination
39. Resolution 525 - Require Pharmacy Benefit Managers to Disclose
40. Resolution 531 - Proper Labeling of Food
41. Resolution 535 - Direct-to-Consumer Advertising (DTCA) of Prescription Drugs
42. Resolution 705 - Development of Infrastructure for Use of Medical Information Technology
43. Resolution 706 - Study of Risks and Benefits of Electronic Medical Records
44. Resolution 709 - CPT Coding

45. Resolution 713 - Create a Public Quality Improvement Information System (QIIS)
46. Resolution 715 - Definition of a Hospital Day
47. Resolution 719 - Mandatory Hospital Privileging for Health Plan Providers
48. Resolution 720 - Hospital Fees for Health Savings Account Patients
49. Resolution 722 - Payment of High Deductible Health Insurance Portion of Health Savings Account Plans with Pre-tax Dollars
50. Resolution 726 - Credentialing Information Requested by Managed Care Insurance Companies
51. Resolution 727 - Tax Deductibility of Health Insurance Combined with Health Savings Accounts

Thursday, June 16

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Nielsen, and the Vice Speaker, Doctor Lazarus, 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 Annual Meeting of the House of Delegates of the American Medical Association has been convened in Chicago, Illinois during the period of June 12-16, 2004; and
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> Whereas, This Annual Meeting of the House of Delegates has been most profitable and enjoyable from the viewpoint of policy deliberations and fellowship; and
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> Whereas, The City of Chicago has extended to the members attending this Meeting the utmost hospitality and friendliness; therefore be it
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> RESOLVED, That expressions of deep appreciation be made to the AMA Board of Trustees for arranging this meeting, to the management of several participating hotels, to the City of Chicago, 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 Annual Meeting of the House of Delegates.

APPROVAL OF MINUTES: The Proceedings of the 57th Interim Meeting of the House of Delegates, held in Honolulu, Hawaii, December 6-9, 2003, were approved.

ADDRESS OF THE PRESIDENT: The following remarks were presented by Donald J. Palmisano, MD, JD, President of the American Medical Association, on Saturday, June 12:

CAPTAINS OF OUR SOULS, MASTERS OF OUR FATE

I am so glad to be here to give you my perspective as president on some of the AMA's efforts this past year--what we've accomplished; where we've made progress; and the work yet to be done. In this House, I see many familiar faces. I am proud to be associated with all of you--who are so passionate about organized medicine--and your patients.

When I became AMA President 12 months ago, I was given a mandate--from you, our House of Delegates--that medical liability reform was our number one legislative priority. Just before I became President-Elect, Dr. Melissa Garretson, a young pediatrician from Texas, told this House of Delegates that "it doesn't matter if you have health insurance if you can't find a doctor. Medical liability reform must be our number one legislative priority."

Eloquently--and accurately--put. And over 533 days on the road later, in the last two years, I believe in this charge--this priority--more than ever. Because nothing so threatens our profession, and the good health of our patients, than the mindless menace of a broken system that drives physicians from certain specialties, from certain states or regions, or out of the profession all together.

In my travels, I've heard stories that have made me angry, and met people who have given me hope. I've met people whose stories would bring tears to your eyes, and seen dedication that inspires one's soul.

Late last year, I spoke to the American College of Surgeons here in Chicago. I told the story of Leanne Dyess, whose husband suffered irreversible brain damage after an auto accident in Mississippi because there was no longer a neurosurgeon at the hospital--because of the medical liability crisis.

Afterward, I was approached by a young surgeon, for whom that story struck like a body blow. In a soft, sad voice, he told me that he understood the story all too well. He said he had just lost his son, 10 years old, to a head injury. It was correctable. But because of the liability crisis, there was no longer a neurosurgeon at the nearest hospital.

Real people. Real stories. Real tragedies.

Dr. Rebecca Glaser, a popular breast cancer specialist in Ohio, retired from surgery on April 1 because of high liability insurance premiums. Listen to one of her patients, who said, "I think it's horrifying when we lose a physician who has literally a one-of-a-kind practice. It is not melodramatic to say that there will be women who die this year because of this. I certainly hope I won't become one of them."

In Florida, at least seven hospitals have closed obstetrical units because of insurance concerns; four other hospitals have reduced or limited obstetrical services. In fact, more than 1,600 doctors from across Florida told the state Senate that the medical liability crisis was forcing them to change their practices--some had stopped delivering babies--others had given up performing complex surgeries. Sixteen hundred physicians. Who see thousands of patients.

Dr. Susan Hagnell grew up right here in Chicago, in Rogers Park. She went to medical school in Illinois and delivered more than 700 babies at hospitals in the northwest suburbs. But when her liability insurance bill soared from $72,000 to almost $120,000 last summer, Dr. Hagnell decided she had to leave. Now she delivers Wisconsin babies--and Chicagoland patients lost another dedicated physician. She said, "If I knew what was going to happen, I would never have become an obstetrician/gynecologist."

Real people. Real stories. Real tragedies.

We know it. Our patients know it. Nobody--not even the plaintiff attorneys--disputes that we're in the midst of medical liability meltdown. And in this debate, we who want reform are holding the trump card--the truth. Read all about it our document "Medical Liability Reform Now!" A new edition is available right here at our meeting, and on our AMA web site, and we've added an index to make it even easier to use.

In this document and elsewhere, we've demonstrated that caps on liability awards for non-economic damages work. We've exposed the falsehood that aggressive litigation makes medical care safer by punishing physicians when errors occur. We've debunked the myth that insurance companies' stock market losses are fueling skyrocketing medical liability premiums.

No, what is driving this crisis are the out-of-sight awards some runaway juries are handing out in certain liability cases. Today the average jury award nationwide is $6.2 million, up from $3.9 million in 2001. In Mississippi in 2001, more than $33 million was awarded in just four medical liability verdicts. If you want to know how this has affected access to care, just ask Leanne Dyess.

In Pennsylvania earlier this year, juries returned $15 million and $20 million verdicts on the same day. Any wonder that our AMA masterfile from 1997 to 2002 confirms that more than 400 Pennsylvania physicians in just four specialties are no longer practicing medicine in the state. Those doctors are neurosurgeons, orthopaedists, obstetricians and general surgeons. You can't replace those talented individuals from a shelf at the supermarket.

Look at Dr. Troy Brennan's research at Harvard showing no correlation between negligence and the amount of settlements or awards. The only correlation is with disability. What a system!

Listen to Dr. John Cafaro, an obstetrician/gynecologist in Garden City, New York, who said some doctors are paying $130,000 for only $1 million of insurance. “But we are getting sued for $85 and $90 million at a time,” he told the *New York Times*. “You do the math. Every time I walk into an operating room I put my family’s life savings on the line.”

It is obvious that New York state physicians and patients are paying the price for jury verdicts in 2002 that included awards of $94.5 million, $91 million and $80 million. Last year, $140 million was awarded in a single liability case. It’s no shock that New York, Mississippi and Pennsylvania are among the 19 states stricken with a medical liability crisis.

The AMA is of course against “bad doctors”--just as the AMA is against physicians who supply plaintiff attorneys with unscientific testimony masquerading as the standard of care. But a national solution is at hand--if Congress has the will. Look to the handful of states that have not experienced a crisis, because they have strong reforms in place. All of these states have legislation worth imitating.

An outstanding example is California. Their Medical Injury Compensation Reform Act of 1975--better known as MICRA--has helped keep California premiums stable for more than a quarter-century. These reforms are time-tested, and proven. And the AMA’s goal is to make them the model for federal medical liability reform. Here is where we stand.

The House of Representatives passed legislation known as the HEALTH Act in March 2003. It was recently reintroduced as H.R. 4280, and again passed the House on May 12, one month ago. This legislation, based on MICRA, would:

- Not restrict proven economic damages.
- Give more of the award to the patient instead of the plaintiff attorney.
- Allow non-economic awards of up to $250,000 for pain and suffering, unless a state already has an established cap, either higher or lower.

In July--11 long months ago--49 senators voted to end a filibuster on S. 11 or the HEALTH Act--11 votes short of bringing it to the floor for an up or down vote. Forty-eight blocked it. Since then, incremental reform legislation--that the AMA has supported--has twice been brought to the Senate, and met the same fate.

So a minority continues to thwart the will of the President and a Congressional majority, even though poll after poll shows that more than 70 percent of Americans support liability reforms, such as a cap on non-economic damages.

The AMA will not be discouraged or dissuaded--we will be relentless. I believe we’re one day away from getting these reforms. Unfortunately, it will be the day that a school bus overturns, and children are seriously injured, and there are no neurosurgeons available nearby--because there was no reform--because some senator ignored the facts.

I believe public outcry on that day will bring about change; will bring about liability reform. But it needn’t come to that. Leanne Dyess, whose husband has permanent brain damage because of this crisis, said it herself, in testimony to Congress: “My attitude is not to get mad,” she said. “Why cry over spilled milk? Let’s fix it. Griping isn’t going to change it.”

Meanwhile, our state and community medical societies are making progress on the local level--and the AMA has been at their sides. Take the wonderful win in Texas--a change to the state constitution--that says unequivocally that caps on non-economic damages are legal when passed by the legislature.

It was the first time a state constitution has been changed to specifically authorize such caps, and its passage will save years of legal wrangling.

Proposition 12 has had an immediate impact. The largest insurer of physicians in Texas has announced a 12 percent decrease in 2004 premiums, and businesses are moving in, because of the improving liability climate. And my “Yes on 12” pin is still in my lapel when I debate liability reform with the trial attorneys. And in the battle for state and national reform, “Remember Proposition 12!” has become a rallying cry.

You'll hear it in Florida, where the state society is working to amend its state constitution to restore fairness to patient awards. The AMA is also supporting this initiative, which would give patients 70 percent of the first $250,000 of any award, and 90 percent after that. This is important, because patients on average now see less than half of the award in medical liability cases.

Florida law requires that over 450,000 signatures from registered voters be obtained and verified to put this on the November ballot--and supporters of reform have more than 476,000 already--and they continue to collect more should errors be found. Let's all lend a hand to the Florida doctors, and push them over the top. This critical vote will strike at the heart of the plaintiff attorneys, who claim they sue for the benefit of patients.

And in Mississippi, the state legislature last week passed reforms that include a $500,000 cap on non-economic damages in medical liability cases. So the fight for reform continues--as it does on the related issue of patient safety. You see, opponents of liability reform claim that litigation makes medical care safer--by punishing physicians when errors occur or allegations arise. But there is no evidence of that. None.

In fact, the Institute of Medicine has reported that "[errors] almost always result from poorly defined systems--not from careless providers." To stop errors, we need to prevent them--through improved systems of safety. Just as is done in the aviation industry. We need to know how errors occur within a given system, and find solutions based on the evidence.

Now, the fear of lawsuits deters health care professionals from reporting problems, and hinders efforts to determine how to keep them from happening again. We need to put a reporting system in place where physicians and other health professionals can report errors without fear of litigation.

That is the goal of the National Patient Safety Foundation, or NPSF--which the AMA helped found in 1996. Since then, the AMA has dedicated approximately $7.3 million in cash and in-kind services to the Foundation's work. We have challenged the Association of Trial Lawyers of America to match these donations. Thus far those attorneys have not given foundation one single penny. A sign, perhaps, that personal injury plaintiff's lawyers are more interested in suing physicians than in saving patients. Even though authoritative studies show that it is system change, not lawsuits, that reduce medical errors.

The time is now for a uniform, federal approach to improving patient safety. Last year, legislation to do just that--H.R. 663--passed the House of Representatives by a 418 to 6 vote, and its companion in the Senate, S. 720, passed the Senate Health, Education, Labor and Pensions committee unanimously on July 23, 2003. This would allow confidential voluntary reporting of errors, review by experts, and changes in the system that led to the error.

We are issuing a call to action now, urging the Senate to pass the bill without further delay so President Bush can sign it into law We are unleashing our grassroots network and our more than 100,000 patient activists. We must be vigilant and certain the plaintiff attorneys don't sabotage this bill by voiding confidentiality. Patients and physicians expect the Senate to deliver a bill that becomes law--no ifs, and or buts. Just get it done.

But liability reform and protecting patients haven't been the only items on the AMA agenda this year. We've also offered solutions to the problem of the nearly 44 million Americans who are uninsured. Central to the AMA proposal are three principles: tax credits for the purchase of insurance; individually selected and owned health insurance; and expansion and formation of new insurance markets.

I outlined this plan in a "Special Communication" in the May 12 issue of the *Journal of the American Medical Association*, along with co-authors David Emmons, PhD, and Greg Wozniak, PhD, from the AMA's Center for Health Policy Research.

The article also cautions against the single payer system. Under this scheme, the US would trade the uninsured issue for an entirely new set of problems that lead to far worse consequences: long waits for health care services, rationing of care, resistance to adopting new technologies, and a mushrooming bureaucracy that can snatch control of clinical decisions away from patients and their physicians.

Instead, we offer a solid policy on insuring the uninsured that builds on the strengths of our current system, that would get 95 percent of our population covered, and which could also be applied to Medicare and Medicaid. In fact, the historic Medicare Modernization Act empowers patients by allowing them greater control over their health care decisions through Health Savings Accounts--the principle of patient choice.

As I told you at our Interim Meeting in December, the passage of the Medicare bill was a victory for Medicine. Earned because the family of Medicine, with its chorus of voices, focused on a single, powerful message. Now, all Medicare patients will be eligible for a prescription drug benefit, and the neediest will receive the most help.

Now, seniors' access to care is protected--because we stopped payment cuts to physicians and other health professionals for the next two years. Instead of cuts, the Medicare bill provides at least a 1.5 percent increase in payments in 2004 and 2005.

Now, we have some regulatory relief--due process and fair play--and more time with patients and less on paperwork. The AMA's voice was heard--and we made things happen--at the highest levels, in the halls of government. President Bush as well as Senate Majority Leader Dr. Bill Frist personally thanked me and said they appreciated all the AMA had done.

But this one isn't over. As long we labor under a flawed Medicare formula that sends us lurching from one payment crisis to the next, we will not rest. We face new cuts totaling 35 to 40 percent from 2006 to 2013. Temporary fixes aren't good enough. We need a permanent solution--as soon as possible.

We've pursued other issues vital to medicine. Dr. Coble has championed quality. Incoming President Dr. Nelson has taken the lead to fix disparities. If the issue is important to medicine and our patients, it's important to us. Our Patients' Action Network has signed up over 100,000 patient activists, who have sent more than 350,000 e-mail messages to Congress.

Our Chair, Dr. Plested, has developed board task forces to make us more efficient, and to dig deeper into critical issues such as Medicare/Health System Reform, Quality, Safety, the Electronic Health Record, Membership, and Medical Liability. The results are very good. Thank you, Dr. Plested.

Our entire AMA continues to enhance our effective communications, and communication is necessary to success. Financially, the AMA is in the black--our membership is up--and on our issues, we have made progress on many fronts. We're stronger together than we are alone, or when we splinter into different directions.

All this and more we're doing in the name and the tradition of physician activism, and for our patients. At times, these challenges can seem daunting, if not impossible. But never underestimate what you can do as an individual to create change. To make history.

Last month, I was reading about the 50th anniversary of Roger Bannister breaking the four-minute barrier for the mile run. Here was a medical student who worked out during his lunch hours at a London park where he had to pay to use the track. No advanced training techniques. No dietary supplements. No steroids. He didn't even have a coach.

On May 6, 1954, Roger Bannister went to work in the hospital in the morning, performed his rounds, on his feet the whole time. He rode the underground--standing up--to Paddington Station, then caught a train to Oxford. He ate a big English lunch and went to the meet. Being England, it was chilly out--and misty.

An amateur athlete, a wet track, a cold day, a full stomach--and Roger Bannister ran a mile in 3 minutes, 59 seconds. He didn't just overcome an obstacle of time, he also shattered a psychological barrier--the belief that no human being could run a mile in less than four minutes.

At the end of the year, Roger Bannister retired from running to pursue his medical studies full-time. He later became one of Great Britain's most eminent neurologists and medical researchers. Years later, asked to explain that first four-minute mile, and what it takes to break a record, Dr. Bannister replied, "It's the ability to take more out of yourself than you've got. The man who can drive himself further once the effort gets painful is the man who will win."

Twenty years ago, I gave my farewell speech as president of the Louisiana State Medical Society. I told the LSMS House of Delegates that it is we who control our destiny. It is up to us to draw from ourselves everything we have and more. To shatter the barriers that tell us "it can't be done." To see this race through to the end.

Our new AMA is doing exactly that, no matter who tries to block us, no matter how wealthy or powerful they may be, we will advocate for our patients--and we advocate for physicians. Each and every one. Each and every day. We will push past our limits. We will do what it takes.

And just like I did 20 years ago with my colleagues in Louisiana, I'll close with these two thoughts, the first adapted from Kipling:

"If you can risk it all standing up for truth,
And the patient's best interest,
Yours is the Earth and everything that's in it.
And--which is more--you will be a Doctor,
In the true sense of the word, my friend."

And the second thought from yesteryear that I will leave you with is from William Ernest Henley's "Invictus":

"It matters not how strait the gate,
How charged with punishments the scroll,
I am the master of my fate:
I am the captain of my soul."

Thank you, and God bless you.

ADDRESS 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, June 12:

THE AMA: A STORY IN NUMBERS

Madam Speaker, Officers and Trustees, Members of the House of Delegates, AMA staff, distinguished guests. It's been said that a picture tells a thousand words. However, I have the letters MBA after my name, as well as MD, and I believe that numbers can tell a pretty good story, too. Today, I want to share with you a story in numbers about our AMA.

Is this a good story or what? Okay, I admit it--we need context. Let me start by saying that these numbers paint a picture of our AMA that reminds us that it is an amazing, powerful, and complex organization. One that's built to last even through the toughest times.

So let's begin with my first group of numbers: 1, 10 and 1. In *Fortune* magazine's most recent listing of the 25 most powerful federal lobbying organizations the AMA was the highest-ranked--or number one--health-related organization on that list.

If you've heard this number before, consider that Washington's *Roll Call* newspaper recently called the AMA "one of the most powerful advocacy organizations in the nation," noting that it is one of the top ten lobbying groups "regardless of which party is in power."

Finally, the *National Journal* ranked the AMA's political action committee the most powerful health-care-related PAC--or again, number one.

All of these numbers give us bragging rights in terms of our advocacy efforts on Capitol Hill. And if these numbers are not enough to remind us of that fact, how about the next number: 17.

Thanks to the AMA's relentless advocacy and the combined effect of two legislative fixes, the average Medicare payment rate to physicians will increase 17 percent between 2003 and 2005, relative to previous law. We achieved this 17 percent difference for the better because the two legislative fixes we supported prevented steep cuts in Medicare payment for 2003, 2004 and 2005 and replaced them with increases instead.

We shored up the foundations of the Medicare program for seniors, and we made it happen in a challenging economic and political environment.

However, we didn't achieve this Medicare victory alone. Every member of the Federation helped--especially physicians and patients at the grassroots. Which leads me to my next number: 25,000. In the days leading up to passage of the Medicare bill, 25,000 phone calls and e-mails went through the AMA system to Capitol Hill. That's the kind of grassroots strength we can muster in a matter of days.

We'll certainly need to show this strength of purpose in the weeks and months to come. And so I turn to our next number: 5. Beginning in 2006, America's physicians will face a 5 percent cut in Medicare payments--each and every year for 7 years--according to projections in the Medicare trustees report. In short, though we have won a two-year reprieve from Medicare payment cuts, the fight isn't over--yet. We need to rally our forces, fix the flawed Medicare payment formula once and for all and stop these anticipated annual cuts of 5 percent from taking place.

We also have to rally our colleagues and our patients in the ongoing battle for federal medical liability reform. On this point, the numbers tell a very interesting story about the medical liability crisis – and how our patients are responding to it.

Consider the following numbers: 148 million, 100,000, and 333,000. Today, approximately 148 million Americans--about half the population of the United States--are living in states where the medical liability crisis rages. These men and women, our patients, run the risk of not having access to a physician when they need one because rising medical liability rates have driven physicians to limit or even stop providing high-risk procedures.

Addressing this crisis remains the AMA's number one legislative priority. Yet it's not just a priority for us--it's also a priority for our patients. At last count, the AMA has rallied more than 100,000 patient activists to our cause. These activists sent approximately a third of a million communications to members of Congress in support of medical liability reform through an AMA-sponsored Web site.

Of course, while medical liability is our number one legislative priority, it's not our only legislative priority, as our next number--6--reminds us.

Today, all of you should have received a copy of "Healing the System: A Plan to Rescue US Medicine." This document is part of a new initiative to brand and to bring sharper focus to the AMA advocacy agenda. "Healing the System" packages together, under one compelling theme, our six biggest legislative priorities: Reforming the medical liability system, strengthening Medicare, expanding health care coverage and choice, financing medical care for low-income patients, improving managed care and enhancing patient safety.

The "Healing the System" initiative underscores the fact that our health system is faltering, and that we must strive for workable solutions to these problems. It provides us with consistent, focused messages about medicine's solutions in this election year.

We must communicate the urgency of our agenda to achieve it. Two years ago, when I first stood before this House as CEO, I promised I would do everything in my power to improve AMA communications and make AMA members feel more connected to our work and its value.

According to the next group of numbers, it appears as if we're doing a pretty amazing job on this front, beginning with 6 and 91. In the past year, we sent out *AMA Voice*, our new, glossy, all-member publication, six times. The evidence strongly suggests that this publication did a great job of reaching out to members. Of the thousands of physicians who responded to our reader survey of AMA Voice, 91 percent rated it as "excellent" or "good."

What's more, *AMA Voice* is not the only publication, nor the only medium, that's new in member communications. Which leads me to my next set of numbers: 53,000, 700,000 and 27.

Let's start with 53,000. In 2003, we launched AMA *eVoice*, a weekly e-mail publication that keeps AMA members literally up-to-the minute on major AMA activities and issues. Last week alone, *eVoice* reached approximately 53,000 physicians.

In terms of the Internet, more people than ever are turning to our web site for news and information. Traffic has increased to 700,000 page hits per day, on average, and we are in the midst of a major web redesign that we are confident will attract even more users.

Finally, members of the Board and our communications team visited 27 major editorial boards, including the *New York Times* and the *Wall Street Journal*. There are few organizations that have this kind of clout with the major media outlets, and fewer still that get the kind of coverage we do, almost every single day of the week. In short, we're doing a better job than ever before of communicating our value to our members and conveying our messages to the wider public, including non-members, patients, legislators and the media.

Some of these messages are about politics, but many others are about science and professional standards. We are equally proud of those communications and the following group of numbers: 21.5, 30 and 10,000.

Our first number--21.5--is the impact factor for the *Journal of the American Medical Association*. Impact factor is the single, accepted, objective indicator of a journal's quality, and JAMA is one of only two scientific, clinical journals with an impact factor of more than 20.

Our next number--30--is the number of state and specialty societies we convened to discuss the problem of racial and ethnic disparities in health care and what organized medicine can do to help address those disparities.

Finally, through the AMA Foundation, we distributed 10,000 complimentary Health Literacy kits to help physicians better care for patients with low health literacy. This is just the tip of the science and professional standards iceberg.

What's particularly amazing, if you take a look at our finances over the past few years, is that we're doing all this for far less than we have in the past, which leads to my next line of numbers: 25.8 million and 1100.

In 2003, the AMA spent 25.8 million fewer dollars on administrative and general expenses on an adjusted basis than we did in 1999, the year we began our strategic turnaround. This number excludes one-time costs and grant expenses, so we really are comparing apples to apples here.

We did all this thanks to the efforts of approximately 1100 AMA staff members – who are doing their work smarter, better and faster. Every one of them deserves our thanks. Let's give them a hand.

Finally, our last number: 5251. We have 5251 more members today than we did in June 2003. We believe this improvement is due to the state medical societies' increased co-marketing efforts, as well as improvements in our direct marketing initiatives. While it's still far too early to tell if we can sustain this increase--there are still six months left in the year, after all--I am optimistic that we are on the right track for membership growth.

We have a road map to help us achieve that goal. The 10 Strategic Membership initiatives provide the organization with the focus and discipline to make the AMA a more member-driven organization. In short, while the environment remains challenging, I have every reason to believe we are on the right path to delivering more value to our members, which will ultimately lead to increased membership growth.

That's my AMA story in numbers for today. Thank you for listening, and for all that you've done to help bring these numbers into being.

However, as fun as it has been to tell my story in numbers, I have to admit they can only give us a snapshot of what the AMA is and does. The whole is far more than the sum of its parts. The AMA is a living, breathing organization, energized first and foremost by the work you do in your practices, in your communities and in your advocacy.

I could never put a number on what that work is worth, any more than I could put a single number on the worth of our AMA. So I want to conclude with the simplest of words. Thank you for all that you do--for the profession, for organized medicine and for patients.

It's positively unquantifiable.

REPORT OF THE AMPAC BOARD OF DIRECTORS: The following report was submitted by Robert E. Hertzka, 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 more than 40 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 patients and physicians.

With the critical 2004 elections on the horizon, AMPAC will be a potent bipartisan force in the nation's political arena. But more than just candidates will be on the ballot this November. The very issues we discuss in the House of Delegates such as medical liability reform, physicians' Medicare reimbursement, patient safety, and helping the uninsured manifest themselves in the candidates AMPAC supports. The House of Delegates has designated medical liability reform as the AMA's top legislative priority and, dollar-for-dollar, the best bang for your buck in the battle to achieve that goal is your AMPAC membership. In the last election cycle, AMPAC was the second largest political action committee in the country in terms of independent expenditures and direct contributions to candidates, spending more than $4.5 million. AMPAC was ranked near the top in terms of successes in competitive races, according to the *National Journal*. The same nationally-respected publication ranked AMPAC as the most powerful health-related political action committee. These successes translated into federal legislative achievements in the 108th Congress.

AMPAC MEMBERSHIP

As of May 31, 2004, AMPAC membership stands at 33,388. This compares with year-to-date membership of 36,899 in 2003, a difference of 3,511. This decline is due to a fall off in members transmitted to AMPAC in several states, a delay in monthly transmittals by numerous states, as well as a slight delay in direct member processing. We anticipate overall membership in AMPAC will increase in 2004.

As of June 2nd, AMPAC Capitol Club membership stands at 253 members. This figure is an increase of 191 members over 2003's year-end total and an increase of 220 members over 2002's. So far this year we have witnessed a 400 percent increase in Club memberships over the entire membership of last year. As the most prominent level of political participation within AMPAC, we encourage all members of the House of Delegates to become 2004 members of the AMPAC Capitol Club. Please visit the AMPAC booth to become a member today.

Following AMPAC's spring meeting in Washington, DC, in March, the AMPAC Capitol Club held an exclusive member-only luncheon in conjunction with the AMA's National Advocacy Conference. The featured speaker was scheduled to be Senior Advisor to the President Karl Rove. Due to a last minute schedule conflict, Mr. Rove was unable to attend the luncheon. However, White House Chief of Staff Andy Card provided well-received remarks to the capacity audience of AMPAC Capitol Club members. The next scheduled AMPAC Capitol Club event is June 15 in Chicago featuring senior surrogates from the two presidential campaigns.

To date, the states with the highest attainment of AMPAC members to potential are Mississippi (29%), Florida (23%), and Oregon (20%). The states with the highest number of student members of AMPAC are Florida (141), New York (105), and Texas (51).

POLITICAL ACTION

Since the AMA's Interim Meeting in December of 2003, AMPAC has already been active in the 2004 election cycle. AMPAC has sent partisan communications fundraising letters on behalf of two candidates, Rep. Allen Boyd (D-FL-02) and Lyle Thorstenson, MD (R-TX-01). Dr. Thorstenson lost in the Republican primary; however, Rep. Boyd continues to buck his party leadership and be a strong supporter of medical liability reform in the US House. Additionally, AMPAC has conducted get-out-the-vote outreach pieces for four candidates in their primary races including Dot Snyder (R-TX-19), a physician's spouse, Rep. Bill Shuster (R-PA-09), Rep. Melissa Brown (R-PA-13) and Rep. Wayne Gilchrest (R-MD-01).

AMPAC continues to work with the Democratic and Republican campaign committees to identify candidates who may benefit from political programs outside of the traditional PAC contribution. This has included polls that AMPAC conducted on behalf of Rep. Rick Renzi (R-AZ-01) and Rep. Heather Wilson (R-NM-01) so far this cycle.

POLITICAL EDUCATION PROGRAMS

The 2004 Campaign School held in April was well-attended by 40 AMA and Alliance members from 17 states, in addition to three Federation staff. And, in March, 25 members from 14 states attended the 2004 Candidate Workshop. Participants included potential candidates for US Congress and Senate, as well as state and local races.

Plans for next year include the three-day Candidate Workshop scheduled for February 18-20, 2005 and the five-day Campaign School scheduled for April 13-17, 2005. Both programs will be held in Arlington, Virginia.

We have revived *AMPAC Update*, a newsletter communicating the political activities and policies of the AMPAC Board to the Federation. The first issue of the newsletter was mailed to state staff and leadership in May. New content was provided for the political education section of the web site including "how to" articles and guest columns by political consultants and other nationally recognized experts.

CONCLUSION

On behalf of the AMPAC Board of Directors, I would like to thank all of our members for their continued involvement in political and grassroots activities. Through this support and leadership we positively impact public policy decisions that are beneficial to our patients and our profession. Perhaps more importantly, I strongly encourage all physicians to vote and to encourage our patients to vote this fall. Just as we have a responsibility to care for our patients, we also have a duty to our profession and to our patients to assure the interests of medicine are properly represented in the halls of Congress.

DISTINGUISHED SERVICE AWARD: John E. Chapman, MD, was nominated by the Board of Trustees and confirmed by the House of Delegates as the 2004 recipient of the AMA Distinguished Service Award, which will be presented at the 2004 Interim Meeting. The following report was presented by William G. Plested, III, MD, Chair, Board of Trustees:

John E. Chapman, MD, Nashville, Tennessee

John E. Chapman, MD, has had a distinguished and remarkable career dedicated to enhancing the quality of medical education not only in the United States but worldwide. At the American Medical Association, Dr. Chapman was the founding member of the Section on Medical Schools in 1976 and served on its Governing Council as Chair, and as Delegate and Alternate Delegate to the House of Delegates. The SMS celebrated its 25th anniversary in 2001 and Dr. Chapman was asked to give the keynote address at the Section's 2001 Interim Meeting as a tribute to his steadfast commitment to the Section over the years.

At the national level, Dr. Chapman served as a member and Chair of the Council on Medical Education; as a representative to the Accreditation Council for Graduate Medical Education; as a member and Chair of the Liaison Committee on Medical Education; as a member of the Steering Committee of the Health Policy Agenda for the American People project; and as a member of the Task Force on Minority-Related Issues.

In his capacity as Chair of the Council on Medical Education he spearheaded three reports on the "ecology of medical education." His interest in the environmental forces affecting medical education has been long-standing and he frequently writes and speaks on this issue.

Dr. Chapman was the Dean of the Vanderbilt University School of Medicine from 1975-2001, and is currently Associate Vice Chancellor for Medical Alumni Affairs and Professor Emeritus of Medical Administration and Pharmacology. During his tenure as Dean, in an annual survey of medical students, he was consistently rated the highest in student satisfaction. Dr. Chapman has been a mentor and role model for many generations of medical students and physicians.

In addition, Dr. Chapman has long been active in the Tennessee Medical Association, which recognized him in 2000 by awarding him its Distinguished Service Award.

Dr. Chapman exemplifies the best in service to medical education and to future physicians. It is through the education of the next generation of physicians that our health care system is maintained at its high level. His unwavering dedication, throughout his remarkable career, to enhancing the quality of medical education and health

care is absolutely commendable. He has significantly contributed to the strength of academic medicine and has been an outstanding advocate for all of organized medicine. Dr. Chapman is a “quiet giant” when it comes to his vision and progressive activity in medical education, and he is an outstanding choice for the AMA Distinguished Service Award.

CITATION FOR DISTINGUISHED SERVICE: Richard Verville, JD, was nominated by the Board of Trustees and confirmed by the House of Delegates as the 2004 recipient of the AMA Citation for Distinguished Service, which will be presented at the 2004 Interim Meeting. The following report was presented by William G. Plested, III, MD, Chair, Board of Trustees:

Richard Verville, JD, Washington, DC

Richard Verville, JD, is an outstanding advisor and advocate for the field of Physical Medicine and Rehabilitation (PM&R). Mr. Verville has made many significant contributions to the growth of the field and to the advancement of disability rights nationwide. He has played an active and passionate role in the passing of important legislation related to civil rights, childhood vaccines, the Americans with Disabilities Act, and the Rehabilitation Act, as well as the creation of the National Center for Medical Rehabilitation Research within the National Institutes of Health. He has also been actively involved with issues surrounding Medicare and Medicaid coverage.

His keen analytic mind and full grasp of public policy imperatives make him one of the most highly respected advisors in PM&R and throughout the Washington community. Mr. Verville’s advice and counsel have been invaluable to all organizations focused on medical rehabilitation. His efforts have helped propel PM&R from the fringes of medicine into the mainstream. Most importantly, Mr. Verville always approaches critical issues related to disability from both a public health and medical perspective. His efforts have helped reshape government, making it more responsive to persons with disabilities.

Mr. Verville has spent ten years as a partner in Powers Pyles Sutter & Verville, specializing in health care law and legislation. He previously was a partner for over 20 years in White Fine and Verville, and before that served as Deputy Assistant Secretary for Legislation, US Department of Health, Education and Welfare. He has received numerous honors and awards, including Distinguished Public Service Award from the Association of Academic Physiatrists, and Charles H. Best Award for Distinguished Service from the American Diabetes Association.

He has become an important link in the advocacy chain, ensuring the AMA, American Academy of Physical Medicine and Rehabilitation, and Washington work together and stay connected. Mr. Verville has an esteemed record of personal and professional service and has been honored by many clinical, professional, and academic organizations. For all these reasons, he embodies the spirit of this prestigious award and is a deserving recipient of the AMA Citation for Distinguished Service.

IN MEMORIAM - RAY W. GIFFORD, MD: The Board of Trustees presented the following in memoriam of Ray W. Gifford, MD:

Ray W. Gifford, MD, a member of the American Medical Association Board of Trustees from 1986-90, died May 4 at his retirement home in Fountain Hill, AZ, at age 80.

Dr. Gifford had a long and distinguished career. He was an internationally known authority on the treatment of hypertension. After graduating from the Ohio State University medical school, he served in the Navy Medical Corps and became attending physician to the United States Congress. He later joined the staff of the Cleveland Clinic, where he spent the remainder of his career.

He was head of the Cleveland Clinic department of hypertension and renal disease from 1967 to 1985, and was widely acclaimed a pioneer in the use of anti-hypertensive drugs. He founded the National Hypertension Association in 1977. He was co-author of 100 Questions and Answers about Hypertension, a widely distributed book for lay audiences.

Dr. Gifford served the AMA as a member of the Council on Scientific Affairs from the time of its founding in 1976 until 1985, when he became a member of the Board. His service to his patients and to his profession exemplified the finest traditions of medicine.

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INAUGURAL ADDRESS: John C. Nelson, MD, MPH, was inaugurated as the 159th President of the American Medical Association on Tuesday, June 15. Following is his inaugural address:

LIGHTING A PATH FOR OUR PATIENTS

It is a great honor for me to be standing in front of you this evening. I know for a fact that without the love and support of many people, I would not be here. Thank you all.

A little more than two years ago, Salt Lake City, my home town, went through an enormous change. As long as I've known it, Salt Lake has been a quiet little Western town. We have been accused of rolling up the sidewalks at about 4:30 every day. The change that took place was, in part, a physical change. But much more than that, it was a change in perception, the world's as well as our own. The 2002 Winter Olympics Games came to town, with its 78 winter sports events and thousands of international visitors. We threw a party for the planet. That party ended after a dream-like two weeks--but the positive energy it promoted goes on still.

Yes, our sleepy little town woke up. And, for a brief time, Salt Lake City became a beacon for the world. And, something that has lasted much longer, we Salt Lakers now see ourselves as more positive and empowered. The Olympic torch touched off a spirit that inspired and enlightened us, and enkindled a fire within each of us that burns on even today.

So why, tonight, on this night when I take on the honor, the privilege, the responsibility of becoming the president of this prestigious national organization, do I hearken back to something that happened over two years ago in a faraway Western city? Because I watched the transformation of my city and its citizens when they finally understood what they could do--and how they felt when they actually did it.

We are all capable of great things; the AMA and the profession of medicine are especially capable of great accomplishments. I want us to know what we can do and to feel that great pride of actually doing it. But we need to re-think, re-envision and re-invigorate our future and the future of our American medical system.

The motto of Salt Lake City's 2002 Winter Games was "Light the Fire Within." Many of you probably remember the opening ceremony. Into an enormous, darkened stadium skated hundreds of children, each carrying a small lantern. Though the lanterns were small, with only a tiny light in each one, when added together, they lit the entire stadium.

We can apply that Olympic theme of "Lighting the Fire Within"--to physicians--and to our AMA. Because I know that all physicians, whether you can see it or not, have within us a fire of compassion, a fire of service to our patients. In fact, it is that fire of compassion and that sense of service that called us all to Medicine in the first place.

I agree with Sir William Osler, who said: "The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."

Medicine has been my calling for almost thirty-five years now. And its flame continues to burn brightly within me. In spite of the winds of change that will always challenge our profession.

As a visual learner, I have always seen the practice of medicine as three interconnecting rings--similar to the intertwined Olympic rings. The first ring or circle represents science--an evidence base for all we do. As men and women of science, we understand that science yields the truth. It is our biggest and most potent weapon in diagnosing and treating our patients. It is indispensable as well in advocating for our profession.

The second circle--just as large, and interlocking with the first--is the circle of caring. Caring not just for our patients, which, of course, we all do, but also caring about our patients. As Francis Peabody said at Harvard in 1927: "For the secret in caring for the patient--is to care for the patient." For the patient-physician relationship to succeed, we must put the patient first--always. When the patient always comes first, we are acting as professionals.

The third circle--interlocking with the first two--is the circle of ethics, the framework in which we employ science and caring. Ethics demands putting patient above self, patient first, patient always.

At the intersection of these three circles is the patient-physician relationship. And when these three circles interlock correctly in an appropriate patient-physician relationship, the result is a quality health care experience for both patient and physician. The patient-physician relationship is the cornerstone of American medicine. We at the AMA welcome any and all attempts to understand it, to measure it, and to strengthen it. But we will not tolerate any attempts to undermine it. This is simply not negotiable.

My father, the late Dr. Dean F. Nelson, was the first obstetrician/gynecologist to become board certified in the state of Utah in the early 1950s. I believe he was an exemplary physician. He was very busy, but always cared deeply about his patients. Wherever we would go in my boyhood home of Ogden, Utah, patients would greet him fondly. I could feel their respect for him. I was, of course, proud to be his son. And, of course, I wanted to grow up to be just like my Dad. When I graduated from medical school, I couldn't tell who was more excited--my Dad or me. I remember that he often would say to me, "Try to leave the profession a little bit better than you found it."

As I have practiced medicine over the years, I have tried to keep in my mind--and in my heart--one fundamental question: How will the profession and my patients be better off for my being here?

This is how I have tried to live my life both professionally and personally. It has been the basis for choices I have made over the years, and it is why I am here tonight. No doubt, it is why all of us are here this evening rather than using this valuable time in countless other ways. Because we all are here together, united by our profession as well as by our professionalism, I feel certain we can improve health care for all Americans.

Let me refer again to that Olympic lantern. But this time, its use is to shed light on our nation's health care system. In this case, the lantern becomes--not just a symbol for the fire that burns within us--but a tool to light the way ahead.

Our national health care system has much to commend it. We have amazing technology, fantastic devices, and miraculous medications. The United States leads the world in medical research. Miracles occur every day because of these wonders.

As hard as we physicians work, our efforts alone cannot improve the American health care system, which currently does not allow health insurance coverage for 44 million of our fellow citizens. We can no longer just put Band-Aids on this problem. Instead, we need to raise the lantern to look for creative, evidence-based solutions to invigorate this system and make sure that health care coverage is available to all.

We propose solutions like those found in the AMA's comprehensive health care campaign, "Healing the System." Here we present our advocacy priorities in a positive and systematic approach to saving and rebuilding our health care system based upon time-honored principles--and adding to them when necessary, using an evidence-base.

Let me share a few highlights of "Healing the System" with you: There are three critical tasks that are particularly important to physicians as well as to our patients: Health care coverage for all, Improving Medicare, and reforming a broken liability system.

We start with our carefully crafted, reasonable and actuarially sound approach for bringing health care coverage to all Americans. The AMA plan calls for refundable, advanceable tax credits which are inversely related to a person's income. This means that a person gets the tax credit whether or not that person pays income tax. It also is paid prior to the income tax year, so that it can be used to purchase health insurance at the beginning of the year. Of course, this subsidy must be big enough to purchase realistic health care coverage. Inversely proportional means that those who have the most need--get the most help. That's only fair.

Clinicians cannot allow race and ethnicity to cloud our clinical judgment, which could lead to disparities in health care. Therefore, we ask those who evaluate our plan not to have their vision blurred or clouded by preconceived notions. Our plan, which has bipartisan support, would likely cover up to 95 percent of Americans. While critics might be quick to chide us for not getting 100 percent coverage, I'd recommend that instead of scoffing, our critics join with us to improve our proposal and work with us to help make it become a reality en route to health care coverage for all Americans.

Our Medicare system needs an overhaul. In addition to the recently enacted prescription drug benefit, the Medicare program needs further work to ensure its future financial stability. This program needs significant change in order to keep up with the advances in clinical medicine, including new procedures, drugs, and diagnostics. It also needs to be able to accommodate a burgeoning population of baby boomers who will soon hit retirement age.

We call for an evidence-based approach to improve the Medicare program--and to help us avoid the partisan politics that might do harm to our patients.

Medical liability reform continues to be the AMA's top legislative priority: To protect access to quality medical care for all Americans. We will continue to press for reasonable limits on non-economic damages and other proven liability reforms. As the evidence clearly tells us, these changes will help bring stability to the huge costs of the current system.

Where proven reforms are in effect--babies are delivered safely, children are treated locally instead of being sent to other states for emergency treatment, and physicians don't have to close their offices or refuse to perform high tech procedures. Even when something works, we still can try to make it better--and we would be remiss if we did not explore options that might improve the system. The AMA has been exploring other options and will continue to do so. For just as the state of medicine advances--so too must the liability system.

To do that, we must initiate a productive dialogue with all stakeholders to identify or create a liability system that will meet the needs of the future. That system must have certain characteristics: It must be fair to all--patient, physician, payer, and yes, the legal profession. But it must also be accountable--both in potential payment to those who are harmed by real negligence and by correctly identifying only those cases where true negligence occurs. The approach must be comprehensive and, where possible, use proven methodology. And whatever system emerges must be for the good of all patients, not just a few who obtain extraordinary payouts, as is currently the case.

Indeed, this system, too, needs to be patient centered. This is clearly going to be a two-step process. It is important that the first step is to implement evidence-based reforms that will stabilize the system. But we must not stop there. We must go on to a better system.

When patients understand that our concern really is their welfare, we will immediately have innumerable allies. "Healing the System" offers a strong, positive agenda for repairing the health care system. It is not going to happen overnight, but we must take the necessary steps to make it happen in order to protect our patients as well as our profession. When I examine this comprehensive campaign in its entirety, I've got to admit I get excited. What to do first? Where should we turn? Which is the first priority?

I have spoken before about my adventures in a small boat on a storm-tossed lake. The lake I was referring to is Lake Powell in Utah, a 200-mile long lake with 96 canyons. The periphery of this lake is longer than the entire west coast of the United States. Of all the places I have ever visited, Lake Powell is my favorite place to vacation. Usually, the weather there is calm and very hot, but desert storms do occur and they are, to say the least, impressive.

On another trip in the houseboat, Linda and I with a couple of our kids had taken our motorboat to the marina for some ice cream and much needed cool drinks. While we were gone, a desert storm arose from nowhere. We were not far from the houseboat, but needed to get back as only three children were there to keep it secure. And the total weight of the three kids combined was barely 200 pounds. We were in the motorboat in the main channel in very choppy water. Our son, Jeff, later told me he actually saw our boat rise completely out of the water and slam back into it. The houseboat was off to our right 90 degrees, about a half mile away. Naturally I cranked the steering wheel of our boat hard to the right, but nothing happened. I repeated it several times without success. I then found if I got the boat on the top of the wave at just the right time and turned just a little, the bow would veer slightly to the right.

I recalled then that, as Scriptures say, "A very large ship is benefited very much in the time of a storm by a very small helm working workways with the wind." That process, when repeated, eventually got us safely back to the houseboat again, and all was well.

That is precisely how I envision the AMA should deal with our enormous and cumbersome health care system that is caught in a storm right now--a storm that threatens the very ship of medicine. Our AMA must position itself on the top of every wave. We will work with the wind, using it to move in the right direction and sail through the storms for our patients.

In this way, we can find a solution for the uninsured and for our low income patients. To do so, we must aggressively advocate the AMA plan to cover the uninsured.

We can define and establish quality in medicine, protecting our patients, and righting the wrongs of managed care. To do so we must use evidence-based solutions with our patients' concerns at the center. And we can mend a broken liability system by advocating for as well as with our patients.

Not all of this can be accomplished in one year, and it won't be easy. But we can work with the wind and move our ship, our magnificent profession, even with little turns at a time in the correct direction to benefit our patients.

As Americans, we can't just settle for a one-size-fits-all system. We expect and receive the empowerment of choice. The AMA's plan for health system reform, a major component of our "Healing the System" effort, will give our patients choice--and will cover approximately 95 percent of the US population. This proposal doesn't depend on a political quick fix or an ideology-driven overhaul, but calls instead for changes that will empower our patients. And we depend on both the private as well as the public sector to do their part.

If we look back in time, we will find that the AMA has been working for universal health insurance coverage, health care for all Americans, since the earliest years of the twentieth century. Isn't it time to turn our vision into reality? And we can.

Recall what has been accomplished in Medicine just in my lifetime. As a boy, I remember not being able to go swimming in the summer for fear of polio. How excited I was to learn of Dr. Jonas Salk's polio vaccine!

While a medical student at the University of Utah, Dr. Willem Kolff completed the final design for the first artificial kidney. And also at the University of Utah, Dr. William DeVries implanted the first total artificial heart in Dr. Barney Clark in 1982. At the same institution, Dr. Mark Skolnick discovered the BRCA-1 gene, which has been linked to certain forms of breast cancer. Today, Dr. Don Berwick at IHI and Dr. Brent James at Intermountain Health care are teaching us how to use data to make our patients' care safer and to improve the quality of that care.

I have no doubt that the coming generation of physicians as well will leave their mark. Students like Ben Galper, Tova Rosen, and Howard Forman at the Albert Einstein School of Medicine are working together with teenagers in the Bronx to help them avoid the pitfalls of alcohol use at an early age.

Some of the students active in the AMA Medical Students Section, who were also recipients of the AMA Leadership Awards this year deserve mention:

Shane Hopkins, of the University of Iowa Carver College of Medicine, recently was appointed as the student representative to the Council on Student Affairs.

Jennifer LaPlante, of the University of Florida College of Medicine, advocates for anti-tobacco legislation, and tutors and mentors her fellow medical students.

And Brooke Bible, of the University of Mississippi School of Medicine, is a medical student activist, with an online medical grassroots newsletter.

It is so true, medical students are the future of our profession. Students like these assure me that our future is in good hands.

Not only must we as physicians always focus on the concerns of our patients, but we must use our influence to make sure that all in the health professions do the same. Thus we can emulate a tool that physicians have used since 1960, the laser, a miraculous device that minimizes the invasiveness of surgery.

Lasers remind us of the power of a unified force, contrasted with the inefficiency and ineffectiveness of randomly applied efforts. A laser's light is concentrated in one specific wavelength. Now that's power. That's energy. But how should we use that power and that energy?

We live in an era of unprecedented advances in medical care. Health outcomes are better, and life spans are longer. Advancements once were only dreamed of are now commonplace. But our future is only as bright as we are willing to make it.

As a profession, we have the duty to define our future. Will it be controlled by budget-cutting bureaucrats, uncaring third parties, and an insatiable liability system? Or will we, using a laser-like focus, make it an era of technical advances, health care coverage for all Americans, and an increase in professionalism? Only we can make that choice, and we must make it together.

Health care coverage for all America, Medicare reform, a better and fairer liability system provide a challenging agenda. Are these tough issues? You bet! Can we accomplish them? Well, are they any tougher than mapping the human genome, developing the PET scan, or finding the causative organism for SARS? I don't think so.

Yes, we can make strides towards these goals in a logical, step-by-step fashion. And we must! Our very future, as well as the future of our profession, depend on it. We can't get frustrated. We can't get angry. We must get involved. When we work together, we wield a laser-like power. We can and we must set the goals, frame the debates, and rekindle the power of our profession that burns deeply in all of our hearts.

In closing, let me share the story of one more lantern. A lantern in the hands of a physician who certainly understood how to light a path, and offer hope: Nobel Peace Prize winner Dr. Albert Schweitzer. In his mission in Africa, he hung a lamp on the pier that led to his hospital in Lambarene. The light served as a beacon of hope for all the area's sick and dying.

But even more welcoming was the sign Dr. Schweitzer hung beneath the lamp:

"At whatever hour you come, you will find light, and hope and human kindness."

Here is an original Olympic lantern actually used in the opening ceremonies of the Salt Lake Olympics in 2002. See how small it is? But recall the effect of hundreds of these lanterns when put together. And like my fellow citizens of Salt Lake City who felt the pride of our capabilities and accomplishments--let that same pride well up within us.

Let our light be the light that illuminates the path ahead, giving our patients hope and human kindness. Let that light shine on us as we work together, rebuilding a health care system that will work fairly and effectively. And let that light shine within us, so brightly that all around us may warm their hands by the light within us. This is what our patients deserve. This is what our profession demands.

Thank you for bestowing on me this incredible honor. As we begin this presidential year together, may Heaven's light shine on all of us in our service to our patients, our profession and our American Medical Association. Together we can--together we will--make a difference.

Good night and God bless the American Medical Association.