

AMERICAN MEDICAL ASSOCIATION**58TH INTERIM MEETING
ATLANTA, GEORGIA
December 4-7, 2004****CALL TO ORDER AND MISCELLANEOUS BUSINESS**

CALL TO ORDER: The House of Delegates convened its 58th Interim Meeting at 3:00 p.m., on Saturday, December 4, in the Centennial Ballroom of the Hyatt Regency Atlanta, Nancy H. Nielsen, MD, PhD, Speaker of the House of Delegates, presiding. The Sunday session, December 5, Monday session, December 6, and Tuesday session, December 7, also convened in the Centennial Ballroom.

INVOCATION: Joseph P. Bailey, Jr., MD, AMA Delegate from Georgia, delivered the following invocation on Saturday, June 15:

Our Father and our God. We come together for the purpose of perceived good. Trusting that our perception is in concert with your desire and the only absolute truth, your word.

We are gathered under the banner of our American Medical Association. Hoping that our actions will be such as to improve the lot of our fellow human beings--your children--our brothers and sisters.

We recognize the frailty of our efforts without your presence and we pray for your intervention in all things that we do. And as well we pray for your mercy in our failures and stumblings. And especially we pray that the hardships of this world fall on each of us with no more weight than a single plume of goose down floating to earth on a cool summer breeze.

In this time of trouble and worldly turmoil watch over our children who we leave placed in harm's way in foreign lands. Be their armor and support and that of their families.

We ask much of God but we do so knowing Thy absolute and omnipotent presence in the Universe.

DISTINGUISHED SERVICE AWARD: John E. Chapman, MD, of Nashville, Tennessee, was the recipient, posthumously, of 2005 Distinguished Service Award, the Association's highest honor. Dr. Chapman was recognized for his remarkable career dedicated to enhancing the quality of medical education not only in the United States but worldwide. In addition to other positions, Dr. Chapman served as chair of the AMA Council on Medical Education, and was a founding member and later chair of the AMA Section on Medical Schools. He was also cited for being a mentor and role model for many generations of medical students.

CITATION FOR DISTINGUISHED SERVICE: Richard Verville, JD, of Washington, DC, was presented the 2005 Citation for Distinguished Service in recognition of his significant contributions to the growth of the field of Physical Medicine and Rehabilitation and to the advancement of disability rights nationwide. Mr. Verville has been actively involved with issues surrounding Medicare and Medicaid coverage and in the passing of important legislation related to civil rights, childhood vaccines, and the Americans with Disabilities Act.

ISAAC HAYS, MD AND JOHN BELL, MD AWARD FOR LEADERSHIP IN MEDICAL ETHICS AND PROFESSIONALISM: Jay A. Jacobson, MD, of Salt Lake City, Utah, received the 2005 Hays Bell Award in recognition of his dedication to the principles of medical ethics and the highest standards of medical practice. Dr. Jacobson was also cited for directing the Partnership to Improve End-of-Life Care in Utah, which greatly improved such care and had a significant legislative impact in the state.

JOSEPH B. GOLDBERGER AWARD IN CLINICAL NUTRITION: Bruce R. Bistran, MD, PhD, of Boston, Massachusetts, was the recipient of the 2005 Joseph B. Goldberger Award in Clinical Nutrition. Dr. Bistran was honored for his landmark contributions to the field of nutrition through research and training of nutrition research and clinical fellows. He was also honored for his excellence in translational research in the field.

MEDICAL EXECUTIVE ACHIEVEMENT AWARD: The 2005 Medical Executive Achievement Award was presented to Thomas J. Curry, of Seattle Washington, to honor his career in organized medicine, especially as Executive Director/CEO of the Washington State Medical Association; and to Thomas R. Russell, MD, in recognition of his service to organized medicine, especially as Executive Director of the American College of Surgeons.

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, December 4, 484 out of 545 delegates (88.8 percent) had been accredited, thus constituting a quorum; on Sunday, December 5, 510 out of 545 (93.6 percent) were present; on Monday, December 6, 527 out of 545 (96.7 percent) were present; and on Tuesday, December 7, 532 out of 546 (97.4 percent) were present. (On Monday, the Minority Affairs Consortium was granted representation in the House of Delegates.)

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Marie G. Kuffner, MD, Chair:

Saturday, December 4

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 her 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.

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 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, December 5

**HOUSE ACTION: LATE RESOLUTIONS 1001 (835), 1005 (836) AND 1006 (837)
ACCEPTED**

LATE RESOLUTIONS 1002, 1003 AND 1004 NOT ACCEPTED

**EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 702,
704, 715, 722, 724, 801, 806, 807, 812, 813, 814, 824, 903, 904 AND 908**

**RESOLUTIONS 705, 711, 712, 723, 805, 809, 906, 921 AND 922
EXTRACTED AND REFERRED TO APPROPRIATE REFERENCE
COMMITTEES**

The Committee on Rules and Credentials met Saturday, December 4, 2004 to discuss Late Resolutions 1001 through and 1006. 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 1006 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 1001 - Fourth Tier Pharmaceutical Benefits
Submitted by New Mexico Delegation
2. Late Resolution 1005 - DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution
Submitted by American Society of Addiction Medicine
3. Late Resolution 1006 - Opposition to CMS Elimination of ASC Payments
Submitted by Georgia Delegation

Recommended Not Be Accepted:

4. Late Resolution 1002 - Possible Anti-Competitive Behavior of Integrated Hospital Systems via the Expectation of Referrals to Hospital System Employed Physicians
Submitted by New Mexico Delegation
5. Late Resolution 1003 - Opiate Replacement Therapy Programs in Correctional Settings
Submitted by New Mexico Delegation
6. Late Resolution 1004 - Advocacy and Access to Care for Patients
Submitted by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont Delegations

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 ten 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, available from the Office of House of Delegates Affairs):

1. Resolution 702 - Physical Therapy Services
2. Resolution 704 - Medicare Savings Using Free-Standing Outpatient Facilities
3. Resolution 705 - Deductibility of Medical Student Loans
4. Resolution 711 - Structuring Health Insurance Benefits to Moderate Costs and Improve Access
5. Resolution 712 - Fair Payment for Professional Liability Insurance
6. Resolution 715 - CMS Implementation of Reimbursement Policies Affecting ESRD Patient Care Without Appropriate Input from the House of Medicine and in Violation of the Administrative Procedures Act
7. Resolution 722 - Influenza Vaccine Shortage
8. Resolution 723 - Medical Research Publishing Proposal from NIH
9. Resolution 724 - Privatization of Medicaid
10. Resolution 801 - Reimbursement for Telephone and Electronic Communication
11. Resolution 805 - Published Reimbursement Schedules by Private Insurers
12. Resolution 806 - Promulgating Equitable Valuation of Physician Services
13. Resolution 807 - Opposition to Precertification Programs
14. Resolution 809 - Pain Management
15. Resolution 812 - Requiring Insurance Companies to Disclose Any Variance From AMA CPT Guidelines
16. Resolution 813 - Nationwide Standardization of Reimbursement Policies for the Insurance Industry
17. Resolution 814 - Patient Assistance for Drug Benefits Based on Individual Need
18. Resolution 824 - Intrusion of Prescription Drug Formulary Requirements on the Practice of Medicine
19. Resolution 903 - Medicare Drug Pricing
20. Resolution 904 - Ensuring Access to Medications for Medicare Beneficiaries with Mental Illnesses
21. Resolution 906 - Medicare Physician Payment Update
22. Resolution 908 - National Prompt Payment Statute
23. Resolution 921 - Tort Reform
24. Resolution 922 - Confidentiality of Peer Review Process

Tuesday, December 7

HOUSE ACTION: ADOPTED

Your Convention 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 Convention 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 Atlanta, Georgia during the period of December 4-7, 2004; 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 Atlanta 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 several participating hotels, to the City of Atlanta, 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 153rd Annual Meeting of the House of Delegates, held in Chicago, Illinois, June 12-16, 2004, were approved.

ADDRESS OF THE PRESIDENT: The following remarks were presented by John C. Nelson, MD, MPH, President of the American Medical Association, on Saturday, December 4:

STATE OF THE AMA - MIDTERM REPORT

Thank you, ladies and gentlemen. Thank you for that kind welcome.

I'm reminded, at this gathering of the leaders of the great House of Medicine, of another gathering of leaders. It was March 15, 1783 in a hall called the Temple. George Washington had called together the officers of his army. He spoke from a prepared manuscript. He stumbled. He squinted. Paused.

Then he took from his pocket a new pair of spectacles. And he said, "Gentlemen--you must pardon me. I have grown gray in your service. And now I find myself growing blind." Most had never seen General Washington wearing glasses before. All recalled the eight hard years of fighting for freedom. All they now saw was a big, still-good, fatherly man grown older. Many of those warriors wept.

My friends, many of us, too, have grown gray in service to our patients, and some of us even find ourselves growing a bit blind. But I can say--for my part--the effort has been worth it. It continues to be a privilege and an honor to represent us, to work for you as your President.

In recent months, my life has been a rather interesting study in contrasts. I have traveled in the largest commercial airplane, a Boeing 747, and one of the smallest, a single-engine, propeller-driven one.

I have spoken with the Emperor and Empress of Japan in Tokyo, and gone door-to-door to speak with housewives in Casper, Wyoming. I have spoken on our behalf in a small, community hospital in Ashland, Oregon, and at the world-renowned Children's Hospital at Harvard University in Boston, Massachusetts.

In all the travel, and meeting, and speaking, I have tried to keep faith with the ideals we discussed back in June at the Annual Meeting. To set the goals, frame the debate and rekindle the spirit of professionalism in us all.

Those goals and that debate must include: Insuring access to quality health care for all Americans; eliminating disparities due to race and ethnicity; curing the broken medical liability system; and revising the flawed Medicare payment system.

Let us recall that the spirit of our profession can be described as three interlocking rings. The first ring, science, is an evidence base for all we do. The second ring, a circle of caring, means caring for our patients, but also caring about our patients. The third ring, the circle of ethics, is the framework within which we employ science and caring.

We are compelled, then, to work tirelessly on behalf of our patients because, if we don't, who will?

As we gather here in Atlanta, as we consider literally hundreds of ideas, reports, proposals and resolutions, we need to keep all of this in perspective. That perspective, I believe, can be found in the ideas of one of the most influential writers of any age, Anatole France, winner of the Nobel Prize for Literature in 1921, who said: "To accomplish great things, we must not only act, but also dream; not only plan, but also believe."

Clearly, this House has a proud tradition of accomplishing great things, of dreaming great dreams, and of having a fundamental belief that is the foundation of all our plans. That belief is rooted in the question: How will our patients be better off because of what we do?

As your President, I am committed to seeing that those plans, once recorded, become a reality. I am committed to our belief, the very rationale of our being, that the patients of America receive the best care that medical science can give them. For every one. All the time.

Our Number One priority is our patients. Period. How do we live that ideal? How do we show that priority? Let me be specific--in four very tangible cases:

First, let me talk about one of the cornerstones of the AMA's plan to heal the health care system: Access to health care coverage for all Americans. Our plan is summarized in this booklet; many of you have read and used it, I know. Our concern is for the 45 million of our fellow-Americans without health care coverage.

We advocate in Congress and across the country, on behalf of our patients, a three-phased solution. First, tax credits--a fair, feasible and effective way to increase coverage. Second, Health Savings Accounts. Third, market regulation--implicit in the entire plan.

Strangled by red tape and mountains of regulations now, the health care system could use some radical surgery on its bureaucracy--surgery that removes barriers to care and creates new incentives for insurers to cover patients with predictably high premiums. For healthy people, the result would be lower-cost coverage, true market-cost pricing, providing a further incentive for individuals to buy insurance.

The AMA plan is a good plan. It is well researched. Based on two decades or more of solid analysis. Focused like a laser on what's best for patients.

We are currently working with Search for Common Ground to act as a go-between among the various factions in the health care system in an attempt to increase access to health care coverage. Make no mistake about it, our American Medical Association is serious about solving this access problem. We will succeed because it's the right thing for our patients.

Second, we'll also succeed, through conviction and dedication and science, in eliminating disparities in health care delivery due to race and ethnicity. It is fitting that we meet in Atlanta, the cradle of the Civil Rights Movement, home base for the Reverend Martin Luther King, Junior. He literally gave his life in the cause of unifying Americans, regardless of color, of fulfilling a dream of unity and service to each other.

If he were here today, he most certainly would point out that racial and ethnic disparities have no place in the American ideal. The AMA asserts that those disparities absolutely have no place in health care in America. They pose additional burdens on an already overburdened system. They waste time, talent and opportunity. They result in insufficient access, lack of physician diversity, lack of cultural competence and poorer care.

The facts are clearly established. Racial and ethnic minorities experience lower quality of care. Victims of disparity are less likely to receive routine treatment. They experience higher rates of morbidity and mortality. But these factors can be reversed.

That's the job description for the Commission to End Health Care Disparities. It includes 37 public health, state and medical specialty societies, and other organizations. It is committed to increasing professional awareness, to educating physician-leaders, to researching clinical ways physicians can change their practices to eliminate disparities and to diversifying the workforce itself.

It will convene again next month in Washington. On January 31st, a press event will kick off the awareness phase of its work. The Commission, launched by the American Medical Association and cosponsored by the National Medical Association, will speak out--set the goals, frame the debate and rekindle our professional spirit. It's 37 organizations strong now, and hoping to attract many more, all in the interest of our patients.

Third, and perhaps the single most visible program the AMA has launched for our patient's benefit is our ongoing quest for reform of the broken medical liability system. I was going to call it a medical liability justice system, but justice just isn't part of the equation.

There is a uniquely American character trait we call “fair play.” As the nation hears our story, America responds, both at the state level and nationally in Washington. Last month, medical liability reform measures were on the ballots in four states and passed in three. In all four, the AMA was there, alongside state and local associations, getting the story to the public. Constitutions can be changed. Just ask Texas. The AMA will not rest until we remove the litigious boot from the neck of medicine.

Think with me for just a minute. The medical liability system, in all its forms and features, carries enormous costs--in dollar terms, in stress, but most importantly in limiting access to care for our patients. It penalizes the high-risk specialties, both those who provide the services and those who need them. It drives physicians into early retirement, or out-of-state, or away from high-risk procedures altogether. It forces insurance companies to close.

In so doing, it hurts our patients. This issue is about patients, first and foremost. Just last week in Chester County, Pennsylvania, a young man suffered severe head trauma in an automobile accident. He was taken to the nearest trauma center, only to learn it had recently lost its only neurosurgeon because of runaway liability premiums. That meant the nearest neurosurgeon was another ambulance drive away. So, instead of care in the critical first, golden, hour, the patient was not treated for two hours and he died. That must not happen in the United States of America.

Today, a system that calls itself “just” is now a system just plain out of control. We’re all in the same boat, physicians and patients, tossed about on a hazardous sea of injustice. Physicians and the courts themselves are suffering. But it’s our patients that suffer most of all.

All we ask at the federal level and in the several states is for reasonable limits on liability awards, a proven mechanism to stem the rate of rise in liability premiums. In Florida, obstetricians pay premiums now totaling \$277,000 per doctor per year. This is not tolerable.

So the AMA is for a proven system, an evidence-based system like the California MICRA system. The people of America agree with us. The House of Representatives agrees with us. The President of the United States agrees with us. We have gained ground in the Senate, but we still face a hard road ahead.

We have fought the good fight. But we can’t stop there. This House and the Council on Legislation, in its recent reports, have examined ways we might do more. So, the obvious questions become: What next? And, where next? Do we stay focused on only one solution? Or do we explore new options, through pilot projects such as: a new Medical Court system, or mandatory arbitration or mediation and conciliation processes.

We need a new system that favors the patient, a system that identifies and eliminates negligence and not just bad outcomes. That provides swift justice not years in civil litigation. That provides monies to patients rather than attorneys. And a system that focuses on patient well being, without putting physicians out of work, into retirement, or relocating them to another state. It’s high time the judicial system of America heard and responded creatively.

Having said that, I want to point out the obvious. It’s not about us versus them. It’s not physicians versus personal injury lawyers. This is all about patients. So is the fourth area of AMA concern--revising the fatally flawed Medicare payment system, again, on behalf of our patients. This time, our senior patients.

When we consider Medicare, there is a very strong message we need to carry on behalf of our patients. Let us hope the Congress listens, at last, to the voice of reason with regard to Sustainable Growth Rates, or SGR. This formula is inappropriately named. It’s not a growth rate. It is a cut. And it certainly is not sustainable. If Congress doesn’t listen, nine years from now Medicare payments to physicians will have shrunk by a third, at the very time practice costs are estimated to rise by 17 percent.

Notice I said Medicare payments, that is, revenue. Not profit. Not take-home. Just revenue in the door from Medicare billings. As you know, private payers and other public program prices link to Medicare pricing. The great tidal wave is coming.

We already have a legal roadmap for taking physician-administered drugs out of the SGR calculations. That change alone would wipe out the cumulative SGR deficit and open the door for subsequent legislative changes, the road to a long-term correction we all want and that our patients need.

We have presented a strong case to the CMS leadership, to the HHS general counsel, and to the director of the Office of Management and Budget. They all know it's an unsustainable growth rate. Our goal is to implement an AMA version of SGR that is simple, gutsy and rational--SGR.

The AMA approach is Simple: We want SGR recalculated to be a growth factor not a destructive force. We believe it is not too much to ask government to cover increases in physician costs at a time when more seniors live longer and with new diseases and can be treated with new technologies. We believe it is not too much to ask government to stop penalizing physicians for administering care for which government's own programs encourage their use.

Our plan is Gutsy: We want to mobilize American opinion, and especially our senior patients, around this issue. As we have in the past, we need to stand up and lead on behalf of our patients.

Our approach is one that is Rational. Instead of rationing, we want to present America with the logic, the fundamental truth that revenue covers costs as well as salaries, and that the proposed SGR cuts will compel physicians to limit the number of Medicare patients who we would like to serve.

What is at stake in the most practical, rational terms is this: These proposed cuts are a threat to the core value of medicine and of Medicare, namely, open access for senior patients to physicians of their choice. No amount of information technology or other process improvements can be implemented in time to offset these cuts. All of that opportunity is sacrificed on the altar of cost cutting. Our patients become the losers because of it.

Any promised or hoped-for improvement in Medicare, and in medicine in general, has one fundamental prerequisite. They all need physicians to deliver that care. Cut revenues, cut incentives and you punish patients. You gamble with access to care. It is rural America that will suffer most. The loss of a physician or two in midtown Manhattan is unfortunate. In rural Utah, it's a disaster.

A simple, gutsy, rational campaign can prevent that. It can ultimately repeal the broken SGR formula, replacing it with a system similar to that use to update hospital payment schedules. We already have received support from more than 70 Senators and 270 Representatives. We're pleased with this broad-based, bipartisan support. Now, let's translate that support into action.

We already have some of the tools you'll need. They are in the new SGR Action Kit you received. With this kit, and other materials being designed, you and I can enlist every physician and, through them, every patient in America in this campaign. The AMA Board of Trustees is backing this campaign with enthusiasm and with budget dollars. The AMA plans to use all its assets, all its know-how and experience, to make sure America's physicians and their patients understand what's at stake, and what to do about it.

Whether you and your colleagues consider yourselves activists or not, this issue is too menacing to sit on the sidelines and support the status quo because that status quo will harm our patients. The AMA action plan calls each of us to act, now, to mount a full-court press. Our challenge is more than merely changing a formula; it's convincing ourselves and everyone we meet that it's about patients.

These payments cuts are threatening physicians' ability to serve Medicare patients in the future. Many of our colleagues have started restricting the numbers of Medicare patients they handle. Some even have stopped altogether.

This is very troubling to me--very troubling. To see America's senior citizens on Medicare threatened by this fatally flawed system. We are talking about the Greatest Generation, about our parents and grandparents, and even some individuals here in this room. This generation was raised in the severity of the Great Depression and sorely tested by the Axis Powers in World War Two. In my mind, this is a generation that sacrificed so much in so many ways.

They were victorious over evil, but not stopping there, they were unselfish yet uniquely successful in building a prosperous nation. Quietly, and without pretense, they have sustained freedom and created the nation you and I are so fortunate to live in. And now, that generation seemingly discarded and written off by a flawed Medicare payment system? That, ladies and gentlemen, is what the SGR problem is really all about.

We meet at a noteworthy time, a time when the operative word in our society seems to be the word “divisiveness.” It’s in virtually every newscast and editorial. It could become a national epidemic unless we use preventive medicine. That means to unite, to bring together, to resolve instead of separate.

There is a need for us, for you and me, to bridge the great division in American society. I thought that there must be an issue that is inclusive, that affects both genders, all ages, all income groups, all Americans, something that transcends that which divides us, and can be used to unite us again. The answer is that there is, in this country, in every region, in every home, in every business, one issue that costs \$1.6 trillion a year, an issue that is, well, a life-and-death matter. You know what I’m going to say next. Of course there is such an issue--and it is health care.

Now more than ever before, the American Medical Association has to play the leading role. Our patients expect us to play that role. They trust us to play that role. It is easy to talk of our vision, the big plan, the great dream. We see a health care system that guarantees access for all Americans. That is patient-centered and physician-driven. We dream of a system that uses unwavering ethics, unstinting service and relentless scientific progress for the good of all Americans--our patients.

We see a system that harnesses information technology as it harnesses all other innovative technologies. We see a system that is affordable, of the highest quality, which prevents more--so that it has to treat less. We see a system that unites our nation, not one that divides it.

Easy to envision. Difficult to attain. Yet, listen again to Anatole France: “To accomplish great things, we must not only act, but also dream; not only plan, but also believe.” As we meet and discuss and vote together, we must consider: What are we willing to give to make this vision a reality? How well do our plans reflect our belief in the well being of our patients? How much should that be?

I think the answer can be found in a favorite story of mine. It’s about a king--King Benjamin, by name--and a king who was no ordinary ruler. He worked in the fields, planting, cultivating and harvesting the crops, so as not to be a burden on his people.

Like everyone else did, he paid taxes, and he stayed close to his people all the time. As he aged, the king became concerned for the future of his people. So, he called them all together. It was to be his final House of Delegates appearance, so to speak.

So many came, no tent could hold them. They pitched all their tents in a semi-circle, with the doors facing a center point. There, the king had his carpenters put up a high tower. He climbed the tower and preached. Unlike my talk, he preached for three days.

He told them two things. First, he told them that he loved them. Isn’t that the very thought Sir William Osler meant when he said: “For the physician to practice medicine as it should be practiced, one must learn to love the patient.” Isn’t that the very basis of our profession?

Then King Benjamin voiced a second profound idea. He said: “When you are in service of your fellow beings, you are only in the service of your god.” That is our calling. That is my hope. And that is what we will do, if the government barriers are torn down, and we, together, realize our dreams.

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, in conjunction with Gary Epstein, Chief Marketing Officer of the AMA, on Saturday, December 4:

BRINGING THE AMA BRAND TO LIFE

Madam Speaker, Mr. Chair, Officers and Trustees, Members of the House of Delegates.

Eighteen months ago, this House voted overwhelmingly to keep our AMA an organization of individual members. On that day, you gave me a mandate to get to the heart of our membership challenge and to turn the situation around.

Since then, we have surveyed hundreds of physicians, members and non-members, and put together a number of focus groups. In the process, we tapped a rich vein of data about America's physicians, how they see the AMA, and what they want us to be for medicine. Today, I want to let these physicians speak for themselves.

Some of what they say may surprise and challenge you. Some of what they say will inspire you. All of what they say adds up to change, particularly in terms of the AMA's brand identity and how we bring it to life. Because the most basic problem that we face as a member-organization is that physicians simply aren't clear about who we are--or what we do.

Take a look at just one of the clips from our focus group. This clip, and many others like it, has told us that physicians feel disconnected from our AMA and its mission. [A film clip was shown.] We need to rebuild this lost connection and transform this association into a member-centric organization that brings value to physicians.

The evidence suggests that a majority of physicians would be open to reconnecting with us. Provided we do it right. You see, the majority of our colleagues, more than 50 percent, are "joiner" physicians. These are the physicians we will see and hear from today.

These "joiner physicians" feel good about the profession. They believe medical societies serve an important role, and they join because they want to make a difference. However, almost 60 percent, or 290,000, of these "joiner" physicians are not AMA members.

The bad news is we haven't won these physicians over. The good news is we can. These "joiner physicians" already believe that the AMA has a unique and important role to play. And they want to see us play it. "Joiner" physicians want the AMA to work for physicians. As a unifier. As an advocate. As the single, strongest voice for medicine in this country.

This is what physicians want us to be, and that vision is the impetus behind our new brand promise: "The AMA helps doctors help their patients by uniting physicians nationwide to work on the most important professional and public health issues. Together we will play an active role in shaping the future of medicine."

These are powerful words for a powerful mission. But a brand promise will remain just that--a promise--unless we take these words and transform them into action. "Joiner" physicians have a remarkably uniform view of what they want us to deliver.

They want: Focused advocacy on priority issues, opportunities for involvement, and communications about progress and results. Or, in their own words: Advocacy. Involvement. Communication. These three pillars offer tangible value for physicians. Value that will inspire them to join our AMA.

At tomorrow's meeting of this House, Mr. Ajay Gupta of McKinsey will provide more details about what physicians want us to do and be. In the meantime, we're already focusing our agenda on the most important physician issues. We're also asking members to help us, using the new AMA Member Connect surveys and the Member Connect Roundtables as tools.

It's the start of a whole new way of being for us. A way of being that will enable us to claim what rightfully belongs to our AMA--the hearts and loyalty of America's physicians. America's physicians want to believe in us. They want to be part of what we do. They want us to be their champion and their voice. A physician from the trenches has put it best: "We want the AMA to be the kind of organization that makes physicians' say, 'Wow, I want to be part of that.'"

Here to show us how we can get there, together, is our new Chief Marketing Officer, Gary Epstein. Gary, who has more than 20 years of marketing experience, has worked on brand development for such icons as Procter and Gamble, Kraft Foods, Intel, Walgreen's, and Pepsi. [Dr. Maves called Mr. Epstein to the podium, and Mr. Epstein began his presentation.]

Thank you Dr. Maves, and thank you, members of the AMA House of Delegates. Standing before this House reminds me of what a privilege it is to serve America's physicians. But I didn't really need a reminder.

No less an authority than my 90-year-old Jewish grandmother has already told me how much the work we do matters. A couple of months ago, she saw fit to call me and congratulate me on my career accomplishments for the very first time, and this after 20 years of marketing some of the biggest brands in the world.

She said, “Bubbala, it’s about time you became a successful doctor like your brother....We were all so worried you wouldn’t amount to anything.” I didn’t have the heart to tell my grandmother that my new position hardly gave me the credentials to hang out a shingle. Nonetheless, I share her enthusiasm for your wonderful profession, and I am honored and privileged to play a part in the world of medicine. Especially this world of the American Medical Association.

It’s amazing to be part of an organization whose existence and purpose really matter to the world. To be part of an organization that is focused on changing and improving our country and its health. I am inspired by the AMA’s mission: Helping physicians help patients, and I believe we need America’s physicians to be inspired, too. Because together we truly are stronger.

As Dr. Maves’ remarks have demonstrated, I have been fortunate to inherit some very good strategic research and data which will serve as the foundation to begin reinvigorating the AMA brand and our membership base. Like Dr. Maves, I am very excited about our new brand statement. I believe it truly captures the essence of who we are, what we do, and how we are unique and distinctive.

But simply putting a statement on paper will not create change, demonstrate value or transform physician perceptions. What is essential is that physicians know we are bringing this brand statement to life through our actions--day in, day out, in every aspect of our organization.

Through this blinding focus on our brand, we will win the hearts and minds of the “joiner” physicians that we have not engaged to date, and of all physicians across this country. So how do we win the hearts and minds of physicians?

For years now, the AMA has been doing important work on behalf of America’s physicians--calling for medical liability reform, preventing Medicare payment cuts, protecting the public health, speaking out for the uninsured. For years, we have hoped, like the lead character in the movie, “Field of Dreams,” that if we build it, they will come.

But life is not a Hollywood movie. Even though we have spent a lot of time and money sharing information about our vast collection of AMA programs, products and services, we have not communicated what is most vital. We have not communicated the very soul of our brand, and thus we have not generated the kind of pride in membership that this great organization deserves.

In the world of marketing, the truly great brands, whether they are a product or a service, achieved their status because they go beyond simply selling product features and attributes to creating a special connection in the customer’s heart and mind. The AMA must make this same kind of brand connection with our physician members.

Our brand must offer them a visceral, emotional connection--the kind of connection they can get nowhere else and from no one else. Take a moment to think about the many brands you likely have an emotional connection with in your life. Perhaps, Disney, or Nike, or Coca Cola. Or other great brands like Starbucks, IBM, or even MasterCard.

None of these brands spend time and money to tell you what they are. Instead, they engage your senses, your emotions--indeed, your very hopes and dreams. They make you feel connected to something bigger. They inspire trust and loyalty. That’s what this brand strategy must do for the AMA.

If you’re skeptical that the AMA has anything in common with these commercial brands, let me remind you of some of the strongest not-for-profit brands in the world, from the Red Cross, to Habitat for Humanity, to the Make a Wish Foundation, to the Salvation Army, just to name a few. All of these not-for-profit brands utilize this very same, carefully crafted and well executed brand-marketing approach in order to achieve their goals.

All around you, you can see the phrases, “Together we are stronger” and “Helping doctors help patients.” These are important and meaningful words, and they are at the very center of our brand promise as they resonate across our entire membership base.

Working together, all doctors united, we are stronger and we will change the future of medicine in America. Working together, doctors and patients, we are stronger and we will succeed at healing the system and improving patient care. Working and collaborating together--the House of Delegates, the Board of Trustees, and the staff--we will be stronger and more effective at achieving our goals.

Together we are stronger, and together, we will have an even greater impact on the future of health care in this country. I would now like to show you a film that is designed to bring the AMA brand promise to life--thematically, emotionally. This is not a television commercial, but rather, a film that is meant to give you an early glimpse of what a potent brand strategy can and will provide. [Mr. Epstein showed a brief film.]

This is our brand and we should be proud of it. It represents the kind of emotional connection we will make with all physicians across this country. It represents the respect you have in the eyes of your patients.

I have developed and presented a three-year marketing plan to the Board of Trustees, and it is a plan designed to focus on our brand in every aspect of the organization. You will see and hear more about our program in the days and weeks ahead.

No doubt that there are challenges ahead, but we will remain committed to this brand strategy, and we will remain highly focused on our member-centered marketing plan. I am here today to ask for your support and commitment to this new brand plan because I know that together we are stronger, and together we can and we will succeed.

Thank you. [Dr. Maves returned to the microphone.]

Thank you, Gary, for showing us what we need to do to reconnect with physicians. I hope that everyone in this audience is as excited as I am about our new brand strategy, and what it will mean for our association.

Because together, we are stronger. Together, we will help physicians help patients. Together, we will transform our AMA into a true champion of medicine.

REMARKS OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY:
The following remarks were presented by David J. Brailer, MD, PhD, National Coordinator for Health Information Technology, on Saturday, December 4:

Thank you for having me here today with you. It is quite an honor. I would also like to thank the other members of the AMA's leadership, Drs. Nielsen, Rohack, and Maves. This is a great honor again to be here and to return to the AMA House of Delegates.

I have had great pleasure today seeing many old friends. In fact, I couldn't walk down the hallway without running into old colleagues from the past, and I would tell you, things have changed. When I was on the Board of Trustees, I can assure you that Jim Sammons would never use MBA-speak, and so it is great to see it move forward and to talk about the real issues that we need to deal with.

I am pleased to speak with you also as a former chair of the Medical Student Section and as a student trustee. This is one of great deliberative bodies of health care, and I think it is incredibly good to have your guiding voice in medicine as you reach out among all of your peers and tell us where we need to go.

I am also, more than anything, pleased to speak to you as a fellow physician and one who is concerned about the forces that shape health care and the practice of medicine today. We all know technical and medical innovation has great promise for our lives and the lives of our patients, and represents fundamental challenges to us at all stages of our careers. We know that too few physicians are able to follow current evidence in the care of patients. We know that we have broad concerns about safety, errors and quality of care, and these are rampant and consumers are aware of these.

While these concerns are focused appropriately on the system of care, they also, and sometimes inappropriately, point to the physician. Liability on the one hand and Draconian cost control measures on the other, squeeze physicians in the middle. In short, our timetable shows enormous promises but also poses dilemmas that will reshape the way care is delivered, and I think with that, and as I have just witnessed here in your earlier proceedings, the AMA and medicine, as well.

One of the most colossal changes coming is the use of information tools and the practice of medicine. Those tools include the electronic health record, health information exchange, clinical data repositories, bar coding, web portals, disease registries, computerized order entry and e-prescribing, to name just a few.

As you heard, I have been charged by President Bush with leading the nation's efforts to gain widespread adoption of these tools. He told me that I had ten years to do it, and some of you know that on a stage with him not long ago, I, for some reason, told him I could do it in seven years. There is something about presidential charisma that you just can't deal with.

You may not know that I got my start in this when I actually student trustee of the AMA. The Board Chair--then it was William Hotchkiss--did not know what to do with a medical student on the Board, so I was charged with working on AMANet. What a great time we had in 1985 allowing physicians to exchange e-mails and use online bulletin boards. It was difficult with character-based screens, but there was no spam, at least.

Just as then, my focus today remains on the physician and how information tools can unlock new opportunities in the practice of medicine. Thankfully I'm not alone in these efforts to bring information technology into health care. I have received just incredible and overwhelming support from the senior leadership of the administration, from Congress, except for my appropriation--and--I suppose you all read the *New York Times*. And, from more than anything, physicians around the United States.

My office gets thousands of calls and e-mail every month from physicians and other clinicians asking how we can help them. We have case studies submitted to us by the hundred about someone's personal experience with health information, good and bad, and we stay on top of these because these are the fundamental data points that we use to drive our policies around adoption.

There is one I just want to cull out from many, and this, in fact, was very encouraging, because it comes from the statement issued by the AMA on July 21. "The AMA welcomes the first strategic framework report on health information technology released today by the national coordinator for health information technology." I will say more about this statement briefly.

I am proud to know that the AMA and I still share a common cause in our efforts to transform care, particularly through the use of information technology. And the AMA is not just talking. It started to act on this through a variety of things, including:

- Formation of the e-Medicine Advisory Committee, as your Council on Long Range Planning and Development advised, as well as the Board of Trustees task force on quality, safety and the electronic health record.
- Participating in Connecting for Health, which is a public-private consortium, and the Physicians' EHR Collaborative, which is a 14-specialty primary care entity to drive EHR adoption; and
- Leading the Physician Consortium for Performance Improvement, alongside CMS and NCQA.

I applaud this, but I do encourage you to go much, much further. We, as physicians, are dependent on information in our work, and we readily embrace new technologies when they are shown to reliably improve patient care. We know that.

Let me read another part of the AMA statement: "Physicians are eager to adopt new technology that helps them improve patient care and increase efficiency. Physicians use the latest technology every day to diagnose and treat patients, and they were among the first to embrace earlier information technologies, such as pagers and cell phones, because these technologies help them serve their patients better."

The electronic health record is the undisputed next step in this process. When used properly in patient care, electronic health records can be, simply put, therapeutic. This observation is well-founded in the scientific evidence that shows that drug-drug interaction checking, allergy checking, public health surveillance, evidence-based decision support and preventive care reminders can systematically and reproducibly improve health status, longevity and overall care.

Consider just one of many studies that address this. A 2003 study from the Center for Information Technology Leadership at Harvard University showed that nationwide adoption of just ambulatory, computerized physician order entry could prevent more than 2 million adverse drug events and nearly 190,000 unnecessary hospitalizations each year. This would also save \$44 billion in reduced medication, utilization and other kinds of expenditures.

These studies, to me--and there are many--demonstrate that electronic health records are part of the therapeutic regimen and are, in short, indispensable to care delivery. Despite its great benefit, though, adopting the electronic health record is a risky and costly decision to the typical physician. The physician who invests in electronic health record today faces a, quote, first mover disadvantage.

Just like the fax machine, the last person to install an interoperable health record benefits from everyone else's prior investment, and the first to install bears most of the cost. And these first movers, and those are the people that are adopting them right now that we're watching very closely, have faced many barriers and challenges that have resulted in incomplete use, postponement of their projects and, in some cases, outright failure.

I can assure you that as we move out of the low end of the adoption curve, this experience will change and this is fundamental to the policies of my office to move us forward. Successful electronic health record deployment by large integrated delivery system and large physician groups is encouraging and is, frankly, becoming commonplace.

I'm worried, though, about small physician offices that struggle to know which electronic health records to buy, to implement them and to get value for themselves and their patients. Without proper implementation and support, electronic health records are just software and computers because the critically important improvements and process of care, decision-making and outcomes just will not be realized.

The AMA already knows this. Let me go back to the statement: "Electronic health records have the potential to be revolutionary, but work remains to be sure that they deliver on this promise." The AMA is committed to helping fulfill the promise of an affordable, standards-based electronic health record.

The federal government is doing a lot to level the playing field for physicians and small offices who adopt electronic health records. First, we have worked with a private sector to form a Product Certification Commission. This group's job is to inspect electronic health records and to provide endorsements of only those products that meet basic and essential functional security and interoperability criteria. Today nearly every electronic health record is marketed with health status improvement claims, and we think it is time that the private sector set standards for what products can do what. This group looks out for physicians. Seven of the 14 commissioners are physicians.

Second, we are developing regional entities. We call them regional health information organizations, a typical Washington term, perhaps, that can organize physicians, hospitals, consumers, and purchasers together so that they can set their own fate and be free of regulation to work forward toward adopting electronic health records and health information exchange for their own local area. These organizations are built across the United States, and I encourage you to join one in your area. Last year we gave \$140 million in support to these entities, and I expect that we will give more support in the coming years.

Third, we are retasking the QIOs to work through regional information organizations to bring their funds and their know-how to physicians who are implementing electronic health records.

Fourth, we are addressing regulations. For example, an interim final rule for community exceptions to Stark that allows communities to come together and provide support directly to doctors under the community supervision was published on July 26th.

Fifth, we are exploring how we can develop a national health information network, sometimes called the medical Internet, which will allow secure, timely, useful exchange of health information between clinicians.

There is more to be done, but we intend to change the marketplace for electronic health records so that they are cheaper, less risky, interoperable, easier to use and beneficial, and at the same time my group has fiscal integrity oversight for the \$5 billion in health information technology spending currently in the federal government, and our charge from the President is to restructure that, align that and get the most value for the American people out of that every year.

I want you to know of my commitment to positive change in health care and to ensuring that physicians continue to lead. We do face challenges, but I think the answer for health care is the same as every other industry, information, automation and standardization that support the central role of the consumer and the professional. That means to me bringing electronic health records to everyone.

I thank you for your support and actions in the past, and I am calling on you to take them even further today. I ask you to make adoption of the electronic health record and health information exchange your top priority for both your member services and your policy activities.

Transforming care delivery is difficult. We know that. We live that. And there will be many tough decisions, barriers and naysayers. Lord knows, I am surrounded by them. However, we face a central question: Is it our goal to set American health care and the House of Medicine on a course toward a better future, or is it to merely keep together and shift the challenges to other?

If we show the courage and do the right thing today, our patients will benefit. The US economy will benefit. Our standard of living will benefit. And physicians and caregivers will be the heroes that we know ourselves to be. We can look back and say, "This was the first day of a bright future." You have said it already in your new, wonderful marketing materials. "Together we are stronger," and we want to be part of that with you, as well. I look forward to working with you and wish you the best during the House's 2004 Interim Meeting. Thank you.

REMARKS OF THE PRESIDENT OF THE AMA ALLIANCE, INC.: The following remarks were presented by Jean Howard, President of the AMA Alliance, on Saturday, December 4:

Forty years ago I was dating a struggling medical student--I think he asked me to marry him because I had a car and a good paying job and would be able to pay his tuition to medical school! Back then, we thought he would be another Marcus Welby, MD.

Wow, were we ever wrong....We never dreamed 30 years ago when he started his practice in internal medicine that DRGs, Stark, HIPAA and many other governmental regulations would have such an impact on how he practiced medicine. We never dreamed that I would be the one contacting and meeting with our legislators about the issues impacting medicine while Bill was busy seeing his patients. We never dreamed that the medical liability crisis would be driving physicians out of practice.

And it is because of all these challenges in medicine today that the Alliance has become the largest most important support group of the AMA and its component state and county medical associations. No one--no one--understands the life of a physician better than an Alliance member--the common interest of the profession binds us. We know that when the AMA and the AMA Alliance work together, our medical family is stronger.

This year is the 10th Anniversary of our SAVE (Stop America's Violence Everywhere) program. This October, the AMA worked together with the Alliance to get the word out about preventing violence and conflict resolution when it imprinted the SAVE logo on 27,650 pieces of mail sent from the AMA mailroom...and when the Alliance and the AMA staff worked together and donated more than 466 pounds of food to our SAVE Anniversary Food Drive.

In this past decade we have created more than 700 SAVE programs in communities across the country. We have distributed over two million pieces of our conflict resolution materials to schools, physicians' offices, and hospital waiting rooms.

We recently received a letter from President Bush congratulating us on celebrating the 10th anniversary of this wonderful program. He stated that "SAVE strengthens communities and brings hope and healing to many....Your efforts contribute to a brighter future and reflect the great compassion of our Nation."

Recently, the AMA Alliance was recognized by the Prevent Child Abuse America Chicago Board for our hard work with the SAVE program when we received their Voice Award for Community Action. This award is designed to recognize an individual or organization working to make a positive impact on children and families at the community level in a volunteer capacity. It was an honor and privilege for me to personally accept this award on behalf of Alliance members across the nation.

It was wonderful to receive this award because we did not start the SAVE program for the applause or recognition. We've always done it because we know in our hearts that we are doing the right thing for the good health of our communities.

We know in our hearts how important it is to help more women escape abusive situations, because in the time I'm talking to you, nearly 140 women will be battered and bruised by a husband or boyfriend. We know in our hearts how important it is to help more children learn how to deal with bullies and violence, because in the time I'm talking to you someone in this country will die because of a violent act.

And the Alliance is already working by your side as you look at how to address the obesity epidemic. Our latest activity book, "I Can Be Healthy," focuses on healthy eating and exercise. A timely topic to address when there are 9 million overweight and obese children in our country.

As *The Wall Street Journal* writes:

"Most parents would never dream of putting a child in a car without a seat belt. They would never allow a child to ride a bike without a helmet...But...how do you protect your child from heart disease, cancer, strokes, diabetes and high blood pressure--ailments that typically don't strike until well into middle age?"

The *Journal* was describing the problem of poor nutrition and resulting obesity, which has reached near-epidemic levels among children in our country. And it is not only children. Obesity and lack of exercise are responsible for 400,000 deaths annually in this country--this health problem is quickly becoming one of the leading causes of preventable death. We stand ready to work together as your strategy is developed for addressing this latest health epidemic.

I talked earlier of how 40 years ago Bill and I never dreamed of all the legislative issues that would impact the practice of medicine. Well, it was wonderful to hear that Florida passed Constitutional Amendment 3--their contingency fee limitation bill--and that Nevada now has a law styled after MICRA for medical liability reform. I know that the Alliance was busy in both these states to help their respective medical societies pass these measures. And in Michigan, the Alliance was busy helping elect a physician to the US House of Representatives.

And every time I read one of Donald's e-mails--where he talks about how the passage of the stalled medical malpractice legislation in Congress is just one day away--I know that working together, the AMA and the AMA Alliance will make sure that meaningful tort reform gets passed in our nation's capital. We have a wonderful window of opportunity in front of us and the Alliance will be by your side as we work together to make sure the citizens of our country continue to receive quality, affordable health care.

I have been married to medicine for almost four decades--and that shows three things: One, I am old; two, I am opinionated; and three, I am grateful...grateful to be part of the family of medicine for all these years...grateful for the opportunity to be standing here today to bring you greetings from the AMA Alliance. I know that as we continue to work together on behalf of medicine, we will become stronger as we build a healthier America.

REMARKS OF THE PRESIDENT OF THE AMA FOUNDATION: The following remarks were presented by Krishna K. Sawhney, MD, President of the AMA Foundation, on Saturday, December 4:

Thank you. It's a pleasure to be here today before the House of Delegates and to be able to share with you some great news from the AMA Foundation. We are having another very good year--thanks in large part to our friends at the AMA Alliance, who always do so much for us--and to you in the House of Delegates, who, year after year, show your loyalty to the Foundation through your financial support.

So my first task today is to thank those of you who have donated, and urge those who haven't to become a Foundation donor as soon as you can. We rely on you, the leaders of organized medicine, to set the standard for giving.

Those of you who know me know how enthusiastic I am about the work we are doing at the Foundation. So you know that I could talk for hours on this subject. But today I only have a few minutes, so I want to focus on just three things. These are the three things I hope each of you will remember about your AMA Foundation during this meeting and after you return home.

Number one, and most importantly: We have made some big changes in the way we do things, from the make-up of our Board to the way we distribute our funds. As of 2004, we are a new and very different Foundation, with a completely new structure, vision and focus for the future.

As an example, I have the privilege of standing before you as the first president of the Foundation who was not previously a member of the AMA Board of Trustees. That's because your Board decided several years ago that it was time to expand Foundation leadership. And in that spirit, we have added to the Foundation Board three new public members and a new student member as well.

I can tell you that this is a fantastic Board, one that puts its heart and soul into its work. Several Board members are in the room and I'd like to ask them to stand now so we can acknowledge them. By adding a student member to our Board, we have strengthened our connection to the next generation of physicians and the future of medicine.

And that brings me to my second point: Your Foundation is committed--totally--to doing something about the horrendous levels of medical student debt in this country...It's appalling to think that tomorrow's physicians leave school \$100,000 in debt...\$120,000 in debt...\$150,000 in debt...and sometimes even more.

Our strategy is simple: We're changing the way we distribute scholarship funds to ensure they have greater impact on students than ever before. By doing things differently, we will make a difference. Let me give you a few examples.

We awarded our first National Scholarship this summer--worth \$10,000--to a young man from Texas with a wonderful dream. Raul Ramirez, who is starting his fourth year of studies at Texas Tech University, plans someday to provide care for indigent workers in his home state, the people who so often fall through the cracks of our health care system. Following up on that action, we have decided that we will give at least six similar, merit-based \$10,000 scholarships next year.

We also significantly expanded our effort to encourage and strengthen diversity among medical students this year by awarding ten \$10,000 scholarships to talented minority medical students across the country.

And we have made major changes to the structure of our Scholars Fund to increase its impact on deserving medical students. We now have much more control over the way these funds are distributed at the various schools--ensuring students receive maximum assistance.

Which brings me to point number three: We are making many of these changes because you asked for them. Our new way of doing things includes seeking greater input from our donors, to find out what you want from us. Five hundred of our donors--perhaps some of you in this room--were kind enough to tell us your feelings as a part of a donor survey recently. You told us what you expect, and we intend to deliver it.

You told us that, in addition to medical education, health literacy is very important to you. That's why we are pushing forward aggressively with our Health Literacy Campaign, which has taught more than 20,000 physicians how to recognize and respond to this terrible problem. Thanks to renewed funding from our friends at Pfizer, Inc., we are planning a major summit on health literacy, to take place in just a few months.

You told us that supporting grassroots public health programs is a good idea. And that's why we are committed to expanding our Fund for Better Health and all of the great work it supports--from reducing domestic violence to promoting better nutrition and physical fitness.

You told us that it's good to support programs involving physicians--and that's why I'll be back at this podium next June to tell you about one of our most ambitious projects ever. This groundbreaking program is in the planning phase as I speak. All I can tell you now is that it involves physician-inspired programs aimed at helping some of America's most vulnerable patients, and it will make you very proud of your Foundation. Believe me, it will be worth the wait to hear the news next year.

So that sums it up--three things that are at the very top of your Foundation's to-do list: First, focus on tomorrow's physicians and the future of health care; second, do things differently; and third, listen to what our donors say. These three steps represent the ingredients for real progress in any endeavor--caring, listening, and changing. And we're committed to each.

Let me close by saying again how important you are to our Foundation. I wouldn't be able to share this good news without the loyal support of so many members of this House. Your help is critical to our success, and we appreciate it.

If you are a donor, please join us Monday night for our special Donor Reception, from 5:30 p.m. to 7:00 p.m. in Regency Ballroom V. If you aren't a donor, please stop by the Foundation Booth during this meeting and become one. We would like to make you a part of our Foundation family. Thank you.

REPORT OF THE AMPAC BOARD OF DIRECTORS: The following report was submitted by David M. Selby, 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 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.

POLITICAL ACTION

AMPAC scored big political gains on behalf of organized medicine in the 2004 election cycle. Across the country, hundreds of "physician-friendly" candidates backed by AMPAC were elected or re-elected to the US House and Senate, further strengthening medicine's support in Congress for its most important issues, such as reforming Medicare's flawed physician payment formula, patient safety, and help for the uninsured. And AMPAC also gave a boost to the AMA's number one legislative issue, medical liability reform (MLR), by helping to elect three new pro-MLR members to the Senate through its independent expenditure (IE) program. All told, AMPAC spent \$4.5 million in the 2004 election cycle, won six of the seven IE races it undertook, mailed nearly one million pieces of political mail to physicians in key states and congressional districts, conducted five nationally recognized campaign schools, and was ranked the fourth most successful political action committee in the country.

In the *National Journal's* post-election survey of 20 large interest group PACs, AMPAC had the fourth best "winning" percentage in the most competitive House and Senate races, finishing ahead of the US Chamber of Commerce, the Sierra Club, and the AFL-CIO, among others. But the "winning" percentage statistic does not tell the whole story. Because AMPAC was involved in more competitive races (37) than any of the other top PACs listed in the survey, it also won more races (27) than any of the others. The AMPAC Board chose to conduct IE campaigns in four Senate and three House races. All four Senate candidates and two of the three House candidates won their races--an outstanding batting average for AMPAC.

A few points about AMPAC's 2004 IE program are worth mentioning for context:

- When AMPAC decided to jump into the four Senate races, only one candidate was leading in the polls (but not by much). Indeed, several pundits had already written off Sen. Lisa Murkowski in Alaska and Rep. Richard Burr in North Carolina.
- In Louisiana, almost no one thought Rep. David Vitter could get more than 50% of the vote to win the Senate seat outright and avoid what would invariably become an extremely expensive and contentious "nationalized" run-off election in December. AMPAC was the only national PAC to "play" in this race with a significant IE in the primary.
- AMPAC IEs played a major role in electing three new pro-MLR Senators, re-electing another, and electing one more physician to the House.

POLITICAL EDUCATION PROGRAMS

Attendees from Ohio, West Virginia, Michigan, Oklahoma, and Texas participated in the first-ever AMPAC Regional Campaign & Grassroots Seminar. Cohosted by the Ohio State Medical Association, this new program was created to make political education opportunities available to AMA members as an option to the longer programs held in the Washington, DC, area. Reviews of the regional seminar were positive. The agendas for next year's Candidate Workshop (February 18-20, 2005) and Campaign School (April 13-17, 2005) are in the works.

The third issue of *AMPAC Update* was mailed to state PAC chairs following AMPAC's September Board meeting in Washington, DC. Plans are to continue the quarterly publication based on positive feedback. The deadline for the nominations for the 2005 Belle Chenault Award for Political Participation is the close of business on Monday, January 31, 2005.

AMPAC MEMBERSHIP

As of November 22, 2004, AMPAC membership stands at 48,776. This compares with year-to-date membership of 53,141 in 2003, a difference of 4,365. In 2002, the AMPAC year-to-date membership was 53,182. The reason for the year-to-date decline is largely attributable to a fall-off in members transmitted to AMPAC in numerous states. To date, memberships from state PACs are 40,345 compared to 43,357 at this point last year and 43,400 at the same point in 2002. This represents a decline of 3,012 members from this point in 2003 and a decline of 3,055 members from 2002.

To date, direct memberships in AMPAC stands at 8,431 compared to 9,784 at this point in 2003 and 9,782 at the same point in 2002. This represents a decrease of 1,353 members compared to same point last year and a decrease of 1,351 compared to 2002. New memberships from the last two direct solicitations are coming in at a steady pace, and should make up most, if not all, of this difference.

As of November 22, AMPAC Capitol Club membership stands at 364 members. This figure is an increase of 302 members over 2003's year-end total and an increase of 331 members over 2002's year-end total.

AMA political membership staff has worked diligently to assist states in recruiting PAC members for 2004 and has been exploring new marketing tools to reinvigorate the state PAC joint marketing program. Additionally, staff has focused on developing a foundation for growth with regard to the AMPAC Direct program for the future.

CONCLUSION

I would like to thank all the outgoing AMPAC Board members for their dedication and many years of outstanding service, including: Robert E. Hertzka, MD, Roy Vandiver, MD, Charles Garrett, MD, Krishna Sawhney, MD, Candace Keller, MD, Robert Crawford, MD, Susan Paddack, and Alik Widge. I would also like to welcome all the new members: William Hamilton, MD, Marilyn Heine, MD, Rick Lentz, MD, John Neeld, MD, Michael Sandler, MD, Brooke Buckley, MD, and Brooke Bible. They will be joining returning members Sheldon Gross, MD, Robert Bonvino, MD, Ken Tuck, MD, and me. I would like to thank all of our AMPAC 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. I encourage every member of the House of Delegates to stay "connected" to AMPAC by visiting our retooled web site at AMPACOnline.org.

IN MEMORIAM - WILLIAM S. HOTCHKISS, MD: The Board of Trustees presented the following in memoriam of William S. Hotchkiss, MD:

William S. Hotchkiss, MD, the American Medical Association's President in 1987-88, died August 12, 2004 in Charlottesville, Virginia. He was 89.

Dr. Hotchkiss graduated from the University of Texas Medical Branch at Galveston in 1939 (recent former AMA Presidents from the University of Texas include Drs. Joe Painter and Daniel "Stormy" Johnson), and later trained at Henry Ford Hospital in Detroit. He served in the US Navy during World War II and while serving on the USS Comanche in the North Atlantic was credited with performing the first recorded appendectomy north of the Arctic Circle. He returned to Henry Ford Hospital after the war but in 1951 began his practice of general and thoracic surgery in Norfolk, Portsmouth, and Chesapeake, Virginia. He continued his practice there until his retirement from active practice in 1989.

Dr. Hotchkiss served organized medicine at many levels. He was president of the Norfolk Academy of Medicine in 1965-66, and was president of the Medical Society of Virginia in 1971.

He was a Virginia delegate to the AMA House of Delegates from 1973-77 and served on the Judicial Council. In 1978 he was elected to the Board of Trustees and was elected Chairman in 1985. He was chosen AMA President-Elect in 1986, and took office as President in June of 1987. His areas of particular interest included anti-smoking activities and the involvement of medical students and residents in AMA activities.

Dr. Hotchkiss devoted much of his life to the service of his patients and his profession. His career exemplified the best of American medicine.

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 Mark Ivey, Jr., MD | North Carolina Charles L. Garrett, MD | American Academy of Family Physicians Mary Elizabeth Roth, MD |
| California Robert D. Burnett, MD Joseph W. Clift, MD Irina S. deFischer, MD Lauren Grayson, MD Gideon H. Lowe, MD Richard G. Rajaratnam, MD Donald I. Van Giesen, MD | Ohio Daniel W. Handel, MD Walter E. Matern, MD W. Jeanne McKibben, MD David J. Utlak, MD | American Academy of Pharmaceutical Physicians Anne Arella |
| District of Columbia Byron S. Cooper, MD | Oregon Frank J. Baumeister, Jr., MD | American Academy of Physical Medicine and Rehabilitation Michael C. Wainberg, MD |
| Illinois Edward J. Fesco, MD Jerome J. Frankel, MD Norman J. Scheibling, MD | Pennsylvania Joseph B. Blood, Jr., MD Victor F. Greco, MD | American Association of Public Health Physicians Mary Ellen Bradshaw, MD Jonathan B. Weisbuch, MD, MPH |
| Kansas Katie Rhoads, MD | South Carolina Daniel W. Brake, MD Jerry R. Powell, MD | American College of Preventive Medicine Michael D. Parkinson, MD |
| Massachusetts Louis F. Alfano, Sr., MD Subramanyan Jayasankar, MD | Tennessee Robert E. Bowers, MD Allen S. Edmonson, MD Robert C. Patton, MD | American Society for Aesthetic Plastic Surgery, Inc. Norman Rappaport, MD |
| Michigan Thomas C. Payne, MD Thomas E. Stone, MD B. David Wilson, MD | Texas Byron L. Howard, MD | American Society for Clinical Pathology Anna R. Graham, MD |
| Maryland J. David Nagel, MD | Washington Mark C. Adams, MD Doug Myers, MD | American Society of Anesthesiologists Michael Scott |
| New York Randall D. Bloomfield, MD Larry S. Charlamb, MD Albert M. Ellman, MD Stanley M. Grossman, MD Donna B. O'Hare, MD Calvin Simons, MD | American Academy of Child And Adolescent Psychiatry Mary Crosby | Society for Investigative Dermatology Irwin M. Freedberg, MD |

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES**REFERENCE COMMITTEE F AND**

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Constitution, Bylaws, Ethics)

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Susan L. Hubbell, MD, Ohio*

Lawrence W. Jones, MD, American Urological
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Arl Van Moore, Jr., MD, American College of
Radiology

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Ronald L. Ruecker, MD, Illinois

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Drew Chronister (Regional Medical Student),
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Mitchell B. Miller, MD, Virginia*

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Craig W. Anderson, MD, Ohio

Lawrence L. Braud, MD, Louisiana

Michael M. Miller, MD, Wisconsin*

Mary Elizabeth Roth, MD, American Academy of
Family Physicians

Despina Siolas (Regional Medical Student), New
York*

Mark S. Wurzel, MD, Wyoming

REFERENCE COMMITTEE L (Legislation)

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Glenn Loomis, MD, American Academy of Family
Physicians

Michael E. Migliori, MD, Rhode Island

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Radiology and Oncology

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* - Alternate Delegate