

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

164<sup>th</sup> ANNUAL MEETING  
CHICAGO, ILLINOIS  
June 6–9, 2015

### CALL TO ORDER AND MISCELLANEOUS BUSINESS

**CALL TO ORDER:** The House of Delegates convened its 164<sup>th</sup> Annual Meeting at 2 p.m. on Saturday, June 6, in the Grand Ballroom of the Hyatt Regency Chicago, Andrew W. Gurman, MD, Speaker of the House of Delegates, presiding. The Sunday, June 7, Monday, June 8, and Tuesday, June 9, sessions also convened in the Grand Ballroom. The meeting adjourned following the Tuesday afternoon session.

**INVOCATION:** The following invocation was delivered by the Rev Dr John M. Buchanan, Pastor Emeritus of the Fourth Presbyterian Church of Chicago, where he was Pastor for 26 years, and now the editor and publisher of the *Christian Century, a Journal of Religion and Culture*, which is based in Chicago.

Good and gracious Creator, Mystery of mysteries, you are the creator of all that is, Giver of the gift of life. With the ancient Psalmist, when we look into a star-filled night sky we find ourselves wondering who we are and who are you? When we look at creation, everything that is - a universe exploding into infinity, or the intricate beauty of a summer flower, or the human body - so complex, so fragile yet resilient, we ask with the philosopher - “Why is there something rather than nothing” and with the Psalmist: “Who are we?” and “Who are you?”

At our best we conclude that we are, somehow, in some way, a reflection of you: that you, Creator, have put yourself, your image, in us: in intelligence, imagination, creativity. You have made us to recognize and appreciate beauty, and to abhor ugliness. You have made us intolerant of suffering and impatient with injustice. You have created in us the impulse to alleviate suffering, heal disease, right wrongs, and establish justice in our communities.

And so we thank you. We thank you, for who you are and for everything that makes human life more human: for artists and musicians, for scientists and athletes and firefighters, for judges, and for physicians. We thank you for Doctors and for all who serve us in medicine, for their devotion and discipline, for their hard work and hours and years of preparation, for their compassion and commitment to wholeness and healing and health.

For this Association and its officers, for our nation, for our President and for all who serve the common good we are grateful.

And, Creator God, we are grateful beyond words for your gift of love which we see in your world, in microscope and telescope and, most of all, in one another - the wondrous diversity of humankind, and in our dearest ones, friends, partners and colleagues.

We thank you and ask your blessing on this assembly and on this meeting. Stimulate good and challenging conversation. Open eyes and minds to new truth. And renew in every heart commitment to Truth and to one another and to the mission we dare to believe is your mission as well, of healing and wholeness and and goodness and Heath.

We offer this in your holy name, and in the name of everything that is is good and kind and loving and holy.  
Amen

**REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS:** The following reports were presented by Mary Carpenter, MD, Chair:

**CREDENTIALS:** The Committee on Rules and Credentials reported that on Saturday, June 6, 466 out of 538 delegates (86.6%) had been accredited, thus constituting a quorum; on Sunday, June 7, 488 delegates (90.7%) were

present; on Monday, June 8, 526 (97.8%) were present at the start of the session and 528 of 540 delegates (97.8%) were present at the end of the session; and on Tuesday, June 9, 528 (97.8%) were present.

Note: During Monday's business session, the American Association for Geriatric Psychiatry and the American Society of Breast Surgeons were granted representation in the House of Delegates

## **RULES REPORT - Saturday, June 6**

### **HOUSE ACTION: ADOPTED**

Mister Speaker, Members of the House of Delegates:

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 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 November 2014 edition of the "House of Delegates Reference Manual: Procedures, Policies and Practices" 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 waiver by the Speaker 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 6. Except for the office of President-Elect, speeches will be limited to officer candidates in contested elections, with no seconding speeches permitted. The order will be selected by lottery.

The Association's 2015 annual election balloting shall be held Tuesday, June 9, as specified in 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 Columbus K-L of the Hyatt Regency Chicago. The 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 teller, who will provide the voter with a ballot and provide assistance as necessary.

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

#### 9. Conduct of Business by the House of Delegates

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

### **SUPPLEMENTARY REPORT – Sunday, June 8**

#### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**

**EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 102, 104, 109, 113, 118, 123, 205, 206, 209, 212, 217, 220, 226, 403, 405, 410, 411, 415, 418, 422, 509, 518, 520, 521, 701, 703 AND 706**

#### **DEFERRED RESOLUTION D-1 NOT ACCEPTED**

##### **(1) REAFFIRMATION RESOLUTIONS**

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

##### **(2) DEFERRED RESOLUTION**

Under the procedures of the House:

When a resolution presents a legal or ethical problem, the Speaker, legal counsel or other AMA staff will contact the sponsor and discuss the problem with the resolution as prepared. If ... it is not possible to resolve the legal or ethical problem, the Speaker will designate that resolution as a “deferred” resolution, and it will be referred to the Committee on Rules and Credentials for its recommendation. No “deferred” resolution will be distributed in the advance Handbook.

Your Committee on Rules and Credentials met with the sponsor of Deferred Resolution 1 and the AMA's General Counsel. Our AMA's General Counsel had raised concerns with the sponsor which the sponsor indicated it could not consider.

Our AMA's General Counsel is concerned about the potential for a legal challenge, and possible civil liability both to the AMA and also to individual member physicians, occasioned by Deferred Resolution 1's call for the AMA to take a stand against participation in ICD 10, Meaningful Use and PQRS "by actively encouraging practicing physicians not to comply with these requirements."

AMA's General Counsel referred to two prior situations [one involving a state medical association and the other involving a local bar association] in which association calls for collective action to protest requirements of existing government programs, in which members had voluntarily chosen to participate, had resulted in legal challenges against the associations.

Representatives of the sponsor explained the sponsor's own procedural rules, once a resolution has been adopted by its House of Delegates, preclude its AMA delegation from making any adjustment in wording in response to concerns raised upon presentation to the AMA or to withdraw the resolution. The sponsor's position, in essence, is that a resolution once adopted by its House of Delegates must be considered by the AMA House of Delegates in that form.

Your Committee on Rules and Credentials appreciates the concerns of AMA's General Counsel. The cost of defending against a challenge, if raised, and resulting adverse publicity could be prohibitive even if a challenge were to be resolved in AMA's favor. Moreover, our AMA already has considerable material designed to educate physicians on how to participate (or not) in various programs and the consequences of a decision to participate or not. These choices are an individual physician's prerogative. Once a physician has chosen to participate, it would be unwise for our AMA to actively encourage non-compliance. A decision not to comply also raises ethical concerns insofar as AMA's Principles of Medical Ethics calls on physicians to follow the law and work to change—not simply refuse to comply with—laws that are deemed unfair or unreasonable.

For these reasons, your Committee on Rules and Credentials recommends Deferred Resolution D-1 not be accepted as business of the AMA House of Delegates.

## APPENDIX

- Resolution 102 - Actual Allowable by Medicare
  - H-400.956 RBRVS Development
  - H-400.959 Refining and Updating the Physician Work Component of the RBRVS
  - H-400.969 RVS Updating
- Resolution 104 - Medicaid, CHIP (Children's Health Insurance Program), and VFC (Vaccines for Children) Payment Reform
  - H-290.976 Enhanced SCHIP Enrollment, Outreach, and Reimbursement
  - H-385.921 Health Care Access for Medicaid Patients
  - H-290.980 Status Report on the Medicaid Program
- Resolution 109 - Medicare Coverage of Physician Administered Medications Procured by Patients
  - D-330.960 Cuts in Medicare Outpatient Infusion Services
  - H-330.888 Exempt Physician-Administered Drugs from Medicare Sequestration
  - H-330.897 Quality Cancer Care Preservation Act
- Resolution 113 - Three Day Stay Rule
  - D-280.988 Observation Status and Medicare Part A Qualification
  - H-280.977 Direct Admission of Medicare Patients to Skilled Nursing Facilities
  - H-280.950 Medicare's Three-Day Hospital Stay Requirement
- Resolution 118 - Economic Freedom of Choice for Physicians
  - H-385.989 Payment for Physicians Services
  - H-385.986 National Mandatory Fee Schedule
  - H-385.926 Physician Choice of Practice

- Resolution 123 - Site of Service Parity
  - D-330.997 Appropriate Payment Level Differences by Place and Type of Service
  - H-330.925 Appropriate Payment Level Differences by Place and Type of Service
  - H-240.979 Intrusion by Hospitals into the Private Practice of Medicine
  - H-240.993 Discontinuance of Federal Funding for Ambulatory Care Centers
- Resolution 205 - Doctor Hospital Ownership
  - H-140.984 Physicians' Involvement in Commercial Ventures
  - H-140.861 Physicians' Self-Referral
  - H-165.838 Health System Reform Legislation
  - In addition, our AMA has engaged in numerous advocacy activities that directly address the goals of Resolution 205, including supporting legislation to lift the ban on physician-owned hospitals. Below is a list of relevant advocacy documents:
    - Letter in support of H.R. 2027, the “Expanding Patients’ Access to Quality Care Act of 2013,” which would lift restrictions on physician-owned hospitals; May 2014
    - Comments on the Federal Trade Commission and Department of Justice Examining Health Care Competition Workshop, highlighting the importance of physician-owned hospitals; April 2015
- Resolution 206 - Trade Deals Must Not Threaten Health or Environment
  - D-505.998 International Trade Agreements
- Resolution 209 - ICD-10 and ICD-11
  - D-70.952 Stop the Implementation of ICD-10
  - In addition, see Board of Trustees Reports 25-A-13 and 15-A-14, “Evaluation of ICD-11 as a New Diagnostic Coding System”
- Resolution 212 - Support for Expanded Funding for National, State and Local Public Health
  - H-100.980 Food and Drug Administration
  - H-130.946 AMA Leadership in the Medical Response to Terrorism and Other Disasters
  - D-130.966 Domestic Disaster Relief Funding
  - D-170.994 School Health Mentoring Program
  - H-170.980 Health Education
  - H-170.986 Health Information and Education
  - H-420.986 Maternal and Child Health Care
  - H-440.912 Federal Block Grants and Public Health
  - H-440.982 Centers for Disease Control Funding
  - H-440.928 Update on Immunizations and Vaccine Purchases
  - H-440.847 Pandemic Preparedness for Influenza
  - H-440.939 Qualifications for State Health Directors
  - H-440.954 Revitalization of Local Public Health Units for the Nation
  - H-440.888 Public Health Leadership
  - D-440.944 Disease Transmission Via Foods: Public Health Disaster in Waiting
  - D-440.997 Support for Public Health
  - H-440.851 Influenza Vaccine Availability and Distribution
- Resolution 217 - Stop the Implementation of ICD-10
  - D-70.952 Stop the Implementation of ICD-10
  - H-70.916 Delay or Canceling of ICD-10
  - D-70.951 Alleviating the Financial Burdens Associated with ICD-10 Implementation
  - D-70.960 Implementation of ICD-10-CM
  - D-70.948 ICD-10 Transparency and Conversion
  - D-70.949 Stop the Implementation of ICD-10
  - In addition, ongoing AMA advocacy activities also cover the goals of Resolution 217, as indicated in the following documents:
    - AMA letter to Kathleen Sebelius, Secretary of HHS, urging CMS to reconsider the ICD-10 mandate; February 12, 2014
    - AMA Statement for the Record to the Committee on Energy & Commerce Subcommittee on Health on ICD-10 Implementation; February 11, 2015
    - AMA letter to Andrew Slavitt, Acting Administrator of CMS, outlining concerns with the planned ICD-10 implementation; March 4, 2015

- AMA letter in support of the Cutting Costly Codes Act of 2015, H.R. 2126, that would stop the implementation of ICD-10; May 14, 2015
- Resolution 220 - Campaign to Promote Transparency Regarding Healthcare Providers and the Physician as the Leader of the Healthcare Team
  - D-35.982 AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care
  - H-405.969 Definition of a Physician
  - Ongoing AMA advocacy activities also cover the goals of Resolution 220, as indicated in the following documents:
    - Truth In Advertising (TIA) Campaign Booklet; 2015
    - Physician-Led Health Care Team Booklet; 2015
    - AMA Truth in Advertising Survey; 2015
    - AMA Model Legislation - An Act to Support Physician Led Team Based Health Care
    - Truth in Advertising legislation map; 2009-2015
- Resolution 226 - Physician Involvement with Health Care Related Businesses
  - H-140.984 Physicians' Involvement in Commercial Ventures
  - H-140.861 Physicians' Self-Referral
  - H-165.838 Health System Reform Legislation
  - In addition, our AMA has engaged in numerous advocacy activities that directly address the goals of Resolution 226, including supporting legislation to lift the ban on physician-owned hospitals. Below is a list of relevant advocacy documents:
    - Letter in support of H.R. 2027, the “Expanding Patients’ Access to Quality Care Act of 2013,” which would lift restrictions on physician-owned hospitals; May 2014
    - Comments on the Federal Trade Commission and Department of Justice Examining Health Care Competition Workshop, highlighting the importance of physician-owned hospitals; April 2015.
- Resolution 403 - Promoting Food Recovery Efforts in Hospitals
  - D-150.978 Sustainable Food
- Resolution 405 - Increasing the Consumption of Healthy Fresh Foods in Food Desert Communities Using Mobile Produce Food Vendor Programs
  - H-150.937 Improvements to Supplemental Nutrition Programs
- Resolution 410 - Mental Health Crisis Interventions
  - H-345.995 Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill
  - H-345.975 Maintaining Mental Health Services by States
- Resolution 411 - Homeless Veterans
  - H-510.986 Ensuring Access to Care for our Veterans
- Resolution 415 - Increasing the Smoking Age
  - H-495.986 Tobacco Product Sales and Distribution
- Resolution 418 - Country Road Intersections
  - H-15.990 Automobile-Related Injuries
- Resolution 422 - FDA Tobacco Deeming Rule
  - H-495.988 FDA Regulation of Tobacco Products
  - H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products
  - H-495.978 Proper FDA Authority to Regulate Tobacco
- Resolution 509 - Long-Acting Reversible Contraception and Teen Pregnancy
  - H-75.987 Reducing Unintended Pregnancy
- Resolution 518 - Increasing Access to Care for Patients with Opioid Use Disorders
  - H-95.979 Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy
  - H-120.960 Protection for Physicians Who Prescribe Pain Medication
  - H-95.990 Drug Abuse Related to Prescribing Practices
  - H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs
  - D-180.998 Insurance Parity for Mental Health and Psychiatry
  - D-120.953 Treatment of Opioid Dependence

- Resolution 520 - Ban Routine Use of Antibiotics in Animal Feed
  - H-440.846 Antibiotic Use in Food-Producing Animals
- Resolution 521 - Promoting Good Fomite Stewardship in Clinical Settings
  - H-440.908 Nosocomial Transmission of Disease via Stethoscope
  - H-440.856 Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease
- Resolution 701 - Payers Misusing Appropriate Use Criteria
  - H-320.946 Radiology Benefits Manager
  - D-385.974 Freedom of Practice in Medical Imaging
  - D-410.995 Fairness in Medical Imaging Interpretation
  - In addition, AMA has been active in its advocacy on issues highlighted in Resolution 701. Attached is a sign-on letter sent March 2015 that addresses concerns that the AMA and specialties have regarding potential problems with CMS's implementation of the AUC program that was created in the Protecting Access to Medicare Act of 2014.
- Resolution 703 - Prevention of Physician Credentialing Abuse in Employed Physician Settings
  - H-180.956 Physician Privileges Application - Timely Review by Managed Care
- Resolution 706 - The Electronic Discontinuance of Medications
  - H-120.939 Physicians Should be Able to Cancel or Rescind Renewals of Prescriptions After the Prescription has Been Delivered to the Pharmacy
  - D-120.965 Pharmacy Review of First Dose Medication

### **CLOSING REPORT – Tuesday, June 9**

#### **HOUSE ACTION: ADOPTED**

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Gurman, and the Vice Speaker, Doctor Bailey, 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 6-9 and

Whereas, This Annual 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 Chicago has extended to the members attending this meeting the utmost hospitality and friendliness; therefore be it

**RESOLVED**, That expressions of deep appreciation be made to the AMA Board of Trustees for arranging this meeting, to the management of the Hyatt Regency Chicago, 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.

Mister Speaker, this concludes the Report of the Committee on Rules and Credentials, and we recommend its adoption.

**APPROVAL OF MINUTES:** The Proceedings of the 68<sup>th</sup> Interim Meeting of the House of Delegates, held in Dallas, Texas, Nov. 8–10, 2014, were approved.

**ADDRESS OF THE PRESIDENT:** AMA President Robert M. Wah, MD, delivered the following address to the House of Delegates on Saturday, June 6.

Mr. Speaker, members of the board, delegates and friends, colleagues and guests – and our international visitors: I’m honored to speak with you as I complete my term as your president. About what we’ve achieved, where we progressed, and what yet needs to be done. Through AMA’s work and your leadership.

We’re reimagining medical education. Easing chronic disease. And ensuring physicians can still put patients first amid disruptive change. Innovative care models are enhancing quality and reducing costs. Millions of previously uninsured Americans are going online to compare prices and buy coverage. We’re fighting to make digital health a useful clinical tool instead of an exercise in meeting regulations. And we’re moving ahead with innovation in new and exciting ways. These reasons and more may be why our membership is up four years in a row. I like how this movie is going.

In my talks with this House, I’ve drawn metaphors from the movies to describe our challenges and progress. This is my third speech. Last June, I talked about a simple country doctor on a 23<sup>rd</sup> century starship. In November, I shared how I became “O.B. Wah Kenobi,” the intern in a galaxy far, far away.

Many of you offered suggestions on how to complete the trilogy. Bewildered by a maze of regulations? “The Matrix.” A noble quest? “Lord of the Rings.” Our relentless pursuit of regulatory victories? “The Terminator.” I decided I like the future – it brings out the optimist in me. So come with me ... Back to the Future!

There’s been lots of internet traffic lately about the vision of 2015 found in the 1989 sequel to the hit movie “Back to the Future.” We see an imagined version of our present day from the vantage point of the past. It hints at what’s to come and what’s already here. Roads? Where we’re going, we don’t need roads!

In “Back to the Future 2,” Marty McFly, assisted by mad scientist Doc Brown, travels decades into the future to save his son from some serious trouble. We arrive with them in a 2015 that looks almost familiar, despite the traffic jams of flying cars. It promises hover boards. They’re actually being developed today by a company using magnetic repulsion. I want one. Of course in the real 2015, people ask me if I have to check my Blackberry out of the museum every morning.

The movie predicted smart phones, flat-screen TVs, and digital glasses, all now a reality. And of interest to many in this room, in the movie, the Chicago Cubs are World Series champions for the first time since 1908. It is, remember, a science fiction fantasy.

In Back to the Future’s 2015, devices are voice-activated. Like Siri. And, you can pay for everything with a thumbprint. In the film, interactive video conversations are commonplace, as is widespread use of tablets. All true today, more or less.

In looking at what “Back to the Future 2” got right and got wrong about 2015, its biggest blunder might be the widespread use of fax machines. In one scene, Marty and Doc pass a post office mailbox that includes a computer terminal that says “Fax here.” This gets a laugh, unless you work in a practice that’s still faxing paper records back and forth because their electronic records can’t interact–can’t interoperate–with outside systems.

While AMA and the broader physician community strongly support the use of technology and innovation to improve the health of our patients, the “Meaningful Use” requirements for electronic records are a heavy burden and a prison for innovation. For a better future, EHRs need to be interoperable, encourage physician-patient interaction, streamline workload and payment and promote team care and coordination.

We’ve made progress. We asked the federal government to cut the reporting period from a year to 90 days. They did it. One troubling performance measure, the patient view-download-and-transmit requirement, will be eased significantly, for now.

It’s a start, but I’ve said it before: harness technology to improve care, don’t let it harness us. The same goes for those who write regulations. Learn from mistakes and act accordingly. If something isn’t working, fix it.

And if you know something won't work, don't do it. One example is our effort to shut down the Independent Payment Advisory Board, IPAB. An appointed body of alleged "experts" charged with recommending Medicare provider payment cuts whenever spending exceeds preset targets. Sounds like the SGR on steroids. A visit back to the future we'd like to avoid.

That's why the AMA has criticized IPAB ever since it was created by Congress. That's why we want to end IPAB's future, before it happens. The AMA and more than 500 organizations called on Congress to repeal the IPAB and we rallied bipartisan support in Congress to get it done. The current Senate bill already has 40 co-sponsors, the House bill 232, including 20 Democrats, well on the way to pass in a bipartisan way. And good news, the House Ways and Means Committee approved the bill this week.

We face another challenge—sort of like Biff the bully: the transition to ICD-10 codes. It's going to take more than fancy skateboarding to deal with this. We believe ICD-10 will further disrupt physician practices when we're already facing headaches like Meaningful Use. Nonetheless, Congress and the Administration seem intent on implementing them October 1.

The AMA and 99 state and specialty societies have urged CMS to put safeguards in place. End-to-end testing showed claims acceptance rates would fall from 97 percent to 81 percent if ICD-10 was implemented today. That's 20 percent failure. And this was among the doctors who volunteered—the ones at the front of the classroom, waving their hands to volunteer!

HHS contends ICD-10 isn't to blame, but this may be the "best case scenario!" If Medicare rejects nearly one in five of the millions of claims in the system each day, we'd see a catastrophic disruption to physician practices. We'll continue to press for more comprehensive testing, a grace period to reduce potential claims denials, hardship exemptions and advanced payment authority to head off cash flow problems.

We've been able to focus even more on these issues because of what the AMA – what all of us – accomplished this spring. Like the plot of a good movie, I've been building up to this. And that's the epic improvement to Medicare by eliminating the SGR. Led by the American Medical Association. Led by physicians. Led by you.

Most of this century we've worked to rid ourselves of the flawed sustainable growth rate and its fickle, capricious hold over Medicare payments. We all know how the SGR's threats of deep cuts created instability in our practices and sowed uncertainty about access among our Medicare and TRICARE patients.

Last year, the message got traction. This year it broke through. On April 14, the Senate followed the lead of the US House and repealed the SGR! I was in Norway for the World Medical Association and watched it unfold at 4 a.m. local time on C-SPAN. A friend of mine, a big fan of military jargon, immediately sent me an email with the subject line: "On your watch!" Well, I'm proud to say the elimination of the SGR happened on our watch!

When the president signed it into law, a cheer went up throughout the land. Organized medicine won a big victory. The Senate passed it 92 to 8. Before that, it was approved by 392 members of the House. That's what's known in Washington as overwhelming, bipartisan, bicameral support, not seen much these days. Working together, we finally ended an era of uncertainty for Medicare patients and their physicians and opened new avenues to provide better care at a lower cost. It wasn't a "doc fix." As I wrote in an article for Forbes, it was Medicare that needed fixing not doctors!

More than 700 state and specialty medical associations and other partners rallied with the AMA banner. In the month before the vote, physicians made more than 60,000 calls and fired off nearly a quarter-million emails to their elected officials. We lit up social media, and set it ablaze. Our action alerts on Facebook, Instagram, and Twitter reached more than 3.5 million online users.

There were questions and doubts, serious ones about whether this effort would get off the ground. Members of Congress told us it would just be patched again for 6 months to a year. A lot of moving parts had to act together at just the right time and in just the right way. Think of Congress as the "flux capacitor." They were "fluxing." We revved up the DeLorean to 88 miles per hour, punched in the coordinates and fueled it with the 1.21 gigawatts of energy put forth by the AMA and America's physicians in a lightning bolt striking at just the right time. We burned rubber and we smashed through the barriers to success.

There are other things for us to cheer in the new law. Annual payment increases through 2019. Streamlined quality reporting programs. Physicians who privately contract with Medicare patients won't have to "opt out" every two years—once you're out, you're out until you say you're in. Medical liability lawyers can't use Medicare quality program standards and measures in lawsuits. And we stopped the CMS proposal to eliminate the 10- and 90-day global surgical services bundles. Incentives to use alternative models or the new fee-for-service program. Participation is entirely voluntary. And did I mention annual payment increases through 2019?

So, many, many thanks to all of you who participated in this overwhelming and overwhelmingly successful grassroots campaign. Medicine's united voice was loud, it was heard, and it was persuasive. Now it calls out for continued physician leadership as change goes forward.

We're already working to shape how this law is implemented to protect physician and patient interests. And America's physicians and the AMA are also sharpening our focus and energy toward improving this nation's health, while enhancing the patient-physician partnership. So I hope you'll understand my wish, one last time, to do a victory lap, maybe just once around the ballroom. Is there a DeLorean in the House? A hover board, maybe?

I've mentioned "Back to the Future 2" and its predictions, from 1989, of what 2015 might look like. This year, 2015, also saw the release of a movie that reveals some of the new realities of our health care system. In specifics or in spirit it reflects much of the AMA's strategic work.

The PBS documentary "Rx: The Quiet Revolution," sponsored by the AMA, looked for challenges and opportunities in our health care system. It found doctors, nurses and others at work in teams to lower costs, improve outcomes and enhance quality. A transformation of the way America delivers and receives medical care. Its stories align with our mission to promote health, prevent sickness and help people live longer, more productive lives.

For instance, in one scene, a diabetic woman in rural Mississippi tests her blood sugar and enters the number on a tablet. Its software sends it to her care team in Jackson. The number's been high lately. The nurse calls the patient and offers to help to lower her blood sugar. And, most hopeful of all, this patient is getting consistently better results. She's lost weight and sharing her experience with family, her friends and her community. Like her care team, she's invested.

This type of interaction among patients and the physician-care team is crucial to AMA efforts to improve outcomes and prevent Type 2 diabetes and cardiovascular disease. Our work is getting results, most recently with our new partnership with the Centers for Disease Control and Prevention: Prevent Diabetes STAT: Screen, Test, Act—Today™. It helps physicians tap prevention programs in their communities or online and drew from our pilot with 11 practice sites in four states in Delaware, Florida, Indiana and Minnesota.

In the 2015 of Back to the Future, Doc got a new spleen and a rebuilt colon at a rejuvenation clinic. We're addressing a reality today where our efforts can prevent deadly outcomes from diabetes and cardiovascular disease. And that means a better, healthier future.

We know as well that tomorrow's physicians need to be better equipped to confront that future. That informs our Accelerating Change in Medical Education consortium of 11 medical schools. These projects will help transform medical education, largely unchanged since the Flexner Report a century ago.

We're investigating new core science to give them skills to navigate an ever more complex health care system and to harness new technology to improve patient care. Designing the medical school of the future is not the stuff of science fiction, but becoming fact, thanks to the AMA and our partners.

The "Rx" documentary and our other strategic work with partners across the country is showing Americans what we already know: High-quality, affordable care is our priority, now and in the decades to come. When our stories are shared, our work is advanced and our patients win.

I'm proud of the exciting work in innovation we're doing at the AMA. For instance, we're developing initiatives to address technology challenges and opportunities facing physicians, like our partnership with the high-tech incubator, Matter. This health IT hub brings doctors to the technology table and gives them the tools to apply it today for a better future.

Imagine if Nathan Davis, riding in a DeLorean, arrived here in Chicago this week. I think he'd be overwhelmed by the changes in medicine and the advances we've made, but I think he'd also be pleased and reassured that our mission and goals at the AMA remain true to the course set back in 1847.

We've worked "for the betterment of public health" in everything from medical ethics, education, vaccinations, treating epidemics and attacking tobacco. Now, AMA and America's physicians are leading the way toward a new era of better health and a better health care system.

Thoughts about the future can be clouded by our daily challenges in the here and now. But meeting those challenges today means a better tomorrow. Each victory takes us back to the future, one with an ever-strengthening bond between physician and patient. Our work to achieve this may never end, but our results will be real, and lasting. The reward: healthier patients and a healthier world.

The challenge of change swirls all around us. We need to see it as an opportunity to maximize those opportunities. It will take hard work, imagination and creativity. I look forward to joining you—working with you—and I'll see you in the future!

Thank you.

**COMMENTS FROM THE CHAIR OF THE AMPAC BOARD:** The following comments were offered by, Robert Puchalski, MD, on Saturday, June 6.

My name is Dr. Bob Puchalski, and I'd like to take a moment, since this is my first time up here, to give you a little bit of background on myself. I'm an otolaryngologist who happens to be married to a pediatric emergency physician. We met in medical school. We have four young children, and we both actively practice in the Carolinas.

I'm also the son of an immigrant couple who immigrated to the United States from communist Poland in 1969 at a time when free speech, legitimate elections and uncensored media were nowhere to be found in Eastern Europe. My parents taught me to cherish free speech, to value the right to vote and that supporting a candidate in a representative democracy was a responsibility of every citizen.

They also taught me the important lesson of leading by example. I'm 43 years old. My retirement's not paid for. College education for my kids isn't paid for, yet I support AMPAC at the highest level allowed by law, \$5,000 annually. And please hold your applause, because I'm not alone. I'm happy to report that the entire Executive Committee of the AMPAC Board all contribute at the same level.

In fact, the entire AMPAC board contributes at the platinum level or greater for the first time in history, which is wonderful. Wonderful! And so we do this not because contributing is easy but because easy is rarely worth doing. We lead by example, because not leading by example makes us examples of failed leadership.

And so I know what you're thinking. You just heard about the SGR victory. You've heard about our legislative advocacy efforts this year. And you must think, gee, AMPAC's probably getting receipts through the roof, right to the top of the ceiling. And, unfortunately, it's not the case. And one example is just our own House.

And so right now House membership is at 48 percent. And last year, we were at 78 percent. Now, I know a lot of you guys haven't gotten a chance to get to the booth in the back, and hopefully you'll be able to do that soon, like today. But let me just emphasize the importance of contributing to AMPAC now. Although we've had these legislative victories, if we don't continue to be hypervigilant, we'll be back on the chopping block in the ways that you've heard from Dr. Wah and others.

It's important that we maintain our hypervigilance. And the best way that I can depict the importance of this is to call upon an analogous story from our US military involving Airman Smithey. Airman Smithey, you see, was assigned to the US Army's Induction Center where he went ahead and advised new recruits on their benefits, mostly life insurance. Airman Smithey was doing phenomenally well. He was enrolling nearly 100 percent of the folks that he met, while others, his peers, were only doing about 48 percent.

And so his CO, his commanding officer, was wondering how this happened. And instead of asking Airman Smithey how it happened, he decided he was going to go ahead and sneak in on one of these little pitches that he had. And so he crawled in the back of the room and just started listening, and he very quickly realized the secret to Airman Smithey's success, because this is what Airman Smithey said, and it's not dissimilar to what I have just told you. He said: 'Look, troops, you can go ahead and not buy the insurance policy, go out to battle and if you die in battle, your family will get \$6,000. Or you can buy the life insurance policy. If you go into battle and you die, you get \$200,000. Now, troops, who do you think they're going to send into battle first?

Ladies and gentlemen, fellow physicians, AMPAC is our life insurance policy. Please take a moment to pay your premium at the booth today and go ahead and get a piece of the rock. Thank you.

**REMARKS OF THE EXECUTIVE VICE PRESIDENT:** The following remarks were presented by James L. Madara, MD, Executive Vice President of the American Medical Association, on Saturday, June 6.

In thinking about this meeting it occurred to me that it was exactly four years ago that I took this position. So I immediately began to learn about all things AMA. For example, I remember being invited to the *JAMA* editorial board dinner. I arrived on time but the editorial meeting had run over and the only other person in the restaurant was an editorial board member whose flight was late getting into O'Hare and so he came straight to dinner. Wanting to engage, I talked with him about my experiences as Editor-in-Chief of the *American Journal of Pathology*. In retrospect, I realize this made him think I was a new member the *JAMA* editorial board.

Finally when others started arriving, he leaned in close and, in a lowered voice said, "so what do you think about this new CEO the AMA just announced?" I told him it would be hard for me to be objective. That I'm pretty close to the guy. Then I made what could have been a mistake. I asked him "what do you think of this new guy?" Fortunately it turned out just fine, and I was able to introduce myself.

Just after that I got to introduce myself to this House as well. In looking back on that introduction, what stuck with me was how rich an example of a pure democracy this House is. You debate; you also collaborate and compromise, eventually getting to ideas, solutions, and our policies. Congress could learn from this. Congress could learn from you.

This House works well because, at the end of the day, everyone in this room has one thing in common: You're here because you care about the future of the practice of medicine. You're here to "promote the art and science of medicine and the betterment of public health," our mission. You want this profession to be its best. And, you're here guiding the AMA to work on the challenges that you encounter in your practices every day. That's what the AMA does, and that's why you're here.

When we work together, as a profession, we can accomplish incredible things; the SGR win is proof of the importance and of the effectiveness of aligning our efforts, and aligning our voices. And unification of voice is achieved through some give-and-take and some compromise. I am still struck by that demonstration of pure democracy. We need that spirit of compromise if we are to have a strong, unified voice in crafting the future of health care in America.

And in thinking about the future, change will be a constant, particularly in this rapidly changing 21<sup>st</sup> century. The ability to manage change requires patience, vision, and leadership. Dealing with change, one has to have the mentality of a marathon runner: quick out of the gate, measured in approach.

To prepare for this, the AMA directs significant resources toward understanding, with high precision, physicians like you and like those you represent. This effort includes research such as the two AMA-RAND studies. The first study captured, defined, and quantitated the challenges of having a satisfying practice. That study has been widely cited because of the real-world insight into physicians' work. And earlier this year, the second AMA-RAND study defined how practices are affected during transition to new models of payment and delivery.

This year, we are having face-to-face conversations with more than twelve hundred physicians of all types throughout our country. We work to keep a finger on the pulse of physician pain points to understand how the changing environment affects physicians. Here's a sampling of what we heard:

(Video of physicians expressing their concerns: 1:10)

These are physician voices, your voices, voices that continue to inform the AMA's ongoing work. So we're scanning the environment; that's good. But what are the AMA's actions in response to what we've learned? First, we've taken broad actions in our Advocacy area shaping better legislation and pushing back to smooth the roughest edges of emerging regulation. Dr. Wah covered our policy and advocacy efforts, so I won't revisit those here.

Rather, I'll focus on a second set of AMA activities, a set of resources and tools. Resources and tools that will help physicians respond to what we've learned. These are largely generated from work on our three moon shots of improving physician satisfaction and practice sustainability; creating the medical school of the future; and improving health outcomes in chronic disease.

Overall, these activities also are producing a culture of innovation and collaboration toward support of physicians in practice—those of today and those of tomorrow. Through this culture, we'll advance the profession by helping physicians stay ahead of the changing environment.

This innovation-enriched approach is exemplified by a brand new product, which we will launch this week. This product is known as AMA STEPS Forward. STEPS Forward was developed as a direct result of the challenges identified by physicians in our first AMA-RAND study. STEPS Forward consists of interactive, engaging, digital modules that help physicians address common practice challenges. These modules have been successfully beta tested by 2,000 physicians in various practice environments. Here is what we heard:

“I reviewed the website, specifically the pre visit planning, prescription synchronization, and team documentation modules. This represents a Herculean effort and I applaud you for your time and passion.”

“For a busy physician who is already feeling overwhelmed by mandates, one of the carrots to choose an improvement project is certainly the potential for workload reduction and for that reason, I really like the inclusion of the calculators and testimonials because they quantify potential impact. I think that is really important.”

STEPS Forward modules also received positive reviews from your practice managers at the MGMA annual meeting. We have also produced four patient health modules to improve the health of your patients while reducing your headaches. In addition, physicians get CME credit for each module, thus meeting your professional obligations while improving your practices. In this broad beta testing with physicians and their practice managers STEPS Forward improved practice efficiency. To learn more, stop at the STEPS Forward booth right outside the ballroom or visit the website.

Innovation and collaboration are also the genesis of how we created a powerful new program to prevent the conversion of pre-diabetes to diabetes. The sobering fact is that 86-million adults in our country have pre-diabetes and 90-percent don't know it. In 2014, the AMA piloted tools and resources in physician practices and gained key learnings around this evidence-based approach to stopping diabetes before it starts. This year, together with the CDC, we launched a web-based initiative called Prevent Diabetes STAT. An AMA-CDC cobranded tool for pre-diabetes is now in the hands of the Departments of Public Health in all 50 states. As an extension of this work we are now in initial conversations with potential partners that would allow scaling of this program. Work we hope will take shape in 2016.

It's important to realize that the work in this area is about even more than diabetes. What we're essentially doing is defining models that might provide effective approaches for chronic diseases of all types, therefore addressing the chronic diseases that account for 75% of our nation's healthcare spending. Preventing these disorders, which are threatening people's health and quality of life, will not only improve the health of the nation, but also diminish a growing burden on physician offices. Visit the website, to joint this initiative.

Likewise, innovation and collaboration are the foundation of AMA's bold initiative to create the medical school of the future. Leading a consortium of 11 partnering medical schools, the AMA is moving to define the future of health care through medical education. Our AMA consortium meets and shares, regularly. Several innovations are emerging. Here are examples of two. First, many new medical students express an interest in an informatics-related career, not surprising given the need of improvement in this domain. But these students have no idea how to develop

knowledge and skill in this area. Work of our consortium, led by Oregon, is establishing key competencies for this combined specialty. Parallel work is defining the optimal relationship between the 21<sup>st</sup> century physician and the data they and others generate about their patients and their practices. A second example of innovation in our consortium is the creation of an electronic “home” for each medical student’s portfolio. This home includes: competency-based assessments, experience logs, written reflections, coach-guided summaries and student-generated learning goals. Vanderbilt is charged with leading this work in our AMA consortium. Our consortium students are coming to understand, as do you, that physicians must lead the conversation to bridge the gap between ideation and the day-to-day realities of patient care.

You know, when I was at University of Chicago, the student union sold a tee shirt. The front read: “that’s all well and good in practice” and then, on the back, “but how does it look in theory?” Changes in healthcare have often allowed theory to trump practice. That has to change.

To seed physician knowledge into the formation of health technologies, earlier this year we opened the AMA Interaction Studio at Chicago’s new health tech hub called MATTER, already home to more than 80 healthcare startups. This AMA Interaction Studio brings together parties that don’t interface to the degree needed: tech entrepreneurs and physicians.

We all know how clunky EHRs are. I describe them as the pinnacle example of deep theoretical promise converted to spectacular practice dysfunctionality. That’s because physicians were not present at the creation phase and consequently the real world usability was not the priority.

By bringing physicians to the table with entrepreneurs, engineers, coders, and designers, physicians can guide and shape new solutions and products as they are being developed. These are all novel collaborations. We can be energized by the promise of innovation as the AMA helps define the future of healthcare. Through these kinds of interactions—sharing broadly with others what we physicians know and need—we can sculpt the office of the future and create and harness health care tools that can save time and empower both physicians and patients.

That’s simply not happening today, but it’s important that it starts immediately. It’s time we stop having tools and products with surprising limitations and deficiencies simply thrown over the transom to us. We need to be at the table and shape the future from the get-go. Toward these ends, we’re developing another innovation effort that will address problems encountered by physicians. Our goal is to unlock physician potential through design, development and leveraging of technology.

For example, imagine having an easy digital solution for claims denials: one that would automatically create a claims workflow, including appeals, sculpted to your existing contracts, and to have this done without involving time and effort by you or others in your practice. The same goes for thinking of digital solutions that could wrestle down the problem of pre-authorization and defang it. Solutions to such common problems should be possible, and we will, by this fall, have begun such work.

All of these efforts—from preventing diabetes, to enhancing practice satisfaction, to creating the medical school of the future, to insuring that emerging healthcare products and services are designed to be optimized for physicians—all of this together creates what I call the AMA innovation ecosystem: An innovation ecosystem that serves the physicians of today and tomorrow and works in parallel with all of our efforts ranging from publishing to advocacy, increasing the power of all efforts.

I’ll end by sharing a story. In a couple of past meetings I touched on a serious illness in my youth that brought me to a remarkable ophthalmologist, events that directed me to medicine. Well, just recently I managed to poke myself in the eye with a branch so, back to the ophthalmologist I went. Entering her office, I saw a couple just a bit older than I, giving Dr. Arun a beautiful orchid. I teased Dr. Arun that, on top of my insurance and co-pay, I was unaware that she now wanted us to bring her flowers as well. But the back-story was this: not only had Dr. Arun cared well for this couple over many years, but she also served as a voluntary advisor to the couple’s daughter. The daughter had just been admitted to medical school.

I see other examples of this special relationship we have with our patients. Last summer our own Dr. Gerry Harmon emailed me a photo of a box of freshly picked corn that a patient had dropped at his door. So here’s another way to think about these events: that orchid and that corn relate to the intrinsic motivation that physicians have to serve

their patients. Those gifts are quality measures, both real and meaningful quality measures. Because these measures are not just of process but they're true measures of a specific outcome, the outcome derived from the compassion physicians have for their patients and their families. It's your relationship with your patients that contributes to excellence of care.

So as health care continues to change—from new legislation to clinical breakthroughs—reflect on similar outcomes that you have achieved. Know that the AMA remains steadfastly devoted to navigating change on behalf of the nation's physicians which, in turn, is in service to the people of this nation. We're listening. We're improving. We're working to better meet the needs of physicians.

Working in this way with the nation's physicians—with you and those you represent—we can and will create better health, better lives, and a stronger nation.

Thank you.

**REPORT OF THE AMPAC BOARD OF DIRECTORS:** The following report was submitted by Robert Puchalski 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 our activities during the current election cycle. Our mission is to provide physicians with the opportunity to support candidates for election to federal office who will work to strengthen our ability to care for America's patients. In addition, we help physicians advocate for their patients and their profession through our political education programs that recruit physicians to work on a campaign or to run for office themselves. We work hand-in-hand with our state medical society PAC partners to carry out our mission.

**AMPAC Membership Fundraising** AMPAC is in the early stages of gearing up for the 2016 election cycle and fundraising receipts are trailing in comparison to the start of last election cycle. To date, AMPAC has raised \$750,418.61 in total, consisting of \$621,613.30 in hard funds and \$128,805.31 in soft funds. This represents a decrease of 11 percent or \$92,950.42. Of AMPAC's hard receipts, \$574,400.80, or 92 percent, is from AMPAC's direct fundraising program.

These figures are concerning given the recent significant victory of repealing the SGR in Congress. In light of this accomplishment, we expected AMPAC's receipts to be increasing rather than decreasing this cycle. In particular, we anticipated the AMPAC participation rate of our own House of Delegates to be much higher than the 48 percent we have today. I don't think I need to remind you that there are many significant challenges that lie ahead and our work is far from over. The need for your support remains great in order to continue our focus on issues ahead such as reducing regulatory burdens on physicians and pursuing new delivery and payment models. We can only overcome these hurdles if we remain united and continue to support our advocacy efforts through AMPAC.

Participation in AMPAC's Capitol Club at this point in the year is 660 members and is growing at the same rate as it did during the last non-election year of 2013, when there were 655 Capitol Club members. There has been increased growth in Capitol Club Platinum which now has 64 members, AMPAC's highest number since the program was created in 2012. In addition to Platinum, Capitol Club participation levels have also achieved 236 Gold members and 360 Silver members. Continuing to grow Capitol Club membership is at the forefront of AMPAC's goals, not only during this meeting as members renew their Capitol Club membership, but for the balance of the year and particularly within the AMA's House of Delegates.

As a benefit of being a Capitol Club member, AMPAC is hosting its annual Capitol Club luncheon on Tuesday, June 9, at 12:00 p.m. with special guest Mark Halperin who is a managing editor of Bloomberg Politics and has covered every American election since 1988. All current Capitol Club Platinum, Gold and Silver members have been invited to attend. Furthermore, AMPAC is promoting its annual sweepstakes which is a breathtaking trip for two to Big Sky Country in Montana. AMPAC's "Big Sky Country Getaway" includes a five day/four night trip for two to the Ranch at Rock Creek in Philipsburg, Montana in September of 2016. The Ranch at Rock Creek is an all-inclusive ranch resort offering guests a piece of western adventure with unprecedented comfort and amenities, including a variety of outdoor activities and a renowned spa for relaxation. The lucky winner will be drawn and announced during the

Capitol Club luncheon at the Interim Meeting in Atlanta, Georgia. All current Platinum, Gold and Silver contributors are automatically entered into a drawing for the sweepstakes.

While AMPAC is committed to improving upon its success, the support of the members of this House is essential in order to stay competitive so AMPAC can be in the best financial position heading into the 2016 federal elections. Once again, I strongly encourage you to stop by the AMPAC booth and contribute; it is the most valuable investment that you can make for your profession.

**Political Action** After playing a significant role in the hard-fought campaign to once and for all repeal Medicare's flawed Sustainable Growth Rate (SGR) formula, AMPAC is gearing up for the 2016 election cycle and once again ensuring that organized medicine impacts the national debate. The AMPAC Board's Congressional Review Committee is working closely with state medical society PACs to begin making early 2016 Primary contributions to House and Senate candidates. Medicine-friendly candidates, lawmakers in key positions of leadership or on committees that deal with medicine's priority issues, in addition to those legislators who distinguished themselves in the recent SGR repeal effort and are expected to face tough races, are the focus at this early stage.

In a post-SGR environment, AMPAC's continued high-profile presence in federal elections will ensure key relationships are built and maintained in order to advance the AMA's evolving legislative agenda.

**Political Education Programs** On January 17, AMPAC held the first Regional Campaign and Grassroots Seminars co-hosted by the Missouri State Medical Association with 40 physicians participating.

The AMPAC Candidate Workshop was held on February 20-22, 2015 at the Ritz-Carlton Pentagon City in Arlington, VA. As was the case in 2014, the Workshop saw a high level of interest, with 37 attendees from 24 states, including 29 physicians, 4 medical students, and 4 physician spouses.

On April 15-19, AMPAC hosted the 2015 edition of the Campaign School in Arlington, VA. The passage of the SGR repeal (H.R. 2) in the US Senate on April 14 set the tone for a very excited and engaged group of participants. There were a total of 28 attendees from 18 states including 19 physicians, 4 medical students, 4 physician spouses, and 1 state medical society staffer.

AMPAC has also announced the dates of the 2016 Political Education Programs, to train physicians and other members of the medical family who want to be more involved in political campaigns. The Candidate Workshop will be held February 19-21, and the Campaign School will be held April 13-17. Both programs will be in Arlington, VA, and AMPAC covers all costs for AMA members except transportation, a significant benefit of your AMA membership. Please stop by the AMPAC booth for more information.

**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. 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 that the interests of medicine are properly represented in the halls of Congress.

### **RETIRING DELEGATES AND EXECUTIVES**

#### **Florida**

Robert Cline, MD

#### **Maryland**

Thomas E. Allen, M.D.  
Mark S. Seigel, M.D.

#### **Ohio**

Melissa Jefferis, MD

#### **Oklahoma**

Steven Crawford, MD

#### **American Academy of Family Physicians**

Reid Blackwelder, MD

#### **American Association of Hip and Knee Surgeons**

Courtland Lewis, MD

## REFERENCE COMMITTEE MEMBERS

### **Reference Committee on Amendments to Constitution and Bylaws**

Nancy L. Mueller, MD, New Jersey, Chair  
 Nicole C. Clark, MD, Montana  
 Pino D. Colone, MD, Michigan  
 Dennis Galinsky, MD, American College of Radiation Oncology  
 March Seabrook, MD, American College of Gastroenterology  
 Jayesh Shah, MD, Texas\*

### **Reference Committee A (Medical Service)**

John J. Ingram, III, MD, Tennessee, Chair  
 Jose F. Arrascue, MD, Florida\*  
 Julia V. Johnson, MD, American Society for Reproductive Medicine\*  
 Ronald H. Kirkland, MD, American Med. Group Association  
 Johnathan D. Leffert, MD, American Association of Clinical Endocrinologists\*  
 Brigitte J. Robinson, MD, Colorado  
 Joseph A. Schwartz, MD, California

### **Reference Committee B (Legislation)**

Theodore A. Calianos, II, MD, Massachusetts, Chair  
 Gary A. Delaney, MD, South Carolina\*  
 John T. Gill, MD, Texas  
 Daniel Heinemann, MD, American Academy of Family Physicians  
 Alex Malter, MD, Alaska  
 Venkat K. Rao, MD, Michigan\*  
 Bruce A. Snyder, MD, South Carolina\*

### **Reference Committee C (Medical Education)**

Daniel B. Kimball, Jr., MD, Pennsylvania, Chair  
 Ricardo Correa, MD, District of Columbia, Sectional Resident  
 Ben Durkee, MD, American College of Radiation Oncology, Sectional Resident  
 Gary R. Figge, MD, Arizona\*  
 Lynn LC Jeffers, MD, American Society of Plastic Surgeons  
 Cynthia Jumper, MD, Texas\*  
 Thomas G. Peters, MD, Florida\*

### **Reference Committee D (Public Health)**

Peter H. Rheinstein, MD, JD, Academy of Physicians in Clinical Research, Chair  
 Jean Elizabeth Forsberg, MD, College of American Pathologists\*  
 Gordon L. Fung, MD, California\*  
 Ralph Schmeltz, MD, Pennsylvania  
 Bollepalli Subbarao, MD, Connecticut\*  
 Eric G. Tangalos, MD, AMDA - The Society for Post- Acute and Long-Term Care Medicine  
 Diana Wieser, Ohio, Regional Medical Student

### **Reference Committee E (Science and Technology)**

Saundra S. Spruill, DO, American College of Phlebology, Chair  
 William Davison, MD, American Academy of Neurology  
 R. Rodney Howell, MD, American College of Med. Genetics and Genomics  
 Benjamin Meyer, South Dakota\*, Regional Medical Student  
 Kevin D. Nohner, MD, Nebraska  
 Carl S. Wehri, MD, Ohio\*

### **Reference Committee F (AMA Finance and governance)**

Robert L. Dannenhoffer, MD, Oregon, Chair  
 Betty S. Chu, MD, Michigan\*  
 Jane C.K. Fitch, MD, American Society of Anesthesiologists  
 Ravi D. Goel, MD, American Academy of Ophthalmology  
 Gary R. Katz, MD, Ohio  
 Jerry D. McLaughlin, II, MD, New Mexico  
 Bassam H. Nasr, MD, Michigan\*

### **Reference Committee G (Medical Practice)**

Courtland G. Lewis, MD, American Association of Hip and Knee Surgeons, Chair  
 Kimberly E. Applegate, MD, Association of University Radiologists  
 Anthony J. Armstrong, MD, Ohio\*  
 Jacob Burns, Florida\*, Regional Medical Student  
 Gary Dennis, MD, National Medical Association\*  
 William R. Latrelle, MD, New York  
 Rodney L. Trytko, MD, Washington

### **Committee on Rules and Credentials**

Mary Carpenter, MD, South Dakota, Chair  
 Patricia L. Austin, MD, California  
 Michael D. Bishop, MD, American College of Emergency Physicians\*  
 Madelyn E. Butler, MD, Florida  
 George M. Lange, MD, Wisconsin\*  
 David T. Walsworth, MD, Michigan\*  
 J. Mack Worthington, MD, American Academy of Family Physicians

### **Tellers**

Charles J. Rainey, MD, JD, Wisconsin, Chief Teller  
*Assistant Tellers*  
 Denise L. Bobovnyik, MD, Ohio  
 Steven P. Furr, MD, Alabama  
 Michael J. Gerardi, MD, American College of Emergency Physicians  
 Alan Plummer, MD, Georgia  
 Sterling Ransone, MD, Virginia  
 Wiley Robinson, MD, Tennessee  
 Jennifer L. Wiler, MD, American College of Emergency Physicians

### *Election Tellers*

Michelle A. Berger, MD, Texas  
 Kevin Burke, MD, Indiana  
 David Fassler, MD, American Academy of Child and Adolescent Psychiatry  
 Robert Gibbs, MD, Kansas  
 Ryan Hall, MD, American Academy of Psychiatry and the Law  
 Brent Mohr, MD, Indiana

\* Alternate delegate

**INAUGURAL ADDRESS:** Steven J. Stack, MD, was inaugurated as the 170<sup>th</sup> president of the American Medical Association on Tuesday, June 9. Following is his inaugural address.

Thank you. I am both honored and humbled to stand before you tonight as AMA president. Of course, I would not be here were it not for the love and encouragement of my family; the support of my colleagues, both in medical practice and in organized medicine; the inspiring examples of previous AMA presidents; or the ongoing labors of our leadership on behalf of the profession. To each of you—to all of you—I am eternally grateful.

It is a special privilege to become the first emergency physician to serve as AMA president. Like many in this room, my specialty has profoundly shaped who I am as a physician, and as a person. One thing I love about emergency medicine is its capacity to teach. Every day I'm in the emergency department I learn something about life. For one thing, I learn what not to do in life. For example, never put a firecracker in an upside down beer can, light the fuse, and put your foot on top to see what happens. And if you're going to hammer a nail into a board, don't swing the hammer toward your face. Believe it or not, you may miss the board entirely and etch a hammer-shaped arc in your two front teeth. It's been said truth is stranger than fiction. Let me assure you, truth in the ED is a lot stranger than fiction.

Of course, it's the deeper, more profound lessons that truly leave their mark. The emergency department is the great equalizer in the health care system—a place where rich and poor, insured and uninsured, those at death's door, and those with minor aches and pains, lie side by side. You quickly realize that illness does not discriminate—that the C-suite executive is no more immune to accidents or emergencies than the homeless man living under a bridge.

You also become increasingly aware of society's failings and the people who fall through the cracks in the system: the elderly woman who visits the ED week after week because she is lonely; the man so addicted to opioids he makes the rounds of all the area emergency departments, scoping out the new physicians and duping them into writing a prescription; the young mother who works two jobs but can't afford health care, so now she seeks care in the ED with a large mass in her pelvis.

Being an emergency physician also teaches you how important it is to be able to adapt. Sometimes there aren't enough beds available. Sometimes there aren't enough nurses or specialists on hand to attend to a patient. So you quickly move from plan A to B. And from B to C. When lives are at stake, there's no time to lament the challenges before you. You make the most of what you've got and move forward. And, more often than not, it works out.

These lessons have furnished me with a sense of perspective regarding the challenges we face in organized medicine. If one lesson stands above the rest, however, it's how tenuous and precious life is and what a gift it is to be a physician.

I recall a particular patient who drove this point home for me. It was about 4 a.m. Christmas morning, 2010. I was working the night shift. A young man arrived in the emergency department with symptoms about as vague as it gets. For the sake of anonymity, I'll call him Joe. Joe had been sitting at his computer doing some work, when he got a funny feeling in his back, a strange pain that just wouldn't go away. So he went to the hospital to get it checked out. Obviously, many conditions, mostly minor, can trigger a funny feeling in the back. But something about the way he described his symptoms led me to suspect a 1 in 100,000 diagnosis: a thoracic aortic dissection.

Joe was in his 30s, by all indications healthy, and his pain could best be described as mild. Nevertheless, something didn't sit right with me. So I ordered a CT scan, and sure enough, my fear was confirmed. I went to Joe and explained that we needed to immediately transfer him to a bigger hospital for emergency surgery. Some of his family had shown up by this point, and I had to make sure they understood the gravity of the situation. If Joe's aorta ruptured, he would die in transit. They needed to take this opportunity to exchange last words. At the same time, I didn't want to deprive them of hope. This was one of those situations where both the patient and his family needed to have the utmost confidence in his physicians. So I did my best to walk that fine line between being compassionate and being strong.

As we were getting him ready to leave, Joe asked his nurse to write down a phone number. He said to the nurse, "Please, don't let me die. But if I do, promise me you'll call my girlfriend and tell her I'm sorry we argued."

As I said, it was Christmas morning. After my shift ended, my wife drove us to Cincinnati to spend the holiday with her family. All day, I kept logging on to check the University health records. As long as laboratory data kept showing up, I knew he was still alive. Now, fast forward to Christmas 2011. I didn't work the holiday that year, but suddenly the phone rings and it's my colleague. He says, "Some guy just stopped by and said you took care of him last year. He wanted to thank you for saving his life."

For many, that life changing moment—that defining moment when what's important suddenly draws into focus and the mundane falls back into relief—occurs in a physician's care: the birth of a child, the loss of a loved one, an unexpected diagnosis. The physician's life is defined not by one, but by hundreds of these moments. Our profession is literally built around them. And to play a part in these moments is a priceless gift. These are the moments we went to medical school for. These are the moments for which we forego nights with our families. These are the moments that sustain us.

Unfortunately, too often these life-changing moments are overshadowed by other, more mundane matters, the day-to-day trials and tribulations we face as we navigate the health care system. During my travels across the country I've been struck by the sense that so many physicians feel under siege. It's easy to understand why. These days just about everyone has an opinion about how we should do our jobs. The government compels us, under threat of penalty, to purchase electronic health records. So we go out and buy them. But instead of increasing efficiency they slow us down, eating up valuable time that would be far better spent at the bedside.

The health system executive institutes policies that don't make clinical sense—abandoning patient interests in favor of spreadsheets and financial models. And physicians are left scrambling to fill in the gaps. The insurance company steps in with its medical opinion, questioning whether a particular procedure was necessary—denying payment for tests that in cases like my patient Joe's—can mean the difference between life and death. And the lawyer circles like a hawk above us, witnessing the failures of the system, looking for any opportunity to assign blame to the person most easily accountable under law—the physician.

All these demands leave us exhausted, accountable to everyone, yet without the autonomy needed to deliver on everyone's expectations. And the highest expectations, of course, come from ourselves. We know the level of care our patients need and deserve. And we are unwilling to compromise on that care, regardless of the obstacles and burdens the system throws in our path.

I experience these trials and tribulations regularly in the ED. I've labored through the 70-page transition of care documents. I've been forced, in this day of nanotechnology and genetic sequencing, to head over to the fax machine because our hospital computer can't talk to the one across town. I've marveled at the sparkling legibility of the reams of paper produced, perfectly legible ... yet utterly incomprehensible. I've marveled at the fact that an industry responsible for one fifth of this nation's economy can be less technologically adept than a fantasy football website or an online video game.

These kinds of daily frustrations are disheartening. And there are days when I feel overwhelmed, powerless to shape my own future, let alone those of my patients. But that is only part of the story. A couple of months ago, I attended the 200<sup>th</sup> meeting of the World Medical Association in Norway. During my stay, I had the opportunity to tour some of Oslo's highlights, including a dramatic bridge by the artist Gustav Vigeland. What makes the bridge so striking are the 58 life-size sculptures perched along its two rails.

As you approach one of the rails, the first thing you encounter is a woman fighting a dragon. Further down, there's a man and woman arguing. A bit further along a child clenches his fists in anger. The images continue in this way, captivating in their own right. But then when you look across the bridge to the other rail you're surprised to see the polar opposites portrayed, the other side of the story. There's a sculpture of a child, but this time he's skipping in reverie. The couple that was so fiercely arguing is now kissing. And the woman who bravely fought the dragon is now clutching it in warm embrace.

All along the bridge this duality is movingly displayed. The joys of love. The anguish of love. The pleasures of childhood. The frustrations of childhood. It's all part of the human condition. Part of the rich pageantry of life. When I reflect on being a physician today, I see many challenges. But for each story of frustration, there is a story of vision, perseverance, and success. There is a story of hope. Think of some of the AMA's recent victories.

For well over a decade, America's physicians toiled to fix the broken Medicare payment system. Year after year we marched to Capitol Hill with solutions. And year after year we were turned away. But we refused to give up. In the face of adversity, we gathered our strength. As the obstacles mounted, we redoubled our efforts. With every passing year, our voice grew stronger. With every year, our voice grew louder. Until finally, we could not be ignored.

Two months ago, because of a quest that started right here in the House of Medicine, Congress passed the Medicare Access and CHIP Reauthorization Act. And because of this law, today 49 million seniors and 10 million members of the military and their families are assured access to care in their time of need. And the one million physicians who serve them have the stability we need to provide the best possible care. This is just one example—just the most recent example—of the kind of impact America's physicians can have when we stand together. And there are more.

Today, because of a quest that started in the House of Medicine, the number of uninsured Americans has dropped to the lowest level in seven years. Today, because of a quest that started in the House of Medicine, 10 million more Americans are taking control of their health, engaging with the system in times of wellness as well as in illness. Today, because of a quest that started in the House of Medicine, physician-led accountable care organizations have become the top performers in Medicare. They're not only improving patient care, they're saving tens of millions of dollars for the system.

Since the AMA was founded in 1847, physicians have faced one obstacle after another. Medical quackery. Substandard medical education. Ethical dilemmas. The perils of smoking. HIV/AIDS. Whatever the obstacles, the AMA has faced them head on. And together, we have overcome them.

As some of you know, I studied the Classics during my undergraduate years. This background has furnished me with a wealth of useful knowledge. For example, when most people hear the name Cicero they think of history's most famous orator. I think of hummus. That's because the Latin word for Cicero essentially translates to chickpea. In addition to giving me a clear advantage in Trivial Pursuit, studying the Classics affords valuable insight into human behavior and politics, lessons as valid today as they were two millennia ago.

For me, one figure that always stood out is Alexander the Great. Crowned king of Macedonia at age 20, by 30 he had amassed one of the largest empires of antiquity. It stretched 3,000 miles across parts of modern day Europe, Asia and Africa. With unparalleled ambition and endurance, Alexander conquered nations, founded cities in his name, and built a personal legacy that endures to this day. But just a few years after Alexander died, his massive empire had fragmented and fallen apart. Rome, by contrast, thrived for centuries. The lesson from the pages of history could not be more clear: an empire built by one man will not stand. An empire built by many endures.

I have always felt that the power of the AMA lies in the sheer diversity of our membership. Instead of representing one particular specialty, or one particular state, we represent all physicians, in all states. We represent medical students, residents, young physicians, international medical graduates. We represent minority physicians, senior physicians, LGBT physicians. Our membership is as diverse as the patients we serve. Each one of us brings something different to the equation. And together, our collective voice is as rich and nuanced as it is strong.

Today our quest is broader, bolder, and more visionary than ever before. Rather than reacting to the changes and challenges transforming health care, the AMA is stepping out to lead the way forward. Rather than waiting for tomorrow, we're creating the future of health care today. Our vision is ambitious: to profoundly improve health outcomes for the 86 million people in this country with pre-diabetes and the 70 million with hypertension; to forge a generation of physicians prepared to meet the needs of our 21st century health care system; to restore the joy in medicine and enable physicians to spend their time where it matters most, helping patients.

These are lofty goals, and achieving them will not be easy. Nothing worthwhile ever is. But as physicians, we have never shied away from challenges. Rather, by working together, we have always found a way to overcome them—one patient at a time, one family at a time, one community at a time.

I recall a truck driver I treated early in my career in Memphis. Let's call him Matt. Matt arrived to the ED in a taxi. I point that out because some folks don't hesitate to call an ambulance for a runny nose. But Matt was the opposite. He made his living crossing the continent in an 18-wheeler, and he'd been having chest pain for hours before he finally decided to pull over. He walked into a truck stop and asked the cashier, "Can you call me a cab? And by the way, can you recommend a hospital?" Matt found us, and we immediately did an EKG. It showed he was clearly

having a heart attack; he'd probably been having it for hours. My team and I administered numerous medications and were able to stabilize him to such a degree that he could be admitted to the hospital.

The next night when I arrived for my shift in the ED, a "Code Blue" was called in the operating room. One of the nurses turned to me and said, "I think the fellow we took care of last night just went up there." So I went up to the OR and sure enough, there was Matt on the table, a cardiac surgeon leaning over him. I asked the surgeon what had happened, and he filled me in on the extraordinary chain of events. After leaving the ED, Matt had spent an uneventful night in the hospital. In the morning he saw a cardiologist for a catheterization. The cardiologist discovered blockage so severe that stents would not be enough, so he scheduled Matt for an urgent open heart bypass. At the appointed time, Matt arrived in the operating room. But the moment the anesthesiologist put him under, he went into cardiac arrest. A code blue was called, and for all intents and purposes, Matt was dead.

That's when the cardiac surgeon made a series of split-second decisions. With lightning speed he attempted to put Matt on the bypass pump so the surgery could proceed. But when he tried to insert the catheters into Matt's femoral artery and vein, they were so calcified that the catheters would not pass. Without blinking, the surgeon moved to plan B. He cracked open Matt's chest, inserted the bypass catheters directly into Matt's aorta and vena cava, and commenced open heart surgery. All of this, within the four or so minutes necessary to prevent brain damage.

A few days later, I stopped by Matt's room to see how he was doing. And in a surreal moment, this man who had nearly died before my eyes in the ED—and literally died before my eyes in the OR—stood up, walked across the room, and gave me a bear hug.

When it comes to something as important as saving a life, numerous factors come into play. Speed. Mental dexterity. Decades of training. Hope. Above all, it takes a team. At the end of the day, which one of us was responsible for saving Matt's life? Was it the quick-thinking cardiac surgeon? Was it the cardiologist who detected the blockage? Was it those of us in ED who stabilized his heart attack? What about the nurses who cared for him, or the assistants in the OR?

Like everyone in this room, I was drawn to organized medicine because I realized that the only way to take on big problems is through collaboration with others. Each one of us has a role to play. Each one of us contributes something the other cannot.

The same can be said of health care in this country. When it comes to something as important as shaping a better, healthier future, it will take every single one of us. Physicians. Payers. Policymakers. Patients. Every one of us has a part to play. We cannot do it alone. As that famous orator Cicero once said, "We were born to unite with our fellow men, and to join in community with the human race."

Colleagues, it is my honor to join with you in the year ahead. It is my honor to fight alongside you, on behalf of this country's physicians and patients. Today the AMA tenaciously pursues a healthier future. And we will get there because of our past. We will get there because of the rich foundation that supports us. We will get there because of the vision and fortitude that are the hallmarks of this profession. We will get there because America's physicians have always stood—and still stand today—united as one.

Thank you.