

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

165<sup>th</sup> ANNUAL MEETING  
CHICAGO, ILLINOIS  
June 11-15, 2016

### CALL TO ORDER AND MISCELLANEOUS BUSINESS

**CALL TO ORDER:** The House of Delegates convened its 165<sup>th</sup> Annual Meeting at 2 p.m. on Saturday, June 11, in the Grand Ballroom of the Hyatt Regency Chicago, Susan R. Bailey, MD, Speaker of the House of Delegates, presiding. The Sunday, June 12, Monday, June 13, Tuesday, June 14, and Wednesday, June 15 sessions also convened in the Grand Ballroom. The meeting adjourned following the Wednesday morning session.

**INVOCATION:** The following invocation was delivered by AMA member David DeMarco, SJ, MD, who is a Jesuit spiritual director and a practicing physician at Loyola University.

In the silence of our hearts...we pray:

Good and loving God, we know you by many names, and through rich and diverse traditions.  
As we gather before you this day, we pause to remember your abundant gifts to us.  
For the gift of our sacred calling to the healing arts we are so deeply grateful.  
We are grateful too for our teachers.  
For we stand in a very long line that stretches back to Hippocrates, and moves forward to,  
    Maimonides and Harvey, Laennec, Virchow, Osler, and Salk.  
We are grateful for our patients.  
They have entrusted us with their very lives, and have taught us how to care for them.  
They have called forth from us "the better angels of our nature."  
We are grateful for the gift of our living in a land that is still filled with wondrous possibilities  
    and historic freedom.

Loving God we ask that you send down your Spirit upon this gathering.  
Animate all who labor here for the wellbeing of every physician and every patient.  
Confer upon all the wisdom of your ways and the generosity of your justice.  
May this gathering enshrine the wise stewardship of an honored profession,  
    while always mindful of the most vulnerable who walk with us.  
We pray this in your most holy name. Amen.

**REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS:** The following reports were presented by Donald B. Franklin, MD, Chair:

**CREDENTIALS:** The Committee on Rules and Credentials reported that on Saturday, June 11, 483 out of 553 delegates (87.3%) had been accredited, thus constituting a quorum; on Sunday, June 12, 506 delegates (91.5%) were present; on Monday, June 13, 530 (95.8%) were present at the start of the session and 531 of 554 delegates (95.8%) were present at the end of the session; on Tuesday, June 14, 535 (96.6%) were present; and on Wednesday, June 15, 535 (96.6%) were present.

Note: During Monday's business session, the American Society of Dermatopathology was granted representation in the House of Delegates, and the American Society of Hematology and International Society of Hair Restoration Surgery were removed from the House (upon adjournment) for failing to meet membership requirements.

**RULES REPORT - Saturday, June 11****HOUSE ACTION: ADOPTED**

Madam 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 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 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, excepting Parliamentary Procedure, the authority for which is the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*.

**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 11. 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 2016 annual election balloting shall be held Tuesday, June 14, 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 12**

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

**LATE RESOLUTIONS 1001 (522), 1002 (240), 1003 (122), 1004 (608), 1005 (241),  
1006 (242), 1007 (431) AND 1009 (243) ACCEPTED  
LATE RESOLUTION 1008 NOT ACCEPTED  
EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS**

Madam Speaker, Members of the House of Delegates:

#### (1) LATE RESOLUTIONS

The Committee on Rules and Credentials met Saturday, June 11, to discuss Late Resolutions 1001–1009. Sponsors of the late resolutions met with the Committee on Rules and Credentials to consider late resolutions, and were given 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.

Recommended for acceptance:

- Late 1001 – Guidelines for Prescribing Opioid Medications
- Late 1002 – Patient Safety Incidents Related to Use of Electronic Health Records
- Late 1003 – Health Coverage for Nutritional Products for Inborn Errors of Metabolism
- Late 1004 – Including Medical Students in STEPS Forward to Prevent Burn Out and Promote STEPS Forward in Medical Schools Nationwide
- Late 1005 – Opposition to the CMS Medicare Part B Drug Payment Model
- Late 1006 – Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) (P.L. 114-10)
- Late 1007 – Funding for Zika Control and Research
- Late 1009 – Preserving Patient Access to Small Practices Under MACRA

Recommended not be accepted:

- Late 1008 – No Compromise on AMA's Anti-FGM (Female Genital Mutilation) Policy

#### (2) 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):

- Resolution 105 Restore Medicare Dual Eligible Payments
- Resolution 109 Development of a CPT Code for PMP Look-Up
- Resolution 116 CPT for Referral to an Addiction Treatment Center
- Resolution 119 Ensuring Appropriate Risk Adjustment Prior to Implementation of Value Based Purchasing Programs
- Resolution 220 Managing Controlled Substance High Utilizer Patients
- Resolution 235 Unfunded Mandates on Physicians
- Resolution 302 Reform and Expand Graduate Medical Education Funding
- Resolution 305 Expanding GME Concurrently with UME
- Resolution 306 Maintenance of Certification / Licensure (MOC/MOL)
- Resolution 307 Diversity in the Health Care Workforce to Reduce Disparities
- Resolution 308 State Programs to Increase Residency Positions
- Resolution 412 Ban Electronic Cigarette Advertisements
- Resolution 508 Banning the Use of Gasoline Powered Leaf Blowers
- Resolution 706 Conflict of Interest Disclosure Exemptions for Non-Reimbursed Medical Staff and Faculty
- Resolution 709 Reimbursement for Distinct Services

#### APPENDIX – Reaffirmed policy and actions taken

- Resolution 105 Restore Medicare Dual Eligible Payments
  - Medicare/Medicaid Dual Eligible Reimbursement H-290.978
  - Medicare/Medicaid Dual Eligibles D-290.998
- Resolution 109 Development of a CPT Code for PMP Look-Up
  - Use of CPT Editorial Panel Process H-70.919
- Resolution 116 CPT for Referral to an Addiction Treatment Center
  - Use of CPT Editorial Panel Process H-70.919
- Resolution 119 Ensuring Appropriate Risk Adjustment Prior to Implementation of Value Based Purchasing Programs
  - Accountable Care Organization Principles H-160.915
  - Physician Payment Reform H-390.849
- Resolution 220 Managing Controlled Substance High Utilizer Patients
  - Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939
  - Prescription Drug Diversion, Misuse and Addiction H-95.945
  - Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
- Resolution 235 Unfunded Mandates on Physicians
  - Unfunded Mandates H-270.962
  - Physician Consortium for Performance Improvement; Unfunded Performance Improvement Projects D-450.978
- Resolution 302 Reform and Expand Graduate Medical Education Funding
  - The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
  - Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
- Resolution 305 Expanding GME Concurrently with UME
  - The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
  - Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
- Resolution 306 Maintenance of Certification / Licensure (MOC/MOL)
  - Maintenance of Certification H-275.924

- Resolution 307 Diversity in the Health Care Workforce to Reduce Disparities
  - Strategies for Enhancing Diversity in the Physician Workforce H-200.951
  - Diversity in the Physician Workforce and Access to Care D-200.982
  - Strategies for Enhancing Diversity in the Physician Workforce D-200.985
  - Reducing Racial and Ethnic Disparities in Health Care D-350.995
  - Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878
- Resolution 308 State Programs to Increase Residency Positions
  - The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
  - National Resident Matching Program Reform D-310.977
- Resolution 412 Ban Electronic Cigarette Advertisements
  - FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973
- Resolution 508 Banning the Use of Gasoline Powered Leaf Blowers
  - Public Health Hazards Associated with Landscaping Services D-135.986
  - AMA Position on Air Pollution H-135.998
  - Noise Pollution H-440.864
- Resolution 706 Conflict of Interest Disclosure Exemptions for Non-Reimbursed Medical Staff and Faculty
  - Protection of Medical Staff Members' Personal Proprietary Financial Information H-225.955
  - Conflict of Interest Issues and Medical Staff Leaders H-235.970
- Resolution 709 Reimbursement for Distinct Services
  - Payment for Concurrent Care H-390.888

#### **SUPPLEMENTARY REPORT - Monday, June 13**

#### **HOUSE ACTION: ADOPTED** **LATE RESOLUTIONS 1010 and 1011 ACCEPTED**

Madam Speaker, Members of the House of Delegates:

#### **LATE RESOLUTIONS**

The Committee on Rules and Credentials met Monday, June 13, to discuss Late Resolutions 1010 and 1011. The sponsors of the late resolutions met with the Committee on Rules and Credentials to consider their resolutions, and were given the opportunity to present for the Committee's consideration the reason their resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1010 – Fixing the VA Physician Shortage with Physicians
- Late 1011 – Gun Violence as a Public Health Crisis

#### **CLOSING REPORT**

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

Madam Speaker, Members of the House of Delegates:

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Bailey, and the Vice Speaker, Doctor Scott, 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 11-15; 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.

**APPROVAL OF MINUTES:** The Proceedings of the 69<sup>th</sup> Interim Meeting of the House of Delegates, held in Atlanta, Georgia, Nov. 14–17, 2015, were approved.

**ADDRESS OF THE PRESIDENT:** AMA President Steven. J. Stack, MD, delivered the following address to the House of Delegates on Saturday, June 11.

Madam Speaker, Members of the Board, delegates, distinguished colleagues and guests, and our international friends, I'm honored to address this House for the last time as President.

It has been my privilege to help lead the American Medical Association during such momentous times. My friends, my colleagues ... our work together is building a bridge to 21<sup>st</sup> Century medicine and shaping the future for a new generation of physicians.

As we navigate these uncertain waters, we do well to remember that the history of our profession is one of innovation and change. And it is in this noble quest to find new cures ... to develop new approaches to preserving health ... and to promote equitable access to the healing arts ... that we move our practice forward.

Last June, I spoke about a bridge I visited in Norway, while attending the 200<sup>th</sup> meeting of the World Medical Association. This remarkable bridge contains 58 life-size sculptures along its two rails. The sculptures on one side depict aggressive images such as a woman fighting a dragon and a man and woman arguing. But across the bridge, on the other rail, these disturbing images reverse themselves and instead show the woman and the dragon warmly embracing and the combative couple now kissing.

These striking images represent the dualities of our lives ... the ups and downs ... the good and bad ... the fair and unfair ... and I shared my moving experience of visiting this bridge to remind us that in our lives as physicians, we face this same duality and often struggle to reconcile opposing forces.

To be a practicing physician today is to feel a range of complex emotions about our work, our patients, and our futures together. There is great joy in medicine, but also profound frustration. Our hope for tomorrow is too often undermined by our pessimism about today.

In my travels this year I have shared my belief that it is our opportunity, our obligation, and our great privilege as leaders to recognize the challenges, but to not allow ourselves to be consumed by them. As your president, I have tried to refrain from finger pointing, but instead acknowledge our reality, describe a vision for a brighter future, outline a path to attain it, and hopefully inspire others to work towards it. The challenges may be great, but none of us doubt the value of our work or the nobility of the cause.

Last April, I worked three grueling night shifts in my hospital's emergency department. These shifts are often stressful, at times overwhelming—and you can commonly count on a surge of patients between 11 pm and midnight.

On this particular weekend, the difficulty of my work was further compounded by more than 13 different error messages, freeze-ups and failures of the EHR and IT systems that stole even more time from my patients. Then, just before midnight, I met "Bob", an 84 year-old man who arrived by ambulance. He'd been vomiting at home for nearly 22 hours. His daughter and I initially thought he'd picked up a common "stomach bug." But we could not stop his vomiting. And then he started vomiting fresh blood. Lots of it.

I escalated his care and everything changed. In addition to acute renal failure and an upper GI bleed, he had massive gastric and small bowel ischemia on CT. It was now clear that his seemingly minor illness was instead an all but certain fatal diagnosis. Given his age, the extent of the ischemia, and his renal failure, my colleagues and I agreed that palliative care, not surgery, was the best treatment we could provide him.

I know I don't have to describe to anyone in this room the gut wrenching experience of holding his daughter as she trembled with the shock of the news. My heart broke for her, and yet it was only 2:30 in the morning, and I still had more than four hours to go on my shift. By 4 am, I was finally caught up and had a moment to decompress. I shared a post on a private emergency medicine group that conveyed the pathos of our work and how, in my 15<sup>th</sup> year, I am still amazed by the emotional strain of our job and how grateful I am for the work of my fellow emergency physicians.

Within 24 hours, I had heard from nearly 400 physicians. The replies should make us all feel proud:

One said: "I bitch and moan more than most, but I still love it... 33 years in."

Another said: "Teddy Roosevelt said that life offers no greater reward than to work hard at work worth doing...it's emergency medicine that gives me the energy, inspiration, courage, enthusiasm and power...throughout these 41 years."

And finally: "We are so privileged to be able to professionally and compassionately share that time with families and add humanness. Yes, it's hard. But it's a calling."

But also, and consistent with my message on the dualities of life, I heard ...

"I'm in year 16 post fellowship and am so beyond burnout I can't stand it ... There are days when one case might bring me some joy – then I'm just back to the grind. Don't know how I'll do this 'til retirement."

Here again, is the other side of the story: The inspiration we draw from our profession and the personal toll it takes on us. We must remember: If we truly want happier, healthier patients, then we must ensure we have happier, healthier physicians to care for them.

We all understand that the biggest stressors we face today aren't with patients, but with administrative hassles and bureaucratic overreach. And the result?

Every year, thousands of our most experienced and competent doctors are leaving medicine because of excessive, and largely unnecessary, demands on our time—meaningless busywork that takes us away from our most important job of caring for our patients. This we know is true. But let me tell you what I also hear when I'm out on the road.

I hear incredible stories of optimism and hope about the future of medicine. I feel the tremendous energy around new technologies and innovations that are transforming our work—making it possible to care for virtually anyone, anywhere, at any time. I see medical students excited about leaving their mark on the profession. And I come across physicians who, when I talk about the challenges ahead, tell me it's still the best job in the world and they wouldn't want to do anything else.

Engaging with these dedicated professionals—people who revel in what they do for patients and remind me why the work of the AMA is so important—has been the best part of my year. I don't mean to suggest the challenges we face

aren't great. But they are not insurmountable. John F. Kennedy once said, "Efforts and courage are not enough without purpose and direction."

For nearly 170 years it has been the mission of the AMA to promote the art and science of medicine and the betterment of public health—but today we are striving to be so much more. Today we are working to support medical students, residents and physicians in their career journey, to eliminate barriers, and, when necessary, to help them channel their frustrations to make positive change. This is the essence of the AMA's strategic efforts, which have become a powerful force for good in American medicine.

How are we delivering on this promise?

Through our tireless advocacy in the nation's capital that will bring an end to Meaningful Use as we know it and working to untangle the convoluted payment systems that contribute to so much physician dissatisfaction. Changing federal policies governing electronic medical records has been one of our major efforts of the past year. We built an army of supporters at our town halls and through our Break The Red Tape campaign to challenge lawmakers so that EHRs better reflect the realities of medical practice and are not simply there to satisfy the needs of accountants, regulators and auditors.

We continue to work in Washington to secure improvements to MACRA to ensure that physicians are fairly rewarded for the important work that they do, and so doctors can succeed in the new payment options and make informed decisions for their practices.

We are delivering on this promise through our Task Force to Reduce Opioid Abuse, which is helping to shape the national conversation around the epidemic of opioid misuse and overdose. Together we are calling on physicians to lead this effort by re-examining their prescribing habits, expanding the use of Naloxone and helping reduce the stigma for those suffering from chronic pain and struggling with substance abuse.

We are doing it through robust physician leadership training programs that encourage doctors across all specialties to take leadership roles in their hospitals, their clinics, and their communities. We are doing it by tackling the biggest public health threat in our country today: the rise of chronic and costly diseases, such as prediabetes and high blood pressure, that negatively impact quality of life for tens of millions of Americans. We are doing it by fighting the mega-mergers of health insurance giants that threaten to further reduce competition, manipulate physician practice, and drive up costs for patients. We are building that bridge to the future through our exciting partnerships with entrepreneurs here at Matter Chicago and our own innovation studio, Health2047, in San Francisco. By reimagining the medical schools of the future through our groundbreaking ACE initiative, bringing together 32 of the best and most forward-thinking medical schools in the country to create the medical school of the future. And by working purposely to improve the perception and reputation of physicians through strategic public appearances, op-eds, editorials, media visits and reporter roundtables in New York City, Chicago, Washington D.C. and elsewhere.

This, my friends and colleagues, is how we lead change in medicine.

When I thought about what I wanted to say today, I kept coming back to one word—perseverance. From the development of life-saving vaccines to our modern-day efforts of organized medicine to repeal SGR ... every great triumph in medicine has required great perseverance.

But I want to tell you another story about perseverance in medicine. One that has made a profound impact in my home state of Kentucky and has improved lives for thousands of our state's most vulnerable. I came to know Dr. Rice Leach during the H1N1 pandemic in 2009. He was medical director and executive director of primary care at the Lexington-Fayette County Health Department; I was Chair of Emergency Medicine at St. Joseph East and a member of our local county emergency medical advisory board.

I didn't know his background at the time, but I was immediately impressed by him. He had a worldliness and sophistication in his approach to complex problems, and a gifted intellect that spoke of a life of uncommon experience. I later learned that he had worked at the highest levels of government, having served as chief of staff to the U.S. Surgeon General and as Kentucky's Commissioner of Public Health for more than a decade. He was an

esteemed professor, an officer in the U.S. Public Health Service and a consultant on health initiatives in Central America.

But what struck me most about Dr. Leach was his easy-going personality, his generous spirit, and his commitment to the community he served. He knew that collaboration was essential and had a knack for putting things in the proper perspective. He liked to say, “There ain’t no such thing as your side of the canoe leaking.”

Here was a giant in our profession who had built his career on public service and caring for the most vulnerable in society. He delivered free vaccinations to young children whose families struggled to put food on the table. He treated transient adults for sexually transmitted diseases. In one of his last projects at the county, he created a needle exchange program to help those suffering from drug addiction.

As anyone who has worked in public health knows, this isn’t the most lucrative way to use your medical training. And, it’s far from the most glamorous. But few specialties offer such profound impact on the lives of so many in need.

Dr. Leach died this year on April 1st after a long battle with lymphoma. He was still at work, tending to the most vulnerable in our Lexington community, until just weeks prior to his death. I thought it important to mention him today because to me this one remarkable man embodies the vision we should all have for ourselves and for our profession: Service. Self-sacrifice. Commitment.

Every day in this country, there are thousands of physicians performing these quiet acts of public service with little recognition or fanfare. They honor themselves and our profession by the duty and reverence they show their communities. And sometimes their quiet work is thrust into the national spotlight for all the right reasons.

I want you to imagine you are a young pediatrician working in one of the poorest communities in the United States, one where the number of able-bodied men and women looking for work is nearly twice the national average. Now, imagine your research into this community has found something alarming. One study showed that twice as many children under age 5 had elevated lead in their blood compared to two years earlier. In some of the poorest neighborhoods in town, the percentage was three times higher.

So, you alert the state ... and they dismiss your findings. They tell you you’re wrong. So, you hold a press conference and alert the public. And you are attacked for your effort. You are accused of being a self-promoter, of deliberately misleading the public, of trying to spark mass hysteria. The state, and their team of epidemiologists, again tells you you’re wrong. They tell the public there is nothing to be afraid of.

Imagine what it takes to hold your ground when researchers, public officials, and even other doctors are questioning your results. You double- and triple-check your data and each time it confirms what you know. So, you press on because the community needs you and lives hang in the balance. Of course, I’m talking here about Dr. Mona Hanna-Attisha, whose pioneering research helped expose the water crisis in Flint, Michigan, and sparked a national re-examination of America’s water supply.

There are many traits that all great doctors share: empathy, compassion, confidence, respectfulness. But it is my belief that perseverance in the face of great challenges is far too often overlooked, and is often responsible for driving change when it is needed most.

Think about what it took Dr. Mona—as she is more widely known—to persevere under those circumstances. Think about the intense pressure on her and her colleagues to stand up for what they knew was right. Earlier this year, I had the opportunity to correspond with Dr. Mona to thank her for her service to her community, and for distinguishing our profession in the face of great adversity. Her modest reply to me reaffirmed the selflessness of her work.

Doctors Mona and Leach may be special people, but the qualities that make them such are common throughout our profession. Physicians care deeply about their patients and want them to lead healthy, happy lives. That’s why we became doctors. But I share these stories to remind us that when the cause is just, as Kennedy might say, physicians shall pay any price, bear any burden, meet any hardship, and weather any storm to do what their experience and training tells them is right.

One year ago, I stood here and I spoke about the power of physicians in large numbers to overcome the bureaucratic obstacles placed before them. And I spoke about the role of the AMA in championing that righteous cause and helping physicians channel their frustrations to bring meaningful, lasting change. But rather than bemoan our challenges, I want to reassure physicians and medical students that, as leaders, we see a brighter future on the horizon and know a path to get us there.

Remember “Bob”, the elderly man from the emergency department I told you about earlier? Well, I confess that I was wrong again. We made him DNR and began palliative measures but did not stop treating him. While all the signs pointed to this illness being his last, amazingly, it was not. Remarkably, his bleeding stopped, his renal function improved, and he made an incredible, perhaps even miraculous, recovery.

I visited him a few days later, the day before his discharge, and I had the chance to celebrate his amazing recovery with him and his daughter. He is a striking reminder of how uncertain, how meaningful, and how humbling our role as physicians can be.

All of us in this room know that what we do is difficult. It’s complicated. And in a world where politicians and bureaucrats have unreasonable promises to fulfill, where bean counters cannot understand why health care is not easily segmented onto spreadsheets, and where lawyers stand ready to armchair quarterback with the benefit of hindsight, there will always be those like us who navigate these obstacles to preserve humanism in medicine and ensure the sacred bond between patient and physician endures.

My friends and colleagues, thank you for your hard work and your perseverance.

With our unwavering commitment to this noble cause, we can, we will, create a future where physicians and patients thrive and where the doctors of tomorrow have the support and training they need to meet any challenge. It has been my great honor to serve as your president over the past year. And it will be my humble privilege to continue this fight with you, side by side, for the lasting betterment of physicians and public health.

Thank you.

**REPORT OF THE EXECUTIVE VICE PRESIDENT:** James L. Madara, MD, executive vice president of the Association, delivered the following address to the House of Delegates on Saturday, June 11.

Madam Speaker, Mr. President, members of the board, delegates and guests:

Over the last five years I’ve used these opportunities to outline the progress in our strategic plan:  
... Creating the medical school of the future;  
... Dealing effectively with chronic disease as modeled by pre-diabetes and hypertension; and  
... Creating tools and resources to help physicians better thrive.

We’ve made significant—and now nationally recognized—progress in all three areas.

I’ll provide a full update at the Interim meeting this November. At that time I’ll also outline our approaches to help physicians adapt to the MACRA legislation—work that’s already started but will be more refined once the final rule is established this fall.

But today, I’d like to provide thoughts on the emerging digital environment we find ourselves in and what we might do to move toward digital tools that lead to professional satisfaction and improvements to care, rather than to further practice disruption.

First, I’d like to reflect on the work of our predecessors; it provides lessons for today. When the AMA emerged in the mid-19<sup>th</sup> century, medicine in the U.S. was poorly developed; lagging well behind our European counterparts. Our AMA predecessors engaged the very heavy lifts of stamping out quackery, creating standards for medical education, and developing the first code of medical ethics. Simply put, the AMA stopped the flow of the snake oil remedies of that time.

Quack remedies—snake oil—were all the rage back then. Here's an example: Clark Stanley, raised as a cowboy in Texas, sold a unique remedy which, he claimed, healed a variety of ailments, doing so absolutely and without fail. Stanley claimed his body was covered with scars from hundreds of rattlesnake bites ... any of which might have killed him but for the benefit of his magical elixir, his snake oil remedy. Since the elixir contained no alcohol, Stanley extended the sell, saying it was suitable for everyone, of any age, without regard to temperance. Incidentally, a skeptic, who was Governor of Texas at the time, heard these claims and responded: "Who would believe there's a better remedy than whiskey?"

It was the AMA that identified these fakes and set standards. Our predecessors did all of this by inserting themselves into the enterprises of the day—public and private; leading massive change by engaging broadly with society.

Today, snake oil elixirs are a comparative rarity. Rather, we have really remarkable tools—robotic surgery, new forms of radiation treatment, emerging biologics; and we live in a time of rapid development in the digital world—telemedicine as an example, as discussed in detail by this House.

But you know something, appearing in disguise among these positive products are other digital so-called advancements that don't have an appropriate evidence base, or that just don't work that well—or that actually impede care, confuse patients and waste our time.

From ineffective electronic health records, to an explosion of direct-to-consumer digital health products, to apps of mixed quality. This is the digital snake oil of the early 21st century. Even those digital products that might be helpful often lack a way of enriching the relationship between the physician and the patient. It's like trying to squeeze a 10-gallon product into a 2-gallon health care knowledge base.

More and more we're seeing digital tools in medicine that, unlike digital tools in other industries, make the provision of care less, not more, efficient. And these digital tools often don't connect with each other—interoperability remains a dream. We were told that interoperability was the future; we didn't expect that it would always be in the future. The age of digital snake oil.

Energizing this rush of new products we find popular books predicting a future of digital health care, that in the near future, will bypass physicians altogether—where patients can largely look after themselves. These extravagant claims did achieve their primary goal: Lots of books were sold. These claims also drew the attention of the lay press and private sector, two groups that couldn't have known any better. One highly praised book touted how patients could order their own blood tests by the hundreds—do it today!—then follow algorithms to essentially self-treat. Snake Oil Stanley would be so proud!

Anyone been reading the papers of late? Been following the many evolving investigations and apparent fraud of such touted new pathways? That hallucination didn't turn out so well, did it? As one of our presidential candidates might tweet: "DUMB!"

Fortunately, more sober analysis of the current state can be found elsewhere, as in Bob Wachter's wonderful book, *The Digital Doctor*. A more promising digital future can be envisioned that enhances the physician-patient relationship, produces better and more efficient care, and allows more time for physician-patient interactions—the type of outcome that has been so falsely promised by much of the current digital snake oil.

But Wachter provides no false illusions as to the current state, and well describes the present. Something I'd call our digital dystopia: From direct-to-consumer digital health devices—which, only in the fine print say "for entertainment purposes only"—to our clunky electronic records, to ICU's that sound like primitive swamps abuzz with a cacophony of bells, alarms, and whistles.

Just as in the mid-19<sup>th</sup> Century when we separated the useful anti-toxins and compounds like aspirin from Stanley's snake oil remedy, today we're tasked with separating the digital snake oil from the useful—and potentially magnificent—digital tools.

The future is not about eliminating physicians, it's about leveraging physicians. Leveraging you by providing digital and other tools that work like they do in virtually all other industries—making our environments more supportive,

providing the data we actually need in an organized, efficient way, and saving time so we can spend more of it with our patients.

A new AMA study analyzed a variety of settings and type of practices: 50 percent of physician time was devoted to the keyboard—50 percent! Only a third of their time was free to interact with patients. To compound this, physicians also spent two hours each evening on the keyboard finishing the data entry from the day, evening hours that used to be spent reading JAMA or decompressing with family.

Our current state? American physicians have become the most expensive data entry workforce on the face of the planet. What a waste. How frustrating. Let's face this 21<sup>st</sup> century digital snake oil the way our predecessors confronted their task in the 19<sup>th</sup> century, by inserting ourselves into the processes from which digital tools emanate.

So, how do we do this? What are we working on? To begin with, we're intensively working with vendors and manufacturers as well as the federal agencies that regulate them. You'll later hear from CMS' Acting Administrator Andy Slavitt on enhanced federal pressure for interoperability and efficiency in our health records. For EHR 3.0, not 1.0.

In retrospect, one might argue that our field was insufficiently embedded in the creation of the first wave of digital products now surrounding us. The result: defective products not informed by physicians. Today, we're active in pursuits toward correcting this—toward having physician knowledge embedded in the development of new products. Here are a few examples:

First, we're conveying to manufacturers what physicians actually need. Digital tools that add layers onto our day are not helpful—those are digital snake oil, we hate them—hate, hate, hate them. In contrast, digital tools that would simplify and better organize our lives, and also adapt to the natural variations in our practices—those that would free more time for patient interactions—that's what we want. Tools like that we'd love—love, love, love. There are too few of these today.

Second, we're forming interactions with the emerging companies that produce health-related goods and services—for example, working with MATTER, a Chicago-based incubator for emerging health care companies. More than 120 companies are now located in MATTER, as well as our AMA interaction space. There, we inform entrepreneurs of the exact needs of physicians at the creation of innovative ideas. Some of you have participated in this—and I thank you for it. We do much better if new products and services are deeply informed by our actual problems and needs, rather than flying on an entrepreneur's incomplete views. We bring the granular understanding of the physician-patient environment. That's difficult to discern from the outside.

Third, in January we launched an innovation studio in Silicon Valley, Health 2047. Health 2047—(the 2047 in recognition of our 200<sup>th</sup> anniversary)—takes many of the problems identified by AMA studies and applies rapid prototyping and design to achieve tools based on physician need. Emerging prototypes will be iterated with physicians until the tool gets it right. This effort is attracting high-level talent in Silicon Valley. Talent that'll be directed to the problems faced by physicians.

Fourth, while shaping this future, we also need to address the current state. That's why we're identifying workflow and practice adjustments that can produce higher practice satisfaction today. These digital modules, which we call Steps Forward™, are available to all physicians and can be accessed through our website. I announced Steps Forward last year at this meeting; and since then more than 70,000 users have accessed these tools to improve practice.

New modules are being produced and tested, and CMS has recognized these as a form by which physicians can be acknowledged for practice improvement, under the MACRA law. These AMA Steps Forward modules have, in just the last few months, received more than five national awards in the digital product area. Several of the new Steps Forward modules address pain points highlighted by physicians in a recent crowd-sourcing exercise of ours. Thanks to those of you who contributed ideas.

Another crowd-sourcing—AMA Innovation Challenge—attracted, just recently, 23,000 users, and over 100 fully-formed product ideas from physicians and trainees. Five finalists have been selected and will present their ideas at

MATTER this evening. The best one will then be supported in design, planning, and development. Also in this effort, 1,000 physicians indicated interest in helping to pilot and evaluate such new products.

I emphasize that all of this work is being done while we're intensifying our advocacy work; our work on innovation is coordinated and integrated with our critical work on advocacy. Thus, we're inserting ourselves in both public and private sectors on behalf of physicians.

In the mid-19<sup>th</sup> century, our predecessors fought the snake oil of the day by interacting with all segments of society—both public and private. We follow their lead. We're now fully engaged on many fronts—engaging not only the important aspect of legislation and regulation, but also directly engaging those who produce the products and services that'll feed our practices, pipeline products that are now being informed from the start—with the knowledge of what physicians actually need.

I'll end with something from Bob Wachter's book: "Even when that wonderful day arrives when we have finally coaxed the machines into doing all the things we want them to do, and none of the things we don't, we will still be left with one human being seeking help at a time of great need and overwhelming anxiety."

That relationship between the physician and the patient isn't a transactional one—but it's one that requires time; time that should be made available by helpful digital tools; tools that work effectively as they do in virtually every other field, but ours. We need that, and we need to be directly involved to make it happen.

What we don't need, is more digital snake oil.

Thank you.

**REMARKS FROM THE CHAIR OF THE AMPAC BOARD:** The following remarks were presented to the House of Delegates on Saturday, June 11 by Robert Puchalski, MD, Chair of the AMPAC board.

My name is Bob Puchalski and I am the Chair of your AMPAC board.

As we open the door to doing the work of our Annual Meeting this year I hope to impart here and now just how important AMPAC is to our organization. As AMPAC Chair I have seen how involved we are in meeting candidates and conveying our messages on Capitol Hill.

It is an election year and while it has been an entertaining one, it is also a critical year that we support the cause of ensuring the collective voice of physicians is heard. As leaders of the AMA it is our cause, our voice and our value that is at stake. If we are to stay competitive and continue to have influence on the very items we discuss here at this meeting, we need to support AMPAC at levels that are higher and more consistent with other professional organizations.

I am proud to report that again this year, all of the AMPAC Board is contributing at the Platinum level. The leadership of AMPAC currently contributes at the \$5000 level annually, the most allowed by law. We will all wear the same ties and scarves again at this meeting because we know the importance of leading by example and stepping up to the plate. Thank you to my fellow AMPAC board members.

Last year, your AMPAC board set out to create institutional standards for giving within the leadership of medicine and this house. We sought to make these contribution goals more consistent with other organizations that perform advocacy work for their membership. Today, I would like to report on our progress in this initiative. Currently, the Board of Trustees is at 50% Capitol Club Platinum. The eligible Council members who participate at the Capitol Club Gold Level or higher is at 41%. I urge you to find the courage to ask our leadership whether they have answered the call of their AMPAC board.

And as of today, the AMA House of Delegates sits at 41% participation in Capitol Club Gold or better, and overall participation is only at 52%. Last year we ended with 74% overall participation in the HOD. While this is better than years past, I know we can do better and get to the 100% mark. As leaders in this room, it is up to us to set the expectation. It is our time to lead.

As I often say, we don't contribute because it's easy, we contribute because easy is rarely ever worth it. We don't contribute to the political system because we think it functions properly, we contribute to the political system because we know that it can't function properly without us.

A cop is directing traffic at a busy intersection when he observed a blind man and his seeing-eye dog waiting to cross. To his horror, he watched as the seeing-eye dog bolted across the street, dragging the blind man behind him.

On the other side of the road, the man pulled out a cookie and offered it to his dog. The officer ran to the blind man and said, "Don't you realize your dog could have killed you, and now you're going to reward him?"

The blind man said to the policeman, "Why, no sir, I'm just trying to find out where his head is so I can kick his butt."

Your contributions to AMPAC aren't used as a reward or an indictment, they are used to help us find the head of the dog.

At this point, I would like to recognize those members of the HOD who have answered AMPAC's call to give at the Capitol Club Level or greater for 2016. If you have contributed more than \$500 to AMPAC this year, please stand.

If you have not contributed already, I urge you to join me and your fellow physician leaders at the Capitol Club level for this election year. It is our sincere hope and prayer that we will have a room full of standing delegates and alternate delegates this November in Orlando.

Thank you.

**PRESENTATION BY THE ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES:** Andy Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services, made the following presentation to the House of Delegates on Monday, June 13.

Madam Speaker, Mr. President, Mr. Chairman, Members of the Board, Delegates, I'm honored to be invited to address this House and the physicians of America. Hello and good afternoon. Thank you for hosting me at the American Medical Association's annual meeting. I want to give special thanks to Doctor Steve Stack, the President of the AMA; Doctor Jim Madara, the CEO of AMA; Doctor Sue Bailey, the Speaker of the House of Delegates; Doctor Steve Permut, the Chairman of the Board; the Delegates and all members of the American Medical Association; and perhaps most of all, the physicians who serve our beneficiaries and consumers everyday—whether you are in the room today or reading the speech on Twitter. Thank you for the honor of allowing me to spend this day with you, and thank you also to Rich Deem for the straight talk, honesty, ideas, and conviction you have brought to our relationship.

In speaking to America's physicians, you represent one of America's most potent and proudest forces of talent and ability. When anyone across the world is in need of care, there is no one they would rather be cared for then by America's doctors. I'm here to talk about the historic opportunity we have before us to change how Medicare pays for care, but I'm also here to talk about something bigger: reversing a pattern of regulations and frustration, and ultimately unleashing a new wave of collaboration between the people who spend their lives taking care of us and those of us whose job it is to support that cause.

Today's discussion continues the conversation Jim and I began publicly last January in San Francisco. At CMS, the conversation has since continued every week with practicing physicians across the country in big practices and small, specialists and primary care, those in new payment models and in traditional ones. We have connected directly now with tens of thousands of physicians and other clinicians in some form and hundreds in more intensive discussions.

It has been a process of giving front line physicians a direct voice to us and of CMS, starting with me and the senior staff, learning how to listen. Most of you became physicians because of the desire to serve and heal people. Since I have been inside CMS, I have seen a similar drive where every day the staff wakes up thinking about the lives of the

140 million Americans, most on fixed or modest incomes, many in the most vulnerable stages of their lives, who depend on you through the Medicare, Medicaid, Children's Health Insurance, and Marketplace programs.

### Goals for the Quality Payment Program

It is because these patients depend on you, particularly at a time of great need and uncertainty, and often at a time when they need guidance through a complex, fragmented system that I stand here today to say: we can and must take this opportunity to do better. We must:

- Sharpen our focus on paying for what works;
- Reduce the time physicians and their offices spend on paperwork;
- Make health care technology a tool, not an industry; and
- Do this by carrying forward an open process that reduces the gulf between how policies are made in Washington and front-line patient care

This afternoon, I will tell you about the opportunity with MACRA, discuss our work to create the proposed rule, how we have been listening since then, and I will lay out the critical challenges we need your feedback on.

Let's begin the discussion of MACRA by looking at what Congress did last April when it passed, and the President signed, the bipartisan Medicare Access and CHIP Reauthorization Act. This ended—permanently—the deeply flawed Sustainable Growth Rate (SGR) formula. This formula had created 17 potentially deep cuts for Medicare physicians over the last 13 years. Thanks to your hard work and advocacy, we now have bipartisan legislation that holds the potential to bring long-term stability and reliability to the Medicare program and to move the system in a direction that works better for patients. It also allows us to end the patchwork of measurement programs created over time and replace them with a new single framework, that while it has several components, can provide the basis for a more flexible, relevant and ultimately simpler to use system.

To be clear, with MACRA, we answered one question and opened up a set of others that are now ours to begin to address. To start with, Congress designed the SGR to control costs in Medicare, so that every American who pays into the system will have the care they need when they need it. Before Medicare, one in three seniors lived in poverty. Today that number is 1 in 10. Without a focused effort at delivering care while controlling costs, Medicare—upon which so many of us depend—risks becoming unaffordable.

As the Medicare program moves into its Golden Years, so does the reality of the job it must do in caring for our nation's elderly and disabled.

- There are 10,000 new Medicare beneficiaries every day,
- A boom generation is turning 70, and
- The 85 and up generation is set to double over the next 10 years.

With the growth of Medicare beneficiaries outpacing the growth of working Americans, we need to find ways, like we do in other sectors, to deliver better care at lower costs.

### Improving Medicare through the Quality Payment Program

Ensuring a stable and reliable Medicare program is a tough task. Through the ACA, we've extended the life of the Medicare Trust Fund from 2018 to 2030, which happens to be the year I turn 64. Together, Congress and stakeholders, designed a law that promotes ever-improving care at a reasonable cost. It replaces the blunt instrument of the SGR with a system that preserves the core structure of Medicare. The new program wraps around changes intended to promote coordinated care at reasonable costs through a uniform Merit Based system. This system is defined in the statute to focus on quality, cost, technology, and practice improvement. The system also allows physicians and other clinicians to define and advance new approaches to care for patients like medical homes, specialty models, and team-based models that improve quality, manage costs, and reward physicians in those models with additional bonuses.

The first question, of course, for many physicians is: What do you really need to know about the program? What new sets of requirements are there to participate?

So let me be clear, while it can be an understandable distraction, the goal of the program is to return the focus to patient care, not spend time learning a new program. Medicare will still pay for services as it always has, but every physician and other participating clinicians will have the opportunity to be paid more for better care and for making investments that support patients—like having a staff member follow up with patients at home.

We will, of course, provide information in as much or as little detail as is helpful. For those who like to read computer manuals end-to-end, there is of course the 900 page proposed rule complete with every detail about how the regulation and the law is proposed to work. But, for most people, who do not need to see every scenario and how each element of the formula works, there are webinars, in-person meetings, fact sheets, and web portals that will bring all the information to suit various needs.

There are several immediate features of the program that I want to start out with that are all designed as improvements over today's payment system.

First, MACRA sunsets three disjointed programs. If you participate in the Physician Quality Reporting System, the Value Modifier, and the Meaningful Use program, your life just got simpler as they are replaced with a single, aligned Quality Payment Program, which will reduce reporting requirements, eliminate duplication, and reduce the number of measures. For those who participate in Alternative Payment Models, those requirements are reduced further or eliminated.

Second, it also reduces the combined possible downward adjustment of 9 percent that is occurring today from the three programs to a maximum of 4 percent in the first year of the Quality Payment Program. The program is designed to build up over the course of several years, with more modest financial impacts in the first year when the vast majority of physicians are expected to be in the MIPS part of the program.

Third, while the Merit-Based Incentive portion of the law is designed to be budget neutral in general, there are new opportunities for additional bonuses. In MIPS, in addition to the 4 percent positive payment adjustment, there is the potential for much higher payments through \$500 million in funding over six years. Physicians earn a 5 percent lump sum bonus for participating in an Advanced Alternative Payment Model.

Under the current proposed timing, the first reporting isn't due until early 2018 for the first performance period in 2017. Off the shelf tools like Certified EHRs and clinical data registries can provide complete capabilities, but other options exist as well, including most types of reporting that a physician is doing today. If CMS can get data automatically or through another source, we will do so.

### Implementation Approach and Priorities

With this legislation, we now have the responsibility and opportunity to work together to fill in the details and do our best to avoid unintended consequences that can be so damaging. My first commitment is that we do this in as open, transparent, and iterative way possible.

I'm starting off talking about our process because I am convinced that adding new regulations to an already busy health care system without improving how the pieces fit together just will not work. I've always been a believer that good policy—like any plans—only usually get you 10 percent of the way there. It's how we implement MACRA over the next 10 years that counts. We have adopted a new outside-in approach we label "user-driven policy design." This approach calls on us to conduct an unprecedented effort of intensive listening and learning.

I will confess this is a new way of working for CMS. I know from my time outside, CMS can appear to be a black box with opaque regulations and limited back and forth about our policy reasoning or our implementation constraints. People won't always agree with us and that's okay. We also need to be convincible when we have something wrong or need to re-steer in a different direction as we recently did with Meaningful Use. And this world isn't filled with perfect answers.

All of this means that policy cannot be written from behind our desks. Our career staff and our regions have been tasked with connecting us closer and closer to where care actually happens. We began this by reaching out and meeting with over 6,300 stakeholders all across the country before we published the proposed rule in April. Our particular focus on meeting with practicing physicians in their offices, in workshops, in focus groups and in weekly

sessions to listen to policy options and to dig into the details of how the concepts in MACRA translate into the realities of a busy practice. Since proposing the rule at the end of April, we've held over 135 events centered on physicians and clinicians affected by the Quality Payment Program.

While it's difficult for any organization to open themselves up to criticism, I can tell you that even in difficult conversations, the staff is incredibly energized by getting out from behind their desks and engaging directly with the many of you that care for our beneficiaries.

Most of all, these conversations are grounding our priorities and we are hearing some hard but important truths. Physicians are frustrated. We hear about the overwhelming sense that measures become exercise in compliance, instead of quality improvement; about how technology has often distracted instead of supported patient care; and how an accumulation of many small things imposed from afar add up to feeling that we just don't get it. This gives us all a place to start thinking about this new Quality Payment Program framework and developing a roadmap that not only improves patient care but does it by beginning to address some of the very real causes of physician burnout. A few examples of what we've heard.

1. One comment summed up the feelings of many, "Let us practice medicine, and not practice documentation and bureaucracy. We don't have it in us. We are caregivers. Let us do our job."
2. A rheumatologist, located in the Mid-Atlantic, said that we needed to, "Figure out how to get doctors noses out of computers and back to patient care."
3. A primary care doctor from Arkansas who was looking forward to joining a medical home commented, "There's so much money in health care, but we need to direct it the right way."

Through our listening sessions, a number of specific areas have been identified for us to work on that could really improve this program. They include:

- Providing reports and using quality measures that are more timely and helpful to practice improvement;
- Providing support specifically for smaller practices, which feel the burden of increased paperwork without the staff to handle it;
- Allowing physicians more participation in selecting measures and only focusing on what's relevant to their specialty or practice;
- Putting more pressure on technology vendors and less burden on physicians, so physicians can do simple things like track referrals when a patient sees another specialist or visits a hospital;
- Making sure there are sufficient paths to participate in Alternative Payment Models; and
- Working to reduce the cost of reporting, so the juice is worth the squeeze.

Openly and honestly addressing these challenges and others we hear about give us a path to improving how the Medicare program works for you and will lead to getting better results for our beneficiaries. After listening to many sessions, personally visiting practices and hearing the concerns expressed by many, I have no illusions that frustrations and challenges that have built up over many years will be resolved overnight. While I know many of you support the MACRA legislation and the Quality Payment Program it introduces, I also know that no one likes all the details and new details create uncertainty. The unintended consequences of new laws and regulations, particularly on top of an already over-burdened physician practice, can make as many things worse as they do better. Complexity is not our friend.

We'll be smart if we look at the Quality Payment Program as a framework we can work with that if implemented with care, can begin the process of turning things around towards a more sensible, simpler approach where physicians and other clinicians will feel supported by laws and regulations, the technology vendors, and the infrastructure that surrounds them. This is why we need to be so committed to a collaborative implementation, increased transparency, and a continual improvement process, so that over the next several years we allow feedback on the ground to inform the policies we implement.

#### Policy Implementing those Priorities

So let me get into a little of the policy red meat. Rather than go through each element of the program, I want to cover four of the crosscutting themes that have emerged to us through our listening sessions with many of you.

1. Be patient-centered not only in the focus of the program, but in our approach to everything, so that we can promote the highest quality and most coordinated care for beneficiaries with the least disruption to the physicians and other clinicians who are treating them.
2. Allow practices the flexibility to drive how they use the program as much as possible so that it supports the unique needs of their patients and allow adjustments as time goes on.
3. Focus on the unique concerns of small practices— as well as rural practices and practices in underserved areas.
4. Simplify wherever and whenever possible so that we can reduce the noise from the signal and give physicians time back to spend with patients.

I will spend a minute discussing some of our activity in each of these areas.

#### Priority #1: Keeping the patient at the center

The law builds on the evidence that care coordination and a focus on quality will improve patient outcomes. Last January, Secretary Burwell committed to moving the majority of Medicare payments to approaches that are linked to quality of care and smarter spending by 2018.

Payment systems are not intended to be finely calibrated models that we expect to be performed to the test. In all my years, I have never met, nor do I hope to meet, a physician who makes her decision on how to treat a patient based on how she gets paid. She does what she thinks is right for the patient and hopes that the system will support her. Physicians, and the patients they treat, deserve approaches that support them for doing the right thing, that encourage physicians to collaborate and reduce waste, and keep people at home and in comfortable settings so their lives continue as normally as possible.

We have been rapidly advancing models that put patients at the center. This includes over 9 million Medicare beneficiaries in Accountable Care Organizations; the recent introduction of largest primary care Medical Home model ever launched; a series of bundled payment initiatives and newer specialty models in Oncology and ESRD. The work in front of us is over time to develop a pipeline of Advanced APM models and work with physicians to generate more.

MIPS is intended to move the focus to patients, as well. There are a menu of more than 90 Clinical Practice Improvement Activities for physicians to choose from which support patient-friendly steps— such as expanding office hours, developing specific care plans, or using evidence-based aids that help support shared decision-making. And if not part of an Advanced Payment Model, the program encourages participation in a clinical registry which provides timely quality improvement feedback. If participating in an APM, no other quality reporting is required. Either way, we need these first steps to help us move away from a compliance program to something truly patient-centered.

It's also time to ask a lot more of the technology and technology vendors. This is particularly true in the area of what many call interoperability— but which most physicians describe as allowing data to move back and forth between systems so they can follow the movement of the patient after they make a referral. A specialist here in Chicago told us, "I think that the one thing that this really could've added to patient care is the one thing that hasn't happened, and that's the systems don't talk to each other. It's actually the opposite. If one of the EMRs I used, I can't even access it at the hospital because of the firewall. I can't even get into the EMR at the hospital to look at patient records."

Along with relief from Meaningful Use, this is the number one ask of many physicians. As in the rest of our lives, the burden needs to be on the technology, not the user. EHR vendors and hospitals that use them will now be required to open their APIs so data can move in and out of an application safely and securely. This will also serve to help eliminate the "desktop lock" that occurred based on early EHR decisions by allowing technology to more easily plug and play. Today's data silos are more a function of business practices than technology capability and we cannot tolerate it any longer.

#### Priority #2: Allow Practices to Drive How They Participate

We heard directly from many physicians, and specialists in particular, that a one-size-fits-all program won't work. In fact, it may not surprise you that many of the physicians who have given us direct input, there are diverse opinions.

We've heard we should reduce measures and add measures, that there's too much complexity and not enough options. That's why we are aiming to build a program that will be as flexible as possible so physicians can focus first, on what's right for their patients or makes sense in their local community and choose from a number of ways to participate in the Quality Payment Program.

That means more options on choosing appropriate measures. Options on whether to participate in models like ACOs and Medical Homes and the flexibility to move between them without having to report multiple times. It also means using quality measures selected directly from work with specialty societies. We worked with front-line physicians, tech companies, and practice managers over an intensive session and through a Request for Information garner direct feedback on the right measures for each specialty and what could be automated.

For specialists, there are many different avenues to success within the Quality Payment Program. Already, nationally, specialists participate in Medicare ACOs at the same rate as primary care clinicians. And we are working on the development of more specialty-focused models, to go along with the oncology care model launching this year.

Priority #3: Focus on policies based on the needs of small practices or practices in rural or underserved areas.

We must make sure our policies fit with the realities of the local markets where you operate. To be blunt, we all need to acknowledge and work against the reality that many changes in health care today make it more difficult for solo and small practices to stay independent. To level the playing field against these things— more complexity, the fast pace of change, the call for more patient collaboration— we need to focus hard on the areas which increase the costs of operating a practice and look for other things we can do to offset these challenges.

We called direct attention to this by publishing a schedule that demonstrates the negative impact on solo and small practices when they don't report. Under the Quality Payment Program, we know that physicians in small practices who report their performance can do equivalently well to mid-sized practices. While the results in the schedule we showed pertained to 2014, we expect reporting for small practices to be well above those levels of reporting. However, to be clear, solo and small group practices that don't report will be negatively impacted.

In our implementation, we are committed to significantly reducing the financial cost and the burden of reporting so that it can be as easy for small physicians to report as for large practices. We are seeking input into how best to do this, but have already taken significant steps such as allowing reporting from multiple sources a physician may already use, increasing the number of items that can be reported through attestation, eliminating duplicate reporting and using data feeds such as claims whenever possible. We are also working with physician user groups to design a simpler portal that is intuitive and easy to use which I will discuss further in a moment.

There are other areas that are of importance to small practices we are focused on, including increased technical assistance, exemptions for small volume practices, and extra credit for participating in medical home models like CPC+, our largest Medical Home model, which was designed based on input from physicians and offers supplemental payments for investments in care coordination. This summer physicians can apply for CPC+ in regions across the country, and we're mapping out other future opportunities to increase small practice participation in APMs. Small practice burden is an area we are soliciting direct feedback on specifically.

Finally, and perhaps more far reaching, through a network of learning collaboratives that are already on the ground educating physicians — including the associations in the room today — we are moving the Quality Payment Program from policy made in Washington, D.C. to medicine practiced across the country. We look forward to further targeting support to small, rural, and underserved providers through \$20 million in funding each year over the next five years.

Priority #4: Simplifying wherever and wherever possible.

The law gives us a unique opportunity. Over the years, because physician performance programs proliferated as one-off programs, over time, regulations multiplied and the documentation burden increased. Even when CMS made improvements, they were piecemeal and the impacts modest as these programs by their nature couldn't be coordinated or rationalized. Without a legislative change, we couldn't address the larger problems.

One of the major opportunities is to use the rule making process to connect these programs together so they can be simplified in a single framework through the new Merit-Based Incentive Program. The good news is that the combined magnitude and reporting effort are far less than they are currently and set a framework for even further simplification over time. However, one reason we are hearing some concern from physicians is that it's the first time the entirety of these programs can be seen end-to-end in one place.

I will call attention to three simplifications in the proposed rule.

1. We reduced burden. We have reduced by one-third the number of quality metrics that need to be reported. We aligned the measures across the reporting categories to end repetitive reporting. We got rid of measures in the Advancing Care Information category that hindered usability, and in that category, we moved the focus from "clicking" to care provision and collaboration. Much of Advancing Care Information can be done through attestation, it's no longer all or nothing and there are a variety of paths that can be selected by a physician practice.
2. We simplified the process. Physicians may report as a group, and be assessed as a group across each of the performance categories. You pick how you want to report, and you can use it throughout the program. You don't have to stop and switch because of differing requirements. We use the core quality measures, so that you can use the same measures across payers.
3. We made it so the programs talked to each other. If you're in an Alternative Payment Model like an Accountable Care Organization or through CPC+, then your job is half done from day one. You report your quality measures using the same process you have always used for your model, plus you automatically earn credit in the Clinical Practice Improvement Activities for being in an APM. If you see a substantial number of patients through an Advanced APM, then you're qualified for a 5 percent bonus.

Even as we look to the development of the program over the first few years, we are committed to making the start as smooth as possible. I know there are specific concerns about whether there is sufficient time for physicians to get ready for the new system when the first performance period is due to begin this coming January. We are in active dialogue on this topic and seeking active input on the options. There are, of course, constraints and tradeoffs—reporting is due to be reduced when the program starts, for example, but we are working together and we are communicating openly about those tradeoffs as we solicit comments on the right approach.

#### We Need Input

We don't profess to have all the answers. Right now, as we are talking through the details with physicians, patient groups and other clinicians and stakeholders, we are also in the process of collecting comments. Over the past month, I've probably asked people to submit their comments on the proposed rule over 100 times. We're making this push because there's no monopoly on some of these approaches and the more input the better. Final comments are due June 27.

All feedback is helpful and we continue to look for comments both on individual policy areas and on crosscutting topics such as:

1. How to simplify further;
2. How to align the performance categories;
3. How to make sure we're not encouraging "compliance" but rather rewarding care;
4. How to simplify and provide transparency to the calculations; and
5. How to encourage and promote participation in APMs and Advanced APMs.

#### Looking Ahead

Once the Quality Payment Program has been rolled out, I want to make it clear that this constant request for feedback and the need to improve will continue. Things won't change overnight. The first year of this new program will hit bumps as new policies run into the realities of every day medicine. Systems will need to adapt to your needs. Long-time frustration won't disappear right away. I'm asking for your ongoing collaboration over the next several years, so that we can implement, receive feedback, iterate, and progress. You may need to think about designing your own feedback report for CMS. Judging from my inbox some days, it's already started.

We don't win back hearts and minds with empty promises of quick fixes. We win them back by listening, by making progress even in small steps, and by calling attention to where the system remains dysfunctional. We don't have the option of running from these challenges because it's at the very heart of the care we get, that our family gets, that our country gets.

I understand the temptation for this program to become a lightning rod for all that's wrong with the practice of medicine. I understand it. But I ask you that you not make it the case that until every element is perfect, physicians remain cynical and on the sidelines. I promise you that this process and this program will be better with your input and participation, as you help make sure it connects as closely as possible to supporting the realities of patient care. It is essential that physicians not only participate in but having a leading voice in the change that is ahead.

### Conclusion

Seven years ago, President Obama came here to the AMA at the onset of his presidency and challenged us to participate in another change—not to accept the status quo and to move the country forward into an unknown path of health reform. It is thanks to your courage, and the hard work and passion of many of the people in this room, that preexisting conditions are a thing of the past. That preventive and comprehensive benefits are a minimum standard. That science, not insurance company policy, determines coverage guidelines. And that 20 million Americans now have access to coverage and care for their families.

We must do the same thing now. Use every opportunity to commit to the quadruple aim as the key to defining a new future for the health care system. I've given you several examples of visits I have had with physicians from across the country and have been sure to share the most critical. But I have also seen what happens when the tide turns and so have many of you.

A physician in New Jersey told me that as part of a Medical Home, he is setting up Skype Villages to connect his elderly patients to each other. Another in Oregon fulfilled her vision of being able to coordinate real-time mental health handoffs as a game changer for her community. A physician in Arkansas told me that, once ready to retire early, they were extending retirement to 70 because how he was getting paid caught up to how we wanted to practice.

When we all—policy makers, physicians, patients, hospitals, and innovators—focus with a unified purpose, we can make this infrequent but significant progress that I believe is ahead of us. We can do it. It's our responsibility to do it. I look forward to taking on these challenges together. Thank you for your having me today. And thank you for bringing your gifts to heal our country when we need it most. I look forward to our continued work together.

**DISTINGUISHED SERVICE AWARD:** Bennet Omalu, MD, French Camp, California, was nominated by the Board of Trustees and confirmed by the House of Delegates to receive the 2016 Distinguished Service Award at the 2016 Interim Meeting. Stephen R. Permut, MD, JD, Chair of the Board of Trustees presented the following report.

### Bennet I. Omalu, MD, MBA, MPH

Bennet I. Omalu, MD, MBA, MPH, is a forensic pathologist and is currently the Chief Medical Examiner of San Joaquin County in California. While working in the coroner's office in Allegheny County (Pittsburgh) Pennsylvania, Dr. Omalu first recognized an abnormality in the brains of first one, and then several subsequent National Football League players who had died at an early age and who had evidenced personality changes or cognitive disorders. He named the condition chronic traumatic encephalopathy (CTE) and described the abnormal accumulation of tau protein in the brains of these individuals.

CTE is now widely accepted as a clinical entity. Significant rules changes have been enacted by the NFL, the NCAA, and lower levels down to Pop Warner football, to minimize head trauma. Dr. Omalu's work has led not only to the description of a new disease, but to a major cultural shift in America's most popular sport.

Because of the service Dr. Omalu has rendered to every player and every family member in the football and other sporting communities, the Board believes he is well qualified to receive the Distinguished Service Award.

**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

After a challenging start to last year's fundraising cycle, AMPAC's hard dollar fundraising is showing modest growth this year over last with direct hard dollar receipts up by 5 percent. Overall 2016 AMPAC hard and soft dollar receipts collected through May 31st are \$737,888 compared to \$756,212 in May of 2015 which is a slight decrease of 2 percent or \$18,324.

AMPAC's Capitol Club participation is slightly ahead this year with 670 members compared to 660 members in May 2016. Due to the importance of an election year we hope to increase and grow Capitol Club with new members in 2016 and will continue efforts to maximize retention. Our current retention rate for 2016 is 57 percent and 114 new first-time members have joined Capitol Club. Additionally, Capitol Club Platinum has 71 members, our highest number since the creation of Platinum in 2012.

HOD AMPAC participation has continued to show slow but steady improvement over the last several years with 74 percent participation in 2015, compared to 73 percent participation in 2014. Currently, participation is 52 percent within the HOD, which is improved over last year's 48 percent at this point in the year. Of the HOD members who have joined AMPAC, 67 percent are participating at the Capitol Club level. With an election year underway, HOD participation, especially in Capitol Club, will be critical to our efforts as we head into the fall. If you have still not given for 2016, please stop by AMPAC's booth to fulfill your commitment.

AMPAC is hosting its annual Capitol Club luncheon for all current 2016 members on Tuesday, June 14th with special guest speaker A.B. Stoddard. Stoddard is the associate editor and a columnist at The Hill newspaper. She also appears regularly on Fox's Special Report with Bret Baier, as well as MSNBC, CNN and BBC for her expertise as a political commentator. Lastly, AMPAC is promoting AMPAC's Anchor's Away Sweepstakes. The name of the winner will be announced at the Interim Meeting in Orlando, FL at the AMPAC luncheon. The recipient will receive accommodations for an 11 day Princess Cruise Lines Alaska Denali Land and Sea Explorer vacation. Current 2016 Platinum, Gold and Silver contributors are automatically entered into a drawing for the sweepstakes.

We need your continued support as leaders of the AMA and we can only be as effective as we are united in our efforts to support our own advocacy efforts. Once again, if you have not made a contribution to AMPAC for 2016, please stop by AMPAC's booth which is located just outside the House of Delegates in the exhibit area.

#### Political Action

While AMPAC does not get involved in Presidential Elections, a great deal of attention has been given to how the top of the ticket candidates might impact down ballot races for the U.S. House and Senate. With regards to the Senate, many believe Democrats have a good chance at taking the majority just by looking at the map and strictly by the numbers. At this point in the cycle it appears the Democratic Party could indeed gain seats, but the majority may also end up just out of their reach. On the House side, Democrats hold roughly 13 seats considered competitive while Republicans currently control 44. Of those, there are only four Democratic toss-up or worse races to 19 for the Republicans. Looking at these numbers, one could surmise that Democrats should be in a position to pick up a number of seats since Republicans have more than three times the number of competitive seats to defend. But while Democrats may indeed pick up seats, they have had some setbacks as well. In districts that could be competitive Democrats were unable to recruit top-tier candidates and some races don't have any candidates at all.

AMPAC is fighting hard to ensure that medicine's political impact is felt in this Congressional election. The AMPAC Board's Congressional Review Committee has worked closely with state medical society PACs to make strategic contributions to House and Senate candidates all over the country. These medicine-friendly House and Senate candidates are 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. Though the election is still five months away, AMPAC's political contributions to date for the 2016 Election cycle total nearly a million dollars.

AMPAC's 2016 investments will continue to create opportunities to further strengthen key relationships and promote the AMA's legislative agenda. Medicine must have a strong voice as Congress tackles important issues such as MACRA implementation, opioid abuse, and telemedicine.

#### Political Education Programs

The AMPAC Candidate Workshop was held on February 19-21, 2016 in Arlington, VA. As was the case in 2015, the Workshop saw a high level of interest, with 30 attendees from 28 states, including 20 physicians, 4 medical students, 4 physician spouses, and 2 state society staffers. The attendees gave the program a perfect score (4.0 on a 4-point scale).

On April 13-17, AMPAC hosted the 2016 edition of the Campaign School in Arlington, VA. There were a total of 27 attendees from 15 states including 21 physicians, 3 medical students, and 3 physician spouses. The School featured an opening address from U.S. Senator John Barrasso, MD (R-WY), himself an alumnus of the programs. 100% of attendees strongly agreed (a 5 on a 5-point scale) with the statement, "This school increased my understanding of the basic elements of a successful political campaign."

Information on 2017 AMPAC Political Education programming will be shared soon.

#### 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 MEDICAL EXECUTIVES****Texas**

A Tomas Garcia, III, MD  
Art Klawitter, MD

**American Association of Public Health Physicians**

Jonathan B. Weisbuch, MD, MPH

## REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES (A-16)

**Reference Committee on Amendments to Constitution and Bylaws**  
 Jan Marie Kief, MD, Colorado, Chair  
 Robert Block, Vermont\*  
 Ben Bush, Alabama, Regional Medical Student  
 Mary F. Campagnolo, MD, New Jersey\*  
 Howard Chodash, MD, Illinois  
 G. Sealy Massingill, MD, American Congress of Obstetricians and Gynecologists  
 Kevin C. Reilly, MD, Radiological Society of North America\*

**Reference Committee A (Medical Service)**  
 A. Patrice Burgess, MD, Idaho, Chair  
 William E. Bowman, Jr., MD, North Carolina  
 Cheryl Gibson-Fountain, MD, Michigan\*  
 Jerry L. Halverson, MD, American Psychiatric Association  
 Russell C. Libby, MD, Virginia\*  
 Nicole Riddle, MD, US and Canadian Academy of Pathology  
 Michael B. Simon, MD, American Society of Anesthesiologists\*

**Reference Committee B (Legislation)**  
 Michael D. Chafty, MD, Michigan, Chair  
 John S. Antalis, MD, Georgia\*  
 Christopher Gribbin, MD, New Jersey\*  
 Charles Moss, MD, New Jersey  
 Charles Rothberg, MD, New York  
 Marta J. Van Beek, MD, American Academy of Dermatology

**Reference Committee C (Medical Education)**  
 Albert M. Kwan, MD, American Society of General Surgeons, Chair  
 Peter Aran, MD, Oklahoma\*  
 Sharon Douglas, MD, Mississippi  
 C. Blair Harkness, MD, American Congress of Obstetricians and Gynecologists  
 Laura Shea, MD, Illinois\*  
 Sarah Smith, California, Regional Medical Student  
 J. Mack Worthington, MD, American Academy of Family Physicians

**Reference Committee D (Public Health)**  
 Michael D. Bishop, MD, American College of Emergency Physicians, Chair  
 Nikita Consul, New York\*, Regional Medical Student  
 Wayne C. Hardwick, MD, Nevada  
 John Montgomery, MD, Florida  
 Shilpen A. Patel, MD, American Society for Radiation Oncology  
 Alisha Reiss, MD, Ohio\*  
 Leslie H. Secrest, MD, Texas

**Reference Committee E (Science and Technology)**  
 Theodore Zanker, MD, Connecticut, Chair  
 Mohammed A. Arsiwala, MD, Michigan\*  
 Michelle A. Berger, MD, Texas\*  
 Lawrence K. Monahan, MD, Virginia  
 William S. Pease, MD, American Association of Neuromuscular & Electrodagnostic Medicine  
 Paresh C. Shah, MD, Society of American Gastrointestinal Endoscopic Surgeons  
 Charles W. Van Way, III, MD, Missouri\*

**Reference Committee F (AMA Finance and governance)**  
 Jane C. Fitch, MD, American Society of Anesthesiologists, Chair  
 David H. Aizuss, MD, California  
 Betty S. Chu, MD, Michigan\*  
 Gary W. Floyd, MD, Texas  
 Ravi D. Goel, MD, American Academy of Ophthalmology  
 Julia V. Johnson, MD, American Society for Reproductive Medicine\*  
 Gary R. Katz, MD, Ohio

**Reference Committee G (Medical Practice)**  
 Steven J. Hattamer, MD, American Society of Anesthesiologists, Chair  
 David J. Bensema, MD, Kentucky  
 Virginia E. Hall, MD, Pennsylvania  
 David M. Lichtman, MD, American Society for Surgery of the Hand  
 Timothy G. McAvoy, MD, Wisconsin  
 Carlo J.E. Milani, MD, American Academy of Physical Medicine and Rehabilitation\*  
 William Reha, MD, Virginia\*

**Reference Committee on the Modernized *Code of Medical Ethics***

Larry E. Reaves, MD, Texas, Chair  
Kavita Shah Arora, MD, American Congress of Obstetricians and Gynecologists  
David A. Hexter, MD, Maryland  
Douglas R. Myers, MD, Washington  
Kenneth B. Simons, MD, Wisconsin\*, Academic Physicians Section  
David T. Walsworth, MD, Michigan  
Richard S. Wilbur, MD, American College of Legal Medicine

**Committee on Rules and Credentials**

Donald B. Franklin, MD, Tennessee, Chair  
Madelyn E. Butler, MD, Florida  
Steven Chen, MD, American Society of Breast Surgeons  
Jerome C. Cohen, MD, New York  
Gary Dennis, MD, National Medical Association\*  
Richard L. Stennes, MD, American College of Emergency Physicians\*  
Corliss Varnum, MD, New York

**Chief Teller**

Anthony Armstrong, MD, Ohio

**Assistant Tellers**

**INAUGURAL ADDRESS:** Andrew W. Gurman, MD, was inaugurated as the 171<sup>st</sup> President of the American Medical Association on Tuesday, June 14. Following is his inaugural address.

Good evening and thank you. I am tremendously honored to stand before you tonight as AMA President. To reach this pinnacle is to travel a great journey. And like all great journeys, I did not travel alone.

First and foremost, I want to thank my family—my wife Nancy, my love, my best friend, strongest supporter and confidant. Lord knows where I would have ended up without you, but it's a sure bet that it wouldn't have been here. Thank you also to my daughter Karen and her husband, Kyle; and my daughter Amy and her fiancé Jason for their love, their strength, and their unwavering support. I love you, and I could not have done this without you. My mother, Adele Konecky, is here as well. Some of you may remember me introducing her to you in Orlando, during one of the funniest moments of my speakership. If you weren't there, or don't remember ... well, I'll tell you later at the cocktail party. Mom, I love you and I am delighted that you are here to share in the joy of this evening.

I would also like to thank my brother and sister, and their families, as well as the many friends, family, and colleagues who are here tonight. Some of you traveled long distances – Israel, California. One of you postponed having a knee replaced. I'll probably hear from the Orthopaedic Surgery contingent about that one.

I would like to recognize Dr. Martin Posner and Dr. Steven Green, who taught me hand surgery and have remained good friends for 30 years now, and also my Hospital CEO Jerry Murray. Thank you to Dr. Steven Stack for his service to the AMA, his leadership, his mentorship, and his friendship. And thank you also to the many colleagues and staff at the AMA and elsewhere who have inspired me, guided me, and have reminded me in difficult times of our power to meet any challenge. Your tireless work on behalf of physicians is shaping the future of medicine and leaving a proud legacy for us all.

In preparing for this moment, I have taken the opportunity to reflect on our profession and the steps I've taken on my personal journey.

My childhood dream, as it was for most kids in my neighborhood outside New York City, was to play for the Yankees. However, my inability to handle a high and tight fastball made it necessary to re-evaluate my career path by age 11. In college, I became interested in biochemistry and basic science research. Medicine wasn't even on my radar until graduate school at the University of Rochester, where I developed an interest in immunology. It was this study that brought me to clinical medicine, since I became convinced, and still believe, that immunology will be one of the fields that yield quantum leaps in the treatment of some diseases.

When I went to medical school in Syracuse, I was assigned a mentor from the medical community; just someone to hang out with, to shadow, or just to have as a resource. My mentor, Ned Hughes, was an orthopedic surgeon. He introduced me to reconstructive surgery, and particularly to hand surgery. I was drawn by the technical challenge of the work, but also by the satisfaction of being able to restore function to a truly remarkable organ. The hand gives life to what the mind sees and what the body feels... I was so taken by the poetry in that. The hand caresses a baby, a child, a lover ... it seals a deal, or provides rescue from the abyss.

The Bible tells us that the children of Israel were delivered from Pharaoh with "A Mighty Hand." My colleague, John Agee asks; "Can anything match the wonder of skilled musicians' fingers dancing on strings?" What a beautiful image that is!

Ned Hughes took me to my first county medical society meeting. Himself the son of a physician, he talked to me about caring for the profession. Twenty years or more before I heard the term, Ned was teaching me about paying it forward. He was the first of many people who mentored me along my path. Most, but not all, were physicians, and from them I learned the great power that medicine has ... the tremendous privilege that being a physician is ... and the responsibility that each of us has to nurture and care for this great profession.

It was a colleague who first brought me to a Pennsylvania Medical Society meeting. Another pointed me towards the PAC in our state. Still others brought me to the AMA. A more senior physician took an interest in me in Pennsylvania, and suggested that I try to become vice speaker of the Pennsylvania House of Delegates. That ultimately led to my run here at the AMA. Without those people, think of the videos you all would have missed! Without those people, I would not have the honor of being here today.

So now you know a little bit about HOW I got here. Let me tell you WHY I am here.

I have had the privilege of practicing hand surgery in central Pennsylvania for 30 years. Early in my career I had the opportunity to take care of a 4-year-old boy who was born without thumbs. I was able to rotate his index finger and make it an opposable digit. We took off the splint at about six weeks. Later that evening his mother called me in tears to tell me that he was sucking his “thumb” for the first time.

On another occasion, I took care of an elderly woman who was living in the house she and her husband had built together. She had really debilitating arthritis that was making even minor tasks difficult, and she was despondent about having to leave her home. I was able to reconstruct her hands so that she had enough function to remain independent, and to remain in the home that meant so much to her.

All of us who practice medicine have stories like these – those moments we cherish when we restore something valuable once thought lost. It is precisely these moments that drew us to medicine. Peter Carmel reminded us that one of the most intimate acts a person can do is to come to you and say “take care of me.” Being a physician is so empowering and uplifting, how can you not love this work?

That is why it is troubling to hear about so many accomplished and brilliant doctors who are leaving the profession. It is disheartening to hear physicians’ stories of being “burned out” … of feeling unsupported by administrators … dogged by unnecessary regulations … stressed by the pace of their jobs … and mired in mountains of paperwork.

A recent study by the AMA and the Mayo Clinic found that more than half of U.S. physicians are experiencing professional burnout, numbers that are getting worse every day. Nearly a dozen specialties have experienced a more than 10 percent increase in burnout between 2011 and 2014. Urology, rehabilitation, family medicine … each with burnout rates at 63 percent or higher. Radiology … 61 percent. Orthopaedic surgery, my specialty, … 59 percent. And we’re supposed to be the fun guys!

There are profound changes happening in medicine right now and as leaders of our profession we must respond. And that response must be two-fold: adapting to change and advocating for our profession. I think we all understand the importance of adapting to the changing landscape in health care. Modern medicine is advancing at a pace unprecedented in human history.

Advocacy, however, is something different. It is fighting back against the powers in government, the private sector, and elsewhere that are inserting themselves into health care—that are wedging themselves between us and our patients. It is fighting against inappropriately narrow networks, unfunded mandates, senseless regulation, and the futility of conforming to protocols and requirements that have no basis in reality, and no relationship to quality care.

I firmly believe that ALL physicians need to participate in advocacy as a professional responsibility, just like we participate in lifelong learning. I plan to spend the coming year bringing that message to as many physicians and medical students as I can.

I can tell you from experience that what happens in the halls of our state legislatures and Congress is as important for our profession as what happens in the halls of our hospitals and clinics. Physicians have been active in politics since the birth of our nation: Four physicians were signers of the Declaration of Independence. We have served in Congress and in the executive branches of state and local governments.

In 1847, Dr. Nathan Davis founded the AMA on the principles of improving conditions for physicians and encouraging them to speak with a unified voice on the issues that impacted their practices and their profession. Nancy Nielsen, in her presidential address, framed our collective call to action by quoting the great sage Hillel: “If I am not for me, who will be for me?” There are two more lines to that saying. We’ll come back to that in a bit.

I know everyone in this room has heard this call to serve; that’s why we are here. But we all have friends and colleagues in medicine who are leaders in their communities, but who choose to remain silent. For the betterment of medicine, we need all those sitting on the sideline to get involved. For the betterment of our profession, we need more ideas at the table. I tell physicians all the time: If you think the AMA is the voice of other people and not you, you need to lend us your voice. Get involved. Help us find solutions and respond to the tremendous challenges we face and those we know are coming.

In these challenges, there is opportunity. Think of it. You and I have access through our smart phones to a seemingly infinite amount of medical literature and data. We have access to technology that allows us to visualize, and to understand disease at a molecular level, and to customize and personalize medical care like never before. We must work together to ensure that, as physicians, we lead the way in delivering these advances to our patients. We must stand up for our patients in the face of excess commercialism, bureaucracy and regulation. We need to be their voice—their advocates, in the true sense of the word. Hillel’s famous second line says it all: “If I am only for me, what am I?”

As AMA president, I will be reaching out to you to ensure that your voice is heard, and that our priorities align as we take on these challenges together.

As leaders, we all must reach out to our elected representatives in Washington DC, and across every state, so that they understand how administrative bureaucracy and over-regulation is contributing to physician burnout and undermining quality care. As leaders, we will be reaching out to the public at-large to raise awareness about preventive care, so that Americans get screened for chronic conditions such as pre-diabetes that can negatively impact their quality of life.

And I will make it a goal of my presidency to reach out to business and community leaders – to civic organizations, chambers of commerce, rotary clubs—so they understand all that the AMA is doing to improve health care and strengthen the health of our communities and our nation. I have been engaged in this work for the past year. Community groups are very excited to hear this message, to learn about our priorities, and to know what they can do to help. They are natural allies as we work towards the betterment of public health.

If I can leave you with one thought tonight, it is this: Relationships. I read recently about a landmark, decades-long study at Harvard to understand the roots of happiness. Think of it: Men and women have lived on this planet for eons and we’re only now trying to figure what makes us happy.

I think men and women are still trying to figure each other out, but that’s another story.

Researchers at Harvard began this study in 1938 by intimately tracking the lives of healthy, able-bodied Harvard students. What they did in school. What they did for leisure. What they ate. Their sleeping and drinking habits. All of it was subjected to study. For the next 75 years they tracked these alumni and recorded tidbits about their daily lives in the hopes of unlocking the secrets of healthy aging.

And what they found—perhaps not surprisingly—is that the number one indicator for good health and happiness over a lifetime is relationships. Those who isolate themselves from others see declining health in midlife and, by and large, go on to live shorter lives. Relationships—whether it’s with a parent, a child, a sibling, a good friend or coworker—shelter us from the negativity in the world, and give meaning to our lives.

So, why do we so often go it alone? Why do we blindly shake our fists at our challenges, ignoring the community behind us confronting the very same hardships that we are?

I began tonight by thanking those who inspired me as a young physician to become an orthopaedic surgeon, but who also helped me to see how I fit into the larger global community of medicine. They taught me that advocacy is a lifetime pursuit. It is not showing up for a specific cause and then stepping back into the shadows.

Advocacy is a process. It’s relationship-building. There is that word again.

It is maintaining a presence in your community, in your field, and in your state. Many of our colleagues do not yet know the power in these relationships; the power in working to create a shared legacy in medicine. We should see that as an opportunity: to create a community of physicians worth joining. To show them the value in what we do. To show them the results of our hard work: Whether it’s protecting physician autonomy, or collaborating with tech entrepreneurs on the next digital breakthrough.

We are the custodians of a marvelous profession and a noble tradition of healing and ethics. Let this be the year we tell our colleagues about all that we are doing on their behalf and on behalf of our patients, so that more may join in our fight.

Let this be the year we show them the value of belonging to a community like the AMA, which is tackling the biggest challenges that are driving some of our best doctors out of the profession.

Through advocacy and action, everyone in this room is doing his or her part to fulfill the mission of the AMA and to move medicine forward.

Let's reach out to those around us. Let's build these relationships.

Let's encourage others to join us—to lend their voices—as we work together to create a future that supports thriving physicians ... expands quality care ... and strengthens the health of our nation.

“If not now, when?”

Thank you.