

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

67th INTERIM MEETING NATIONAL HARBOR, MARYLAND November 16–19, 2013

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 67th Interim Meeting at 2 p.m. on Saturday, Nov. 16, in the Maryland Ballroom of the Gaylord National Resort & Convention Center in National Harbor, Maryland, Andrew W. Gurman, MD, Speaker of the House of Delegates, presiding. The Sunday, Nov. 17, Monday, Nov. 18 and Tuesday, Nov. 19, sessions also convened in the Maryland Ballroom. The meeting adjourned Tuesday morning.

INVOCATION: The following invocation was delivered by Reverend Thomas Gaunt, S.J., Executive Director of the Center for Applied Research in the Apostolate at Georgetown University.

Today we live in a polarized world that so often emphasizes the need to multi-task and the demand to be constantly engaged. In such an environment a sense of balance and peace can seem impossible.

Jean Vanier, a French Canadian philosopher, founded the L'Arche Community 50 years ago outside of Paris, in what has become an international network of communities of people with and without developmental disabilities. Vanier has written numerous books over the years on faith and spirituality grounded in his experience of sharing life with those so often excluded from our society. On the subject of finding balance and peace Vanier writes:

“It is difficult to make people understand that the ideal doesn't exist, that personal equilibrium and the harmony they dream of come only after years and years of struggle, and even then only as flashes of grace and peace. If we are always looking for our own equilibrium, I'd even say if we are looking too much for our own peace, we will never find it, because peace is the fruit of love and service to others.

“Stop looking at yourselves – look instead at your brothers and sisters in need. Be close to those God has given you today... Then you will find peace. You will find rest and that balance you're looking for between the exterior and interior, between prayer and activity, between time for yourself and time for others.’

To be good instruments of God's love we must avoid being over-tired, burnt-out, stressed, aggressive, dispersed or closed up. We need to be rested, centered, peaceful, aware of the needs of our body, our heart and our spirit. Jesus says that there is no greater love than to give our lives. But let us not give over-tired, stressed and aggressive lives, but rather joyful ones!” (*Community and Growth*, pp. 46-47)

Let us pray:

God, creator of all things, give us balance. Open our hearts to those who enter our lives each day especially those who are weak, those who are suffering, those who yearn for our compassionate touch or word. Allow our eyes to be open to Your presence, and bless us with your love and peace. AMEN.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Brigitta J. Robinson, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, Nov. 16, 462 out of 527 delegates (87.7%) had been accredited, thus constituting a quorum; on Sunday, Nov. 17, 495 delegates (93.9%) were present; on Monday, Nov. 18, 505 (95.8%) were present; and on Tuesday, Nov. 19, 505 (95.8%) were present.

RULES REPORT - Saturday, Nov. 16**HOUSE ACTION: ADOPTED**

Your Committee on Rules and Credentials recommends that:

1. House Security

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

2. Credentials

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

3. Order of Business

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

4. Privilege of the Floor

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

5. Procedures of the House of Delegates

The November 2013 edition of the "House of Delegates Reference Manual: Procedures, Policies and Practices" shall be the official method of procedure in handling and conducting the business before the AMA House of Delegates

6. Limitation on Debate

There will be a 3-minute limitation on debate per presentation subject to waiver by the Speaker for just cause.

7. Election of Affiliate Members

The election of affiliate members shall take place during the second opening session of the House of Delegates.

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

SUPPLEMENTARY REPORT – Saturday, Nov. 16**HOUSE ACTION: ADOPTED**

The Committee on Rules and Credentials met Saturday, November 16, 2013, to discuss the vacancy on the Board of Trustees. While American Medical Association bylaws allow the Board of Trustees to appoint someone to fill a vacancy, it is not required to do so, and the Committee was advised by the Board Chair that no appointment will be made.

Bylaw 3.63, “Election to fill Vacancy,” states:

Any vacancy in the office of ... Trustee ... shall be filled by election by the House of Delegates at the earliest convenient time recommended by the Committee on Rules and Credentials and approved by the House of Delegates.

The Committee consequently discussed the earliest convenient time to schedule an election, weighing a number of factors before reaching its recommendation, including:

- The Board’s decision not to fill the vacancy by appointment;
- The Board’s judgment and Counsel’s concurrence that the vacancy creates no legal impediments or problems;
- Two cases in recent history in which vacancies did not impede Board operations;
- The relatively short time between announcement of the vacancy and this Interim Meeting;
- The consequent inability for candidates to prepare an election campaign;
- The unknown number of candidates;
- The difficulty of scheduling interviews for an unknown number of candidates given the likelihood of other pre-existing commitments;
- The idea that candidates should be subject to the same evaluative process as candidates at the Annual Meeting given that the successful candidate will be elected for a full four-year term;
- The fact that the Interim Meeting is one day shorter than the Annual Meeting and the possibility of adjourning Monday;
- Uncertainty about scheduling an election and the potential need for run-off balloting; and
- The inability to develop firm plans and schedule activities before the House of Delegates acts on this Committee’s recommendation.

The Committee on Rules and Credentials recommends that the vacancy on the Board of Trustees be filled in the normal course of elections at the 2014 Annual Meeting.

SUPPLEMENTARY REPORT – Sunday, Nov. 17**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS**

**LATE RESOLUTIONS 1001 (605), 1002 (228) AND 1003 (822) ACCEPTED
AND ASSIGNED TO REFERENCE COMMITTEES AS INDICATED**

**EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 203, 210, 213,
215, 803, 809, 810, 908 and 918.**

The Committee on Rules and Credentials met Saturday, November 16, 2013 to discuss Late Resolutions 1001–1003. Sponsors of Late Resolutions are informed of the time the Committee on Rules and Credentials meets to consider Late Resolutions, 8:30 a.m. on Saturday, and 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. Sponsors of Late Resolutions 1001–1003 appeared to discuss their resolutions.

(1) LATE RESOLUTIONS

Your Committee is including its recommendation on a consent calendar based upon whether or not the resolution met the criteria for consideration as a Late Resolution.

Recommended for acceptance:

1. Late 1001 – Criminalization of Errors in Medical Documentation
2. Late 1002 – EHR Stark Exemption
3. Late 1003 – Prepayment Review by Third Party Payers

(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 that such policies will remain viable for ten years from the date of reaffirmation. The Committee recommends that current policy be reaffirmed in lieu of the following resolutions (current policy and AMA activities are listed in the Appendix to this report):

1. Resolution 203 - Nationwide Prohibition of the Sale of Tobacco Products in Businesses That Provide Health Care and Health Care-Related Services
2. Resolution 210 - Support FFS as the Most Appropriate Way to Reimburse Physicians
3. Resolution 213 - AMA Advocate for the Physician-Led, Multi-Specialty, Organized, Group Practice Model as a Viable Option for Practice Selection Coincident with SGR Reform
4. Resolution 215 - National HIE and EHR Usability and Interoperability
5. Resolution 803 - Electronic Payment and Record Access
6. Resolution 809 - Centers for Medicare & Medicaid Services Proposed Change Circumvents the AMA/Specialty Society RVS Update Committee Process
7. Resolution 810 - Medicare Economic Index Inaccuracy
8. Resolution 908 - Hydraulic Fracturing
9. Resolution 918 - HIV Screening, Continuum of Care and Maintenance of Funding

APPENDIX

1. Resolution 203 - Nationwide Prohibition of the Sale of Tobacco Products in Businesses That Provide Health Care and Health Care-Related Services
 - D-495.994 Oppose Sale of Tobacco Products in Pharmacies
 - H-495.986 Tobacco Product Sales and Distribution
 - H-495.977 Banning the Sale of Tobacco Products and/or Tobacco By-Products in Retail Outlets Housing Store-Based Health Clinics
2. Resolution 210 - Support FFS as the Most Appropriate Way to Reimburse Physicians
 - H-390.844 Recognizing the Diversity of Practice Models in the Transition from the SGR to a Higher Performing Medicare Program
 - H-385.989 Payment for Physicians Services
 - H-385.926 Physician Choice of Practice
 - D-380.997 Private Contracting by Medicare Patients
 - AMA/State and Specialty letter to Rep. Tom Price supporting H.R. 1310, the "Medicare Patient Empowerment Act;" April 10, 2013
 - AMA letter to Representative Tom Price supporting H.R. 1310, the "Medicare Patient Empowerment Act;" March 26, 2013
 - AMA letter to Senator Murkowski supporting S. 236, the "Medicare Patient Empowerment Act;" February 8, 2013

3. Resolution 213 - AMA Advocate for the Physician-Led, Multi-Specialty, Organized, Group Practice Model as a Viable Option for Practice Selection Coincident with SGR Reform
 - H-390.844 Recognizing the Diversity of Practice Models in the Transition from the SGR to a Higher Performing Medicare Program
 - D-390.961 Medicare Physician Payment Reform
 - H-160.912 The Structure and Function of Interprofessional Health Care Teams
 - D-405.988 The Preservation of the Private Practice of Medicine
4. Resolution 215 - National HIE and EHR Usability and Interoperability
 - D-478.981 Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities
 - D-478.995 National Health Information Technology
 - D-478.996 Information Technology Standards and Costs
 - AMA Testimony Before the Health IT Policy Committee's Workgroups on Certification/Adoption and Implementation, Implementation and Usability of Certified Electronic Health Records; July 23, 2013
 - AMA/AHA Letter on Improvements to the EHR Meaningful Use Program; July 23, 2013
5. Resolution 803 - Electronic Payment and Record Access
 - H-190.983 Submission of Electronic Claims Through Electronic Data Interchange
 - H-190.992 Electronic Claims Submission
 - H-190.978 Promoting Electronic Data Interchange
6. Resolution 809 - Centers for Medicare & Medicaid Services Proposed Change Circumvents the AMA/Specialty Society RVS Update Committee Process
 - H-400.969 RVS Updating - Status Report and Future Plans
 - H-390.992 Prospective Payment System and DRGs for Physicians
 - H-70.980 Bundling CPT Codes
7. Resolution 810 - Medicare Economic Index Inaccuracy
 - H-400.966 Medicare Payment Schedule Conversion Factor
 - D-390.963 Improving the Medicare Economic Index
 - D-400.985 Geographic Practice Cost Index
8. Resolution 908 - Hydraulic Fracturing
 - D-135.976 Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976
9. Resolution 918 - HIV Screening, Continuum of Care and Maintenance of Funding
 - D-20.992 Routine HIV Screening
 - H-20.899 HIV Testing
 - H-20.922 HIV/AIDS as a Global Public Health Priority
 - H-20.907 Financing Care for HIV/AIDS Patients

CLOSING REPORT – Tuesday, Nov. 19

HOUSE ACTION: ADOPTED

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

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

Whereas, The Interim Meeting of the House of Delegates of the American Medical Association has been convened in National Harbor, Maryland, during the period of November 16-19, 2013; and

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

Whereas, The city of National Harbor 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 Gaylord National Resort & Convention Center, to the members of the Alliance who always contribute so substantially to our meetings, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Interim Meeting of the House of Delegates.

APPROVAL OF MINUTES: The Proceedings of the 162ND Annual Meeting of the House of Delegates, held in Chicago, Illinois, June 15–19, 2013, were approved.

ADDRESS OF THE PRESIDENT: AMA President Ardis Dee Hoven, MD, delivered the following address to the House of Delegates on Saturday, Nov. 16.

Mister Speaker, members of the Board of Trustees, delegates, friends. It is an honor to address you today.

Five months ago I spoke to you about the importance of leadership, of collaborating, innovating and coming together to drive productive change. I'm happy to say that since then, I have seen countless examples of just such leadership. I have seen collaboration between the AMA and state and specialty societies yield more than 85 legislative victories. I have seen medical students lead a campaign to save GME—meeting with more than 40 legislators and sending more than 7,000 letters to Congress.

I have seen significant progress on medical liability reform in states like Florida, Oklahoma and Pennsylvania. I have seen national advocacy efforts yield more than 200 cosponsors for a bill to repeal IPAB. I have seen Maine become the fourth state to enact AMA truth-in-advertising legislation this year alone.

I have seen more than 50 state and specialty medical societies collaborate with the AMA to confront prescription drug abuse, to advocate for a nuanced approach that includes public health, incentives to promote awareness, point-of-care decision support for physicians, addiction treatment, and enforcement.

I have seen membership in the AMA increase for the third year in a row.

I have seen our AMA Litigation Center engage in seven cases this year that were argued before and decided by the US Supreme Court, proof that the AMA is not only fighting for physicians but doing so at the very highest levels.

I have seen the AMA strategic plan begin to take shape, from the innovative proposals unveiled at the first meeting of the medical education consortium to novel partnerships that will help improve outcomes for Type 2 diabetes and cardiovascular disease to a RAND report that provides the statistical backing we need to convince Congress of something you and I already know: clumsy EMR technology, rigid quotas and a sea of regulations don't help us serve patients; they get in the way of serving patients. In short, I have seen that when America's physicians stand together—united in vision and commitment—we can shape the health care system this country needs.

Now while these victories have inspired me, in the past five months I have also seen some disturbing developments in the halls of government. I have seen an attempt to help uninsured individuals enroll in affordable, competitive health care become thwarted by a flawed federal website. And I have seen ongoing division over the Affordable Care Act lead to the unthinkable, a full-blown government shutdown.

In my mind, these missteps are examples of what happens when people fail to communicate, when two opposing sides get so caught up in being “right” that productive conversation becomes impossible. The point I want to make today is that productive conversation is always possible. And it's not just possible, but incredibly necessary. In fact, over the next few days I hope to hear a great deal of it.

And I encourage it, because today we've arrived at a crossroads on a familiar issue, an issue that has consumed innumerable hours and even more dollars over the past decade: the broken Medicare system. As I'm sure you're aware, right now a discussion draft is circulating in Congress that would repeal the irrational Sustainable Growth Rate formula once and for all. No more annual threats. No more patches. No more Sword of Damocles dangling over our heads.

At first glance, it seems like a cause for celebration. But let us not be so hasty, because as with almost everything on Capitol Hill these days, the proposal before us is a mixed bag. I'm not going to sugar coat it. There are things I really don't like about the proposal, chief among them, the idea of a 10-year payment freeze.

I don't need to explain to anyone in this room why freezing Medicare payment where it is right now—a full 20 percent below the actual costs of providing care—just doesn't make sense. It makes you want to throw up your hands and scream. But after my emotions settled I took a long, reasoned look at the options before us, and I realized that walking away right now would be a colossal mistake. Now, more than ever, America's physicians need to maintain the pressure. And here are five reasons why.

Number one. We must all recognize that this is a draft document. It is not legislative language, and it is not written in stone. To walk away now, before we know what modifications may be made and before we have seen the final details, would be ill-advised. I understand the urge to put a stake in the ground, but if we walk away at this critical time, decisions about the future of Medicare will be made without us. Decisions that impact our livelihoods. Decisions that impact the future of health care delivery. Decisions that impact the welfare of our patients. That's not an option. Right now we have an opportunity to negotiate. Right now we have an opportunity to advocate for the elements we like, and change the elements we don't. And that's why we need to keep pushing.

Number two: the support for this draft is not only bicameral, but bi-partisan. Think about that for a moment. We're talking about a Congress that actually closed its doors for 16 days rather than sit down and reach a compromise. The fact that this Congress has come to agree on anything—let alone something as important as SGR repeal—is itself an incredible accomplishment, proof of the widespread recognition that SGR has to go.

Unlike passage of the Affordable Care Act, which split conspicuously along party lines, SGR repeal enjoys support from Republicans and Democrats alike. In the House and in the Senate the desire is there. The timing is right. And that's why we need to keep pushing.

Number three. By Congressional standards, SGR repeal is “on sale” right now. At this time last year, the cost for repeal was projected at \$297 billion. Today, it's \$138 billion. That's a savings of more than fifty percent. We may never see a number like this again. We may never get this opportunity again, and that's why we need to keep pushing.

Number four. The status quo, as dysfunctional as it may be, is itself under threat. What do I mean by that? For a number of years, the status quo has gone something like this: the SGR formula mandates a 20–30 percent cut, physicians and patients express outrage, Congress institutes a temporary patch, and on occasion—when we're lucky—we might get an update; half a percent here, one percent there. It's less than ideal, but when you consider the prospect of a 10-year freeze, suddenly a 1 or 2 percent increase starts to look pretty good. Right?

Well I hate to say it, but after countless meetings on Capitol Hill I've come to realize that the status quo may not be around much longer. Today, many rank-and-file members of Congress and their staffs are questioning why physician cuts have been off the table in budget discussions, and they're hearing a chorus of calls from other health care providers that physicians should bear the pain of absorbing the cost of a temporary SGR patch.

The fact is, today a one-year SGR patch costs \$18 billion dollars. Given the current fiscal environment, there's a real possibility that next time the cut comes around, Congress will choose to save the \$18 billion and replace it with a cut for physicians. That's the reality of the situation. It is ugly, and that's why we need to keep pushing.

Lastly, most importantly, we cannot forget the chaos SGR has created for physicians and our patients over the past decade. We cannot forget the five patches in 2010 alone, how physicians had to take out bridge loans to keep their practices afloat, how practices had to let employees go, how physicians had to stop taking new Medicare patients, and how some patients were forced to delay critical procedures.

Walking away from the single greatest opportunity we've had to remove this scourge once and for all, walking away before we even have legislative language before us would be a colossal mistake. And that's why we need to keep pushing, until we push through.

In my experience, meaningful change, truly groundbreaking change, does not come overnight. As much as we wish it were otherwise, change takes time.

Five months ago I told you a bit about my experiences treating patients in the early days of the AIDS epidemic. One of my patients during those days was a talented young photographer named John Kelly Cooper. Well one day he came to the office and gave me a framed photo he'd taken. In the center was a wine glass full of pills. Behind them, forming a semi-circle, was a sea of bottles, at least 15, maybe 20. And to the right there was an IV bag, a vital part of treatment back then. The title of the photo was: "my daily dose."

During the early days of the AIDS epidemic, this depressing picture was simply the best we could do. Our patients' immune systems were so compromised that their bodies had become fertile ground for a host of diseases: lung infections, meningitis, brain malignancies. The best we could do was tackle the symptoms. Try to bring down that 105 degree fever. Try to stop the patient from shivering. Try different combinations of antibiotics and hope one would work.

We made the most of what we had on hand. Sometimes it helped relieve the patient's pain. Sometimes it did not. At that time, the concept of a cure for HIV didn't even seem within the realm of possibility. Five or six years later, researchers had not only begun to understand the disease but also develop a host of drugs that could help slow it down. Zerit. Crixivan.

Unfortunately, these medications came with horrible side effects. Kidney stones, pancreatitis. Some even caused a patient's fat cells to redistribute, so patients developed humps on their necks, or distended abdomens. We were making progress, but it was slow-going, and it wasn't without a price. It wasn't until the 90s that things really started to get better, not just the medications but also our understanding of how to prevent complications from developing. Our patients began to not only live longer, but also live better.

And today, today I tell my patients that the biggest threat to their health isn't necessarily HIV, but the poor habits so many of us in this country are battling: poor diet, lack of exercise, smoking. Today, instead of taking 15 or 20 medications like John Kelly Cooper did, my HIV patients can take just 3 medicines bundled into one pill, with minimal side effects.

When I look back at the progress we've made toward treating HIV I'm struck by just how long the journey has been, some 30 years and counting. Sometimes the resources on hand were woefully insufficient, but we seized on every improvement as it emerged. We took it one step at a time, always with our eye on the long-term goal, a cure. Needless to say, we haven't gotten there yet. But that doesn't make our end goal any less important. And we're a lot closer today than we were 30 years ago.

So what is our goal for health care in this country today? When it comes down to it, what do we ultimately want? We want America's physicians to be able to do what we do best, serve America's patients. We want to serve young and old. We want to serve rich and poor. We want to provide them with the highest level of care possible, regardless of whether they have insurance. We want the ability to treat patients when and where it counts, in the office, before that lump in a woman's breast has turned into untreatable cancer, instead of in the nation's emergency departments, when it is too late. We want people with chronic conditions to get the care they need. Better yet, we want to help them prevent those conditions from developing in the first place. We want more autonomy, less bureaucracy; more time with the patient, fewer hassles getting in our way. In short, we want to do the job we went to medical school for.

We want to cure. We want to comfort. We want to save lives. And if there's one thing we don't want, it's the prospect of a 24 percent cut, threatening our ability to do that job, threatening care for the nation's seniors, threatening care for the nation's disabled, and threatening care for the nation's veterans.

Colleagues, a few weeks ago I had the pleasure of attending the meeting of the Pennsylvania Medical Society. During an afternoon with a few hours to spare, I was able to visit the National Civil War museum in Harrisburg. I

don't think any of us who never fought in battle can really comprehend the trauma of war, but having walked through that museum and seen the personal accounts—from the manuscripts to the photos to the personal effects of the many men and women who died—I now view the war in a different light. I am now keenly aware of the human cost that went into forging this great nation.

I also view those 272 words Abraham Lincoln delivered in Gettysburg in a different light, words delivered on a battlefield where more than 50,000 people lost life or limb. On a gloomy day in 1863, Lincoln stepped up to the podium at the dedication of National Soldier's Cemetery and said: "(T)hat we here highly resolve that these dead shall not have died in vain... that this nation, under God, shall have a new birth of freedom... and that government of the people... by the people... for the people... shall not perish from the earth."

Lincoln delivered those words in the face of uncertainty. He could not know that the Civil War would rage for another 18 months. He could not know about the challenges of Reconstruction. He could not know the ultimate fate of the nation nor the triumphs it would achieve in the years ahead or that the United States would not just survive, but become a world superpower. Those were the victories that awaited, but they did not come easily. And they did not come quickly.

Why am I telling you this? Because two days from now, we will celebrate the 150th anniversary of the Gettysburg Address, and two days from now, many of us will find ourselves on Capitol Hill, exercising our rights as Americans.

So as we meet with our elected officials let's draw some inspiration from one of our greatest presidents. Let's be vigilant. Let's hold on to our vision for a better future. And let's remember our long-term goal: to do right by America's physicians. And above all to do right by America's patients. Thank you.

REMARKS OF THE CHAIR OF THE AMPAC BOARD: The following comments were offered by John W. Poole, MD, on Saturday, Nov. 16.

Good afternoon, everyone. My name is John Poole. And I'm back to ask for money. I'm back to ask you to invest in AMPAC.

My message is simple today. You know, the AMA is an advocacy organization. In fact, we pride ourselves that we are the advocacy organization for the house of medicine.

In today's environment, we cannot expect to be a truly effective advocacy organization unless we can influence Congress. Without that, we risk becoming nothing but a debating society. And one of requirements to influence Congress is a well-funded PAC. Your investment in AMPAC can then get some of the policy that we propose, debate and pass in this House enacted into law.

You may be wondering why the Chair of AMPAC is standing before you with a cup of Dunkin' Donuts coffee. This is all the average donation to AMPAC would buy. We need to do better than that. I know we can do better than that.

I know that many of you in this room have invested far more than a cup of coffee in your future, but that means that the rest of your colleagues back home are expecting you to carry them, carry them on your back. The cold hearted truth is that's the price of leadership. You are carrying your colleagues back home.

For those of you who didn't even notice my cup of coffee because you were so jealous of the tie I'm wearing, let me explain how can you get one. This is one of the most expensive pieces of clothing that I own, but one of the best investments I've ever made. This tie is on sale now at this meeting. For just \$2500, you can become a Capital Club Platinum Member and proudly wear this tie or scarf as an outward sign of your commitment to advocacy.

You know, you are the leaders of the house of medicine. That's why you're here. Leaders lead by example. Leaders want to set an example. A hundred percent of this House should be AMPAC members, at least at the \$100 level. That's just the price of admission. That gets you in here. And yet I'm sorry to say that right now only about 62 percent of this House are members of AMPAC. I know we can do better. We need to do better.

If you are a council member, especially a chair or vice chair or a chair or co-chair of your state or specialty society delegation, I urge you to invest at AMPAC at the Capital Club Platinum, Gold or Silver level. That is the price of leadership.

You know, as I travel around the country and ask doctors for money on behalf of AMPAC -- the easiest job in the world, by the way—some of the things I hear is, I don't give to AMPAC because I give to my state society or I don't give to AMPAC because I give to my specialty society. So do I. Here are my pins. But you still need to invest in AMPAC.

I am going to close by also quoting Lincoln and the Gettysburg address. Dr. Hoven stole a little bit of my thunder. If you recall in June, I stood before you, and I was going to quote Lincoln—I mean, I was going to quote Shakespeare, but I related to you that I am a general surgeon and non-cognitive specialist, and that I wasn't even going to attempt that.

Well, I am still a general surgeon. I'm still non-cognitive, and I don't have the ability to on-the-fly change my closing, so I am still going to quote Lincoln. And, by the way, everybody is allowed to quote Lincoln, including surgeons.

When Lincoln stood in that battlefield in Gettysburg and he dedicated that—in Pennsylvania, and he dedicated that battlefield, he was far from certain that government of the people, by the people and for the people would survive. It did, indeed, survive. At times it appears broken, but because of that—because of that, we have the right, guaranteed in the Bill of Rights, to petition our government.

If there was ever a time in our country that our patients and our profession needed us to petition, advocate and educate Congress, now is the time.

Your investment in AMPAC will help us protect our practices, patients and profession.

Thank you.

REMARKS OF THE EXECUTIVE VICE PRESIDENT: The following remarks were presented by James L. Madara, MD, Executive Vice President of the American Medical Association, on Saturday, Nov. 16.

Mister Speaker, Madam President, members of the Board, delegates, guests:

It's been just five months since we last gathered; but I'm delighted to report substantial progress in our work to improve outcomes for America's physicians, patients, and medical students. This whirlwind of activity can be summed up in three words: progress, partnerships and promise.

But before an update, let me offer both a question and a confession. My question: Have you hugged an AMA member lately? My confession? I did. About three months ago. I'll explain. Last summer, I met with the leadership of the Heart, Lung and Blood Institute on the NIH campus. They wanted to hear about our improving health outcomes initiative. I outlined the AMA's Strategic Plan emphasizing potential intersections of our work with theirs. One of the most senior NIH officials in the room who had been sitting quietly, suddenly spoke up, saying: "Excuse me. I don't mean to interrupt, but I just have to say I've never thought of the AMA quite like this. I've never been a member, but I going to join today right after this meeting."

Well, I was a little caught off guard and found myself spontaneously getting up, walking across the room and giving the guy a great, big hug, a technique I learned from our former President, Peter Carmel. Everyone in the room thought the hug was hilarious. And while it was a funny moment, I meant it. It is heartening that our ambitious work strikes a chord with such respected senior thought leaders.

This new-found appreciation for the AMA is not an isolated incident. This past September, the AMA hosted one of the leading authorities on social determinants of health, Sir Michael Marmot. Many of you are familiar with his work. During a spirited, hour-long presentation Sir Michael applauded the AMA's decision to work toward improving health outcomes. At one point, he paused, then said this: "A few years ago, I could not have conceived of

engaging the AMA, but the work you're doing in health outcomes is so important that I must engage and am simply delighted to do so."

Later that same week, Chicago Mayor Rahm Emanuel stopped by the AMA to help dedicate our new headquarters. He used the occasion to recognize the AMA's work and our commitment to improving the health of our Nation and thus, by extension, the health of the 2.7 million citizens of Chicago.

All three of these episodes—and I could recite many more—offer telling snapshots of how others are viewing the AMA and our important work. They see the AMA's commitment to impact through focus as new and exciting . . . they see our willingness to reposition the AMA as bold and compelling, and they see our developing partnerships with others as smart and strategic.

Furthermore, and this is very important, this work brings additional power to our Advocacy efforts in Washington and nationally. In fact, our Advocacy team is convinced that our work on the strategic plan greatly strengthens our stature on Capitol Hill and with the public.

With that in mind, let me update you on the progress we're making toward improving outcomes for physicians, patients, and medical students, all work that, as you know, is based on the policies of this House.

I'll start with our work to enhance physician satisfaction and to ensure practice sustainability.

Just last month, we released the initial findings from our collaboration with RAND Health. I hope you saw it. It appeared in more than 200 media reports across the country. As you'll recall, our study examined over 50 sites from 30 diverse practices across 6 states to better understand the drivers and detractors of physician satisfaction. Let me thank our state medical societies that helped with this: Colorado, Massachusetts, North Carolina, Texas, Washington and Wisconsin.

The 150-page RAND report provides a wealth of information on the challenges physicians are facing in the current environment. Most of which, could have been articulated by this House.

So why an external study? In short, hospitals, payers and regulators need an empiric body of rigorously conducted, on the ground, social science research to be convinced, to be moved on this topic. This work now is not only in hand, but has the imprimatur of RAND, a respected third party. Very important.

So let me touch on two critical factors influencing professional satisfaction: quality of care and electronic health records.

In regard to quality of care the study showed physicians want desperately to be able to deliver high quality care to their patients. Indeed this is our greatest satisfier. When able to provide such care, physicians are fulfilled. Unfortunately, obstacles too often get in the way. Physicians are frustrated by the increasing number of clerical and administrative tasks that detract them from their calling: patient care.

A second major finding—just a little surprising for how stunningly dramatic it was—was the effect of electronic health records on satisfaction. Physicians in the study recognized the potential of EHRs to improve patient care, and did not want to go back to paper; however, if I described the effect of the current state of EHRs on professional satisfaction as dismal, I'd fear I might be insulting dismal.

Let's be frank. EHRs as they exist today are constructed to optimize two things: claims billing and risk mitigation. They are not optimized for efficient entry and extraction of clinical data needed by physicians to help their patients. This needs to change. EHRs must serve and enhance the physician-patient interface. Other functions should be retrofitted and subservient to this higher clinical need. So how do we proceed?

The AMA is launching both short-term and long-term strategies to help physicians navigate some of the frustrations documented, now with undeniable rigor, by this study. Short-term: we have identified a list of a dozen or so practice flow and practice architecture issues that we can address to help physicians, regardless of practice mode or care model. These resources will begin rolling out by the coming summer. For our longer-term strategic approach, the AMA will pursue four initiatives to help physicians in their practices. These include:

- Developing tools to address intrusions on physician practice
- Engaging both EHR vendors and regulators to improve EHR usability
- Enhancing understanding of emerging payment models and their impact on the physician practice to detect obstacles and nip them in the bud, and
- Promoting shared management and physician engagement with hospitals that employ physicians

Just last month something occurred that hadn't happened since 1975: the AMA and the American Hospital Association convened a multi-day joint meeting in DC to discuss some of the important issues that are emerging in this new landscape. A critical take-away for all participants was that high functioning hospital-physician models depend upon physicians having a real shared partnership in leading the enterprise. The key isn't so called physician "alignment," the key is shared leadership with physicians.

We are also hard-wiring this work in physician satisfaction to our Advocacy efforts. Because improvements which make things better for physicians while improving both quality and the patient experience need to be embedded in our national policies. The AMA is committed to this goal, and our work—now built on a strong fact base—is well underway. In short, if you can't get no satisfaction, that needs to change. And the AMA is ready to help.

Second, let me update you on our next strategic objective: improving health outcomes. As you know, our initial focus is on two of the most pervasive, devastating, and costly conditions in the country, cardiovascular disease and Type 2 diabetes. No matter what your specialty, every single day each of us interfaces with patients, neighbors or loved ones who have at least one of these conditions, or risk developing them in the future. So how will the AMA help?

First, diabetes. As physicians with a full panel of patients, it can be hard to find enough time to address our patients' acute conditions, let alone the ones they risk developing in the future. But the need to do so is critical; because while 26 million Americans have diabetes, nearly 80 million have pre-diabetes.

Surprisingly, a model community asset with a large national foot-print is available to help: the YMCA. If you're like me, you probably view the Y as a place to work out in the gym, or swim in the pool, or in my case, develop a healthy fear of the water. But as Neil Nicoll, CEO of the Y, told me recently, the Y has changed its long-term strategy to one of community health and wellness. What an asset for our patients!

We need help in promoting simple but proven disease prevention strategies such as exercise and dietary improvement. And by linking this help to physicians' offices, we accomplish two major things. First, we gain a needed ally in supporting our treatment plans. Second, individuals at risk who do not have a physician, now have a community resource that can establish one if we shape this correctly. A win-win.

The AMA has a new pilot program, now active, focused on increasing physician referrals of people with pre-diabetes to local YMCA Diabetes Prevention Program sites in three cities. Our pilot will establish a communication channels between clinical practices and these sites.

The Y Program is based on the CDC's successfully piloted, evidence-based National Diabetes Prevention Program. Initial experience has shown this program can reduce the number of new cases of type 2 diabetes by 58 percent among adults, and 71 percent in adults over the age of 60. 71 percent!!

Our first step is working with physician practices and Ys in our pilot sites in Indianapolis, Minneapolis and Wilmington. Our joint work is under an innovation grant from CMS, thus qualifying seniors who have pre-diabetes can participate in this program at no cost. Preliminary conversations with private payers show potential to broaden the payer base.

As we learn from these pilot sites, we will expand our efforts to engage more physicians and Ys in other communities. Our novel approach is attracting attention from the likes of CDC and is a new way of thinking about the physician's link to the community. This is critical.

Over the last quarter century, we have converted acute disease to chronic manageable disease; we did so with heart disease and stroke, and it appears we will do the same with cancer in the coming decade. But converting disease from acute to chronic compels us to identify community resources and link these to physician practices. Public

Health is underfunded and we need to find new sites like the Ys that offer huge national footprints and sustainable business plans to add a new and more fiscally stable public health strategy, by pulling in private sector elements.

Likewise, we are dealing with the problem of cardiovascular disease. Our initial efforts are focused on the common precursor: hypertension. Today there are 30 million patients who have high blood pressure and a source of healthcare, and yet still suffer from unmanaged hypertension.

The AMA has recently created a partnership with The Armstrong Institute at Johns Hopkins in this effort. During a year-long pilot phase, launched just recently, we're partnering with physician practices in Chicago and Baltimore to develop a set of evidence-based recommendations. We're also exploring how to engage community resources to help control blood pressure, using the same logic I outlined just a while ago.

Our work is very consistent with the highly regarded Million Hearts initiative and in fact Million Hearts has indicated that it is willing to work with us to spread our findings. We'll refine these programs based on our initial findings, and then expand them in practices just as in our diabetes work.

Finally, let me update you on our work to accelerate change in medical education. As you know, the AMA awarded \$11 million dollars in grants to 11 medical schools across the country this past June to enhance how we train the next generation of physicians. Just last month, these 11 schools returned to Chicago for the first meeting of our Consortium. Joining our grant recipients were other medical education leaders, including representatives from groups such as AAMC and ACGME

The Consortium meeting was followed by a two-day AMA Medical Education Conference. It was inspiring to see leaders from diverse schools coming together—each with their own slice of innovation, and each committed to working together to craft the essential components of the Medical School of the Future.

Let me highlight some of the themes.

Two consortium schools, Indiana and NYU, are using new technologies to create virtual patients and medical records from actual de-identified cases. Such new innovation offer advanced teaching tools to enhance clinical decision-making. Meanwhile, other schools are testing new models of earlier clinical immersion and more realistic outpatient exposures. Both Penn State and Vanderbilt have innovative and complementary approaches in this area.

East Carolina is planning new core curriculum in patient safety, while the University of California, San Francisco, aims to evaluate students based on their progress on quality improvement and team-based care. Michigan is creating a program that shapes training uniquely to each individual student.

All the schools are adopting competency-based assessments, offering faster-moving students the opportunity to graduate in less than the traditional four years.

Lastly, within this consortium, three schools, Brown, UC Davis and East Carolina, will work together to explore different innovative angles in education focused on health disparities and underserved populations.

These are all innovative ideas, but more powerful than any one is the consortium itself bringing together several divergent innovations into one view, one construct, that construct being the medical school of the future. Our AMA is driving this once in a century structural transformation.

As you can see, we are making significant progress on all fronts. This important work, built upon the policies of this House, not only provides a pathway for improving outcomes for patients, physicians, and medical students, but importantly, it strengthens the platform from which we launch our critically important advocacy and policy efforts.

Our work is just beginning, but already we have an exciting story to share. And I do so every chance I get, with individuals as well as large groups. For example, I recently found myself sitting next to a physician on an airplane. Like many physicians, he had a compellingly unique story. After doing his medical training here in the states, he worked for several years in a remote African village. After returning home, he decided to earn his divinity degree. He now serves as both physician AND pastor to a small community in the Pacific Northwest. What a commitment to community; talk about 24/7!

Well, I began speaking with him started to share the AMA's work in some detail, but he politely interrupted and said, "But listen, can you tell me what the AMA's new work means to someone like me."

Here's how I answered: "For more than 165 years the AMA has been focused on protecting and enhancing the physician-patient relationship. Let's consider the components of that. Patients want us to protect that relationship because they value their health; they want good health outcomes. Physicians obviously want us to protect that relationship, but it can only be protected if it occurs in a practice environment that is sustainable and satisfies their desire to provide quality care. And society needs us to protect that relationship by ensuring future physicians are optimally trained for the healthcare systems of tomorrow.

In a nutshell, I said that is what we are doing, improving health outcomes, enhancing physician satisfaction, and training the next generation of physicians to meet the demands of tomorrow. After I said that, he looked at me, thought for a bit then replied, "Well I didn't know all of that, but I'm a little isolated. It makes sense to me. It sounds important and like the right thing. You know, how can I join the AMA?"

I told him. But in retrospect, I should have given him a big hug.

REPORT OF THE AMPAC BOARD OF DIRECTORS: The following report was submitted by John W. Poole, MD, Chair of AMPAC:

It is my privilege to present this report of the AMPAC Board of Directors to the members of the AMA House of Delegates. AMPAC continues its proud tradition of more than 50 years representing organized medicine's political interests. Looking ahead to 2014, AMPAC is again ready to work together with state medical political action committees to elect federal officeholders who are supportive of the critical issues that matter to patients and physicians alike.

AMPAC Membership Fundraising

AMPAC is having an exceptional year with its fundraising efforts and is off to an impressive start for 2013. So far this cycle, AMPAC has raised \$1,277,154.11 in total, consisting of \$1,015,422.03 in hard funds and \$261,732.08 in soft funds. AMPAC is currently outperforming its fundraising from the start of the 2012 election cycle and has continued the trend of raising more hard dollars from members with receipts up by 13 percent.

Capitol Club participation continues to be a tremendous source of strength for direct AMPAC receipts. Through November, there are 829 Capitol Club members, surpassing 2012's year-end total of 741 Capitol Club members and we are on track to exceed AMPAC's all-time record of 833 members that was set back in 2008. AMPAC's Capitol Club Platinum currently has 60 members, surpassing last year's 42 Platinum members. Capitol Club Gold currently has 274 members and Capitol Club Silver has 495 members.

House of Delegates participation as AMPAC members is currently at 62 percent. Only 38 percent of members are participating at the Capitol Club level including 19 Platinum members, 77 Gold members and 87 Silver members. I know we can do better. As your colleague and a \$5,000 contributor to AMPAC, I strongly encourage you to stop by the AMPAC booth and contribute. It is one of the most important investments you can make in your profession. Ask yourself, how many thousands of dollars in tuition, years of school and training and long hours have you invested to become a physician? Now, ask yourself: Is it worth making a contribution to support a group that is dedicated to fighting for the future of my profession? I hope that like me, you will answer YES!

AMPAC is hosting its annual Capitol Club luncheon on Monday, November 18, and all current Capitol Club Platinum, Gold and Silver contributors have been invited to attend with Congressman Kevin Brady as our special guest. Congressman Brady represents the 8th District of Texas and serves as Chairman of the influential Ways and Means Subcommittee on Health. Chairman Brady will give us his perspective on key legislative items surrounding medicine today and efforts in Congress to address the flawed SGR reimbursement system.

Additionally, AMPAC is raffling off a trip for two to Napa Valley, California in September 2014. The lucky winner of AMPAC's "Napa Valley Fall Harvest Getaway" will be drawn during the Capitol Club luncheon on Monday and all current 2013 Platinum, Gold and Silver contributors are automatically entered into a drawing for the

sweepstakes. The lucky winner and a guest will enjoy accommodations for 4 days and 3 nights at the luxurious Meadowood Napa Valley Resort located in St. Helena, California. Meadowood offers golf, tennis, croquet, hiking, swimming, spa, wine education and a Michelin three-star restaurant dining experience all on a private 250-acre estate.

Political Action

While it is still early in the 2014 election cycle, AMPAC has seized on early opportunities to strategically give to key lawmakers. Working in concert with state medical society PACs, AMPAC has so far contributed a total of \$154,450 to Republican and Democratic legislators in leadership positions or on key committees in the US House and Senate. A select number of bipartisan leadership PACs have also received contributions. These early contributions have been extremely helpful in creating opportunities both in DC and in select states to meet with targeted members of Congress. Positioning physicians and other AMA advocates to take part in these meetings and events is serving to strengthen key relationships and further amplify medicine's voice on the Hill.

As Congress debates how to address Medicare's broken SGR formula as well as other important physicians' issues, AMPAC will be watching closely and stand ready to demonstrate strong support for those emerging as champions for medicine's agenda. The near-term actions of Congress in addition to continued feedback and consultation with the states will have the AMPAC Board well-prepared for the election cycle and help shape the strategy for contributions and other political activities for the remainder of the year.

Political Education Programs

Sixty-two physicians and Federation staff attended the September 19–20 AMPAC Federation Meeting in Washington, DC. This annual meeting provides an opportunity for state PAC leaders to come together and share ideas for effective political action. The meeting has also provided opportunities for state leaders to lobby their Congressional delegations. This year, meeting participants scheduled over 100 meetings with Congressional offices to push for a final full repeal of the SGR.

In 2014, AMPAC will once again host the Candidate Workshop and Campaign School to help AMA members become more effective advocates for medicine as both candidates and skilled campaign volunteers. The Candidate Workshop, to be held February 14–16, is ideal for those considering a run for public office. The Campaign School, to be held April 2–6, is an intensive hands-on seminar that trains participants as campaign experts. Both programs will be held in the Washington, DC area. Enrollment is open to AMA members, their spouses and immediate family members, and Federation staff. AMPAC, through its Political Education Fund, covers lodging, meals, tuition and course materials, a significant benefit to AMA members. Brochures are available at the AMPAC booth.

Building upon successful 2013 sessions in Colorado and New York, AMPAC is pleased to announce that six states thus far have agreed to co-host regional campaign and grassroots seminars in 2014: Kentucky, Nevada, New York, North Carolina, Ohio and Oregon. The seminars are designed to provide training in political campaigns and grassroots lobbying, so that physicians and friends of medicine can help advance medicine's agenda at all levels of government. Costs and responsibilities are shared by AMPAC and the state society.

Conclusion

On behalf of the AMPAC Board of Directors, I want to thank those of you who support AMPAC in ensuring physicians have a strong, powerful voice in the political process across the country. For those of you who are not yet members, I encourage you to join for 2014. Remember that 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 MEMBERS OF THE HOUSE OF DELEGATES AND MEDICAL EXECUTIVES

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Richard T. Bell, MD
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Michael Migliori, MD

South Carolina

John P. Evans, MD

Texas

Carolyn Evans, MD
Bruce Malone, MD

American Academy of Family Physicians

Glen Stream, MD
Herbert F. Young, MD

American Academy of Psychiatry and the Law

Howard Zonana, MD

American Psychiatric Association

Eugene Cassel, JD
James (Jay) H. Scully, Jr, MD

Association of Military Surgeons of the United States

Major General Byron Hepburn, MD

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