AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

163rd ANNUAL MEETING
CHICAGO, ILLINOIS
June 7–11, 2014

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 163rd Annual Meeting at 2 p.m. on Saturday, June 7, in the Grand Ballroom of the Hyatt Regency Chicago, Andrew W. Gurman, MD, Speaker of the House of Delegates, presiding. The Sunday, June 8, Monday, June 9, Tuesday, June 10, and Wednesday, June 11, sessions also convened in the Grand Ballroom. The meeting adjourned Wednesday morning.

INVOCATION: The following invocation was delivered by Speaker Gurman:

Last year I had the privilege of doing an invocation at Dr. Hoven's inauguration, and I talked to you about the ancient yearning for healing. We talked about images on cave walls. There is only one prayer in the Old Testament in Hebrew. It's "El na rafa na la," "God, please heal her," when Moses is asking for his sister Miriam to be healed.

> So we, as the guardians of this profession, are the custodians of that very human longing and need. So it is my hope and prayer that we keep that in mind and that we have the guidance and the wisdom of those who came before us as we enter our deliberations. The Aaronite benediction is, "May the Lord bless you and keep you, may the Lord lift his countenance upon you, and may the Lord grant you peace."

That is my prayer for you today.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Martin D. Trichtinger, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, June 7, 475 out of 527 delegates (90.1%) had been accredited, thus constituting a quorum; on Sunday, June 8, 492 delegates (93.4%) were present; on Monday, June 9, 514 (97.5%) were present at the start of the session and 515 (97.4%) out of 529 were present at the conclusion of the session; on Tuesday, June 10, 519 (98.1%) were present; and on Wednesday, June 11, 516 (97.5%) were present.

> Note: On Monday afternoon, the House admitted the American Society of Metabolic and Bariatric Surgery and the International Society for the Advancement of Spine Surgery, increasing the number of delegate slots by two during the session.

RULES REPORT - Saturday, June 7

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. Nominations and Elections

   The House will receive nominations for President-Elect, Speaker, Vice Speaker, Trustees and Council Members on Saturday afternoon, June 7. Speeches will be limited to candidates for officers, with no seconding speeches permitted. The order will be selected by lottery.

   The Association's 2014 annual election balloting shall be held Tuesday, June 10, as specified in the Bylaws, and the following procedures shall be adopted:

   Accredited Delegates may vote any time between 7:30 a.m. and 8:45 a.m. by reporting to the polls in Columbus K-L of the Hyatt Regency Chicago. The Committee on Rules and Credentials will certify each delegate and give him/her an "authority to vote" slip. The slip will then be handed to an election teller, who will provide the voter with a ballot and provide assistance as necessary.

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

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

8. Conflict of Interest

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

9. Conduct of Business by the House of Delegates

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

SUPPLEMENTARY REPORT – Sunday, June 8

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS

LATE RESOLUTIONS 1001 (233) AND 1003 (523) ACCEPTED AND ASSIGNED TO REFERENCE COMMITTEES AS INDICATED

LATE RESOLUTION 1002 NOT ACCEPTED

EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 116, 119, 121, 122, 123, 128, 214, 216, 221, 402, 404, 405, 406, 407, 417, 418, 419, 720, 722, 726, 728, 729 AND 731

(1) LATE RESOLUTIONS

The Committee on Rules and Credentials met Saturday, June 7, 2014, to discuss Late Resolutions 1001, 1002 and 1003. Sponsors of late resolutions that are received prior to a week before the opening of the House of Delegates are informed of the time the Committee on Rules and Credentials meets to consider late resolutions, and are 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. The sponsors of Late Resolutions 1001, 1002 and 1003 appeared to discuss their resolutions.

Recommended for acceptance:

Late 1001 – Immediate Resolution of Veterans Administration Waiting Lists for Veteran Access to Care
Late 1003 – President's Council on Science and Technology Report

Recommended not be accepted:

Late 1002 –Including Penile Prosthetics as Part of the Essential Benefits Plan

(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):

1. Resolution 116 - Site of Service Differential
2. Resolution 119 - Counter Efforts by Insurance Companies to Drop Physicians from Plans
3. Resolution 121 - Multiple Mail-Order Prescription Co-Pays
4. Resolution 122 - Fairness in Pharmaceutical Pricing
5. Resolution 123 - Attestation Statement
6. Resolution 128 - Insurance Coverage for Interpreter Services for Hearing Impaired Patients
7. Resolution 214 - Regulation and Taxation of Ammunition
8. Resolution 216 - Increasing the Current J-1 Visa Waiver Allotment
9. Resolution 221 - The Continued Funding of the Children's Health Insurance Program (CHIP)
10. Resolution 402 - Limiting Access to Tobacco Products
11. Resolution 404 - Prevention of Mosquito Transmitted Diseases
12. Resolution 405 - Elimination of Tobacco Products Sold by National Retailers
13. Resolution 406 - Air Pollution
14. Resolution 407 - Toxic Mercury in the Water Supply
15. Resolution 417 - Nutrition Literacy and Improving Outcomes
16. Resolution 418 - Condom Use in Films

17. Resolution 419 - Raising the Purchase Age of All Tobacco Products
18. Resolution 720 - Compensation for Prior Authorization Efforts
19. Resolution 722 - EHR in Post-Acute and Long-Term Care Settings
20. Resolution 726 - Internet Review of Physicians
21. Resolution 728 - Development of a Transparent and Fair Payment Process for ERISA Plans
22. Resolution 729 - Exemption Criteria for Electronic Health Record Adoption and Cloud- Based Electronic Health Record Packages
23. Resolution 731 - Requirement for Medical Insurance Companies to Provide Online Real-Time Insurance Claim Adjustment

APPENDIX

1. Resolution 116 - Site of Service Differential
   H-330.925 Appropriate Payment Level Differences by Place and Type of Service
   D-330.997 Appropriate Payment Level Differences by Place and Type of Service
   H-240.979 Intrusion by Hospitals into the Private Practice of Medicine

2. Resolution 119 - Counter Efforts by Insurance Companies to Drop Physicians from Plans
   H-285.991 Qualifications and Credentialing of Physicians Involved in Managed Care
   D-285.972 Tiered, Narrow, or Restricted Physician Networks

3. Resolution 121 - Multiple Mail-Order Prescription Co-Pays
   H-120.962 National Mail Order Pharmacy Practices

4. Resolution 122 - Fairness in Pharmaceutical Pricing
   D-110.993 Reducing Prescription Drug Prices
   H-285.965 Managed Care Cost Containment Involving Prescription Drugs
   D-330.933 Restoring High Quality Care to the Medicare Part D Prescription Drug Program

5. Resolution 123 - Attestation Statement
   H-160.907 Hospital Inpatient Admission Order and Certification
   D-160.932 Medicare's Two-Midnight Rule

6. Resolution 128 - Insurance Coverage for Interpreter Services for Hearing Impaired Patients
   D-160.992 Appropriate Reimbursement for Language Interpretive Services
   D-90.999 Interpreters For Physician Visits
   H-385.928 Patient Interpreters

7. Resolution 214 - Regulation and Taxation of Ammunition
   H-145.985 Ban on Handguns and Automatic Repeating Weapons

8. Resolution 216 - Increasing the Current J-1 Visa Waiver Allotment
   D-255.985 Conrad 30 - J-1 Visa Waivers
   D-255.993 J-1 Visas and Waivers
   D-200.980 Effectiveness of Strategies to Promote Physician Practice in Underserved Areas
   D-310.992 Limits on Training Opportunities for J-1 Residents
   AMA letter supporting S. 616, the "Conrad State 30 and Physician Access Act;" March 22, 2013.
   AMA letter supporting H.R. 2131, the "SKILLS Visa Act;" June 7, 2013
   AMA letter supporting S. 1979, the "Conrad State 30 Improvement Act;" January 3, 2012.

9. Resolution 221 - The Continued Funding of the Children's Health Insurance Program (CHIP)
   D-290.982 State Children's Health Insurance Program Reauthorization (SCHIP)
   D-290.985 Protecting Children, Adolescents and Young Adults in Medicaid and the State Children's Health Insurance (SCHIP) Program
   H-290.971 Expanding Enrollment for the State Children's Health Insurance Program (SCHIP)
   H-290.969 Medicaid Waivers and Maintenance of Effort Requirements

10. Resolution 402 - Limiting Access to Tobacco Products
    H-495.986 Tobacco Product Sales and Distribution

11. Resolution 404 - Prevention of Mosquito Transmitted Diseases
    H-135.938 Global Climate Change and Human Health

12. Resolution 405 - Elimination of Tobacco Products Sold by National Retailers
    H-495.986 Tobacco Product Sales and Distribution

13. Resolution 406 - Air Pollution
    D-135.996 Reducing Sources of Diesel Exhaust
    H-135.998 AMA Position on Air Pollution
    H-135.991 Clean Air
    D-135.985 Air Pollution and Public Health
    H-135.984 Federal Clean Air Legislation

14. Resolution 407 - Toxic Mercury in the Water Supply
    D-135.992 Mercury Pollution

15. Resolution 417 - Nutrition Literacy and Improving Outcomes
    H-150.937 Improvements to Supplemental Nutrition Programs
    D-150.975 Eligibility of Sugar-Sweetened Beverages for SNAP
    D-150.983 Food Stamp Incentive Program

16. Resolution 418 - Condom Use in Films
    H-365.978 Adult Film Industry Worker Safety and Health

17. Resolution 419 - Raising the Purchase Age of All Tobacco Products
    H-495.984 Tobacco Advertising and Media
    H-495.986 Tobacco Product Sales and Distribution

18. Resolution 720 - Compensation for Prior Authorization Efforts
    H-320.944 Standardized Prior Authorization Forms
    D-190.974 Administrative Simplification in the Physician Practice

19. Resolution 722 - EHR in Post-Acute and Long-Term Care Settings
    D-478.996 Information Technology Standards and Costs
    D-478.995 National Health Information Technology
    D-478.994 Health Information Technology

20. Resolution 726 - Internet Review of Physicians
    D-478.980 Anonymous Cyberspace Evaluations of Physicians

21. Resolution 728 - Development of a Transparent and Fair Payment Process for ERISA Plans
    D-385.984 ERISA Preemption and State Prompt Pay Laws
    D-385.973 ERISA Plans and the United States Department of Labor
    H-185.975 Requiring Third Party Reimbursement Methodology be Published for Physicians

22. Resolution 729 - Exemption Criteria for Electronic Health Record Adoption and Cloud-Based Electronic Health Record Packages
    H-478.993 Implementing Electronic Medical Records
    D-478.982 Redefine “Meaningful Use” of Electronic Health Records
    D-478.996 Information Technology Standards and Costs
    D-478.995 National Health Information Technology
    D-478.994 Health Information Technology
    In addition, AMA’s advocacy with the Centers for Medicare and Medicaid Services regarding the Meaningful Use program continues to emphasize the need for changes to the program to help physicians avoid financial penalties and burdens that jeopardize patient care. (May 8, 2014 letter to Marilyn Tavenner)

23. Resolution 731 - Requirement for Medical Insurance Companies to Provide Online Real-Time Insurance Claim Adjustment
    D-185.999 Information Included On Health Insurance Identification Cards

CLOSING REPORT – Wednesday, June 11

HOUSE ACTION: ADOPTED

Your Committee on Rules and Credentials wishes to commend the Speaker, Doctor Gurman, and the Vice Speaker, Doctor Bailey, for the outstanding manner in which they have assisted our deliberations by their fair and impartial

conduct of the House of Delegates and to commend the members of the House for their cooperation in expediting the business before us.

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

Whereas, The Annual Meeting of the House of Delegates of the American Medical Association has been convened in Chicago, Illinois during the period of June 7-11; and

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

Whereas, The City of Chicago has extended to the members attending this meeting the utmost hospitality and friendliness; therefore be it

RESOLVED, That expressions of deep appreciation be made to the AMA Board of Trustees for arranging this meeting, to the management of the Hyatt Regency Chicago, to the City of Chicago, to the members of the Alliance who always contribute so substantially to our meetings, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Annual Meeting of the House of Delegates.

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

APPROVAL OF MINUTES: The Proceedings of the 67th Interim Meeting of the House of Delegates, held in National Harbor, Maryland, Nov. 16–19, 2013, were approved.

ADDRESS OF THE PRESIDENT: AMA President Ardis D. Hoven, MD, delivered the following address to the House of Delegates on Saturday, June 7.

Mister Speaker, members of the Board of Trustees, delegates, and friends. It is an honor to address this house for the last time as your president.

Truth be told, it's also a bit surreal. It seems like just yesterday I was being sworn in. So needless to say, I've done some reflecting in recent weeks. I have reflected on the accomplishments of the AMA over the past year. I have reflected on the challenges ahead. And I have reflected on my personal experiences as president and how those experiences fit into my larger goals as a physician.

In the course of these reflections I found myself thinking back to my childhood and a conversation I had with my father one day. I was about seven or eight years old at the time. We were sitting at the kitchen table eating supper when I proudly announced that I wanted to be a doctor. Not just any doctor. A missionary doctor. In Africa.

My father was a minister, and my favorite church services growing up were the ones that featured visiting missionaries–doctors and nurses who had worked in various African nations. I was fascinated by their stories, how they were able to save countless lives using only the most basic equipment and medications.

But when I proclaimed my intentions to my father his answer surprised me. He said, "Ardis, you can be a missionary doctor. But you don't need to go to Africa. There are too many mission fields at home you need to attend to first." As you know, my father's words proved prophetic. I found my mission right there in my own backyard in Kentucky. Fighting for patients with HIV. Fighting against discrimination. And fighting for the rights of the uninsured.

All these years later, as I think about the AMA and why we are all here today, I can't help but turn to my father's words once again. We are here today because we have a mission: to create a better, healthier future for the people of this great nation.

During the past year the AMA has worked hard to achieve that mission. And we have had many successes. As the government continued to roll out the Affordable Care Act, the AMA was there, addressing gaps and finding solutions to meet the needs of patients and physicians. We created six model bills to help state medical societies navigate health insurance exchanges, to ensure that the 8 million patients who have signed up receive true, meaningful access to care, not just an insurance card. And that physicians are not faced with unfair contracts or increased administrative burdens. Washington state has already enacted a law based on these bills. And three other states are working to do so.

The AMA also made significant progress on our strategic plan. Our Rand Report on physician satisfaction is shifting the conversation on delivery reform, highlighting the bureaucracy and red tape that stand between physicians and patients. Today we are working hard to ease those burdens – through dedicated practice tools, research and advocacy.

On the medical education front, the 11 schools in the AMA learning consortium have met twice to share findings. I've attended those meetings, and I can tell you the innovations they're working on–from individualized learning plans to population health–will enable the next generation of medical students to hit the ground running. And our efforts to reduce the toll of diabetes and cardiovascular disease continue to take shape, from partnerships with the YMCA and Johns Hopkins, to pilot programs, to our new framework for identifying and effectively managing hypertension.

The AMA also scored numerous advocacy victories, both federally and at the state level. We convinced CMS to award nearly one billion dollars in grants to fund innovations in the delivery of specialty care. We secured delays on Meaningful Use requirements of electronic medical records – increasing the prospects for physicians to earn incentives, and lowering the risk of cuts when the penalty phase kicks in. We played a leading role in the national effort to help prevent death from overdoses. We helped six states pass truth in advertising legislation – so patients understand who is, and who is not, a medical doctor. And we helped four states achieve important medical liability reforms – so physicians can spend more time focusing on the patient, and less time worrying about lawsuits.

While all these victories are important, in my mind the biggest victory of the past year is one many of you probably don't see as a victory at all: our effort to repeal the sustainable growth rate formula. Now I know what you're thinking Ardis has been traveling too much. She must be suffering from jet lag. I'll admit there has been a day or two of jet lag in the past year. But not today. I know many of you looked at the outcome of our SGR effort, another temporary patch, and wrote it off as a failure. But let me tell you what I saw.

I saw a House of Medicine that had been deeply divided by conflict over the Affordable Care Act, come together to fight for America's seniors.

I saw members of the SGR task force, including many of you in this room, develop a set of principles for replacing SGR, and I saw over 100 physician groups embrace those principles.

I saw an SGR repeal campaign that garnered over a million emails and 45,000 phone calls to Congress.

I saw a year of intensive advocacy culminate in bicameral, bipartisan legislation to replace SGR with a system that encourages innovation. I saw an unprecedented 600 medical organizations come together to support that legislation.

I saw politicians on both sides of the aisle–in the Senate and the House–voice their approval for the legislation. I saw them look me in the eye and tell me they would get it done. And then, a few weeks later, I saw those same politicians vote that bill down.

Colleagues, I like to think of myself as a straight shooter, and when I make a mistake, I'm the first to admit it. But when I review the facts surrounding this unprecedented opportunity to fix Medicare, I come to one conclusion: The AMA didn't fail America's physicians and America's patients. Congress failed America's physicians and America's patients.

Recall that the price tag for SGR repeal had been cut in half. Recall that the pathway for transitioning to a more effective system was there. Recall that three separate Congressional Committees devoted countless hours and countless taxpayer dollars to develop a solution. Recall that the AMA lobbied successfully for several crucial

legislative improvements, achieving a set of Medicare payment reform policies that enjoy broad support among Congress and physicians. No matter how you look at it, in the end just one thing prevented Medicare reform from passing, politics.

So where does that leave us? If organized medicine flexed its muscle and it wasn't enough to make Congress do the right thing, what is our course of action going forward? How can we make progress not just on SGR, but on the other challenges confronting our health care system?

If I've learned anything from my days fighting HIV it's that giving up is not an option. So today I want to offer you three solutions. Number one: We need to hold politicians accountable.

Picture this. A sick patient arrives in your office. You diagnose the problem. You arrive at a treatment plan. Then at the last moment, you decide not to implement it because someone, somewhere might not approve. Can you imagine how many lawyers would descend on you with medical liability suits?

We physicians are held accountable every day. It's time Congress was held accountable too. We need to let Congress know that business as usual is unacceptable. It is unacceptable for taxpayers. It is unacceptable for physicians. And most importantly, it is unacceptable for the nation's seniors.

The wonderful thing about democracy is that each of us has a vote. We have a vote in our city. We have a vote in our state. We have a vote in our country. We need to use our votes. We need to remind our elected officials that the nation's physicians and the nation's patients matter.

Number two: We need to educate. One of the biggest surprises to me during my year as president was how many organizations don't know what the AMA does. I'm talking about businesses, civic groups, even some academic institutions. The misinformation circulating around the AMA is incredible. And it's not just the AMA, but the Affordable Care Act and some of the fundamental realities of our health care system.

I can't tell you how many people think the AMA is just a trade organization fixated on pocketbook issues, who think death panels are part of the Affordable Care Act or that the reason health care costs are soaring is because doctors are charging too much.

You should see the alarm on their faces when I talk about SGR and how it spells a more than 25% cut to physician pay. How it would force many physicians to close their doors or start refusing patients. You should see how surprised they are to hear the AMA is working to reduce the toll of diabetes and cardiovascular disease, that the AMA brought national attention to the plight of the uninsured during the 2008 election cycle, that when patients and physicians were being overcharged for out-of-network services, the AMA went to court and won a $350 million dollar lawsuit on their behalf.

The more people who know about the AMA–who we are, what we are, and what we're fighting for–the stronger we will be. A moment ago I told you an unprecedented 600 organizations stood together to demand SGR repeal. Imagine if that number had been 1,200. Imagine if in addition to medical organizations, we had been joined by community associations, businesses and civic groups. Imagine a number so large it would be impossible for Congress to ignore, even during an election cycle. When we educate people, we empower them. And when we empower them, we can make a difference.

Number three: We need to be leaders in our communities. Now I may be preaching to the choir on this one, because during this past year I have been privileged to see how many of you do lead back home. Still, it bears repeating. At the end of the day, health care is local, and if we want to improve health care in this country, it starts at home.

If we want to tackle obesity, we need to collaborate with local schools and community organizations. If we want to teach the newly insured about the importance of prevention, we need to work with community health centers. If we want to explore accountable care organizations, we need to reach out to hospitals and other potential partners to talk about collaboration.

As physicians and as leaders, we need to continue to put ourselves on the front lines, whether it's caring for our patients, collaborating with community organizations, or paying a visit to our local congressional representatives to

advocate for reform. There are countless roles we can play back home as we work together to shape a better health care future. Remember: one physician can make a difference. I saw this time and time again through my travels this past year.

Now I know I've given you a lot of directives, and I can just imagine what Dr. Wah is thinking. "Gee thanks, Ardis. Any other tasks you'd like to assign before you retreat into the sunset as Immediate Past President?" And now Dr. Lazarus is rolling his eyes, "Retreat into the sunset? Was I supposed to be cycling through the mountains this past year? Didn't get that memo"

Rest assured, I hold no one more accountable to these directives than myself, and I will do everything in my power to advance them when I return to practice in Lexington. That's not to say it will be easy. With so many stakeholders involved, we are bound to encounter obstacles on our quest to improve health care. But while obstacles matter, what matters a great deal more is our reaction to them.

Over the year you've heard about some of the trials my HIV/AIDS patients faced in the early days of the epidemic. Well today I want to share a more recent story. One of my current patients is a beautiful African American woman with HIV/AIDS. For the sake of anonymity, I'll call her Sarah.

When I met Sarah in 2003 she was in a great deal of pain. She had acquired HIV from her drug-abusing husband and was suffering from a range of physical side effects due to her medications, headaches, fatigue, severe leg pain and depression. Sarah's husband had already died from the disease. She was alone, scared and losing hope. She saw no way out, nothing but pain in her future.

Fortunately, medicine's ability to treat HIV improves every day. With the right regimen of medications I was able to get Sarah's physical symptoms under control, and soon her spirits began to lift. Sarah met a man. She fell in love, got married and bought a house. Things seemed to be looking up.

But then, out of the blue, Sarah's in-laws began giving her the cold shoulder. They weren't just avoiding her, they were shunning her. Alarmed, she confronted her husband, and he revealed the ugly truth. Sarah's husband had told his family about her illness, and they reacted with utter contempt. From that day forward they spurned Sarah, refusing to even be in her company. In the end, sadly, her marriage fell apart.

Now many of us would throw in the towel at this point. A life-changing diagnosis. The death of a spouse. Divorce. But Sarah is stronger than that. Instead of succumbing to depression she grew determined to fight. She went out into the community and began speaking about prevention and treatment of HIV. She shared her personal experiences with anyone and everyone who would listen. She addressed not only the physical but also the social implications of the disease. Today she is a prominent spokesperson in the fight against HIV/AIDS and an inspiration to everyone she meets.

During this tumultuous period of change for America's health care system, I believe we too can draw inspiration from Sarah's story. When we encounter setbacks, we can regroup and fight back. When we encounter obstacles, we can find new ways to overcome them. Instead of retreating, we can hold politicians accountable for their actions. Instead of falling back, we can engage the public in the fight for reform. Instead of giving in, we can take matters into our own hands, leading by example in communities across the nation.

It is no small thing to be tasked with improving America's health care system. But then it is no small thing to stand over a critically ill man or woman and find a way to save them. As physicians, achieving the impossible is something we are called to do every day. And on this day, in this hour, our mission is clear: to create a better, healthier future for this great nation.

A year ago I stood before you and said that organized medicine stood at a crossroads. Ahead of us were two paths. One was the path of glorifying the past, lamenting the changing health care environment and thwarting any attempt to move forward. The other was the path of action, of collaborating, innovating and leading the drive toward productive change.

I am happy to say the AMA took the second path. It has been my honor to walk that path alongside you as your president this past year, and it will be my honor to continue walking alongside you in the weeks, months and years ahead.

Thank you.

COMMENTS FROM THE CHAIR OF THE AMPAC BOARD: The following comments were offered by John W. Poole, MD, on Saturday, June 7.

Good afternoon. My name is John Poole, and I'm back to ask for money. I'm back to ask you to invest in AMPAC, but actually what I'm here today is to actually show you a way that you can prove that you're a leader in the House of Medicine.

At AMPAC, our message is simple. If you're in medicine, you're in politics, whether you like it or not, especially now. You know, I acknowledge there has never been a more frustrating time to practice medicine, whether you're in private practice, whether you're employed or whether you're in academics.

There has certainly never been a more challenging time to be involved in medical advocacy. We were deeply disappointed that despite our advocacy efforts and along with the support of over 600 specialty societies and state delegations, as well as bipartisan and bicameral support in the House–in Congress, that Congress failed to enact permanent SGR repeal.

So what are we going to do now? Are we going to give up? So we are the leaders of the House of Medicine. We don't have that option. Our colleagues back home, they're high water mark of political action is to sit in the cafeteria and to complain. But as the leaders of the House of Medicine, we don't have that option.

To paraphrase General Eisenhower 70 years ago today, 70 years ago addressing the troops prior to the invasion of Normandy, to take the eyes of the country. The eyes of the patients and the country are upon us. Sorry, the eyes of country's doctors and patients are upon us.

So why is the Chair of AMPAC standing on front of you today in a running suit? Let me explain. Like some in this house, I have run in several marathons, and I think training for a marathon and participating in political advocacy share some common things, particularly when it comes to achieving our goal.

So let me explain. These are pools, principles for participating in patient-centered politics. How is that for a literation? But not bad for a noncognitive specialist.

The first step to run a marathon is, you actually have to enter the race. So the first step in participating in political action, you actually have to join AMPAC. You actually have to participate in AMPAC. Like it or not, the success of our message is ultimately related to the most delivered and the amount of money raised. Right now, only 49 percent of the delegates of this House, the leaders of medicine, are members of AMPAC. That's embarrassing. We need to do better. I know we can do a lot better.

The next step to run and finish a marathon, is you have to train. You actually have to train and nobody else can do that for you. That's time consuming. It's hard. It's painful. At a time, it's torturous, but it's a long-term commitment. Likewise, for political advocacy, you need to establish an ongoing relationship with your elected member of Congress. That also can be hard, painful and at times torturous, but it's required. It's time consuming. No one else can do it for you. It means more than writing one check to AMPAC. It means more than showing up in D.C. one time a year. Otherwise, when you go to D.C.–if your idea of political advocacy is an afterthought when we show up for our ask, we are going to have as much success with that elective representative as you would showing up at the starting line and running a marathon.

And, finally, when you run a marathon, you need to establish a realistic goal, run your race and finish the race. One time when I was running in the New York City marathon, I was at the halfway point and people were holding up signs about who won. But I still kept going. I had 13 miles to go. But I finished (laughter), and I got close to the time I was running for, and there was no delusion that I was going to win the race.

So are we going to get the prefect bill passed in Congress? Considering the dysfunction in Congress right now, you don't need me to give you the answer. But the policy that we debate and pass in this House is the best thing that can happen for the health of our patients.

So let me repeat that: The policy that we debate and pass in this House is the best thing that can happen for the health of our patients. So let's not let the present paralysis in Washington divide us. Let's not make it allow us to take for granted the freedoms that others have sacrificed so valiantly for on our behalf.

You know, the Bill of Rights guarantees us the right to petition Congress for redress of our grievances, and our grievances are many. Whether you believe it or not, AMPAC can help you exercise your constitutional right and help protect your patients, practice and profession.

Now, many in this House are going to grumble that we worked hard and it's not fair that Congress isn't listening to us. I agree. But, you know, when I am running a marathon and I'm looking at it, this is a marathon, it's not a sprint. And when I run a marathon, when you hit the wall at mile 20 with SGR fatigue and I'm ready to give up, I remembered that there's other people in the race, trial lawyers, big pharma, hospitals, insurance companies, nurses, and they all don't share medicine's views, but they're running the race and they always don't get what they want from Congress, but they keep on running.

So at that time do I quit when I feel like giving up? No, I keep on running. I keep moving forward, hopefully running, sometimes limping, but I keep moving forward. And one final thought along those lines, is that by mile 20 or so, if your form isn't perfectly to move forward, if you're wasting any energy moving to the side, your arms are swinging too much, your foot isn't landing right, you're going to be in big trouble.

The same thing, if the House of Medicine isn't completely united, if we're not moving forward together, we are going to be in big trouble. So for those of you that have joined AMPAC and are running the race with us, I want to thank you. For those of you that have yet to join AMPAC, this is your opportunity to prove you're a leader. This is your opportunity to take back your profession. We have a booth right outside. It's only a hundred dollars. I would certainly hope that everybody, though, in this House would join at the Capitol Club level.

I'd like to thank you for the privilege of addressing this House on such an important topic. I am going to close with the worst pun ever. And I promise you if I raise enough money, I will never mention it again. I have a lot more to say, but I got to run.

Thank you.

REMARKS OF THE EXECUTIVE VICE PRESIDENT: The following remarks were presented by James L. Madara, MD, Executive Vice President of the American Medical Association, on Saturday, June 7.

Mister Speaker, Madam President, members of the Board, delegates, guests: It’s been three years since I was introduced to this House by then Chair, now outgoing President, Ardis Hoven. I’m grateful that your search committee recommended me for this position. It’s a great privilege to serve our mission of “promoting the art and science of medicine and the betterment of public health.”

Working with a talented management team, supported by outstanding staff, under the oversight of our committed Board, and based on the policies of this House, together we have created a strategic vision that aligns squarely with a vital, core tenet that has served as the AMA’s “True North” for 167 years: That core tenet is the physician-patient relationship.

Think about it. The vital work done here and across the AMA has had a common and indisputable feature: enabling, enhancing and protecting this sacred physician-patient relationship. We celebrated this relationship again last night during our special “Inspirations in Medicine” event. I hope many of you had a chance to attend, and this relationship continues to be a focal point as we advance our strategic plan. Today, I will target most of our time toward discussing how we can best achieve success in advancing this important agenda. I want to talk about one of the most important assets we have: our collective voice.

But first a quick update on the progress we are making in our strategic plan. Our work toward improving health outcomes, focusing on the areas of pre-diabetes and poorly controlled hypertension is well underway. Our collaboration with the YMCA to prevent type 2 diabetes is progressing. Currently we are working with physician practices in the state of Delaware, and the cities of Indianapolis, and Minneapolis/St. Paul to connect patients with prediabetes to a proven Diabetes Prevention Program. We are also engaging public and private insurers to collaborate on strategies for expanded coverage of the CDC's National Diabetes Prevention Program.

Meanwhile, our collaboration with Johns Hopkins to help prevent cardiovascular disease by improving hypertension control continues to move forward. We are working with physicians and care teams at 10 diverse clinical sites in Illinois and Maryland, to develop and test a framework for achieving optimal hypertension control. We will take what we learn from these pilot clinical sites, including how to work with community partners, and spread effective models to more practice settings and communities.

Our work to accelerate change in medical education continues to gain momentum as well. Our 11 grant recipient schools are working together to implement innovative curricula to better prepare the next generation of physicians. These curricula focus on key areas and disciplines that are important cornerstones for the future of care delivery and include, for example, chronic health management, population health, team-based care and the improvement of health technologies. Just two months ago, the 11 consortium schools assembled at the University of Michigan to share their progress and to map out joint innovations going forward. Michigan's Dean, Jim Woolliscroft, was a wonderful host and expressed how honored Michigan is to be working with the AMA.

I'll provide a more detailed progress report on both our improving health outcomes and medical education initiatives at the upcoming Interim Meeting. But as I indicated today I want to concentrate on a different topic, one that connects directly with our work to enhance physician satisfaction and practice sustainability; and that is increasing and leveraging the full potential of our physician voice.

Let me start with a personal story that speaks to the power of that voice. My story, and an underlying reason I became interested in medicine, began on the school playground in my small hometown in the Appalachians of central Pennsylvania. I was playing basketball with some of the other sixth graders and saw an opening for what I imagined would be a spectacular layup. I ran full speed, tripped and ended up flinging myself head-first into the iron pole holding the backboard.

Yeah I know what many of you are thinking: not surprising, sounds like something Jim might do. That night, around 3 a.m., I developed a terrible headache. My mother came and was dismayed to see the exophthalmos of my left eye. I was admitted to the local hospital, then quickly transferred to Pennsylvania Hospital in Philadelphia. Diagnosis: cavernous sinus thrombosis. I remained hospitalized in Philadelphia for about two months, the first few weeks isolated and the remainder in an open children's ward.

What is still a fresh recollection from that time is my physician; his name was Dr. Edward Speath. Each morning Dr. Speath visited me with an entourage of young physicians. Even now I vividly recall, as he examined my retina, the deep spicy smell of his aftershave comingled with the odor of coffee on his breath. Dr. Speath took the time to chat. He asked how I was doing. He answered my questions. He even suggested I develop a jump shot and stay away from the layups (he meant this as a joke, but as an 11 year old I took this as serious, serious advice). Dr. Speath put me at ease. In his hands, I knew I'd be fine.

Now a story like mine isn't unique. Americans across the country have experienced their own special, memorable, life-changing moments with a physician. And you all know what I'm talking about, because you play a starring role in such moments. As physicians, we're privileged to touch our patients' lives in profound and lasting ways. We earn their trust and respect.

A 2013 Gallup poll shows that physicians are among the most trusted professionals. The public's trust in physicians is 50% greater than judges, 3½ times greater than lawyers. Physicians garner more trust from our citizens than hospitals, big pharma, or insurers. And when it comes to Congress, well I don't like running up the score on folks, but our trust rating is 8 times greater than our lawmakers on Capitol Hill. Congress by the way just narrowly loses to car salesmen.

A working paper by Alan Gerber at Yale in the Journal of Health Politics, Policy and Law, reveals that Americans view physicians as "harder working, more trustworthy, and more caring than other professions." The same study found that the public has more trust in healthcare proposals supported by physicians than those supported by either Democrats, Republicans or even bipartisan commissions.

The trust and visibility physicians have with the public, combined with the respect and influence the AMA has earned over 167 years, affords us a unique opportunity for impact. Patients trust us. They respect us. They want us to lead the way toward a better health care future. Yet, at times our voice seems to lack the power and influence that one would logically expect given these facts.

So how can we leverage this widespread status of respect more consistently and fully and realize it in our voice? I think it comes down to two key things. First, we must understand and respond to the needs of physicians who today are immersed in often chaotic environments. Doing so will help unify our physician community. Second, we must harness our collective voice – by striving for more consistency and thus more effectiveness. So how do we do these things? Let me take them in order.

First, understanding and responding to physician needs. Our environment is changing, thus physician needs are as well. We have to understand what those needs are today and what they will be tomorrow. This is a driving force behind the AMA's physician satisfaction and practice sustainability work. Simply put: the more we know about physicians – the better we can serve them. And our plan is to know the needs of physicians more precisely than anybody. Period.

Our initial collaborative work with RAND has identified common drivers of physician satisfaction and dissatisfaction, and we have begun developing practice-related resources to help physicians reduce the non-clinical demands on their time. As Dr. Chris Sinsky puts it to me: physicians want to be doctors, not typists. Initial issues we're addressing include systematic prescription renewal, pre-visit planning, expanded rooming and discharge and collaborative documentation. We are developing user-friendly resources to address such issues and will be piloting them later this fall.

Meanwhile, EHRs are one of the biggest sources of frustration. In their current form they largely hinder, rather than help, the physician-patient relationship. So the AMA is engaging vendors and regulators to help make EHRs more user-friendly and better aligned with physician practice.

Speaking of our work with RAND, it bears mentioning that since our initial report last fall, the term "physician satisfaction" and its link to improving health care delivery is gaining traction. The concept has been mentioned in more than 300 media reports related to our work. Many outside our profession are finally starting to take note that physician satisfaction is critical to healthcare.

Elsewhere, we are making business intelligence and physician insights a priority across the organization. Our newly created Physician Engagement unit is working to develop deeper insights around key physician segments to better understand their needs by variables such as demographics and mode of practice.

In addition, we're working to make our AMA Masterfile more robust and apply it in ways to benefit physicians. Many physicians say they're frustrated by how physician directory websites mischaracterize their information. The AMA is looking to develop a "best-in-class" product that will allow physicians to accurately portray their practices, providing a better resource for patients and other physicians.

Another way the AMA is gaining a better understanding of physicians is through intensive market research. We've developed deeper health analytics to better understand trends and factors affecting physician practices in the current environment, from the impact of the ACA to changing practice demographics.

We are also examining the impact on physicians of emerging new payment models, such as accountable care organizations, medical homes and bundled payments. A second national study, again in collaboration with RAND, will examine the impact of these new care models on physician practices. While these models may hold promise for increasing quality and efficiency; to what extent have physicians begun adopting them? What has been their experience? What can be done to improve these experiences? And are there some models that are just unworkable from a physician perspective and need be resisted or radically restructured?

We also want to pinpoint physician frustrations within the current environment and the mitigating steps we can take to address them. We will use these insights to develop tools and to guide our advocacy efforts to ensure that practice satisfaction and sustainability are important markers in evaluating proposed changes in healthcare.

All these efforts are aimed at increasing our knowledge of physicians and giving us the insights we need to serve them better. But gaining a better understanding of physicians' needs and forging innovative solutions to address them is just the first part of what we must do to be successful. The second piece is working to ensure our respected positioning is more fully realized by employing the power of our voice.

A strong, unified voice is one of the greatest assets we have. Our status and reputation among the public is revered and respected. However, I ask you: do we leverage this attribute fully? The potential power of our collective voice was underscored during this year's National Advocacy Conference. Those of you who attended will recall that we heard from Robert Gibbs, the former press secretary for President Obama, and Dana Perino, the press secretary under President Bush. Both offered their advice on how physicians could strengthen our voice. And while Gibbs' and Perino's political perspectives are polar opposites, their advice to us was the exactly the same.

Here's how Dana summed it up:

> Based on some things that I've heard and you've probably heard this feedback from members as well is that you're a very powerful group if you're speaking collectively with one voice about an issue that you can drive home. You might have a specialty area or you might have something that a congressman particularly likes and I think one of the things that's happened with all big groups that have members from all over the country coming that have lots of different types of practices and specialties and abilities and capabilities and talents is that sometimes it can get a little bit splintered.

The advice of these communication experts bears repeating. We're a powerful group when we speak collectively, with one voice. However, we're greatly weakened when our voice is splintered. In DC, they call that splintering: stepping on your own message, and frankly, at times our voice seems less unified than hospitals, payers and other groups.

This hurts us in both the short and the long run. It allows other interests to divide and conquer us. It's frustrating. I'm frustrated. I know you're frustrated. If my hero Dr. Speath were still with us, he'd be frustrated.

The good news is that this condition is curable. Diversity of opinion is both important and beneficial. The debates that characterize this House lead to better, more informed policies. In fact, I must confess that my first exposure to this body three years ago surprised me. After that meeting I thought to myself, "that just might have been the purist form of the open democratic process I have ever witnessed."

But once consensus is achieved, it's critical, if we want to take advantage of the natural position of power we intrinsically have, that we take that next step, an even tougher step of supporting these policies and with a single, unified voice to assure they gain traction with our colleagues, our lawmakers and the American public. I don't think I'm naïve in saying this. If we can simply shift, even marginally, toward more uniformly supporting the majority view, our voice will be so much stronger.

I'm confident that we can further bolster the power of our collective voice. Working together, we are advancing a strategic plan that invites and inspires physician unity, a plan that serves us well with the public because it reflects the power of our mission statement; a plan that guides our advocacy efforts and focuses them on the things that matter most to America's patients, medical students and physicians.

Our respected voice is a tremendous asset, one that has been hard-earned. Hard-earned not only in the 167 years of work by this House, but also in quieter conversations each of you share with your patients daily, like those Dr. Speath shared with an 11-year-old boy years ago in a Philadelphia hospital.

The potential power of our AMA voice is immense. Let's exercise that voice fully by casting a clear and unified voice for all to hear.

Thank you.

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

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities during the current election cycle. Our mission is to provide physicians with the opportunity to support candidates for election to federal office who will work to strengthen our ability to care for America's patients. In addition, we help physicians advocate for their patients and their profession through our political education programs that recruit physicians to work on a campaign or to run for office themselves. We work hand-in-hand with our state medical society PAC partners to carry out our mission.

AMPAC Membership Fundraising

AMPAC is in the middle of a busy election year and fundraising receipts continue to be robust. AMPAC has raised $2,260,370.78 in total, consisting of $1,798.067.72 in hard funds and $462,303.06 in soft funds. AMPAC continues to outperform totals from the 2012 election cycle by 12 percent. Participation in AMPAC is also steadily improving with 5,444 members compared to 4,918 in May 2012 for an 11 percent increase. Of AMPAC's hard receipts, $1,607,005.53, or 89 percent, is from AMPAC's direct fundraising programs.

AMPAC's Capitol Club is off to an impressive start with 700 members compared to 655 this same time last year. Increasing Capitol Club participation is key in strengthening the overall success of AMPAC. Capitol Club receipts are at $422,619.86 to date, a 6 percent increase compared to this point in 2013. Capitol Club participation levels are up as well with 56 Platinum members, 250 Gold members and 395 Silver members.

As a benefit of being a Capitol Club member, AMPAC is hosting its annual Capitol Club luncheon on Tuesday, June 10, at 12:00 p.m. with special guest speaker, Tucker Carlson. All current Capitol Club Platinum, Gold and Silver members have been invited to attend. Tucker Carlson is a co-host on Fox and Friends Weekend and the editor in chief of Daily Caller, one of the largest and fastest growing news sites in the country. He is a trusted voice by Washington insiders and will be discussing the political playing field of this election year.

In addition, AMPAC will be promoting an exciting international trip for two to Italy in 2015. AMPAC's "All Roads Lead to Rome" trip will include visits to Rome, Florence and Venice over the course of 7 nights. Winners will receive round-trip airfare for two to Rome, Italy, and departure from Venice, Italy. The winner will be drawn and announced during the Capitol Club luncheon at the Interim Meeting in Dallas, Texas. All current Platinum, Gold and Silver contributors are automatically entered into a drawing for the sweepstakes.

Last, as we navigate the future of medical policy and continue to drive our ideas to Members of Congress in Washington, DC together I urge you to join AMPAC. I am a firm believer in strength in numbers and as leaders of the Association our participation within the House of Delegates is too low. HOD participation is at 49 percent, with just 29 percent of members participating at the Capitol Club level. As your colleague and a Capitol Club Platinum member, I strongly encourage you to stop by the AMPAC booth and contribute; it is the most valuable investment that you can make in your profession.

Political Action

AMPAC is well on its way to ensuring medicine's political impact is felt in the 2014 Congressional midterm elections. The AMPAC Board's Congressional Review Committee has worked closely with state medical society PACs to make strategic 2014 Primary contributions to House and Senate candidates all over the country. Over half a million dollars has been spent in these races to help medicine-friendly candidates and those lawmakers in key positions to move medicine's agenda forward in Congress. In addition, AMPAC has made bipartisan contributions of $140,000 to House and Senate campaign committees and Leadership PACs.

AMPAC's investments in the 2014 cycle will continue to create opportunities to further strengthen key relationships and promote the AMA's legislative agenda. This will position physician advocates well for when Congress returns to important issues such as Medicare payment reform.

Political Education Programs

In the first half of the 2014, AMPAC has significantly increased the number of Regional Campaign and Grassroots Seminars, which are co-hosted with state societies and designed to sharpen the advocacy skills of physicians in both the legislative and political arenas. Six Seminars have been held thus far, the most AMPAC has ever held in one year:

- Oregon Medical Association: January 24, Portland (40 attendees);
- Kentucky Medical Association: February 26, Frankfort (50 attendees);
- North Carolina Medical Society: March 22, Raleigh (40 attendees);
- Ohio State Medical Association: April 4, Columbus (80 attendees);
- Medical Society of the State of New York: April 10, Tarrytown (35 attendees); and
- Nevada State Medical Association: April 25, Lake Las Vegas (30 attendees)

On Feb. 14–16, 2014, AMPAC conducted the annual Candidate Workshop in Arlington, Va. Despite a crippling Feb. 13 snowstorm that affected travel all along the east coast, 38 attendees participated, including: 24 physicians; 7 medical students; 6 physician spouses/immediate family members; and 1 Federation staffer. The attendees hailed from 19 states. On April 2-6, AMPAC held the 2014 edition of the Campaign School in Arlington, Va. Thirty-one attendees (the largest group in several years) included 20 physicians, 5 students, 4 spouses/family members, and 2 Federation staff from 22 states.

AMPAC has also announced the dates of the 2015 Political Education Programs, to train physicians and other members of the medical family who want to be more involved in political campaigns. The Candidate Workshop will be held February 20-22, and the Campaign School will be held April 15-19. Both programs will be in Arlington, VA, and AMPAC covers all costs except transportation for AMA members, a significant benefit of your AMA membership. Please stop by the AMPAC booth for more information.

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all of our members for their continued involvement in political and grassroots activities. Just as we have a responsibility to care for our patients, we also have a duty to our profession and to our patients to assure that the interests of medicine are properly represented in the halls of Congress.

RETIRING DELEGATES AND EXECUTIVES

Alabama
Richard Esham, MD
Alan Goldstein, MD

Illinois
Chris Dangles, MD
John Schneider, MD
Eldon Trame, MD
Arthur Traugott, MD

Georgia
Joseph P. Bailey, Jr, MD

Maryland
Allen D. Jensen, MD
George S. Malouf, Sr, MD

Massachusetts
Virginia T. Latham, MD

Minnesota
Blanton Bessinger, MD

Nebraska
Les Spry, MD

New Hampshire
Gary Woods, MD

Ohio
Gregor K. Emmert, Jr, MD

Texas
Vijay Koli, MD

American Academy of Disability Evaluating Physicians
Sandy Yost

American Academy of Family Physicians
Jeffrey J. Cain, MD
Fred Ridge, MD
Perry Pugno, MD

American Academy of Orthopaedic Surgeons
Richard McKay, MD

American College of Radiology
Harvey L. Neiman, MD
William R. Poller, MD

American College of Surgeons
Richard B. Reiling, MD

American Urological Association
William Gee, MD

Congress of Neurological Surgeons
Philip W. Tally, MD

Endocrine Society
Scott Hunt

Society of American Gastrointestinal Endoscopic Surgeons
John Coller, MD

REFERENCE COMMITTEE MEMBERS

Reference Committee on Amendments to Constitution and Bylaws
Lynn Parry, MD, Colorado, Chair
John P. Abenstein, MD, Minnesota*
Art L. Klawitter, MD, Texas
Vidya S. Kora, MD, Indiana*
Camran Nezhat, MD, Society of Laparoendoscopic Surgeons
Richard L. Stennes, MD, American College of Emergency Physicians
Wickii Vigneswaran, MD, International College of Surgeons, US Section*

Reference Committee A (Medical Service)
Gary L. Bryant, MD, American College of Rheumatology, Chair
John Bizon, MD, Michigan*
Steven J. Fleischman, MD, American Congress of Obstetricians and Gynecologists
Candace E. Keller, MD, American Society of Anesthesiologists
Johnathan D. Leffert, MD, American Association of Clinical Endocrinologists*
Janice Tildon-Burton, MD, Delaware*
Harsh K. Trivedi, MD, American Psychiatric Association

Reference Committee B (Legislation)
Eli Lerner, MD, Society of Gastrointestinal Endoscopic Surgeons, Chair
Mark N. Bair, MD, Utah
Hoyt Burdick, MD, West Virginia*
John N. Harrington, MD, American Society of Ophthalmic Plastic and Reconstructive Surgery
Robert R. Orford, MD, American College of Occupational and Environmental Medicine
Dina Marie Pitta, Wisconsin*, Regional Medical Student
Chris Pittman, MD, American College of Phlebology*

Reference Committee C (Medical Education)
Kesevan Kutty, MD, American College of Physicians, Chair
Sharon Douglas, MD, Mississippi
Aaron George, DO, American Academy of Family Physicians
Zachary N. Litvack, MD, Congress of Neurological Surgeons*
Cameron Paterson, Florida*, Regional Medical Student
John J. Wernert, III, MD, American Psychiatric Association*
John P. Williams, MD, Pennsylvania

Reference Committee D (Public Health)
Diana E. Ramos, MD, Minority Affairs Section, Chair
Erik A. Eiting, MD, California*
James D. Felsen, MD, West Virginia*
Lee A. Goscin, MD, Florida*
Rebecca Hierholzer, MD, Missouri
Christina Kratschmer, New York, Regional Medical Student
Robert Monger, MD, Wyoming

Reference Committee E (Science and Technology)
Jay A. Gregory, MD, Oklahoma, Chair
Peter N. Bretan, Jr., MD, California*
Thomas H. Hicks, MD, Arizona
Brent Mohr, MD, Indiana*
Barry W.Wall, MD, American Academy of Psychiatry & the Law
Gerald A. Wilson, MD, South Carolina
Theodore Zanker, MD, Connecticut

Reference Committee F (AMA Finance; AMA Governance)
Shannon P. Pryor, MD, American Academy of Otolaryngology-Head and Neck Surgery, Chair
Robert L. Dannenhoffer, MD, Oregon
Jane C. K. Fitch, MD, American Society of Anesthesiologists*
Craig L. Hensle, MD, Virginia*
Shannon M. Kilgore, MD, American Academy of Neurology
Jerry D. McLaughlin, II, MD, New Mexico
Bassam H. Nasr, MD, Michigan*

Reference Committee G (Medical Practice)
Craig A. Backs, MD, Illinois, Chair
Peter C. Amadio, MD, American Association for Hand Surgery
Thomas M. Anderson, Jr., MD, Illinois*
Dana Block-Abraham, DO, American Congress of Obstetricians and Gynecologists, Sectional Resident
Steven N. Clay, MD, Pennsylvania
Kenneth M. Louis, MD, Florida*
Stephen J. Rockower, MD, Maryland*

Committee on Rules and Credentials
Martin D. Trichtinger, MD, Pennsylvania, Chair
James Bull, MD, Illinois*
Jerome C. Cohen, MD, New York
Charles J. Hickey, MD, Ohio
Michael B. Hoover, MD, Indiana*
James A. Rish, MD, Mississippi*
Hugh Taylor, MD, American Academy of Family Physicians

Chief Teller
Melissa Garretson, MD, American Academy of Pediatrics,
Assistant tellers
- Melissa Behringer, MD, Alabama*
- Ryan Hall, MD, American Academy of Psychiatry and the Law*
- Tripti C. Kataria, American Society of Anesthesiologists*
- Raj B. Lal, MD, Illinois*
- Kenneth B. Simons, MD, Wisconsin*, Section on Medical Schools
- Janet West, MD, American Academy of Family Physicians*

Election tellers
- Sherri Baker, MD, Oklahoma*
- Dirk S. Baumann, MD, California*
- Brad G. Butler, MD, Texas*
- Meredith Englander, MD, Society of Interventional Radiology*
- Kay Lozano, MD, American College of Radiology*
- Gregory Threatte, MD, New York*

* Alternate delegate

INAUGURAL ADDRESS: Robert M. Wah, MD, was inaugurated as the 169th president of the American Medical Association on Tuesday, June 10. Following is his inaugural address, titled A Foundation of Tradition, a Tradition of Change:

I asked for somewhat different arrangements on the dais this year, adding specialty society presidents and leaders of AMA sections. I was Chair of the Young Physicians, and the sections are one of the great strengths of our AMA.

This is a visual metaphor of the totality of medicine and the sound of medicine as well, adding voices to amplify the AMA's presence on the national stage where it has stood for 167 years atop solid ground in a storied tradition. A space of synergy among old and new, states and specialties, colleagues and friends, and the ever advancing art and science of medicine. Augmented by the willingness and courage to change. Change that respects our traditions. Protects them. Expands on them. And yes, perhaps, improves on them. A tradition that set standards in medical ethics and science. That built a framework for medical education. A tradition that now embraces a bold strategy to improve outcomes for patients, the environment for physicians and the training of students.

Note that I'm speaking of tradition, not convention. Convention is routine. Static. Thinks only inward. And looks only backward. But tradition is flexible. Tradition recognizes reality, overcomes obstacles, learns to adapt and inspires innovation. Tradition is a foundation, not a prison.

The AMA has not shied from change. Instead, we have seized opportunities for renewal. And what is opportunity? Opportunity is what happens when optimism meets a challenge.

Few organizations boast the AMA's rich traditions and its flair for ceremony. One is the U.S. Navy, where I served more than 23 years. I've witnessed the respect for tradition in both organizations. I've seen the courage to try something new or do things differently. To build on traditions, not be bound by convention.

In both medicine and the military, training often focuses on preparing for the unexpected. Events may surprise us, but our reactions should not. It instills a way of thinking, a willingness to act and the ability to perform as a team. That makes overcoming the unexpected possible.

Here's an example, an exercise some of you veterans might recall, part of training for chemical, biological or nuclear attack. It was the dreaded "gas mask exercise." Known also as the "confidence chamber." Here's how it works. We were taken to a concrete block building in an isolated field. The only light comes through a few small windows. We were given brief instruction, and then asked to put on our gas masks. Then they roll a tear gas canister into the middle of the room. Dealing with tear gas with the mask on? Not such a big deal. But then it gets complicated.

We were told to remove our masks, even as the canister continued spewing tear gas. We then had to help each other clear the masks and help each other put them back on. We were being taught how to react to the unexpected. To rely on a shipmate we may have only just met on the bus ride out there. It involves teamwork and trust and how to overcome adversity by using both.

Of course, these lessons were taught and learned long before the creation of the "confidence chamber." Since ancient times there have been sailors, brave souls who cast off into the unknown, who used discipline to function, common sense to adapt and visionary thinking to survive.

The Navy has a saying: back then, the men were iron and the ships were wood. A ship's crew forms a society. Confined to a certain space, reliant on each other, tapping a variety of talents, working together to keep alive a floating community amid a hostile environment. Sounds a little like the AMA at times. From this ancient history, from this sense of adventure, from this impulse for exploration the Navy draws its tradition and its core values of honor, courage and commitment. And they use that tradition as both a foundation for leadership and innovation. Something I've seen up close in my own experience.

I'm proud of the impact military medicine has had on and off the battlefield. I've served during two wars. We treated nearly 50,000 injured personnel. More important, we lowered mortality from 25 percent to five percent. Marines who see a medic within an hour of injury have a 96 percent chance of survival. 96 percent. This remarkable progress is grounded in advances in all aspects of trauma care, from the point of injury through treatment toward

recovery. And much of it made possible using data and through innovations like the Joint Trauma System, a program that improves delivery across the continuum of care by taking in data directly from the front lines, analyzing it, developing best practices, and returning it to the field of battle.

In the Navy, I made the transition from clinical medicine to health information technology. Eventually I was privileged to manage the health IT program for the US military. It was a $900 million proposition that includes 65 hospitals and 10 million patients. I also helped set up the Office of the National Coordinator, ensuring every US citizen has an electronic medical record in this decade. And now I've expanded to a global perspective on clinical IT in my current role at Computer Sciences Corporation, CSC.

Fortunately, I didn't have to start from scratch. When I arrived, the military already had a proven record of success in this area. For instance, I haven't written a prescription on a piece of paper in a military clinic for 20 years. And here's the important lesson that I've learned about digitization of healthcare: if it's to fulfill its vast promise it must be shaped and led by physicians. We all know implementing new technology can be a rocky road, and I'm not talking about ice cream. The road is smoother if we keep in mind our goals. Like for e-prescribing, it's not just to get the label remotely typed in the pharmacy. The real innovation is that it might prevent a drug-drug reaction or a drug-allergy reaction or a duplication of medication. The real innovation is in the ways it improves the care and the lives of our patients. Not high-tech for tech's sake, but an application of science that promotes well-being. And advances tradition.

As medical records transition from the convention of paper to the innovation of digital and as we connect and network the resulting torrents of data, the next logical step is to analyze all this information. Study it and use it and share it in new and innovative ways that we never could do with a pad and pencil, just as the Joint Trauma System has used technology to reduce mortality in the last two wars. It's the use of better information, delivered at lightning speed, to make better decisions in healthcare.

Given my interest in information technology, it's probably not surprising that I've been a fan of "Star Trek" since I was a kid. I am a bit of a Trekkie. I often hear controversies about Captain Kirk and Mr. Spock. Who is better, who should one aspire to be? Who's like Kirk and who's like Spock? I find the speculation fascinating, but the character I want to talk about is Dr. McCoy, Bones, a physician, a key member of the Enterprise leadership team. Willing to collaborate to solve problems, but also willing to question decisions from a scientific perspective. An advocate for health – a driver of change. Dammit Jim, he's a doctor! Bones bridged the gaps among the extremes of logic and instinct, rules and regulations, rational thought versus impulsive action, scientific knowledge and human compassion. He was a simple country doctor on a 23rd century starship.

And at a moment when we're inundated by amazing new technologies, we need a similar approach as we apply them to treat the very human issues facing our patients. Because where health information technology, cloud computing and cyber-security intersects we'll find our patients. While it sounds like science fiction, it's really just an ancient tradition, respecting the doctor-patient relationship and keeping it in confidence while tapping new technology as yet another tool to help us take better care of our patients. Physicians must harness technology; not let technology harness us. And with that Prime Directive in mind, we can be open to new ideas, new techniques and new perspectives. Build on tradition. Not be bound by convention.

Now to build on that tradition, one must survive and thrive. That's what we're doing here, right now at our AMA. Organized medicine is essential to help physicians navigate our own confidence chamber. To confront the fog of issues that swirl around us. SGR. ICD-10. IPAB. Medical liability reform. Medicare data dumps. The Sunshine Act. Narrow networks. And the onslaught of legislative intrusions on women's health that are barging into our exam rooms.

Think of all we do. The AMA represents physicians across all specialties, geography, practice settings and career stages. Our members work together to address the pressing issues we and our patients face together. I'm excited about our long-range strategic plan:

Improve health outcomes for patients;
Improve physician satisfaction and practice sustainability –.
Improve medical education to better prepare the next generation of physicians.

Our goals are ambitious but obtainable. Moreover, achieving them is crucial if we're to shape a better future and not have it shaped for us. Even as we celebrate tradition, we recognize that any tradition is built on seizing and maximizing opportunities. At that place where optimism meets challenge. That's a hallmark of our country's history, the relentless pursuit of renewal and improvement. Attracting people and their traditions from around the world and integrating them into a national mosaic.

My grandfather immigrated to eastern Oregon early in the last century. It was then home to thousands of Chinese who came to work in the mines and build the railroads. They left China to escape abject poverty and to seek freedom, to leave oppression and to find opportunity. Like so many immigrants they risked it all to work in a foreign land, of unfamiliar tongues and an alien culture, a place where tradition met the unknown.

Some welcomed their labor; others did not. One of the largest Chinese settlements in eastern Oregon was Canyon City. In 1885 a mob burned it to the ground. The Chinese fled to a smaller nearby town called John Day and settled in swampland strewn with rocks that no one else wanted. About 3000 Chinese called John Day home. At its hub was the Kam Wah Chung building, a general store that served as the center of the community. And minding this store were two men, Lung On and Doc Hay. Lung On was an entrepreneur who spoke and wrote English and ran the business. Doc Hay was a traditional Chinese doctor. He prescribed ancient Chinese herbal remedies.

Soon, non-Chinese patients sought out Doc Hay for cures and treatment. They came from as far away as Canada and Oklahoma. All this, even though he was totally blind. And when Lung On, the entrepreneur who spoke English, died, the call went out for someone to come help Doc Hay.

Answering that call was one of his relatives. Bob Wah, my grandfather. And he worked at Kam Wah Chung until Doc Hay died. And when my grandfather died, the building was willed to the city. When they reopened it, what was found was like a time capsule of life in the early 20th century. Dusty cans of food still on the shelves. Money in the cash register. And a trunk under Doc Hay's bed filled with uncashed checks. Twenty three thousand dollars worth. Most in tiny denominations, 75 cents, a dollar twenty. Most written before and during the Great Depression. They were vivid reminders of a man's dedication to the people of his community during their hard times, in both their personal health and their personal finances. Today, the Kam Wah Chung building is a museum and a national historic landmark.

In these communities, people persevered. They succeeded through hard work, a relentless pursuit of excellence and no small amount of luck. Like all immigrants, they saw change as an opportunity. Their optimism met the challenge, and through their success, their community–and our country–is better for it.

This heritage is as central to my story as my service in the military and my time in the AMA. Even as I explore the technological marvels of today, I'm touched by the example of Doc Hay, a healer who used traditional methods from a distant time and place. Kind of like a simple country doctor on a 23rd century starship. But at any time and place, it's a privilege to take care of patients. At an Interim Meeting a few years back my wife suggested we find a quiet restaurant, just the two of us. We sat down and soon noticed a woman at a nearby table staring at us.

My wife, her hopes for a quiet meal slipping away, said "I don't believe it; that person knows you!" And sure enough, the woman walked over and says: "You saved my life." That kind of interruption is always welcome and brings a deep sense of satisfaction. The knowledge of the great privilege it is to take care of patients. I had helped her through a health emergency. She remembered, and she was grateful that a physician was there to do the job. We all have these very powerful stories. We must remember this and celebrate our profession and the unique position we hold in society. And recognize the responsibilities that go with it.

When the cry goes out "is there a doctor in the house?" We respond. Accidents, disasters, disease, acts of violence. Acts of war. Physicians run towards danger, not away from it. We are the doctor in the house. We are the doctors in this House.

As I stand here, surrounded by colleagues, immersed in the AMA's history, I am humbled by what we've accomplished. But I'm also energized and inspired by the hopes and dreams of what more we can do, together. For our patients, for our communities and for this country. We can boldly go where no physician has gone before. Together, we can draw strength from our bonds. Escape the confines of convention. Expand our horizons. And build a new tradition. Thank you.