

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

167th ANNUAL MEETING CHICAGO, ILLINOIS June 9–13, 2018

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 167th Annual Meeting at 2 p.m. on Saturday, June 9, in the Grand Ballroom of the Hyatt Regency Chicago, Susan R. Bailey, MD, Speaker of the House of Delegates, presiding. The Sunday, June 10, Monday, June 11, Tuesday, June 12, and Wednesday, June 13 sessions also convened in the Grand Ballroom. The meeting adjourned following the Wednesday morning session.

INVOCATION: The following invocation was delivered by Reverend Joseph L. Morrow from Chicago's Fourth Presbyterian Church, where he serves as Minister for Evangelism.

Creator God, who spun the whirling planets, who formed the earth and every creature that roams its seas and fills its lands, who knit together each human person, who gathered us from many places to gather in these halls today, to you I lift up thanks and praise, for you clothed humanity in a dazzling array of cultures, traditions and languages, and have gifted us with every manner of knowledge. And if we truly seek it with wisdom, you have bequeathed us the power to give life or to take it.

Each of us conceives of you differently. We call out to you by different names, yet we are all drawn by a common desire to seek meaning and purpose beyond ourselves, to heal rather than harm, to mend what is broken. As Jesus healed many and restored them to community, so am I grateful for all those present here who have dedicated their lives to medicine, to valiantly healing and caring for tender and precious bodies, through your ineffable but assuring presence here today, bless such devotion and intention.

In their conversations and deliberations, keep these physicians' minds keen on listening and learning, and their hearts full of compassion and empathy for those entrusted in their care. Increase their tenderness and appreciation for the many colleagues and workers who partner in their healing endeavors. But I also pray that your presence would challenge them. Give them holy curiosity and discontent with easy answers. In their desire to heal and care for persons, let them not neglect the communities and systems from which the sick come. Extending mercy, may they also seek justice. Press them to speak against abuse of power and preserve human dignity by promoting policies and practices that will make for whole and healthy communities. Through such affirmation and challenge, might true human flourishing be realized in the labors of this association and its members. And, Lord, when long hours and little rest bring weariness, when their dreams are delayed only to be realized in the fullness of time, root them in the assurance that they are beloved. Help them to persevere by setting their eyes to whatever is true, noble, right, pure, lovely; whatever is admirable, excellent or praiseworthy.

In your holy name I pray, Amen.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by John M. Montgomery, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, June 9, 525 out of 612 delegates (85.8%) had been accredited, thus constituting a quorum; on Sunday, June 10, delegates 562 (91.8%) were present; on Monday, June 11, 591 (%) were present at the start of the session and 594 of 617 delegates (96.3%) were present at the end of the session; on Tuesday, June 12, 598 (96.9%) were present; and on Wednesday, June 13, 598 (96.9%) were present.

Note: During Monday's business session, the American Rhinologic Society, American Society for Reconstructive Microsurgery, American Society of Neuroimaging, North American Neuromodulation Society, and the North

American Neuro-Ophthalmology Society were granted representation in the House of Delegates (see Board of Trustees Report 2), which increased the number of delegates seats to 617.

RULES REPORT - Saturday, June 9

HOUSE ACTION: ADOPTED

Your Committee on Rules and Credentials recommends:

1. House Security

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

2. Credentials

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

3. Order of Business

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

4. Privilege of the Floor

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

5. Procedures of the House of Delegates

The November 2017 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 2-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 9. Except for the office of President-Elect, speeches will be limited to officer candidates in contested elections, with no seconding speeches permitted. The order will be selected by lottery.

The Association's 2018 annual election balloting shall be held Tuesday, June 12, 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.

10. Respectful Behavior

Courteous and respectful dealings in all interactions with others, including delegates, AMA and Federation staff, and other parties, are expected of all attendees at House of Delegates meetings, including social events apart from House of Delegates meetings themselves. Hugs and embraces, while not always inappropriate, are not universally accepted. Meeting attendees are reminded of their personal responsibility, while greeting others, to consider how the recipient of their greeting is likely to interpret it. Instances of unwelcome or inappropriate behavior should be brought to the attention of the Speakers.

SUPPLEMENTARY REPORT - Sunday, June 10

HOUSE ACTION: ADOPTED AS FOLLOWS

LATE RESOLUTIONS 1002 (255), 1003 (256) and 1004 (257) ACCEPTED

LATE RESOLUTION 1001 NOT ACCEPTED

EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 101, 106, 107, 110, 112, 113, 206, 207, 210, 213, 214, 220, 228, 234, 406, 415, 501, 510, 519, 520, 708 and 709

Madam Speaker, Members of the House of Delegates:

(1) LATE RESOLUTIONS

The Committee on Rules and Credentials met Saturday, June 9, to discuss Late Resolutions 1001–1004. Sponsors of the late resolutions met with the committee to consider late resolutions, and were given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1002 – 340B Program
- Late 1003 – Federal Aviation Administration BasicMed Exams to be Done by Physicians with Prescriptive Authority
- Late 1004 – Separation of Children from their Parents at Border

Recommended not be accepted:

- Late 1001 – Financial Protections for Doctors in Training

(2) REAFFIRMATION RESOLUTIONS

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

- Resolution 101 – Medicaid Reform
- Resolution 106 – Prohibit Retrospective ER Coverage Denial
- Resolution 107 – Opposition to Medicaid Work Requirement
- Resolution 110 – Return to Prudent Layperson Standard for Emergency Services
- Resolution 112 – Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs
- Resolution 113 – Survivorship Care Plans
- Resolution 206 – Appropriate Use of Telehealth Services
- Resolution 207 – Quality Improvement Requirements
- Resolution 210 – Banning the Sale of Bump Stocks
- Resolution 213 – Utilization Review
- Resolution 214 – Strengthening the Background Check System for Firearm Sales
- Resolution 220 – Strengthening the Background Check System for Firearm Sales
- Resolution 228 – Medicare Quality Incentives
- Resolution 234 – Support for Primary Care Enhancement Act
- Resolution 406 – Support for Public Health Violence Prevention Programs
- Resolution 415 – Reducing Gun Violence in America
- Resolution 501 – Synthetic Cannabinoids
- Resolution 510 – Alcohol Use and Cancer
- Resolution 519 – Warning Labels for Children’s Digital and Video Games
- Resolution 520 – Handling of Hazardous Drugs
- Resolution 708 – Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission
- Resolution 709 – Prior Authorization for Durable Medical Equipment

APPENDIX – Reaffirmed policy and actions taken

- Resolution 101 Medicaid Reform
 - Medical Care for Patients with Low Incomes H-165.855
 - Giving States New Options to Improve Coverage for the Poor D-165.966
 - Health Savings Accounts in the Medicaid Program H-290.972
- Resolution 106 Prohibit Retrospective ER Coverage Denial
 - Access to Emergency Services H-130.970
 - Out-of-Network Care H-285.904
- Resolution 107 Opposition to Medicaid Work Requirement
 - Opposition to Medicaid Work Requirements H-290.961
- Resolution 110 Return to Prudent Layperson Standard for Emergency Services
 - Access to Emergency Services H-130.970
 - Out-of-Network Care H-285.904
- Resolution 112 Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs
 - Three Day Stay Rule H-280.947
- Resolution 113 Survivorship Care Plans
 - Survivorship Care Plans H-55.969
 - Use of CPT Editorial Panel Process H-70.919
- Resolution 206 Appropriate Use of Telehealth Services
 - Coverage of and Payment for Telemedicine H-480.946
 - Evolving Impact of Telemedicine H-480.974
- Resolution 207 Quality Improvement Requirements
 - Pay-for-Performance Principles and Guidelines H-450.947

- Resolution 210 Banning the Sale of Bump Stocks
 - Restriction of Assault Weapons H-145.993
 - Ban on Handguns and Automatic Repeating Weapons H-145.985
 - Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
- Resolution 213 Utilization Review
 - Utilization Review by Physicians H-320.973
 - Medical Necessity and Utilization Review H-320.942
 - Utilization Review Standards: Local Considerations H-320.988
 - Confidentiality and Utilization Review H-320.986
 - Medical Necessity Determinations H-320.995
 - Postpayment Utilization Review H-335.999
 - Physicians Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
 - Physicians Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995
- Resolution 214 Strengthening the Background Check System for Firearm Sales
 - Waiting Periods for Firearm Purchases H-145.991
 - Waiting Period Before Gun Purchase H-145.992
- Resolution 220 Strengthening the Background Check System for Firearm Sales
 - Restriction of Assault Weapons H-145.993
 - Ban on Handguns and Automatic Repeating Weapons H-145.985
- Resolution 228 Medicare Quality Incentives
 - MIPS and MACRA Exemption H-390.838
 - Preserving Patient Access to Small Practices Under MACRA D-390.949
- Resolution 234 Support for Primary Care Enhancement Act
 - Direct Primary Care H-385.912
 - The Role of Cash Payments in All Physician Practices H-380.984
- Resolution 406 – Support for Public Health Violence Prevention Programs
 - Violence as a Public Health Issue H-515.979
 - Injury Prevention H-10.982
 - Violence Activities H-515.964
 - Public Health Policy Approach for Preventing Violence in America H-515.971
- Resolution 415 – Reducing Gun Violence in America
 - Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
 - Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
 - Epidemiology of Firearm Injuries D-145.999
 - Gun Violence as a Public Health Crisis D-145.995
- Resolution 501 – Synthetic Cannabinoids
 - Addressing Emerging Trends in Illicit Drug Use H-95.940
 - Emerging Drugs of Abuse are a Public Health Threat D-95.970
- Resolution 510 – Alcohol Use and Cancer
 - Setting Domestic and International Public Health Prevention Targets for Per Capita Alcohol Consumption as a Means of Reducing the Burden on Non-Communicable Diseases on Health Status H-30.937
 - Screening and Brief Interventions For Alcohol Problems H-30.942
- Resolution 519 – Warning Labels for Children’s Digital and Video Games
 - Emotional and Behavioral Effects of Video Game and Internet Overuse H-60.915
 - Harmful Effects of Screen Time in Children H-60.911
 - Mass Media Violence and Film Ratings H-515.974
- Resolution 520 – Handling of Hazardous Drugs
 - USP Compounding Rules H-120.930
 - Opposition to USP 800 D-120.941
 - Access to In-Office Administered Drugs H-330.884

- Resolution 708 – Arbitrary Paperwork and Signature Deadlines for Hospital and Rehabilitation Unit Admission
 - Reduction of Burdensome CMS Signature Compliance Requirements D-330.919
 - 48-Hour Signature Rule D-160.987
- Resolution 709 – Prior Authorization for Durable Medical Equipment
 - Medical Necessity and Utilization Review H-320.942
 - Prescription of Durable Medical Equipment H-330.955
 - Managed Care H-285.998
 - Approaches to Increase Payer Accountability H-320.968
 - Prior Authorization and Utilization Management Reform H-320.939

CLOSING REPORT

HOUSE ACTION: ADOPTED

Madam Speaker, Members of the House of Delegates:

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

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

Whereas, The Annual Meeting of the House of Delegates of the American Medical Association has been convened in Chicago, Illinois during the period of June 9-13; 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, 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.

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

APPROVAL OF MINUTES: The Proceedings of the 71st Interim Meeting of the House of Delegates, held in Honolulu, Hawaii, Nov. 11-13, 2017, were approved.

ADDRESS OF THE PRESIDENT: AMA President David O. Barbe, MD, delivered the following address to the House of Delegates on Saturday, June 9.

Madam Speaker, members of the board, delegates, colleagues and guests,

It's truly a privilege and a pleasure to speak to you today as my presidency nears an end. It has been an amazing year. My sincere thanks to all of you for the support and the encouragement that you've given me during my time as your president. Over the past year, I've spoken to this house about the critical importance of physician leadership, to advocate in today's political environment, to describe and shape the future of healthcare, and to mentor those who will one day follow us in this profession. Now, as my time winds down and we prepare to transition the AMA

presidency to the very capable hands of Barbara McAneny, I'd like to share some parting thoughts about physician leadership, AMA physician leadership in particular, and the important gains we've made, and the work that remains.

A year ago, I asked all of us to consider this question: "What kind of leaders will we be?" And I challenged us to be the kind of leaders who bring consensus to difficult issues, who use our creativity and drive to shape the future of medicine, and who mentor our next generation of physicians. And then at our interim meeting in November, we looked at the kind of leadership that is needed to produce a winning team.

Like other winning teams, the AMA shares a common vision and works aggressively to achieve it. The AMA led the way on health system reform last year because of our shared vision of maintaining and expanding health coverage for Americans. Winning teams create partnerships that make us stronger. Let me give you an unexpected example. Anthem, the health insurance company. Who would have imagined a few months ago that we would not have only convinced Anthem to back off of its plan for a 50 percent cut whenever the CPT 25 modifier was used, but that we could extend that dialogue to work on patient literacy, right-sizing prior authorization, and other payment issues? Amazing.

And winning teams chart a course for a better future. The AMA continues its aggressive advocacy to reform the crippling prior authorization processes that delay patient care, to reduce the regulatory burdens on physician, and to improve EHR and other information technologies, all of which currently take too much of our time away from our patients, and they waste precious resources. We've carried that strong momentum into the first half of 2018.

To the casual observer, it might seem that congress only works in the dark of night, at the last minute, or when they're up against a deadline. But even those late night deals, such as the two-year budget deal in February, are the culmination of months, and even years, of hard work and negotiation.

Kudos to our advocacy team, and kudos to all of you, our physician advocates, for several wins on key issues for the AMA this past year. I want to name a couple of those.

We have long fought for improvements to the electronic health record and an easing of the unrealistic federal requirements. The budget deal eliminated a mandate making EHR standards more stringent. And we have long fought for repeal of the Independent Payment Advisory Board, or IPAB, which gave too much power to an unelected body to cut Medicare payments. The budget deal repealed IPAB.

And we have long fought for federal safety net programs like the Children's Health Insurance Program, or CHIP. The budget deal extended the CHIP program 10 years.

And we have long fought for changes in the MACRA law to provide greater flexibility for physicians participating in Medicare and to encourage the development of alternative payment models. The budget deal included important improvements to MACRA as well.

Along with all these provisions, the AMA was also able to stop a very bad proposal that was initially included in that package, a misvalued codes policy that would have led to across-the-board Medicare payment cuts and a conversion factor that was actually less than when the SGR was repealed. We were able to stop that provision.

These wins were only possible because our winning team put in the hard work of advocacy, we took a stand, educated policymakers, and we activated our grassroots physicians to speak with their legislators.

This process can take days, as in the case of the misvalued codes policy, months, or even years, as in the case of IPAB. So we must remember that it is important that we keep fighting, all the time, and not lose momentum or become discouraged because of temporary setbacks or because nothing seems to be happening.

So, yes, it takes leadership. It takes a team that is persistent. But it also takes innovative, dedicated individuals. The AMA is fortunate to count among its members some of the most talented individuals in the country, who are leading the way on a variety of healthcare issues.

Nelson Mandela, the former South African president, said, “There are times when a leader must move out ahead of the flock, go off in a new direction, confident that he is leading his people the right way.” It’s that concept of leadership that I’d like to share with you today, how some of our individual AMA members are moving medicine.

The opioid crisis continues to reverberate through our communities and is now the leading cause of death—the leading cause of death—among Americans under the age of 50. That is a national tragedy. And it demands that our profession continue our diligent work to end it. And that is exactly what we are doing.

Due to the hard work of our Opioid Task Force and other organizations in recent years, we are making headway on several fronts. More physicians are becoming certified to provide medication-assisted treatment. More physicians are registering for and using their state PDMPs and completing education on safe opioid prescribing. And perhaps the best news of all, opioid prescribing has decreased for the fifth straight year in a row, now down 22 percent from 2013 to 2017.

However, despite these efforts, deaths from opioid overdose continue to climb. Addiction is a fierce adversary, and no one understands this better than Dr. Jerome Adams, our Surgeon General and AMA member, who has made fighting the opioid epidemic his top priority.

Dr. Adams understands the devastating toll that addiction has on individuals, families and communities. He is very open about his younger brother’s struggle with substance abuse disorder that has even led to time in prison. And he encourages all of us to fight the stigma around substance use disorders, and he has written, and I quote, “... we must also acknowledge that addiction is a chronic disease that changes the brain, not a moral failure.” As Indiana’s state health commissioner from 2014 until last year, he fought for and implemented a wide range of interventions, including needle-exchange programs, wider availability of naloxone, and better access to evidence-based and comprehensive treatment.

Dr. Adams recently issued an advisory—the first advisory from the Surgeon General’s Office in more than a decade—an advisory on naloxone and opioid abuse. And that advisory urges those at high risk for opioid overdose, and their family members and friends, to ask their physicians or pharmacists about naloxone, to learn the signs of opioid overdose, and to get trained to administer naloxone in the case of an overdose emergency. We strongly endorse the advisory, and we applaud Dr. Adams for issuing it. And we look forward to hearing from him directly as he addresses this house on Monday. So Dr. Adams, thank you for being an AMA Member Moving Medicine.

Would you stand and let us recognize you? Thank you.

Another top advocacy priority in recent years was repeal of the Sustainable Growth Rate Formula, and then helping physicians make a successful transition to the new MACRA Quality Payment Program. We’ve worked diligently with the Centers for Medicare and Medicaid Services, or CMS, both to reduce physician burdens under the new law and to create physician-focused payment pathways, called Alternative Payment Models, which reward physicians for their creativity in improving healthcare quality and in reducing costs.

Understandably, there is some fear, and even some resistance, to moving to these new models. Thankfully, there are AMA members like Dr. Larry Kosinski to help show us the way. Dr. Kosinski is a gastroenterologist from Elgin, Illinois, who has developed a specialty medical home for patients with Crohn’s disease. Several years ago, he analyzed the claims data on Crohn’s patients and found that hospitalization for the treatment of complications drove much of the excess cost. But, as importantly, he also learned that fewer than one-third of the patients who ended up in the hospital had any contact with their healthcare provider in the preceding 30 days, so he developed a system that he called “Sonar” to intervene with patients before they even realized they need it.

The way Dr. Kosinski describes it is that patients are like submarines: they’re out there underwater, but they only come in when they are in trouble. Now instead of waiting for patients to call when their condition worsens, Dr. Kosinski’s office pings each Crohn’s patient every month, asks them a few structured questions, and that way he can intervene quickly if a patient’s responses suggest that his or her condition is worsening.

This Sonar program has cut hospitalizations in half, has reduced spending, and actually improved patient satisfaction. Last year, the Physician Technical Advisory Committee, or PTAC, recommended that Medicare program test his Sonar model.

Think of the patients who could benefit if they can avoid hospitalization, and all because one physician had a really good idea and pushed hard to make it happen. So, Dr. Kosinski, we thank you also for being an AMA Member Moving Medicine.

And another group of members that I would like to recognize today are the medical students who are fighting to protect DACA–status individuals.

You'll recall that the DACA program shields hundreds of thousands of undocumented young people who came to this country as children and allows them to work. Dozens of medical schools have considered, and many have admitted, DACA–status students, understanding the value that they can bring to the healthcare system. Research tells us that DACA–status individuals can help us alleviate the physician shortages, especially in high–need areas, and provide culturally competent care. Some of our own AMA members have DACA status. They're our colleagues. Protecting them is a priority that has increased in urgency in light of the actions to terminate the DACA program.

So during our 2016 interim meeting, one of our members confided in another member fears of being deported. That friend and other supporters within the Medical Student Section immediately sprang into action. They stayed up all night writing a resolution to call on the AMA to go beyond studying the issue and to take a stand, to go on record in staunch support of healthcare professionals with DACA status. To his credit, Bob Goldberg, a member of the AMA's Council on Medical Education, introduced their resolution, and it was adopted with overwhelming support from the entire house.

So led by the Medical Student Section, the AMA continues to pressure congress to enact both short–term and long–term solutions for DACA–status individuals in the medical community.

So to the leaders on the DACA issue in the Medical Student Section, like Pratistha Koirala, Ruth Howe and many others, and the people that supported them, like Dr. Goldberg, thank you all for being AMA members moving medicine.

The final group of physicians who are moving medicine forward are sitting in this room today, and that is you, the delegates, alternate delegates and trustees of the AMA. Today I challenge each of us to think about the significant wins we have achieved by working together as a winning team, and to think about the individual AMA members moving medicine whose examples I've shared, and also about the significant work there is still left to do as we strive to shape a better future for students, residents, physicians, and our patients.

So let us each ask ourselves: how can we get even more involved, become even more effective, and actively encourage more of our colleagues to join this transformational organization that is our AMA so we can truly continue moving medicine forward?

At this meeting, we will have an opportunity to demonstrate physician leadership on a public health crisis that has so far defied solution: gun violence. At the start of our annual meeting in 2016, shocked by the Pulse Nightclub massacre in Orlando, this house acted. We led with a critical declaration that gun violence in America is a public health crisis.

But in the two years since that time, we have been horrified by yet more carnage: in Parkland, in Sutherland Springs, Santa Fe, Las Vegas. And those are just a few of the incidents that made the headlines. On average, gun violence claims the lives of nearly 100 people every day in the United States. People are dying of gun violence in our homes, in our churches, in our schools, on our street corners, and at public gatherings. Colleagues, we, the America's physicians, have an opportunity, and I would suggest we have a responsibility, in the coming days to act on several resolutions that address this devastating crisis of our time.

The AMA has demonstrated leadership on this issue for decades: we've recommended common–sense gun safety protections, waiting periods and background checks for those seeking to purchase a gun, and increased funding for mental health services. We've called upon the Center for Disease Control and Prevention to conduct epidemiological research on gun violence. It is perhaps the only leading cause of death where such research is not being conducted. Yet the fact that this problem continues to worsen has spurred a new sense of urgency in this house, even while congress fails to act.

To those who feel we should not address this as an organization because it is too controversial, I would ask: Did we shy away from fighting discrimination against AIDS patients in the early days of that epidemic, even though much of society stigmatized those with HIV? No, we let science lead us. And did we mute our opposition to smoking, because Big Tobacco defended it? No, we let science lead us. And even now, have we backed away from our support on universal vaccinations or the gains made through the Affordable Care Act because they are controversial? No, we've let science lead us. So similarly I would submit to you that the AMA must not back down from addressing gun violence.

On the contrary, we must address it head on scientifically, in an evidence-based, principled fashion, and with the health and safety of our communities, our fellow Americans, and our children as our chief concern. And while we will not all agree on every proposal introduced on gun violence, we can all agree that this issue must be addressed, and that the only way, the only responsible way forward is for women and men of good faith to continue to search for and advocate for science-based solutions.

That is true physician leadership, and that is our AMA.

Thank you.

REPORT OF THE EXECUTIVE VICE PRESIDENT: James L. Madara, MD, executive vice president of the Association, delivered the following address to the House of Delegates on Saturday, June 9.

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

Conversations in medicine often note the rapid evolution in healthcare and how physicians, health systems and patients have to adapt to that, and that's simply the nature of progress. You know, it can yield incredible breakthroughs, but also induce a fair amount of anxiety.

Consider this description of our nation. The American people find themselves consumed by mistrust and anger. Immigration is a hot-button issue. There's a widely shared perception that innovation is moving almost too fast, at a pace once unimaginable. In parallel, inequality grows. Those with enormous wealth play an increasing role in politics. The country is sharply divided between red states and blue. In a surprise, a Republican candidate wins the White House while losing the popular vote. Sound familiar?

Well, that happened in 1888. The AMA wasn't even a half-century old. Benjamin Harrison had just defeated Grover Cleveland for the presidency. And I add, by the way, that the Southeast and Texas were solid blue and the Northeast and California solid red.

So this isn't to minimize current challenges or discredit current anxiety, but rather to remind ourselves of the cyclical nature of events, the fact that all times have their challenges, and those challenges can even recycle. Simply put, by one view, we've been here before.

For the AMA, our resiliency in such times takes root in our mission, which derives from the bedrock principles of medicine, and that emanates from this house. Those principles enable the AMA to be a unifying voice and a strong ally for physicians, as well as for our patients, and all for a healthier nation.

Over the last several years, the AMA has refined its strategic approach, aligned with the changing needs of patients and physicians. We developed three strategic arcs, each anchored by one of the original focus areas.

First, we reimagine medical education, training and lifelong learning to help physicians throughout their careers. This began with our Accelerating Change in Medical Education initiative and evolved to include expansion of JAMA and creation of the JAMA Network, as well as our soon-to-be-launched Education Hub.

Second, we improve the health of the nation by confronting the rise in chronic disease. We began this effort concentrating on prediabetes and hypertension, and we've seen these efforts evolve from pilots to emerging programs of scale.

Third, we focused on professional satisfaction and practice sustainability, which has evolved to encompass our broad work to attack the dysfunction in healthcare, having the goal of removing obstacles that interfere with patient care and also waste the time of physicians. These efforts include our advocacy work, elements of our innovation ecosystem, and I'll touch on that in a bit, and our work on mitigating physician burnout.

So here are some brief updates on work across these evolving arcs.

This spring we celebrated the first graduating classes from our ACE consortium schools, graduates that have been in the ACE consortium since their entry into medical school. These tech-savvy physicians entered their residency with new skills and competencies proven by measurement: knowledge of what electronic records could and should be; a deep understanding of the social determinants of health, of population health; and teamwork within the healthcare environment. We've produced new physicians who are adaptive learners, capable team leaders with a greater awareness of policy. This is a major shift in medical education. Consequently, this requires creation of resources for this new type of physician throughout her career.

We now build on this success by extending these innovations to graduate programs in order to create a seamless transition from medical school to residency. To support lifelong learning, and following nearly two years now of internal work, we'll soon launch the AMA digital Education Hub. This education hub takes broad AMA content areas, ranging from opioids and practice management to ethics and JAMA, all reduced to simple and effective learning modules that can be assessed by any means: desktop, pad or mobile. We hope the Hub will be attractive and sufficiently advanced that some of the societies might also consider using this platform.

We've also just launched JAMA Network Open, our new open-source clinical research journal, and this is the third new journal launched in the last three years, joining JAMA Oncology and JAMA Cardiology, which, by the way, are now great successes. Likewise, our leading work to reduce the burden of chronic disease by preventing Type 2 diabetes and by controlling hypertension, it really continues to expand. Through various efforts, including our highly visible and popular national ad campaign, as well as our partnership with the CDC, the American Diabetes Association and others, we've introduced prediabetes into the national conscience, and inspired many to seek help through defined programs. More than a million people have self-screened for prediabetes, either through the AMA's risk assessment site that's online or through their Samsung phones last fall. This shows how we are advancing from pilots to scale.

That's also true of our work in hypertension. Tools we developed and tested in pilot settings have shown success in a range of practices across the US. So now we partnered with the American Heart Association on another Ad Council campaign designed to increase public awareness of blood pressure and encourage patients and physicians to work together to get blood pressure under control. Our ultimate goal? All Americans with normalized blood pressure. Our near-term goal? By 2020, working with our partners, apply our tools to control blood pressure of 20 million Americans who are currently in need. Twenty million by 2020.

In the last two months, we've partnered with Google and launched a corporate challenge to create a new means by which accurate home blood pressure measurements can be automatically collected in digital form and not only be sent electronically to the patient's record, but also organized within that record. This initiative has already generated interest from more than 20 entrepreneurs.

That work complements the AMA's Integrated Health Model Initiative launched last fall, an initiative in which various data elements relating to specific diseases or states can be better organized. IHMI also captures the key elements of patient goals, functions, social determinants, giving physicians more meaningful clinical data at the point of care, and doing so without paper shuffle.

Currently, electronic records, some say, are reasonably organized for administrative workflow and even somewhat interoperable in that domain. What's missing is that second level of clinical data organization and interoperability, and that's what this initiative is all about.

Partnerships are essential in advancing our work, along with strategic arcs, whether we're creating new strategies around medical education and training, confronting the rise of chronic disease, or helping develop the technologies that will reduce the dysfunction that so frustrates us.

For example, in our effort to extract greater meaning from health data, we have built relationships with some of the industry leaders in information and technology, including IBM Watson, Accenture, and two that I've already mentioned, Google and Samsung. Key in these relationships is that we define problems that need solutions from the vantage point of the patient-physician interface, not from the vantage of the administrative level. That means we're flipping the current construct for medical innovation, introducing a model that's been missing from our health system. And missing this has contributed much to the dysfunction that we see today. This is a bold shift, but I'm already seeing some evidence that this new thinking is taking root.

At a recent high-level meeting of healthcare CEOs, the top executive from a large, multi-hospital system said this to the audience: "I went through a phase where I wanted to own the doctors, employ them so I could manage them. I no longer want to do that, because I've learned that doctors are better at managing themselves." And he went on to say, "The doctors just need the time and support to do that." So, you see, executives are starting to understand the importance of engaging and incorporating the physician perspective into new technologies, new strategies and new systems, and those systems will be those that define the future of medicine.

But better-organized and meaningful clinical data is just one piece of the solution. We also need that data to be connected, and that's the concept behind the new company Akiri, which is the first spin-out from our pioneering Silicon Valley innovation company, Health2047.

Akiri might be viewed as a utility for permissions-based and secure transport of health data. And, importantly, it has been crafted to reduce cost and reduce effort while creating improved data sharing, an effort that has the potential to drastically improve the flow of data in healthcare, what the field refers to as data liquidity.

We anticipate other spin-offs will launch from Health2047 later this calendar year, companies that were created based on the experience and the expertise and the need of physicians. And that's the secret to the success of Health2047: flipping the model to define big system problems at the patient-physician level. We simply need to avoid what has happened in the past: solutions created at the administrative level then thrown over the transom to the site where medicine actually occurs, and often not working very well there.

Now, I don't know what our health system will look like in 2047, the year of the AMA's 200th birthday, but I do know physicians need some major changes, regardless of what system emerges.

Physicians need to be educated for this century, not the last century. Electronic clinical data needs to be much better and more meaningfully organized. Such organized clinical data needs to flow through an interconnected utility that decreases, not increases, cost. And in the face of the still-rising burden of chronic disease, we need both prevention and control approaches that are evidence-based and scalable.

These are huge issues, some of the biggest challenges healthcare faces today. And the work ahead of us is not going to be easy. It will require years of focus and commitment on the part of the AMA and our partners. But this hard work, this work that is based on the policies of this house, has already begun. And we've gained footholds in these mountains that in the recent past appeared nearly insurmountable.

Now, we also continue to move forward in our strategic arcs by deploying a really clever competency, and that's continuously placing one foot in front of the other toward a directed goal, and doing so in the context of flipping the model so that physician perspective and physician experience becomes the driver of future innovation in healthcare.

In moments like these when chaos seems to encircle us, it's important that we pause and reflect on the really remarkable opportunities before us, on the cyclical nature of progress, and on that virtuous mission that guides our work, promoting the art and science of medicine and the betterment of public health.

So thank you for all you do, and thank you for being the House of Medicine.

REMARKS FROM THE CHAIR OF THE AMPAC BOARD: The following remarks were presented to the House of Delegates on Saturday, June 9 by Vidya Kora, MD, Chair of the AMPAC board.

Madam Speaker, Mr. Vice Speaker, friends and colleagues in the house, good afternoon.

My name is Vidya Kora. I am a general internist from Michigan City, Indiana. As chair of the AMPAC, ardent supporter of AMPAC and AMA's advocacy efforts, having served on various PAC boards for many years, I realize that asking for contributions is never easy, but it is very important. But it's something, it has to be done. So I'm here to say thank you to all of you who have already made your contribution to AMPAC this year. And for those of you who have not had a chance to do so, please join us in this very important mission.

All of us in this house understand firsthand the importance of advocacy. You are the leaders, you are the principal policymakers, and you establish policy on health, medical and professional matters. The midterm election is coming down to the wire, and the stakes in the senate and the house couldn't be higher.

Speaking of stakes, later today the oldest of the Triple Crown races, the Belmont Stakes, will be run in New York. You may be thinking, "Where is he going with this?" I see a parallel in the traditions of horseracing and political activism, or, as I like to say, the Triple Crown of Politics: fundraising, activism and grassroots. All three elements are essential in order for us to be effective and to keep winning in the legislative arena, the kind of wins Dr. Barbe just spoke about.

In PAC fundraising, much like horseracing, you need to get out of the gate fast, you need to get to the frontrunner position, and you need to maintain momentum down the home stretch. Right now we have 50 percent participation in the house. We need everyone to participate to get us across the finish line in November. A well-funded AMPAC demonstrates the commitment of our profession and bolsters our advocacy efforts on Capitol Hill.

So, friends, I want everyone to take out your phones now and text "AMPAC" to 202-831-8785. The number is on the screen: 202-831-8785. You'll receive a link, and I urge you to follow the prompts to make a personal contribution to AMPAC. If you would like an AMPAC board member to get credit for your contribution, please select their name in the drop-down and follow the prompts to make your contribution.

Your best bet is to invest in AMPAC, and you'll strengthen our voice in Washington; you'll safeguard the interests of our profession. The stakes couldn't be higher.

So thank you. I also want to thank Kim Moser, our Alliance president, for putting in a plug for AMPAC. Thank you, Kim, for doing that. And I want to thank you all for your support and your contribution. And, Madam Speaker, thank you so much for giving me this opportunity to speak on behalf of AMPAC.

REPORT OF AMPAC'S BOARD OF DIRECTORS: The following report was submitted by Vidya Kora, 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 this election cycle. In these uncertain times, our mission remains to provide physicians with opportunities to support candidates for election to federal office who have demonstrated their support for organized medicine, including a willingness to work with physicians to strengthen our ability to care for America's patients. In addition, we continue to help physician advocates through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully work on a campaign or to run for office themselves. We continue to work hand-in-hand with our state medical society PAC partners to carry out our mission.

AMPAC Membership Fundraising

With the 2018 midterm elections well underway, it is necessary that AMPAC's participation be at an all-time high in order to remain effective this election cycle. AMPAC receipts for the cycle are \$1,760,771, and our success this election cycle begins with you, the leaders in our House of Delegates. It is imperative that we have support from members, preferably at the Capitol Club level. Currently, the HOD AMPAC participation stands at 50 percent and there is much work to be done as the House ended 2017 with a record breaking 77 percent participation rate.

When reviewing the 50 percent of HOD members that contribute to AMPAC, 186 or 77 percent participate at the Capitol Club level. Of the HOD members who participate in Capitol Club are 25 Platinum members, 73 Gold members and 88 Silver members. A special thank you to those members who have already contributed to AMPAC in 2018, your early support is important to our success. If you have not made a 2018 contribution to AMPAC yet, I strongly encourage you to stop by the AMPAC booth today to join or renew your membership.

All current 2018 Capitol Club members have been invited to attend an exclusive Capitol Club Luncheon on Tuesday, June 12 with special guest David Axelrod. Mr. Axelrod is a political adviser and analyst and was the Chief Strategist for Barack Obama's Presidential campaigns. He currently serves as Director of the University of Chicago's non-partisan Institute of Politics and will be discussing the current political landscape and providing an outlook for what lies ahead with the mid-term elections.

AMPAC is promoting its 2018 Sunset in Sedona Sweepstakes and the winner will be announced during the Interim meeting. The lucky winner will receive accommodations for 4 days/3 nights in a creekside cottage at L'Auberge de Sedona in Sedona, Arizona in September 2019. This trip includes a private day trip to the Grand Canyon, a four-course dinner for two at Cress on Oak Creek and a variety of daily on-property guided activities. Current 2018 Platinum, Gold and Silver contributors are automatically entered into the drawing for the sweepstakes.

Political Action

The AMPAC Board's Congressional Review Committee continues to process 2018 primary contributions and is beginning to look ahead to the general election in the fall. Medicine-friendly candidates, lawmakers in positions of leadership or on committees that deal with medicine's top issues, in addition to those legislators who are otherwise in unique positions to favorably impact key legislation remain our top priorities.

As the November midterm elections draw near, the national political landscape remains very much in flux and a shift in power in one or both chambers of Congress is a distinct possibility. Regardless of the outcome, AMPAC's robust involvement in key U.S. House and Senate races all over the country will ensure that medicine has a place at the policy-making table.

Political Education Programs

On March 2-4, 26 physicians and medical students had registered to take part in AMPAC's 2018 Candidate Workshop, held at the AMA's Washington, DC headquarters. Unfortunately, due to a sudden and severe wind storm that struck Washington, DC the day that most participants were scheduled to arrive, 10 registrants were unable to attend due to flight cancelations and other weather related issues. The participants who were able to attend were provided a hands-on learning experience featuring political experts from both sides of the aisle providing expert instruction on how to run a winning campaign. Sessions included topics such as: effective fundraising techniques, crisis management, public speaking, grassroots organization and, in general, how to run a disciplined campaign.

Building on the success of this new programmatic model, AMPAC is proud to announce that the dates for the 2018 Campaign School have been set for December 6-9 at the AMA Washington, DC offices. Running an effective campaign can be the difference between winning and losing a race. Coming off the heels of the 2018 election, the AMPAC Campaign School is designed to give participants the skills and strategic approach they will need out on the campaign trail. Our team of political experts will teach them everything they need to know to run a successful campaign.

I am also proud to announce that nominations are now open for the AMPAC Award for Political Participation. Formerly the Belle Chenault Award for Political Participation, the award recognizes an AMA or AMA Alliance member for outstanding accomplishment through volunteer activities in a political campaign or a significant health care related election issue such as a ballot initiative or referendum. Deadline to submit a nomination is January 31, 2019.

For more information on this or any of the Political Education Programs you are encouraged to stop by the AMPAC and AMA Grassroots booths during this meeting, or by visiting ampaconline.org.

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine a powerful voice in Washington, DC.

ADDRESS OF THE US SURGEON GENERAL: The following remarks were presented to the House of Delegates on Monday, June 11 by Jerome M. Adams, MD, MPH.

In the words of the great philosopher LL Cool J, don't call it a comeback, because I've been here for years. You know, I'm having a little HOD PTSD, because after hearing my name announced by Sue, I'm used to it being followed by, "You're out of order." But you're still my favorite Sue in Chicago.

Thank you for your kind introduction and for your leadership.

It's a great honor and a privilege to be here to address all of you today. I'd like to acknowledge Dr. Harmon for the invite. Thank you so much, and the entire Board of Trustees, and the senior management for their continued leadership and service. I'd also like to give a shout out to my peeps in Indiana and to my folks from the Anesthesia Delegation, as they've been my home and my ticket to the AMA for the past 20 years.

There are too many of you to thank, so I won't even try. I don't want this to turn into the Jesse Ehrenfeld acceptance speech from Saturday. I seriously thought that Oscar music was going to start playing. But seriously, Jesse is an amazing person and friend who worked with me in the Surgeon General's Office earlier this year. And just a few weeks ago he organized a packed discussion among community partners that I participated in in Vanderbilt. In every way, he is influencing policy, and he's a member who is moving medicine.

The AMA has a long and laudable history of bringing physicians and communities together to improve our nation's health, and I'm delighted to be seated among you as a delegate representing the United States Public Health Service. You, each and every one of you, have done extraordinary work to prevent and treat chronic diseases. You've helped countless patients overcome barriers to quality health care. And you continue to be committed to addressing our nation's opioid crisis.

In addition to your advocacy, your AMA is a critical support for physicians throughout their careers and across all specialties. You offer essential tools and resources, you guide the transformation of medical education, you fight to improve day-to-day medical practice.

As I look out among you, I see so many friends and so many successful leaders in medicine today; colleagues that have truly made an impact on the field of health through scientific excellence and through public health service. And I look forward to the many contributions you will continue to make, especially the students—where are you at, MSS? [Cheers]—the residents—where's my RFS? [Cheers]—and the Young Physicians. [Cheers] These folks will carry the baton forward.

But delegations, we're family, we've got to have some family talk. They can't carry the baton forward if you refuse to hand it to them. To continue the sports metaphor, do we have any hockey fans here? [Cheers] I am missing the Stanley Cup parade. It is literally going by my office back in D.C. right now.

But anyone remember what Wayne Gretzky said about what makes him great? Wayne Gretzky said he was great because he skated to where the hockey puck was going and not where the hockey puck has been.

Experience and wisdom is critically important. But I challenge you all to look at your delegations, to look at age, to look at gender, to look at race, to look at sexual identity and ask yourselves if your delegations reflect where the puck is going.

Providing a pathway for people to grow within the AMA is critical to their future as advocates and to the future of the AMA. In fact, I joined the AMA 20 years ago as a medical student. And can I be totally honest here? I joined it because

someone said, "They'll pay for you to go to Hawaii." So don't take Hawaii off the rotation or you may miss out on the next Surgeon General.

And, yes, I did my fair share of networking in the evenings, but I also developed a powerful taste for advocacy. Seeing how passionate many of my colleagues were and having the opportunity to watch them literally change the practice landscape, it lit a fire in me, and I have been back every year since.

Being part of this community, part of this family provided me with the knowledge, the networks, the resources, and the mentorship that made me into the physician that I am today. I want you all to hear me say this from the bottom of my heart: if it weren't for the AMA, I wouldn't be standing here before you right now as the 20th United States Surgeon General.

I want you to know that as your Surgeon General I promise to promote health, to prevent disease, and to lead with the science. Right now I'm focused on three main areas. I want to help us promote healthier communities by making the connection between health and economic prosperity.

You know the number one issue people vote on, Democrat or Republican, black or white, rural or urban? Jobs and the economy. Health usually doesn't factor into the top five. Quite frankly, it's most often not even in the top ten. Now, some of you will say, "Healthcare is up there"; but I'd argue that healthcare is up there because folks are going bankrupt because they can't pay their medical bills. It's still a function of a lack of economic prosperity. And as Surgeon General I plan to put out a Surgeon General's report on health and economic prosperity and making that link between a community's health and their ability to attract the next Amazon to their town. We need Amazon, we need Exxon, we need Walmart carrying our water for us in congress and in the statehouses if we're going to make the case for true community health.

Number two, I want to raise awareness of the link between health and national security, because you know the number two issue people vote on consistently? It's safety and security. And unfortunately right now in our country 70 percent, seven out of ten, of our 18- to 24-year-olds are ineligible for military service because they can't pass the physical, because they can't meet the educational requirements, or because they have a criminal history; seven out of ten. Our nation's poor health isn't just a matter of chronic disease 30 or 40 years down the road. We are a less safe country right now because we are an unhealthy country.

And then, third, it's imperative that as your Surgeon General we partner to address the opioid epidemic. The opioid epidemic has been a top priority for the administration, for HHS Secretary Azar, and for my office. Did you know that in America right now more people are dying every day from opioid overdoses than are dying from breast cancer? People with opioid use disorder are not just our patients. They're our family, they're our friends, and, if you're like me, they're your brother. To address this epidemic, my office is focusing on three critical areas: prevention through better pain management and safer prescribing, educating the public, and saving lives with naloxone. Four out of five heroin users got started with prescription opioids, theirs or someone else's. And it's important that you hear that, theirs or someone else's, because a lot of you out there say, "It's not my patients." But do you know where all those pills that you prescribed ended up? Maybe not in the hands of your patient, but maybe in someone else's hands. They may be that gateway to a child becoming a person with substance use disorder.

As physicians, we have to help prevent addiction before it starts. My office is working with healthcare professionals to improve prescribing practices by using resources like the CDC Guidelines, and we're trying to help patients understand the benefits of alternatives to opioids and how to safely store and dispose of prescription opioids. Critically, critically important.

I'm also working to educate the public about the severity of the epidemic and to destigmatize addiction. Just last week I was on the Today Show and NBS Nightly News to announce the administration's launch of a new PSA campaign aimed at 18- to 25-year-olds. Two-thirds of those in treatment say they got started with an opioid pill before the age of 25. We partnered with the Ad Council and the Truth Initiative to show how quickly addiction can happen and the unimaginable things people will do to maintain their addiction. It's a collection of four different vignettes: one about a young man who broke his own hand with a hammer and another about a gentleman who kicked a jack out from under his car while he was laying underneath of it and broke his back so that he could get opioids. True stories. I encourage you to go to opioids.thetruth.com to see these shocking ads.

I'm further asking folks to help destigmatize addiction by sharing your own personal stories at crisisnextdoor.gov. I share my story about my brother and my family's fight with addiction on that website, and the President has shared his story about addiction, but there are so many other stories of both tribulations, but of recovery on there. I really encourage you to take a look.

We must help the public understand addiction is a chronic disease and not a moral failing. Now, make no mistake about it, my brother made some bad decisions. There are often bad decisions involved. But I've got to ask you, when's the last time you refused to give someone insulin because they ate fast food? When's the last time you refused to do CPR on someone because they had a pack of cigarettes in their pocket when you found them? And as physicians we must say loudly for all to hear, "We will not deny treatment to individuals with the brain disease of addiction." Won't do it.

Like all other diseases, addiction must be treated with skill, with compassion, and with urgency. And like other chronic diseases, we have evidence-based treatment that works, and we know recovery is possible, but we have to help the public and policymakers understand that.

Finally, I'm focused on putting naloxone in the hands of first responders and community members. In April I issued the first Surgeon General's advisory in over ten years highlighting the use of naloxone as a way to combat opioid overdoses. You've heard the statistics: there's a person dying every 12.5 minutes of an opioid overdose. But here's the shocker: over half of them, 56 percent, are dying in a home environment. This means we can't rely on docs, we can't rely on EMS, we can't rely on police to reverse these trends. All Americans need to become first responders.

My advisory is well aligned with the AMA's Opioid Task Force recommendations urging more Americans to carry naloxone. And speaking of that Opioid Task Force, I applaud Dr. Patrice Harris and the Opioid Task Force for its work to reduce and reverse the opioid epidemic. As documented in a recent AMA report, the combined efforts of the Opioid Task Force and other leading national health organizations showed that physicians, all of you, have decreased opioid prescriptions nationwide by 22 percent in the last five years. PD&P registration and use nearly tripled between 2014 and 2016, and treatment capacity is increasing. As of last month, there were more than 50,000 clinicians certified to provide buprenorphine in office for the treatment of opioid use disorder. That's a 42 percent increase in the past 12 months. And we are making progress. I'm confident we will end this opioid epidemic, but we can only get there by working together. As highlighted in the AMA report, this will take a concerted effort amongst prescribers, pharmacists, drug manufacturers, policymakers, and insurers.

I want to close the discussion on opioids by talking for just a minute about stigma.

We're in the midst of dual crises, dual crises of undertreated pain and overprescribed opioids. And stigma is a significant problem both for those living with chronic pain and for those with substance use disorders. And that stigma exists not just among the public, but if we're going to be honest, among our colleagues, and perhaps even among some of you. Eleven percent of adults, over 25 million people in the United States, are living with daily pain. That's more than the number of people in the State of Texas. As a nation, we have to examine our attitudes about patients suffering from chronic pain.

As clinicians focused on providing patient-centered care, we have to remember that the vast majority of patients with chronic pain are not drug-seeking. We must take the time to listen to our patients without judgment and learn about how they got to where they are and the challenges that they face as they seek a return to function, or at least a way to cope, especially if we're pulling the rug out from under them by decreasing availability of opioids without providing reasonable alternatives.

And we must use the same discernment to reduce the stigma for individuals with substance use disorders. We need to change the conversation about what it means to have the disease of addiction. We must help America understand that MHE, harm reduction and naloxone do not enable continued drug use. What they do is #EnableRecovery.

I applaud the AMA for providing resources that can help physicians better understand, treat and remove stigma in their practice and their community. And I encourage you all to visit end-opioid-epidemic.org for more information. But as we bring it home, it's important that we realize the opioid epidemic is not so much the problem as it is a symptom. As clinicians, we especially must resist the temptation to view this epidemic as needing only a healthcare solution. The deeper problem lies in the lack of health and wellness in our communities. So many of today's most

pressing health issues have shared risk factors, whether it's opioid addiction or unwanted pregnancies, gun violence or suicide, heart disease or cancer. We can't solve these health issues without focusing on upstream prevention and tackling the root causes plaguing the health of our communities.

How many of you all have heard out Don Berwick's Triple Aim, by a show of hands? He talks of lower cost, improved patient experience, and higher-quality outcomes. I personally think it's important that we intentionally include health equity in this framework. But many in the AMA have talked of adding clinical experience, clinician experience as part of the Quadruple Aim. This is to address physician burnout.

I asked Dr. Google, and Dr. Google said burnout is physical or mental collapse caused by overwork or stress. I contend to you that you won't truly make a dent in the Quadruple Aim, including addressing burnout, unless we become better at upstream prevention.

With credit to Richa Manchanda for some adaptations, I'm going to tell you a quick story to close that may be familiar to some of you.

There were three friends: David, Barbara and Andy. Sound familiar? They were having a picnic alongside a river when they noticed several people were struggling in the water. Those in the water were not only struggling to stay afloat, but they were headed towards a big drop-off that would surely kill them if they didn't drown first.

Now, Andy, he was a great swimmer, so he ran to just above the drop-off and he dove in, and Andy was amazing. Person after person he saved. But his energy started to wane, physically, mentally and emotionally. At first Andy gave all the people he saved a big smile and a high five. But now he barely looked most in the eye. To some, Andy said, "Didn't I save you once already?" At his lowest point, he even snapped, "Didn't your parents teach you how to swim?"

So Dave went a little further upstream. Dave grabbed some sticks and some string and he made a raft, and he used his raft to pull people out of the water before they got near the drop-off. Now, Dave's raft, it worked great, but he couldn't catch everyone. There were too many people, the water was going too fast, the raft was too small. The effort did provide some downstream relief to Andy, but both he and Dave were still overwhelmed and cranky. They were burned out.

Suddenly, they both said, "Where the heck is Barbara?" She was walking further upstream. "Hey, Barbara, where are you going?" Anyone know what Barbara replied? She said, "I'm going to go and find out where and why all these people are falling into the dang river." And she did. She put up signs and barriers and educated passersby, and Dave and Andy's efforts were still needed downstream, but fewer people fell in and the three friends had a much better experience when they were at the river. They even had time to get back to their picnic.

Now, there's no doubt that we make Andy and Dave's jobs harder if we make them get a prior authorization before they rescue someone. Their day is harder if they're inundated with lawsuits based on the people they couldn't save, or if we make Andy and Dave stop after every save and spend time documenting the details. If that hypothetically were to occur, fixing such problems would be incredibly important. But I'd contend they alone won't solve the burnout problem. We know 10 percent of healthcare, of getting and staying out of the river, 10 percent of health is getting and staying out of the river is healthcare, while 60 percent is behavior and environment.

So if you have ten people to save and you focus only on making healthcare delivery, or the save, easier, you're still going to have ten people to save. You may help one; the other nine are going to slip by and go off the drop-off or they're going to end up right back in the river again. But if you focus upstream, six of those ten people never fall into the river in the first place, and maybe fewer of the ones that do fall in never end up coming back.

So I ask you, imagine you're Andy or David; would you rather have Barbara spending all her time trying to make it easier for you to save the ten knowing many of them will come back and add onto another ten and another ten and another ten? Or would you want her to spend some of her efforts to decrease the number of people who are falling in upstream? Which approach, the singular one or the combined approach, is going to be more effective at lowering cost, at improving outcomes, at making for happier patients, and at relieving provider burnout?

So how do you get upstream? Whether we're looking to combat the opioid epidemic, improve our nation's health outcomes or strengthen our national prosperity and security, we need partnerships and we need collaboration. And

that's why my motto is "Better Health through Better Partnerships," because we can't achieve our individual or mutual goals unless we're at the table together sharing lessons learned and challenging each other to do more, to do it better, and to do it together.

For an even more concrete description of how you can become an upstreamist, I suggest looking up Dr. Manchanda's talk on YouTube. It talks about practical ways you can partner; for instance, by partnering with community groups to provide food for diabetics, which we know in many cases can be more powerful than changing their insulin. I'm proud to hear about the work that AMA members are undertaking to foster new partnerships, such as the Target BP effort with the American Heart Association and the Prediabetes Risk Assessment with Samsung.

I want to close by stating that the AMA is not just a community of physicians; it's a community of leaders. That means you not only have an opportunity, but I'd contend to you as a fellow AMA member that you have an obligation to make a difference in the lives of patients beyond your day-to-day practice. We must deliver more health to our nation so we can deliver both less sick care and better healthcare.

So I'd like to leave you with a few challenges.

First, as you advocate for your patients and our nation's health, I challenge you to think of ways you can move your care upstream and to think of at least one new person or organization you can partner with. Second, if you haven't already joined me in raising awareness for the use of naloxone, an easy-to-save lifesaving medication that can reverse the effects of an opioid overdose. I want every single one of you the next time you go into a pharmacy to ask whether or not you can get naloxone, because the folks tell me it's supposed to be available by standing order in all 50 states. But we need to normalize it. If you're someone who comes in and asks for naloxone and they roll their eyes at you, they judge you, you're just going to walk out. We need to normalize it the way we normalized CPR. Fourth, as clinicians you've been on the front lines of the opioid epidemic, so I challenge you to share your stories on CrisisNextdoor.gov and on the AMA's website, End-Opioid-Epidemic.org. Your story can empower others the way me sharing my story about my brother has empowered so many.

And finally, to be a leader in health conversations, I implore you—hear me when I say this—I implore you to reject the binary. Life isn't black and white, and neither are the health issues you and our society are debating: guns, abortion, drug policy, access to healthcare and who pays. Now more than ever our society needs to be able to have a bold and a civil discussion on these issues. And physicians, especially members of the AMA, need to lead that discussion.

Finger-pointing and sound bites from entrenched camps don't get us to where we're going to need to be. No matter what they say about the AMA and its membership, I can tell you from my own personal experience members really do move medicine. The AMA is who congress listens to; the state medical societies and associations are who the state legislators listen to. And if we don't have a fully vetted position on these issues, or worse, if we get sucked into the morass and the bickering, the all-or-none, the good-vs.-evil rhetoric, our society will suffer.

So be the leaders that America needs us to be. Be the leaders I know you can be. Be the change that you want to see in this world, because AMA members don't just have the ability to move medicine, my AMA moves hearts, my AMA moves minds. AMA members, our AMA moves the world.

Thank you so much for the opportunity to address you. It's the honor of my life to be your United States Surgeon General, and I look forward to continuing the rest of this meeting and coming back for many, many more. Thank you so much.

RETIRING DELEGATES AND MEDICAL EXECUTIVES

American Academy of Family Physicians
John Meigs, Jr, MD

American Psychiatric Association
Carolyn Robinowitz, MD

American Society of Anesthesiologists
John Neeld, MD

Connecticut
Seyed Aleali, MD

MedChi: The Maryland State Medical Society
George H.A. Bone, MD

Georgia
Joy A Maxey, MD

Michigan
Alan Mindlin, MD

Senior Physicians Section
John Knot, MD
Claire Wolfe, MD

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES (A-18)

Reference Committee on Amendments to Constitution and Bylaws

Peter H. Rheinstein, MD, JD, Academy of Physicians in Clinical Research, Chair
 Mark Adams, MD, New York*
 Thomas M. Anderson, Jr., MD, Illinois
 Douglas R. Myers, MD, American Academy of Otolaryngology-Head and Neck Surgery
 Camran Nezhat, MD, Society of Laparoendoscopic Surgeons
 Robert Panton, MD, Illinois*
 Brandi N. Ring, MD, American College of Obstetricians and Gynecologists*

Reference Committee A (Medical service)

Jonathan D. Leffert, MD, American Association of Clinical Endocrinologists, Chair
 Toluwalase Ajayi, MD, American Academy of Pediatrics
 Peter Aran, MD, Oklahoma*
 Micah Beachy, DO, American College of Physicians
 Christine P. Bishop, MD, Illinois*
 Maryanne C. Bombaugh, MD, Massachusetts
 Beverly Collins, MD, American College of Medical Quality*

Reference Committee B (Legislation)

R. Dale Blasier, MD, North American Spine Society, Chair
 Edward P. Balaban, DO, American Society of Clinical Oncology
 Erin Harnish, MD, Washington
 Mark Kogan, MD, California*
 William Monnig, MD, Kentucky*
 Gary Pushkin, MD, Maryland*
 Luis Seija, Texas, Regional Medical Student

Reference Committee C (Medical education)

Sherri Baker, MD, Oklahoma, Chair
 Grayson Armstrong, MD, American Academy of Ophthalmology, Sectional Resident
 Cheryl Gibson Fountain, MD, Michigan*
 Alan Klitzke, MD, American College of Nuclear Medicine
 David Lewin, MD, American Society for Clinical Pathology
 Kim Templeton, MD, American Academy of Orthopaedic Surgeons
 Jessica Walsh-O'Sullivan, Florida, Regional Medical Student

Reference Committee D (Public health)

Shannon M. Kilgore, MD, American Academy of Neurology, Chair
 Michael A. DellaVecchia, MD, Pennsylvania
 Diana E. Ramos, MD, American College of Obstetricians and Gynecologists
 Cynthia C. Romero, MD, Virginia*
 Ralph Schmeltz, MD, Pennsylvania
 Victoria Sharp, MD, Iowa

Reference Committee E (Science and technology)

Douglas W. Martin, MD, International Academy of Independent Medical Evaluators, Chair
 Allan A. Anderson, MD, American Association for Geriatric Psychiatry
 Jessica Cho, MD, New York*, Sectional Resident
 Robert H. Emmick, Jr., MD, Texas*
 Jean Elizabeth Forsberg, MD, College of American Pathologists*
 J. Leonard Lichtenfeld, MD, American College of Physicians

Reference Committee F (AMA finance, governance)

Julia V. Johnson, MD, American Society for Reproductive Medicine, Chair
 Anthony J. Armstrong, MD, Ohio
 A. Patrice Burgess, MD, Idaho
 Melissa J. Garretson, MD, American Academy of Pediatrics
 Jerry L. Halverson, MD, American Psychiatric Association
 Ann R. Stroink, MD, Congress of Neurological Surgeons
 Greg Tarasidis, MD, South Carolina

Reference Committee G (Medical practice)

Theodore A. Calianos, II, MD, Massachusetts, Chair
 Joseph A. Adashek, MD, Nevada*
 Steven M. Falcone, MD, American College of Radiology
 Brian Gavitt, MD, American College of Surgeons
 Kathryn Lombardo, MD, Minnesota*
 Michele Manahan, MD, American Association of Plastic Surgeons*
 Peter S. Rahko, MD, American Society of Echocardiography

Committee on Rules and Credentials

John M. Montgomery, MD, Florida, Chair
 Jerome C. Cohen, MD, New York
 Sharon Douglas, MD, Mississippi*
 Jan Marie Kief, MD, Colorado
 H. Timberlake Pearce, Jr., MD, South Carolina
 William Ritchie, MD, New Mexico*
 Cyndi J. Yag Howard, MD, American Academy of Dermatology

Chief Teller

James Bull, MD, Illinois

Assistant Tellers

Rebecca Brendel, MD, American Psychiatric Association*
 Nikan H. Khabiti, MD, California*
 Loralie D. Ma, MD, Maryland*
 Jill M. Owens, MD, Pennsylvania*
 Keshni Ramnana, MD, Wisconsin*
 Sherif Z. Zaafran, MD, Texas*
 Robert Zaring, MD, Kentucky*

Election Tellers

Daniel Edney, MD, Mississippi*
 Christopher Flanders, DO, Hawaii*
 Terrence Grimm, MD, American Urological Association*
 Shane Hopkins, MD, American Society of Radiation Oncology*
 Woody Jenkins, MD, Oklahoma*
 Steve Lee, MD, American Society of Clinical Radiology*

* Alternate delegate

INAUGURAL ADDRESS: Barbara L. McAneny, MD, was inaugurated as the 173rd President of the American Medical Association on Tuesday, June 12. Following is her inaugural address.

When Physicians Lead

Good evening and thank you. It is my great honor to stand before you as the President of the American Medical Association. When I was accepted into medical school, it never occurred to me that one day my peers would select me for this position. I am truly humbled and I promise you that I will do my best to live up to your expectations.

As physicians we are – first and foremost – healers. That has been true throughout human history and it remains true even in the highly-specialized, highly regulated and technologically advanced environment of health care today. In all cultures, healers are accorded a respected status, and held to a higher standard of behavior. Our profession is unique in many ways, and our privilege as healers derives from our patients’ trust, the means through which we are able to see people as they really are in body and spirit. Physicians and patients understand that any betrayal of that trust can be devastating, which is why the doctor-patient relationship is sacred and the cornerstone of health care.

But the role of physician, of healer, comes with great responsibility. We pledge ourselves to a code of ethics, promising to uphold the standards that define our work, and committing ourselves to mastering our craft through lifelong learning. As leaders, we join medical associations and specialty societies to develop and enact new policies, working to build a legacy we can be proud of. As healers, we will always put the needs of our patients first. We are medicine’s moral compass, and our strength lies in our collective expertise, our insights and our values.

As we gather tonight we are at an urgent time for health care in America. The practice of medicine as we have long known it is changing at a dizzying rate, bringing disruptive challenges but also great opportunity. As our nation struggles to provide high-quality, affordable health care to everyone, our practices must now integrate concepts we weren’t taught in medical school: population health, team-based care, estimations of quality and value, and more.

Some changes have dramatically improved care: amazing advancements in technology, in genomics and precision medicine. Who could have imagined 10 years ago that today we’d treat metastatic melanoma as a chronic disease instead of a death sentence?

But each of us in this room, and our colleagues in the field, know that these sweeping changes also bring an increasingly dysfunctional economic model to health care. Daily, we confront obstacles that make the delivery of care less efficient and, in some cases, less effective. We see an increasing concentration of wealth and power in large corporations altering the power dynamic, challenging our values and straining the critically important doctor-patient relationship.

Consider the term “providers” as we are so often called these days. It devalues our expertise, our education, and our empathy. It demeans our status as professionals and erodes public trust. We are not providers. We are physicians! And as physicians we are increasingly tied up in regulations, requirements and procedures that interfere with and often delay how we care for our patients.

Our daily grind now includes two more hours every night on the computer, clicking away on electronic health records after we’ve put the kids to bed. Market consolidation. Shareholders. Benefit managers. Profit margins. Rising administrative salaries. Options for good insurance are dwindling and becoming unaffordable to large numbers of people, supplanted by choices that tout lower premiums but provide shabby benefits when life-saving care is required.

We see our patients losing the ability to choose their physicians and their site of care. This hasn’t produced healthier people. Giant insurance companies, now hand-in-hand with national pharmacy chains, seem determined to merge and further consolidate power at the very top, inevitably raising prices and shrinking options for us, and for our patients. Hospital consolidation is squeezing out competition and driving up profits while health disparities in our communities grow, and too many people are priced out altogether.

Even the simple but important act of choosing the most appropriate consultant to whom a patient is referred—a long established tradition that independent physicians depend on—has been largely stripped from our control. This has eliminated one more crucial touch-point: discussion between peers that ensure our patients receive well-coordinated, fully informed care. Communication between physicians can never be replaced by navigators. And for those faced

with a life-threatening diagnosis, the patients I see in my clinic, moving ahead with treatment often means choosing between the financial security of their family and their own health. After all, a majority of bankruptcies in the U.S. are triggered by a medical emergency or long-term illness, and often those happen to people with health insurance.

As physicians, as healers, we see all of this and far too often we feel powerless to change the direction where health care is headed. The challenges are immense. It's painful. It's frustrating, and it's burning us out because the health care system doesn't seem to respect us, our patients or the values we are committed to uphold. I fear we're seeing the dawning of the Medical Industrial Complex, where Americans spend far more on health care than any country on earth, and yet we rank just 19th in the industrialized world in health outcomes and 31st in life expectancy.

But here's the good news; yes, there is good news. As physicians we have everything we need to fix what ails our health care system. We have the most important ingredients in our hands. We have our patients' trust. We have the will, the expertise, and the view of our system from its most crucial point: inside the exam room with patients.

And thanks to organizations such as the AMA, as well as state and specialty societies, we have a voice. We have a platform from which we can lead on any issue and work to re-align our health care system so that patients and physicians are back in the center!

You, my colleagues here tonight, and those I meet when I'm on the road, inspire me and give me hope that all is not lost. I am encouraged by history. Nelson Mandela, from prison, took on institutional racism and apartheid in South Africa, ushering in a new era of freedom and social justice for his countrymen. I consider the words of Margaret Mead, who wrote, "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has." Or the writer Sylvia Plath, who once famously observed, "I don't believe the meek will inherit the earth; the meek get trampled and ignored."

This is our moment; we cannot waste it. We will not be meek. You want some more good news? As physicians, we don't have to go it alone. We have each other: dedicated, smart, creative physicians working together.

The AMA reflects our values and our interests because we write the policies, and we represent all of our diverse physician community, all backgrounds and all specialties. I look at the fantastic leaders that we have chosen seated behind me on this dais. I have seen it change in my time on the board to become more diverse and inclusive, reflecting the changing make-up of America's doctors, and I am incredibly encouraged.

Over the last year, the AMA has been the leading voice nationally to protect patients from losing their health coverage, a precept grounded in our Code of Ethics: that we are to support access to care for all people and provide that care with compassion and respect for human dignity and rights.

We, the AMA, are the champions in this new era of value-based care, working directly with CMS to ease the transition for physicians, helping us avoid payment penalties, and keeping the focus where it belongs on improved outcomes for patients.

As the AMA, we know that when physicians suffer it impacts nearly every segment of medicine, which is why we have sounded the alarm about the importance of physician wellness, and worked aggressively in Washington, DC to reduce administrative burdens and the most common sources of burnout. We can and we must create a health care system that deserves to be our life's work. We directed our AMA, this remarkable collection of dedicated doctors and management and staff, to lead the charge to reform prior authorization, which often delays treatment and negatively affects patient outcomes. And we will keep working on regulatory burdens until we have a system that no longer impedes doctors' ability to care for patients.

We, the AMA, led a national coalition to protect consumers from further consolidation in the insurance marketplace, and we continue to analyze and keep close watch on new attempted mergers and acquisitions. We, the AMA, have committed ourselves to ending health disparities for at-risk populations, raising awareness about early detection for chronic disease and expanding treatment options in underserved communities. And we, the AMA, are committed to a more inclusive profession, one that includes new voices, new ideas, and new leaders at the table.

The AMA is doing all of this and still our health system is suffering, so we must do more. Health care already runs on our licenses, our knowledge and our expertise. We must make it run on our values as well! Because when physicians

lead, we reject the politics and the policies that divide us. We speak out for patients. When physicians lead we recognize the complex social determinants of health and their impact on our patients, and we will find a way through the AMA's investment in new data models to measure and address them.

When physicians lead we are willing partners with data scientists, software engineers, and tech innovators, working to bring value to the next digital breakthroughs in medicine. When physicians lead we create a system with protections and resources for our colleagues, whether in independent practices, working in large hospital systems, or in academic institutions training our future colleagues. We must arm doctors with the skills needed to align the resources of their institutions with the goals of health. When physicians lead we care for people regardless of race, religion, economic status or sexual orientation, and we fight policies that treat immigrants or refugees in a manner that we would not tolerate for our own families. As physicians, as leaders, we work every day to honor the values that best represent us, to be worthy of the trust our patients place in us and the respect that our family and friends have for us.

I am thankful to have so many of my friends and loved ones here with me tonight. I'm immensely grateful for the support and love of my husband, Steve Kanig, Chair of the small but mighty New Mexico delegation. I am honored that my family, Larry, Faye, Grant and Bren McAneny, Julie and Al Pitts, and Gary Kanig, are here to share this special night with me.

The partners with whom I started the New Mexico Cancer Center, Clark Haskins and Richard Giudice, and the partners who will lead it into the future, Annette Fontaine and Jose Avitia, as well as many good friends, some of whom are also patients, have traveled to be with me as well. I am so honored to have each of you here.

We have come a long way together. Many of you have been part of my life since I began my career as an oncologist. Back then all I wanted was to take care of every cancer patient in New Mexico. Some of the best lessons I've learned, that have guided me in my career, have come from my patients in their most vulnerable moments.

It's not safe to ever assume you know what someone wants; you have to ask. Approach each patient with humility because you can't really know the values and customs of differing cultures. But I also learned that some problems cannot be solved one patient at a time; some require solutions that change the system.

As we work to create a system that benefits patients instead of the Medical Industrial Complex, we must realize that there is always more than one way to look at a problem. We cannot assume that one system will work for every medical condition, every specialty, every culture or every community. Most importantly, to change the system, our most valuable asset is the trust of our patients, and that trust must be earned every day.

We cannot avoid change. What is not yet decided is who will manage the changes ahead in medicine. Will the changes reflect the values of doctors or the expectations of shareholders? Will they increase health, or only increase profit? Will we show respect in caring for all people, or save money by carving some people out of the system? Who can be a better steward of our resources, doctors working with patients to provide the care they value, or CEOs in the corner office?

Our patients need us to fix health care. Now is the time for doctors—armed with our Code of Ethics, the values of our profession, and the resources of organized medicine—to step up and create a system that is worthy of our patients and their trust! We are physicians! We are healers! We are the AMA!

Thank you.