

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

74th INTERIM MEETING

Honolulu, Hawai'i

November 12–15, 2022

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 74th Interim Meeting at 1 p.m. Saturday, November 12, in the Kalakaua Ballroom at the Hawai'i Convention Center in Honolulu, Hawai'i, Bruce A. Scott, MD, Speaker of the House of Delegates, presiding. The Sunday, Nov. 13, Monday, Nov. 14, and Tuesday, Nov. 15 sessions also convened in the Kalakaua Ballroom. The meeting adjourned following the Tuesday session.

INVOCATION: The House was welcomed to Hawai'i in the form of a native chant by AMA members S. Kalani Brady, MD, MPH, and Hawai'i Medical Association Angela Pratt, MD, both of whom are also native Hawaiians. They also delivered the invocation as a native chant.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Marilyn Laughead, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Saturday, Nov. 12, 562 out of 692 delegates (81.2%) had been accredited, thus constituting a quorum; on Sunday, Nov. 13, 632 delegates (91.3%) were present; on Monday, Nov 14, 660 (95.4%) were present; and on Tuesday, Nov. 15, 662 (95.7%) were present.

RULES REPORT - Saturday, Nov. 12

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 his judgment, it will expedite the business of the House, subject to any objection sustained by the House.
4. Privilege of the Floor
The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.
5. Procedures of the House of Delegates
The June 2022 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 90 second limitation on debate per presentation subject to waiver by the Speaker for just cause.

7. Conflict of Interest

Members of the House of Delegates who have an interest that is or may be material to the matter being considered and that would reasonably be expected to impair the objectivity of the individual who is testifying, must publicly disclose that interest immediately prior to testifying at a reference committee on the matter or speaking on the floor of the House of Delegates on the matter.

8. Conduct of Business by the House of Delegates

Each member of the House of Delegates and the AMA Officers resolutely affirm a commitment to abide by our AMA Code of Conduct.

9. Respectful Behavior

Courteous, collegial and respectful behavior in all interactions with others, including delegates, is expected of all attendees at House of Delegates meetings, including social events apart from House of Delegates meetings themselves.

SUPPLEMENTARY REPORT - Sunday, Nov. 13

HOUSE ACTION: **ADOPTED AS FOLLOWS**

LATE RESOLUTIONS 1001 (228) and 1002 (609) ACCEPTED EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS

(1) LATE RESOLUTIONS

The Committee on Rules and Credentials met Saturday, November 12, to discuss Late Resolutions 1001 and 1002. The sponsors of the late resolutions met with the committee and were given the opportunity to present for the committee's consideration the reason their resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended for acceptance:

- Late 1001 - Urgent AMA Assistance to Puerto Rico and Florida and a Long-Range Project for Puerto Rico
- Late 1002 - AMA Declares Its Support for Turkish Physicians Imprisoned in Turkey in Violation of the Human and Professional Rights

(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 007 – Consent for Sexual and Reproductive Healthcare
- Resolution 207 – Preserving Physician Leadership in Patient Care
- Resolution 217 – Restrictions on the Ownership of Hospitals by Physicians
- Resolution 218 – Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse
- Resolution 220 – Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis
- Resolution 314 – Balancing Supply and Demand for Physicians by 2030
- Resolution 315 – Bedside Nursing and Health Care Staff Shortages
- Resolution 803 – Patient Centered Medical Home – Administrative Burdens
- Resolution 807 – Medicare Advantage Record Requests
- Resolution 922 – Firearm Safety and Technology

- Resolution 927 – Off-Label Policy

APPENDIX - Reaffirmed Policy and AMA Activities

Resolution 007 – Consent for Sexual and Reproductive Healthcare

- Confidential Healthcare for Minors 2.2.2
- Mandatory Parental Consent to Abortion 2.2.3
- In addition, at the A-22 meeting, “Resolution 621 - Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted” was adopted and created a taskforce to preserve the patient-physician relationship against bans or restrictions of abortion and other evidence-based care. This task force responds to third part of Resolution 007’s resolved clause which asks for: “protecting physician autonomy to provide sexual and reproductive health care with minor consent, without parental consent.”

Resolution 207 – Preserving Physician Leadership in Patient Care

- Protection of the Titles “Doctor,” “Resident” and “Residency” H-275.925
- Definition and Use of the Term Physician H-405.951
- Definition of a Physician H-405.969

Resolution 217 – Restrictions on the Ownership of Hospitals by Physicians

- Hospital Consolidation H-215.960

Resolution 218 – Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse

- Addressing Emerging Trends in Illicit Drug Use H-95.940

Resolution 220 – Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis

- Licensure and Telehealth D-480.960

Resolution 314 – Balancing Supply and Demand for Physicians by 2030

- US Physician Shortage H-200.954
- Revisions to AMA Policy on the Physician Workforce H-200.955
- Primary Care Physicians in Underserved Areas H-200.972
- Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
- Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958

Resolution 315 – Bedside Nursing and Health Care Staff Shortages

- The Growing Nursing Shortage in the United States D-360.998

Resolution 803 – Patient Centered Medical Home – Administrative Burdens

- Physician Burnout D-405.972

Resolution 807 – Medicare Advantage Record Requests

- Limiting Access to Medical Records H-315.987

Resolution 922 - Firearm Safety and Technology

- Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
- Ban on Handguns and Automatic Repeating Weapons H-145.985

Resolution 927 - Off-Label Policy

- Patient Access to Treatments Prescribed by Their Physicians H-120.988

CLOSING REPORT

HOUSE ACTION: ADOPTED

Mister Speaker, Members of the House of Delegates:

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

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

Whereas, The Interim Meeting of the House of Delegates of the American Medical Association has been convened in Honolulu, Hawai'i, during the period of November 12-15; and

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

Whereas, The City of Honolulu 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 Hilton Hawaiian Village and the Hawai'i Convention Center, to the City of Honolulu, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Interim Meeting of the House of Delegates.

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

APPROVAL OF MINUTES: The Proceedings of the 2022 Annual Meeting of the House of Delegates, June 12-15, 2022, were approved.

ADDRESS OF THE PRESIDENT: AMA President Jack Resneck, MD, delivered the following address to the House of Delegates on Saturday, Nov. 12.

Dr. Speaker, Dr. Vice Speaker, Members of the Board, delegates, colleagues and guests,

On my inauguration night, I shared the story of Georgene Johnson, a middle-aged woman who having recently taken up jogging thought she'd signed up for a local 10k race only to realize several miles in that she had mistakenly started running the Cleveland Marathon. If you heard my speech, you may recall that after a bit of crying and some failed efforts to get herself back to the starting line, she finished all 26.2 miles. Asked later what she had been thinking out on the course, Georgene said: "This isn't the race I trained for. This isn't the race I entered. But for better or worse, this is the race I'm in."

You know, physicians have been running our own marathon these last three years, and we too are discovering unexpected challenges at every mile. How can a profession that put its lives on the line to lead our nation through this pandemic, that continues to fight an onslaught of medical disinformation amid increasing hostility and threats, how can we at the same time face ominous Medicare cuts as practice costs surge, as giant health care mergers concentrate market power, and as an ever-growing list of administrative demands pull us away from what drew us to medicine in the first place: caring for our patients?

A scary question just crossed my mind: How much will all of our EHR in-baskets grow in the few minutes that I'm up at this microphone? I kind of shudder to imagine. So predictably, we're now seeing soaring rates of physician burnout, climbing from 38 to 63 percent in 2021. One in five physicians say they will leave practice within the next two years.

I've felt many different emotions over the past five months. Mostly I've felt pride in our profession and gratitude for the privilege to serve. But those statistics, they have me deeply worried.

An article in the *The Atlantic* last year got right to the heart of the matter. The author wrote: "Health care workers aren't quitting because they can't handle their jobs. They're quitting because they can't handle being unable to do their jobs." I think a lot of us here, and our colleagues around the country, can identify with this sentiment. We haven't lost the will to do our jobs, we're just frustrated that our health care system is putting too many obstacles in our way.

That's why we need the AMA. That's why we need organized medicine, and that's why we need each other: to remove these obstacles that are driving burnout in the first place, barriers erected in Washington and state capitals, by health insurers and PBMs, and in our places of work.

But let me first talk about another emotion I've been feeling lately. It's brought on by something most of us as doctors really never expected to face. I'm angry. I'm angry about how science and medicine have been politicized, about the flood of disinformation that seeks to discredit data and evidence, undermine public health, and misrepresent the wise policy of this House and our AMA's work to implement it.

It began with COVID and lies meant to sow confusion and divide our nation; lies about masking: "You don't need them, so don't wear them"; lies about vaccines: "They have microchips or don't work, so don't use them"; lies about public health leaders and even frontline physicians: "They're profiteering from the pandemic, so don't trust them."

You are ambassadors of truth, doing the difficult work to reject these falsehoods and impart your knowledge to a weary public. But this fight is intensifying. More and more we're seeing attempts to undermine the work of organized medicine by those who seek to divide, by those who are weaponizing disinformation and misrepresenting our health equity efforts, distorting what gender-affirming care entails, ignoring mountains of evidence about what is needed to address the public health crisis of gun violence or denying the serious health consequences patients face in states that are restricting access to comprehensive reproductive health care, including abortion.

You know and I know that we did not pick these fights, and that our organization isn't on any political team. The AMA is fiercely nonpartisan. We have evidence-based, open debates in this House, and our actions are driven by the policies you create. And you represent every state, every specialty, employed and independent settings, rural and urban communities. You come from every point across the political spectrum, and I can attest to that last part from the emails you all send me. Keep them coming.

We are influential individually as physicians and collectively as the AMA because we are the grownups in the room. We follow the evidence, science is our North Star and because we work with political leaders from any party, at any time, when they are willing to help us improve the health of the nation. But make no mistake, when politicians insert themselves in our exam rooms to interfere with the patient-physician relationship, when they politicize deeply personal health decisions or criminalize evidence-based care, we will not back down. We will always stand up for our policies, for physicians, and for our patients.

This House recently reaffirmed the importance of access to comprehensive reproductive health care services, including abortion and contraception. Since we last gathered in Chicago in June, many states have raced to criminalize abortion in the wake of *Dobbs*, and the drivers of disinformation have been at it again. Now they are falsely claiming that we have exaggerated or even fabricated stories about the real consequences of those laws, stories about patients with ectopic pregnancies, sepsis, or bleeding after incomplete miscarriages, or cancers during pregnancy; patients who are suddenly unable to get the standard of care that was unremarkable for decades; patients who now must absurdly travel hundreds or thousands of miles across the country to exercise their choice and obtain basic medical care. Denying our experience is helping prop up restrictive laws that are creating chaos and leaving physicians in impossible positions.

I never imagined colleagues would find themselves tracking down hospital attorneys before performing urgent abortions, when minutes count, asking if a 30 percent chance of maternal death or impending renal failure meet the criteria for a state's exemptions or whether they must wait a while, a while longer, until their pregnant patient gets even sicker. In some cases, unstable patients are being packed into ambulances and shipped across state lines for care.

To those who are forcing physicians into these ethical dilemmas, your efforts are reckless and dangerous. As I told Congress, medicine is complicated, and doctors didn't pick this career because it's easy. What makes the practice of medicine interesting are the uncertainties of diagnosing and treating patients, and how each patient brings their own preferences and values into the equation. The tough decisions we make together with patients every day, they don't fit neatly into statute. Our jobs are hard enough without politicians second guessing our decisions.

We're already seeing serious downstream consequences. Some patients with lupus and rheumatoid arthritis can't get their methotrexate prescriptions filled. Medical students, residents and fellows in many states are being robbed of opportunities to train in the breadth of reproductive health care. Who will want to train in states where physicians can go to jail for providing the care their patients want and need?

We also know the impact of these unjust laws fall most directly on low-income communities and those who have been historically marginalized. So the AMA has filed briefs in about a dozen state and federal courts this year, met with the White House, testified before Congress, called attention to these injustices in media interviews, and continue to work on every front to mitigate the risks our patients face in the post-*Dobbs* era. But I can't sugar-coat just how dangerous it is for physicians to know that governors, legislators, state attorneys general, and law enforcement are all perched right on their shoulders in exam rooms, waiting to judge decisions we make in partnership with our patients. It's getting mighty crowded with all those folks squeezing into our exam rooms. No, we didn't pick this political fight, but we will stand up for our patients, for the policies of this House, and for our profession.

More lies cloud our ability to care for transgender patients. Drivers of disinformation say that gender-affirming care clinics are performing genital mutilation surgeries on teens, or not involving families in care decisions, or using medical treatments on young children who show up after wondering for one day if they're trans.

The bearers of these damaging falsehoods now say that our call for the DOJ to investigate those who threaten, provoke, and carry out violence against physicians or children's hospitals was a call for censorship or for government to investigate and detain anyone who disagrees with us. Simply untrue, but it's part of an effort to criminalize gender-affirming care. Physicians understand the evidence that it, along with lessening stigma and discrimination in the community, reduces depression and suicide risk among transgender or nonbinary adolescents.

Or consider the unscrupulous tactics of those who misrepresent our work on health equity, whether raising awareness and addressing hypertension in Black women, suing the FDA to crack down on menthol cigarettes, pushing upstream to influence determinants of health, or working to ensure equity in digital health and innovation. We undertake this work because we see clear evidence of appalling inequities and racial injustice, and because our ethical and moral compasses demand that we act. And, again, the genesis of this work lies in the policies of this House. But a recent *Wall Street Journal* op-ed erroneously and offensively claimed that because of these efforts we are admitting unqualified Black and Hispanic students to medical school or risking the public's health. And a fascist group protested outside a Boston hospital alleging that specific physician leaders who were engaged in health equity work were killing White patients.

Enough is enough. You know, we cannot allow physicians or our patients to become pawns in these lies. All of this is exacerbating the burnout crisis in medicine. Doctors, facing threats and obstacles on so many fronts, are tired. Some are wearing down and leaving the profession that they've dedicated their lives to. Telling them to be more resilient, do a little more yoga or enjoy a free dinner from the hospital CEO, that's not going to heal burnout. Wellness certainly has its place, but to focus solely on resilience, that's to blame the victim. We need to fix what's broken, and it's not the doctor.

While the AMA is partnering with practices and health systems to implement proven strategies and remove the pain points that make caring for patients harder, we're also addressing the larger obstacles that drive burnout at the system level. That's the foundation of our Recovery Plan for America's Physicians. One pillar of that plan is Medicare payment reform.

As we emerge from the worst of COVID, as practice costs have surged in the face of substantial inflation and physicians struggle to retain staff, I can't think of a worse time for Medicare to threaten almost eight-and-a-half percent across the board payment cuts. How demoralizing. Our AMA is fighting to stop those cuts, and I'm glad to see all of medicine aligned, aligned in this effort. We must and we will keep the pressure on Congress to act before the end of the year.

But simply blocking every planned cut, as we've done before, that's not good enough. Physicians deserve financial stability, including automatic, positive, annual updates that account for rising practice costs. And it's time for reform of unfair budget neutrality rules that penalize doctors for things beyond our control. That is exactly what the AMA and over 120 other national medical societies are demanding, state societies, and we are laying the groundwork to achieve these goals. It's not going to happen overnight, but Congress is finally beginning to understand how unsustainable and unfair it is to treat physicians so differently than hospitals and nursing facilities and others.

Restoring joy in medicine, it also requires reducing friction and the obstacles that interfere with quality patient care. There's not a more infuriating example than onerous prior authorization demands. It's not just costly and annoying for our practices; it does real harm to our patients. I'm not going to repeat the statistics; you've all heard me rail about

this before. But yet again this week, from my hotel room right here in Hawaii, I found myself filing out prior auth form for generic topical steroids invented in the 1960s.

As somebody who pretty rarely loses my temper, my clinic staff know that if I do start hollering and they hear me all the way down the hallway, I'm probably on a so-called "peer-to-peer" appeal call, arguing about a denial or some nonsensical alternative recommendation with somebody at the other end who has never heard of the disease I'm treating or the medication I'm trying to prescribe. But I'm glad to report the momentum is shifting. Almost every policymaker I talk to has experienced an unfair delay or a denial for themselves or a family member.

The House of Representatives overwhelmingly and in bipartisan fashion passed a bill that would begin to address prior auth on Medicare Advantage plans. We've still got some hurdles to overcome in the Senate, but I'm encouraged by what we've done, and that includes work in states around the country that are enacting their own prior auth reforms, many modeled on AMA's proposals. Also at the state level, the entire House of Medicine has partnered to stop dozens and dozens of unsafe scope expansion proposals. In my home state of California, our governor was persuaded to veto a pretty radical bill that would have allowed optometrists to perform laser eye surgery, ocular injections, and other complex procedures. Not only is it unsafe to remove physicians as leaders of the health care team, but a growing body of evidence shows that doing so actually increases cost. Guided by evidence, driven by quality and patient safety, we'll keep fighting for physician-led teams.

Some of the challenges we're facing weren't unexpected, but like Georgene Johnson in her unplanned marathon, some, some are a little surprising. Taking a lesson from Georgene, I'm neither deterred nor hopeless. I'm determined. The wise policy that emerges from debates in this House gives us the map we need to navigate the course ahead, even if it's not exactly the race we trained for.

Yes, we face the threat of reckless Medicare cuts and too many obstacles erected by health insurers at a time of growing burnout. Yes, there are unprecedented attacks on our profession, on science, and on our patients. But like me you are here because you believe our collective action can make a difference. You believe in science and the humanity of our profession. And most importantly, you share a resolve to use the power of organized medicine to fight back against the pressures we face, to create a health care system that is more equitable, more accessible, and that works better for doctors and patients. On this we are united. On this we will never waver. We will never back down.

Thank you very much.

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, Nov. 12.

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

2022 is a year of milestone anniversaries at the AMA. In my remarks at our Annual Meeting in June, I celebrated our 175th anniversary and our remarkable legacy. Today, I'll focus on another anniversary: it's been 10 years since the launch of the AMA's long-term strategic plan.

When I arrived at the AMA in 2011, the search committee, composed of both members of the House and the Board, charged me with two tasks: that the AMA ever more strongly reflect our mission statement and to create a long-range strategic plan, since the committee recognized that our work meandered somewhat from year to year. Additionally, our Board at its retreat that year added an atmospheric element to the charge: that the AMA's ultimate goal must always be one of impact. But for impact, one needs focus.

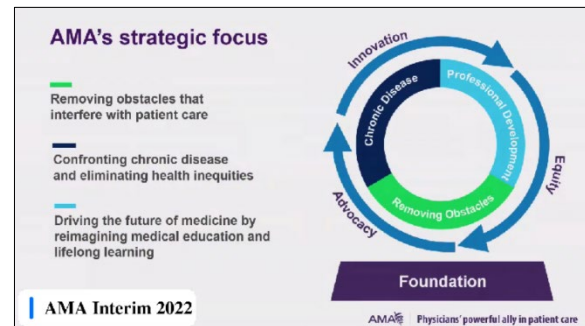
An audit of our work at that time revealed that we had over a hundred different projects, many unrelated to one another; often modest in scale. At the same time, our policy portfolio was quite broad, and policies were numerous. By zooming out to a bird's eye view of those projects and policies, just like one does using Google Earth, we could see what I'll refer to as meta signals from our House policy, as well as some thematic clustering of some projects that could be better aligned and thus more focused, and therefore more impactful. Consolidating and focusing on those meta signals was key to developing an AMA long range strategic plan. Now, I'll review that in a second, but first I'd like to make two related points.

First, our long-range plan is dynamic. The framework of the plan evolves based on the needs of our ever-changing health care environment. Each year, management, working with the Board and informed by the work of our councils, refines a five-year environmental outlook. This allows us to continually shape the plan. Second, there will always be short-term needs to be attended to.

While a focused long-range strategic framework concentrates our work and increases our impact, it does not consume one hundred percent of our effort. What better example than the COVID pandemic? There will always be unanticipated short-term needs, as well as resolutions from this House that require immediate attention. Balancing focused long-term needs with diverse short-term needs, that's the art of what we do.

So what are the meta signals in our policy portfolio that allowed focused work on a critical set of issues? And these will be familiar to you.

Here is a graphic of the strategic framework. Bottom right, you'll notice that the entire framework rests on a foundation of ongoing "must haves," such as membership, finance, science and public health, as well as several other essential teams. Those foundational elements support the three strategic arcs, the arcs being listed on the left and shown on the right as the inner circle. The arcs, in no particular order, are Chronic Disease (that is, confronting this public health crisis that consumes 90 percent of our nation's health care cost), Professional Development (which drives the future of medicine through reimagined education and lifelong learning), and Removing Obstacles that interfere with patient care and that is minimizing administrative hassles and, in their place, substituting more time with our patients.



As shown on the right in the outer circle, work in three arcs is further powered by the cross-cutting accelerators of Advocacy, Equity, and Innovation. Advocacy helps memorialize progress in each arc by, for example, sculpting the regulatory domain. Advancing health equity is how we help to ensure optimal health for all people. And innovation is critical if we are to be an organization that goes beyond simply convening to one that does and creates.

Typically in these presentations I focus on updates of progress in these areas. However, my goal today is to explain the origin and the evolution of the strategic framework and how it contributes to making us the leading organization that we are today.

For example, the arc of Professional Development; that is driving the future of medicine through physician education. That arc initially focused on undergraduate medical education. The rationale was that medical schools were a tightly circumscribed universe of education that had limited space for innovative future-oriented work. This work eventually expanded to a consortium of 37 medical schools. It created the third science of medical education, health system science, and spun out many other innovations now being broadly integrated into curricula. Over time this arc grew and expanded, but in a way that maintained intellectual cohesion. We now have an additional consortium of 11 integrated health systems focused on reimagining residency with the singular goal of optimizing the transition from medical school to residency and residency to practice. We also created the AMA EdHub for digital education. We're early on in this work, but already we offer more than 9000 online resources developed from nearly 40 trusted sources, and that includes 13 federation societies, and with the additional participation of numerous specialty boards, state licensing boards and other institutions, such as the CDC and Stanford.

So you can see how a meta signal, in this case medical education, has matured in the decade since its introduction from a sole focus on undergraduate medical education into a budding cohesive and coordinated pipeline of lifelong learning that physicians need in the 21st Century.

Another example is from the arc dedicated to improving the clinical environment by removing obstacles interfering with patient care. One extension of this work is the recently launched AMA Recovery Plan for America's Physicians, and that was covered in detail by Dr. Resneck. Longer-term examples in this arc include innovative approaches to improving the physician environment represented by newly formed companies from our Silicon Valley-based Health2047 enterprise. These include a company, Emergence, that aims to support the back office and other

organizational management needs in practice. Importantly, the model here is of the company working for and serving physicians, not the other way around. Another company, SiteBridge, imagines smaller practices being able to participate in clinical trials without the usual administrative and capital complexity, something that federal health agencies have expressed an interest in as they hope to obtain real-world data from diverse sources.

Now, the future of these companies will be revealed in the next several years. Venture formation takes time. But the point is that in all of the arcs, the AMA is taking longer-term innovation approaches, as well as attending to critical short-term concerns.

The third arc, focused on chronic disease, displays other general principles of our long-range framework. Here we help patients at high risk for heart disease better manage their blood pressure, and we provide support for physicians to help patients get there. Hypertension being the number one cause of death and disability in our nation makes it an obvious place to start. A key component of this arc, as with all of our arcs, is that to truly act on large problems it is best to do it in partnership with others.

Over the last 10 years, we've raised public awareness of the risks of chronic disease in partnership with the American Heart Association, the CDC, the American Diabetes Association, the National Medical Association, the Association of Black Cardiologists, the Ad Council, and others. We launched our AMA blood pressure quality improvement program with peer-to-peer coaching and a digital dashboard that is being used in health systems now around the country, work that has demonstrated positive impact on blood pressure control when used in collaboration with physicians. Also with the American Heart Association, we recently recognized 1300 health care organizations committed to blood pressure control, organizations that help more than eight million people with hypertension improve their heart health.

This arc of chronic disease also underscores the importance of our health equity work. Chronic disease such as hypertension disproportionately affects those from historically disinvested and minoritized communities. Our work on hypertension is enhanced by our broad efforts to advance racial justice in medicine and eliminate health inequities, this work led by the AMA Center for Health Equity.

Now, to summarize, we've traveled far in the last ten years, as reflected in the growth and evolution of our long-range strategic plan. Understanding how we got here and the origin of what we set out to do, that information and an informative vantage point to evaluate the relevancy of our work today.

I don't know what our health system will look like in 10 years, let alone mid-century, but I do know that if physicians don't have a better practice environment supportive of their efforts in patient care, if we don't train and educate physicians for the needs of 21st Century medicine, if we don't better handle the tsunami of chronic disease now cascading on physician offices, if we don't do these three things on which our strategic framework focuses, then our health care system, regardless of its structure, will function even worse than it does today. It will be up to physicians, it will be up to physicians and physician leadership, and that's to all of us, to realize the promise of this work, which in the most basic and fundamental of ways promotes the art and science of medicine and the betterment of public health.

Thank you.

REMARKS OF THE CHAIR OF THE AMPAC BOARD: The following remarks were presented to the House of Delegates on Saturday, Nov. 12 by Stephen Imbeau, MD, Chair of the AMPAC board.

I'm Steve Imbeau, Chair of AMPAC.

AMPAC makes sure it's in the DC room no matter the political wind so that the AMA can be there, too, when decisions are being made on our critical issues. Our voice is heard in DC because of AMPAC and because of you.

To those of you who have invested in AMPAC this year, thank you. To those of you who have not yet invested, please ask yourselves if you want to stay on the sidelines or do you want to come and join in our fight?

Visit our booth, which is just outside the door, and I forget which one Dr. Scott said is the right one to use—over there [Points toward stage left side toward rear], and on the slide. Well, the slide doesn't show anything. Okay.

Politically, it appears the sands may be shifting in the halls of Congress, but our interests and those of our patients remain the same. They're constant, no matter what party is in the majority, or almost. That is why AMPAC needs you and why you need AMPAC.

We just had our drawing for AMPAC's big game day Super Bowl sweepstakes. The game of course will be held in Phoenix, Arizona, on February 12. I'm delighted to announce that Dr. Thomas Epps, Jr., of Forest, Virginia, is the lucky winner. Tom, the staff will reach out to you with the details. Congratulations, and enjoy the Super Bowl.

And, by the way, I want some pictures for the newsletter.

I first came to AMA in 1977, for three years with the Resident Section. I came back in 1992, as the Speaker has mentioned. In 2014, I was appointed to the AMPAC Board for the mentorship of doctors Randy Smoak and Gerry Harmon. Now I am come to my end. I want to thank you all for so many years of friendship, collegiality and, yes, support. Thank you so much. I will miss you. Farewell.

Mahalo. Mahalo.

REPORT OF THE AMPAC BOARD: The AMPAC Board of Directors, Stephen A. Imbeau, MD, Chair, provided this written report to the House of Delegates:

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. As the nation continues to recover from the recent COVID-19 pandemic and its effects on health care delivery, our mission remains important as ever, to provide physicians with opportunities to support candidates for federal office who have demonstrated their willingness to work with physicians to strengthen our ability to care for America's patients. In addition, we remain committed to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

AMPAC Membership Fundraising

Thank you to the House of Delegate members who gave to AMPAC in 2022, especially those who contributed at the Capitol Club levels. AMPAC fundraising is emerging from the pandemic years with numbers trending in the right direction, with an increase in participation and overall totals. During this midterm election year AMPAC's upward fundraising trend could not be timelier in helping us achieve adequate support for champions and allies of medicine running for federal office.

Thus far AMPAC has raised a combined total of \$1,659,738 in hard and corporate funds for the 2022 election cycle. AMPAC's Capitol Club has 729 members to date, which is up from the prior two years. AMPAC also established a special Election Investor level this year where members contributed \$222 in 2022 and there were 240 members who invested at this level. Currently, HOD State delegation AMPAC participation stands at 68 percent compared to 2021 where the House ended with a 52 percent participation rate.

Due to the logistical challenges of having a speaker in Hawaii, AMPAC is not hosting a Capitol Club luncheon during this meeting. Although AMPAC is not having an official event, all 2022 Capitol Club members should be sure to stop by the AMPAC booth to pick up a special Capitol Club gift. The AMPAC booth is located right outside the House of Delegates meeting room in the Convention Center and will be open for business on Saturday through Tuesday. Of note, AMPAC is accepting contributions for the 2023 membership year.

Finally, as we close the door to 2022, this is a reminder that the next election cycle has already begun. We are only as effective as we are united in our advocacy efforts, and we look forward to the support of our House of Delegate members as we set out to engage in a successful 2023.

Political Action (as of 11/9/22)

In an increasingly toxic political environment, AMPAC once again made an indelible mark on behalf of medicine investing more than \$1.3 million in the 2022 cycle. The job was made more difficult by candidates on the extreme ideological fringe of both parties seemingly more intent on partisan conflict rather than seeking solutions to serious policy challenges. But AMPAC navigated this landscape well with help from the AMA's government affairs team as well as input from state medical society PACs to guide the Board towards those candidates who will work to advance medicine's agenda. This pragmatic strategy paid off by creating access to key decision makers and giving the AMA the ability to shape and ultimately affect the outcome of legislation in critical areas including telehealth, Medicare physician payment and prior authorization.

With close to 60 House and Senate contests still to be determined, the final outcome of the 2022 midterms remains murky. What is clear as of now however, is that neither party was provided a clear mandate and that the American people will expect bipartisan cooperation from their leaders in Washington, DC to solve the challenges that face our country. This should be a good legislative environment for medicine and one where solutions-oriented candidates backed by AMPAC thrive.

AMPAC's direct contributions to 247 physician-friendly House and Senate candidates from both political parties (62% to Democratic lawmakers and 38% to Republican lawmakers) will continue to ensure that medicine has a place at the table when important health care policy debates take place. Of those races that have been decided, a total of 196 AMPAC supported candidates won election/reelection. The number of physicians in Congress will at least stay at 17 due to Rich McCormick, MD, and his victory in Georgia's sixth district. Currently, there are four other races involving physician candidates that have yet to be called. One is the incumbent in Washington State's eighth district, pediatrician Kim Schrier, MD. Two physician challengers in California and one in Colorado are also waiting for the final vote to be tallied. Once all results are in, the total number of physicians in Congress will be between 17 and 21.

Political Education Programs

After two years of conducting the political education programs virtually, AMPAC is proud to announce that on September 29 – October 2, the 2022 Campaign School was held in-person at the AMA offices in Washington, DC. Physicians, residents, medical students, and physician spouses from across the country participated in the three-day training program. With a hands-on approach our team of veteran campaign trainers walked them through a simulated Congressional campaign, teaching each of them everything they need to know to run a successful race as either a candidate or campaign staff. They also heard from a group of bipartisan political experts on topics including polling, messaging and strategy, digital media, and speech coaching. The program once again received high marks from the participants this year.

Barring any COVID-19 related setbacks, the 2023 AMPAC Candidate Workshop will also return to an in-person format in the spring of 2023. The program will once again offer participants the skills and strategic approach needed to be a winning candidate for office. During the one-and-a-half-day program, participants will learn how and when to make the decision to run, the importance of a disciplined campaign plan and message, the secrets of effective fundraising, the role of spouses and family and much more. Dates for the 2023 Candidate Workshop have not been finalized.

AMPAC is also currently accepting nominations for the 2023 Award for Political Participation. Awarded every two years, the AMPAC Award for Political Participation recognizes an AMA or AMA Alliance member who has made significant personal contributions of time and talent in assisting friends of medicine in their quest for elective office at the federal or state level. These can include volunteer activities in a political campaign or a significant health care related election issue such as a ballot initiative or referendum. The full criteria for the 2023 AMPAC Award for Political Participation including how to submit a nomination can be found on ampaonline.org.

Conclusion

On a final note, James Milam, MD, Anna Yap, MD, Hart Edmonson, and I are completing our terms on the AMPAC Board of Directors. The newly appointed members of the Board will be Bruce MacLeod, MD from Pennsylvania, Sion Roy, MD, from California, resident Victoria Gordon, DO, from Texas, and medical student Juliana Cobb, MS,

from Kentucky. We wish them a rewarding and successful experience as they join the returning members of the AMPAC Board to achieve AMPAC's critical mission in support of the AMA's federal advocacy agenda.

RETIRING AMA OFFICERS, DELEGATES AND MEDICAL EXECUTIVES**Connecticut**

Michael Carius, MD

Georgia

Jack Chapman, MD

Gary Richter, MD

Illinois

Peter Eupierre, MD

Nestor Ramirez, MD

Laura Shea, MD

Indiana

Stephen Tharp, MD

Thomas Vidic, MD

Iowa

Michael Kitchell, MD

Louisiana

Floyd Buras, MD

Jeff White, MD

Minnesota

David Estrin, MD

New York

Laurel Mayer

Oregon

Sylvia Emory, MD

South Carolina

Stephen A. Imbeau, MD

Texas

Asa Lockhart, MD

**American Academy of Child and Adolescent
Psychiatry**

Louis Kraus, MD

American Academy of Dermatology

Andrew P. Lazar, MD

American Academy of Pediatrics

Charles J. Barone II, MD

American College of Emergency Physicians

Michael Bishop, MD

American College of Radiation Oncology

Dennis Galinsky, MD

American Society of Colon and Rectal Surgeons**Ronald Gagliano, MD**

Harry Papaconstantinou, MD

Society for Vascular Surgery

Timothy F. Kresowik, MD

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES (I-22)

Reference Committee on Amendments to Constitution and Bylaws

Susan L. Hubbell, MD, American Academy of Physical Medicine and Rehabilitation, Chair
 Afifa Adiba, MD, Connecticut, International Medical Graduate Section
 Emily Briggs, MD, American Academy of Family Physicians
 Amish Dave, MD, Washington*
 John C. Kincaid, MD, American Association of Neuromuscular & Electrodiagnostic Medicine*
 Laila Koduri, Louisiana, Regional Medical Student
 Carlos Latorre, MD, Mississippi

Reference Committee B (Legislative advocacy)

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 Kenneth S. Blumenfeld, MD, American Association of Neurological Surgeons
 Tilden L. Childs, III, MD, American College of Radiology
 Daniel Choi, MD, New York, Private Practice Physicians Section*
 Kelly Clark, MD, American Society of Addiction Medicine*
 Karl Steinber, MD, AMDA - The Society for Post-Acute and Long-Term Care Medicine
 Kiersten Woodyard, MD, Ohio*

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 Marygrace Elson, MD, American College of Obstetricians and Gynecologists
 Renato Guerrieri, MD, American College of Physicians
 Heidi Hullinger, MD, American Academy of Orthopaedic Surgeons
 Pauline Huynh, MD, California, Sectional Resident
 Alex Malter, MD, Alaska

Reference Committee F (AMA finance, governance)

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 Shilpen A. Patel, MD, American Society for Radiation Oncology
 William Reha, MD, American Association of Clinical Urologists*
 Michael Simon, MD, American Society of Anesthesiologists

Reference Committee J (Advocacy on medical service, practice and insurance)

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 Amar Kelkar, MD, American Society of Hematology
 Anne Mongiu, MD, American Society of Colon and Rectal Surgeons
 Jason Schwalb, MD, Congress of Neurological Surgeons
 Natalia Solenkova, MD, International Medical Graduate Section*

Reference Committee K (Advocacy on science and public health)

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 Elisa Choi, MD, American College of Physicians
 Cee Ann Davis, MD, American College of Obstetricians and Gynecologists
 Leanna (Leif) Knight, New York, Regional Medical Student
 Christopher Paprzycki, MD, Ohio*
 Jennifer Stall, MD, American Society for Clinical Pathology
 Raymond K. Tu, MD, District of Columbia

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Andrea Hillerud, MD, Minnesota

Assistant Tellers

Deepak Azak, MD, Indiana*
 Donaldo Hernandez, MD, California*
 Vikram B. Patel, MD, Illinois*

* Alternate delegate