AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

150TH ANNUAL MEETING
CHICAGO, ILLINOIS
June 17-21, 2001

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 150th Annual Meeting at 9:00 a.m., on Sunday, June 17, in the International Ballroom of the Hilton Chicago and Towers, John A. Knote, Speaker of the House of Delegates, presiding. The Tuesday session, June 19, Wednesday session, June 20, and Thursday session, June 21, also convened in the International Ballroom. There was also a closed session of the House on Tuesday, June 19, with only Delegates, Alternate Delegates, and ex officio members of the House in attendance.

INVOCATION: J. Edward Hill, MD, AMA Trustee, delivered the following invocation on Sunday, June 17:

Let us pray. Almighty God, ruler of the universe, we come together to seek your presence. We gather here of diverse faiths but unified purpose. Pause to consider our blessings, mindful that we may be more fortunate and more privileged than many. May we be grateful and humble knowing that we are each subject always to the unforeseen and the unknown.

Our Father, endow us with a strong and increased sense of responsibility. Bless us with a sense of responsive dedication to each other. Bring forth the ability we need as we try to meet the demands of our work for this generation and those to follow.

Lord, we ask your blessing for our leaders, our staff, and each member of this House of Delegates of the American Medical Association as we make important decisions for our patients and our organization. Prepare us for a deepening of our professional unity and our professional collegiality through dedication and personal investment to unselfish service to all persons.

Father, forgive our faintheartedness and forgive us for those times when we have become impatient or overbearing in our decisions and judgments. O Lord, we seek your guidance in making vital decisions, inspire us with a sense of fairness as we work to direct the course of medical care. Many times we have hesitated and faltered. So in the future help us all to be gentle yet decisive and firm in reaching our conclusions. Always let understanding prevail.

Lord, today is Father's Day. As physicians and fathers and grandfathers, we pray for a world free from violence for all our children. We ask that you use each of us when and where we are able to contribute to ongoing peaceful efforts. Heavenly Father, each of us comes before you with special hopes and dreams, each of us has personal worries and concerns. Each of us has a prayer that no one else can say. Each of us brings praise that no one else can offer. Each of us feels joy no one else can share and each of us has regrets which others cannot know.

Give us the vision and purpose to meet the challenges before us. Unite us, Lord, as we strive to do your will and make us worthy instruments of your peace and love so that in the fullness of time, it will be said of each us, well done, thy good and faithful servants. Amen.

CREDENTIALS: The Convention Committee on Rules and Credentials reported that on Sunday, June 17, 503 out of 547 delegates (92.0 percent) had been accredited, thus constituting a quorum; on Tuesday, June 19, 540 out of 547 delegates (98.7 percent) were present; and on Wednesday, June 20, and Thursday, June 21, 545 out of 549 delegates (99.3 percent) were present. (On Tuesday, two additional national medical specialty societies were granted representation in the House of Delegates.)

REPORTS OF THE CONVENTION COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Sandra Adamson Fryhofer, MD, Chair:

Sunday, June 17

HOUSE ACTION: ADOPTED

Your Committee on Rules and Credentials recommends that:

1. House Security

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

2. Credentials

   The registration record of the Convention 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 2000 edition of the "Procedures of the House of Delegates" shall be the official method of procedure in handling and conducting the business before the AMA House of Delegates.

6. Limitation on Debate

   There will be a 3-minute limitation on debate per presentation subject to the Speaker, who may waive the rule for just cause.

7. Nominations and Elections

   The House will receive nominations for President-Elect, Speaker, Vice Speaker, Trustees, and Council Members on Sunday morning, June 17. Speeches will be limited to candidates for Officers and Trustees with no seconding speeches permitted. The order will be selected by lottery.

   The Association's 2001 annual election balloting shall be held Wednesday, June 20, between the hours of 7:30 a.m. and 8:45 a.m. as specified in Sections 3.40 and 6.90 of 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 the Normandie Lounge of the Hilton Chicago. The Convention 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 company technician, who will direct the voter to a voting machine and provide any assistance that is requested.

   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 Sunday.

8. Conflict of Interest

Members of the House of Delegates who have a substantial financial interest in 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.

Supplementary Report, Sunday, June 17

HOUSE ACTION: LATE RESOLUTIONS 1001 (247), 1002 (248), 1003 (134), AND 1004 (818) ACCEPTED

EXISTING POLICY REAFFIRMED IN LIEU OF RESOLUTIONS 105, 106, 112, 113, 116, 123, 124, 125, 126, 128, 201, 206, 212, 213, 215, 219, 227, 228, 232, 241, 311, 312, 405, 417, 502, 703, 706, 710 AND 712

RESOLUTIONS 102, 103, 203, 217, 223, 229, 233, 236, 239, 504, 704, 705, 708, 711 AND 713 EXTRACTED AND REFERRED TO APPROPRIATE REFERENCE COMMITTEES

The Convention Committee on Rules and Credentials met Saturday, June 16, 2001 to discuss Late Resolutions 1001 through 1004. Sponsors of Late Resolutions that are received prior to a week before the opening of the House of Delegates are informed of the time the Convention Committee on Rules and Credentials meets to consider Late Resolutions, 1:00 p.m. on Saturday, and the opportunity to present for the Committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting. Sponsors of Late Resolutions 1001 through 1004 appeared to discuss their resolutions.

LATE RESOLUTIONS

Because of the number of Late Resolutions, your Committee is including its recommendations on a consent calendar based upon whether or not the resolution met the criteria for consideration as a Late Resolution.

CONSENT CALENDAR

Recommended for Acceptance:

1. Late Resolution 1001 - Modification of Pending Federal Bankruptcy Legislation
   Submitted by Florida Delegation

2. Late Resolution 1002 - Collective Bargaining and the Definition of Supervisors
   Submitted by Michigan Delegation

3. Late Resolution 1003 - Medicare Reimbursement for Vitamin D Therapy for Dialysis Patients
   Submitted by Florida Delegation

4. Late Resolution 1004 - Vignettes from Aspen Systems Corp. Proposed for Medicare Carrier Audits
   Submitted by American College of Chest Physicians, American Thoracic Society, American Academy of Allergy, Asthma and Immunology, American College of Allergy, Asthma and Immunology, Society for Critical Care Medicine, American Academy of Sleep Medicine, Oklahoma Delegation, Missouri Delegation, Pennsylvania Delegation, and Nebraska Delegation

REAFFIRMATION RESOLUTIONS

The Speakers asked the Convention 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. The Committee recommends that current policy be reaffirmed in lieu of the following resolutions:

1. Resolution 102 - Medicare/Medicaid Dual Eligibles
2. Resolution 103 - Prescription Drug Plan for Medicare Patients
3. Resolution 105 - Medical Savings Accounts
4. Resolution 106 - Cost Differential of Drugs in the US and Abroad
5. Resolution 112 - Reimbursement for Physician Services
6. Resolution 113 - Increasing Physicians' Awareness of Pharmaceutical Programs for Patients who are Uninsured, Underinsured or Indigent
7. Resolution 116 - PhRMA's Prescription Drug Patient Assistance Programs
8. Resolution 123 - Physician Payment for Services Provided
9. Resolution 124 - Cost of Living Adjustment to Compensate for Rising Overhead Medical Expenses
10. Resolution 125 - Federal Laws Controlling Medical Savings Accounts Should be Revisited
11. Resolution 126 - Proposed $1.50 Surcharge by the Department of Health and Human Services for Each Paper Claim Submission to Medicare
12. Resolution 128 - Unfair Retroactive Denial of Medicare Payments for Twenty-three-Hour Post-Ambulatory Surgical Stays in the Hospitals that Occurred Three to Ten Years Ago
13. Resolution 201 - Health Care for the Economically Disadvantaged
14. Resolution 203 - DNR Bracelets
15. Resolution 206 - Honoring Assignment of Benefits
16. Resolution 212 - Mandatory Survey Participation
17. Resolution 213 - Collective Bargaining
18. Resolution 215 - Deductibility of Interest on Student Loans
19. Resolution 217 - Medicare Law
20. Resolution 219 - Qui Tam Lawsuits
21. Resolution 223 - National Data Bank for Adverse Information on Physicians and Other Health Care Practitioners
22. Resolution 227 - Independent Contracting Outside Medicare
23. Resolution 228 - National Practitioner Data Bank
24. Resolution 229 - Coverage for Emergency Services
25. Resolution 232 - Cost to Physicians to Implement Government Mandated Rules and Regulations
26. Resolution 233 - Costs to the Private Medical Practitioner of Complying with New Unfunded Federal Mandate Called the "Needlestick Safety and Prevention Act"
27. Resolution 236 - Expansion of Medicare Coverage for Preventive Services
28. Resolution 239 - Peer Review Protection under Federal Law
29. Resolution 241 - Medical Error Reporting
30. Resolution 311 - Full Reimbursement for Training Costs of PGY V and VI of Child Psychiatry Training
31. Resolution 312 - Medicare Cuts and Teaching Hospitals
32. Resolution 405 - Drug Coverage for Smoking Cessation
33. Resolution 417 - Vaccination Schedule Should be Accepted by all Insurance Carriers
34. Resolution 502 - Use of Animals in Research
35. Resolution 504 - Genetic Discrimination
36. Resolution 703 - Elimination of Unilateral Managed Care Contracting
37. Resolution 704 - Managed Care Plans and the Right to Set Fees
38. Resolution 705 - Claims Denial and Payment Delays
39. Resolution 706 - Confidentiality of Medicare Peer Review Information
40. Resolution 708 - Physician Privileges Application--Timely Review by Managed Care
41. Resolution 710 - Class Action Lawsuits
42. Resolution 711 - The Distinction Between a Late Claim and an Interrupted Claim Filing
43. Resolution 712 - Preapprovals Under Medicare Part B
44. Resolution 713 - Medical Necessity Determinations under Medicare

Thursday, June 21

HOUSE ACTION: ADOPTED

Your Convention Committee on Rules and Credentials wishes to commend the Speaker, Doctor Knote, and the Vice Speaker, Doctor Nielsen, 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 Convention 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 17-21, 2001; and

Whereas, This Annual Meeting of the House of Delegates has been most profitable and enjoyable from the viewpoint of policy deliberations and fellowships; 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 several participating hotels, to the City of Chicago, to the members of the Alliance who always contribute so substantially to our meetings, and to the splendid men and women of our American Medical Association staff who participated in the planning and conduct of this Annual Meeting of the House of Delegates.

APPROVAL OF MINUTES: The Proceedings of the 54th Interim Meeting of the House of Delegates, held in Orlando, Florida, December 3-6, 2000, were approved.

ADDRESS OF THE PRESIDENT: The following remarks were presented by Randolph D. Smoak, Jr., MD, President of the American Medical Association, on Sunday, June 17:

TAKING ON OUR SHARE OF THE GLOBAL HEALTH BURDEN:
OPPORTUNITIES FOR THE PHYSICIANS OF AMERICA

Thank you, Mr. Speaker.

As you know, this is my last address to this House as your President. Soon the long, incredible journey of my Presidency will draw to a close. It has been a privilege to serve you and an honor to speak to you, especially today, on this one-hundredth anniversary of our House of Delegates.

As a Southerner, history and tradition are both passions of mine, and so I want to share a few facts about 1901, the year when the House of Delegates was reconfigured to resemble what we know today.

That year, Dr. Emil Von Behring, from Germany, was given the first Nobel Prize in medicine for his work on diphtheria--work that led to a vaccine and to the end of much human misery.

Here in the United States, the American Medical Association was striking out for a new and better world. Our lobbying efforts helped prevent passage of a bill that would have thwarted medical research on animals. And *JAMA*, which we had founded barely twenty years earlier, achieved the largest circulation of any medical journal in the world.

That same year, we sent delegates to France, Cuba, Mexico, and Canada, because, even then, the AMA understood the importance of the world beyond our borders. Today, JAMA is published in 12 languages and 18 countries--in fact I recently saw a copy on a physician's desk in Japan. I was there representing the AMA just as those delegates represented us in 1901.

Indeed, it has been my privilege to represent the AMA in many international forums this past year.

It is said that journeys transform the traveler. As I have boarded aircraft headed to El Salvador and Paris and Beijing, I have felt the powerful truth of these words, and I have come to understand, in a new and profound way, that being a physician in today's global village means serving as a guardian of the world's health.

Especially when it comes to the diseases that recognize no borders or boundaries. Diseases such as antibiotic-resistant tuberculosis, West Nile Virus, and, of course, AIDS.

I remember in the early 1980s, when the House of Delegates first began addressing AIDS. The Council on Scientific Affairs recommended that an expert panel be formed to report the latest scientific facts. This would help the House fulfill its resolution to "develop and issue advisories for physicians...responding to AIDS, and to encourage research aimed at eliminating this syndrome."

Back then, 40 percent of those infected were dead within a year, and we needed the science to help set the policies. Today, thanks to breakthroughs in treatment, we have transformed AIDS into a manageable, chronic illness, and massive educational efforts have enabled us to reduce the rate of infection in certain populations.

The House has supported both the research and the awareness campaigns in these intervening years. And we should be proud of what we have helped to accomplish, even as we continue to explore what more we can do in terms of prevention, education, and treatment.

But today, I want us to look beyond our own experiences and practices--indeed beyond our own borders--to nations that are, literally, dying of AIDS.

According to recent estimates, approximately 36.1 million people in the world have AIDS. The vast majority of those infected live in sub-Saharan Africa. Approximately 4 million of those people were diagnosed last year alone. By 2010, it is estimated that sub-Saharan Africa will have 71 million fewer people than it would have had--had AIDS not decimated its adult population. Of those who survive in 2010, 40 million will be orphaned children.

The figures are mind numbing--and heartbreaking, especially when we remember that each one of those millions is a human story and a human face. And that in places like Russia, China, and India, the epidemic has just begun.

What's even more chilling, however, is that AIDS is not the only killer our planet faces. These millions of AIDS deaths are only a portion of the preventable deaths that will take place in the new century.

One of the most devastating killers we will face is one that began its journey around the globe over four hundred years ago: Tobacco.

Now this might seem funny coming from a guy named Smoak. But the bare facts aren't funny at all. In our nation alone, tobacco kills more than 430,000 of its best customers each and every year – more people than AIDS, alcohol, car accidents, murders, suicides and illicit drugs combined.

Globally speaking the situation is much, much worse. In the United States, somebody dies from tobacco use every eight minutes. But in the world, there are eight tobacco-related deaths per second. By 2025, tobacco-related illnesses will claim 10 million lives worldwide every year.

That's like taking the population of the Chicago metropolitan area--from Kenosha, Wisconsin to Gary, Indiana--and wiping it out. Year after year. Most of the victims will be from developing nations, where there is little regulation--and less education--about the dangers of tobacco.

So what can we do, in the shadow of these two killers and in the face of so many other threats to global health? The question itself threatens to overwhelm us, especially as individual physicians and citizens. Especially from these distant shores. Especially across the barriers of language and culture.

But we need to recall the devastating diseases that we have already conquered--like smallpox. And diseases that we are close to eradicating--like polio. Last year, I was proud to present the first International Nathan Davis Award for a Global Public Health Initiative to the Polio Eradication Initiative, a coalition of organizations that hopes to certify the eradication of polio by 2006.

Last night, I attended the second International Nathan Davis Awards dinner. There our AMA honored Sir Richard Doll for his work of fifty years ago on tobacco and its relationship to cancer, and to the Gates Foundation for its commitment to global health, including AIDS prevention and treatment.

The efforts of these people are an example for all of us. Especially men and women like you, who know how to partner with other people and organizations--to get the job done, and who know what it means to use our collective moral authority as physicians--to have an impact on the world we share.

In my time as President, I have witnessed our influence firsthand in my interactions with the World Health Organization and the World Medical Association.

Indeed, one of the most powerful experiences I have had as AMA President was testifying at a meeting of the World Health Organization in Geneva in support of its Framework Convention on Tobacco Control. This working document outlines international parameters on issues such as tobacco taxation, advertising and marketing, and it forms the basis of what we hope will be the world's first public health treaty.

The regulation of the sale and use of tobacco is not a new concept for Americans. In this country, there have been massive efforts to prevent tobacco use, particularly in children and teens. Thanks to these efforts, we've reduced smoking by almost 20 percent in the last 10 years.

If we could do for the world just what we have managed to do in our own country, millions upon millions of lives could be saved. And that's a powerful thing.

Another arena where I have seen physicians have an impact is with the World Medical Association, or WMA. The WMA is best known for establishing the highest international medical standards in science and ethics--through the creation of "The International Code of Medical Ethics" and "The Declaration of Helsinki." This function is vital to global health--by setting standards for research, treatment, and prevention.

The WMA also advocates for international health policy on issues that range from the problem of communicable diseases in prisons to the impact of poverty on well being to tobacco control.

We have made it part of our own AMA agenda to work in partnership with the World Medical Association for the betterment of human health. But you don't have to be the President of the AMA or attend a meeting of the World Health Organization or the World Medical Association to change the world.

Just look deep into your heart for the spark of idealism that first called you to become a physician. The same spark that brought you here today.

Then turn your gaze outward, beyond the borders of this great nation, and go to those places where our care is so desperately needed--and bring along your medical bag. Be inspired by the example of Dr. Albert Schweitzer in Africa. Or Dr. Tom Dooley in Asia. Or Doctors Without Borders--all over the world.

You don't have to give a lifetime. Or even six months. There are dozens of programs that help place physicians in short-term assignments abroad. For six weeks. For two weeks. Or even one.

I have seen how even in short time frames we can change the world. One day at a time. One life at a time.

Several years ago, I traveled to the Caribbean. I saw a child who had lost both hands from grasping an electrical wire. The child had just been fitted with artificial limbs by a visiting physician. She put on those limbs and for the first time in over two years, she was able to pick up a pencil.

The look on her face was something I will never forget. There wasn't a dry eye in the room. That one physician and his work made all the difference in the life of that child.

In the coming year, I am making it my personal mission to make more of these opportunities possible--for the children, and for us--by gathering information about international programs for physicians and by making that information more accessible--beginning with a web page. Such a web page, sponsored by the AMA, would link the programs that need our help to the physicians of this country.

Residents, with their energy and enthusiasm. Physicians at mid-career, at the peak of their form. And retired physicians, who have a lifetime of experience to share.

If I've come to believe anything in the past year, it's this: The physicians of America are the greatest, untapped resource that we have when it comes to preserving global health. I can't think of anyone better than our AMA to help mobilize them.

My time as AMA President is drawing to a close. But when I get back home, I won't forget what I have seen and learned. When I cross the bridge over the Cooper River in Charleston, I'll stop to look at the massive cargo ships docked below--and I'll think about the countries they have come from and where they might be headed next.

I'll also remember that one human being can make a difference in this world.

Because every ship in that harbor carries a mark--called the Plimsoll line. It's the line that shows the depth to which a properly loaded ship can sink, and it's named for one man – Samuel Plimsoll.

In the nineteenth century, English sailors were often forced to work on ships that were overloaded. Ships that sank. Then a man called Samuel Plimsoll took note and took action. He became a Member of Parliament and waged a long, arduous campaign. Thanks to his efforts, Parliament eventually passed the Unseaworthy Ships Bill. The Plimsoll line was named in his honor. Today this line is an international marker that ensures crews and cargoes are safe.

For us, in this 21st Century, the overloaded ships are a metaphor for the health systems of our world, many of which are sinking under the collective weight of humanity's ills. Every day, we are losing lives that could have been saved had these ships not been loaded beyond what they could bear.

Today, more than ever, we need to learn from the example of Samuel Plimsoll--that an individual man or woman can make a difference.

By starting with the problems we see in our own shipyards--or backyards. And creating standards to address these issues. By participating in the political process--as Plimsoll did in Parliament and as you are doing here today. And, finally, by bringing all that we have learned and achieved to the world. Just like the Plimsoll line marks every cargo ship on international waters.

I can think of no better time than today, the occasion of the one hundredth anniversary of our House of Delegates, to renew our commitment to these ideals--as citizens and as physicians.

So let us all take up our piece of the global health burden. And let the person who makes a difference...be you.

REPORT OF THE AMA FOUNDATION: The following report was presented by Herman I. Abromowitz, MD, President of the Foundation, on Sunday, June 17:

Mr. Speaker, members of the House, honored guests, it's a great pleasure be with you here today.

This is a truly exciting time for the American Medical Association Foundation--a time when a number of new and important initiatives are underway that will help all of you in your efforts to put your patients first. Today, in addition to our traditional areas of support, we are directing our focus to programs that will enhance the patient-physician relationship beginning with the AMA Foundation's health literacy initiative. This program is designed to help you as physicians by addressing our need for new and meaningful models for interacting with our patients, and for ways to overcome communications barriers that often exist. Ultimately, we believe that these programs will provide greater opportunities for you to connect with your patients and enable them to partner in their own health care.

As leaders in medicine, we are well aware of how broad and complex the patient-physician relationship is. That is why we have developed this multi-year program. Low health literacy affects approximately 90 million Americans, costs the health care system an estimated $73 billion annually, and may result in unnecessary hospitalizations and longer hospital stays. Yet, until recently, this enormous problem has gone largely unrecognized and rarely discussed.

As physicians, we need to make sure our patients understand us and create and environment that encourages questions and makes it okay to say, "I don't understand." We must remove the idea of shame or fear of asking questions and create an environment conducive to building a better patient-physician relationship. It is my personal belief that most physicians don't realize how big the problem of low health literacy is until they start to take a closer look at the patients in their own practice.

At the AMA Foundation, we believe this problem needs serious attention and that is why just one year ago we launched a nationwide campaign to address low health literacy. Since the program's launch, we have brought together experts and corporate leaders to define the scope of the program; created a health literacy introductory kit that is being used throughout the medical community to initiate dialogue and create programs on low health literacy; launched a public awareness campaign that is receiving tremendous coverage from the news media; engaging other organizations in the program and working with government agencies on national policy initiatives. We also held a one-day symposium on low health literacy during the AMA's National Leadership Conference that was enthusiastically received by all the participants and received tremendous coverage by local and national news media.

Today, we are expanding this program with new tools and expanded resources to help reach patients, physicians and community leaders. With the feedback we've received from our early activities, we are developing new guidelines to help physicians, raise awareness, and provide new solution-oriented materials.

Our goal for this initiative is to make low health literacy so widespread that it becomes basic to health care. We believe the result of this initiative will be increased levels of communication between physicians and patient, better overall patient safety, and improved compliance and patient understanding.

As leaders in organized medicine and your communities, I ask you to work with the AMA Foundation and become dedicated ambassadors of this issue and work to identify opportunities to develop programs and partnerships with other physician leaders in your communities.

I believe that public interest is often served by private initiative. As the philanthropic arm of the American Medical Association, the Foundation has a unique opportunity to focus its strengths towards supporting areas where we can make the greatest difference. If all of you gathered here today accept my challenge to share the Foundation's vision for the future by supporting our proposed programs for medicine and the medical community, I know that we can be a powerful catalyst for change. But the future depends on your help!

I believe that now, more than ever before, the Foundation is poised to advance health care and support the medical community through a wide range of important philanthropic programs.

This year, in addition to our work with health literacy, the Foundation has continued its support for education and research. We enhanced our support to medical students and residents through our Seed Grant Research Program that encourages interest and involvement in research activities and careers. We also supported further involvement in organized medicine for medical students and residents through the Leadership Awards program. And we funded the National and three Regional Student Research Forum. Today the Foundation provides more support and has a stronger commitment to the medical community than ever before.

This year we also strengthen the leadership of the AMA Foundation with the addition of several new physician leaders who have joined our Board of Directors. These individuals have served as leaders in organized medicine at the local, state and national levels and it is a great honor to have their experience and expertise

These individuals include: Dr. Robert Bogin, formerly of Colorado and now working in New Jersey; Dr. Joseph Hatch of Utah; Dr. Barbara Rockett of Massachusetts; Dr. Krishna Sawhney of Michigan; Mr. Michael Stern of New York; and Dr. Faser Triplett of Mississippi.

Finally, I want to thank of all you who helped us celebrate the Foundation's 50th anniversary this past year and contributed to the Foundation through the "50 for 50 Challenge." Your generous response is an example of what we can achieve by working together. With the support of the House of Delegates, we raised over $25,000 during last year's Annual and Interim Meetings and this support will enable us to support a broad range of new programs.

I also thank everyone who has made a major unrestricted gift to the AMA Foundation this year. Many of our contributors come to us for designated purposed, but these unrestricted donations represent important discretionary funding for the development of new programs that address today's critical health care needs.

The philanthropic support of thousands of people has helped us get where we are today, and we want to thank all of you for being a meaningful part of the Foundation's past, especially the AMA Alliance who has served as the Foundation's primary fundraiser. Their ongoing support enables us to do some much as we are tremendously grateful.

As you can see, the AMA Foundation is developing a blueprint to strengthen our service to the medical community. We have ambitious goals and a lot of work ahead of us--and we can't do it alone. As leaders in medicine, I want to present you with an open invitation. An invitation, and a challenge--to join in partnership with the Foundation and share the Foundation's vision for the future by supporting our programs for the community of medicine.

There are many exciting changes underway at the Foundation and you'll be hearing more about each of them in the coming months. For a Foundation that has provided support to the community of medicine for over 50 years, it is certainly an important time.

As President of the Foundation, I am very proud of our past, honored to be part of its present, and excited about our future--a future that seeks to do even more. I hope that you'll join our efforts and lend your support. Thank you.

REPORT OF THE EXECUTIVE VICE PRESIDENT: The following remarks, in addition to the printed Report of the Executive Vice President, which follows his comments, were presented by E. Ratcliffe Anderson, Jr., MD, Executive Vice President of the American Medical Association, on Sunday, June 17:

Mr. Speaker, Mr. Chairman, officers and Trustees, Members of the House of Delegates, AMA staff, distinguished guests, ladies and gentlemen. Thank you for that warm welcome. This is the fourth year I have spoken before the House in my role as Executive Vice President.

And I believe that this year's news is better than ever before. The AMA is strong and vigorous. Fiscally sound. Politically powerful. Nationally respected. Ready to do medicine's business wherever and whenever we are required to do it.

Fiscally, in just one year we realized a $17.7 million turnaround. We charted a bold course and stuck to it, imposing a more cost-focused fiscal discipline that is resource-driven, and targeted at building and maintaining financial strength.

We tightened our belts considerably--reducing staff, curtailing or eliminating some programs. It has not been easy--but the results have been excellent. As we all know--no pain, no gain. And the gain has been well worth it.

Now I want to pause here for a second and thank the person who is most responsible for this turnaround. Even though many people participated in the work, it is our own splendid CFO, Denise Hagerty, who should get the lion's share of the credit for this. And I would like her to stand, and let us give her a rousing round of applause.

Not only does the AMA possess a new inner strength--it also commands an expanding outer strength that is palpable inside the Washington Beltway and perceptible to physicians, patients, and the American public outside the Beltway.

Listen to this: a recent Harris poll showed that favorable ratings for the AMA increased by 21 percent between the third quarter of 2000 and the first quarter of 2001--largely due to the public's approval of the AMA's fight for patients' rights.

And just last month, Fortune Magazine ranked the AMA number 12 in its Power 25 Survey of Washington's most powerful lobbying groups--up from number 13 two years ago. No other medical or health care organization rated higher. The Power 25 listings come from a survey of Washington insiders--lawmakers, lobbyists, Congressional and White House aides--who decide which associations, labor unions and interest groups have the most clout to get things done. And they see the AMA as more influential than ever.

And I agree. This is no accident. The AMA has the right positions on the right policies at the right time. And the best advocacy team it's ever had to drive our messages home.

Take for example, the fight to reform HCFA, the Medicare agency, now known as the Centers for Medicare and Medicaid Services. We need this reform to reduce the burden on physicians who want to focus on patient care--not paperwork and other hassles.

MERFA, the Medicare Education and Regulatory Fairness Act, the legislative vehicle for this reform, already can claim more than 30 cosponsors in the Senate--and we're pushing 200 cosponsors in the House. That's more than 200 Congressional legislators--both sides of the aisle, both houses of Congress--who support reining in some of the more abusive practices of the Medicare carriers. Who recognize Medicare's overzealousness--in using such tactics as extrapolations to terrorize the medical profession.

How do you think these lawmakers learned about the ridiculous hassles that tangle physicians up in red tape?

How some physicians spend an hour completing Medicare forms and other administrative requirements for every 1 to 4 hours of patient care? How Medicare has generated more than 110,000 pages of rules, policies and regulations? How one Georgia neurosurgeon's office receives 35 pounds of regulations a year? How at one hospital, two nurses take care of patients, while six nurses check the paperwork to make sure that it complies with all the regulations? How physicians increasingly are creating documentation in their patients' charts, not for the patient's benefit, but purely to meet government demands?

Educating lawmakers is what lobbying is all about. And nobody--no other medical or health care organization--does it better--than the AMA. That's why we are closer than ever before to a true bipartisan patients' bill of rights--just follow the action we're all seeing in Washington this week.

And the AMA is also seeing results of its advocacy efforts on other fronts. We've been encouraging Secretary Thompson--who will address this House later this morning--to prohibit funding for the regulation that requires physicians to pay for language interpreters themselves.

And we've also helped develop a multi-specialty task force to limit the scope of EMTALA and to alert the Administration to physician concerns about EMTALA. And the tax relief legislation we supported--that has now been signed into law--that will ease the staggering burden of debt medical students, residents and young physicians carry.

All thanks to the AMA's advocacy expertise. And I think Lee Stillwell and his advocacy team should also stand--and let us give them a round of applause.

Our advocacy isn't limited to inside the Beltway. Since it first rolled out last year, the AMA National House Call has firmly established itself as a magnet for the media throughout the nation. And a political force that moves the needle in Washington.

In just the past three months, House Call has put AMA officers and trustees in touch with the media and the public through 45 events in seven states: Texas, Ohio, Louisiana, Nevada, Oregon, Maine and New Hampshire.

During this time, House Call generated at least 48 radio and TV broadcasts, ten editorial board visits, four news conferences and more than 11 articles in print media, online and over the news wires--all in support of the AMA advocacy agenda--with powerful messages on patients' rights, providing health insurance coverage for all Americans, MERFA and the need for antitrust relief.

The AMA's National House Call provides the opportunity to partner with the leadership of state and local medical societies and their Alliances on their home ground and in their hometowns. So many of you have been helpful in sharing your contacts and expertise about the local media--and adding your voices to make our messages even stronger and tailored to your hometowns. Nothing targets a medical message better than the face and the voice of a local doctor. And it has given the AMA the chance to get to know grassroots physicians even more closely--so their concerns can better be addressed at the national level. And now I would like Linn Weiss and the Communications team to stand up and be recognized.

Partnership is the name of the game these days. Bridge-building--bringing together the various voices and concerns of our Federation. The power of partnership is getting things done. Like the joint response to the Institute of Medicine Report number two on medical errors and quality of care we worked on with some of the specialty societies.

Together with the AAFP, ACP-ASIM and the ACS, we sent out a message of our support for continued improvements in the health care system and a focus on system-wide improvements. That coalition put more than half a million physicians nationwide behind our message--giving it greater strength and credibility. When the leaders of organized medicine work together, it's amazing what can be accomplished.

Our approach to collaboration is seeking out the common ground. And while the common ground is sometimes hard to find, the common commitment is everywhere--everybody really does want to come together. Beginning with the shared commitment to the welfare of patients and the profession of medicine--and by continuing to ask the fundamental question, "Is it good medicine?," at every point in the health care debate--to bring focus and establish common purpose.

And nowhere is this spirit more enthusiastically embraced than by the leadership of the various sections that comprise the future of the AMA: the Medical Student Section, Resident and Fellow Section, and Young Physicians Section.

I congratulate these sections for the successful outcome of their collaboration on seeking legislative relief for medical school debt. They worked closely with our lobbyists in DC to help pass the "RELIEF Act of 2001," which increases the ranges for eligibility for the student loan interest deduction.

And during their Assembly meetings earlier this week, they suggested an innovative approach to membership--setting up phone banks so that individual members can call physicians and colleagues back home--and ask them directly to sign up as AMA members.

And it will be great to see what can be accomplished--when you who are sitting here in the House are given the opportunity--to pick up the phone and contact colleagues in your states and in your specialties--because the phone banks and lists of potential members will be available to make those calls from Monday through Wednesday.

Thinking about what the sections are doing makes me realize that organized medicine needs to pay a whole lot more attention to our younger colleagues. We need to really hear what they have to say. Because they really are not just the future of our profession--they are the now of our profession. And they shouldn't have to wait 30 or 40 years before they get folks to listen to them.

Looking around this room today, you certainly don't get a clear picture of the diversity of our profession--and most certainly of the diversity the profession will display 10 to 20 years from now. What I see when I look out from this podium is a group that is predominately white, middle-aged--and older--men. If the AMA is to survive throughout the twenty-first century, the view from here should be a potpourri of races, colors, ages and genders, to fully represent the medical profession as it appears today. And the AMA needs to figure out ways to attract that brilliant diversity.

I tell you, sometimes I feel like a public television announcer on pledge night, asking for support from our viewers when I know--and they know--they can get what we offer without ever signing up and paying for it. America's physicians can get most of what the AMA offers--our advocacy, our ethics, our professional support--without anteing up anything at all. Neither their money nor their time--just like the viewers of public television.

But like the management of the public TV stations--and other membership organizations that are trying to run in the black--those who enjoy the services of organized medicine, must be motivated to invest in the future of those services. And the AMA has to be realistic in how it does this.

The members on the phone banks look like those faithful supporters of public TV--who volunteer to be on the phones on pledge nights, signing up callers. The difference here is AMA members are making the calls, calling their colleagues to urge them to sign up--so they can add their voices, so the AMA can truly represent the majority of our nation's physicians.

There's a third arena where AMA advocacy is working hard to support the physicians of America. And that is on the Internet. The AMA is working to put physicians squarely--and securely--in the forefront of today's electronic world. And helping them practice the best medicine possible in the 21st century.

In the 19th century, the AMA worked to protect the nation from unscrupulous quacks who preyed upon an unsuspecting public, pretending to be doctors. In the 20th century, the AMA helped establish the Federation of State Medical Boards to ensure medical schools properly educate America's physicians. Now, in the 21st century, the AMA is authenticating physicians on the Internet--with the AMA Internet ID.

This digital certificate acts like a passport, allowing physicians to travel throughout the Internet and be recognized as medical professionals--assuring them that their privacy and security are guaranteed by the AMA and our new technology partner, VeriSign, a leader in Internet trust products and services.

Another Internet venture, Medem, is a partnership of more than 35 of the state, local and specialty societies, including the AMA. Through Medem, the AMA can offer members their own, customized web site--a way to establish their presence and their practices on the Internet. Giving them their own location on the World Wide Web that lets them communicate securely with their patients--around the world and around the clock. And offering them an array of business services like secure messaging, automated appointment reminders and online prescriptions.

The AMA's third Internet offering, HealthCarePro Connect--or HCPC--is a work in progress. And you'll have the opportunity at this meeting to help it progress. Ultimately, HCPC will use the latest information technology to give physicians greater control over how they are contacted and what kinds of information they receive--as well as offering physicians the unique ability to access and customize their own data. The AMA, together with Acxiom, will lead the way and create the gold standard for the collection and dissemination of information from and for physicians.

At this stage, the AMA's technology partners in HCPC are looking for us to offer feedback and advice. So when you're in the exhibit hall, make sure you drop by the HCPC booth--and help design the latest e-medicine business tool.

Some of you may know that I'm a graduate of Louisiana State University--undergraduate and med school--and I learned the other day that the Tigers' long-time baseball coach, Skip Bertman, is retiring. Coach Bertman has had quite a career with the Tigers--18 seasons, 11 trips to the College World Series, and five NCAA titles. He is someone who knows what leadership is all about. And this is his motto:

> "Anything you vividly imagine, ardently desire, sincerely believe and enthusiastically act upon must--absolutely must--come true."

I vividly imagine and ardently desire certain realities for the AMA.

I began my remarks today by telling you how pleased I am about the fiscal turnaround we've accomplished this year--and I firmly believe the AMA must continue to operate in a fiscally sound, resource-based manner--to remain viable--in Washington, DC, throughout the communities and capitals of America, and even in the uncharted territory of the Internet.

As Coach Bertman calls it--what we all vividly imagine and ardently desire--will come true. So that the AMA will succeed in the 21st century.

In closing, I thank you for all that you have done--to put the AMA where it is today--and for the opportunity to have led this magnificent Association for the past three years.

Report of the Executive Vice President

On behalf of the officers and trustees of the American Medical Association, welcome to Chicago for the 2001 Annual Meeting--the centennial anniversary of the House of Delegates.

Since we met in December, the AMA has continued its important work for America's physicians, their patients and the profession of medicine--and we've seen many accomplishments. Here are some highlights:

Making the voice of America's physicians heard. The AMA's advocacy power remains palpable inside the Washington beltway and perceptible to physicians, patients and the American public outside our nation's capital. As this year's Annual Meeting convenes, we are closer than ever to getting strong, meaningful patients' rights legislation passed in Congress. And last month, Fortune magazine ranked the AMA twelfth in its Power 25 Survey of Washington's most powerful lobbying groups. No other medical or health care organization rated higher, proving that the AMA in 2001 is more influential than ever.

Serving our members. Building membership remains one of our most challenging priorities. There are some bright spots, however. For example, although Federation membership is down this year, direct membership is up by 3,000 members. We continue to look for ways to motivate those who enjoy the AMA's services--our advocacy, our ethics, our professional support--to invest in the future of those services and join our organization. With the launch of our Unified Service Center this year and some new recruitment strategies being unveiled at this Annual Meeting, we are confident that we can realize some positive gains in membership in the second half of 2001.

Exploring new e-health opportunities. Just as it has done throughout its 154-year history, the AMA is assisting physicians and patients in a time of rapid change. It is continually identifying and developing e-health solutions--from online physician locators to customized web sites to a digital authentication system--that help streamline a physician's practice and safeguard the bond of trust between patients and their physicians. Among these initiatives is the AMA's partnership with Medem--a "dot.com" that not only has remained solid in a market full of chaos, but also is growing in its usership, support and scope.

The following pages provide a comprehensive look at the above initiatives, as well as complete activities from each of the AMA's core areas. Please read on to see what the AMA has done for America's physicians and their patients during the first half of 2001.

ADVOCACY

Government Affairs

- Aggressively advocated that HCFA's Physician Regulatory Initiative Team (PRIT) take meaningful steps to reduce the regulatory burden placed on physicians. In response to AMA's advocacy efforts, PRIT consulted with the AMA and a handful of medical specialty societies to develop a list of 15 regulatory relief projects it could undertake to reduce the burden of Medicare rules and regulations on the medical profession. The Practicing Physician Advisory Council (PPAC) reviewed and prioritized the list. This marks the first time HCFA has committed to devoting resources to resolving problems identified by the medical profession. PPAC and HCFA's priorities will include revising the Advanced Beneficiary Notice, coverage of pre-op evaluations, coverage of follow-up visits for cancer patients, certificates of medical necessity, diabetics' glucose monitoring supplies, medical residents and physician supervision requirements, and local medical review policies for laboratory services.

- Convened a specialty society work group to develop a strategic plan to bring attention to the expanding scope of the EMTALA regulations. The AMA urged the former administration and the Bush administration to refrain from issuing further EMTALA regulations until after the General Accounting Office (GAO) completed an EMTALA survey requested by the previous Congress. The EMTALA regulation has been delayed. The AMA convened the specialty societies and the GAO to make certain that the GAO was aware of physician concerns as it compiled its EMTALA report. The GAO report is expected to be published in June. The AMA/specialty society work group also developed legislative language reforming EMTALA. The legislation is expected to be introduced in the near future.

- Submitted lengthy comments in response to both the proposed and final medical privacy rules that went into effect in April. Physicians and other health care providers do not need to comply with the privacy rules until April 2003. While a number of the AMA's concerns were addressed in the final rule, problems remain. The AMA recently met with Secretary Thompson's staff to express concern about the high costs and administrative burdens imposed on the medical profession by the privacy rules. The AMA emphasized that physicians already have a strong ethical obligation to protect patient privacy. The administration is planning to make changes to the privacy rule and the AMA will continue to aggressively pursue modifications on behalf of patients and physicians.

- Continued to raise concerns about the Limited English Proficiency (LEP) guidance that was issued in August 2000. The AMA recently met with Secretary Thompson's staff to indicate that while we support the need for patients and physicians to effectively communicate about the patient's medical condition and proposed course of treatment, the unfunded mandate requiring physicians to provide interpreters for non English-speaking patients ought to be abandoned. To date, only two states have taken advantage of an offer for federal matching dollars to have state Medicaid programs pay for interpreter services. The department now is arguing that treatment of just one Medicaid patient would require the physician or other health care provider to offer interpreter services to all patients in the physician's practice. The AMA will continue to aggressively pursue this unfunded mandate, and we will look for creative solutions to address this issue.

- Monitored HCFA as it continues to develop its 2000 documentation guidelines to replace or supplant the 1995 and 1997 guidelines, but at a slower pace than initially envisioned. HCFA, through a contractor, has developed 640 pages of proposed "clinical examples" of proper documentation for 20 different specialty societies. The clinical examples currently are being reviewed by the specialties who have until early July to submit their comments. In the meantime, HCFA has agreed to refine a peer review pilot test on medical review of E&M documentation--an AMA and California Medical Association proposal. As the process proceeds, the AMA will continue to aggressively raise physicians concerns.

- Strongly advocated to HCFA and Congress that Medicare streamline the process and forms for obtaining a Medicare provider number. The AMA described to HCFA the problems that arise from physicians having to wait 6-9 months to get a provider number or make changes, such as changing their practice location. We also developed comments on a revised enrollment application form which, in addition to addressing the changes in the form, underscored many of the AMA's concerns about the procedures and timelines required to process the form. The AMA strongly recommended that HCFA make available temporary provider numbers that could be used by physicians just as temporary license plates are used--to allow them to submit claims for treating Medicare patients before their permanent Medicare number has been assigned.

- Continued to advocate--in meetings and testimony before the Medicare Coverage Advisory Committee--that the views of practicing physicians and clinical experts are reflected in Medicare coverage policies. The AMA successfully advocated that HCFA consider such clinical information as it develops policy on coverage for ambulatory blood pressure monitoring. The AMA called for HCFA to cover all drugs and biologic products that have been approved by the FDA, rather than limiting coverage only to those products that are listed in the United States Pharmacopeia National Formulary, a very limited compendium of drugs. Finally, the AMA began coordinating the development of recommendations to HCFA's Coverage and Analysis Group on how HCFA can best obtain coverage-related information from the physician community.

- Together with other physician and hospital organizations, convinced Secretary Thompson to retract and significantly improve the Clinton administration's interim final regulations governing seclusion and restraint regulations for residential treatment centers. The AMA will continue to press the Bush administration to revise an interim final rule regulating the use of seclusion and restraint in the hospital setting and to work with all affected parties to develop a consistent set of standards to replace the four inconsistent sets of standards that are now in place.

- Worked with HCFA to make the standards that Medicare+Choice plans must follow in credentialing participating physicians and hospitals consistent with those of the National Committee for Quality Assurance. New standards will require recredentialing every three years rather than every two years and permit provisional credentials for new physicians. The AMA also is talking to HCFA about ways to improve physicians' ability to acquire timely eligibility information for their Medicare patients.

- Secured changes in the proposed revised application form for obtaining Medicare provider numbers that would require advanced practice nurses to document their collaborative agreements with physicians. AMA and nearly 50 other Federation organizations had submitted a citizens petition to HCFA last June noting that the law requires nurses to have collaborative agreements in order to independently submit claims to Medicare, but that HCFA had not been enforcing this requirement. The change in the form for obtaining a Medicare provider number is a very positive step toward better HCFA oversight of this provision.

- Worked closely with the American Society of Anesthesiologists to urge the administration to withdraw a final rule, which would have eliminated the need for physician supervision of nurse anesthetists. The administration recently delayed the effective date of the previous rule and decided to publish a new proposed rule. In the meantime physician supervision will continue to be required.

- Obtained a two-month deadline extension for comments on the physician self-referral final rule. The AMA brought specialty societies together to discuss the rule and developed and circulated to the Federation a draft AMA comment letter.

- Assisted the US General Accounting Office (GAO) in identifying physician practices to participate in its study of how Medicare communicates with physicians. The AMA provided extensive input to the GAO project staff on the problems with Medicare's failure to educate physicians about its rules and models for better ways of communicating with physicians.

- Worked to ensure that $100 billion was included in the 10-year budget package--proposed by the Bush administration and just enacted by Congress to cover the uninsured--with $71 billion dedicated to providing refundable, income-related tax credits to individuals and families who do not have employer-based coverage and $28 billion dedicated to a variety of public and private approaches to expand coverage, including improving and expanding Medicaid and the State Children's Health Insurance Program and providing tax credits to small employers to purchase coverage for low-income employees.

- Successfully worked to ease student, resident and young physicians medical education debt burdens by supporting S. 152 and H.R. 436 as examples of bills that provide tax relief for those working to pay back staggering medical school debt. The Senate Finance Committee, at the request of the AMA, included several provisions from S. 152 in its version of the tax bill (H.R. 1836). The act increases the income phase-out ranges for eligibility for the student loan interest deduction to from $50,000 to $65,000 for single taxpayers and from $100,000 to $130,000 for married taxpayers filing joint returns. These income phase-out ranges are adjusted annually for inflation after 2002. The act repeals both the limit on the number of months during which interest paid on a qualified education loan is deductible and the restriction that voluntary payments of interest are not deductible. Finally, the act provides that amounts received by an individual under the National Health Service Corps Scholarship Program or the Armed Forces Scholarship Program are eligible for tax-free treatment as qualified scholarships. President Bush signed the bill into law in early June.

- Successfully lobbied federal policy makers on the negative consequences of creating a mandatory, punitive error reporting system to reduce health care errors. Instead, HHS and the Agency for Healthcare Research and Quality (AHRQ) are pursing a confidential, voluntary, de-identified patient safety reporting system that will gather and disseminate data for research and learning purposes to improve patient safety. The AMA has been asked to advise the AHRQ in this effort. The AMA also is working with AHRQ to enact federal legislation that would provide peer review protections to sensitive data in any safety reporting system.

- Advocated passage of H.R. 1097, the FDA Tobacco Authority Amendments Act, which is bipartisan legislation that would grant the FDA the authority to regulate tobacco products. We also urged the administration to oppose an alternative proposal developed by Philip Morris. The AMA pressed the Department of Justice to continue its lawsuit against Big Tobacco and devote sufficient resources to it, and asked the administration to reconsider and withdraw its proposed changes in the world tobacco treaty that would weaken its effectiveness.

- Advocated for passage of the Bipartisan Patient Protection Act of 2001. This bill was introduced in the House by Reps. Greg Ganske, MD (R-Iowa) and John Dingell (D-Mich.), and in the Senate by Sens. John McCain (R-Ariz.) and John Edwards (D-N.C.). These bills are the only ones that meet the AMA's criteria for strong patient protection, as well as holding HMOs accountable for their medical decisions. The AMA has opposed, as introduced, the Bipartisan Patients' Bill of Rights Act of 2001, introduced by Sens. Bill Frist (R-Tenn.), John Breaux (D-La.) and James Jeffords (I-Vt.). This bill does not meet the AMA's principles, does not provide meaningful patient protections, exposes physicians to new liability in federal court, and fails to hold HMOs accountable.

- Worked with several specialty societies in preparing a new bill to provide antitrust relief for physicians. The new bill is needed because the previous Campbell bill was referred to an unfriendly committee in the Senate. The new bill would subject all negotiations to antitrust scrutiny under the rule of reason. It would define "all-products" requirements as tying arrangements under the antitrust laws. Finally, the bill would create a maximum of six demonstration projects, limited to one project per state, conducted in conjunction with a study that would allow two or more physicians or other health care professionals to engage in negotiations with health plans under the antitrust laws without challenge. The new bill is being reviewed by a key group of bipartisan members of Congress in both Houses.

- Lobbied for the introduction in March 2001 of the Medicare Education and Regulatory Fairness Act of 2001 (S. 452/H.R. 868). The bills, introduced at the initiation of the AMA, are sponsored by Sens. Frank Murkowski (R-Alaska) and John Kerry (D-Mass.), and Reps. Pat Toomey (R-Penn.) and Shelley Berkley (D-Nev.). The legislation would ensure that the costs of new government regulations are reflected in Medicare payment rates and prevent Medicare from collecting overpayments from physicians while their appeals are pending. Most importantly, the bill would curtail the use of extrapolation, which substantially magnifies overpayment amounts. HCFA would be required to devote a larger share of funds to education about compliance with the rules. The bill has enjoyed widespread bipartisan support in a short period of time.

- Advocated for passage of structural reforms to provide enhanced patient choice of plans and long-term solvency of the Medicare program. At the moment, it appears that Congress will not deal with Medicare reform and prescriptions drugs until 2002.

- Advocated for legislation that facilitates voluntary reporting, research to identify best practices and provides legal protections for sensitive peer review data. The AMA has been working with Sens. James Jeffords (I-Vt.) and Edward Kennedy (D-Mass.) on a new draft bill, which should meet most of the AMA's objectives.

- Continues to lobby on behalf of legislation designed to expand tobacco control efforts, reduce violence, promote healthy communities, increase access to health and mental health care services, reduce access to and risk from firearms for children and youth, and reduce exposure to media violence.

Political Affairs

- Activated the AMA Physicians Grassroots Network in support of patients' rights legislation and seeking co-sponsorships for the Medicare Education and Regulatory Fairness Act (MERFA). Facilitated contacts with members of Congress the Grassroots Action Center on the AMA in Washington web site and toll-free telephone access to congressional offices.

- Provided an AMPAC grassroots grant to the medical student and resident and fellow sections for a congressional day in conjunction with the National Leadership Conference.

- Began development of a new vote record for members of the 107th Congress on issues of importance to medicine.

- Maintained regular contact with state medical societies regarding activities in the US House and Senate and within the new administration.

- Developed a new congressional and state legislative district matching program for use by the state medical societies to reflect redistricting changes in the states.

- Presented two AMPAC-funded political education programs, the Campaign Management School and the Candidates Workshop.

Legislative Affairs

- Continued successful testimony program and formal communications to Congress--a major part of our advocacy focus in Washington. With both a new administration and Congress in place this year, this activity continued at a strong pace appropriately reflecting the degree to which these two branches of government are working to become fully operational and staffed to deal with the full range of health issues. The AMA testified at five major hearings and dispatched more than 70 separate written communications to Congress and the Bush administration. As always, this program provides the opportunity for AMA to communicate issues and positions directly to policy makers and establish a record of participation and involvement.

- Renewed the AMA's fight for meaningful and effective patients' rights legislation through additional fine-tuning and reintroduction of bipartisan patients' right legislation, the Bipartisan Patient Protection Act of 2001, in both chambers. We also continued to advocate for the AMA's policy principles by analyzing and distinguishing other emerging legislation in both the House and Senate, such as the Frist bill that would not provide the same protections as the AMA-endorsed bills, and which would, in fact, make the situation for patients and physicians practicing under managed care plans dramatically worse.

- Contributed significantly to the AMA's drive for physician antitrust relief by recrafting AMA's preferred legislative approach for introduction in the Congress. As proposed and based on current political realities in the Senate, the AMA's new preferred approach would build off our victory in the House of Representatives in the last Congress, where the Quality Health Care Coalition Act of 2000 passed by a wide margin. Again this year, through joint drafting sessions, AMA legislative staff worked with supporters and coalition partners on key provisions modeled on the Campbell bill.

- Worked with and led a broad-based coalition and reintroduced the AMA's Medicare Billing and Education Act in both the House (H.R. 868) and Senate (S 452). This bill is based on language previously developed by the AMA Council on Legislation and approved by the Board. An intensive AMA grassroots and direct lobbying effort has netted large numbers of House and Senate cosponsors for each bill.

- Continued working to advance AMA policy on patient safety issues through fruitful negotiations with interested members of Congress and key committee staff. Legislation that would promote patient safety while ensuring appropriate confidentiality protections for physicians is expected to be introduced shortly.

- Worked on a continuing basis to ensure that the proposed medical records privacy regulations under HIPAA would not add burdensome new requirements for practicing physicians, especially in their office settings. The AMA's detailed additional comments were submitted to Secretary Thompson after he reopened the rule for additional comments.

- Worked with the Council on Legislation to consider major new assignments from the 2000 Interim Meeting, and that have already resulted in the drafting by the council and consideration or approval by the Board of Trustees of five new AMA model bills. These bills set the stage for lobbying or further work on fair fraud and abuse enforcement, restrictions on dietary supplements, the use of physicians' names in managed care materials, the HCFA seclusion and restraint rule, and economic loyalty criteria for medical staff privileges.

- Conducted a successful 27th Annual State Health Legislation Meeting in January. The meeting provided both an overview and an in-depth analysis of emerging state legislative issues facing the 2001 legislatures, including medical privacy, pharmaceutical cost regulation, prompt payment of claims and a post-election wrap-up. In addition, the meeting provided a physicians-only breakout session focusing on grassroots advocacy through mock legislative hearings.

- Provided on-site assistance to medical societies during the 2001 state legislative sessions. ARC staff accompanied an AMA witness to Juneau, Alaska, to testify in support of S.B. 39 permitting joint physician negotiations.

- Provided significant assistance on scope of practice issues by issuing letters of AMA support or opposition for an initiative of concern to both state medical and national specialty societies.

- Significantly modified the Virtual ARC web site to a new format that provides ARC staff with the capability of frequent updates.

- Launched a new confidentiality campaign on Virtual ARC web site, which includes AMA policy, analysis of National Association of Insurance Commissioners (NAIC) and the National Council of Insurance Legislators (NCOIL) model bills on the subject, and AMA comments on the proposed and final HHS rules. New information on prompt payment, external review, joint negotiations and ERISA also was added.

- Continued advocating AMA policies with organizations that develop model state legislation for introduction in state legislatures, including NAIC and NCOIL. ARC staff regularly participate in quarterly meetings of both associations and follow work groups pertaining to pharmaceutical issues, as well as medical privacy and managed care issues. ARC staff recently presented oral arguments opposing an American Legislative Exchange Council (ALEC) resolution that would permit direct patient access to physical therapists without physician referral.

- Developed an ARC campaign relating to the regulation of pharmaceutical costs, including an analysis of target groups for state proposals, an analysis of existing laws and pending legislation, a discussion of causes for price increases, and AMA policy. Campaign materials are expected to be included on the ARC web site by the Annual Meeting.

- Provided analysis of state patients' bill of rights proposals for use during National House Call visits and federal PBR advocacy.

- Continued advocating AMA views on state legislative issues, including prompt payment, joint physician negotiations, patient safety, scope of practice, regulation of pharmaceutical costs, and medical privacy. Such advocacy at the state level includes analysis of legislative proposals across all 50 states and regular interaction with Federation members.

Private Sector Advocacy

- Succeeded in dramatically raising the public awareness of the serious problem of health insurers' late payment to physicians, particularly through our very visible work with a number of state medical associations (Alabama, Colorado, Oregon, Nebraska, New Jersey and Utah) as part of the AMA's ongoing payment timeliness campaign. Those initiatives have resulted in a flurry of local and national press coverage highlighting the problem and the serious repercussions on physician practices and access to care. These activities, especially the prompt payment survey data collection and presentation process, also have put additional pressure on state regulators to enforce existing prompt payment laws and on state legislators to pass effective prompt pay legislation.

- AMA's three-year campaign challenging Aetna, Inc.'s onerous contracting practices and "all products" clause resulted in Aetna pulling back on all-products clauses nationally. The AMA continued to advocate for a total elimination of all-products requirements and continued to send a message to Aetna that physicians needed to see meaningful change over a sustained period of time if Aetna truly sought a new relationship with physicians.

- Provided substantial support to the Medical Association of Georgia in its challenge of Wellpoint Health Networks Inc.'s, acquisition of Cerulean, Inc., the for-profit parent of Blue Cross and Blue Shield of Georgia. The AMA sent a letter to the Georgia Commissioner of Insurance expressing our concern about the merger, and attended the public hearing on the merger. Also, we currently are assisting several state medical associations on issues relating to mergers and acquisitions in their markets.

- Publicly addressed the problems caused by mental health carve-outs through our strong support of the Medical Society of New Jersey (MSNJ). MSNJ raised major concerns about business practices of Magellan, the largest provider of mental health carve-out services in that state, and the largest in the country. The AMA participated in an MSNJ news release asking state regulators to investigate some of Magellan's practices, and sent a separate letter to those regulators in support of the MSNJ.

- As part of ongoing outreach to national health insurers, met with a number of national insurers to discuss and promote AMA policy and to communicate serious physician concerns about objectionable and unfair business practices.

- In response to growing concerns across the country about health plans downcoding and bundling claims, developed a comprehensive educational piece for physicians titled "Downcoding and Bundling: What Physicians Need to Know About These Reimbursement Practices," which is available on the PSA web site.

- In partnership with the California Medical Association, began work on a comprehensive study of actuarial sound capitation rates.

- Continued ongoing monitoring of managed care and marketplace trends, including tracking major health insurer activities, increases in premiums, executive compensation, insurer profitability, and the conversion of not-for-profit insurers to for-profit companies.

- Continued to provide support for Physicians for Responsible Negotiation while educating employed physicians and resident groups about their organizational opportunities. Assisted several groups of resident physicians in initiating the formation of an independent house staff organization at their institution.

- Assisted the AMA Group Practice Advisory Committee in finding ways to address grievances between group practices and their physicians.

- Continued to provide physicians with tools and resources to survive in the current managed care environment. These materials are available on the PSA web site. The site continues to be a primary source of information for physicians and the Federation about health care marketplace trends and other private sector issues such as prompt payment of claims, bundling and downcoding, bankruptcy, and hassle factor issues. The site is averaging more than 1,000 hits a week, and we anticipate this number to grow over the course of the coming year.

- Began discussions with various members of the employer community to present the AMA's proposal for expanding access to health insurance.

Health Policy

- Through the Council on Medical Service, developed a number of new AMA socioeconomic policy recommendations. Reports prepared by the council for the 2001 Annual Meeting address expanding coverage to the uninsured, the growing nursing shortage in the United States, medical care online, access to mental health services, contact capitation of specialists, evolving Internet-based health insurance marts, and the effects of individually owned health insurance on risk pooling and cross-subsidization.

- Prepared, for completion by the 2001 Annual Meeting, a new pamphlet that highlights the key components of the AMA's health insurance reform proposal.

- Created and managed the successful implementation of "Advocacy U," a policy and communications program intended to enhance the skill of the Board of Trustees in advocating the AMA's proposal for health insurance reform. We also implemented a similar education program for key AMA staff units.

- Coordinated the development and implementation of a one-day conference--in collaboration with the US Chamber of Commerce, the National Center for Policy Analysis and the Galen Institute--on market-driven health care.

- Successfully advocated for the incorporation of key AMA policy into the current draft utilization management and claims processing standards being developed by the American Accreditation HealthCare Commission/URAC.

- Coordinated the identification of the 20 issues included on the Policy Coordination Team's 2001 Policy/Advocacy Initiatives Survey of physicians.

- Through the AMA/Specialty Society RVS Update Committee (RUC), met in February and April to review the work relative values for 322 new and revised codes. These recommendations were submitted to HCFA in May, and if HCFA accepts the RUC's recommendations, the new work relative values will be implemented January 1, 2003. The RUC also recommended new values for nine high priority thoracic surgery codes as part of an additional installment in the five-year review of the RBRVS.

- In February and March, the RUC's subcommittee, the Practice Expense Advisory Committee (PEAC) met and submitted recommendations for 1,257 codes to the RUC for approval. The PEAC continued to refine the data HCFA utilizes in its practice expense methodology to help ensure that HCFA is using accurate data based on physician input. To date, HCFA has accepted virtually all of the PEAC recommendations.

- In February, published the 2001 edition of "Medicare RBRVS: The Physicians' Guide," a useful AMA publication containing all the relative values for the 2001 Medicare payment schedule as well as an explanation of various Medicare payments.

- Through the Market Research and Analysis unit, completed research studies that assessed physicians' opinions of how they would like the AMA to communicate with them; evaluated the use in physicians' offices of technology for practice management; and measured the public's perception of the AMA.

- Implemented Member Connect, an online advocacy tool, that provides physicians with the ability to easily and quickly have input to the AMA through surveys and receive information on advocacy issues. To date, 1,800 AMA member physicians are registered for Member Connect, and two surveys--one on Medicare administrative burdens and the other on managed care accountability and payment issues--have been conducted.

- Through the Center for Health Policy Research, conducted a tax credit simulation workshop for health policy analysts and others who influence policy making on tax credit reforms. We also provided a grant to Stephen Woodbury, PhD, and the W.E. Upjohn Institute for Employment Research to simulate access and cost impacts of tax credit designs consistent with AMA reform principles.

- Collaborated with the National Center for Policy Analysis on a Congressional briefing on tax credit reforms, and provided consultation to Sen. Rick Santorum (R-Penn.) and key Congressional staff working on President Bush's tax credit proposal.

- Produced reports on sustainable growth rate (SGR) updates, analyzed factors contributing to the favorable 2001 update (4.5%) and developed projection scenarios for 2002. Discussions of HCFA's payment preview with HCFA staff resulted in revisions to its work. We also reviewed MedPAC chapters dealing with the issue of replacing SGR with cost-based update system and provided substantial input to AMA comments.

- Incorporated the 1999 Medicare data with summary files and documentation into their modeling framework. Estimated the impact of lower limit or floor on geographic practice cost indices (GPCIs) at the specialty and Medicare locality level and simulated alternatives approaches to imposing a floor on the GPCIs, noting methodological associated with each. Also, we developed summary files from Medicare procedure files for use by the RUC staff and the RUC's five-year review activities.

- Calculated "practice expense per-hour" numbers from the 1999 AMA Socioeconomic Monitoring System survey in response to HCFA's request.

- In collaboration with the AMA's Private Sector Advocacy Group, began work with actuarial consultants and the California Medical Association to develop benchmark capitation rates for physicians to use in assessing rates offered by managed care firms for their services.

- Worked closely with the Private Sector Advocacy and Stephen Foreman, PhD, an economist at Pennsylvania State University, to develop managed care penetration rates using InterStudy data. In particular, we worked with Dr. Foreman to develop a defensible econometric method of dealing with missing data.

Federation Relations

- Led or participated in coordinated campaigns with medical specialties on a variety of issues including regulatory reform, the Emergency Medical Treatment and Labor Act (EMTALA), privacy, antitrust relief, patients' bill of rights, patient safety, and mental health parity. We sponsored specialty briefings with federal officials and others on a range of issues, including Medicare coverage, privacy, and physician payment rules. Also, the AMA initiated joint sign-on letters for a number of legislative and regulatory initiatives, including certified registered nurse anesthetists, limited English proficiency, and EMTALA.

- Convened another successful National Leadership Conference (NLC) in Washington, DC. The 2001 NLC program focused on Leadership in the Profession; Leadership in Washington and Leadership in Global Public Health. The AMA Foundation's Signature Program on Health Literacy also was highlighted. Nationally known speakers included Laurie Garrett, *Newsday*; Alan Guttmacher, MD, National Human Genome Research Institute; Rep. John Kasich, former chairman, Budget Committee, US House of Representatives; Reps. Robert Andrews, Billy Tauzin and Greg Ganske; and Sen. Jon Kyl.

- Convened a meeting of the Federation Advisory Committee (FAC) on March 4. The FAC continues to monitor organizational dynamics occurring within the Federation. A growing number of geographic medical societies have restructured to rule out redundant functions between state and local organizations. Optimally, this results in improved financial and organizational effectiveness to better serve members.

- Considerable effort went into the development of options under which the AMA could provide dispute resolution processes on behalf of the Federation. These options have been shared with the SAGE work groups on advocacy and inter-society relations/governance, which are currently in the process of refining the methods for dispute resolution.

- Convened one meeting and one conference call of the Federation Unity Project's inter-society relations and governance work group. The work group has made considerable progress in developing a dispute resolution process for Federation organizations, including the creation of a committee on organizational conduct and cooperation. The work group also continues to develop the characteristics and responsibilities of the core, participating organizations and Congress.

GOVERNANCE AND OPERATIONS

Constituency Groups

<u>House of Delegates (HOD)</u>

Shortening the House of Delegates - An analysis of a survey of the members of the HOD resulted in some suggestions for beginning a process of shortening House meetings. The speaker and the vice speaker prepared a report to be submitted to the 2001 Annual Meeting that addresses many of the concerns and ideas expressed by the delegates and the alternate delegates. This report recommends, as a first step, that the opening session of the House be scheduled for Saturday afternoon, beginning with the 2001 Interim Meeting. The report also recommends that the AMA elections be moved up one day beginning with the 2002 Annual Meeting. Having the elections on Tuesday instead of Wednesday is in response to some concerns about the attention devoted to the election process and also is a first step toward ending the Annual Meeting on Wednesday at some future meeting.

Special Publications - The "Pictorial Directory of the House of Delegates" has been published in book form at the urging of the HOD. It is available for $10 per copy at the AMA registration desk at the Annual Meeting. The directory continues to be posted on the AMA web site and is regularly updated. The "Proceedings of the House of Delegates" continues to be available on CD-ROM. It also is available on the web site along with reports and resolutions and annotated reports detailing the House action on every item of business. This information is placed on the web site quickly and has become a valuable resource to members of the House and other society leaders and staff.

Communications - Weekly and monthly news reports from AMA headquarters are sent electronically to House of Delegates members. Also, late-breaking news about the AMA and government actions affecting medicine are transmitted instantly.

Federation Unity Project - The AMA Board of Trustees held a meeting of representatives of the Federation in February of this year in Orlando, Florida. The purpose was to determine if and how the Commission on Unity Report could be implemented.

The Special Advisory Group Extraordinaire (SAGE) was named by Dr. Lewers and held its first meeting following the National Leadership Conference in Washington, DC. Dr. Lewers was elected Chair of the SAGE and Mary Anne McCaffree, MD, of Oklahoma, was elected Vice Chair.

Five work groups have been formed: membership, business relationships/products and services, advocacy/ communications, inter-society relations and governance, and finance. All groups but finance have met either face-to-face or by conference call. A progress report will be presented at A-01. Recommendation from the work groups will be sent to the SAGE in early September, and SAGE recommendations will be forwarded to the Board by mid-September. The Board will present final recommendations to the House at I-01.

Medical Student Section (MSS)

The MSS continues its efforts to promote and enroll children in the Children's Health Insurance Program (CHIP) as part of the MSS National Service Project. The MSS project began one year ago at the 2000 Annual Meeting when students went to Lincoln Park Zoo to educate families about CHIP. CHIP was enacted in 1997 to begin addressing the needs of our nation's children in families with incomes too high to qualify for Medicaid but too low to afford private health insurance. The I-00 project was held at the Central Florida Fairgrounds, where students distributed CHIP information and assisted families in enrolling in the Florida KidCare program. Given the two successful national events, many student chapters have developed similar CHIP programs at the local level. The MSS is coordinating another exciting outreach project during the MSS 2001 Annual Meeting in conjunction with Chicago's Puerto Rican Parade.

A major advocacy issue for the MSS is addressing the issue of rising medical education debt. The MSS continues to work with residents and young physicians to bring this issue to the forefront and achieve legislative successes that will provide some debt relief. We are excited to be working closely with the AMA's Washington, DC, office on this important issue that is galvanizing the grassroots membership.

Also on the Washington front, the MSS Government Relations Internship Program is entering its fourth summer session. Through this program, stipends up to $2,500 are available for selected students to participate in their own legislative internship programs and seminars conducted at the AMA's Washington, DC, office. Fourteen medical students will participate in 2001 with internship sites ranging from the office of Senator Tim Hutchinson (R-Ark.) to the Health Care Financing Administration, the Department of Health and Human Services, and the American College of Emergency Physicians.

Membership numbers for medical students at year-end 2000 totaled a high of 48,205, equating to a 61% AMA market share. The spring recruitment program entered its final year of a three-year pilot. This program addresses membership transition into residency by offering multi-year student members their initial year of RFS membership "free" with completion of a brief survey.

The MSS and the RFS held the second annual Leadership Award Program sponsored by the AMA Foundation at the 2001 National Leadership Conference (NLC). The award program focuses on non-clinical leadership skills in medicine or community service and sends 25 students and 25 residents to the NLC. Special programming is offered in addition to an awards banquet. The objective of the program is to encourage involvement in organized medicine and continue leadership development among these promising young leaders. An AMA Award of Special Commendation was given this year to fourth-year medical student Garrett Cuppels. In addition, AMPAC sponsored a Congressional Day for student and resident attendees of NLC that focused on the issue of educational debt and enabled participants to lobby on the Hill.

Resident and Fellow Services (RFS)

Over the last six months, the RFS has educated resident groups on their representational options, including an overview of the recent NLRB ruling and comprehensive information regarding PRN. The RFS also has assisted resident groups in developing Independent Housestaff Organizations by providing specific informational and technical assistance.

The RFS has been working closely with the AMA's legislative staff, Council on Legislation and other sections to develop and promote proposals to Congress on student loans. The AMA has lobbied members of Congress to allow deferment for economic hardship easier to obtain and to restore the deductibility of student loan interest. Progress is being made on many of these agenda items for the AMA and its younger members.

On March 2, more than 75 resident and student AMA members converged on Capitol Hill to meet with members of Congress to ask for their support on issues including student loan deferment, patient safety, and funding for graduate medical education. To prepare, participants attended several legislative briefings and an educational session on effective lobbying techniques. This important event would not have happened without the support of AMPAC. Given its tremendous success, the RFS will try to make this an annual event.

With the help of a generous grant from the AMA Foundation, the RFS held its Annual AMA Foundation Leadership Award for 2001. This award was given to 25 resident and fellow physicians and 25 students, who exhibited outstanding leadership abilities in organized medicine, civic or non-clinical medical school or hospital activities during the year. Award winners were given the opportunity to attend AMA's National Leadership Conference in Washington DC, in March, which included a number of targeted workshops on leadership development for residents and students.

Finally, the RFS Governing Council has made resident work hours a top-priority for the section and has prepared a report for the RFS annual assembly with recommendations for work hour reform and action to be taken. The AMA believes residents play a vital role in our nation's health care system. Their needs, such as resident work hours, must be addressed and additional measures may be needed to ensure resident well-being, quality physician training and patient safety.

Young Physicians Section (YPS)

The YPS has worked with several sections on issues and programs of interest to younger physicians. Working with the Office of Group Practice Liaison and RFS, the YPS offered its first live webcast/teleconference on contracting issues to young physicians and residents. More than 65 physicians participated in the program. Working with the Washington, DC, office, RFS and MSS, the YPS actively lobbied for tax relief for student loan debt.

In March, the YPS Chair and Chair-Elect, with leaders from the RFS and MSS, began a dialogue with AMA Executive Vice President E. Ratcliffe Anderson Jr., MD, and other key AMA staff to discuss new AMA membership and communication initiatives.

The YPS continues its success in the AMA HOD through the mainstreaming of young physicians into delegate and alternate delegates and through the submission and passage of resolutions focusing on issues of importance to young physicians.

The AMA-YPS took the initiative this year to begin streamlining its meeting activities in an attempt to become more relevant to its young physician members. The section will discuss changes to its meeting schedule that will make the meetings more time and cost efficient and allow for increased participation.

Fifty physicians, many of them young and representing a diverse group of "emerging leaders," participated in a one-day AMA/Glaxo leadership development program, convened in Washington, DC.

Organized Medical Staff Section (OMSS)

At the 2000 Interim Assembly Meeting, the OMSS began a pilot study to access the value of opening its doors to all physicians--regardless of practice affiliation or membership status--as a way to reposition itself and increase involvement in organized medicine. Reversing a three-year downward trend, the OMSS achieved a 6% increase in physician attendance, and 58 physicians attended an assembly meeting for the first time. The pilot was extended to the June 2001 Assembly Meeting, and after its conclusion, we will complete an assessment of the value of changing the credentialing criteria for participation in the OMSS.

The OMSS continues to be effective in identifying and addressing critical issues affecting medical staffs and bringing them to the attention of the AMA. As a result of an OMSS comprehensive report identifying problems with the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations, the House of Delegates

adopted a resolution calling on the AMA to develop an action plan to return to the original congressional intent of EMTALA. The Balanced Budget Refinements of 2000, passed by Congress at the end of the last Congressional session, mandates that the Government Accounting Office submit a report to Congress this year evaluating many of concerns identified by the OMSS. The Office of Inspector General also issued two reports on EMTALA in January that confirm problems raised by the OMSS and the growing concern that a crisis in emergency medicine is imminent.

At the initiation of the OMSS, AMA's Private Sector Advocacy, Health Law and Professional Standards divisions joined in efforts by the BlueCross and BlueShield Association of America (BCBSA) to implement AMA's organizational principles for physician involvement in health plans. BCBSA's "Guidelines on the Role of Participating Network Physicians in Health Plans" are very similar to AMA's organizational principles. The BCBSA's National Council of Physician Executives and the AMA's Board of Trustees approved the guidelines, and they have been distributed to BCBSA's 45 member plans, state medical societies and national specialty medical associations.

International Medical Graduates Section (IMGS)

Following up on lengthy discussion at the 2000 Interim meeting regarding licensure and credentialing issues, the IMG Section Governing Council took the lead on policy adopted by the House of Delegates at I-00. Specifically, the council wrote to each of the 54 licensing jurisdictions reminding them that the ECFMG and the AMA Masterfile are recognized for the purpose of primary source verification of medical school credentials by the JCAHO and other quality assurance organizations. In addition, the section conducted its fourth mail ballot to select the new members of the 2001-02 IMG Section Governing Council. At least three new physicians will be joining the seven-member council; names will be announced and officers selected at the section's 2001 Annual Meeting on June 16.

Senior Physician Services (SPS)

This year, AMA-SPS will be hosting their first open forum Sunday afternoon at the Annual Meeting. The forum will provide SPS members an opportunity to hear about and discuss the AMA's proposal to expand coverage and choice. SPS has never before hosted a function open to the general membership, and the governing committee believes initiating such an event at the Annual Meeting is a great way to start building collegiality among the ranks of SPS members. In addition, the traditional 50-Year Luncheon will be hosted on Monday to honor AMA members at least 50 years beyond their medical school graduation.

Office of Group Practice Liaison

The Advisory Committee on Group Practice Physicians elected a new Vice Chair, Sanford Kurtz, MD, of the Lahey Clinic, this spring and is involved with two new projects. The first is a joint project with the Council on Long Range Planning and Development aimed at better understanding the issues that medical groups are facing today and how organized medicine can better respond. The second, in conjunction with AMA's Health Law Department, is geared toward developing alternative dispute resolution procedures for group practices.

The committee just completed its planning of the second Group and Faculty Practice caucus that will be held Saturday, June 16 at the Marriott Hotel. Attendance is estimated at 100-150 AMA members. The caucus will include a policy discussion as well as an educational session on HIPAA. The caucus will continue to be a staple at all Annual and Interim Meetings.

Women Physicians Congress (WPC)

The WPC continues to expand in activities and membership, now at more than 3,500 members. The WPC's extended leadership network of the governing council and the WPC liaisons serve as key contacts on identifying and addressing issues of concern to women in medicine. Following a new round of liaison appointments from the Federation, this group recently convened at a successful Women Physicians Leaders Retreat that featured an outstanding roster of speakers on leadership issues and the role of the brain in women's health. The WPC continues its communication efforts through regular electronic and print newsletters, a members-only electronic discussion forum, and periodic opinion polls such as a recent survey on life-balancing issues for women physicians. The 2001 September Women in Medicine Month campaign will have the theme "Leaders Making a Difference."

Minority Affairs Consortium (MAC)

The MAC, now with more than 2,600 members, provides a forum for advocacy and action on minority health and minority physician issues. MAC members receive electronic and print newsletters with minority news and opportunities, and are currently being surveyed on the key issues facing minority physicians and patients today. As part of the MAC's ongoing collaboration with national ethnic medical associations, a pilot membership project in being launched with the National Hispanic Medical Association. The MAC continues to play an important role in the implementation of our work with the Department of Health and Human Services to eliminate racial and ethnic health disparities and in developing a new project to enhance cultural competency in the profession.

Strategic Management and Planning

During the last year, the AMA began implementing its new strategic planning process, which seeks to increase stakeholder input at the beginning of the process. At its February meeting, the Board of Trustees reviewed the recommendations of councils, sections and special groups, and it began a prioritization process to develop a focused issue agenda for the AMA. In June, the Board will review the first set of program strategic plans, which provide a road map for the AMA's activities within each program (e.g., public sector advocacy, public health, medical education, etc.). Through this new planning process, the AMA is in a better position to evaluate risks and benefits of actions, allowing the AMA to make decisions that are in the best interest of the association and its members.

Information Technology

The primary goals of the Information Technology Group (ITG) are to enable operational improvements, support new business opportunities, and implement cost-effective solutions that enhance the ability of the AMA to achieve our mission of serving the physicians and patients of America.

AIMS Project Update

As we near the completion of our systems modernization efforts, we are already beginning to realize the benefits of our investment in AIMS. At present, more than 500 AMA employees are using the AIMS systems. To recap, AIMS is an integrated family of products consisting of four major enterprise systems:

Computer Aided Matching (CAM) - AIMS-CAM provides an automated way to match and update our physician data with the hundreds of external data sources we receive (i.e., state licensing boards). AIMS-CAM saves many hours of manual labor required to hand match information, and improves the accuracy, quality and timeliness of our physician data.

Constituent Management (CM) - AIMS-CM was the first end-user application that enabled AMA staff to view all information on physicians from a single unified system--rather than in separate systems for residents, students, physicians, etc. This unified customer view has given AMA staff a complete longitudinal view of our members and enables them to update this information while speaking with a member or prospective member. Having a single "holistic" view of the customer helps all of us to better serve our members.

Customer Data Warehouse - AIMS-Customer Data Warehouse is the foundation of the AIMS family of applications. It currently contains up-to-date and historical information on more than 1 million individuals (members, prospective members and non-physician customers). This database:

- serves as a decision support tool for health policy research;
- is a statistical modeling tool to help membership marketing perform predictive studies on member retention;
- enables AMA Press to analyze customer purchasing patterns and create tailored marketing campaign;
- generates in excess of $40 million per year in revenue.

Invoice & Payment (IP) - AIMS-IP is the remaining system to be implemented and will go live in August. AIMS-IP contains all billing and payment information for members and prospective members, and will process more than $60 million in annual dues revenues. Thus, with the implementation of AIMS-IP our "view" of the customer will be complete, as will our membership systems modernization efforts.

As our use of the AIMS family of systems matures and broadens, we anticipate leveraging the AIMS foundation architecture to support new and existing business opportunities.

E-Commerce Initiatives

- E-Profiles, the first e-commerce initiative leveraging the AIMS foundation architecture, is currently generating $25,000 per day, with a 20% increase in new customer accounts. Monthly revenues are up 33%, and nearly 70% of all orders are taken online.

- Home Health Care Providers is a new product that enables home health care providers to certify physician licensing online. This is the first such product available for this industry segment.

- Leveraging the same e-commerce technology, the process of ordering, payment processing, and delivery of the CPT Assistant and CPT Data Files are now available via the web.

- CPT Quizzes is a new online product that enables physicians and coding staff to earn CME credits for their knowledge of CPT codes. Since going live late last year, more than 620 quizzes have been taken online.

Future e-commerce projects are currently under consideration or in development for Medical Education, Ethical Standards, *JAMA* Reprints, AMA Press and others.

Other IT Initiatives

AMA Press - To automate the development and maintenance of CPT codes, and to ensure compliance with CPT-5 mandates from HCFA, we implemented a workflow/document management system.

Publishing - In April, upgrades to critical production systems for *JAMA* and the *Archives*, as well as for the publishing ad tracking system, were successfully implemented — with no disruption to publication schedules. We are working actively with representatives from *JAMA* to develop an RFP to replace or upgrade their systems in FY2002 for their editorial, manuscript tracking and peer review systems.

Finance and HR - In April and May, we implemented three major upgrades to the Lawson Financials and Human Resources Systems to keep them up to current releases, with no disruptions to the business units.

Internet Service Provider (ISP) Conversion

In late April, we were hit by the sudden and unannounced termination of Internet services by Pilot Network Services (now defunct). Thanks to a great deal of patience on behalf of AMA staff and advanced planning, we were able to execute our contingency plans with relatively minor disruptions to critical business processes. We expect to resume full Internet service with a new ISP prior to the Annual Meeting.

FY2000 Financial Results

We ended 2000 with actual spending of $25,615,000--$1,286,000 below our 2000 budget plan of $26,901,000. The total spending reduction in 2000 was $3,087,000, compared to 1999 actual spending of $28,702,000. Savings were achieved in nearly all areas of operations with significant savings occurring in outsourcing and other outside consulting expenses. Capital expenditures also were significantly reduced, resulting in long-term operating savings from lower future depreciation and amortization expenses.

Planning for FY2002

As we approach the planning horizon for FY2002, IT leadership will be proactively seeking ways to ensure that our staff and services remain aligned with the business goals of the AMA in FY2002 and in years to come.

Corporate Services

The Corporate Services group continued to manage building and meeting services effectively, resulting in substantial cost containment and cost savings to the AMA.

Facility Planning and Coordination successfully consolidated all but a few operating units, improving adjacencies, efficiencies and maximizing use of furniture resources with very little capital expenditure. Construction and Building Services contracted and managed in the remodeling of the new ACGME office space and in construction and startup of the Unified Service Center.

Meeting Services continued to provide savings in the areas of airline and hotel rates. The cost for air travel was $3 million savings from full coach fares and hotel room cost was $3.5 million savings from rack rates. Hotel rates for AMA meetings averaged 33% below the industry rate.

Administrative Services increased the awareness, value and accessibility of the Archives collection and AMA's history to members, Federation executives and staff through the redesign of its web page to include more exhibits, FAQs, timelines and collection information. Visitors to the web page increased from 600 to 2,400 per month.

Risk Management

A more formal, comprehensive risk management program has been initiated at the AMA per the recommendations approved last year by the AMA Audit Committee and the Board of Trustees. Key attributes of the program are:

- Consolidation of the Corporate Compliance, Risk and Insurance and Contract Compliance functions into one AMA risk management staff unit reporting to the Senior Vice President of Governance and Operations, who in turn reports to the Executive Vice President. Regular updates by this unit are given to the Board Audit Committee.

- Consolidation and wide publication of AMA's risk tolerance thresholds and decision-making authority levels for various AMA functions and activities.

- Ongoing, well-attended education program targeted to AMA managers reviewing the risk management policies and procedures at the AMA.

- Creation of a risk assessment tool to be used by all levels of management for all major new initiatives.

- Development of an online Intranet site providing AMA staff and management with information, risk assessment tools and policies related to risk management.

It is anticipated that the comprehensive risk management program will result in a more proactive and disciplined management of critical risks, real reduction in exposure to unacceptable risks, an identification of acceptable risk levels, and a less risk-adverse culture at the AMA.

Human Resources

During the first quarter of 2001, HR was reorganized into three units: Organization Development (OD), Employment Services, and HR Operations & Programs. The realignment is designed to serve the needs of AMA units and employees in more strategic ways, and to integrate HR more effectively into the fabric of the organization. The vision of HR at the AMA as we go forward into the 21st century is to work with senior management and Association leaders to attract and retain a best-of-class workforce; encourage employees to make their highest contribution towards serving and representing members' interests; and create a culture that promotes the AMA vision and values throughout the organization.

To make this vision a reality, the role of the HR Rep was redefined to provide strategic consultative services, trend information and support on a variety of employment and staff issues, as well as to assist management in determining their short and long-term hiring needs. In their enhanced roles, all HR Reps attend unit staff meetings, maintain a more visible presence in the areas they serve, and provide hiring and turnover data to their Senior Vice Presidents.

Another arena of HR is Organization Development, which has designed and is delivering a harassment prevention workshop in response to the recent Supreme Court decisions in this area. Through May 2001, approximately 190 managers have attended the workshop. Beginning in June, employees without supervisory responsibility will begin to attend the non-manager workshop. All employees will have attended the harassment prevention workshop by the end of 2001. This is the same type of program that will be offered to the BOT later this year.

A new orientation program for our new employees was introduced in January. A new orientation video is being developed to introduce the new staff to AMA's culture and work environment.

In the first quarter of 200l, new compensation guidelines on base pay were revised as part of a larger HR initiative to better recognize and reflect the contributions of high performing employees. Additionally, a special incentive bonus was paid to eligible employees in the second quarter, to reward the hard work of our staff in 2000.

Work continued with the Board's Compensation Committee and the pension plan actuary to review alternatives for the AMA retirement plan. Costs and funding and implementation implications for six options were presented to the committee for review in April. Because of the complexity of the issues involved, this work continues.

Corporate Relations

- Nearly doubled corporate funding for AMA projects from 1999 to 2000.
- Distributed the new corporate opportunities booklet to more than 200 companies throughout the country.
- Finalized corporate funding for seven media briefings in 2001, the Medical Communications and Health Reporting Conference and the Science Reporters Conference.
- Initiated an international roundtable with corporate representatives to exchange information on international activities.
- Established new relationships with a number of biotechnology companies and several non-pharmaceutical companies.

Office of International Medicine

We are in the second year of a successful new program, the Dr. Nathan Davis International Awards in Medicine and Public Health. At the inaugural presentation in 2000, more than 200 guests attended a black-tie awards dinner to honor recipients in two categories: (1) Outstanding International Physician and (2) Outstanding Global Health Initiative. This year, the awards are presented to Sir Richard Doll, MD, DSc, FRS, and the Bill & Melinda Gates Foundation Global Health Program. Each recipient receives a crystal sculpture and a cash award of $50,000 administered through the AMA Foundation to continue the work for which they were honored. The Gates Foundation will accept the non-cash portion of the award only.

In the past six months we have hosted two groups from the Netherlands. These groups visited us to learn more about advocacy, health policy and physician use of the Internet.

An important component of our mission of international advocacy is the AMA's involvement in the World Medical Association (WMA). AMA President Randolph D. Smoak Jr., MD, was recently elected to a two-year term as Chairman of the WMA. In this capacity, Dr. Smoak will preside at business meetings of the Council of the WMA and its General Assembly, a body that represents 8 million physicians worldwide.

We are coordinating the planning of the 2002 WMA General Assembly meeting scheduled to take place in Washington, DC. The scientific session topic is bioterrorism and will be open to US physicians; AMA Category I CME will be offered. More than 300 physicians are expected to attend the General Assembly.

The Office of International Medicine, in cooperation with Corporate Relations, organized the first meeting of an international roundtable in New York City on April 23. The meeting provided an opportunity for pharmaceutical corporations with a significant international presence to exchange information with each other and with the AMA. Topics discussed included public-private partnerships and philanthropic strategies.

AMA Foundation

Health Literacy - The Foundation took a lead role in presenting health literacy at the National Leadership Conference. During the conference, national media picked up the AMA's health literacy initiative. The topic was featured prominently in major newspapers and on television. The AMA Foundation developed a presentation and sponsorship benefit package for the implementation of the health literacy program. The program was approved by the CRT committee. Representatives of Pfizer and Bristol Myers met with staff and viewed the presentation. Following a second meeting with Pfizer, the Foundation is awaiting word on funding and hopes to hear something by the middle of June. Meetings currently are being scheduled with other potential corporate sponsors. The Foundation is taking a lead role in the development of a health literacy task force made up of representatives of the major health care associations. The Foundation is working with the National Institute on Literacy to arrange a meeting this fall. Joanne Schwartzberg, MD, continues to meet with national organizations to discuss the AMA health literacy program.

Strategic Planning - The AMA Foundation Board held a strategic planning session on April 10-11. The session included an orientation on fundraising and an overview of the pass-through fundraising program of the Alliance. A representative of Deloitte Touche was there to review the expenses related to the pass-through fundraising programs. As a result, Board members overwhelmingly decided that the Foundation should continue to move forward in its fundraising efforts. A conference call with Board members to determine next steps will take place.

Board Members - Six new board members were selected to serve on the Board. All of the new members were assigned to committees and will begin taking an active role in the Foundation. Following the AMA Board elections in June, the AMA Foundation will select new members of the executive committee.

Corporate Fundraising - KPMG Consulting joined "Partnerships in Health" as the first member. We are enthusiastic that this is a non-pharmaceutical company and hope to continue to bring companies that are new to AMA into the program. As a result of their support of the Foundation, KPMG has started funding other AMA programs.

Major Donors - As we await the strategies of the Strategic Planning Committee, we will begin to look at potential major donors and start a small program of cultivation. A director of development has been hired and will be working to attract major donors to the Foundation.

Awards, Grants and Scholarships - The spring awards have been selected and letters and checks went out to the winners during the third week in May.

Alliance - Foundation staff have worked closely with the Alliance during the past year to look at new methods of fundraising that might direct funds to the AMA Foundation instead of the medical schools. The Alliance has prepared a proposal and is introducing a new initiative for Alliance members to fund.

PROFESSIONAL STANDARDS

The Professional Standards Group continues to focus on providing physicians with the foundations of professionalism. The group's strategic plan provides a continuum of support for the medical profession that stresses the encouragement and development of medical knowledge, integrates that knowledge into medical practice and public health, measures and analyzes clinical outcomes to improve medical performance and knowledge, and encourages refinement of health and medical practice based on evaluation and data.

The areas within Professional Standards are Ethics; Medical Education; Professional Standards Advocacy and Policy; and Science, Quality and Public Health.

Ethics Standards

Council on Ethical and Judicial Affairs (CEJA)

Principles of Medical Ethics - The House of Delegates adopted, after amendments, a CEJA report recommending that the principles be revised. As dictated by the AMA Constitution and Bylaws, the amended principles will be presented to the House for final approval at the 2001 Annual Meeting. If two-thirds vote in favor of these proposed revisions, these will become the new Principles of Medical Ethics, which each AMA member swears to uphold.

Ethics Forum - Ethics Forum continues to provide a channel for AMA members and *AMNews* readers to ask ethical questions they face in their day-to-day practice. During the last six months, Ethics Forum columns have covered issues surrounding the ethical and professional considerations regarding autopsies; asking former patients to send letters to a practice group requesting that a physician be reinstated into the group; genetics; organ donation; and conflicts of interest related to health web sites containing information provided by manufacturers of health-related products. Responses are prepared by either CEJA members, when AMA ethics policy speak to the issue, or Institute for Ethics faculty and fellows, as well as outside ethicists, who draw from ethics research and broader ethical principles.

Ethics Resource Center

Code of Medical Ethics Online Curriculum - An ethics course based on the AMA's Code of Medical Ethics currently is under development. This interactive course will be offered on the Internet, giving physicians the opportunity to obtain CME credit. At least seven modules will allow physicians to familiarize themselves with the core ethical concepts that make up the code in a way that will be immediately applicable to their everyday practice. A preliminary module will be on display at the Annual Meeting, and the first CME module is scheduled to be released later this summer.

The Virtual Mentor - The Virtual Mentor is an interactive, web-based forum for analysis and discussion of ethical and professional issues that medical students, residents and other new physicians encounter during their training and practice. It continues to gain an increasing audience with more than 10,000 web hits per month. A registry of physicians who want to serve as online mentors will be available by June.

National Health Care Decisions Week - In collaboration with the American Bar Association, the AMA is co-sponsoring a weeklong (October 21-27) national educational and outreach campaign to conduct community programs on the topics of health care advance directives and organ and tissue donation, and to provide pro bono assistance with preparation of advance directives and donation declarations. We hope to build upon last year's effort, through which 72 local community programs were conducted.

Federation Repository of Ethics Documents (FRED) Online - Building on a research project of the Institute for Ethics, FRED Online is a web-based repository of ethics documents from members of the Federation. This searchable database includes the capacity to compare ethics-related policies at numerous medical professional associations on critical topics in health care ethics. It is scheduled to be available this summer.

Institute for Ethics

Ethical Force (E-Force) Program: Performance Measures for Ethics - The E-Force program was established on two core ideas: (1) all organizations involved in the health care system must accept some special ethical/professional obligations, and (2) being able to measure which organizations are living up to these shared ethical expectations would be of value to improve the health care system. An article describing this groundbreaking program was published in the American College of Physicians/American Society for Internal Medicine's journal, Effective Clinical Practice, in December 1999. Recent developments include:

- Privacy: With the help of a national expert advisory panel on privacy and confidentiality, the E-Force oversight body approved a set of potentially measurable expectations for the protection of privacy throughout the health care system. The set was released January 30, and a set of national expert working groups is being assembled to develop plans for field-testing performance measures based on the E-Force consensus report.

- Benefits: A national expert advisory panel on benefits has developed a set of consensus expectations to ensure and improve the fairness of coverage decisions. This document is under review by the oversight body, and a final consensus report is expected this summer.

In addition, a report based on two sets of focus groups, conducted with employer benefits decision-makers and with insurance brokers in 1999-2000, is under development. The report describes how these key decision-makers assimilate and use quality information when selecting which health plans to recommend. The E-Force Codes of Ethics project also has been completed. This consisted of the first complete collection of the Codes of Ethics of every member of the Federation, as well as a number of complete sets of ethics policies from managed care plans and large physician group practices. These codes and policies have been systematically analyzed and compared, and a report on this research is being submitted for peer review. In addition, the codes and policies of the Federation members are being scanned and reformatted to be placed in a web-based, searchable repository. Finally, a smaller collection of physician group practice mission statements, ethics policies, patients' rights statements and other relevant documents has been prepared for member use and is available on request.

Oath Project - One characteristic that distinguishes professionals is the act of "professing" to abide by a set of ethical values and ideals, usually in the form of an oath. Many medical schools in the United States and Canada, however, administer oaths other than the traditional Hippocratic oath. These non-Hippocratic oaths may espouse different ethical values and priorities. The Ethics Standards Division has collected and analyzed the oaths used at all US medical schools. Content analyses are completed, and the division is preparing a manuscript for publication in a peer-reviewed journal. In addition, the medical oaths will be made available on the AMA Ethics Standards web site.

Medical Education

The Medical Education Group is the unit responsible for the development, promulgation and implementation of policies fulfilling the profession's responsibility to ensure the competence of its members. Guided by the Council on Medical Education and the Section on Medical Schools, the unit addresses issues related to maintenance of educational quality through accreditation; the welfare of medical students, resident physicians and faculty; health care delivery systems; physician professional development; and publication of educational data. Medical Education is the key liaison with the Accreditation Council for Graduate Medical Education and the Accreditation Council for Continuing Medical Education, and with the AAMC, the support for the Liaison Committee on Medical Education.

<u>Environment of Medicine/Medical Education</u>

Annual Updates in the Journal of the American Medical Association (JAMA) - The annual medical education issue of *JAMA* contains data that serve as a major contribution to medical education literature. The 2001 medical education issue will continue to focus on how medical education is addressing the internal and external challenges to the profession of medicine, including the growth of specialization in graduate medical education.

Medical Student Debt - The Council on Medical Education and the Section on Medical Schools have reviewed the level of medical school tuition, including changes over time, the contribution of tuition to medical school financing, and the level of debt that medical students incur. The amount of financial planning/debt management counseling that is available and other strategies to reduce debt also were examined. The council and section are considering innovative ways to reduce medical student debt.

Medical Education Bulletin - In recognition of the importance of the continuum of medical education, the scope and distribution of the former Graduate Medical Education Bulletin has been expanded to include information and reports on issues related to undergraduate as well as graduate medical education, concentrating on the interface between those activities and the process of accreditation of medical school programs and residency training. The bulletin now is distributed to all members of the Section on Medical Schools as well as residency program directors, medical education directors at US teaching hospitals and AMA appointments to residency review committees.

<u>Physician Workforce Issues</u>

Creating an Appropriate Work Environment - Because excessive work hours affect the ability to learn and to provide care, the Council on Medical Education is co-sponsoring a workshop with the American Academy of Sleep Medicine to determine the effect of acute fatigue and chronic sleep deprivation on resident and student education,

resident physician performance and well-being. As a further outcome, the council will work to develop recommendations for work hours, including moonlighting, to promote the highest quality of education and patient care.

Principles for Graduate Medical Education - In addition to continuing support of current AMA policies on graduate medical education as delineated in the report prepared by the Council on Medical Education, the council is working with the Medical Student Section and the Resident and Fellow Section to promote a better understanding of accreditation of educational institutions and residency training programs.

Curriculum and Professional Issues

Career Information for Premedical and Medical Students - The Medical Education Group has developed a web site for high school and college students interested in medicine as a career. The site links to other relevant sites to provide potential applicants and their advisors comprehensive information.

FREIDA Online - Available through the AMA home page, FREIDA (Fellowship and Residency Electronic Interactive Database Access) Online is used extensively to search more than 7,800 ACGME-accredited programs and 200 board-approved combined specialty programs. FREIDA 2001 offers summary statistics on training in each specialty/subspecialty and allows AMA student members to request up to 30 free mailing labels. Program directors are able to make basic changes to their information online.

Joint GME Survey - Last year, the AMA and AAMC launched a joint web-based survey of accredited residency programs. The successful completion of that process required the use of supplemental hard-copy instruments. A new and more functional version of the survey is due to be released in July. The exchange data from the survey is seamless with both organizations, having immediate access to information as it is entered. The results of this survey provide data used in research on workforce and to update FREIDA Online and the AMA Masterfile.

Graduate Medical Education Directory - The 2001-02 edition of the "Green Book" was printed in March. It includes contact information for nearly 8,000 ACGME-accredited and combined specialty programs and 1,600 GME teaching institutions, as well as institutional and program requirements for 112 specialties/ subspecialties and medical specialty board certification requirements. New this year are program requirements in five newly approved subspecialties.

New GME Publication - "GMED Companion: Supplemental Data for Choosing Your Residency Program, 2001-02," is new this year. The 500-page book features key data on 4,200 specialty programs--such as salary, start dates, hours of duty per week and curricula--displayed in a grid format for easy comparison between programs. It also includes articles on obtaining a residency, international medical graduates, and growth of specialization in GME as well as medical education data tables and lists of women's health residency/fellowship programs and GME programs in Canada.

Cultural Competence Course - The Medical Education group is working with staff from AMA Solutions, the AMA Minority Affairs Consortium, and AMA Medicine and Public Health to develop a course for physicians on cultural competence.

Domestic Violence Education - In response to Resolution 419 (I-00), the Medical Education group is working with the National Advisory Council on Family Violence and other groups to define the competencies that physicians need to identify, respond to and prevent violence and abuse. The next step will be to develop recommendations about how to incorporate these competencies into the continuum of medical education (undergraduate, graduate and continuing).

Accreditation Processes and Related Health Professions

Affiliation with Accrediting Bodies - The AMA continues to play a fundamental role in setting standards for medical education and ensuring adherence to these educational standards through sponsorship of the Liaison Committee on Medical Education and participation in the Accreditation Council for Graduate Medical Education and the Accreditation Council for Continuing Medical Education. Interest in establishing new medical schools and developing new models of affiliation has enhanced the consequences of these activities.

Reorganization of Accreditation Standards - The Liaison Committee on Medical Education is in the process of reviewing, revising and reorganizing the standards for accreditation of educational programs leading to the MD degree. This revision process, due to be completed in fall 2001, will eliminate redundancies and make the standards easier for schools and accreditation reviewers to interpret.

Health Professions Education - The new edition of the "Health Professions Career and Education Directory" was published in January, with information on more than 6,100 educational programs and 2,800 educational institutions in 52 different professions. Also, the "Health Professions Career and Education E-letter," a monthly e-mail newsletter sent to 5,000 health professions' program directors, institution presidents/CEOs, professional associations and federal agencies, was one year old in April.

Professional Standards Policy and Advocacy

The Professional Standards Policy and Advocacy area works to ensure the best science and the highest professional standards inform AMA efforts on behalf of patients. It also supports AMA participation in the JCAHO, COLA and the National Quality Forum.

National Quality Forum (NQF) - The NQF is a private sector, non-profit membership organization formally launched in 1998 and beginning operations in late 1999. It is an outgrowth of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

AMA President Randolph D. Smoak Jr., MD, is a non-voting liaison member of the NQF board of directors and sits on the Research and Quality Improvement Council. AMA Immediate Past President Thomas R. Reardon, MD, is the Vice Chair of the Provider and Health Plan Council.

The NQF's projects are closely related to important AMA initiatives--patient safety and quality measurement. Two safety projects have been identified. The first calls for development of a compendium of "safe practices" supported by good evidence, which hospitals and other health care organizations can use to prevent errors and identify serious, egregious and preventable "never events." The second initiative is designed to help standardize hospital quality measures.

Accreditation Activities - The AMA continues its commitment to quality improvement through voluntary accreditation at all levels and active participation in JCAHO, COLA and the American Accreditation Healthcare Commission (AAHCC/URAC). Through these venues, the AMA advocated policy positions on issues such as using restraints and seclusion (including the one-hour rule), small office-based surgery, patient safety, responsibilities of health professionals who are not licensed independent practitioners, critical access hospitals, staffing effectiveness in health care facilities and supervision of residents.

Patient Safety - The AMA has laid a framework of principles to advocate for patient safety in health care settings, which were outlined in Board of Trustees Report 13-I-00. The AMA is advocating these principles through collaborative efforts with the National Patient Safety Foundation, JCAHO and other health care organizations.

Science, Quality and Public Health

The Science, Quality and Public Health area is charged with promoting medical science, collecting that knowledge, and disseminating it to physicians. It also is responsible for public health advocacy initiatives that bring medicine and public health together. The Quality area is committed to facilitating a unified physician-driven effort in medicine pertaining to clinical practice guidelines and performance measurements.

<u>Science in Clinical Practice</u>

Influenza Vaccine - The AMA and the Centers for Disease Control and Prevention (CDC) co-sponsored a meeting with all major stakeholders in March to learn about the flu vaccine distribution system and the unique circumstances that led to last season's delays and shortages. The findings of this meeting and recommendations on how to prevent this from occurring again are forthcoming.

Bioterrorism - Since the Council on Scientific Affairs presented its report on medical preparedness for terrorism and other disasters (I-00), several expert panels also have commented on the need for better involvement of the medical community in the response to terrorism. To assist in these efforts, the AMA testified before the Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction (also known as the Gilmore Commission) and also is participating in the Bioterrorism Preparedness and Response Core Capacity Project initiated by the CDC.

Genetics - At the 2000 Interim Meeting, more than 300 physicians attended the forum "Genetic Medicine: Challenges and Opportunities," hosted by the Council on Scientific Affairs. Questionnaires on current usage and perceived need for a family history tool were answered by more than 100 physicians. Slides from the meeting are available on the AMA's Genetics and Molecular Medicine web site. A session on pharmacogenomics was held at the 2001 National Leadership Conference. The role of pharmacogenomics in speeding drug development and real-time application of pharmacogenomics in asthma therapy were discussed. The Genetics and Molecular Medicine web site--www.ama-assn.org/go/genetics--has expanded to cover more topics, including a "Genetics 101" section for those requiring a refresher course in genetics. The web site also includes information on pharmacogenomics, proteomics, gene therapy and cloning. A CME-eligible module on ethical, legal and social issues in genetic testing for hereditary breast and ovarian cancer is under development.

Drug Policy - The AMA continues to address drug policy issues including medication errors, direct-to-consumer advertising of prescription drugs, the professional package insert, drug formularies, electronic prescriptions, Internet prescribing, prescribing of controlled substances for pain, antibiotic resistance, influenza vaccine delays and shortages, immunization of adults and children, therapies for asthma and foodborne illnesses, patient medication information, off-label uses, Rx-to-OTC switches, dietary supplements, genetically modified foods, medical marijuana, and selected issues in infectious disease (e.g., hepatitis C, use of safety needles, HIV/AIDS, tuberculosis).

United States Adopted Names (USAN) - The USAN program continues to participate in review of potential brand names with the Institute for Safe Medication Practices, and it has developed new liaisons with the Brand Institute and Crescent Pharmaceutical Branding to eliminate names that may cause medication errors due to confusion. Re-nominations to the USAN Council and USAN Review Board were finalized in December 2000. The new USAN web site is scheduled to go live in June.

Clinical Research Roundtable (CRR) - In response to requests from the AMA and numerous other sponsoring organizations, the Institute of Medicine and the Commission on Life Sciences at the National Academies convened a Clinical Research Roundtable (CRR). The AMA has pledged to support the CRR for its inaugural three-year period. The CRR now has entered its second year of operation and has begun to define an ambitious agenda around the concept of a "National Clinical Research Enterprise." The Council on Scientific Affairs will continue to monitor activities of the CRR and will provide periodic reports to the House and post relevant materials on the CSA web site as appropriate. Further information on membership and activities of the CRR is available on its web site.

Organ Donation - The AMA has been awarded a grant from the Health Resources and Services Administration to study the barriers and opportunities for physicians in the organ donation process. The AMA's Organ Donation web site--www.ama-assn.org/go/organdonation--is receiving national attention with its provision of a portal to current news stories on organ donation and updates on legislative initiatives to promote organ donation.

Educating Physicians and the Public

Foodborne Illness - As part of the President's Food Safety Initiative and supported by a House resolution from I-97, the AMA--in collaboration with the CDC, the US Department of Agriculture, and the Food and Drug Administration--has produced an educational primer on diarrheal foodborne illnesses, "Diagnosis and Management of Foodborne Illnesses: A Primer for Physicians." As of May 1, more than 6,000 copies had been distributed. The primer also was published in Morbidity and Mortality Weekly Review and received national media coverage.

Internet - Web sites on violence prevention, SmokeLess States and alcohol and other drug abuse, came online in early 2001. The Council on Scientific Affairs web site--www.ama-assn.org/go/csa--provides summaries of all 138 CSA reports produced by the council from 1994 through December 2000. The full text of 67 of these reports also is posted, as well as complete bibliographic information for the 66 CSA reports published between 1991 and the

present. Web sites for adolescent health, public health, resources on infectious disease, organ donation, genetics and molecular medicine and clinical quality improvement continue to offer physicians and the public information on a variety of medical, quality improvement and public health issues.

Federation of State Physician Health Programs - The Federation of State Physician Health Programs, working with the Physician Health Program, coordinates activities among the various state medical society-sponsored physician health programs to build common practices and policies and carry out liaison activities with licensing authorities.

Special Themes to Promote the Health of the Public

Family Violence - The AMA's National Advisory Council on Family Violence met in Chapel Hill, NC, in May. The advisory council discussed working with the Council on Medical Education to implement Resolution 419 (I-00) calling for efforts to educate physicians about family violence. The advisory council also developed a strategic plan to guide future efforts.

Youth and School Violence - To study the context, causes and solutions for youth and school violence, the AMA convened a partnership--the Commission for the Prevention of Youth Violence--with the American Academy of Pediatrics, American Academy of Family Physicians, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, American Public Health Association, American Nurses Association, AMA Alliance, American College of Physicians/American Society of Internal Medicine and the office of the US Surgeon General. A report to the nation containing the commission's recommendations for action, "Youth and Violence," issued in December 2000, received widespread media attention. The commission will meet in June to discuss education, training and advocacy issues in violence prevention. The AMA's violence prevention web site--www.ama-assn.org/ama/pub/category/3242.html--provides information and resources about preventing violence in their families and communities.

Health Literacy - A daylong program on health literacy, co-sponsored by the AMA Foundation, was held at the AMA National Leadership Conference. This well-attended program consisted of introductory lectures, panel discussions and smaller breakout sessions. Additional national meetings that featured the AMA's health literacy initiative include the annual meetings of the Federation of State Medical Boards, the Society for General Internal Medicine and the National Patient Safety Foundation's Annenberg Conference.

The AMA continues to distribute the Health Literacy Introductory Kit to raise physicians' awareness about the prevalence of health illiteracy and how it may directly affect their relationship with patients. The kit includes a video with vignettes illustrating the range of persons affected by this issue and the problems they experience in the medical encounter; the Council on Scientific Affairs' report, "Health Literacy" (A-98); and other written materials for self-study and discussion. Kit materials have been used in medical schools, residency programs, group practices, hospital staff programs and national conferences.

Alcohol - The "A Matter of Degree (AMOD): Reducing High Risk Drinking Among College Students" program (ten university-city partnerships), funded by the Robert Wood Johnson Foundation (RWJF), has been extended for up to four years per project. The first four universities will be completing their first cycle this August. External interim evaluation indicated that the program is meeting its objectives to establish effective campus community policy advocacy coalitions, to revise and expand enforcement of campus and community alcohol policies, and to reduce the second-hand effects of alcohol abuse (crime, violence, arrest, vandalism, alcohol poisonings). The four-site policy advocacy project accompanying AMOD is fully underway and already has resulted in the change of one state law and one local ordinance and initial approval of two additional ordinances.

The RWJF-funded "Reducing Underage Drinking through Coalitions" program has begun its second four-year cycle. It has published a new policy issue brief on preemption of local alcohol control by state legislation. Recent state coalition victories include passage of a keg registration law and blocking of an alcohol web sales law in Georgia, removal of alcohol and tobacco advertising in Texas state park and wildlife publications, and mandatory responsible alcohol service training--with increased penalties for serving minors or intoxicated persons--in Pennsylvania. Both projects had their joint annual meeting in San Antonio at which Hope Taft, First Lady of Ohio, was the keynote speaker.

Tobacco - The AMA/RWJF "SmokeLess States Tobacco Policy Initiatives" program has completed its selection process for the 2001-04 grant cycle. The new grants will be used for policy development and other advocacy activities, emphasizing tobacco excise tax increases, protection from the effects of passive smoking, and coverage for smoking cessation by managed care and insurance companies. Details are available on the SmokeLess States web site--www.ama-assn.org/ama/pub/category/3229.html. AMA and SmokeLess States staff are working to integrate the program's activities throughout areas such as Federation Relations, the Advocacy Resource Center, Communications, Minority Affairs Consortium, Women Physicians Congress, Medical Student Section and Resident and Fellow Section.

The AMA was part of a group of health organizations that filed an amicus brief in support of the state of Massachusetts in its efforts to regulate tobacco advertising near schools and playgrounds. The case was heard by the US Supreme Court in late April.

Health Needs of Medically Underserved Populations

Special Needs of Adolescents - The AMA's National Coalition on Adolescent Health met in May in Washington, DC. Speakers discussed the State Children's Health Insurance Program; the Commission for the Prevention of Youth Violence's recent report, "Youth and Violence"; resources for parents of adolescents; substance abuse treatment; and cultural competence. Approximately 40 organizations were represented. The AMA is applying to the Health Resources and Services Administration and the Maternal and Child Health Bureau for another five-year cooperative agreement to support the work of the coalition. The AMA Child and Adolescent Health Program recently published and distributed its "Lessons Learned--National Development to Local Implementation: Guidelines for Adolescent Preventive Services (GAPS)," a monograph that features a review of the AMA's GAPS program.

Special Needs of the Elderly - More than 15,000 copies of the AMA's "Diagnosis, Management and Treatment of Dementia: A Practical Guide for Primary Care Physicians" have been distributed. More than 43,000 copies of the second edition of the AMA's "Guidelines on the Medical Management of the Home Care Patient" have been ordered by physicians and other health care professionals. The AMA continues to participate in the HCFA-sponsored Coalition for Quality in Medication Use.

Special Needs of Family Caregivers - To assist the 22 million Americans who are caregivers for a family member with chronic illness and their physicians, the AMA has developed and tested a caregiver health self-assessment questionnaire to help physicians add this preventive service to their busy practices. This simple tool, for use in the waiting room, includes easy scoring and resources for referral. The questionnaire is available in English and Spanish.

Medicine and Public Health

Safe Community Syringe Disposal - A fact-finding meeting co-sponsored by the AMA established a coalition called the National Organizations for Sharps Safety and Training in the Community (NO-SSTIC) to address this public health problem. The coalition includes key representatives from professional associations, industry and public health to identify and discuss major barriers to safe disposal of used sharps in community settings, formulate strategies for improving options for safe community disposal of used sharps, and develop an action plan for developing practical recommendations to improve safe sharps disposal options at the community level.

Medicine/Public Health Initiative - The AMA and the American Public Health Association co-chair the Medicine/ Public Health Coalition, which includes key national leaders in medical education, research, managed care and public health. The next meeting will be held in September.

Clinical Quality Improvement

2001 Annual Meeting Forum - In conjunction with the Speaker of the House and the Division of Clinical Quality Improvement, the Council on Scientific Affairs is hosting a forum at the 2001 Annual Meeting on measurement of physician performance. Assessments of physician performance are an increasingly important priority for health care organizations, employers and patients. Evidence-based clinical performance measures can enhance the quality of patient care. Three nationally recognized experts will provide brief overviews of selected issues, followed by a moderated question-and-answer session.

Clinical Quality Improvement Forum (CQIF) - The 2001 CQIF, "Virtual Medicine," took place in March. This well-attended national conference was designed to assist physicians in exploring potential and existing data collection methods used for improving performance and clinical quality; to evaluate electronic medical record tools; to evaluate the advantages, disadvantages and risks associated with electronic communication of patient information; and to more effectively and efficiently use e-mail to communicate with patients.

Practice Guidelines Partnership - The Practice Guidelines Partnership met February 23. The partnership heard a presentation on the Physician Consortium for Performance Improvement and continued its discussion of the role of the partnership in relation to the Consortium and to other CQI activities.

National Guideline Clearinghouse™ (NGC) - As one of three sponsors represented on the NGC policy board, the AMA continues to ensure physician input into further development and enhancement of this web site. The NGC currently includes summaries of more than 900 clinical practice guidelines from more than 150 organizations. Since its activation, the NGC web site has been visited more than 2.3 million times and has processed more than 25 million requests. A new initiative, preliminarily referred to as the National Measures Clearinghouse, is currently under consideration by the Agency for Healthcare Research and Quality.

Quality Care Alert - Quality Care Alerts on diabetes, chronic stable coronary artery disease and prenatal testing are under development. In May, QCA experts reviewed recent publications on colorectal cancer screening and surveillance to finalize recommendations that each clinical expert and sponsoring national medical specialty society believes best reflect the science related to this disease.

Physician Consortium for Performance Improvement - The consortium met on April 6 and approved physician performance measurement sets for chronic stable coronary artery disease and prenatal testing; development work on measures for asthma and preventive care are nearing completion. In addition the consortium expressed broad support of the AMA/ JCAHO/National Committee for Quality Assurance (NCQA) consensus document on diabetes measures, "Coordinated Measurement for the Management of Adult Diabetes." The consortium is charged with improving patient health and safety by identifying, developing and promoting the implementation of evidence-based clinical performance measures that enhance the quality of patient care and foster accountability, as well as advancing the science of clinical performance measurement and improvement.

Consortium Demonstration Projects - Several demonstration projects to test the consortium's performance measurement sets are in the planning stages. Among their intended purposes, these projects will test the validity and reliability of measures; the usefulness of the measures to practicing physicians; and, toward lessening redundancy, physician hassles and practice intrusion, they will seek to identify efficient methods of data collection. Upcoming projects include working with two quality improvement organizations, or peer-review organizations--the Arkansas Foundation for Medical Care and the Iowa Foundation for Medical Care--to test the validity and reliability of consortium-developed prenatal testing measures. In addition, the AMA is collaborating with the Maine Medical Assessment Foundation (MMAF) and NCQA to test the concept of single data collection for adult diabetes measures, which could lead to future reductions in data collection redundancy. Other potential partners for demonstration projects include national medical specialty societies and state medical societies, some of which already are engaged in discussions on participation with staff, individual physicians, and public and private payors.

Collaborative Work with JCAHO and NCQA - Since phasing out the Performance Measurement Coordinating Council in September 2000, the AMA, JCAHO and NCQA have continued their collaborative work on the coordination of performance measurement. The chief executives of the three organizations met in February to reaffirm their shared commitment to the coordination of performance measurement by the private sector. The partners have made substantial progress in the three ongoing projects--adult diabetes, cardiovascular disease, and pregnancy and neonatal care--and are planning measure set development for other highly prevalent clinical conditions in the American population. The first condition-specific product of the collaboration, Coordinated Performance Measurement for the Management of Adult Diabetes, was completed and released in April. The document aligns each organization's existing measures for diabetes care, eliminating redundancy and minimizing the burden of data collection. The consensus measures for outpatient diabetes care will be the basis of a demonstration project in Maine, testing the concept of single data collection (described above). Draft measures for cardiovascular care are being prepared for discussion by the Cardiac Expert Panel at its next meeting in July. The Pregnancy and Neonatal Care Clinical Expert Panel held its first meeting in January and produced an initial list of measurement priorities. Discussions also are underway to begin the coordination of measurement for asthma care and pain management.

For each project, one-third of the expert panel membership is comprised of representatives of the consortium. The work of consortium work groups, including the completed measurement sets for chronic stable coronary artery disease and prenatal testing, contributes significantly to the ongoing collaborative work.

Clinical Quality Improvement Web Site - Publicly available pages on the Clinical Quality Improvement web site, www.ama-assn.org/go/quality, continue to be added and enhanced. In April the web site was expanded to include a limited access location where meeting agendas and supporting materials are disseminated to consortium members to assist in the development of physician performance measures.

COMMUNICATIONS AND CORE IDENTITY

Member and Business Communications

The Member and Business Communications unit distributes AMA news and information to AMA members and other important internal stakeholders. Key to this effort are partnerships within the AMA--including Advocacy, Federation Relations, Professional Relations and Membership--to better coordinate and integrate all communications for AMA audiences.

Member Communications

The ultimate goal of the Member Communications department is to keep AMA members and prospective members well informed of AMA activities and of all aspects and dimensions of AMA membership. The department's most recent project was producing editorial content for and designing the 2000 Annual Report.

Ongoing Member Communications projects and publications:

Web communications - "News from the AMA," Member Communications' web site--www.ama-assn.org/go/news--provides a direct portal at the AMA home page for members, the public and the press looking for the latest information about advocacy, initiatives and AMA products. It is updated daily and provides links to AMA leaders' speeches, media releases, statements and electronic versions of print materials produced by the department. The department also writes the weekly feature article that appears on the AMA's home page. Since adopting this "daily journalism" strategy, Member Communications has seen a dramatic increase in web traffic. In June 2000, the "News from the AMA" site averaged 900 hits per day; by May 2001, it was averaging more than 2,400 hits per day.

Member Communications also produces "From the President," a web site of the current AMA President, which includes monthly messages from the President on current issues in organized medicine. This electronic forum also allows members to communicate directly with the President by e-mail.

Weekly electronic newsletters - "AMA E-mail News Briefs," sent to approximately 40,000 AMA members, offers diverse, value-added news in a concise format that links readers to the AMA web site for more extensive information. "AMA/Federation News," produced in collaboration with AMA Federation Relations, brings members of the Federation (executives, communicators and presidents at state, local and specialty societies; AMA Alliance leadership; AMA Board of Trustees) timely news and useful information from the AMA.

Communications with the House of Delegates - "Meeting Highlights," an on-site newsletter at annual and interim meetings, serves as a primary news source during the meetings and provides delegates and alternate delegates information on significant House actions that they may pass on to their member constituents. Delegates also receive a monthly e-mail letter from the AMA Board Chair highlighting in-depth news and activities from the AMA and giving them important information they can share with their constituents.

Communication with AMA sections and lifecycle group - Member Communications produces customized newsletters for the Women Physicians Congress, Minority Affairs Consortium and Senior Physician Services that offer concise news and an emphasis on developing "two-way" communication between section leaders and their constituents. The department also produces materials for medical students, residents and fellows, young physicians, practicing physicians and senior physicians, which include feature articles targeted to each group's interests and miscellaneous section news. These materials are "piggy-backed" with other AMA mailings to reach the members.

"AMA for You" - "AMA for You" runs twice a month in *AMNews*. Stories and graphics highlight AMA advocacy, news about the Federation, AMA initiatives and benefits of AMA membership.

Support for AMA campaigns and special projects - Member Communications played a vital role in supporting special AMA advocacy campaigns--particularly the AMA's National House Call. The department produced comprehensive materials, including web sites, news releases, op-eds, talking points, speeches, print advertisements, displays and targeted blast faxes and e-mails. Also, the department has assisted with a number of special projects, including advocacy achievement cards, flyers highlighting the Pride in the Profession award winners, feature articles for use in membership materials, and an AMA headquarters tour brochure for Records Management and Archives.

Business Communications

The area of Business Communications was created to provide communications strategy for AMA business ventures, ensuring that the core purpose, message and positioning of new ventures adheres to the AMA's overall strategic mission and vital priorities. This unit serves as a liaison, working with internal and external partners to ensure seamless execution of all phases of the AMA's business ventures and to provide consistent communication of business developments to all stakeholders. Since its creation in July, Business Communications has provided support for the AMA's ventures with Intel, Medem, Acxiom and VeriSign. Business Communications also has provided support for Finance, helping to plan and create the 2001 Plan and Budget book as well as the 2000 Annual Report.

Integrated Communication Services (ICS)

From November to June, ICS provided marketing communications support for approximately 300 AMA projects of varying complexity--from business cards to books to full-fledged campaigns. Projects include:

- Promotional support for initiatives such as gifts to physicians, caregiver health and health literacy.
- Newsletter production for tobacco and alcohol initiatives, physician credentialing and licensure services, and women and senior physicians.
- Promotions, displays and "packaging" of meetings, programs and campaigns, such as the OMSS open house for nonmembers at the 2001 Annual Meeting.
- Web art, ads and/or direct mail for many projects, including the Group Practice web site map and the Health Reporters Conference.
- Production for books such as "Lessons in Patient Safety" for the National Patient Safety Foundation and "An Environmental Analysis," which serves as the information base for the AMA strategic plan.
- Program brochures, among them: "Modernizing Medicare, AMA Health Insurance Proposal" (for general audience), and "Rethinking Employment-based Health Insurance."
- Official publications, including the AMA 2000 Annual Report, 2001 Election Manual and the 2001 House of Delegates 100th Anniversary Pictorial Directory.
- Recognition items (certificates, plaques, ribbons and custom awards), such as professionally illustrated likenesses with calligraphy of three retiring AMA Trustees.
- Program and business identity packages for the Ethics Standards division--Virtual Mentor and Soliciting Physicians' Ethical Attitudes and Knowledge (SPEAK); Science, Quality and Public Health; and the National Patient Safety Foundation.

Employee Communications

The Employee Communications unit has been fully staffed since mid-March. The primary vehicle for internal communication is "PM Update," a daily, afternoon e-mail newsletter that ties together breaking health news, AMA program updates and employee news. Staff response to "PM Update" has been very positive and employees are enthusiastic about contributing information.

Employee Communications also is working toward increasing opportunities for face-to-face communication, including working closely with the EVP Office to promote special events such as Staff Appreciation Week and the first-ever AMA-co-sponsored health fair. The unit also is identifying strategies for better use of the AMA Intranet and display space throughout AMA Headquarters.

Advocacy Communications

A primary goal of Advocacy Communications, a new unit created in last year's reorganization, is to apply the power of national and grassroots communications campaign techniques to leverage the AMA's ongoing lobbying in Washington for our principal public policy and public health advocacy goals. Core components of our campaign are media outreach, advocacy advertising and public speaking by AMA leaders.

To strengthen this effort, we shifted one media relations position and one speechwriter position from Chicago to Washington and transferred a communications Vice President from Chicago to supervise all advocacy communications activity by staff in both cities and to strategically coordinate the unit's operation with DC-based legislative and lobbying staffs.

Enhanced perceptions of the AMA's influence quickly followed. According to a Harris poll, the AMA's "favorable" ratings among the public increased by 21% between the third quarter of 2000 and the first quarter of 2001, largely through our higher-profile advocacy for patient protections. In addition, Fortune magazine ranked the AMA #12--up from #13--in its listing of the nation's most powerful lobbying organizations. No other medical or health care group rated higher.

One reason: During the first 150 days of the Bush administration, we aggressively inserted the AMA's voice into the ongoing and increasingly urgent national debate on patients' rights and health system reform, with an integrated sequence of advertorials, media activity and speeches that laid down our principles for congressional action.

Our most powerful strategic tool is proving to be the AMA's "Is It Good Medicine" National House Call program, jointly directed by AMA Communications and Advocacy staffs. Launched with the help of state and county medical societies during the 2000 presidential primaries, National House Call was fully formed during a targeted, multi-state push for patients' rights last fall. Following more activity last winter and this spring, it is now established as a nationally-recognized media magnet and political force.

For example, between mid-February and mid-May, AMA officers and trustees participated in 45 National House Call events in seven states--Texas, Ohio, Louisiana, Nevada, Oregon, Maine and New Hampshire. Appearing with state and local physician leaders, AMA trustees advocated for patient protections, health care coverage for all Americans, and the elimination of Medicare red tape so that physicians can concentrate on patient care--not paperwork.

Grassroots activities included meetings with physicians and other health care professionals, ten editorial board visits, four formal news conferences, dozens of media interviews, meetings with governmental officials, discussions with patients and meetings with state and local medical societies. Media activities produced broadcast interviews on 48 separate local programs, stories in at least 11 local newspapers and widely published reports from the Associated Press. A successful tactic is placing AMA leaders on popular local and statewide radio talk shows; often US senators and representatives will call in themselves to discuss pending patient protection legislation with the AMA spokesperson.

During late spring, as momentum mounted for congressional action, we supported National House Call activities with a strong advertorial--"Don't Let Big Insurance Ambush Patients' Rights"--strategically placed in 12 major local newspapers in states targeted for the Washington role of their US senators in patients' rights discussions--Oregon, Nevada, Louisiana, Maine and New Hampshire.

These advertorials were part of a tightly-focused strategic messaging campaign that we implemented inside Washington, DC, beginning shortly after President Bush's inauguration in January. Public messages were deliberately timed to enhance the efforts of more private AMA lobbying. Ad headlines included "Rx for Better Health Care," quotes about health system reform from the President's inaugural address, and factoids exposing anti-patients' rights misrepresentations made by the insurance industry. For details, go to www.ama-assn.org and www.kaisernetwork.org/adwatch.

In one real-world gauge of the spring campaign's power, AAHP scrambled to announce an "aggressive" $1 million television and print campaign targeted at Congress and designed specifically to neutralize the gains made in Washington by the AMA's National House Call grassroots activities. The lasting measure of our effectiveness, however, will be the final action taken by the US Senate on patients' rights.

In anticipation of that action, at the end of May we briefed the national news media in Washington on House of Delegates policy and principles guiding the AMA's seven-year campaign for patient protections. Attendees included representatives of *The New York Times*, Associated Press, CNN, *National Journal*, Gannett News Service and Reuters. In response to editorials on patients' rights, we placed letters from AMA leaders to the editors of *USA Today*, *The Wall Street Journal* and the *Washington Times*.

Although patients' rights has commanded center stage, we also have maintained the AMA's visibility on (1) providing health insurance coverage for all Americans; (2) upcoming congressional action on legislation to relieve physicians from HCFA red tape and paperwork; and (3) gathering support for legislative antitrust relief, an issue which has become even more urgent in view of the May 30 Supreme Court decision sharply limiting the ability of physicians to collectively negotiate with health plans. We will conduct separate communications campaigns on each of these advocacy issues when the political time is right.

Executive Speaker Program

The messages delivered to key audiences by top AMA leaders are an important element in our advocacy effort. Through the first five months of 2001, the executive speechwriting team produced 81 presentations, columns and other communications for AMA's physician leaders. Strategic messages included reports on AMA initiatives and accomplishments such as the AMA's National House Call, patients' bill of rights, the AMA proposal for health system reform, as well as on the uninsured, HIPAA, MERFA, international medicine and a variety of public health issues.

Addresses by AMA leaders included major presentations to seven state and ten county or local medical societies, 11 specialty societies, 13 business or professional groups, three government, three educational and two international venues. In addition, AMA leaders delivered a total of 17 speeches at the National Leadership Conference, held in March in Washington, DC.

In a March address to the City Club of Cleveland, "Health Care Coverage for All Americans," AMA President Randolph D. Smoak Jr., MD, detailed the AMA's proposal to extend tax credits for individually owned health care coverage. The address received national attention and was reprinted in the prestigious "Vital Speeches of the Day." In this speech, Dr. Smoak told of discovering that the woman who normally cut his hair was among the uninsured. "One of the most powerful doctors in America says a haircut brought home to him the plight of Americans without health insurance," reported *The Cleveland Plain Dealer*.

Media Relations

The AMA's three media relations divisions: News & Information, Science News and *JAMA*/*Archives* continue to utilize proactive media outreach strategies in promoting the AMA and its work to all audiences.

News & Information

News & Information handles approximately 150 calls per week and has garnered major media coverage for the AMA's initiatives and policy positions. Since December, AMA Trustees have been quoted frequently in national and local media outlets, including: ABC World News Tonight, CNN, PBS, MSNBC, National Public Radio, The Associated Press, *The New York Times*, *Washington Post*, *Chicago Tribune*, *Los Angeles Times*, *USA Today*, *Dallas Morning News*, *The Wall Street Journal*, *Atlanta Journal Constitution*, *Medical Economics* and WebMD.

Media outreach efforts made in conjunction with the AMA's National House Call campaign have generated articles and favorable editorials on the AMA's push for patients' bill of rights, Medicare regulatory relief and State Children's Health Insurance Plan. Since January, House Call has made stops in Texas, Ohio, Georgia, Tennessee, Louisiana, Oregon, Maine and New Hampshire. In addition, strategic outreach by the News & Information staff have resulted in favorable coverage on patient privacy, prompt pay legislation, health literacy, physician use of the Internet and AMA guidelines for food-borne illness. The division has developed and placed 20 letters-to-the-editor during the past six months. Letters have promoted AMA views on wide ranging issues, appearing in top news publications including: *The New York Times*, *USA Today*, *The Wall Street Journal*, *Los Angeles Times* and *US News and World Report.*

In April, AMA Media Relations hosted the 21st Annual Medical Communications and Health Reporting Conference. US Surgeon General David Satcher keynoted and discussed strategies for preventing youth violence.

Science News

Science News continues to serve as an important liaison for communicating important science and public health initiatives to the media. Since the 2000 Interim Meeting, the division has hosted three successful media briefings on diabetes, heart disease and Alzheimer's disease. These day-long briefings drew an average of 50 reporters for each event and resulted in numerous stories about these important public health concerns. Other briefings scheduled for 2001 include obesity, diseases of the bones and joints, food biotechnology and asthma and allergy. The division is also hosting the AMA's 20th Annual Science Reporters Conference scheduled for October at the University of California at San Francisco.

The division has begun working more closely with the AMA Council of Scientific Affairs to better promote the council's work. In March, staff worked with CSA Chair Mike Williams, MD, in preparation for his appearance on Chicago Tonight to discuss Mad Cow disease.

JAMA/*Archives*

The division produces 48 news release packets during the year highlighting studies from *JAMA* and the *Archives* journals. Packets are sent via e-mail to approximately 1,600 reporters and medical institutions around the world. Studies receiving wide media coverage during the past six months include new cholesterol guidelines, cell phone use not being associated with a risk of brain cancer, the ineffectiveness of St. John's wort for major depression and the risks of estrogen use.

Newspapers that reported on *JAMA* articles included *The New York Times*, *USA Today*, *The Wall Street Journal*, *Washington Post*, *Chicago Tribune*, *Los Angeles Times*, *International Herald Tribune*, the *Times* of London, *Boston Globe*, and the *San Francisco Chronicle*. All the major television networks covered various *JAMA* articles, including NBC Nightly News, ABC's World News Tonight, the CBS Evening News, CNN and the Today Show on NBC. For radio, the national networks (NBC, ABC, CBS, CNN) reported on *JAMA* studies, as did National Public Radio. Magazine coverage included *Newsweek*, *US News & World Report* and *Time*. The Associated Press wire service, which is used by 1,700 newspapers and 6,500 broadcast outlets, covers *JAMA* on a weekly basis. In the last six months, millions of people heard or read about important medical information published in *JAMA* and the *Archives* journals.

The division also produces a weekly video news release, seen by an average of 19 million Americans. Major stories from *JAMA* receiving coverage during past six months include fruit and vegetable consumption not being associated with a reduced breast cancer risk (29 million viewers/127 cities/205 stations), the benefits of moderate exercise for women (34 million viewers/156 cities/299 stations), the increased medical needs for children with ADHD (25 million viewers/139 cities/225 stations), the ineffectiveness of back belts (30 million viewers/162 cities/326 stations) and no link being found between cell phone use and brain cancer (47 million viewers/162 cities/340 stations). *JAMA*/*Archives* staff also have coordinated two successful media briefings since I-00. These briefings highlighted articles from *JAMA* theme issues on medical research in the 21st century and women's health. Both briefings generated national media coverage.

PUBLISHING, MEMBERSHIP AND BUSINESS SERVICES

AMA Publishing, Membership and Business Services is made up of seven principle areas: Membership, Periodic Publishing, *AMNews* Editorial, AMA Press, Internet and Database Operations, New Business Development and AMA Insurance Agency. In 2000, these areas accounted for more than $230 million in revenue and almost $120 million in contribution margin. This contribution margin provides much of the funding for all of the good work the AMA does in the areas of advocacy, communications and professional standards, while also contributing to cover the infrastructure necessary to run the organization.

The group also serves as the incubator for many of our new business venture ideas. Prudent investment in new business ventures and revitalization of current business is critical to the continued financial success of the AMA.

Membership

We have been focusing much attention on membership in the AMA this year, both on evaluating alternative models of memberships and reengineering the current processes of membership marketing.

Our membership has remained stable since the late 1980s, with only small gains and losses throughout the last decade. As the number of physicians in the country has increased, our stable membership count has meant that our share of the physician population has declined. Despite this long-term trend, we are making some progress this year, and we project small positive growth over last year's membership. This is due to our persistence in implementing our professional lifecycle membership marketing plan, focusing our activities on key stages within a physician's career. Because of this focus, both student and resident membership will increase this year. Significantly, we are 2,000 ahead of last year in resident membership to date. This represents an investment of our membership marketing dollars, but it will pay off by building loyalty in the next generation early in their professional career.

Membership of physicians-after-residency through the Federation continues to decline this year. The five-year average decline is 4%, but it will likely exceed that this year. The deunification of Illinois is leading to a reduction of more than 3,500 regular Federation members. Five other states are showing significant reductions to last year.

To offset this downturn, direct recruitment of regular physicians is up 10% so far this year. More than 1,500 Illinois physicians who previously had joined through Illinois have joined directly this year, and the same pattern is holding for other states.

However, the overall reduction in the number of physician-after-residency members translates into a current 2001 forecast of dues revenues that may be as much as $1.9 million below the original 2000 budget. AMA efforts during the second half of the year may reduce this decline.

Membership through our web site has taken off this year. Spurred on by the 10% dues reduction for membership through the web authorized by the Board of Trustees last year, we now have 5,737 members through this channel, a 400% increase over the 1,109 by this time last year. Residents and full physicians account for almost this entire number.

The new Lifetime Membership option has reached its first birthday with more than 1,300 lifetime members--almost triple our initial projections for this first year. Our youngest lifetime member is a 26-year-old medical student from Livingston, New Jersey, studying at the University of Iowa College of Medicine. Our most senior lifetime member is a 91-year-old retired anesthesiologist from Oxnard, California, a longtime member who had been dues-exempt for many years before paying his Lifetime Membership. Seeing the growth of this new program in a time of radical rethinking of membership is one of the most satisfying aspects of this past year.

Developing an internationally renowned service center is a multi-step, multi-year process, but we took significant steps this year with the consolidation of several of our customer and member service units into one. The new Unified Service Center provides one-stop shopping to build and sustain loyal relationships with members and potential members. This unification permits us to provide knowledgeable, prompt and courteous service that exceeds members' expectations.

Despite our recent membership innovations, our overall challenge in the membership arena remains formidable. To achieve substantial progress, all key elements of the AMA need to be working together and focused on increasing the value that physicians perceive in being a member. As our Advisory Committee on Membership has articulated, this means fundamental reform in the way we approach membership development within the Federation, and without those reforms, progress will continue to be difficult. At the same time, we remain optimistic because we know we are up to the task.

Periodical Publishing

In late 2000, the medical publishing industry experienced an unexpected downturn in advertising and subscription revenue. This downturn continued through the first quarter of 2001 and began to moderate in April and May. Despite this difficult market, the journals have experienced market share gains compared to competitors.

To revitalize advertising revenue, the Association of Medical Publications (AMP) has commissioned a major promotion effectiveness study. The findings demonstrate a return on investment (ROI) for journal advertising of $4.97 for every $1 spent versus 19 cents for every dollar spent on direct to consumer advertising. These findings were presented across the industry in May and will continue to be presented in a variety of forums. We hope this will help the pharmaceutical industry refocus its marketing budget on medical journal advertising.

It is also significant to point out that the periodical publishing group has been successful in diversifying its revenue base. In 1996, display advertising revenue accounted for 69% of total publishing revenue. In 2000, that number shrunk to 53%. While cyclical trends in this industry are typical, they have served to refocus our attention on continuing to diversify our revenue base to protect against such trends in the future.

Regardless of market fluctuations, we view the publication of *JAMA*, *AMNews* and the *Archives* journals as central to our mission of remaining the world leader in information dissemination on health and medical practice.

American Medical News

Through *AMNews*, the AMA provides members and other readers valuable, reliable information about today's medical practice environment, facilitating efficient and ethical health care delivery and enhancing the patient-physician relationship. Though masked by the weak advertising market, recent dramatic improvements in readership efficiency scores have generated increased revenue in 2001.

To further capitalize on this position and translate recent readership improvement into financial results, we announced the appointment of a dedicated publisher of *AMNews* and International Markets. We believe this strategic realignment of resources will provide improved focus on the economics of *AMNews* and enable maximization of revenue and optimization of expenses. A full business plan for this publication that addresses both sales and operations will be completed shortly.

AMA Business Products Group

At the end of last year, we announced the development of the Business Products group, which consists of AMA Press, Reimbursement and Coding Products and AMA Solutions. In the first part of this year, this group has been successful in integrating these disciplines and creating a cohesive message in a cost-efficient manner that will maximize our Business Products group revenues.

Additionally, the Business Products group has worked diligently to improve all relationships with outside vendors. In completing this task, it successfully renegotiated the purchase price for CPT and ICD-9 products with suppliers, which will result in significant future savings.

From a strategic perspective, the group has worked to expand product offerings, especially in the professional clinical publishing area. This entry into the $300 million medical book market will stimulate the continued growth of the group.

We are also pleased to announce that the Department of Health and Human Services (HHS) has selected Current Procedure Terminology (CPT) as the standard code set for reporting health care services in electronic transactions. This announcement reinforces the commitment of HHS to work with the medical industry to eliminate local codes

and transition to national standard codes. We believe this is an important step toward the standardization of national health care information and will support patient care by facilitating data collection and communication among health care professionals.

However, despite these early successes, the Business Products group has continued to address challenges associated with new fulfillment center including shipping and system issues and accounts receivable management. Early financial results indicate some upside potential, despite fulfillment center challenges.

Electronic and Database Products

Despite some initial concern, Database Licensing and Credentialing anticipates another strong year as a result of increased contract compliance, improved customer support and a strong direct-sales effort.

The AMA's Online Oversight Panel (OOP) continues to play an active role in the AMA's Internet strategy and direction. Meetings are held via conference calls and in person during the Annual, Interim and NLC meetings. The OOP is briefed on all new Internet initiatives.

We have chosen to continue the AMA/Intel Internet Health Road Show as an effective tool for teaching physicians how to utilize the web for patient care and education as well as professional enhancements. Four courses have been scheduled for this year.

Originally built to hold three years of journals, the James S. Todd Memorial Library now accommodates an average of 10 years for a majority of the 1,200 titles in our serial collection. As a member benefit, our library staff provides a variety of free, value-added services for AMA members, including mediated literature searches, reference assistance, subject bibliographies, and photocopies of articles published by the AMA. Each day our library staff provides expertise to visiting AMA members and responds to telephone, fax and e-mail requests.

Staff continues to improve the quality of the AMA Physician Masterfile by collecting licensure data from most of the 67 licensing boards on a monthly basis rather than twice a year.

We also have moved our physician profile service (now called E-Profiles) to the Internet. Now customers can pay for and receive a biographic and practice record of a physician directly from the Internet, thereby eliminating staff intervention. Initial results indicate that more than 70% of the orders were fulfilled online within 24 hours.

AMA Insurance Agency, Inc.

The AMA Insurance Agency, Inc. continues to be a strong performer. Pre-tax profit at year-end 2000 was $8.4 million, bringing the pre-tax total to almost $60 million since its inception 13 years ago.

In 2001 several strategic efforts are underway, including the completion of the "Compendium of Medical Society Sponsored Insurance Plans" for 2000-01. The study was mailed to the 234 medical societies who participated in the study, and copies were provided to the 436 remaining medical societies who did not participate. At the request of our members, the agency developed a "stand alone" Caremark prescription drug card. More than 1,700 physicians and families are participating in this important discount program. Finally, the agency's third-party administration (TPA) services represents $2.7 million in total annualized premium. TPA services represent a critical potential revenue stream that will help secure the agency's financial future

Medem, Inc.

The AMA, along with the American Academy of Ophthalmology; American College of Obstetricians and Gynecologists; American Society of Allergy, Asthma and Immunology; American Society of Plastic and Reconstructive Surgeons; American Psychiatric Association and the American Academy of Pediatrics, formed Medem, Inc. in late 1999. Medem continues to move from concept to action in 2001.

In the early part of this year, the AMA in conjunction with the six other founding societies, worked with Medem in securing a third round of funding for Medem. This additional funding is expected to ensure that Medem's financial needs are met through the end of 2001. Medem appears well on its way to achieving business plan goals for this year.

Your Practice Online is a service that allows AMA and participating society members to build their practice web sites as a free benefit of membership. Through May, more than 25,000 physician sites have been constructed. To learn more, visit www.yourpracticeonline.com.

Under the direction of AMA Past President Nancy W. Dickey, MD, as editor-in-chief, Medem editorial staff has transferred quality information from the AMA's vast resource of medical information to the Medem site. For more information on Medem's content, visit www.medem.com.

Medem is continuing discussions with interested specialty and state medical societies. To date, 37 societies form the Medem partnership. Medem will continue to work with the partner medical societies to exhibit and register physicians at the organizations' annual meetings. Medem also will continue to work with the founding societies to enhance communications to their respective members including advertising in society publications and articles for use by the societies.

AMA Internet ID

In April, the AMA announced that VeriSign, Inc. is the new technology partner for the AMA Internet ID service. The service was launched in October 1999 with underlying technology supplied by Intel's Internet Authentication Services (IAS). When Intel decided to exit the IAS business, it deemed VeriSign, the market leader in Internet trust products and services, the best choice for the continuing development and enhancement of the AMA Internet ID product.

The AMA's relationship with VeriSign offers access to new technologies that will enhance the AMA Internet ID, providing physicians with a host of new features and benefits not previously available. The AMA also will have access to the existing relationships that VeriSign has with a number of leading providers of health care products and services on the Internet. This access will help make the AMA Internet ID more widely accepted, more quickly.

HealthCarePro Connect

In September of last year, we finalized a new business partnership between the AMA and Acxiom Corporation. The new company, called HealthCarePro Connect (HCPC), will use the latest in information technology to bring physicians greater control over how they are contacted and the kind of information they receive. At the same time, it will enable those who market to physicians to control costs and improve response rates by more closely targeting product and service offerings to match physician preferences.

To ensure privacy of information and help give physicians a greater voice in controlling and shaping the flow of product and service information they receive, HealthCarePro Connect will provide physicians the unique ability to access and customize their own data.

Since that time, HCPC has been working diligently to implement its business plan. A key aspect of the HCPC business model is the ability of physicians to review their data online, ensure its accuracy and make decisions on how they want to be contacted. To enable this to occur, a contact preference product has been developed. This product is in the final testing phase and is due to be released shortly.

On another front, HCPC has taken steps to create a world class Privacy Advisory Board. The slate of nominees has been developed and will shortly be presented to the HCPC board for action.

OFFICE OF THE GENERAL COUNSEL

The Office of General Counsel provides legal advice and services to the Board of Trustees, the House of Delegates, and the AMA as an organization when legal issues arise in the context of staff's work. OGC also manages the litigation of the AMA, and its Litigation Center advances AMA policy on behalf of our members.

Health Law and Litigation Division

The Health Law and Litigation division provides legal advice and litigation support to the AMA, and serves as counsel on disciplinary matters to CEJA. The division also advances AMA policy in the courts and before other legal and regulatory bodies, provides information and advice to the specialty sections, and monitors and analyzes the health law issues that affect the AMA, its members and their patients.

During the past year, Health Law has focused on the following current issues and projects:

- Working as part of an interdisciplinary staff team to fashion the AMA's response in the areas of advocacy, education, technology and litigation to HIPAA regulations on the privacy of individually identifiable information;

- Working with Advocacy to evaluate and educate state medical societies on a variety of ERISA preemption issues, in an effort to preserve state causes of action against MCOs;

- Revising the Medical Staff Bylaws Update, a document that addresses the hot issues that OMSS has brought to our attention, which will be rolled out presently;

- Providing information for the criminal justice system on the appropriate use of forensic techniques; and

- Fraud and abuse compliance guidelines.

In addition, the Litigation Center has been very active on behalf of our members and has filed two class-action lawsuits against three large insurance companies. In one of these cases, the AMA contends that Aetna US Healthcare systematically violates the Georgia prompt payment law, and that two other insurance companies, Metropolitan Life and United Healthcare, use faulty data when paying physicians on a uniform, customary and reasonable basis. Also, with the expert assistance of the CPT division, the Litigation Center is supporting a lawsuit against CIGNA Insurance Company for breach of physicians' PPO contracts. The court recently certified this suit for nationwide class status.

In the ERISA arena, the Litigation Center met with the acting Solicitor General of the United States to seek support for patients' rights legislation in Texas and Illinois. The US Supreme Court has asked the Office of the Solicitor General for its advice in two pending cases concerning these laws. The Litigation Center and the Pennsylvania Medical Society, in an amicus brief, adopted argument made by the Pennsylvania Supreme Court, holding that ERISA does not preempt claims derived from sub-standard medical care.

The Health Law and Litigation division also provides counsel to CEJA, particularly in its disciplinary role.

Corporate Law Division

The Corporate Law division provides a broad range of support to all operating units within the AMA. The division's business law services include the structuring, negotiation and documentation of transactions for publishing, data licensing, vendor, e-commerce and other commercial ventures. The division also provides business law advice and services for AMA's non-commercial ventures including Science and Technology, Medical Education and Ethics. The division provides valuable legal services to various councils and affiliated organizations such as the AMA Foundation, World Medical Association, AMPAC, Council on Constitution and Bylaws, and AMA subsidiaries. In addition, the division provides the full range of corporate legal services to the AMA relating to employment law, benefits, real estate, taxation, governance and intellectual property protection. The division also responds to requests for general legal information from members of the AMA and staffs of state and specialty medical societies.

Corporate Law serves as transaction counsel for AMA Business Operations. Most recently, Corporate Law provided substantial services to the AMA's business team, participating in extensive negotiations with Intel Corp. regarding the assignment of the AMA Internet ID development agreement to VeriSign Corp., in connection with Intel's effort to sell its Internet authentication business. The division also continues to evaluate the appropriate corporate structure for AMA's business operations.

Corporate Law provides contract drafting, negotiation and transaction counseling to all the AMA's revenue generating operations, and facilitated the execution of approximately 110 list house and end-user licenses that form the backbone of the AMA's profitable database licensing operation, Corporate Law also finalized approximately 150 licenses and related agreements in support of the AMA's CPT business. Recently, Corporate Law assisted CPT management in finalizing and implementing an amendment to the HCFA/AMA agreement that allows HCFA's insurance carriers and intermediaries to post specified CPT information on the Internet in a manner that protects AMA's copyright. The lawyers also are working with HCFA for expanded Internet distribution of CPT.

Corporate Law is responsible for the maintenance of the AMA's portfolio of more than 50 trademarks and service marks, and it assists management in obtaining new registrations. The division represents all business units in cases where others infringe AMA trademarks and copyrights.

Corporate Law continues to assist in the development and monitoring of the legal parameters that allow the AMA to use Internet technology in support of its mission. During the first quarter of 2001, the Corporate Law division was instrumental in finalizing third round financing for Medem, Inc., the AMA-affiliated e-health enterprise.

Corporate Law provides legal support for the expanding area of licensing of *JAMA*, the *Archives* journals and *AMNews* over the Internet and through other electronic media. The division provides legal services for the publications' web sites, which allow access to full-text articles of *JAMA* and the *Archives* journals, and continues an aggressive initiative of registering the *JAMA* trademark in foreign countries and opposing competing registrations. The division also is protecting vigorously the *JAMA* trademark domestically, notifying infringers to cease promptly and, when necessary, filing suit to stop the use of *JAMA*'s name in advertising.

Corporate Law staffs the Council on Constitution and Bylaws and provides preliminary review to resolutions submitted to the House of Delegates that relate to governance, antitrust, business and corporate law issues.

Corporate Law handled the legal documentation for AMACO's declaration of a $7.2 million dividend that recently was approved by the Illinois Department of Insurance.

FINANCE

The Office of Finance continues to focus its efforts on financial discipline and strengthening financial policies and procedures. Redesigning financial budgeting and reporting processes to provide more timely and useful information for senior management and the Board of Trustees, as well as updating investment policies and practices, have also been high priorities.

CONCLUSION

As you have seen in this report, the AMA remains strong and vigorous, fiscally sound, politically powerful, nationally respected--and ready to advocate for the profession of medicine wherever and whenever we are required to do it.

But the AMA could not continue to realize these successes without your support. The time and energy you devote to organized medicine--through your state, county or specialty societies and more importantly, through the AMA's House of Delegates--remains crucial to our work. Thank you for all your contributions during the past year, and for all you do for this nation's patients.

REPORT OF THE AMPAC BOARD OF DIRECTORS: The following report was submitted by Roy W. Vandiver, Chair of AMPAC:

On behalf of the AMPAC Board of Directors, I am pleased to submit this report to the House of Delegates concerning AMPAC activities. We are working closely with our state medical PAC partners to assure that our involvement in federal campaigns and elections is effectively advancing medicine's advocacy goals. We are tracking congressional activity relating to campaign finance where the Senate has already passed significant reforms and action in the House is expected later this summer. Emphasis for reform is being placed on either eliminating or sharply reducing corporate contributions (soft money), and political action committees are now being held up as the model for responsible involvement in campaigns and elections.

MEMBERSHIP

As of May 31, AMPAC membership stands at 37,489. This compares with year-to-date membership of 37,803 in 2000 and 28,099 in 1999. Memberships received from the states continue to decline although we continue to aggressively seek recruiting opportunities with the states. As has become the custom, Florida, Indiana, Mississippi, and Missouri have already reached their AMPAC membership goals-for the year. Eight other states are within reach of their membership goals. They are California, Georgia, Hawaii, Kentucky, Louisiana, New York, South Carolina and Texas.

AMPAC direct membership is running slightly ahead of 2000. Through the end of May, there are 5,893 direct members compared to 5,328 last year. We remain confident that our direct recruitment efforts will continue to be effective through the balance of 2001.

Once again, AMPAC will be seeking to gain 100% membership among state delegations at this annual meeting. Special recognition will be given to those states that reach this goal. In addition, AMPAC is soliciting for its Major Donor Program. We encourage you to stop by the AMPAC/AMA Grassroots Booth at this meeting for more information on these programs.

AMPAC now has the ability to accept membership via the Internet. Through a partnership with the Federation, physicians can join AMPAC and their state PACs at AMPAConline.org.

GRASSROOTS GRANTS

For the past decade, AMPAC has provided grassroots grants for state medical societies to enhance their grassroots outreach and advocacy programs. During this election cycle when changes in many state legislative and congressional districts will occur, AMPAC will be providing legislative district matching assistance to state medical societies. Initial responses from the Federation on this program have been overwhelmingly positive. As states finalize their redistricting efforts, we will work with individual states to determine an appropriate timetable for completing this project. We continue to be firmly committed to keeping the AMA in the vanguard of grassroots mobilization efforts in support of our legislative and regulatory initiatives.

CONGRESSIONAL VOTE RECORDS

Empowering members and other grassroots advocates for organized medicine is a critical tool in efforts to effectively persuade members of Congress to support the AMA's initiatives--and access to information on congressional activity is the key to that empowerment. AMPAC encourages members and supporters of organized medicine to visit the AMA in Washington web site, which can be accessed at www.ama-assn.org/grassroots and provides a constantly updated resource for the AMA's grassroots efforts. In the "Grassroots Action Center" of the web site, visitors can either enter their zip code or simply look up a member of Congress by name to see how that individual voted on key AMA measures. The web site also provides up-to-date lists on bill sponsorship. Armed with voting and sponsorship records, web site visitors are encouraged to contact their members of Congress through e-mail, regular mail or by calling the Grassroots Hotline, which will patch them directly to the offices of their members of Congress. In this age of instant communication, the AMA's ability to quickly and effectively mobilize supporters when key legislation comes up for a vote has a tremendous impact.

AMPAC CAMPAIGN SCHOOLS

The 2001 AMPAC Campaign School was held in February and was attended by enthusiastic, dedicated physicians, medical students, spouses and staff. Participants were entrenched in a classroom for five long days learning the professionals' secrets of political campaigns. The 2001 Candidate Workshop occupied three full days at the beginning of April. The goal of those attending the workshop was to discover how to become a winning candidate. The skills and techniques taught in each program apply to campaigns at all levels and allow the AMPAC graduates to assess a district, target their voters and put our candidates in the best light.

Planning for the 2002 campaign and candidate schools is in process. The next AMPAC Campaign School is scheduled for March 13-17, 2002 in Washington, DC. The date of the next Candidate Workshop will be announced soon. Information on both programs will be posted to the Political Education section of the AMA in Washington web site.

THE BELLE CHENAULT AWARD FOR POLITICAL PARTICIPATION

Co-winners of the prestigious Belle Chenault Award for Political Participation have been named for the first time. Alliance members Cheryl Dolan of Florida and Carole Thompson of Texas will receive the 2001 award. Large poster identifying the winners are on display at both the Drake Hotel and the Hilton Chicago and Towers. Information on the winners and a description of the award will be distributed to the AMA House of Delegates. Mrs. Dolan and Mrs. Thompson will be honored at the AMPAC/Alliance breakfast at the Drake Hotel on Monday, June 18. A large silver bowl displays the names of each winner since the award began in 1987.

CONCLUSION

Your involvement in the political and grassroots activities of the AMA and AMPAC is critical to our continued success in Washington, DC. We need your leadership and support to be able to positively impact public policy decisions affecting our patients and our profession.

REMARKS OF THE SECRETARY OF HEALTH AND HUMAN SERVICES: The following remarks were presented on Sunday, June 17, by The Honorable Tommy G. Thompson, Secretary of the United States Department of Health and Human Services:

It is certainly wonderful for me to have this tremendous opportunity to address the House of Delegates at this very important gathering to be with such distinguished professionals, individuals that are working so hard to improve the quality of health care in America. I also am very pleased to be welcomed, my very good friend Tim Flaherty, who has been a friend, a supporter, a critic, whatever, all these years and has been always there for me and I want to thank Tim Flaherty and all that he has done in regards to his professional career.

Ladies and gentlemen, I will talk to you about several subjects today. I am excited about being here. I really didn't plan on being Secretary of Health and Human Services. When the President called me, he asked me to join his cabinet. He offered me or considered giving me the Secretary of Education, Secretary of Transportation, and the Secretary of Health and Human Services. It got down to Secretary of Health and Human Services, and I am delighted with the opportunity.

I didn't realize what you have to go through, though, in order to become a Secretary. First thing you have to do is fill out all kinds of forms. It tied up my governor's office for ten days to get all the forms in. You have to go back to when you were born and every place that you have lived and every place you have worked and every person you have met with and so on. By the time you get that done, then you go to getting an FBI check.

And I have had them done before but not to the complete depth that this one was. They sent ten full-time FBI agents into Wisconsin to check me out. And you can well imagine looking out at your audience whether or not you would like to have ten FBI agents looking at your past.

And I worked my way through college by sometimes being a bartender and a bouncer. And I've got to admit, I've led a full life.

And I didn't then know what I was going to get into. They even went back to my hometown of Elroy, which is a very small rural community in Wisconsin, and Elroy is so small, you can call somebody, get a wrong number and still talk for half an hour. That's my hometown.

They found this kid that I got in a fistfight when I was 16 years of age. He couldn't remember who won the fight or who lost, but he said nice things about me, which led me to believe that I lost the fight.

After I got through with the FBI and got that done, then, because Health and Human Services is so large, as you all know, is involved in so many things, that they decided that I should have two Senate committees. And each Senate committee wanted different forms filled out different from the White House. One committee wants all the bills that I had introduced as a legislator, and that was the Finance Committee and the Health Committee headed by Senator Kennedy, wanted all of the bills and all the speeches I had given in 35 years, and since I was quite prolific as introducing bills and vetoes and speeches, we boxed up boxes. I know nobody ever looked at them, but we still had to comply.

And after you get done with the hearings, then you get the privilege of going in front of the ethics board before you can serve. And the ethics board said because Health and Human Services is so large, that, you know, I don't have much but the few shares of stock I did have, I sort of liked, but they said that all the stock that I had had a potential conflict. So I had privilege--well, the requirement, to sell all of my stock. I don't know what you--if you have been following the stock market in January and February. It was just a great time to sell your stock.

But now that I am there, I am thoroughly enjoying the tremendous opportunity. Health and Human Services is the one department that I call the department of compassion, the department that can do things for people to improve their quality of life. And you realize that the Department of Health and Human Services interacts with each and every one of you on a daily basis, whether it be the food that you eat, the medicine you take, and especially in your profession, the rules and regulations under which you operate, the Health and Human Services is that department.

It is very large. It is the largest department of the federal government, 65,000 employees. Our budget is $450 billion. Only five countries in the world are bigger than the Department and Health and Human Services: the United States, Japan, Germany, England and Italy. And if Italy doesn't watch out, we will overtake them and be the fifth largest power.

But it is a tremendous opportunity, a tremendous responsibility, and I very humbled by this chance to be able to direct health care and many other programs in America. But I need your help.

The American Medical Association is one of the most important organizations in order for me to do my job properly. And I happen to be very much a people's person, and you will find that my office is always open. In fact, I think my office has received more people from more organizations in four months than that Department has probably seen in years before.

And I want you to be a guest. I want you to be a frequent visitor. And I want you to come in with suggestions on how we, together, as partners, can improve the quality of health care in America.

The AMA has one of the most impressive legacies of any policy group in this country. Your work in advancing the quality of care Americans receive has been both substantial and consistent. Not an easy combination to achieve in the give and take of politics.

The House of Delegates has developed the policies that have guided the AMA's efforts, and I want to thank you both for your historic and your current contributions.

The practice of medicine has come a long way since 1767 when a Dr. Thomas Wise of Philadelphia advertised what he claimed then was his capacity for healing cancerous cysts without surgery and proclaimed his ability to do so in his words, with small expense and small pain to the patient.

I am sure you would like to have met Dr. Wise and maybe talked to a couple of his patients. And according to the historian Vincent Bobrick, our colonial ancestors believed in administering saltpeter for everything from measles to headache. Saltpeter is now used as a source of fertilizer. Kidney beans were advocated as a remedy for kidney stones. And sassafras, a root now used to make a type of tea, was regarded at that time a kind of miracle herb.

We have come a long way, but we have, ladies and gentlemen, a long ways to go. And since its founding in 1847, the AMA has been a pioneer on the journey of medical progress and continues to open new paths to better care for the people of our country.

So today I want to talk with you about what we can do together as partners, in order to keep transforming the way the American people receive health care.

First, let me discuss briefly some of the major changes that we are making in the Department of Health and Human Services. During my first four months at the department, we have announced a number of initiatives that directly impact you and your profession.

The first wave of reforms at the Centers for Medicare and Medicaid Services are moved to bring some overdue changes to the regulatory system. And I move to help each of you provide a higher quality of care for your patients.

I would also like to take a couple of minutes to outline a few of the projects we have in development. And, finally, I'll discuss the President's view of how we should be able to ensure together that patients have the protections they need through a comprehensive patients' Bill of Rights.

Now, I know that there is one federal agency that all of you love to hate. It's called HCFA. And as governor, it was the federal agency I loved to criticize and hate as well. Well, as of this past Thursday, that organization no longer exists.

I do things a little bit differently. I am moving my office one week out of each month to a different division and actually operating that. The month of May--tomorrow I go out to HRSA--but the first week in May I went out and operated HCFA for a week as the Secretary.

No Secretary has ever done that. And I went out there and I assembled all 5,000 of the employees together, and I talked to them. And I said, "You know, something, ladies and gentlemen, nobody likes you. And then I go on Capitol Hill, everybody, Democrats, Republicans, now the Independent Party, they all dislike you."

And I say, "You know, it is hard to really get excited about something called a HCFA." And I said, "We're also going to change your attitude out here. We are going to try, instead of finding ways to say no, we are going to try and find ways to say yes." And when we have to say no, it's just not going to be a curt no. We are going to be able to send out instructions why if you would change it, we could say yes and we could be able to work together in a better fashion.

I announced this past Thursday the first wave, and I just want to mention that, the first wave. There are going to be many changes in the Department and in the new administration. HCFA will now be known as the Centers for Medicare and Medicaid Services. And what that new name intends to reflect, ladies and gentlemen, and this is what I want to tell you, it's just not a new name, but we could not change the structure, we could not change the attitudes without changing the name.

I thought at the beginning we were going to change it to the Medicare and Medicaid Association. Then it would be called MAMA, but a lot of people didn't like that (laughter), so the new name is Centers for Medicare and Medicaid Services, CMS, and what this new name intends to reflect is a new culture, a new attitude of responsiveness and renewed efforts to reach out to patients and providers like yourself.

To give this agency a new direction, a new spirit, it is necessary to give it a new name and one that truly reflects the agency's vital mission to serve millions of Medicare and Medicare beneficiaries across the country. And as part of the renaming, we are going to reorganize the CMS around three centers to clearly reflect what precisely it does and how it serves millions of Americans.

The Center for Beneficiary Choices will focus on the Medicare+Choice program and will provide beneficiaries with the information they need to make informed choices about their health care.

Two, the Center for Medicare Management will focus on the traditional fee for service Medicare program.

And, three, the Center for Medicaid and State will focus on the programs administered by the state, including Medicaid, SCHIP and insurance regulation, and all three of these centers are going to have an educational component like you've never seen before.

It is going to reach out to the providers on a state by state basis. We are going to have one person in each state working with you and with the state. We are going to have a person working with the beneficiaries in each state.

We are going to put out an educational program this fall. We are going to spend several millions of dollars educating not only the professionals, but also the beneficiaries about what is the most apt and best program for the individual. We are also going to open up our Center 24 hours a day, seven days a week, so anybody anyplace in the country, whether it be from Alaska or California, will be able to get their questions answered in a timely fashion.

We are excited about these changes, and we are going to have many more coming. These programs are vital to millions and millions of Americans, and our jobs should not be to make it more difficult for you to provide medical services to those beneficiaries, but my job is to make it easier for you.

I also told HCFA, now the Centers, that I am going to be reading the rules and if I can't understand them as a country lawyer, they are going to be rejected.

So as I have already mentioned, the medical horizon is filled with new treatments and new technologies, but that landscape before that horizon is clotted with reams of paper, bundles of rules and heaps of regulations. That frustrates me even as I know it aggravates you on a daily basis.

You were not called to be file clerks or accountants or to have your time and resources drained away by filling out form after form. At the Department of Health and Human Services, we are forming a new regulatory reform group that will look for regulations that prevent physicians and other health care providers from helping people in the most effective way possible. This group will determine what rules needs to be better explained, what rules need to be streamlined.

And what I want from you, and I'm asking you this and I'm not only asking you this, I'm asking you this from the hospitals, I'm asking it from the nurses and anybody else that wants to hear me speak, if you run into a rule, which you will, in your daily profession, don't complain. You can criticize, but don't complain. I want you to stop right there, write down what the rule is, but also write down what you want the solution to be and send it directly to me.

And don't be surprised--don't be surprised if, in fact, I call you up and said, will this really work. And if you do your job of bringing to the forefront those things that don't make any sense with advice and suggestions how we can improve it, we are going change this system together, and we are going to change it for the better, not only for you, but for patients and for the delivery of health care in America.

And I want to thank your organization for their support of this initiative. We need your continued support and your counsel to make it work, and I am looking with a great deal of excitement working with you to make it happen.

The good news is that despite excessive regulations, new technologies afford us the hope of reducing the paperwork burden as it exists today. The growing movement towards a paperless medical environment encourages that hope, more extensive use of computers for the entry of prescriptions, as well as medical records and helping you, the physicians, keep track of patients' histories with electrons rather than with paper and ink and thereby enabling you to provide a higher quality of care.

Each of you spend many years of training to become highly skilled as physicians. America needs you practicing medicine, not pushing paper. And lifting the excessive regulatory burden and reducing the quantity of paperwork on physicians is one component of our aggressive effort to improve the quality of health care and patient safety.

Like you, we want patients to receive the best care possible. And the new HHS is going to be your partner in achieving this goal. That's why at the Department of Health and Human Services, we are investing in measures to help us better identify specific practices that will lead to improved patient care across the board.

For example, I recently announced the formation of a patient safety task force to find ways to integrate the information on risks to patients. John Eisenberg, as all of you know, is leading that effort. This task force will also try to simplify the reporting of adverse events by creating a single Web-based data entry screen that will enable clinicians and hospitals to file the required reports with state and federal agencies using a single form.

By simplifying, at the same time expanding clinical reporting tools, we can better use the information we collect. This means that physicians will be able to spend more time with patients and less time hunched over a stack of forms.

We are not interested in finding doctors that make mistakes. We are not interested in blaming doctors for errors in quality problems. We simply want to gain a better understanding of what is occurring and how to improve the care patients receive. And I have suggested to Congress, and I am asking you for your support, and I ask Tim Flaherty and Dr. Knote to support me, and the present and future leaders of this organization.

I would like to take the money that comes in through the fraud investigations of abuses, and to plow that back in to best practices, maybe a mini Hill-Burton law to set up best practices in hospitals of the new technology and invest in it, and then to be able to use those best practices to be able to export it to other hospitals and clinics across America. That's how I think we can do it and do it better.

The next thing that I would like to discuss with you is something I think is vitally important for us to improve health care in America. Looking forward, I am going to be looking to your organization for help on setting up a very important initiative, focusing on preventive health care.

We look at things backward in this country. We wait until people get sick and then we provide them with care. I think it is time for us, you as your profession, me as Director of Health and Human Services, to come up with new important ways that we can improve the quality of care in this country in order to prevent people from developing debilitating diseases, like diabetes and asthma, in the first place.

So I am going to be calling on all of you for your ideas and your suggestions, your help in communicating to your patients simple steps that all of us can take to live healthier and more quality lives. Don't smoke, don't overeat, exercise, get vaccinated, simple things that can improve the quantity and the quality of care in this country. It's a long-term task that will require sustained commitment.

The federal government cannot improve the quality of health care on its own. We need your help. We need to collaborate with state governments, stakeholders, organizations and private sector partners and, most especially, physicians like you. You are the experts. You are the leaders.

By making a mutual commitment to quality and building on the important work we have already done together, our health care system can more consistently provide the high quality and the safe care that it is capable of delivering.

And certainly one of the most significant ways of providing quality care is through ensuring that patients are protected from a medical bureaucracy that can be insensitive to patients' needs and difficult for patients to understand.

Of course, I'm talking about the various measures pending before Congress that seek to provide a Bill of Rights for patients. All of them have wonderful good ideas. Some of them also contain serious weaknesses.

First, let me underscore that we agree far more than we disagree. President Bush is committed to making sure that patients receive genuine protections, and we are eager to work with you to that end. We want to join with you in finding a place where our minds and our legislative proposals can fully and effectively meet. And we believe we are 90 percent there.

The President and I were both governors. And in our respective states, Texas and Wisconsin, there are already patient protection laws that contain provisions to enable patients to appeal denials of health care services by requiring reviews of provider decisions, and they require that medical coverage decisions be resolved quickly with minimal cost instead of dragging out into expensive litigation.

And in Wisconsin, as in Texas, Republicans and Democrats alike reached a common accord. The President and I are proud of what we helped to accomplish in our home states, and we want to achieve the same results for the people of our country nationwide.

There is a broad bipartisan support for the principles, the President has said, must be in the kind of bill that he will sign. For example, all of us want a federal patients' Bill of Rights that provides every American strong patient protections. Because many states have passed patient protection laws that are appropriate for their states, of deference should be given to these state laws and to the traditional authority of states to help regulate health insurance.

In addition, every patient should be able to get the treatment that he or she needs, period. This includes emergency room care at the closest emergency room possible, and the right, and I say that emphatically, the right to see the specialist when a specialist is needed.

The care you receive should not be contingent on the guesswork of an actuary or accountant. Patients also deserve a rapid medical review process when they are denied the care that they believe they need.

President Bush has said that he wants to sign a bill that includes a binding independent review process. If a health plan denies someone health care, that person should be able to appeal to an impartial review panel of physicians and get a quick, thorough response. This would put decisions about care in the hands of those best equipped to make it, you, men and women, the physicians like yourselves.

So despite our disagreements, we shared these important commitments. We need to build on these commitments to overcome our differences. Of course, our disagreements are real, legislation that includes high caps on damage awards which would invite lengthy trials and more expensive health costs, and when health insurance companies and providers are sued, the corporations and small businesses that use them should not be held liable for their mistakes.

That could well do serious damage to the voluntary employer-based health care system we depend upon. And I am, for one, am going to do everything I can to reduce the uninsured in America, not increase it.

Some of the proposals allow for punitive damage caps. They extend only to federal lawsuits, but other damage claims would have no caps whatsoever. It would also be a serious mistake to make state and federal jurisdictions so intertwined, the trial lawyers could shape their pleadings to get into either state or federal courts or, in many cases, both.

And under this plan, more lawsuits against employers and insurance companies will surely result in others being sued. The possibility for state and federal lawsuits against physicians under this provision is real and dangerous. But with all of this, ladies and gentlemen, let me emphasize once again, that by drawing attention to our differences, I am not, also, drawing a line in the sand.

None of our disagreements is insurmountable. We must not view them as logs jamming a river but as planks to build a bridge. We all need to join together in a successful effort to build that bridge. Across the things that currently divide us as we do, we can, together, provide for the real pressing needs of Americans of every walk of life, men, women and children who should have access to quality, affordable care in a timely manner.

On his desk in the White House, President Reagan kept a little sign that captures the spirit we all need to have as we address this issue. It said, "There is no limit to what you can accomplish if you don't care who gets the credit." And President Kennedy put it another way, "Defeat is an orphan, but victory has a thousand fathers." On this Father's Day, let's all be fathers and mothers of a patients protection measure that will ensure the kind of care that all of you care passionately about, as well as myself and President Bush and provide the president an opportunity to be able to sign this bill into law.

I, for one, am 90 percent there. I can't, for the life of me, understand we should pass a bill that the President cannot sign. It is so important for us to work together on a bipartisan basis to get a bill through the Congress quickly, efficiently and one which the president can sign.

There are two other quick subjects that I want to talk about that are not in my notes, but are very near and dear to me. And I wanted to, and I know I'm running out of time, but I really want to touch upon them. The first one is our international, as well as domestic, problem with HIV/AIDS. There are 36 million people around this world that have AIDS or are HIV infected. 25 million of those are in Africa. We have 14 million orphans caused from AIDS. A little over 12 million of those are in Africa.

And this is a problem, ladies and gentlemen, that is one in which we, as Americans, cannot overlook. We have to address the international AIDS program and problems, and we have to develop, I believe, a martial plan, a martial plan to go in there and redo the whole health care system in Africa. Seven countries in Sub-Saharan Africa today have over 22 percent of their population infected. Some countries are going to fall because of this. The middle class professionals, doctors and nurses and teachers, are infected. South Africa, many companies recruit two individuals for every job because one of those individuals will more than likely have AIDS and will not be able to finish the job.

We have to do this. America, under the leadership of the President, under money that's being given up by the Department of Health and Human Services and the Department of State--Colin Powell and myself are the joint leaders of this new initiative--are going to do everything we can to build this fund.

And I am encouraging the President to put together a small amount of money for health care professionals, which is a scholarship to go to Africa and practice for a period of time, for six to eight weeks, and be able to cover your expenses and to set up a scholarship for you to do so. I think it would be very effective for you and especially for our fight against AIDS.

The second thing I wanted to talk about quickly, is the fact that we have 76,000 Americans in this great compassionate country of ours waiting for organs. And, to me, that is just not right. And, you know, this is a real cause for me, as the AIDS is, to try to do whatever we can to motivate public opinion against the fight against HIV and AIDS and be able to do what we can to encourage more people to get involved and be able to sign that card, that driver's license, and talk to your loved ones. Because without talking to your loved ones, we lose about 50 percent of our organs.

We need to have more people contributing to blood and tissue and marrow. All of these things are in short supplies. You know better than I do.

And what we need to do is put out a great educational campaign to encourage people to get involved. And I tell people this, I said, "If you are going to die and you're on your death bed and your organs had a chance to vote, don't you believe that your eyes would vote to continue to see? And don't you think that your heart would vote to continue to beat in somebody else's body?" And I know, without a doubt, your kidney and livers would vote to continue to drink Wisconsin beer and eat Wisconsin cheese.

And so, ladies and gentlemen, in conclusion, let me tell you that you're great professionals. It is truly an honor. I believe sincerely that you, as I told the University of Chicago medical school graduating class a week ago, that your profession is, and I didn't even qualify it, is the most noble profession of all, and this is difficult for an attorney to say that.

I sincerely mean that, because you have the hope and aspiration of so many people in the palm of your hand, and I want to be your partner. I want to work with you to develop the best health care system in America, and I can't do it alone. I need your assistance, your advice and, yes, your criticism. But if you are going to criticize, come up with suggestions on how to improve it.

And let's work together. My office is always open, and I am a workaholic, as Tim Flaherty will tell you. And I'm there 15, 16 hours a day. If you want call me, call me, or send an e-mail message, but stay in contact.

This organization can be the leader to really change the direction that we practice medicine and deliver health care in America for the better. And all of you got into your profession so you could provide better service, better hope for millions of Americans.

So let's work together so that all of us truthfully can say that we did our part to improve the quality of health care, that it will be better tomorrow than it is today.

Thank you, and God love you, and have a wonderful day. Thank you very much.

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INAUGURAL ADDRESS: Richard F. Corlin, MD, was inaugurated as the 156th President of the American Medical Association on Wednesday, June 20. Following is his inaugural address:

THE SECRETS OF GUN VIOLENCE IN AMERICA: WHAT WE DON'T KNOW IS KILLING US

Thank you for joining me tonight. It's my great pleasure to introduce to you the friends, colleagues and family members without whom I would not have made it here tonight. And without whose presence this wouldn't be a special evening for me.

I grew up in East Orange, New Jersey in the 1940's and 1950's. My high school was a mosaic of racial and ethnic diversity--equal numbers of blacks and whites, some Puerto Ricans, and a few Asians. We'd fight among ourselves from time to time--sometimes between kids of the same race, sometimes equal opportunity battles between kids of different races and nationalities. Our fights were basically all the same: some yelling and shouting, then some shoving, a couple of punches, and then some amateur wrestling. They weren't gang fights--everyone but the two combatants just stood around and watched--until one of our teachers came over and broke it up.

My old high school reminds me a little of "West Side Story." Only without the switchblades. Or a Leonard Bernstein score. And there were no Sharks or Jets. Remember, those were the days of James Dean and Elvis Presley. Nobody pulled out a gun--none of us had them and no one even thought of having one. The worst wound anyone had after one of those fights was a split lip or a black eye.

It was just like kids have always been--until today. Back then, no parents in that town of mostly lower-middle class blue collar workers had to worry that their children might get shot at school, in the park or on the front stoop at home. But then again, that was also a time when we thought of a Columbine as a desert flower, not a high school in Littleton, Colorado.

Even in my first encounter with medicine, when I was only 14 years old and got a summer job at Presbyterian Hospital in Newark, New Jersey, there were no guns. I worked on what was called the utility team--moving patients back to their own rooms after surgery, starting IVs, taking EKGs and passing N-G tubes. I told them I wanted to be a doctor, and unbelievably, at the age of 14, they let me help the pathologist perform autopsies. I was so excited about helping with the autopsies that I used to repeat the details to my Mom and Dad over dinner. Before long, they made me eat by myself in the kitchen.

When I was old enough to get a driver's license, I got a job working as an Emergency Room aide and ambulance driver at Elizabeth General Hospital. In all that time, in five summers of working in two center city hospitals--in the recovery room, in the morgue, in the emergency room, and driving the ambulance--I never saw even one gunshot victim.

Today, it's very different. Guns are so available and violence so commonplace that some doctors now see gunshot wounds every week, if not every day. It's as if guns have replaced fists as the playground weapon of choice. The kids certainly think so. In a nationwide poll taken in March after two students were shot to death at Santana High School near San Diego, almost half of the 500 high school students surveyed said it wouldn't be difficult for them to get a gun. And one in five high school boys said they had carried a weapon to school in the last 12 months. One in five. Frightening, isn't it?

I began by telling you how I grew up in a world without guns. That has changed for me, as it has for so many Americans. Recently, the violence of guns touched me personally. Not long ago, Trish, one of our office staff members in my practice--a vibrant, hard-working young woman from Belize--was gunned down while leaving a holiday party at her aunt's home in Los Angeles.

Trish had done nothing wrong--some might say that she was in the wrong place at the wrong time--but I don't buy into that. Here was a woman who was where she should be--leaving a relative's home--when she was gunned down. Someone drove down the street randomly firing an assault weapon out the car window, and he put a bullet through her eye. Trish lingered in a coma for eight days, and then she died, an innocent victim of gun violence.

With the preponderance of weapons these days, it comes as no surprise that gun violence--both self-inflicted and against others--is now a serious public health crisis. No one can avoid its brutal and ugly presence. No one. Not physicians. Not the public. And most certainly, not the politicians, no matter how much they might want to.

Let me tell you about part of the problem. In the 1990s, the CDC had a system in place for collecting data about the results of gun violence. But Congress took away its funding, thanks to heavy lobbying by the anti-gun control groups. You see, the gun lobby doesn't want gun violence addressed as a public health issue. Because that data would define the very public health crisis that these powerful interests don't want acknowledged. And they fear that such evidence-based data could be used to gain support to stop the violence. Which, of course, means talking about guns and the deaths and injuries associated with them.

We all know that violence of every kind is a pervasive threat to our society. And the greatest risk factor associated with that violence is access to firearms. Because--there's no doubt about it--guns make the violence more violent and deadlier.

Now my speech today is not a polemic. It is not an attack on the politics or the profits or the personalities associated with guns in our society. It isn't even about gun control. I want to talk to you about the public health crisis itself, and how we can work to address it, in the same way we have worked to address other public health crises such as polio, tobacco, and drunk driving.

At the AMA, we acknowledged the epidemic of gun violence when, in 1987, our House of Delegates first set policy on firearms. The House recognized the irrefutable truth that "uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and death." In 1993 and 1994, we resolved that the AMA would, among other actions, "support scientific research and objective discussion aimed at identifying causes of and solutions to the crime and violence problem."

Scientific research and objective discussion because we as physicians are, first and foremost, scientists. We need to look at the science of the subject, the data, and, if you will, the micro-data, before we make a diagnosis. Not until then can we agree upon the prognosis or decide upon a course of treatment.

First, let's go straight to the science that we do know. How does this disease present itself? Since 1962, more than a million Americans have died in firearm suicides, homicides and unintentional injuries. In 1998 alone, 30,708 Americans died by gunfire:

- 17,424 in firearm suicides
- 12,102 in firearm homicides
- 866 in unintentional shootings

Also in 1998, more 64,000 people were treated in emergency rooms for non-fatal firearm injuries.

This is a uniquely American epidemic. In the same year that more than 30,000 people were killed by guns in America, the number in Germany was 1,164, in Canada, it was 1,034, in Australia, 391, in England and Wales, 211, and in Japan, the number for the entire year was 83.

Next, let's look at how the disease spreads, what is its vector, or delivery system. To do that, we need to look at the gun market today. Where the hard, cold reality is--guns are more deadly than ever. Gun manufacturers, in the pursuit of technological innovation and profit, have steadily increased the lethality of firearms. The gun industry's need for new products and new models to stimulate markets that are already oversupplied with guns--has driven their push to innovate. Newer firearms mean more profits. With the American gun manufacturers producing more than 4.2 million new guns per year, and imports adding another 2.2 million annually, you'd think the market would be saturated.

But that's why they have to sell gun owners new guns for their collections – because guns rarely wear out. Hardly anyone here is driving their grandfather's 1952 Plymouth. But a lot of people probably have their grandfather's 1952 revolver. So gun manufacturers make guns that hold more rounds of ammunition, increase the power of that ammunition, and make guns smaller and easier to conceal.

These changes make guns better suited for crime, because they are easy to carry and more likely to kill or maim whether they are used intentionally or unintentionally. In fact, one of the most popular handgun types today is the so-called "pocket rocket": a palm-sized gun that is easy to conceal, has a large capacity for ammunition and comes in a high caliber.

The Chicago Tribune reported that the number of pocket rockets found at crime scenes nationwide almost tripled from 1995 to 1997. It was a pocket rocket in the hands of a self-proclaimed white supremacist that shot 5 children at the North Valley Jewish Community Center and killed a Filipino-American postal worker outside of Los Angeles in August of 1999.

Now, we don't regulate guns in America. We do regulate other dangerous products like cars and prescription drugs and tobacco and alcohol--but not guns. Gun sales information is not public. Gun manufacturers are exempt by federal law from the standard health and safety regulations that are applied to all other consumer products manufactured and sold in the United States.

No federal agency is allowed to exercise oversight over the gun industry to ensure consumer safety. In fact, no other consumer industry in the United States--not even the tobacco industry--has been allowed to so totally evade accountability for the harm their products cause to human beings. Just the gun industry.

In a similar pattern to the marketing of tobacco, which kills its best customers in the United States at a rate of 430,000 per year, the spread of gun-related injuries and death is especially tragic when it involves our children. Like young lungs and tar and nicotine, young minds are especially responsive to the deadliness of gun violence.

Lieutenant Colonel Dave Grossman, a West Point professor of psychology and military science, has documented how video games act as killing simulators, teaching our children not just to shoot--but to kill. Grossman, who calls himself an expert in "killology," cites as evidence the marksmanship of the two children, aged 11 and 13, in the Jonesboro, Arkansas shootings in 1998. Both shooters were avid video game players. And just like in a video game, they fired off 27 shots--and hit 15 people. Killing four of their fellow students, and a teacher. Such deadly accuracy is rare and hard to achieve, even by well-trained police and military marksmen.

I want you to imagine with me a computer game called "Puppy Shoot." In this game puppies run across the screen. Using a joystick, the game player aims a gun that shoots the puppies. The player is awarded one point for a flesh wound, three points for a body shot, and ten points for a head shot. Blood spurts out each time a puppy is hit--and brain tissue splatters all over whenever there's a head shot. The dead puppies pile up at the bottom of the screen. When the shooter gets to 1000 points, he gets to exchange his pistol for an Uzi, and the point values go up.

If a game as disgusting as that were to be developed, every animal rights group in the country, along with a lot of other organizations, would protest, and there would be all sorts of attempts made to get the game taken off the market. Yet, if you just change puppies to people in the game I described, there are dozens of them already on the market--sold under such names as "Blood Bath," "Psycho Toxic," "Redneck Rampage," and "Soldier of Fortune." These games are not only doing a very good business--they are also supported by their own Web sites. Web sites that offer strategy tips, showing players how to get to hidden features like unlimited ammunition, access more weapons, and something called "first shot kill," which enables you to kill your opponent with a single shot.

We do not let the children who play these games drive because they are too young. We do not let them drink because they are too young. We do not let them smoke because they are too young. But we do let them be trained to be shooters at an age when they have not yet developed their impulse control and have none of the maturity and discipline to safely use the weapons they are playing with. Perhaps worst of all, they do this in an environment in which violence has no consequences. These kids shoot people for an hour, turn off the computer--then go down for dinner and do their homework.

We need to teach our children from the beginning that violence does have consequences--serious consequences--all the time. Gunfire kills 10 children a day in America. In fact, the United States leads the world in the rate at which its children die from firearms. The CDC recently analyzed firearm-related deaths in 26 countries for children under the age of 15, and found that 86 percent of all those deaths occurred in the United States.

If this was a virus, or a defective car seat, or an undercooked hamburger--killing our children--there would be a massive uproar within a week. Instead, our capacity to feel a sense of national shame has been diminished by the pervasiveness and numbing effect of all this violence.

We all are well aware of the extent of this threat to the nation's health. So why doesn't someone do something about it? Fortunately, people are. People we know, people we don't know, and people we have only heard about are working hard to abolish the menace of gun violence--of all forms of violence--from the American scene. Some of them are with us tonight.

One of them is Elizabeth Kagan, the newly inaugurated president of our AMA Alliance. Elizabeth will head the Alliance campaign for Safe Gun Storage.

Another is Dr. William Schwab. Chief of trauma surgery at the University of Pennsylvania in Philadelphia. He is truly one of the heroes in this battle. His work has shown us just the kind of information we really need to reduce this violence. We are extremely pleased that he has agreed to be one of our ongoing advisors in this activity.

These are the people who stand and deliver when it comes to educating the nation about the threat of gun violence. Elizabeth and Bill, will you please stand? They certainly deserve a hand.

Elizabeth and Bill will be with us through the evening, and I urge as many of you as possible to spend a few minutes with them. They came here because they understand that gun violence in the United States is a problem that is bigger than every one of us. And the blood in America's streets--and classrooms--is a problem for all of us.

I was gratified when earlier today, Terry Hillard, Superintendent of the Chicago Police Department, stopped by to join me in talking with reporters. We discussed the importance of data collection and how the physician community can work together with law enforcement to tackle this important issue of gun violence.

The question remains, what are we, the physician community, going to do about it? I can tell you first what we're not going to do. We're not going to advocate changing or abolishing the Second Amendment to the Constitution. We really don't have to, to make our point.

The gun lobby loves to use the Second Amendment as a smokescreen--to hide the reality of the damage that guns do--and to prevent our looking any deeper into the facts and statistics of that damage. We've all heard that tired old statement: Guns don't kill people, people kill people. But how does that explain these facts? A gun kept in the home for self-defense is 22 times more likely to be used to kill a family member or a friend than an intruder. The presence of a gun in the home triples the risk of homicide, and increases the risk of suicide fivefold.

And listen to this quote:

> "...the Second Amendment has been the subject of one of the greatest pieces of fraud, I repeat the word fraud, on the American people by special interest groups that I have ever seen in my lifetime....The very language of the Second Amendment refutes any argument that it was intended to guarantee every citizen an unfettered right to any kind of weapon. Surely the Second Amendment does not remotely guarantee every person the constitutional right to have a Saturday night special or a machine gun....There is no support in the Constitution for the argument that federal and state governments are powerless to regulate the purchase of such firearms."

These are the words of a respected conservative jurist, the late Chief Justice of the Supreme Court, Warren Burger.

As I said, our mission is not to abolish all guns from the hands of our fellow citizens. We're not advocating any limitations on hunting or the legitimate use of long guns, or for that matter, any other specific item of gun control. And we won't even be keeping a scorecard of legislative victories against guns in Congress and in the statehouses.

Why not? Because all these well-intentioned efforts have been tried by good people, and they have not met with success. Instead, they have been met with a well-organized, aggressive protest against their efforts by powerful lobbies in Washington and at the state and community levels. We, the American Medical Association, are going to take a different route--not just calls for advocacy, but for diplomacy and for statesmanship and for research as well. And make no mistake about this: We will not be co-opted by either the rhetoric or the agendas of the public policy "left" or "right" in this national debate about the safety and health of our citizens.

One of the ways we will do this is to help assemble the data. Current, consistent, credible data are at the heart of epidemiology. What we don't know about violence--and guns--is literally killing us. And yet, very little is spent on researching gun-related injuries and deaths.

A recent study shows that for every year of life lost to heart disease, we spend $441 on research. For every year of life lost to cancer, we spend $794 on research. Yet for every year of life lost to gun violence, we spend only $31 on research--less than the cost of a taxi ride here from the airport.

That's bad public policy. It's bad fiscal policy. And it certainly is bad medical policy. If we are to fight this epidemic of violence, the Centers for Disease Control must have the budget and the authority to gather the data we need. As I mentioned earlier, the CDC's National Center for Injury Prevention and Control researched the causes and prevention of many kinds of injuries. But in the mid-90s the gun lobby targeted the NCIPC, and scored a bullseye when Congress eliminated its funding. It wasn't a lot of money--just $2.6 million--budget dust to the Federal government. But it meant the difference between existence and extinction for that project.

Just think, gun injuries cost our nation $2.3 billion dollars in medical costs each year, yet some people think $2.6 million dollars is too much to spend on tracking them. Every dollar spent on this research has the potential to reduce medical costs by $885.

The CDC is intent on doing its job and is now heading up the planning for a National Violent Death Reporting System--coordinated and funded at the federal level--and collecting data at the state level. Because knowing more about the who, what, when, where, why and how of violent homicides, suicides, and deaths will help public health officials, law enforcement, and policy makers prevent unnecessary deaths.

We must further insist that such a system be expanded to cover data about non-fatal gunshot injuries so that we can prevent these as well. Such a system of data collection and analysis has already helped us address another national epidemic, motor vehicle fatalities. Prompting preventive measures like mandatory seat belt laws, air bags, improved highway signage, and better designed entry and exit ramps--not the confiscation of cars. The establishment of a National Violent Death and Injury Reporting System would help us establish similar preventive measures against violence. And help us fill in all the blanks about violent death and injury in America. Including such basics as:

- How do kids with guns get their weapons?
- Do trigger locks work?
- What can we do to reduce accidental, self-inflicted gun injuries?
- What are the warning signs of workplace or school shootings?
- During which hours of the week and in what specific parts of town (down to individual blocks--not just neighborhoods) do the shootings occur?
- Do we need to work with Police Departments to change patrolling patterns based on these data?
- And finally, the realization that the answers to these questions are apt to be different from one town to the next.

Today, we can't answer these questions--because we are not allowed to collect the data. Collecting and considering the facts isn't a matter of opinion or politics, it's essential. It's a matter of working with other committed leaders to get the job done.

The good news is that we have HELP--the Handgun Epidemic Lowering Plan--with membership of 130 organizations including the AMA, and, among others, the Rehabilitation Institute of Chicago, and the Minnesota Department of Health. We also have the Surgeon General's *National Strategy for Suicide Prevention*, released last month, which also supports the National Violent Death Reporting System.

We will not advocate any changes at all based on urban legend, anecdote or hunch. We will only base our conclusions on evidence-based data and facts. It's just good, common sense--the kind of solid epidemiology that has been brought to bear on other public health hazards--from Legionnaire's Disease to food-borne illnesses to exposure to dioxin or DDT. Trustworthy science that can help us prevent harm before it happens. For, as we physicians know, prevention is usually the best cure.

One of the giants of American medicine, Dr. William Osler, proposed using preventive medicine against serious public health threats like malaria and yellow fever. And the tools he advocated--education, organization and cooperation--sound like a pretty good definition of diplomacy to me. We will put these same tools to use in removing the threat of gun violence from our society.

As we have in the past, we have already sought the cooperation of the American Bar Association, and we are grateful that our invitation has been accepted. We will be working with the ABA on their Forum on Justice Improvements, taking place this October in Washington DC. The forum, set up by their Justice Initiatives Group, will focus on gun violence.

We are being advised by a panel of physicians and other experts who have worked long and hard in tackling the many-headed monster of gun violence and its grisly outcomes. They have welcomed our involvement in this issue and look forward to a newly configured playing field with allies that command such clout as the ABA and the AMA.

People have told me that this is a dangerous path to follow. That I am crazy to do it. That I am putting our organization in jeopardy. They say we'll lose members. They say we'll be the target of smear campaigns. They say that the most extremist of the gun supporters will seek to destroy us. But I believe that this is a battle we cannot not take on.

While there are indeed risks--the far greater risk for the health of the public, for us in this room, and for the AMA, is to do nothing. We, as physicians and as the American Medical Association, have an ethical and moral responsibility to do this--as our mission statement says--"to promote the science and art of medicine and the betterment of public health." If removing the scourge of gun violence isn't bettering the public health, what is?

As physicians, we are accustomed to doing what is right for our patients, and not worrying about our comfort, ease or popularity. Our goal is to help cure an epidemic, not to win a victory over some real or imagined political enemy. Anyone who helps us in this fight is an ally--anyone.

We don't pretend to have all the answers. Nor do we expect the solution to be quick--and we certainly don't expect it to be easy. In fact, I am certain that we will not reach the solution during my term as your president. But together as the American Medical Association, guided by our stated mission, we recognize our obligation to contribute our voice, our effort and our moral imperative to this battle. And we will.

Almost a century ago, in his book *Confessio Medici*, Stephen Paget, the British physician and author, referred to medicine as a divine vocation. This is part of what he said:

> "Every year young people enter the medical profession...and they stick to it...not only from necessity, but from pride, honor, and conviction. And Heaven, sooner or later, lets them know what it thinks of them. This information comes quite as a surprise to them...that they were indeed called to be doctors....Surely a diploma...obtained by hard work...cannot be a summons from Heaven. But it may be. For, if a doctor's life may not be a divine vocation, then no life is a vocation, and nothing is divine."

We are here today as the guardians of that divine vocation and as such are dedicated to do what is right, whether or not it is comfortable, whether or not it is easy, and whether or not it is popular. Stephen Paget, you can rest well tonight. Your divine vocation is in good hands. We will guard it well. We will live up to our mission--we will do what is right.

Thank you.

UNFINISHED BUSINESS - REPORT OF THE HOUSE OF DELEGATES

The following unfinished business from the 2000 Interim Meeting was considered by the House of Delegates on Sunday, June 17:

ACTION ON THE PROPOSED REVISION OF THE *PRINCIPLES OF MEDICAL ETHICS*

HOUSE ACTION: ADOPTED

BACKGROUND

At the 2001 Interim Meeting, the Council on Ethical and Judicial Affairs presented Report 1-I-00, "Proposed Revision of the *Principles of Medical Ethics*" in response to several resolutions, which were referred to the Council.

Over a period of three years, the Council sought extensive input from the Federation to determine whether it would be advisable for the House of Delegates to amend or revise the current *Principles of Medical Ethics*. The Council also undertook an extensive overview of other codes of ethical conduct. Though this process, the Council identified issues that are fundamental to the ethical practice of medicine and to the integrity of the profession but upon which the *Principles* were silent. Accordingly, the Council on Ethical and Judicial Affairs recommended "that the House of Delegates revise and update the *Principles of Medical Ethics* to reflect the need for a renewed commitment to the ethical foundation of the practice of medicine in response to the profound changes that have reshaped the provision of health care." In addition, the Council put forth a proposed revision of the *Principles* for consideration by the House of Delegates.

PROCEDURE

Ordinarily, recommendations included in CEJA reports cannot be amended, except with the concurrence of the Council. However, according to the Bylaws, only the House of Delegates has the authority to amend the *Principles*. Therefore, it was determined that it would be appropriate for the House to accept, not accept, refer, or amend the proposed revision presented in CEJA Report 1-I-00.

The report was assigned to the Reference Committee on Amendments to Constitution and Bylaws, which heard extensive testimony. The Reference Committee, in turn, offered amendments to the proposed version, which were presented to the entire House of Delegates in the report of the Reference Committee on Constitution and Bylaws. There was additional debate on the floor of the House and one amendment to the version put forth by the Reference Committee was adopted.

Bylaw 13.20 specifies that amendments to the *Principles* must be introduced at one meeting of the House of Delegates and approved by a two-thirds vote at the following meeting. The proposed version resulting from the action taken by the House at the 2000 Interim Meeting is now presented for a vote. If amendments to the version presented are made at this meeting, the vote to approve the amended *Principles* will be postponed to the next meeting of the House of Delegates.

RECOMMENDATION

This report recommends that the proposed revision of the *Principles of Medical Ethics,* which was introduced at the 2000 Interim Meeting, be adopted and the remainder of the report be filed:

Proposed Version

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Current Version

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.