Dr. Robert F. Jackson:

It is without a doubt, one of the greatest honors I've had to be able to introduce Dr. Barbara McAneny. Over the years, I've campaigned for a lot of people in the AMA, but I don't think I've ever campaigned any harder for anybody than I did for Barbara whenever she was running for both the board of trustees and later on for the president and CEO of the AMA. Barbara is a renowned oncologist from Albuquerque, New Mexico. As you know, she's the president of the AMA, a highly respected leader in her home state and nationally. Dr. McAneny is a practicing physician, successful businesswoman and a co-founder and CEO of a multidisciplinary oncology practice.

And by the way, there was a bunch of the establishment to try to keep her from having that, but she won. Dr. McAneny has served the AMA as a board member since 2010. Prior to that, she was on the Governing Council for the Triple S, which is what we're a part of. She served previously on the Board of American Society of Clinical Oncology as a president of New York Medical Associates Society, and the Greater Albuquerque Medical Association. Minnesota Native, she has been decorated with numerous awards. She received a nearly $20 million innovation grant from the Centers for Medicare and Medicaid in 2012 to test how oncology private practice could provide cancer patients with better care at lower costs.

She received the New Mexico Woman on the Move in 2005, Woman of Influence award in 2009. She had been voted multiple times by her peers as Albuquerque magazine's top doc in her specialty. I really think it's a great honor for us to have her here and to listen to her. As I told you, I'd been going to the AMA and listening to presidential addresses for 30, I think I've heard 30 of them now. The best one I ever heard was last year in our interim meeting, and it was given by Dr. Barbara McAneny. I will say though, she couldn't figure out how we could have fun in a cadaver lab. It's funny coming from an oncologist, but Barbara, welcome. We're glad to have you here.

Dr. Barbara L. McAneny:

Thank you. Thank you. Thank you very much for that very warm welcome. No pressure there. Greetings from the American Medical Association. I'm going to tell you a bit about how we work. And, I realize as I stand here that it's a little intimidating because you can look at me and know that I don't know a lot about cosmetic surgery. I want to ask a question, how many of you have to deal with the insurance industry? A good number of hands. How many of you are in private practice? All right, I'm home.

I'm going to talk a good bit about what happens in private practice and what our challenges are, and what our opportunities are. First, I'm going to start about talking about the AMA itself. You are well represented by your delegation. I also come from a small delegation. ASCO had one delegate as well, American Society of Clinical Oncology. And so, even if you're from one delegate society and I came from a two delegate state, you can still make your voice heard at the AMA.
And the AMA is an incredibly democratic organization. And by that I mean that it is driven from the ground up. The policy is set by the members. If you come up with a wonderful idea that you think that the house of medicine needs to work together on and you take it to your delegates, and they write a resolution, and as you saw, they bring it to the House of Delegates. And if you can convince enough of your colleagues that your idea’s a good idea, then that becomes the policy of the American Medical Association. And then we take all of our efforts and we take our infrastructure, and the machinery of the AMA, and we work to advocate for your policy. The members and the House of Delegates drive the agenda of the AMA.

We do create a lot of business tools to help people in all practice settings to do well in the business part of medicine. And we also do a huge amount of research and education through our journals, through our continuing education part. And then of course, we do advocacy. And the sum total of all that is the AMA, and now we’re embarking on innovation in terms of funding an innovation company to come up with the next generation of tools and apps, and various other things that we can use it to make our care of our patients better.

Now, we do have a goal of trying to make the AMA leadership look more like the country. We have a goal of trying to make the physician profession look more like the country. At my request, everyone decided they wear the royal blue. The men were a little alarmed actually, but it just proved that women can get organized. There’s a lot of topics you may have noticed that we are struggling with in healthcare today. Over half of physicians don’t want to be physicians anymore. I find that the saddest thing ever because this is the best profession possible.

Our patients are struggling to get access to care. They cannot afford it. They can’t afford their premiums, they can’t afford their co-pays, they can’t afford their deductibles. And that is a struggle, and it’s fueled by the consolidation of hospitals and health plans, and now pharmacy benefit managers and others. And that makes it harder and harder for us to have our voices heard and patients only get their voices heard through us. We have to keep ourselves in the forefront of that. And then you add on top of that the joys of the electronic medical record and the scary parts of the opioid epidemic.

When we take all of these things, you have to have a construct to think of them because you can’t come up and have 83 highest priorities or you getting nothing done. What we did was we divided the work that we do into three large arcs. The first one is about the health of the nation, and we’ve put that as the bottom, the foundation, everything we do. Because as you know, patients don’t actually want healthcare, they want health. They want us to keep them healthy, they want us to return them to health when they’re sick.

And we look at what we spend our money on in this country, and 90% of what we spend is on chronic disease, and of that chronic disease, a huge amount of it is diabetes and hypertension. And so, we decided we would work to address that, because if you’re concerned about the high cost of healthcare and you want to keep people healthy, the best way to do that is to take people who are pre diabetic and teach them, give physicians the tools to help patients learn to manage their own lives in such a way that they don’t develop diabetes. The best way to treat diabetes is to prevent it. Yet we live in a system that is more apt to pay you to be put in the hospital because you need dialysis from your diabetes instead of teaching you how to live your life to avoid it. And so we’re trying to change that.
In education, the AMA commissioned the Flexner Report in the early 1900s, maybe it's time we look at it again. And we came up with $11 million of grants that we gave to medical schools to look at undergraduate medical education to say, what is it that you need to know to really be able to practice 21st century medicine? And now we're branching into the graduate medical education realm because the medical students, the young physicians are the doctors of tomorrow, and we need to make sure that they have all the tools they need and maybe get rid of some of the tools we make them learn that they don't need. How many of you use the Krebs Cycle in your daily practice?

And then of course the area that I'm most concerned about is the dysfunction of the healthcare system. The fact that doctors are burning out and depressed. The fact that we are pricing ourselves out of the range of many of our patients, and the fact that we spend two hours dealing with paperwork for every hour we get to spend putting our hands on a patient, that's just wrong and it's wasteful, and it's unstable. One of the messages that I try very hard to get across to physicians is that this healthcare system is going to change and it is going to change because it is going to collapse under its own weight.

Currently this year, we spent three point $3.3 trillion on healthcare. Medicare predicts that by 2026, which is not that far away, we will spend $5.5 trillion on healthcare. That's over 20% of gross domestic product. It means that if we actually do that, then there's no money for schools or roads, or bridges that don't fall down, and we know that that is not possible. The country cannot spend all of its discretionary income on healthcare anymore than you can in your family. We're going to have to make a change and we have to figure out where we're going to make that change. And I would say to the people in this room, we've got to figure out who is going to make that change.

People being priced out is a frightening thing. Now, I'm a cancer doctor and I see patients who come and say, "I now have an insurance card. I've been watching this lump in my breast and now I have an insurance card," and I tell them, "You have a $5,000 deductible." And they just look at me. We can't have healthcare that people can't afford. One in three Americans struggles to pay their premium. It's do I buy food, do I pay my insurance premium? And then when they buy that, they discover that their deductibles and their co-pays are so high that even with Medicare, about 40% of the care is out of pocket.

And we know that over a quarter of Americans have delayed getting care or decided not to get care because they couldn't afford it. We know that about a third of prescriptions never get filled because people look at the cost of the drug and say, “Forget it. I can't do it.” And one of the things that you will hear as a theme is that when we look at what we're spending money on, we don't go to the hospital more than other countries. We do not see doctors more than other countries. We do not get more MRIs than other countries. We don't have more emergency room visits in other countries, but we cost a lot more when we do go.

And if this was a shocking statistic that I just found in Forbes, that the spending for hospital care is more than most people pay in taxes, federal taxes. That's a lot of money going to hospitals and this is one of the problems that we have. If you look at this graph, that top blue line is what we pay hospitals. That's the hospital outpatient perspective payment system, which is the rules under which hospitals are paid. Which means that every year they got a market basket increased from Medicare of 2.5% to 3.5% raise. I haven't had a 2.5% to 3% raise. If you look at where physicians are, we're that bottom red line, and that's what we have been given by Medicare, it's about a 1%, 3% raise over 15 years.
And so, that difference from there to there is the site of service differential. The green line in the middle is Medicare's estimate of what it costs to run a practice. Now, many of you will laugh to learn that Medicare bases your cost to run a practice on apartment rent in your area. Last time I checked, you can't do surgery in an apartment, and that the people working in your clinic are classified as non-pharm labor. My nurses do not consider themselves non-pharm labor yet the government takes that as the estimate. I think that green line is probably low.

When you're struggling with a healthcare system that's pricing itself out of control, the first thing you need to do is to figure out is are you pay for the value that you're getting or are you paying too much? And if I sold my practice to a hospital, I would pay, each patient would be charged double what they're paid now for Medicare, it wouldn't come to the physician, but the cost of the system would be double. And why is that happening? Because of the consolidation that there's really ... when hospitals consolidate and insurance companies consolidate, there is good data to prove that the quality doesn't change. But the price tag goes up and the choice goes down.

And we do a study every two years at the AMA where we look at the consolidation of the markets, and we discover that as these markets consolidate, the voices of individual physicians get lost. And that's a problem. And that's why we do the work that we do with antitrust lawyers to try to block a lot of the consolidation that occurs in these markets. And if you haven't seen that analysis that's put out, it's on the website, I would take a look at that. It's very instructive.

Now, I used, for the site of service, I use oncology examples, which are probably irrelevant here, but I know something about oncology, so you have to put up with that. But what we find is that as we look at these part B, the part B drugs for you guys, it's Botox for me, it's chemotherapy, that are used in, in the practices. Hospitals can buy those drugs under a thing called 340B, which means that they get a 25 to 50% discount on the drug, and then they can charge the insurance company's full freight, which is sometimes 2X to 7X Medicare. That's a lot of money they're making and that's why they're scooping practices.

This is shifting care significantly and I think that is partly why we see so many physicians who are frustrated with the practice of medicine. It's interesting, as I talked to people around the country, I see in various specialties, I see common themes and then I see individual variation on those themes. From private practice groups, I see the frustration of I'm not getting paid anymore, but they want me to do more and more documentation, more running in place, more of the same stuff with less and less resources.

From academic physicians, I hear the frustration of I have a five year research project and my grant got cut year three, and all that time and my career is impacted. From hospital employed physicians. I hear loneliness and powerlessness. They're lonely because they're in their practice running as fast as they can to chalk up more RVUs, and the collegiality between physicians seems to be lacking in many of those situations. And the lack of power, you can't even create the team that you work with every day is incredibly frustrating to physicians.
And I say to them, “You are doctors, the system runs on your license. If you learn the language of power, which is the language of business, and you come up with a plan to say, “We can do this better,” you can take charge of that system and you can make your life better and that makes your patient's life better.” And they just look at me. There's an issue with shortages coming up and I'm very concerned about this. Particularly I'm concerned about primary care, but I'm also very concerned about surgeons, because especially for rural areas where that golden hour is important.

If you're hit by a car driving through New Mexico, you'd best have a surgeon there who can take out your ruptured spleen. As we see the shortfall of surgeons, that is really the economic engine of small medical communities and small hospitals. And the number of rural surgeons is diminishing and the number of surgeons in general are diminishing. I applaud you for doing what you're doing, keep training those young people to be surgeons. What are we doing about all this? Well, we recognize that physicians are pretty frustrated when they go home every night and they, after they put the kids to bed, they spend until ten o'clock at night putting data into the computer. And a lot of that data, nobody ever really looks at.

You know what? It does increase your star rating so that the CEO of the hospital will get a raise. But I don't find that an overwhelmingly motivating factor, and I find that most physicians don't as well. We are really interested in trying to work with this administration who says that they want to decrease the paperwork we have to do. We are all for that. Unfortunately, the way they decided to do it was to collapse down the ENM codes down to where the evaluation and management codes, down to where you would be paid the same for if you saw somebody for the sniffles as if you took care of their diabetes, heart disease and cancer.

And we didn't think that was quite the right idea, so we're working with them and we're convening a subgroup of the RUC, the relative value update committee to say, “Let's come up with a logical way to look at these evaluation and management codes, which really impact all of the specialists and all of the internal medicine, neurology, et cetera.” The other thing that they wanted to do was to get rid of the ability to bill for multiple procedures on the same day. If you see a patient and you remove the lesion, you wouldn't get paid, it would get cut by 25%. We fought that first with Anthem, now we have to fight it with CMS. We did get that one removed in the final rule.

Now, prior authorization must be particularly funny in cosmetic surgery. Is that right? How many of you really enjoy sitting on the phone with someone who's a retired pediatrician discussing whether or not you should do a procedure on someone? I have to prior authorize every chemotherapy I give. They never turn me down. They just want to torture me for a while before they'll let me take care of the patient. And so, we recognize that every physician across the country has that frustration.

And so, we've coalesced a group of insurance companies and other regulators and said, “Let's come up with some degree of rationality. Let's look at those things that never get turned down and stop torturing doctors and patients. Let's look at the delay it causes when a patient goes to the pharmacy and they say, “We have to prior auth your prescription, come back in three or four days,” and in three or four days, they still don't have it prior auth. How many people keep coming back to get that prescription? About a third of people never do, that is not good care.” We look at this as being right in the way of us doing our job. It puts a speed bump in the way of our taking care of our patients and that is completely unnecessary, and we need to get rid of it.
Now, payment reform is a major issue. All of these payment reform processes that we're dealing with. At first, we had the sustainable growth rate formula, which it kept physician fees so low for so long. Now we have MACRA, which did some good things. It got rid of the sustainable growth rate formula, we got rid of this year of the iPad or last year, I guess, now it's 2019, but we were able to get in place a process where physicians could come up with alternative payment methodologies so that we could come up with ways to be paid for what we really do and what we would like to be able to do for patients instead of having it regimented into little codes and into global budgets for surgeries, and into ENM codes that you can only do so much per each day if you click on 13 review of systems boxes.

We would like to be able to have physicians who know what happens in their own specialty and in their own community come forward and be able to say, “This is how you can do an alternative payment method that makes sense for us.” And so, we have a process called the PTAC, which stands for the Physician Facing Payment Technical Advisory Committee, and that helps people get ideas through to CMS to be approved. Now, the problem is once they get to CMS, right now, that's where all good ideas go to die and they haven't approved any, but we're still pushing our way forward on that.

Now, when we talk about electronic health records, the industry thinks we're all Luddites. They think we don't like technology. How many of you have an iPhone or an android? Everybody. Doctors love technology. We just actually like technology that works and EMRs do not work, and we don't … I went to medical school, not data entry school, and to have doctors, the most highly paid employee in your practice, spending time entering data into a computer is something that no other industry would tolerate. You do not have people do things that are below their level of expertise. You want everyone working to the top of their license.

And so, if we had been involved when the electronic medical records were being created, maybe they wouldn't evolved out of the billing machinery of hospitals, which is how they came to be. The Affordable Care Act, again, from our House of Delegates, everyone agreed that we want patients to have access to healthcare. I mean, we're doctors that sort of basic. We want people to have access to healthcare and therefore, we support anything that increases access and we oppose anything that decreases access. We never thought that any bill was perfect. And I don't know how many of you do lobbying, it truly is sausage making. But no bill comes out perfect. Nobody gets everything they want.

The usual process is you get a bill and it's got some good stuff and some bad stuff, and then over time you say, “This is the good stuff. Let's keep that. This is the bad stuff, let's get rid of that and fix it.” We have been struggling to do that with the Affordable Care Act and we did succeed at getting rid of the iPad, and we did oppose this Texas versus United States lawsuit where they wanted to repeal what's left of the Affordable Care Act. As you know, the IRS set the penalty for purchasing insurance or for not purchasing insurance to zero. And so, the Texas Attorney General says that he thinks that means it's unconstitutional.

But what's left are the things that everybody likes. No rescission. Now, I've seen rescission in my practice. I've seen patients who are halfway through their treatment for cancer and the insurance company found that they forgot to mention that they saw their dermatologist for a Seborrheic keratosis two years ago. They didn't mention that, so they canceled the insurance. That's rescission. Then what do I do? What does that patient do? Why would we allow insurance companies to put 40% of the premium dollars into their own pocket for administrative overhead, which reads skyboxes and stadiums?
We need to be able to control that part. We want preventative care covered. Having a co-pay or deductible before you allow somebody to get preventative care makes no sense. Don't penalize people for doing what you want them to do. Encourage them to do the things that make us a healthier nation. And so, we filed an amicus brief, so far we haven't won, but we're going to continue with the appeal on that because we think that the more people who have health insurance in this country, the better off the country will be.

We also work on many state levels. We work with states when our specialty societies when we are requested, we don't barge in where we're not asked. But one of the things that we do create that you guys have been a big part of is the scope of practice coalition where we do work to say everyone should work to the top of their license, the top of their education, but not beyond. And we want to have what people can do be based on the education they received, not on what some state legislature thinks they ought to be able to do.

We continue to work on the balance billing issue and what the industry is now calling the surprise billing, what we call that is insurance company network inadequacy. That they do not negotiate with all of the physicians that are needed to provide the care and then they want us to say, well, they can just be out of network or they want to decide what they pay you if you are. We continue to work for telemedicine. We're obviously working significantly on the opioid epidemic and medical liability reform is an ongoing event. We will probably never get finished with that because there's always people who want to take away the gains that we've made.

And one of my favorites is looking at the crisis of drugs, 43% of which is the cost of the middleman between the manufacturer and the physician, and user. 43%, what value does that add? Is that a place where we can maybe make our healthcare system less expensive? Works for me. Let me talk about private practice because this concerns me a bit. When we see the number of physicians who own their own practices dropping and for the first time in 2015, it went under 50%.

And so, that is very alarming because as we look at physicians, we want them to have a sense of ownership of their patients, of the care of their patients. We want us all to feel responsible for how well that patient does, and we do not want a profession to change into, “I punched the clock in and I punched the clock out.” And I recognize that with 50% of physicians now being employed, there are a lot of physicians who don't think that way and they still will go the extra mile, and they will still work hard for those patients, and they still take ownership. The difference is they are no longer rewarded for that. It's something we have to consider.

Now, older physicians are more likely to be in private practice than younger ones. This is, I look at an opportunity because what happens so often is that when physicians are considering what to do, they're taught in there for residencies and their fellowships, “Oh, business is hard. You can't possibly manage your own business. You don't want to do that.” How many of you can add? If you can add and subtract, you can do business and therefore, if you want that ownership, it is our responsibility to mentor young physicians into understanding that this is not rocket science. It's something that you can actually do and have more control in your life.

People are often saying now that they're joining hospitals for financial stability and they're worried about all the payment reform. Financial stability is interesting. Recently in my state, one of my favorite
breast surgeons got marched out of her hospital and fired. She was the major producer in that hospital. I
don't know the details, but I've known this person for a long time. There were no qualms with her work.
I saw her work, so I think it was all a money decision. They hired a younger surgeon for less money. I
don't think that sounds like financial stability to me.

And as for payment delivery reforms, the ones that work come from physicians, the ACOs that have
saved money are physician driven ACOs. They might contract with the hospital, but they're physician
driven ACOs. And work life balance, if you're spending every night doing your records till ten o'clock at
night, that doesn't sound overwhelmingly balanced to me. It's really a difference in specialties as well.
And I haven't found any data on cosmetic surgeons, but I suspect that most of you, that there's a higher
level here of people owning their own business than among others. You have something to teach us.

And because we are all part of the house of medicine, because none of us can do what we do without a
lot of other people doing what they do as well, I think it is partly the responsibility of people like you
who know how to manage your business to teach the rest of us how to do it. And we need to do that for
the sake of the country, because if you look at that quote from MedPAC, which is an entity set up by
Congress to advise HHS on Medicare specifically in all things medical generally, even when they have
recognized that it's double the price to the system for the exact same service done in a hospital
outpatient department than in a physician office, and we're on track to spend $5.5 trillion on healthcare,
this is perhaps one of the solutions.

Again, for chemotherapy, for what I do, we learned with a careful study that if the number of oncology
practices that got scooped by hospitals were still in private practice, it would have saved the country $2
billion that year. Now, $2 billion isn't very much anymore, but gee, it starts to add up. And I won't go
through a lot of this, but a lot of the people who are employed directly by a hospital are starting to now
see that perhaps they can switch. The people who approached my practice are what I call hospital
refugees because we are seeing that the acquisition has started to slow, and I find that a reinforcing
piece of data, so we continue to look at that.

I think that's one of the ways we're going to deal with the burnout issue because what I hear from
Physicians for burnout is the frustration at the amount of non-patient work that you're asked to do. The
joy that we get in our work is making a difference to your thing, making a difference in the lives of the
person in front of you. That is priceless. If you feel like you're on a treadmill and you don't have time to
make that difference, if you feel like you have no control over how well you can do your job to make
that difference, then physicians struggle with burnout and that is something we have to fix.

And it's not going to just be yoga at lunch. It's going to have to be something that fixes the underlying
system so that we work in a system that is worthy of our talents and our efforts, and we'll continue to
work with that. We have first had to do research to prove to people that it mattered, that when
physicians are burnt out, they don't do as good a job. They don't empathize with their patients, they
can't put themselves in the patient's shoes as well as they should and the carrot drops, and that's not
good. And we find that over half of physicians wanting to leave the practice or have thought about
leaving the practice, or considering of cutting down hours at a time when we are facing a shortage of
physicians, and we need all hands on deck.
We have to address this and we have to prove that it's worthwhile to hospital administrators. We had to do the financial study to say it takes $1 million to replace a physician who quits, and then they said, “Oh, maybe we should pay attention to this.” We continue to work on a lot of those. We have in our steps forward, we have a lot of processes to help with burnout, but I think the main way we're going to help with burnout is for physicians to look at their colleagues working in the same specialty, look at their colleagues working in the specialties that you collaborate with and link arms and say, “Let's move forward on this. Let's address these issues. Let's come up with a healthcare structure that allows us to do what we want to do, and then we'll discover that burnout decreases.”

We work on regulatory relief, we continue to try to get rid of the meaningless use requirements. They now call it promoting interoperability because they got tired of everybody calling it meaningless use. And we continue to work along that because guess what? It's not a technical problem. Electronically, they can move things from one EMR to another with no difficulty. This is a political and financial problem. This hospital does not want to be interoperable with that hospital or with your office because then patients might leave that hospital and go to your office or a different hospital.

We need to be able to push that and so, the AMA is taking on interoperability as one of our initiatives because the people who want it are physicians. We don't care where you got your scan, we just want to know what it shows, and therefore, we will continue to work with that. The insurance consolidation I talked about a bit, if Anthem and Cigna had merged, that that would have cost physicians across the country half a billion dollars in reduced payments because they don't do this because they want to do a better job of paying us. They do it because they want to do a better job of collecting premiums and not paying it out.

And we'll continue to work on this because I'm very concerned about the CVS purchase of Aetna, which was allowed to go through, so that was a defeat for us. But they took into consideration one of our requests, which was that the Caremark, the PBM that is hiding behind CVS pharmacy not be allowed to be a part D player. Because if you can control the price of the drugs and you control the insurance company that says where people can buy their drugs, you get an increased consolidation, you get increased drug prices and we plan to be watching that.

The quality payment program is what I was talking about, about system reform in terms of payment. It's the macro law and because we don't have enough acronyms in medicine, Medicare renamed it QPP for quality payment program. And so, we have a whole bunch of resources on our websites about how to navigate through this process. Please check that out for help on that. One of the things, I threw this in just to say as an example of a new form for private practice.

This is a group of oncology practices that I put together. It's 16 practices across the country, 230 oncologists and we are all working together on sharing data, sharing best practices, doing research together, purchasing goods and supplies together from medical liability insurance to health insurance, to figuring out how to do things better so that we increase the bandwidth of what we can do. Because when you're running your own practice, there's so many things to think about that it's hard to get it all done.

But if you get together with other groups, other practices and other states so there's no collusion and nobody goes to jail, then you can end up saying, “This is a way I can figure it out. I'll have you think
about that problem. I'll think about this problem. We'll come together with solutions.” And so, this is an organization that's helping independent oncology practices stay independent and I think it's a good model to help support independent practices.

We also ended up in the Litigation Center. I like to bring up the Litigation Center because it is a little known part of the AMA. That when AMA members find themselves being pushed out of hospitals, having privileges denied, discovering that your blocked time is from 9:00 PM to midnight on Fridays because you're not employed by the hospital, all of these issues that occur, we can help with that. We have a brilliant team of lawyers who file amicus briefs to help physicians who are discovering that they are being unfairly treated by the system. And membership dues pays for the Litigation Center and they have reversed some really egregious practices.

We have a couple of them. Some of them are the freedom of speech idea and these can be difficult. This started out with the Docs versus Glocks, which was the lawsuit in Florida where they passed a law that said the physicians cannot even discuss with their patients or their patients' parents whether or not there's a gun in the home. We know that for example, a child who is very depressed who finds a firearm, their chances of completing a suicide is exceedingly high. It seemed logical that the pediatricians would want to tell those parents, “Why don't you make sure your guns are locked up?” The law forbid them to discuss gun safety with their parents, with the parents of their patients.

We went to court with that and we won, that they cannot stop a physician from being able to tell a patient about all of the things that are important as physicians see it for those patients. We continued to do all of these things. It's a team sport. Every specialty, every physician, every community, and every side of practice is part of the house of medicine. We are stronger when we work together. We need to defend one another. We need to teach one another.

We need to share our resources and our knowledge, and our experience with one another because if we're going to create a healthcare system that works for patients and by working for patients, that means it works for doctors. Then we need to take control of these systems away from the corporate folks who want to use it as a profit center and make it into a profession that takes care of the people we care about. Thank you.