



Memo to: AMA-RFS Assembly

From: Stephen Sherick, MD
AMA-RFS Vice Chair

Date: November 2008

Subject: Reports of Council and Committee Representatives

On the following pages, you will find the reports of the AMA-RFS members who serve on Councils and Committees as representatives of resident and fellow physicians. Unfortunately, the Assembly Meeting agenda cannot accommodate verbal reports from the council and committee representatives.

The following reports inform you of the activities of the various bodies in organized medicine and the accreditation process. I urge you to read them carefully and directly approach those representatives with whom you wish to discuss questions and concerns.

AMA-RFS Council and Committee Representatives
2008 Record of Reports
As of October 28, 2008

Council/Committee	Representative	Report
ACGME*	William J. Walsh, II, MD	No
AMPAC	Robert Oldham, MD	No
Advisory Cmmt. on Gay, Lesbian, Bisexual & Transgender Issues	Jennifer Chaffin, MD	No
Council on Constitution and Bylaws	Jason Sharp, MD	Yes
Council on Ethical & Judicial Affairs	Hilary Fairbrother, MD	Yes
Council on Legislation	David Winchester, MD	Yes
Council On Long Range Planning and Development	Hillary Johnson, MD	Yes
Council on Medical Education	Joe McDonald, MD	No
Council on Medical Service	Jana Montgomery, MD	No
Council on Science and Public Health	Ilse Levin, DO, MPH	Yes
International Medical Graduates Governing Council	Anagh Vora, MD	Yes
Minority Affairs Consortium	Shubhada Hooli, MD	No
Nat Bd. of Med Examiners	Raj Ambay, MD, DDS Jason Etheredge, MD	Yes
Residency Review Committee for Internal Medicine*	Karen Hsu Blatman, MD	Yes
Standing Committee – Legislative Advocacy	Christina Shults, MD	No
Standing Committee – Long Range Planning	Alisa B. Lee, MD	Yes
Standing Committee – Medical Education	Kayla Pope, MD	Yes
Standing Committee – Membership	Benjamin Galper, MD	No
Standing Committee – Poster	Stephen Darrow	No
Standing Committee – Public Health	Fatima Cody Stanford, MD, MPH	Yes
Surgical Caucus Exec Committee	Kathryn L. Berndt, MD	Yes
Women Physicians Congress	Kristin M. Ondecko Ligda, MD	No

* Resident member of this Council/Committee is not required to report back to the RFS Governing Council. Reports not submitted by October 10, 2008 will be distributed at the meeting.

Report of Jason Sharp, Resident Councilor
Council on Constitution and Bylaws

The Council on Constitution and Bylaws serves as a fact-finding and advisory committee on matters pertaining to the Constitution and Bylaws. The Council recommends changes to the Constitution and Bylaws in response to direction from the House of Delegates and serves as advisory to the Board of Trustees in reviewing the rules, regulations, and procedures of the AMA Sections.

The Council has just completed a year-long project at the Speakers' behest to update the Procedures of the House of Delegates, initially developed in 1969 and periodically updated since that time. The Council discovered that there were several resources in use, including the *Procedures of the House of Delegates*, the *Guide to the House of Delegates*, the *HOD Standing Rules*, the *Election Manual*, the Bylaws, and relevant AMA policy statements. Subsequently, CCB decided to develop a single "reference manual" to the HOD for use by both new and experienced delegates which will be presented at this meeting [CCB Report 6].

The Council will be presenting a several additional reports to the House at I-08: a report changing the Bylaws requirement of two nominations for all elected positions {response to BOT Report 37 (A-08)} [CCB Report 1], a report amending the Bylaws regarding items that are outdated or conflict with current practice, i.e. Order of Business and a difference in parliamentary procedure with the AMA's change from *Roberts Rules of Order* to the *Standard Code* [CCB Report 2], and a policy modernization and sunset policy review [CCB Reports 3 and 4].

In response to CEJA report 14 (A-07), the Council has developed a report refining Bylaw 2.4311 *Exempted Resolutions* to clearly define those entities entitled to submit resolutions to the AMA HOD after the 30-day deadline to only include state or specialty society houses of delegates [CCB Report 5].

Additional information about the Council on Constitution and Bylaws can be found at www.ama-assn.org/go/ccb.

Respectfully submitted,

Jason W. Sharp, M.D.

The Council on Ethics and Judicial Affairs (CEJA)

COUNCIL REPORT I-08 (the shortest EVER!)

Hilary Fairbrother, MD, MPH

PGY-3 Emergency Medicine, New York Methodist Hospital; Brooklyn, NY

Hey there. Just another quick summary of what CEJA has been up to over the past 6 months and what we are bringing to the House of Delegates for this meeting. I always include the next section so skip it if you have read this before.

A little CEJA background...

Ideas for CEJA reports are generated by resolutions from the floor of the HOD, from current ethical debates within the medical field, and from direct feedback from AMA members. If possible an Open Forum is held on the subject to elicit feedback from the AMA member community. These occur each national meeting in a moderated discussion that allows CEJA members to gain perspective from AMA members. These forums take place Monday morning during the HOD meeting (the Monday immediately following the residency meeting) and if possible, I recommend that you attend. We do not often receive much feedback from resident members, and your input is greatly desired by the council! Residents have a unique perspective that is not always covered by the AMA membership.

After a report is written, it is brought to the HOD during either the Annual or Interim meeting. These reports are sent to a reference committee and discussion is heard. The reports are often controversial and receive heated debate. These reports and the recommendations at the end of each report are not allowed to be amended (as they are in other reports). These reports can be accepted, rejected, or sent back to the Council for revision.

Once CEJA reports are passed, the recommendations become part of the AMA Code of Ethics. The Code of Ethics is used by the medical community in this country to guide physicians in the ethical practice of medicine. The Code is can be found in its complete form online at: http://www0.ama-assn.org/apps/pf_new/pf_online?category=CEJA&assn=AMA&f_n=mSearch&s_t=&stp=&nth=1&.

The code is often used in court cases and cited nationally. The basis for the code is nine Principles and they are found at the very start of the code. I have attached them at the end of this document because I think that it is important for all physicians to occasionally re-read these items and remember what our ethics are built upon.

After the excitement we brought to the house last meeting (i.e. the infamous CEJA Report 1 about industry funding for medical education) this meeting should be much quieter.

We are bringing three reports to the CC & B reference committee this meeting:

- ***Physician Self Referral*** – there are inherent financial conflicts of interest within the practice of medicine. A delicate ethical balance is maintained between the physician’s ability to maintain a career and livelihood and the medical interest of the patient. This report seeks to give guidance to physicians as they navigate the varied interests of the practice of medicine within the confines of self-referral. This report has come before the HOD during the past 4 meetings, and hopefully the concerns brought forth by members have been addressed and we can strengthen the code of ethics with the passage of this report and opinion at this meeting.
- ***Quality*** – quality can be defined as giving the right care to the right patient at the right time. The Institute of Medicine writes that quality care should be safe, effective, efficient, patient centered, timely, and equitable. This report examines some of the ethical responsibilities of physicians and organized medicine when it comes to delivering quality care to our patients.
- ***Secret Shopper Patients*** – secret shopper patients are individuals hired by outside organizations to monitor aspects of service quality. There are many ethical concerns within the use of these patients and they have a very limited clinical use. This report has been brought before the HOD during the past 2 meetings, but was modified greatly for this meeting.

The opinions (CEJA reports passed by the HOD last meeting) being published at this meeting are:

- ***Peers As Patients*** (a report that was initiated by a resolution from the RFS) – a report that gives ethical guidance towards the unique nature of the patient-doctor relationship when the patient is a health care provider.
- ***Sedation to Unconsciousness in End-of-Life Care*** – a report that gives ethical guidance towards using palliative sedation to help relieve suffering of the terminally ill.
- ***Expedited Partner Therapy*** – a report that gives ethical guidance to using the CDC guidelines for EPT. EPT is the act of giving multiple prescriptions to a patient diagnosed with Chlamydia or gonorrhea so that they and their partner(s) are treated. There are major ethical dilemmas within this practice, and this report gives guidance in how to ethically use EPT.

If you have any questions while you are here, call me or email me:

Hilary Fairbrother, hilaryfair@gmail.com

(404)323-1512

Come to the Open Forum, Monday, November 10th.

Principles of Medical Ethics

PREAMBLE:

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.

Council on Legislation (COL)

The COL met on Sept 12 and heard legislative updates on many issues from staff including:

--Professional liability reform, which is likely to continue to be a state level issue and states which are expected to have a good deal of legislative activity.

--Physician Workforce issues ranging from the effects expected from HEA reauth, to state increases in medical school enrollment, to availability of GME positions for those students, to funding for programs such as the National Health Service Corps, and more.

--The relationship that physicians have with industry and how it has changed in the last year and what we might expect in the near future.

--The Medicare physician payment update and changes to the entire reimbursement system that have been proposed. (Such as HR 1841 <http://www.thomas.gov/cgi-bin/bdquery/D?d110:6:./temp/~bdhUh9::/bss/d110query.html> | <http://www.thomas.gov/cgi-bin/bdquery/D?d110:6:./temp/%7EbdhUh9:%7C/bss/d110query.html%7C>)

--Concepts such as comparative efficacy and "academic detailing", currently being implemented on a state level but with some federal interest.

Respectfully submitted,
David E. Winchester
RFS Member of the AMA Council on Legislation

AMA Council on Long Range Planning and Development

The AMA's Council on Long Range Planning and Development (CLRPD) is charged to study and make recommendations concerning the long-range objectives of the AMA. The CLRPD serves the AMA's Board of Trustees and plays a role in the Board's ongoing cyclic strategic planning process. Input regarding suggestions about the AMA's future strategic directions is gathered from the AMA's special groups and sections, including the RFS.

Current CLRPD Projects:

A) Emerging Issues: Globalization and Universal Coverage

The Council monitors emerging health care issues to help prepare appropriate strategies to address them. *Roles of medical societies in selected countries with universal coverage* (such as Canada, France, Chile, Thailand...) have been investigated to help imagine how the AMA could be positioned if the US were to move toward similar health care systems. The impact of *globalization* or the fast-paced dissipation of barriers to trade, travel, and communications across the world is another long-range issue affecting medicine that is undergoing intensive research.

B) Publication of the Health Care Trends Report

Every year, the CLRPD updates a *Health Care Trends Report* reviewing and prospecting changes in the health care environment. Issues directly related to residents and fellows are included, such as medical education, workforce planning, and access to care. AMA members may access this document upon request or view it on the AMA's website.

C) CLRPD Reports: Following the June 2008 meeting of the AMA House of Delegates (HoD), the CLRPD received two resolutions for consideration and action. Reports on the following resolutions are being prepared for A09.

1. *Resolution 7 – Enhancing the voice of the minority affairs consortium*

This resolution seeks to change the role of the Minority Affairs Consortium (MAC) in the AMA's organizational structure. The MAC has 9 members on its governing council and a delegate to the HoD. Its current status is a "special group" to which interested individuals may join; there are approximately 1200 members. Designation as a "section" is sought, equivalent to the Resident and Fellow Section, for example.

2. *Resolution 625 – Community-based private practice physicians*

The goal of this resolution would be to facilitate the organization and support of physicians in solo practice.

If you have suggestions on these issues or ideas for emerging issues the AMA should keep on the radar screen, please email me at hillary.johnson@gmail.com. I look forward to hearing from you! It is my privilege to serve as your representative on the CLRPD.

Council on Science and Public Health: RFS Report for I-08

Resident Member: Ilse Levin, DO, MPH&TM

Thank you for giving me the opportunity to represent the residents and fellows on the CSAPH. Below is a brief description of the Council on Science and Public Health, and the upcoming reports that will be addressed by the Council. I look forward to seeing all of you in Orlando.

I. Overview of the CSAPH

The Council on Science and Public Health was established to advise the AMA on scientific and biomedical research, public health, and policy issues as they apply to these areas of medicine. The goals of the Council are to improve the quality of our healthcare system by promoting public health and scientific initiatives as they apply to the practice and understanding of medicine. The Council itself is comprised of 11 active members, including a resident, and one medical student member.

II. Upcoming Topics

The Council on Science and Public Health will be addressing reports at the Interim AMA Meeting on the following: 1) Global Climate Change and Human Health; this report addresses issues such as population movement, new and emerging infectious diseases, increases in the frequency of natural disasters and the resultant health problems that follow and respiratory health effects, 2) Green Initiatives and the Healthcare Community; this report discusses management of medical waste, the use of “green” building techniques for hospitals, energy efficiency in medical facilities, and sustainable food, looking to healthcare facilities to serve as a role model for their communities, 3) Covering and Financing of Adult Immunizations; this report analyzes the barrier to obtaining adult vaccines, where we as a nation currently stand in vaccine coverage of the population and the goals for Healthy People 2010, work that the AMA and other organizations have done to improve adult immunization rates in the US, and recommendations for improvement from the perspective of the provider, federal and state governments, the insurer, and the manufacturer, 4) Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Prescription Drug Misuse and Addiction; this report addresses the nonmedical use of prescription drugs, including trends in drug use and where the nonmedical prescription drugs are obtained, as well as where to draw the line with regards to what constitutes physician-controlled pain management versus misuse of medications.

III. Looking Ahead to Annual 09

As with the current reports up for discussion during the Interim meeting, reports for the Annual 09 meeting will consider the need for changes in our current healthcare system to improve public health as well as new and innovative technology as it emerges. The philosophic as well as the research-based aspects of each topic will be addressed by the Council each report.

GOVERNING COUNCIL SUMMARY

ATTENDEES:

Hugo Alvarez, MD, Chair
Gamini Soori, MD, Immediate Past Chair
Jayesh Shah, MD, Vice Chair
Mitra Kalelkar, MD, At-Large
Sarala Rao, MD, Delegate
Padmini Ranasinghe, MD, MPH, At-Large
Anagh Vora, MD, Resident
J. Mori Johnson, Director
Carolyn Carter-Ellis, Policy Analyst
Robert Wah, MD, BOT Liaison

GUESTS:

Dr. Sudhir Khanna, Oklahoma State Med.
Assoc.

ABSENT:

Rajendra Seth, MD
Peter W. Carmel, MD, BOT Liaison

Delegates Meeting

A meeting was held with the IMG Section Delegate, Chair and IMG staff to provide an orientation and training for the Delegate's responsibilities. Dr. Rao will be serving on Reference Committee B at I-08.

Orientation Session

J. Mori provided a brief orientation of the historical background of the International Medical Graduates Section from Tabs A-G of the agenda book. Staff will add to the IMG Section History grid the date when the Advisory Committee on International Medical Graduates was established.

HOD Timeline – The timeline for the November meeting will be incorporated into the IMG Section's timeline as they consider resolutions for the HOD publication deadline.

HOD Delegates/Alternates – Governing Council members discussed the HOD Delegates/Alternates listing as well as ideas of how to get the Delegates and Alternates involved with the IMG Section. Ideas included:

1. Sending an official letter of introduction;
2. Sending a second letter asking how the IMG Section can be of assistance to them/their delegation; and
3. Recruit the Delegates/Alternates to serve on IMG Committees.

Delegation Listing – The Delegation listings will be used for networking purposes. The Council on Legislation, American Medical Political Action Committee and American Foundation Board members will be added to this resource list. IMG staff will check with other Caucus delegations to gather more information.

IMG Section Work Plan --The 2008-2009 Work Plan was approved as printed.

The Governing Council members agreed that their Work Plan should work in tandem with the AMA's Strategic Plan. The IMG Section's strategic plan will be discussed at each meeting to review the status as well as to monitor the progress of each objective.

Web Site – The Governing Council suggested an update to the list of frequently asked questions with answers to assist international medical graduates that would include links to AAMC, ECFMG, NRMP, ACGME, Web sites. Disclaimers also will be included on the Web site pages.

Communications

Governing Council members suggested the following ideas for Communications:

- ❖ Include one or two frequently asked questions and answers in the weekly eVoice;
- ❖ Include successful resolutions for the past and present;
- ❖ Reprint hot news items on frequent basis – include in eVoice, Web site, and AM News; and
- ❖ Create a frequently asked questions and answers for those seeking to go to medical school offshore.

Expense Reimbursement Guidelines – The Governing Council members were advised that the mileage reimbursement rate has changed. The mileage reimbursement guidelines were modified July 1, 2008 to 58.5 cents per mile which will be reflected in the Section's expense reimbursement guidelines.

Observerships – Dr. Sudhir Khanna, Chair of the IMG Section at the Oklahoma State Medical Association (OSMA) attended this meeting to discuss the OSMA externship program. Dr. Khanna serves on an Externship Program Task Force who developed documents that were shared with the Governing Council. Dr. Khanna reported that the observership program has become very popular which has resulted in the Oklahoma State Medical Association becoming overwhelmed. The Oklahoma program is on hold and is pending review of the documents shared with the Governing Council by the Board of Trustees. The current OSMA Externship program has no costs associated with its program. The State's plan is to charge \$900 for an application fee plus \$100 to cover other administrative costs.

The Governing Council will form a Work Group to develop the structure to roll-out the AMA guidelines. It is estimated that it will take approximately one year to finalize the AMA observership/job shadowing guidelines.

IMG Sections in Other States – Dr. Soori suggested that the Governing Council work with states that do not have IMG Sections. The IMG staff does have a listing of the states with IMG Sections. It was suggested to have the IMG Governing Council members serve as an ambassador or facilitator to states without IMG Sections. States with IMG Sections could serve as the model for those states without IMG groups.

House of Delegates Resolutions Follow-up – The following Resolutions will be modified for possible consideration at I-08:

- ❖ Resolution 2 -- Improving the Health of Minority Populations – Dr. Shah will work with the Delegate of the Minority Affairs Consortium on this resolution.
- ❖ **Resolution 4 -- Research Visa for Physician Scientists – Dr. Ramamurthy will collaborate with the MSS, RFS and YPS on this resolution.**

- ❖ Resolution 10 -- Hospital Seek Patients Credit Rating – GC members noted this is not an access to care issue and this resolution may be better suited with the Organized Medical Staff Section.

The following Resolutions will be modified for consideration at the A-09 Meeting:

- ❖ Resolution 7 -- Denial of Medical Licensure to Qualified IMGs
- ❖ Resolution 12 -- Ensuring Diversity in USMLE Exams – Dr. Ramamurthy will provide ECFMG’s methodology on the change in the pass and fail score on USMLE exams.
- ❖ Resolution 1 -- Health Care Cost Education in Medical School Curriculum – Governing Council members agreed to share this Resolution with the Council on Medical Education.
- ❖ Resolution 2 -- Fifth Pathway – This Resolution will be shared with the Council on Medical Education to solicit their input.

I-08 Resolutions Process – J. Mori provided a new process in order to have IMG Section resolutions approved in advance and have testimony discussed and ratified by the Congress before the I-08 meeting. The Section will pilot test having a virtual Congress with Resolutions and testimony placed online, the IMG Section will move their resolutions deadline to early September in order to allow time for the Congress members to review all Resolutions and meet the September 24th deadline in order to have the IMG Section resolutions included in the House of Delegates handbook. This new timeframe will allow Delegations to review IMG Section business in advance and garner support on IMG Section reports and resolutions.

2008-2009 Committees Structure: The Committee structure for 2008-2009 will be split into 3 categories as outlined below: It was suggested that Governing Council members Chair the respective Committees.

I. Adhoc Committees

- a. Nominating Committee, Gamini Soori, MD, Chair. The Governing Council discussed how this Committee could improve the election process and increase the diverse amount of people running for the Governing Council. The call for nominations will be done in December 2008. Governing Council members felt there should be more objective criteria for running in the election. Staff will notify the state, specialty and ethnic associations about nominations for the 2009 IMG Section Governing Council.
- b. Desserts Committee, Muhammad Hammami, MD, will be requested to Chair this Committee.
- c. 2009 Workforce Paper (Chair will be obtained at A-09 meeting)

II. Standing Committees

- a. External Relationships, Sarala Rao, MD, Chair
- b. Internal Relationships, Rajendra Seth, MD, Chair
- c. Resolutions/Reports, Jayesh Shah, MD, Chair

- d. Leadership Development, (Chair will be obtained at I-08 meeting, possibly Venkat Rao, MD). Governing Council members suggested having the Immediate Past Chair should chair the Leadership Development Committee.
- e. Advocacy, Mitra Kalelkar, MD, Chair
- f. Membership Committee, Hugo Alvarez, MD, Chair. During this discussion, Dr. Wah suggested that the Governing Council members brainstorm on membership ideas for a possible future membership meeting with AMA staff.

III. Liaisons

- a. Initiative to Transform Medical Education, Padmini Ranasinghe, MD, MPH, Chair
- b. Commission to End Health Care Disparities, Nestor Ramirez-Lopez, MD

Observerships Work Group – The IMG Section will lead this initiative. The Governing Council members that will staff this work group include: Drs. Soori, Shah and Vora. It was suggested that the timeline for rollout of the Observerships will be June 2009. The first meeting will be arranged followed by conference calls every two months. Work in between conference calls will be done via e-mail.

Other interested parties will be invited to participate in the observerships work group.

State Medical Boards

How do we get IMGs on state medical boards? They must join their state Political Action Committee. Local involvement and donations are key. Look into mini-internships with local legislators.

AMPAC – Governing Council members were advised that they should be come a member of the AMPAC. The campaign school and candidate’s workshop are very beneficial for those enhancing their leadership development skills.

Plans for 2008 Interim Meeting – J. Mori discussed the following timeline and paradigm shift from previous Interim IMG Section meetings.

- ❖ Proposed timeline and process:
 1. Call for items of business (4 months before Annual and Interim meetings)
 2. Deadline for items (8 weeks prior to Annual and Interim meetings)
 3. Online testimony of items (8-6 weeks prior to Annual and Interim meetings)
 4. GC amendments based on discussions and members’online testimony (6 weeks prior to Annual and Interim)
 5. Reports and resolutions are ratified by Congress members online (5 weeks prior to Annual and Interim)
 6. IMG resolutions are submitted for AMA HOD staff by publication deadline (4 weeks prior to Annual and Interim)
 7. Late resolutions can still be submitted, but resolutions will need to be approved by the GC first, then acted upon at the Congress meetings.

8. GC members still would review assigned portions of the HOD handbook in advance of the Annual and Interim meetings.

This new process was approved by Governing Council members. A pilot test of this new process will be implemented for the I-08 meeting.

- ❖ Governing Council members agreed that there should not be a Saturday IMG Caucus meeting. This time will be used for networking and collaboration at other Caucuses. During the June Annual meetings, there will be a Saturday Caucus for candidate interviews and for the joint Sections and Special Group Caucus.
- ❖ Joint Sections & Special Groups Caucus – The Joint Sections and Special Groups Section will be held on Saturday, November 8 from 5:30 pm – 6:30 pm. Dr. Shah will Chair this session. The format will be roundtable discussion where Sections will discuss their business items and collaborate with members of other Sections and Special Groups.
- ❖ Busharat Ahmad, MD Leadership Development Program – This program is scheduled for Monday, November 10, 2008 at 9:00 am. Dr. Elias Zerhouni from the National Institute of Health has been invited to the leadership program. Dr. Hammami from the National Arab American Medical Association will call Dr. Zerhouni directly. If Dr. Zerhouni cannot attend, a suggested backup plan could be to turn this program into roundtable discussion with past IMG leaders regarding their leadership experiences.
- ❖ Involve the Florida Medical Association IMG Section with our meetings.

Strategy for Increasing Representation in the AMA House of Delegates – The Governing Council discussed this issue and offered the following suggestions:

1. Work on plan to bring AAPI and Korean American Medical Association delegates in the IMG Section fold. Get other ethnic societies into the AMA House of Delegates. (Rao)
2. Develop mechanism for building relationships and Resolutions (Soori)
3. Get more delegates involved. Review specialty society composition. Have delegates review resolutions ahead of time. (Shah)
4. Develop resolutions that would appeal to all Sections, not just IMGs (Shah)
5. Start process now. Develop a resolution that calls for looking at the structure of House of Delegates in order to make it more representative of the profession. (Shah)
6. It was reported that the next Council on Long Range Planning demographics report is an opportunity to bring another resolution from the IMG Section. The resolution could call for a study with a specific timeframe.
7. Build coalition of supporters with other Sections. The Joint Section and Special Groups Caucus could be the forum to discuss this issue.
8. Articulate the catch 22 that IMGs in the HOD face represent their delegation not the IMG Section.

Plans for Annual Meeting – 2009 – Governing Council members were instructed to arrive on Friday, June 12, 2009 and depart on Monday, June 15, 2009. The meeting could begin with a brunch/lunch. More details will be finalized at a later date. The Chair, Delegate and RFS representative would arrive on Thursday, June 11, to attend the Joint Sections meeting with the Council on Medical Education.

1. Suggested list of speakers:
 - ❖ Dr. James Hallock, retiring ECFMG President (Friday, June 12 – Dr. Hallock could also speak at the Monday, June 15th Leadership program). Dr. Hallock's replacement will be invited too.
 - ❖ ACGME (discussion on discrimination in residencies against IMGs)
 - ❖ Regina Benjamin, MD, Chair, FSMB Board
 - ❖ Navin Shah, MD (history of IMGs)
 - ❖ California Licensing Board Member (Rao)
2. Candidates Forum – Will be planned as usual, but there is an opportunity to have the Candidates Forum on Friday or Saturday. This issue will be discussed by the March 2009 meeting.
3. Desserts Reception – The AMA Alliance would like to continue to be involved with the IMG Section's Desserts Reception. Suggestions were made to include diabetic and Cuban desserts as part of the desserts menu. Other suggestions included having an IMG Section sticker which indicates "I am proud to be an IMG" and "I am proud to be an IMG supporter."
4. Busharat Ahmad Leadership Development Program – IMG staff will have a back-up speaker in the event that Dr. Hallock cannot attend this program.
5. Suggestions for resolutions and reports: Governing Council members will discuss ideas for reports and resolutions at the March 2009 meeting. Staff will create a communications blurb to promote the new resolution timeline and procedures.

Addendum 1 – Ohio Survey – Governing Council members suggested having a procedure when there are requests received for IMGs to get involved with surveys. Governing Council members agreed that more information should be obtained on the methodology and hypothesis before making a final decision to promote this IMG survey or not.

Addendum 2 – Fight for Equality Publication and American Professional Exchange Association – Governing Council members discussed the issue having AMA endorsement or distribution of this publication. IMG staff will obtain more information on the role, responsibility and liability of the American Professional Exchange Association. As a second step, it was suggested to invite Dr. Navin Shah to the Governing Council's March meeting. Staff will arrange for Dr. Niran Shah to be profiled on the IMG Web site.

Addendum 3- Stakeholders Input for 2009 Planning Cycle – The Governing Council members discussed the plan for stakeholder input from AMA councils, sections and special groups. This information is an important component of the information base which the Board utilizes to identify potential topics for the AMA strategic plan. Some ideas included cost of health care, environmental pollutants, healthy lifestyles, structure of the HOD, membership issues, liability relief for pro bono care, and the slow death of primary care physicians. The deadline to provide input to Don Ziegler, PhD, Secretary to the Council on Long Range Planning and Development,

is October 15. Staff will draft the GC's response based on their discussion for their review by mid-September.

Addendum 4 – Articles Related to Caribbean Medical School Buying Slots at New York Hospitals – The Governing Council members discussed the articles. Governing Council members agreed to study and review the pros and cons before they take a position on the issue. GC members indicated former resident member, Dr. Nirav Shah may be able to provide comments on this issue. What is the American Hospital Association's opinion on this issue?

Paperless Meetings – The Governing Council members agreed to pilot test the 2008 Interim Meeting as a paperless meeting initiative by implementing the new process improvements and timeline, bringing laptops and conducting a virtual Congress.

March 2009 Leadership/GC meeting – J. Mori discussed the specifics of the Excellence in Medicine Awards meeting. Two Governing Council members will be funded to attend the National Advocacy Conference. Governing Council members agreed to meet March 7-8, in Washington, DC at the Grand Hyatt hotel. Selection Committee members will be covered to stay through Monday, Monday, March 9. Selection Committee members selected are:

- ❖ Dr. Padmini Ranasinghe – Young Physicians
- ❖ Dr. Sarala Rao – Resident and Fellow Physicians

June 12-15, 2009 Meeting – Governing Council members will be funded to arrive on Friday, June 12 and will depart on Monday, June 15. Delegate and Alternate are funded to depart on Wednesday, June 17.

Roster – Changes on the Governing Council roster will be made and returned to Governing Council and Board of Trustees liaison members for their information.

Committees – A schedule grid of conference calls will be developed for A-09. Additionally each Committee chair should give or forward a status report each quarter.

Adjournment -- The meeting adjourned at 10:30 am.

National Board of Medical Examiners

American Medical Association Interim Meeting Report

RFS Representatives

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The National Board of Medical Examiners meets in full session in Philadelphia to conduct the majority of its business in March each year. During the remainder of the year, business is conducted by the Executive Board, the six governance committees, the Test Committee, and/or staff as appropriate.

One issue of particular ongoing concern to physicians, and which the AMA continues to follow with interest, is the decision by the NBME Executive Board in April to work with the Council for the Advancement of Comprehensive Care (CACC) to develop and administer a certification exam for graduates of Doctor of Nursing Practice (DNP) Programs. The DNP examination will assess the knowledge and cognitive skills necessary to support advanced clinical practice by DNP graduates. It will be comparable in content, similar in format and will measure similar competencies and apply similar performance standards as the USMLE Step 3. The DNP examination will assess some of the competencies assessed by Step 3 and will be administered to DNP graduates for the first time in November 2008. This decision was made after the Board's Annual meeting and despite overt opposition by both the AMA and the Federation of State Medical Boards. The NBME press release stated that the collaboration with the CACC, "is consistent with NBME's mission to protect the health of the public through state of the art assessment of health professionals." This is clearly a crucial issue to physicians as the step provides a distinct level of legitimacy to a cohort of health professionals already fighting for an expansion of their clinical powers in heated scope-of-practice battles in state legislatures across the country.

The cooperative efforts between the NBME Clinical Skills Evaluation Collaboration and the AMA National Clinical Skills Evaluation Initiative continue to bear fruit. In September, the NBME announced they would be providing additional feedback to those examinees who failed the USMLE Step 2 Clinical Skills exam starting with results reported in October. The expanded feedback will be on the *Communication and Interpersonal Skills* Subcomponent of the exam, one of the more enigmatic and frustrating sections for examinees. This is an important step in the right direction. It is our hope that it will lead to an even greater release of feedback to all examinees in the near future.

Finally, the NBME newest committee, the *International Collaborations Advisory Committee* (ICAC), is gathering steam. International work is the fastest growing section of the National Board and is increasingly seen as a major avenue for development of research and financial resources. The NBME is currently conducting the Panama Residency Selection Exam as well as the Foundations of Medicine exams in Italy and Portugal. Discussions for exam programs are ongoing in Singapore, Spain, Belgium, Norway, the Czech Republic, and Puerto Rico. The ICAC, of which your RFS Representative Jason Etheredge, MD, PhD is one of the seven members, will be meeting in Philadelphia on January 20th and 21st, 2009 in order to oversee the work of the International Programs Department and prepare a series of reports for the upcoming Annual meeting of the NBME in March 2009.

Interim I-08

Report from Karen Hsu Blatman, Resident representative to Internal medicine RRC.

I am the AMA resident representative to the internal medicine residency review committee for the ACGME. We meet four times a year to review programs and to work on policies affecting the internal medicine residencies. This year, we have been working on revision of the internal medicine and the internal medicine subspecialty program requirements. Every five years, program requirements for each of the residencies are reviewed.

For internal medicine, the changes will become effective in July 2009, so many of you will see your programs tweak your programs in preparation for the changes. For the internal subspecialties, the revised program requirements become effective July 2010.

The major changes:

What's **NO** longer in the program requirements:

- Minimum numbers of clinic patients per session
- Review of goals and objectives by the attending at start of each new rotation
- Non-internal medicine clinical experiences (such as ophthalmology, dermatology) only need opportunity (geriatrics and neurology remain as required rotations)
- Autopsy Reports
- Counting weeks of continuity clinic
- 1:8 Teacher:Learner ratio

What has changed in educational program:

- Support for core faculty
 - Increased numbers per resident
 - Will not impact programs with <60 residents
- ***Presence of or commitment*** to creation of an electronic health record
- 1/3 ambulatory
- 1/3 inpatient
- Emergency Medicine counts for 2 weeks of ambulatory medicine. Also, emergency medicine rotation required must not exceed 2 months (you can do more as elective). That is a decrease from 3 months.
- Didactic curriculum
 - May consist of lectures, web-based content, pod casts, etc. (more flexible)
 - Must have availability for review and repetition (for those away or at another hospital)

Inpatient ward changes (decrease numbers from before):

- Intern census no more than 10

- Supervising resident
 - One intern – no more than 14
 - >one intern – no more than 20

The BIGGEST CHANGE will be resident continuity clinic: goals were to liberalize what “counts” as a continuity session and lessen scheduling burdens. Requiring clinic each week meant people schedule post-night float clinic, which could be a dissatisfier.

The RRC also wanted to ensure teaching and mentorship during clinic at lower staff to resident ratios (decreasing 5 resident per attending ratio down to 4 residents per attending).

- **Current Requirements** for resident continuity clinic
 - 108 “sessions” weekly over 3 years
 - No more than a month between sessions
 - Exclusive of resident vacation
- The number of patients
 - seen by a first-year resident, when averaged over the year, must not be fewer than three or greater than five per scheduled half day session.
 - seen by a second-year resident, when averaged over the year, must not be fewer than four or greater than six per scheduled half day session.
 - seen by a third-year resident, when averaged over the year, must not be fewer than four per scheduled half day session.

NEW REQUIREMENTS:

- 130 continuity “sessions” (number increased, but “weekly” sessions taken out)
 - Requirement for performance and quality data
 - Maximum ratio of 1 preceptor to 4 residents (decrease from 1:5)
 - Preceptors can’t have other direct patient care duties if supervising more than 2 residents
 - Demonstrate longitudinal mentorship in the clinic setting
 - Demonstrate resident ownership and participation in care between clinic sessions and across venues of care
- Key Points:
 - The removal of absolute numbers of patients/session and liberalization of time between sessions was the driving factor to increase the 108 session requirement
 - ABIM/SGIM/et al survey showed that >50% of programs would meet the 130 standard

- NEW FLEXIBILITY
 - More experiences “count”
 - Example: An intern on an ambulatory block experience could have 3 continuity experiences each week over 4 weeks and they would all “count”. It used to be that you could only count one of the sessions a week.
 - No upper or lower limit on patients per session
 - Example: A resident and preceptor could hold a meeting with one of their panel patients and their families to discuss end-of-life care in a home visit or a nursing home and it would “count” as a session
 -
 - PDs can choose when to schedule clinics
 - Can select lesser intensity on the wards (such as less patients or less clinic during MICU)
 - Can have multiple clinics per week during outpatient blocks
 - The sessions STILL have to have something to do with the resident’s continuity panel
 - Will potentially minimize conflicts of residents in continuity experience distracted by inpatient duties
 - Changed clinic continuously over 30 months (instead of 36 months)
 - Flexibility at the beginning and end of residency

I review up to 10 internal medicine or IM subspecialty residency programs with a RRC attending co-reviewer quarterly. Those reviews are confidential.

All the residents who serve on RRCs meet twice a year as an advisory council the ACGME. Twenty-seven residents in the 25 RRCs and 1 institutional review committee. I am currently the chair of the Council of Review Committee Residents and sit on the ACGME Board of Directors in that capacity.

If you are interested in serving as the next internal medicine RRC resident, I am happy to answer questions. In the near future, the AMA will be soliciting applications for the next resident. There are 2 residents on the internal medicine RRC, and the AMA appointee will start July 2010.

I know the program requirements can be confusing. If you have any questions, please contact me at khsblatman@gmail.com. My cell phone is 319-621-5198.

Respectfully submitted,

Karen Hsu Blatman

Report of Committee on Medical Education
Kayla Pope, MD, JD, Chair

Committee Members:

Jason Etheridge, MD, PhD
Renee Solomon, MD
Summer Hanson, MD
Erin Dunnigan, MD
Heather Brislen, MD

The Committee on Medical Education has been very active over the past months. A brief summary of the main activities of the Committee are as follows:

1. Residents' Bill of Rights: Committee members, Jason Etheridge and myself developed a draft BOR and a resolution for consideration at the I-08 meeting. The proposed BOR was reviewed by the entire committee and their comments were incorporated. The proposed BOR has also been sent to the ACGME Resident Committee and to the APA Resident and Fellow Committee for their review. It is the opinion of the Committee that the BOR in its current form will serve as a resource document. From this document a more concise statement of the BOR will be developed for broad dissemination to trainees.
2. Childcare Resolution: Committee member Jason Etheridge and myself reviewed the Freida data from the AMA staff which detailed which programs indicate that they provide childcare services. The data are somewhat unclear, and will require further information to be useful. Next steps will include developing a small survey and contacting a sample of the programs. Committee members Etheridge, Brislen and myself will continue to work on this project.
3. Report E on Credentialing: The Committee reviewed Report E and proposed that it be accepted with minor changes.
4. Handoff Report: Committee members Erin Dunnigan, Heather Brislen and Summer Hanson, are reviewing source documents in preparation for a report to the RFS for A-09.
5. The committee members plan to meet at the I-08 meeting to discuss new projects and to review current undertakings.

Report of the Committee on Long Range Planning

Bylaws Changes for AMA-RFS Sectional Delegates and Alternate Delegates Election Procedures and Vacancies

INTRODUCTION

At the 2008 Annual Meeting, the Resident and Fellow Section (RFS) Assembly passed Governing Council Report H, "Voting Systems for Election of RFS Sectional Delegates and Alternate Delegates," which changed the voting mechanism from Instant Run-Off Elections to Simple Majority. The Governing Council and the RFS Committee on Long Range Planning were asked to determine appropriate language for the RFS Internal Operating Procedures (IOP) to reflect this change. Additionally, in the light of recent vacancies in the Sectional Delegate/Alternate Delegate position, the Governing Council and the Committee on Long Range Planning drafted IOP language that would reflect how these situations should be dealt with.

BACKGROUND

I. Voting System for Sectional Delegates & Alternate Delegates

The initial RFS voting system for the Election of Sectional Delegates and Alternate Delegates to the AMA-House of Delegates (HOD) was Instant Runoff. At the 2008 Annual meeting, the RFS Assembly determined that a voting system which used Plurality was most desirable for the election of Sectional Delegates and Alternate Delegates. Using this system a voter does not rank candidates but instead selects the top number n of candidates as winners for n positions available. Despite adopting this change, there was no consensus at the time of the meeting on the IOP changes needed to implement the new system for the 2008 Interim meeting. It was requested that proposed IOP changes be made at the 2008 Interim meeting, which could be then be implemented at the next meeting in which an election of Section Delegates or Alternate Delegate would take place.

II. Internal Operating Procedure Changes Needed

In the following excerpt from the IOPs, shaded sections highlight text that would require modification to reflect the change from Instant Runoff to Plurality voting.

RFS Internal Operating Procedures section IV. RFS Sectional Delegates, G. Election of Sectional Delegates, i. Balloting

i. Balloting. All nominees for the office of Sectional Delegate shall be listed on a single ballot. A separate ballot will be provided to each elector, listing each nominee's name and endorsing society. Each elector will rank-order the nominees numerically, with the rank of "1" being the highest rank. Electors must rank order all nominees otherwise the ballot is voided. Also, duplicating a rank (i.e. ranking two candidates with the same number), and/or skipping a rank (e.g. ranking 5 candidates 1, 2, 4, 5, 6) will void the ballot. When counting the ballots, the voided ballots shall be placed in a separate stack and shall not be considered in the total required to elect. A majority of the legal ballots cast shall be required for election. Each legal ballot shall be examined for the nominee with the highest rank and sorted accordingly. After sorting, ballots assigned to each nominee shall be counted, any nominee receiving a majority of the legal ballots cast shall

be elected. If in any round, no nominee receives a majority, the nominee(s) with the fewest votes shall be eliminated. In either circumstance, ballots are then redistributed to the highest designated of the remaining nominees and then recounted. This process will continue until all Sectional Delegate seats are filled.

ii. Limitations. If there is more than one nominee from an endorsing society, then the nominee from that endorsing society who has a majority and who has the most votes shall be elected. All other nominees from that society shall be eliminated from the remaining counting of ballots. This process will continue throughout the counting of ballots to ensure that there is only one RFS Sectional Delegate per endorsing state and specialty society.

iii. Unfilled Seats. If after the counting process, and due to limitations of representation and/or failure of remaining eligible nominees to gain a majority vote, there are unfilled Sectional Delegate seats, the following processes will be used to fill those seats. When using these legal ballots to decide unfilled seats, original ranking will be used.

a) First, all nominees eliminated from consideration in the above section (ii. Limitations) due to limitations on representation of endorsing societies, and who still has a majority of legal votes may be elected under a secondary state and/or specialty society endorsement if that particular state or specialty society has not already been represented.

b) If unfilled seats still remain, then the counting process will recommence using the original rank order votes to establish majorities within that remaining group. Again, limitations will be placed only allowing one extra Sectional Delegate per endorsing state and specialty society. This process will continue through as many counting rounds as needed until all Sectional Delegate seats are filled. With each subsequent counting round the limitation of Sectional Delegates shall increase by one.

III. Vacancies of Sectional Delegate and Alternate Delegate Positions

Since the election of our 2008 RFS Sectional Delegates and Alternate Delegates at the 2007 Interim meeting, there have been two separate circumstances in which the promotion of a Sectional Delegate/Alternate Delegate left a vacancy. The first situation occurred when the promotion of a Sectional position occurred during the Annual meeting, though the vacant position would not need to be fulfilled until the following meeting. With this vacancy, immediate elections for the vacant position were held, and the winner obtained society endorsement after the meeting. The second vacancy occurred between the Annual and Interim meetings, and the vacant position needed to be filled at the Interim meeting. Because of the late nature of this vacancy and the IOP requirement of holding elections for the vacant position, the election for this position are to be held at the same meeting as the fulfillment of the sectional position term. Having elections at the same meeting as the fulfillment of the term is difficult for multiple reasons, not limited to requiring a member to take time away from their program and find housing during the meeting without winning the position ahead of time, obtaining endorsing sponsorship for that meeting despite a potential election loss, and the amount of preparation the potential electee may need to do for the HOD even if he or she is not elected to the position. Because of these situations and the hardships caused by replacing a vacant Sectional position at the same meeting as the term is to be fulfilled, our Committee determined that further clarification and adjustment to the IOP is needed.

It was determined that when elections could be held in advance of a vacancy (i.e. when the person leaving the vacancy can fulfill their position at the meeting during which the elections are

taking place), the IOP should be unchanged; an election using Plurality vote should be used, and the position filled based on majority vote. In the situation in which elections cannot be held at a full meeting in advance of the Sectional position fulfillment, it might be in the best interest of the person filling the vacancy to be aware of the work-load, and requirement to stay for the entire length of the AMA-HOD ahead of time. Because of this, we would recommend that the Governing Council appoint an AMA-RFS member who would be willing to fill the vacancy, and who would meet the requirements of the Sectional position.

RECOMMENDATIONS

The RFS Committee on Long Range Planning recommends that the following be adopted and that the remainder of the report be filed:

1. That the AMA-RFS IOP be changed (by deletion and insertion) in Section VI.G.5.a. as following to reflect the Plurality voting system adopted at the 2008 Annual meeting:
 - i. ~~Balloting. All nominees for the office of Sectional Delegate shall be listed on a single ballot with their endorsing society. The ballot will contain clear voting instructions with a brief explanation of ballot counting procedures. The voter may select up to and including the number of candidate positions. Ballots will be counted and delegates selected based on an approval-based, plurality-at-large voting system. Only nominees receiving a simple majority of the legal votes cast shall be elected. A separate ballot will be provided to each elector, listing each nominee's name and endorsing society. Each elector will rank order the nominees numerically, with the rank of "1" being the highest rank. Electors must rank order all nominees otherwise the ballot is voided. Also, duplicating a rank (i.e. ranking two candidates with the same number), and/or skipping a rank (e.g. ranking 5 candidates 1, 2, 4, 5, 6) will void the ballot. When counting the ballots, the voided ballots shall be placed in a separate stack and shall not be considered in the total required to elect. A majority of the legal ballots cast shall be required for election. Each legal ballot shall be examined for the nominee with the highest rank and sorted accordingly. After sorting, ballots assigned to each nominee shall be counted, any nominee receiving a majority of the legal ballots cast shall be elected. If in any round, no nominee receives a majority, the nominee(s) with the fewest votes shall be eliminated. In either circumstance, ballots are then redistributed to the highest designated of the remaining nominees and then recounted. This process will continue until all Sectional Delegate seats are filled.~~
 - ii. ~~Limitations. If there is more than one nominee from an endorsing state or specialty society, then only the nominee from that endorsing society who has a majority and who has the most votes shall be elected. All other nominees from that society shall be eliminated from the remaining counting of ballots. This process will continue throughout the counting of ballots to ensure that there is only one RFS Sectional Delegate per~~

endorsing state and specialty society.

iii. Unfilled Seats. If there are unfilled Sectional Delegate seats after the election, the ballot counting process will begin again, allowing only one additional Sectional Delegate per endorsing state/specialty society. This process will continue through as many counting rounds as needed until all Sectional Delegate seats are filled. With each subsequent counting round, the limitation of Sectional Delegate from a given state or specialty society shall increase by one. If after the counting process, and due to limitations of representation and/or failure of remaining eligible nominees to gain a majority vote, there are unfilled Sectional Delegate seats, the following processes will be used to fill those seats. When using these legal ballots to decide unfilled seats, original ranking will be used.

a) ~~First, all nominees eliminated from consideration in the above section (ii. Limitations) due to limitations on representation of endorsing societies, and who still has a majority of legal votes may be elected under a secondary state and/or specialty society endorsement if that particular state or specialty society has not already been represented.~~

b) ~~If unfilled seats still remain, then the counting process will recommence using the original rank order votes to establish majorities within that remaining group. Again, limitations will be placed only allowing one extra Sectional Delegate per endorsing state and specialty society. This process will continue through as many counting rounds as needed until all Sectional Delegate seats are filled. With each subsequent counting round the limitation of Sectional Delegates shall increase by one.~~

iv. Run-Off Elections. If there are two or more candidates that tie for the highest number of votes, though there are fewer positions available than tied candidates, a Run-Off election will occur. The candidates who tied will be placed on a subsequent ballot with all other candidates removed, and a subsequent vote shall take place. The candidate(s) who receive(s) the highest number of votes, with a majority of legal votes cast, shall be elected. If in any round, no nominee receives a majority, the nominee(s) with the fewest votes shall be eliminated. This process will continue until all Sectional Delegate and Alternate Delegate seats are filled.

2. That the AMA-RFS IOP be changed (by deletion and insertion) in Section VI as following to reflect the issues related to vacancies in the Sectional Delegate/Alternate Delegate position:

I. Vacancies.

1. Vacancy to be filled at the next meeting. In the case that a vacancy in the position of Sectional Delegate or Alternate Delegate occurs one meeting prior to which the term is to be fulfilled, the Governing Council shall inform the assembly of the number of vacancies and an

election according to the procedures defined in RFS Internal Operating Procedures VI.G shall occur at the following meeting of the RFS Assembly.

~~Between meetings of the House of Delegates. In the case of a vacancy in the position of Sectional Delegate or alternate delegate in between meetings, the governing council shall inform the assembly of the number of vacancies and an election according to the procedures defined in RFS Internal Operating Procedures VI.G shall occur at the following meeting of the RFS Assembly.~~

2. Other Vacancies. Should a vacancy arise in the position of Sectional Delegate for which an election will not take place prior to the start of the meeting during which any portion of the term is to be fulfilled after the close of elections in the RFS assembly and prior to close of business of the House of Delegates, elected alternate delegates shall assume the role of delegates. Should there still remain Delegate vacancies, these, along with the alternate delegate vacancies shall be filled by a nomination and majority vote of the members of the RFS Governing Council who are present. These Delegates and Alternate Delegates shall not be subject to the requirement of state or specialty society endorsement.

Acknowledgements:
RFS CLRP Members

Special thanks to AMA-RFS Staff:
Sharyn Grose
Anu Gupta



AMA- RFS Public Health Standing Committee I2008 Update

Submitted by: Fatima Cody Stanford, M.D., M.P.H. – Chair

Committee Members:

Julie Lynn Bartholomae, D.O.

Albert Einstein Medical Center- Philadelphia, PA
Specialty: Psychiatry

Scott Randolph Chalet, M.D.

University of Wisconsin Hospitals/ Clinic- Madison, WI
Specialty: Otolaryngology

Melissa Cunningham, M.D.

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Specialty: Family Medicine

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Specialty: Physical Medicine & Rehabilitation

Fatima Cody Stanford, M.D., M.P.H. - Chair

Palmetto Health/ University of South Carolina- Columbia, SC
Specialty: Internal Medicine/ Pediatrics

FOR ANY QUESTIONS OR FEEDBACK- Please contact Fatima at fcodystanford@gmail.com

AMA- RFS Public Health Standing Committee Agenda (2008-2009)

- ❖ Physical activity patterns of resident and fellow physicians, medical students, and attending physicians
 - We will be conducting a nationwide web survey through the AMA to determine physical activity of the groups mentioned. Once the survey is available, we will notify the entire AMA-RFS (and other AMA sections such as the AMA-MSS) to obtain data representative of these populations.

- ❖ Promoting health screening events and preventive care educational sessions in the local communities as well as on a national level
 - The AMA RFS Public Standing Committee has developed a document that will be posted on the website as a resource for individuals preparing local or city wide health fairs in their respective areas. Also, ideas are presented about possible screening options (i.e. blood pressure measurement vs. osteoporosis screening).

- ❖ Identifying public health opportunities for residents
 - The committee has prepared a comprehensive document with national public health opportunities that range from positions with the Public Health Service Corps to fellowship opportunities with the ASPH. The detailed list has been published on the AMA website at the following address:
<http://www.ama-assn.org/ama/pub/category/7138.html>

- ❖ Resident and Fellow Shift Work Nutrition Report
 - During the 2007-2008 year, the AMA- RFS PH standing committee began to evaluate shift work nutrition. Unfortunately, residents usually do not have proper nutrition available while conducting work shifts, and they have to compromise basic nutritional standards for resident and fellow physicians. The committee aims to develop specific recommendations for residency and fellow programs to improve the nutrition of their residents while on-call in the hospital.

- ❖ Suicide Report
 - The AMA-RFS Public Health Standing Committee is designing a 5 week program geared towards high school students to educate them about the high prevalence of suicide in their population (an act which stems from diagnoses such as depression). Look for further information to follow as the AMA sheds light on this serious issue.

- ❖ Public Health Power Point Updates (under Health Care Education Initiative)-
<http://www.ama-assn.org/ama/pub/category/7092.html> -

Previous AMA- RFS public health standing committees have developed detailed power point documents that residents and fellows may use when they want present on the following public health topics:

- Health Literacy
- Tobacco Use
- Obesity
- Patient Safety
- Medicaid Made Simple

Our committee will review these documents to ensure they are current (changes will be made appropriately).

The Surgical Caucus of the American Medical Association (SCAMA)

A report from Kathryn Berndt, AMA-RFS Representative to the Executive Committee

The Surgical Caucus of the American Medical Association (SCAMA) is an organization created to provide a forum at each session of the House of Delegates for discussion and recommendations concerning professional and socioeconomic issues of particular interest to surgeons. Membership is open to all physicians who are designated by the AMA as practicing surgery or any of its subspecialties and who serve as delegates or alternate delegates at AMA meetings. Membership is open to RFS delegates, and dues are waived for resident members. Membership is also extended to physicians who are not surgeons but who practice in specialties with significant clinical interactions with surgeons such as anesthesiology, critical care, emergency medicine, interventional cardiology and interventional radiology.

At each AMA Annual and Interim HOD, SCAMA holds two important sessions. The first is a caucus to review the Resolutions, Reports, and other business of the HOD. This is an open forum, and issues felt to be relevant to the surgical professions are discussed, and SCAMA positions determined.

The other important session is a CME session, which is the highlight of the SCAMA program. At the AMA Annual meeting in June, 2008, the topic of discussion was "Medical Tourism", presented by Dr. Unti, a member of the FACS. The presentation was informative and provocative as Dr. Unti spoke of the many American insurance companies that are providing financial incentives for their insured to go to other countries to receive their medical care/surgeries and the pros and cons of such actions. After an excellent presentation, there was an animated question and answer period. It was an outstanding session.

The SCAMA Executive Committee is working hard on both recruiting new members and continued collaboration with other specialty societies. We will continue to offer outstanding CME sessions at every meeting. An invitation is extended for any who wish to attend SCAMA meetings. If you have any questions, or want to address a particular resolution at I-08, please feel free to contact me. We look forward to seeing you in Orlando.

Respectfully Submitted

Kathryn L Berndt, MD