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A
Meeting schedule, announcements, and registrants
# 2017 Interim Meeting

## AMA Academic Physicians Section and Governing Council

### November 10-11, Hilton Hawaiian Village and Hawaii Convention Center, Honolulu, Hawaii

### AMA House of Delegates meeting

#### November 11-14, Hawaii Convention Center, Honolulu, Hawaii

<table>
<thead>
<tr>
<th>Friday, November 10</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 a.m.</td>
<td>APS Governing Council: continental breakfast available (invitation only)</td>
<td>Hilton – Sea Pearl 3</td>
</tr>
<tr>
<td>7:30 a.m. – 12 p.m.</td>
<td>APS Governing Council meeting (invitation only) (Lunch served at 11 a.m.)</td>
<td></td>
</tr>
<tr>
<td>12 p.m.</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>12:30 p.m. – 1:15 p.m.</td>
<td>APS orientation/networking session: Special topic: Professional development and membership - Ken Simons, MD, APS delegate - Jacqueline Bello, MD, chair, Nominations Committee, Council on Medical Education - Peter Carmel, MD, APS membership committee chair</td>
<td>Hilton – Tapa 1</td>
</tr>
<tr>
<td>1:15 p.m.</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>1:30 – 3:50 p.m.</td>
<td>APS business meeting, first session: Streamlining the UME/GME transition</td>
<td>Hilton – Tapa 1</td>
</tr>
<tr>
<td>1:30 p.m.</td>
<td>APS meeting welcome and introductions George Mejicano, MD, chair, APS Governing Council</td>
<td></td>
</tr>
<tr>
<td>1:45 p.m.</td>
<td>Greeting from host medical school: University of Hawaii John A. Burns School of Medicine Patricia Lanoie Blanchette, MD, MPH, Associate Dean for Clinical Affairs</td>
<td></td>
</tr>
<tr>
<td>2 p.m.</td>
<td>Update on the AMA Accelerating Change in Medical Education initiative Susan Skochelak, MD, MPH, group vice president, medical education, AMA</td>
<td></td>
</tr>
<tr>
<td>2:15 p.m.</td>
<td>Changes to Accreditation Council for Graduate Medical Education Core Requirements and their impact on academic physicians Ken Simons, MD, APS delegate</td>
<td></td>
</tr>
<tr>
<td>2:30 p.m.</td>
<td>Networking break</td>
<td></td>
</tr>
<tr>
<td>2:45 p.m.</td>
<td>Streamlining the residency application and match process for program directors and medical students: Video interviews, E-SLOE, MSPE, VSAS, and more Zach Jarou, MD, president, Emergency Medicine Residents’ Association Arnab Sarker, medical student, University of Virginia School of Medicine</td>
<td></td>
</tr>
<tr>
<td>3:45 p.m.</td>
<td>Open discussion, new business, and organizational updates</td>
<td></td>
</tr>
<tr>
<td>3:50 p.m.</td>
<td>Closing remarks and adjournment (first session) George Mejicano, MD, chair, APS Governing Council</td>
<td></td>
</tr>
<tr>
<td>4 – 6 p.m.</td>
<td>AMA Research Symposium (APS members are requested to serve as judges)</td>
<td>Center - Kamehameha Exhibit Halls – 1st Level</td>
</tr>
<tr>
<td>7 p.m.</td>
<td>Joint Council on Medical Education and APS Governing Council dinner (invitation only)</td>
<td>Tommy Bahama 298 Beachwalk Drive</td>
</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td>Location</td>
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<td>--------------</td>
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</tr>
<tr>
<td>7:30 – 8:45 a.m.</td>
<td><strong>APS business meeting, second session</strong></td>
<td>Center – 317B</td>
</tr>
<tr>
<td>7:30 a.m.</td>
<td>APS meeting welcome and introductions&lt;br&gt;George Mejicano, MD, chair, APS Governing Council</td>
<td></td>
</tr>
<tr>
<td>7:40 a.m.</td>
<td>APS debate/voting on AMA House of Delegates’ business items&lt;br&gt;Ken Simons, MD, APS delegate</td>
<td></td>
</tr>
<tr>
<td>8:45 a.m.</td>
<td>Closing remarks and adjournment of APS business meeting&lt;br&gt;George Mejicano, MD, chair, APS Governing Council</td>
<td></td>
</tr>
<tr>
<td>8:50 a.m.</td>
<td>Networking break</td>
<td></td>
</tr>
<tr>
<td>9 – 10 a.m.</td>
<td>Educational sessions, Track 1 (Advocacy and Practice Trends, Professional Satisfaction, Physician Leadership)</td>
<td>Center – 310, 315, or 320</td>
</tr>
<tr>
<td>10 a.m.</td>
<td>Networking break</td>
<td></td>
</tr>
<tr>
<td>10:10 – 11:10 a.m.</td>
<td>Educational sessions, Track 2 (Advocacy and Practice Trends, Professional Satisfaction, Physician Leadership)</td>
<td>Center – 310, 315, or 320</td>
</tr>
<tr>
<td>11:10 a.m.</td>
<td>Networking break</td>
<td></td>
</tr>
<tr>
<td>11:20 a.m. – 12:20 p.m.</td>
<td>Educational sessions, Track 3 (Advocacy and Practice Trends, Professional Satisfaction, Physician Leadership)</td>
<td>Center – 310, 315, or 320</td>
</tr>
<tr>
<td>12 – 1:30 p.m.</td>
<td>Keeping your brain fit&lt;br&gt;Allan A. Anderson, MD, Assistant Professor, Johns Hopkins School of Medicine; Jeremy A. Lazarus, MD, Past President, AMA</td>
<td>Center - 312</td>
</tr>
<tr>
<td>2 p.m.</td>
<td>AMA-HOD opening</td>
<td>Center - Kalakaua Ballroom; 4th Floor</td>
</tr>
<tr>
<td>5 p.m.</td>
<td>Academic Medicine Caucus</td>
<td>Center 323A</td>
</tr>
<tr>
<td><strong>Sunday, November 12</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7:30 a.m.</td>
<td>APS preparation for Reference Committee testimony (optional)&lt;br&gt;APS delegate/alternate delegate and all APS members testifying on behalf of the APS</td>
<td>Center Conference Room A</td>
</tr>
<tr>
<td>8 a.m.</td>
<td>AMA-HOD second opening</td>
<td>Center - Kalakaua Ballroom; 4th Floor</td>
</tr>
<tr>
<td>8:30 a.m. – noon</td>
<td>AMA-HOD Reference Committee hearings&lt;br&gt;APS delegate/alternate delegate</td>
<td>As assigned</td>
</tr>
<tr>
<td>1:30 p.m. – 5 p.m.</td>
<td>Educational/ancillary sessions</td>
<td>As assigned</td>
</tr>
<tr>
<td><strong>Monday, November 13</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 – 11 a.m.</td>
<td>Educational/ancillary sessions</td>
<td>As assigned</td>
</tr>
<tr>
<td>9:30 – 11 a.m.</td>
<td>Academic Medicine Caucus</td>
<td>Center – 322B</td>
</tr>
<tr>
<td>2 – 6 p.m.</td>
<td>AMA-HOD business session&lt;br&gt;APS delegate/alternate delegate</td>
<td>Center - Kalakaua Ballroom; 4th Floor</td>
</tr>
<tr>
<td><strong>Tuesday, November 14</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 a.m. – noon</td>
<td>AMA-HOD Business Session&lt;br&gt;APS delegate/alternate delegate</td>
<td>Center - Kalakaua Ballroom; 4th Floor</td>
</tr>
</tbody>
</table>
2 Meeting announcements

- **Evaluation form**—To help us improve our future meetings, please be sure to complete the online meeting evaluation, available at: surveymonkey.com/r/i17-aps.

- **Elections**—To be credentialed as a voting member of the APS, current membership in the AMA will be verified. Nominations for the 2018-2019 Governing Council open in January 2018 (see Tab C).

- **Join the APS**—All AMA-member physicians with an interest in medical education, including those with or without a faculty appointment to a U.S. medical school, are welcome to join the APS. Please fill out the APS membership form in this book and provide it to staff.

- **Testify at Reference Committee hearings**—Section members are encouraged to attend the AMA House of Delegates Reference Committee meetings to help present the views of the Section. Those who wish to provide testimony on behalf of the APS should attend the meeting to prepare for APS testimony, Sunday morning at 7:30 a.m. in Center Conference Room A.

- **Academic Medicine Caucus**—All academic physicians and AMA delegates and alternates with an academic appointment are invited to attend the AMA Academic Medicine Caucus, 5 to 6 p.m. on Saturday, November 11, in Center 323 Room, and/or 9:30 to 11 a.m. on Monday, November 13, in Center 322B Room. Attendees will discuss issues of mutual concern and interest pertaining to academic medicine. Come network with your colleagues and share your ideas on how the AMA can continue to provide leadership in medical education.

- **Next Section meeting**—June 8-9, 2018, in Chicago.
## 3 Meeting registrants

*As of October 21, 2017*

<table>
<thead>
<tr>
<th>Institution</th>
<th>State</th>
<th>Name, title</th>
<th>Dean APS member</th>
<th>First-time attendee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edward Via College of Osteopathic Medicine</td>
<td>AL</td>
<td>Jeremy White, DO, PhD, Chair of Emergency Medicine</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of Arizona College of Medicine</td>
<td>AZ</td>
<td>Katie Marsh, Regional Medical Student</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of Arizona College of Medicine</td>
<td>AZ</td>
<td>Marlys Witte, MD, Director, Medical Student Research Program, Director, Lymphology Laboratories, Professor of Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keck School of Medicine of the University of Southern California</td>
<td>CA</td>
<td>Erick Eiting, MD</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of California, San Diego School of Medicine</td>
<td>CA</td>
<td>Kyle P. Edmonds, MD, Clinical Associate Professor, Palliative Care, AAHPM delegate</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>University of Colorado School of Medicine</td>
<td>CO</td>
<td>Donald G. Eckhoff, MD, Professor, Orthopaedics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yale University School of Medicine</td>
<td>CT</td>
<td>Tobias D. Wasser, MD, Assistant Professor of Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yale University School of Medicine</td>
<td>CT</td>
<td>Stephen J Huot, MD, PhD, Associate Dean for Graduate Medical Education, Professor of Medicine</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Charles E. Schmidt College of Medicine at Florida Atlantic University</td>
<td>FL</td>
<td>Henry Haire, MD, Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nova Southeastern University College of Osteopathic Medicine</td>
<td>FL</td>
<td>Sean Willis</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of Central Florida College of Medicine</td>
<td>FL</td>
<td>Nita Kohli, MD, Volunteer faculty, Assistant Professor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emory University School of Medicine</td>
<td>GA</td>
<td>Shaminie Das, MD, MBA, MPH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emory University School of Medicine</td>
<td>GA</td>
<td>Tracey Henry, MD, Assistant Professor Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercer University School of Medicine</td>
<td>GA</td>
<td>Hassan Yousaf, MD</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Morehouse School of Medicine</td>
<td>GA</td>
<td>Titilope Olanipekun, MD, Resident Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Hawaii John A. Burns School of Medicine</td>
<td>HI</td>
<td>John Melish, MD, Professor of Medicine</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of Hawaii John A. Burns School of Medicine</td>
<td>HI</td>
<td>Patricia Lanoie Blanchette, MD, MPH, Interim Associate Dean for Medical Education, Emeritus Professor of Geriatric Medicine</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>American Academy of Pediatrics</td>
<td>IL</td>
<td>Toluwalase &quot;Lase&quot; Ajayi, MD</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Chicago Medical School at Rosalind Franklin University of Medicine &amp; Science</td>
<td>IL</td>
<td>Muhammad Padela, BA</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Chicago Medical School at Rosalind Franklin University of Medicine &amp; Science</td>
<td>IL</td>
<td>Tamara Spasojevic, MD</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of Illinois College of Medicine</td>
<td>IL</td>
<td>Muhammad Junaid, MD</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of Illinois College of Medicine</td>
<td>IL</td>
<td>Allison Jones, MD, MS, FACOEM, AMA-ACOEM, YPS rep</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of Illinois College of Medicine</td>
<td>IL</td>
<td>Nimrod Deiss-Yehiely, MD, Candidate, 4th year medical student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University of Kentucky College of Medicine</td>
<td>KY</td>
<td>Suzanne Lababidi, MD</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>University of Louisville School of Medicine</td>
<td>KY</td>
<td>John L. Roberts, MD, Vice Dean for</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Institution</td>
<td>State/Province</td>
<td>Name</td>
<td>Title</td>
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<tr>
<td>26.</td>
<td>Louisiana State University School of Medicine - New Orleans</td>
<td>LA</td>
<td>Subramanya Konde, MD</td>
<td>Yes</td>
</tr>
<tr>
<td>27.</td>
<td>Louisiana State University School of Medicine - New Orleans</td>
<td>LA</td>
<td>Tina Benoit, MD, Clinical Assistant Professor &amp; Associate Program Director</td>
<td>Yes</td>
</tr>
<tr>
<td>28.</td>
<td>Boston University School of Medicine</td>
<td>MA</td>
<td>Carolyn Kan</td>
<td>Yes</td>
</tr>
<tr>
<td>29.</td>
<td>Harvard Medical School</td>
<td>MA</td>
<td>Fatima Stanford, MD, MPH, MPA, Obesity Medicine Physician</td>
<td>Yes</td>
</tr>
<tr>
<td>30.</td>
<td>Harvard Medical School</td>
<td>MA</td>
<td>Henry L. Dorkin, MD, Associate Professor, Pediatrics, Co-Director, Cystic Fibrosis Center</td>
<td>Yes</td>
</tr>
<tr>
<td>31.</td>
<td>American Association of Colleges of Osteopathic Medicine</td>
<td>MD</td>
<td>Tyler Cymet, DO, Chief of Clinical Education</td>
<td>Yes</td>
</tr>
<tr>
<td>32.</td>
<td>Beaumont Hospital</td>
<td>MI</td>
<td>Vivek Jayaschandran, MBBS</td>
<td>Yes</td>
</tr>
<tr>
<td>33.</td>
<td>Henry Ford Hospital</td>
<td>MI</td>
<td>Asaad Nakhle, MD</td>
<td>Yes</td>
</tr>
<tr>
<td>34.</td>
<td>Michigan State University College of Human Medicine</td>
<td>MI</td>
<td>Venkat Rao, MD, Clinical professor, Department of Medicine</td>
<td>Yes</td>
</tr>
<tr>
<td>35.</td>
<td>Michigan State University College of Osteopathic Medicine</td>
<td>MI</td>
<td>Sunit Tolia, DO, Fellow</td>
<td>Yes</td>
</tr>
<tr>
<td>36.</td>
<td>Oakland University William Beaumont School of Medicine</td>
<td>MI</td>
<td>Christienne Shams, MD</td>
<td>Yes</td>
</tr>
<tr>
<td>37.</td>
<td>Wayne State University School of Medicine</td>
<td>MI</td>
<td>Robert J. Sokol, MD, Emeritus Dean and Emeritus Distinguished Professor, Obstetrics &amp; Gynecology &amp; Physiology, Adjunct Professor of Epidemiology, Mich State U College of Human Medicine</td>
<td>Yes</td>
</tr>
<tr>
<td>38.</td>
<td>Western Michigan University Homer Stryker M.D. School of Medicine</td>
<td>MI</td>
<td>Mohamed Mrtagy, MD</td>
<td>Yes</td>
</tr>
<tr>
<td>39.</td>
<td>Western Michigan University Homer Stryker M.D. School of Medicine</td>
<td>MI</td>
<td>Hal B. Jenson, MD, MBA, Founding Dean</td>
<td>Yes</td>
</tr>
<tr>
<td>40.</td>
<td>University of Minnesota Medical School</td>
<td>MN</td>
<td>Raymond G. Christensen, MD, Associate Dean for Rural Health, Assoc Prof, FM</td>
<td>Yes</td>
</tr>
<tr>
<td>41.</td>
<td>University of Missouri-Columbia School of Medicine</td>
<td>MO</td>
<td>Scott E. Kinkade, MD, MSPH, Associate Professor</td>
<td>Yes</td>
</tr>
<tr>
<td>42.</td>
<td>University of Mississippi School of Medicine</td>
<td>MS</td>
<td>Sharon P. Douglas, MD, Associate Dean for Veterans Administration Education, Professor of Medicine</td>
<td>Yes</td>
</tr>
<tr>
<td>43.</td>
<td>Rutgers New Jersey Medical School</td>
<td>NJ</td>
<td>Adaora Madubuko, MD</td>
<td>Yes</td>
</tr>
<tr>
<td>44.</td>
<td>Rutgers Robert Wood Johnson Medical School</td>
<td>NJ</td>
<td>David E. Swee, MD, Associate Dean for Faculty Affairs</td>
<td>Yes</td>
</tr>
<tr>
<td>45.</td>
<td>Albany Medical College</td>
<td>NY</td>
<td>Siddharth Bhargava, BS</td>
<td>Yes</td>
</tr>
<tr>
<td>46.</td>
<td>Albert Einstein College of Medicine</td>
<td>NY</td>
<td>Sean O'Keefe</td>
<td>Yes</td>
</tr>
<tr>
<td>47.</td>
<td>Albert Einstein College of Medicine</td>
<td>NY</td>
<td>Dahlia Kenawy, BSE</td>
<td>Yes</td>
</tr>
<tr>
<td>48.</td>
<td>Not applicable/none</td>
<td>NY</td>
<td>Ogechukwu Egini, MD</td>
<td>Yes</td>
</tr>
<tr>
<td>49.</td>
<td>SUNY Buffalo Jacobs School of Medicine and Biomedical Sciences</td>
<td>NY</td>
<td>Alan Kiltzke, MD, FACNM, Assistant Professor of Radiology, Nuclear Medicine and Oncology</td>
<td>Yes</td>
</tr>
<tr>
<td>50.</td>
<td>Touro College of Osteopathic Medicine</td>
<td>NY</td>
<td>Johanna Javier, DO</td>
<td>Yes</td>
</tr>
<tr>
<td>51.</td>
<td>Case Western Reserve University School of Medicine</td>
<td>OH</td>
<td>Kavita Shah Arora, MD, MBE, Assistant Professor of Reproductive Biology and Bioethics, YPS alternate delegate</td>
<td>Yes</td>
</tr>
<tr>
<td>52.</td>
<td>The Cleveland Clinic Foundation</td>
<td>OH</td>
<td>Hans C. Arora, MD, PhD, Resident, Urology, RFS delegate</td>
<td>Yes</td>
</tr>
<tr>
<td>53.</td>
<td>University of Cincinnati College of Medicine</td>
<td>OH</td>
<td>Colleen Kraft, MD, President-Elect</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Institution</td>
<td>State</td>
<td>Name</td>
<td>Position/Title</td>
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<tr>
<td>54</td>
<td>University of Toledo College of Medicine</td>
<td>OH</td>
<td>Donna Woodson, MD</td>
<td>Professor, Department of Public Health &amp; Preventive Medicine, Director of Women's Health, Office of Medical Education</td>
</tr>
<tr>
<td>55</td>
<td>Oregon Health and Science University School of Medicine</td>
<td>OR</td>
<td>George Mejicano, MD, MS, FACP, Senior Associate Dean for Education, Professor of Medicine</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Geisinger Commonwealth School of Medicine</td>
<td>PA</td>
<td>Raghuvaner Puttagunta, MD, Resident - Internal Medicine/Pediatrics</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Geisinger Medical Center</td>
<td>PA</td>
<td>Michael J. Suk, MD, JD, PhD, Chairman, Orthopaedic Surgery</td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Raymond and Ruth Perelman School of Medicine at the University of Pennsylvania</td>
<td>PA</td>
<td>Adam L. Rubin, MD, Assistant Professor of Dermatology</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Sidney Kimmel Medical College of Thomas Jefferson University</td>
<td>PA</td>
<td>Theodore A. Christopher, MD, Professor and Chair, Emergency Medicine Administration Management &amp; Leadership</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>University of Pittsburgh School of Medicine</td>
<td>PA</td>
<td>John P. Williams, MD, Professor</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>University of Pittsburgh School of Medicine</td>
<td>PA</td>
<td>Wendy E. Braun, MD, MPH, MSEd, FACP, Professor, Health Policy and Management, Director and Associate Dean, Center for Public Health Practice</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Meharry Medical College</td>
<td>TN</td>
<td>Esengohe Adun, Biology BS</td>
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<td>TX</td>
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<td>Makenzie Hodge, MD, Resident</td>
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<td>UT</td>
<td>Eric Millican, MD</td>
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<td>Cynda Ann Johnson, MD, MBA, President and Founding Dean</td>
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<td>Kenneth B. Simons, MD, Senior Associate Dean for Graduate Medical Education and Accreditation, Executive Director and DIO, MCWAH, Inc.</td>
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<td>Klint Peebles, MD, Assistant Professor of Dermatology</td>
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<td>69</td>
<td>University of Wisconsin School of Medicine and Public Health</td>
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<td>Chiadika Nwanze, Medical Student</td>
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HOD business items of relevance to medical education and academic physicians

**October 25, 2017**

**Reference Committee B**

1. **Res 229: Opposition to Licensing for Individuals Holding the Degree of Doctor of Medical Science**

**Reference Committee J**

2. **Res 812: Medicare Coverage of Services Provided by Proctored Medical Students**

**Reference Committee K**

3. **CME 1: Promoting and Reaffirming Domestic Medical School Clerkship Education (Resolution 308-I-16)**
4. **Res 914: Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposure**
5. **Res 952: Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training**
7. **Res 954: Developing Physician Led Public Health/Population Health Capacity in Rural Communities**
8. **Res 955: Minimization of Bias in the Electronic Residency Application Service Residency Application**
10. **Res 957: Standardization of Family Planning Training Opportunities in OB-GYN Residencies**
11. **Res 958: Sex and Gender Based Medicine in Clinical Medical Education**
12. **Res 959: Lifestyle Medicine Education in Medical School Training and Practice**
Resolution: 229 (I-17)

Introduced by: Georgia

Subject: Opposition to Licensing for Individuals Holding the Degree of Doctor of Medical Science

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

1 Whereas, Ensuring access to quality medical care is unquestionably a challenge in Georgia and across the country; and
2 Whereas, Physician education and training is rigorous and reliably tested through our SHELF exams, Step Exams, and our Board exams; and
3 Whereas There has been an influx of non-physician providers who wish to practice independent of physician supervision or collaboration, ostensibly to help fill the need for medical care in underserved areas; and
4 Whereas, It has been shown that non-physician providers do not, indeed, practice in underserved areas in any greater numbers than physicians do; and
5 Whereas, A new degree, the “Doctor of Medical Science”, has been created by a single university, and is intended to allow Physician Assistants a pathway to fully independent practice of medicine; and
6 Whereas, This “Doctor of Medical Science” degree is not yet recognized by any state as valid for producing a competent, independent medical practitioner; and
7 Whereas, We believe that all patients deserve to be treated by a fully trained medical physician (MD or DO); therefore be it

RESOLVED, That our American Medical Association develop model legislation for states that would oppose the holders of the degree of Doctor of Medical Science from being recognized as a new category of health care practitioners licensed for the independent practice of medicine.

(Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/24/17

RELEVANT AMA POLICY

Scope of Practice Model Legislation D-35.996
Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners’ scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and
demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation as a framework to deal with questions regarding non-physician independent practitioners’ scope of practice.

Res. 923, I-03; Reaffirmed: BOT Rep. 28, A-13

Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners H-270.958
1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.
2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

BOT Action in response to referred for decision Res. 902, I-06; Reaffirmed: BOT Rep. 06, A-16

Physician and Nonphysician Licensure and Scope of Practice D-160.995
Our AMA will: (1) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (2) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (3) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.


Practicing Medicine by Non-Physicians H-160.949
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Whereas, Current trends in medical education in the US often lead to medical students providing medical services under the practiced eyes of proctoring medical professionals (both teaching physicians and other health care providers such as medical assistants and respiratory therapists); and

Whereas, Services provided by intern or resident physicians are billable under Centers for Medicare and Medicaid Services (CMS) through the Medicare Physician Fee Schedule if a teaching physician is physically present during the critical or key portions of the service; and

Whereas, Services provided by medical students (such as obtaining a Pap smear or setting up a nebulizer treatment) are not currently billable under CMS even if proctoring medical professionals are directly assisting or overseeing the service as part of medical education; and

Whereas, The inability to bill for these services may result in unnecessary duplication of services for patients, including the potential risk of repetitive minor procedures; and

Whereas, The inability to bill for these services may also result in restrictions in medical student education access since the educational facility may not be able to sustain the educational process without the procedural revenue; therefore be it

RESOLVED, That our American Medical Association amend Policy, H-390.999, “Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries,” by addition as follows:

When a physician assumes responsibility for the services rendered to a patient by a medical student, a resident, or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services to require coverage of medical services performed by medical students while under the physician's personal observation, direction, and supervision. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 09/29/17
RELEVANT AMA POLICY

Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries H-390.999
When a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision.


Clinical Proctoring H-375.974
AMA policy states that clinical proctoring is an important tool for education and the evaluation of clinical competence of new physicians seeking privileges or existing medical staff members requesting new privileges. Therefore, the AMA:

1. encourages hospital medical staffs to develop proctoring programs, with appropriate medical staff bylaws provisions, to evaluate the clinical competency of new physicians seeking privileges and existing medical staff members requesting new privileges; and

2. encourages hospital medical staffs to consider including the following provisions in their medical staff bylaws for use in their proctoring program:
   a. Except as otherwise determined by the medical executive committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring.
   b. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance of an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine the suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee.
   c. The members shall remain subject to such proctoring until the medical executive committee has been furnished with: a report signed by the chair of the department(s) to which the member is assigned as well as other department(s) in which the appointee may exercise clinical privileges, describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogative of the category to which the appointment was made, and that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

Citation: (BOT Rep. 30-A-94; Amended: CMS Rep. 3, A-99; Reaffirmed: CLRPD Rep. 1, A-09)

Supervision and Proctoring by Facility Medical Staff H-375.967
Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:

1. Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.

2. Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.

3. AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.

4. The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.

5. The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.

6. The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.

7. Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.

8. Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcripted by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.

9. Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports.

Citation: (CMS Rep. 3, A-99; Reaffirmed: CLRPD Rep. 1, A-09)

APS meeting, Nov. 2017 16 of 116
REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-17)
Promoting and Reaffirming Domestic Medical School Clerkship Education (Resolution 308-I-16)
(Reference Committee K)

EXECUTIVE SUMMARY

The catalyst for this report was Resolution 308-I-16, “Promoting and Reaffirming Domestic Medical School Clerkship Education,” from the Medical Student Section, which asked that our American Medical Association (AMA): 1) pursue legislative and/or regulatory avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition amongst medical schools and prevent unnecessary increases in domestically-trained medical student debt; 2) support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and 3) reaffirm policies D-295.320, D-295.931, and D-295.937. Due to the complexity of the issues surrounding this topic, the resolution was referred.

This report considers concerns that have been raised about the availability of clinical clerkship training sites due to continuing increases in the enrollment of U.S. allopathic and osteopathic medical schools and in the absolute numbers of U.S. medical schools—as well as the growing number of foreign medical schools that seek to place their students in clerkships in U.S. institutions. These schools, which cater primarily to U.S. citizen international medical graduates (USIMGs), are generally located in the Caribbean, and are sometimes referred to as “offshore medical schools.” The educational experience of U.S. medical students could be compromised through competition with other learners for faculty attention and access to patients.

This report comprises:

- A review of state efforts to address this issue, in New York and Texas
- A summary of relevant medical school accreditation standards
- An analysis of potential implications for the physician workforce
- Consideration of legal and antitrust issues around this issue
- A review of past Council on Medical Education reports and AMA policy on this topic
- Proposed emendations to current AMA policy to strengthen and streamline the AMA’s position on this important topic
REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-17

Subject: Promoting and Reaffirming Domestic Medical School Clerkship Education (Resolution 308-I-16)

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee K (L. Samuel Wann, MD, Chair)

GENESIS AND OUTLINE

Resolution 308-I-16, “Promoting and Reaffirming Domestic Medical School Clerkship Education,” introduced by the Medical Student Section, asked that the American Medical Association (AMA): 1) pursue legislative and/or regulatory avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition among medical schools and prevent unnecessary increases in domestically-trained medical student debt; 2) support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and 3) reaffirm policies D-295.320, D-295.931, and D-295.937.

Testimony at Reference Committee C during the 2016 Interim Meeting was unanimous in support of referral of Resolution 308. This is a complex issue, with numerous factors, ranging from state law to physician workforce implications. It was felt that a thorough analysis by the Council on Medical Education was required to ensure an in-depth, nuanced solution to this issue—one that involves all key stakeholders and places patient care and education needs at the forefront. Accordingly, Resolution 308-I-16 was referred.

This report comprises:

- A review of state efforts to address this issue, in New York and Texas.
- A summary of relevant medical school accreditation standards.
- An analysis of potential implications for the physician workforce.
- Consideration of legal and antitrust issues around this issue.
- A review of past Council on Medical Education reports and AMA policy on this topic.

BACKGROUND

Clinical clerkships are required of medical school programs accredited by the Liaison Committee on Medical Education (LCME). These clerkships are conducted, at least in part, within teaching hospitals with which the medical school has an affiliation or formal agreement for instruction of its students. The clinical phase of education traditionally takes place in years three and four in LCME-accredited medical schools.
Concerns have been raised about the availability of clinical clerkship training sites due to continuing increases in the enrollment of U.S. allopathic and osteopathic medical schools and in the absolute numbers of U.S. medical schools, as well as competition for placement sites from other health professions programs, such as nurse practitioner and physician assistant programs. Further, the extensive and ongoing consolidation in the health care industry has led to closure of multiple hospital facilities, with concomitant reduction in the number of sites available for clinical education. The educational experience of U.S. medical students could be compromised through competition with other learners for faculty attention and access to patients.

A final factor (which is most pertinent to this report) is the growing number of foreign medical schools that seek to place their students in clerkships in U.S. institutions—in particular, those schools that cater primarily to U.S. citizen international medical graduates (USIMGs). Many of these institutions are located in the Caribbean, and are sometimes referred to as “offshore medical schools.” The eight largest of these institutions (by number of students certified by the Educational Commission for Foreign Medical Graduates [ECFMG] in 2013) include:

- St George’s University School of Medicine (Grenada) 891
- Ross University School of Medicine (Dominica) 815
- American University of Antigua College of Medicine (Antigua and Barbuda) 347
- American University of the Caribbean (Sint Maarten) 281
- Saba University School of Medicine (Saba) 156
- Windsor University School of Medicine (Saint Kitts and Nevis) 139
- Medical University of the Americas (Saint Kitts and Nevis) 135
- Saint Matthew’s University (Cayman Islands) 129

(Note: A full list is available in Appendix A, as adapted from Eckhert NL, van Zanten M. Overview of For-Profit Schools in the Caribbean. 2014. Foundation for Advancement of International Medical Education and Research.)

Accreditation/approval of these institutions is the purview of a variety of bodies, each with varying standards and requirements for quality of education. These include seeking recognition through the Ministry of Education or Ministry of Health of the institution’s home country, or accreditation or approval from regional agencies, such as the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) and the Accreditation Commission on Colleges of Medicine, (a nonprofit organization in Ireland that inspects and accredits medical schools in countries that do not have a national medical accreditation body). As of 2023, the ECFMG will require that physicians applying for ECFMG Certification graduate from a medical school that has been “appropriately accredited”—that is, “accredited through a formal process that uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education (LCME) or that uses other globally accepted criteria, such as those put forth by the World Federation for Medical Education (WFME).”

Offshore medical schools typically do not own teaching hospitals. It is common for these students to complete their required clinical clerkships in another country, and the level of supervision and instruction provided to the medical student can vary widely. Medical students attending these schools tend to complete their required clinical clerkships in the U.S. Offshore medical schools are often willing to provide significant financial remuneration to secure slots for their students’ clerkship experiences. These funds are often an attractive source of revenue, particularly for urban hospitals/institutions in underserved areas.
In theory, U.S. medical schools could provide similar financial incentives to gain access to clinical sites or faculty. However, the cost would most likely be passed on to students in the same way such costs are covered for students who are attending offshore medical schools. This could result in raised tuition, and ultimately increase U.S. medical student debt (as noted in Resolve 1 of Resolution 308-I-16).

The buying (and selling) of clerkship slots benefits the offshore medical student seeking a clerkship as well as the offshore medical school and the stateside institution providing the clerkship. Medical schools (and medical students) in the United States, however, may be negatively affected. Data compiled from the 2012-2013 LCME Annual Medical Questionnaire (Part II) showed that, of the 136 medical school programs accredited at that time, 52.2 percent (71) saw increased difficulty in finding inpatient clinical placements for students in core clerkships. Of these schools, 25 attributed this increased difficulty in part to “competition for placement sites from offshore international medical schools” (along with other factors, including increase in class size and other U.S. schools in the region). Of the 15 states with the highest number of schools reporting such issues, 12 are in the northeast and mid-Atlantic regions and the upper Midwest.

STATE REGULATIONS

Nine states evaluate the physician’s clinical clerkships in connection with an application for licensure. In most states, clerkships for U.S. medical students must take place in hospitals affiliated with medical schools accredited by the LCME or with residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). A number of states have special rules that apply to students of non-LCME-accredited medical schools in the Caribbean.

New York

Since 1981, the New York State Board of Regents has had in place regulations on the eligibility of students enrolled in offshore medical schools for clinical clerkships in New York hospitals. In summary, only students from offshore medical schools that have been approved by the New York State Education Department are eligible to complete clinical clerkships totaling more than 12 weeks in New York teaching hospitals. In addition, students wishing to participate in such clerkships must pass the United States Medical Licensing Examination (USMLE) Step 1 examination, and the clerkship may only occur in a teaching hospital with which the offshore medical school has an approved affiliation agreement. In addition, the teaching hospital must have a residency program accredited by the ACGME in the clerkship discipline.

The approval process for offshore medical schools, handled by the New York State Education Department, is based on an assessment of educational quality similar to a medical school accreditation review. Students from medical schools that are unapproved by the department are limited to no more than 12 weeks’ clerkship experience in New York teaching hospitals.

In 2008, New York City Health and Hospitals Corporation signed a 10-year, $10 million exclusive contract with a state-approved offshore medical school, through which the school pays $400 per student per week for training slots. Several other such schools soon entered into similar agreements with other New York institutions, and a 2009 report subsequently found that “about half of the 4,000 medical students doing third- and fourth-year rotations in New York State were from offshore medical schools.” These agreements began to raise concern among U.S.-based educators as to the availability of clerkships for their own students, as well as concerns that accreditation standing might be jeopardized if the quality of clerkship experiences was negatively affected due to the sheer number of students in a given rotation.
One challenge in evaluating these concerns is that the literature is silent with respect to the appropriate number of medical students in a clerkship or the resources needed to assure that a rotation is “adequate,” and indeed, the “adequate” number of students may change based on patient population and geographic location. To attempt to better ascertain these data, the Association of Medical Schools of New York (AMSNY) fielded a survey of clerkship directors in 2009. A second iteration of that survey is scheduled soon. The survey, which included questions on the availability of an adequate number of faculty/residents/staff and patients, as well as physical and IT resources, concluded that:

- LCME and COCA standards control the educational behaviors of accredited schools, but have no influence on hospitals seeking to enhance revenue streams through the sale of clerkship “slots” to unaccredited bidders.
- The establishment of quantitative benchmarks may help schools in negotiations with their traditional academic affiliates.
- Legislative action may be needed to assure quality training and patient safety in state- or federal-regulated care delivery-sites.

Texas

In April 2013, the Texas legislature passed legislation to address growing concerns that affiliation agreements between offshore medical schools and Texas hospitals and other health care facilities would limit Texas medical students’ options for clinical training. Through the enacted legislation, the following subsection was added to the state’s Education Code:

(c) The board may not issue a certificate of authority for a private postsecondary institution to grant a professional degree or to represent that credits earned in this state are applicable toward a degree if the institution is chartered in a foreign country or has its principal office or primary educational program in a foreign country. In this subsection, “professional degree” includes a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Veterinary Medicine (D.V.M.), Juris Doctor (J.D.), and Bachelor of Laws (LL.B.)

The legislation was supported by the Texas Medical Association (TMA) and the state’s medical schools, which feared a diminution in the number of clinical clerkships for its medical students, due in part to the willingness of offshore medical schools to pay for clerkships for their students. With only one exception, Texas medical schools do not pay for clerkships and are in no position financially to do so. Had the state legislation not been passed, it would have been expected that Texas medical schools would not have been able to afford to compete in paying for clerkships, thereby displacing Texas medical students from long-standing clerkships at Texas teaching hospitals. As a result, medical schools would likely have been forced to participate in bidding wars for clerkship space, and, consequently, pass on this added cost to medical students, resulting in increased tuition and likely, increased student debt. Noted one of the co-authors of the Texas legislation, “Our Texas medical students should be prioritized, and we must ensure they have access to those clinical rotations without doing anything to jeopardize that. They are our investment. [The state] invests in medical education, and we have to protect that investment.”

The TMA’s advocacy on this issue was buttressed by policy adopted in 2013, which resulted from a report of the association’s Council on Medical Education (see Appendix B). The policy stated, in part, that the TMA “strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, our association strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities that lack sufficient educational resources for the
supervised teaching of clinical medicine.” In addition, the policy states, “2. Institutions that accept
students for clinical placements should ensure that all such students are trained in programs that
meet requirements for curriculum, clinical experiences, and attending supervision as expected for
[LCME- and COCA-accredited] programs…. 3. TMA opposes extraordinary payments by any
medical school for access to clinical rotations. 4. Foreign medical students should not displace
Texas medical students in clinical training positions at Texas health care facilities. Priority should
be given to Texas medical students and other health care professionals for clinical training.”

RELEVANT LCME STANDARDS

A number of LCME standards are relevant to the topic of this report, including:

4.1 Sufficiency of Faculty
A medical school has in place a sufficient cohort of faculty members with the qualifications and time required to deliver the medical curriculum and to meet the other needs and fulfill the other missions of the institution.

5.5 Resources for Clinical Instruction
A medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in ambulatory and inpatient settings and has adequate numbers and types of patients (e.g., acuity, case mix, age, gender).

5.10 Resources Used by Transfer/Visiting Students
The resources used by a medical school to accommodate any visiting and transfer medical students in its medical education program do not significantly diminish the resources available to already enrolled medical students.

10.8 Visiting Students
A medical school does all of the following:
• Verifies the credentials of each visiting medical student
• Ensures that each visiting medical student demonstrates qualifications comparable to those of the medical students he or she would join in educational experiences
• Maintains a complete roster of visiting medical students
• Approves each visiting medical student’s assignments
• Provides a performance assessment for each visiting medical student
• Establishes health-related protocols for such visiting medical students
• Identifies the administrative office that fulfills these responsibilities

LCME requirements also provide guidance as to faculty serving as supervisors for medical students from more than one institution. For example, a 2014 LCME white paper notes the following, in part:

4. A given medical school must evaluate the quality of its education across sites, including at the site(s) that serve(s) students from multiple schools, and must ensure and document that comparability exists in the curricular core, including in required clinical encounters.

5. There must be sufficient patient resources and faculty numbers so that medical students from each medical education program are able to meet their defined objectives and required clinical encounters and have appropriate levels of supervision and assessment.
The presence of students from another school must not diminish the access to resources needed by students from a given medical school to meet the objectives of the specific course/clerkship, including appropriate patients/procedures and faculty.

6. If two or more LCME-accredited medical schools share faculty at a given instructional site, there should be coordination between the schools, for example, an agreement that each medical school will have appropriate access to needed resources to support its medical education program.

Resources include: 1) faculty with sufficient time to teach each cohort of students and to participate in relevant faculty development, 2) patients sufficient to meet the required clinical conditions specified by each medical school, and 3) appropriate facilities for the total numbers of students at the site at any given time.

LIMITATIONS ON AMA ACTIONS

The types of actions that the AMA can take are limited by antitrust considerations. That is, the AMA as a private entity cannot act in concert with others to limit competition by attempting to deny or restrict access of medical students from offshore medical schools to U.S. teaching hospitals. The AMA can, however, advocate to governmental entities for such limitations as a means to assure the ongoing quality of the U.S. medical education system. The AMA can also develop model state legislation that would reflect best practices for financial remuneration of clerkships.

PAST COUNCIL ON MEDICAL EDUCATION REPORTS AND RELEVANT AMA POLICY

The availability of clerkships for medical students has been the topic of three recent Council on Medical Education reports:

2. Report 4-I-09, “Factors Affecting the Availability of Clinical Training Sites for Medical Student Education” (http://bit.ly/2tmi4ds)

As a result of these and other reports and resolutions, the AMA has a number of policies on this topic:

3. H-295.995 (30, 31), “Recommendations for Future Directions for Medical Education”
4. D-295.320, “Factors Affecting the Availability of Clinical Training Sites for Medical Student Education”
5. D-295.931, “Update on the Availability of Clinical Training Sites for Medical Student Education”

This report includes recommendations for revisions to consolidate and streamline these policies, as shown in Appendix C.
DISCUSSION

The issue of adequate availability of clerkships for U.S. medical students can be seen in the context of larger issues—in particular, the quality and quantity of the future physician workforce. That workforce comprises both U.S. medical school graduates as well as a significant number of IMGs (both U.S. citizens and noncitizens). To clarify thinking in this regard, several questions may be posed. For example, is the quality of education/training for U.S. medical students imperiled by competition for clerkships by students from offshore medical schools? Also, are USIMGs receiving an adequate education to prepare them for residency and practice in the U.S.?

Recent literature on this topic urges increased scrutiny of offshore medical schools and their graduates. Eckhert11 writes, “Just as the Flexner Report strengthened medical education by raising standards, recommending quality improvements, and suggesting closure of weaker schools, a present-day review of the schools [in other countries] whose purpose is to train physicians for the United States could lead to recommendations for improvement and/or accreditation, educational innovations, or sanctions against poorly performing medical schools.” She argues that the U.S. must “look beyond our borders to ensure that physicians around the world obtain the best possible education. To begin this effort close to home—in the Caribbean Basin—makes good sense, because the growing number of graduates from the [offshore medical schools] there will be part of the next generation of physicians caring for the U.S. public and practicing alongside U.S.-trained physicians.”

Likewise, note Halperin and Goldberg,12 “U.S. medical education today faces a threat similar to that leading up to the Flexner Report, although this time the schools that do not meet the training standards necessary to ensure public health are outside U.S. borders. A dire emergency is approaching that could compromise American medical education.” They call for a number of potential solutions; most pertinent to this report, these include that state higher education boards “deny students of proprietary offshore schools access to clinical education in U.S. teaching hospitals unless these schools meet accreditation standards equivalent to those expected of U.S. medical schools.” In addition, they urge additional legislation at the state level, similar to that passed in Texas in 2013, described above.

Related to the second question posed above, the educational standards of offshore medical schools are a topic of some concern—particularly as students at these institutions are able to obtain federal funding. Attrition (and tuition) rates are high, and educational resources often lack in comparison to those at LCME-accredited medical school programs. Norcini et al. raised concerns about “striking” gaps in clinical performance among practicing USIMGs versus their non-citizen IMG and U.S. medical school graduate counterparts, and proposed further research “to clarify whether [USIMG] performance is a result of their medical education experiences or their ability. To the degree that it is the former, U.S. citizens will need information about international medical schools on which to base their application decisions. To the degree that it is the latter, and as additional training opportunities become available for U.S. citizens, medical schools and residency programs will need to be more vigilant in their selection procedures and not accept students who lack the ability to perform as physicians.”13

As to the resolve clauses of Resolution 308-I-16, the AMA can pursue or support legislative and regulatory advocacy to promote fair competition amongst medical schools vying for clerkship positions. Additionally, the AMA can focus on educational quality, to include the appropriate number of students on a given clerkship at any one time, and address such educational aspects as curriculum, supervision, and procedural experience (logbooks). The AMA can work with interested
state and specialty medical associations to pursue legislation that addresses this issue and helps ensure a quality experience for all medical students.

Related to Resolve 2 of Resolution 308-I-16, fostering partnerships with hospitals that are not currently used for clinical teaching may benefit both students from offshore schools as well as U.S. students; this possibility also aligns with AMA policy on addressing geographic disparities in access to care. In fact, it may be appropriate that clerkship training slots be treated as public resources to help expand the physician workforce—particularly in underserved areas—versus being seen as the “property” of academic medical centers and teaching hospitals.

Finally, Resolve 3, which asks for reaffirmation of AMA policy, is obviated through the recommendations below, which incorporate changes to consolidate and streamline existing policy.

RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 308-I-16, and the remainder of the report be filed.

1. That our American Medical Association (AMA):

   1) Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: a) infrastructure and faculty development and capacity for medical school expansion; and b) delivery of clinical clerkships and other educational experiences. (Directive to Take Action)

   2) Encourage clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students. (Directive to Take Action)

   3) Advocate for federal and state legislation/regulations to:

      a. Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA);

      b. Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and

      c. Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA. (Directive to Take Action)

   4) Encourage relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so,
advocate for the development of appropriate regulations at the state level. (Directive to
Take Action)

5) Work with interested state and specialty medical associations to pursue legislation that
ensures the quality and availability of medical student clerkship positions for U.S. medical
students. (Directive to Take Action)

2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering
into appropriate relationships directed toward providing clinical educational experiences for
advanced medical students who have completed the equivalent of U.S. core clinical clerkships.
Policies governing the accreditation of U.S. medical education programs specify that core
clinical training be provided by the parent medical school; consequently, the AMA strongly
objects to the practice of substituting clinical experiences provided by U.S. institutions for core
clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the
placement of medical students in teaching hospitals and other clinical sites that lack
appropriate educational resources and experience for supervised teaching of clinical medicine,
especially when the presence of visiting students would disadvantage the institution’s own
students educationally and/or financially and negatively affect the quality of the educational
program and/or safety of patients receiving care at these sites. (New HOD Policy)

3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen
international medical students between foreign medical schools and teaching hospitals in
regions that are medically underserved and/or that lack medical schools and clinical sites for
training medical students, to maximize the cumulative clerkship experience for all students and
to expose these students to the possibility of medical practice in these areas. (New HOD
Policy)

4. U.S. citizens should have access to factual information on the requirements for licensure and
for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into
graduate medical education programs, and other relevant factors that should be considered
before deciding to undertake the study of medicine in schools not accredited by the LCME or
COCA. (New HOD Policy)

5. Existing requirements for foreign medical schools seeking Title IV Funding should be applied
to those schools that are currently exempt from these requirements, thus creating equal
standards for all foreign medical schools seeking Title IV Funding. (New HOD Policy)

and D-295.937 be rescinded, as described in Appendix C to this report. (Rescind HOD Policy)

Fiscal Note: $1,000 for staff time
APPENDIX A: OFFSHORE MEDICAL SCHOOLS IN 2013, BY NUMBER OF ECFMG-CERTIFIED STUDENTS/GRADUATES

<table>
<thead>
<tr>
<th>School</th>
<th>Location</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>St George’s University School of Medicine</td>
<td>Grenada</td>
<td>891</td>
</tr>
<tr>
<td>Ross University School of Medicine</td>
<td>Dominica</td>
<td>815</td>
</tr>
<tr>
<td>American University of Antigua College of Medicine</td>
<td>Antigua and Barbuda</td>
<td>347</td>
</tr>
<tr>
<td>American University of the Caribbean</td>
<td>Sint Maarten</td>
<td>281</td>
</tr>
<tr>
<td>Saba University School of Medicine</td>
<td>Saba (Special Municipality of the Netherlands)</td>
<td>156</td>
</tr>
<tr>
<td>Windsor University School of Medicine</td>
<td>Saint Kitts and Nevis</td>
<td>139</td>
</tr>
<tr>
<td>Medical University of the Americas</td>
<td>Saint Kitts and Nevis</td>
<td>135</td>
</tr>
<tr>
<td>Saint Matthew’s University</td>
<td>Cayman Islands</td>
<td>129</td>
</tr>
<tr>
<td>American University of Integrative Sciences</td>
<td>Sint Maarten</td>
<td>86</td>
</tr>
<tr>
<td>University of Medicine and Health Sciences</td>
<td>Saint Kitts and Nevis</td>
<td>56</td>
</tr>
<tr>
<td>Saint James School of Medicine</td>
<td>Saint Vincent and the Grenadines</td>
<td>49</td>
</tr>
<tr>
<td>Xavier University School of Medicine</td>
<td>Aruba</td>
<td>38</td>
</tr>
<tr>
<td>Avalon University School of Medicine</td>
<td>Curacao</td>
<td>24</td>
</tr>
<tr>
<td>Spartan Health Sciences University</td>
<td>Saint Lucia</td>
<td>23</td>
</tr>
<tr>
<td>Trinity School of Medicine</td>
<td>Saint Vincent and the Grenadines</td>
<td>16</td>
</tr>
<tr>
<td>Aureus University School of Medicine</td>
<td>Aruba</td>
<td>12</td>
</tr>
<tr>
<td>23 additional institutions</td>
<td>varies</td>
<td>Fewer than 10</td>
</tr>
</tbody>
</table>

APPENDIX B: REPORT 3-A-12 OF THE TEXAS MEDICAL ASSOCIATION COUNCIL ON MEDICAL EDUCATION

Subject: Clinical Training Resources for Texas Medical Students
Presented by: Cynthia A. Jumper, MD, Chair
Referred to: Reference Committee on Public Health, Science, and Education

A medical school in the Caribbean is seeking to establish affiliation agreements with Texas hospitals and other health care facilities to provide clinical training for its third- and fourth-year medical students to complete their core clinical clerkships in Texas. Our council has grave concerns about the potential damaging effects of a proposal that has the risk of displacing Texas medical students from the already limited clinical training capacity in our state. Our educational institutions already have commitments to Texas students to provide reasonable access to training opportunities. Diminishing our own students’ access to clinical training in the state would negatively affect the quality and affordability of education for Texas medical students, resident physicians, and other health professionals — all who need and deserve priority access to clinical training in the state.

Economic Impact

State support for educating medical students, resident physicians, and other health professionals was severely reduced in the 2012-13 state budget. At the same time, in response to increasing physician demand, Texas medical schools plan an increase of 30 percent in enrollments by 2015. This will result in an estimated total of 3,300 third- and fourth-year medical students each year — the highest numbers ever for our state. There is also a strong potential for a new four-year medical school in South Texas. This vigorous growth in enrollments clearly dictates a need for more hospital clinical training space for our own students in the very near future.

Adding foreign medical students simultaneously with the large Texas enrollment growth will only exacerbate the shortage of clinical training space. The limited supply could result in a considerable increase in the cost of clerkships for medical schools, as is occurring in northeastern states, that could force increases in medical school tuition and related student debt as well as the displacement of our own medical students, and threaten the accreditation status of our own schools.

Benefit to the State

Recognizing that the state has only limited training capacity and the potential financial impact on Texas medical schools and students, thoughtful consideration must be given to the potential benefit to the state. Texas ranks second in the nation, behind California, in the retention of our medical school graduates in the state, at 59 percent.1

In contrast, it is not known how many students enrolled in foreign medical schools would even have an interest in practicing in Texas. Substituting foreign students for Texas medical students would not benefit the state’s escalating physician workforce needs. It makes little sense for the state to invest at least $170,000 per year for each Texas medical student yet not provide for their reasonable access to core clinical clerkships in the state.

Further, as reported by the American Medical Association Medical Student Section in November 2011,
U.S. medical school accreditation standards require both a broad and significant portfolio of undergraduate experiences as well as a rigorous and specifically defined standard of preclinical education in the first two years of medical school before admitted, visiting, or transfer American medical students are allowed to participate in third year clerkships, yet for-profit offshore medical schools do not provide any standardized or equivalent system of evaluation before they participate in third year clerkships in American hospitals.

Availability of Clinical Faculty and Student Supervision Rules

Given the increases in our own medical school enrollment, it is unclear whether there are sufficient numbers of qualified clinical faculty to oversee the training of our own medical students in addition to foreign medical students. The Texas Medical Board has regulations that delineate specific requirements for physicians eligible to supervise medical students. The board’s rules also must be considered to ensure that medical students who complete clerkships in Texas would ultimately be eligible for medical licensure in the state.

Policy Proposals

Our council believes it is in the best interest of the state … for quality, education, workforce, as well as economic considerations … to ensure that Texas medical school students are provided first access to core clinical clerkships in the state. The council proposes adoption of the following principles as Texas Medical Association policy, including relevant policies of AMA, with their adaptation for Texas.

1. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the Texas Medical Association strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, our association strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities that lack sufficient educational resources for the supervised teaching of clinical medicine.

2. Institutions that accept students for clinical placements should ensure that all such students are trained in programs that meet requirements for curriculum, clinical experiences, and attending supervision as expected for programs accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation.

3. The Texas Medical Association opposes extraordinary payments by any medical school for access to clinical rotations.

4. Foreign medical students should not displace Texas medical students in clinical training positions at Texas health care facilities. Priority should be given to Texas medical students and other health care professionals for clinical training.

Recommendation: Approval as TMA policy.


ii. Texas Medical Board Program Rule, §162.1. Supervision of Medical Students.

(a) In order to supervise a medical student who is enrolled at a Texas medical school as a full-time student or visiting student the physician must have an active and unrestricted Texas license.
(b) In order to supervise a medical student who does not meet the criteria in subsection (a) of this section the physician must:

(1) have an active and unrestricted Texas license;
(2) hold a faculty position in the graduate medical education program in the same specialty in which the student will receive undergraduate medical education;
(3) supervise the student during the educational period; and
(4) supervise the student’s medical education in either a Texas hospital or teaching institution, which sponsors or participates in a program of graduate medical education accredited by the Accrediting Council for Graduate Medical Education, the American Osteopathic Association, or the Texas Medical Board in the same subject as the medical or osteopathic medical education in which the hospital or teaching institution has an agreement with the applicant’s school.

(c) If the physician is not licensed in Texas as required in subsection (a) or (b) of this section, the physician must be employed by the federal government and maintain an active and unrestricted license.

(d) Physician applicants who receive medical education in the United States in settings that do not comply with statutory requirements set forth in Texas Occupations Code §155.003(b) - (c) may be ineligible for licensure.
APPENDIX C: RECOMMENDED ACTIONS ON HOUSE OF DELEGATES’ POLICIES RELATED TO CLERKSHIPS

H-255.988, “AMA Principles on International Medical Graduates”

Delete 6, 23, and 25, for incorporation into the proposed new policy. These three items are more relevant to the topic of availability of clinical clerkships than to principles on international medical graduates.

Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school.
7. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
8. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
9. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
11. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
12. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
13. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
14. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state,
county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

16. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

17. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

18. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

19. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

20. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

21. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

22. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

23. Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school.

24. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

25. Our AMA supports the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

H-255.998, “Foreign Medical Graduates”

Rescind and incorporate into the proposed new policy.

Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs): Our AMA supports the practice of U.S. teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine.


H-295.995, “Recommendations for Future Directions for Medical Education”

Delete 30 and 31, for insertion into the proposed new policy.

Our AMA supports the following recommendations relating to the future directions for medical education:

1. The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
2. Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
3. Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
4. Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
5. Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
6. Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
7. Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
8. Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
9. Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one
of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.
(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.
(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.
(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.
(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.
(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.
(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.
(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.
(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.
(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be
assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME.

(31) Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects
to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine.

(32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(37) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.


D-295.320, “Factors Affecting the Availability of Clinical Training Sites for Medical Student Education”

Rescind and incorporate into the proposed new policy.

1. Our AMA will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion.
2. Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students.
3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured.
4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies.
5. Our AMA will advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of United States LCME/COCA students in clinical rotations. (CME Rep. 4, I-09 Appended: Sub. Res. 302, A-12 Modified: Res. 903, I-12 Modified: CME Rep. 1, I-13)

D-295.931, “Update on the Availability of Clinical Training Sites for Medical Student Education”

Rescind and incorporate into new proposed policy.

1. Our AMA will work with appropriate collaborators to study how to build additional institutional and faculty capacity in the US for delivering clinical education.
2. Our AMA, in collaboration with interested stakeholders, will:
   (a) study options to require that students from international medical schools who desire to take clerkships in US hospitals come from medical schools that are approved by an independent public or private organization, such as the Liaison Committee on Medical Education, using principles consistent with those used to accredit US medical schools;
   (b) advocate for regulations that will assure that international students taking clinical clerkships in US medical schools come from approved medical schools that assure educational quality that promotes patient safety; and
   (c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for curriculum, clinical experiences and attending supervision as expected for Liaison Committee on Medical Education and American Osteopathic Association accredited programs.
3. Our AMA will study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.
4. Our AMA opposes any arrangements of US medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially. (CME Rep. 2, I-08 Modified: CME Rep. 4, I-09 Reaffirmed: CME Rep. 1, I-13)

D-295.937, “Competition for Clinical Training Sites”

Rescind; this analysis was completed through Council on Medical Education Report 2-I-08, “Update on Availability of Clinical Training Sites for Medical Student Education.”

Our AMA will, through the Council of Medical Education, conduct an analysis of the adequacy of clinical training sites to accommodate the increasing number of medical students in the US accredited medical schools and study the impact of growing pressure, including political and financial, to accommodate clinical training in US hospitals for US citizen international medical students. (Res. 324, A-08)
### APPENDIX D: SUMMARY OF PROPOSED POLICY CHANGES

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
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<tr>
<td><strong>Our AMA will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion.</strong> D-295.320 (1)</td>
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<td><strong>Our AMA will work with appropriate collaborators to study how to build additional institutional and faculty capacity in the US for delivering clinical education.</strong> D-295.931 (1)</td>
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<td><strong>Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students.</strong> D-295.320 (2)</td>
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<td><strong>Our AMA will advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of United States LCME/COCA students in clinical rotations.</strong> D-295.320 (5)</td>
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<td><strong>Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies.</strong> D-295.320 (4)</td>
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<td><strong>Our AMA will advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for educational quality, (c) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for</strong></td>
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Our American Medical Association (AMA) will:

1. Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion and delivery of clinical education. (Directive to Take Action)
<table>
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<tr>
<th>Curriculum, clinical experiences and attending supervision as expected for Liaison Committee on Medical Education and American Osteopathic Association accredited programs. D-295.931 (2)</th>
<th>Curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA. (Directive to Take Action)</th>
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<tr>
<td>(b) advocate for regulations that will assure that international students taking clinical clerkships in US medical schools come from approved medical schools that assure educational quality that promotes patient safety D-295.931 (2)</td>
<td>4. Encourage relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level. (Directive to Take Action)</td>
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<td>Our AMA will study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level. D-295.931 (3)</td>
<td>5. Develop and disseminate to interested states model legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students. (Directive to Take Action)</td>
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<td>(new)</td>
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<td>Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs): Our AMA supports the practice of U.S. teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. H-255.998</td>
<td>Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution’s own students educationally and/or</td>
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<td>financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites. (New HOD Policy)</td>
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<td>The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school. H-255.988 (6)</td>
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<td>Our AMA opposes any arrangements of US medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially. D-295.931 (4)</td>
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<td>Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. D-295.320 (3)</td>
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<td>(new) 3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas. (New HOD Policy)</td>
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<td>Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school. H-255.988 (23)</td>
<td>U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of</td>
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<td>U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME. H-295.995 (30)</td>
<td>medicine in schools not accredited by the LCME or COCA. (New HOD Policy)</td>
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<td>Our AMA supports the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. H-255.988 (25)</td>
<td>Existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. (New HOD Policy)</td>
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<td>2. Our AMA, in collaboration with interested stakeholders, will: (a) study options to require that students from international medical schools who desire to take clerkships in US hospitals come from medical schools that are approved by an independent public or private organization, such as the Liaison Committee on Medical Education, using principles consistent with those used to accredit US medical schools D-295.931 (2)</td>
<td>Note: This is not needed in the new policy; as of 2023, the Educational Commission for Foreign Medical Graduates has announced that physicians applying for ECFMG certification will be required to graduate from a medical school that has been appropriately accredited. To satisfy this requirement, the physician’s medical school must be accredited through a formal process that uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education (LCME) or that uses other globally accepted criteria. The World Federation of Medical Education Recognition Programme will allow medical schools accredited by recognized agencies, and their graduates, to meet ECFMG’s accreditation requirement.</td>
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Resolution: 914
(I-17)

Introduced by: American Academy of Pediatrics

Subject: Support of Training, Ongoing Education, and Consultation In Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures

Referred to: Reference Committee K
(L. Samuel Wann, MD, Chair)

Whereas, A number of medical conditions have been associated with exposures to environmental chemicals in utero or during early development; and

Whereas, Differentiating likely causal connections from coincidental associations or confounders is complex and prone to misrepresentation; and

Whereas, Budgetary concerns threaten current and ongoing pediatric toxicological education and consultation services; and

Whereas, Socioeconomically disadvantaged and other susceptible populations are more likely to bear the health burden of many chemical exposures; therefore be it

RESOLVED, That our American Medical Association support the mission of and ongoing funding of academically-based regional Pediatric Environmental Health Specialty Units (PEHSU) by the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention (ATSDR/CDC) and the Environmental Protection Agency (EPA) (New HOD Policy); and be it further

RESOLVED, That our AMA support educational and consultative activities of the PEHSU program with local pediatricians, medical toxicologists, obstetricians, and others providing care to pregnant patients (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the continuing training of physicians specializing in pediatric environmental health. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/11/17
Resolution: 952
(I-17)

Introduced by: Resident and Fellow Section

Subject: Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training

Referred to: Reference Committee K
(L. Samuel Wann, MD, Chair)

Whereas, Inequalities in determinants of health and health outcomes continue to exist, with the color of a patient’s skin determining, at least in part, the quality of their health care; and

Whereas, Some of these disparities are due to differential treatment and care by physicians; and

Whereas, An ever-increasing number of patients in the United States identify as a member of a minority group, including approximately 38% of the current population; and

Whereas, Recognition of implicit bias and training in diversity and inclusion may mitigate both intentional and unintentional disparities in the provision of care to minority patients; and

Whereas, Reducing disparities requires national leadership to coordinate thoughtful, intentional action by leaders at each medical school and residency training program; therefore be it

RESOLVED, That our American Medical Association: (1) actively support the development and implementation of training implicit bias, diversity and inclusion as a component of medical education in all medical schools and residency programs; (2) identify and publicize effective strategies for educating residents in all specialties about disparities in their fields according to race and ethnicity, with particular regard to access to care and health outcomes; and (3) support research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes according to race and ethnicity. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 09/06/17


RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, race and ethnicity.

8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.


See also: Reducing Racial and Ethnic Disparities in Health Care D-350.995, Diversity in the Physician Workforce and Access to Care D-200.982
Whereas, The process of board certification has a central role in self-regulation of physician quality standards; and

Whereas, Each specialty has established non-profit organizations to administer this required evaluation to obtain and maintain board certification; and

Whereas, These organizations charge fees for the examination process that averages $110.00/year for family medicine to $610.00 per year for colon-rectal surgery; and

Whereas, The physicians taking the examination incur other costs such as review courses, travel expenses, and lost wages from their current practice; and

Whereas, Physician reimbursement has declined for many and further complicates the process involved in the cost of taking the exam; and

Whereas, The cumulative net assets of the various certifying organizations as stated in the reference below, is excessive and totals more than 584 million dollars (JAMA, August 1, 2017, Volume 318, #5: pages 477-479); therefore be it

RESOLVED, That our American Medical Association request reductions in Maintenance of Certification examination fees so as to work towards a balanced/neutral budget of ABMS medical boards given their status as non-profit organizations. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 09/18/17

The topic of this resolution is currently under study by the Council on Medical Education
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 954
(I-17)

Introduced by: West Virginia

Subject: Developing Physician Led Public Health/Population Health Capacity in Rural Communities

Referred to: Reference Committee K
(L. Samuel Wann, MD, Chair)

Whereas, Approximately 70% of the determinants of health status can be traced to environmental, preventive and life-style factors that are influenced by both primary care - patient and public health - community interventions of physicians; and

Whereas, There is a shortage of expertise in both such specialties, especially in rural communities; and

Whereas, Although many primary care physicians serve as “health officers”, other non-physician (even non-health professional) individuals with limited public health knowledge and skills lead the public health community effort in most rural communities; and

Whereas, Many primary care physicians have expressed a desire to greatly expand their public health/population health capacities, competencies and community leadership involvement but are not in a position to leave their practices for long periods to obtain board eligibility in preventive medicine and public health; and

Whereas, Many of these physicians have expressed a willingness to obtain the requisite public health board competencies through alternate “experiential” preceptorships, short didactic courses and other arrangements, while still maintaining the integrity of their practice; and

Whereas, The development of such expertise would greatly improve public health leadership, competencies and performance in such communities while, also, increasing physician presence and influence in overall community health policy and activities; therefore be it

RESOLVED, That our American Medical Association study, with the participation of the appropriate educational and certifying entities, innovative approaches that could be developed and/or implemented to promote interested physicians to obtain board eligibility in preventive medicine/public health to strengthen public health leadership, especially in rural communities. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 09/01/17
WHEREAS, the current Electronic Residency Application Service (ERAS) Residency Application should conform to the requirements of the U.S. Equal Employment Opportunity Commission (EEOC) by blinding the ERAS Residency Application to the "applicant's age, race, religion, national origin";¹ and

WHEREAS, the ERAS Residency Application has non-academic identifiers (including a picture) that may identify or suggest age, race, religion, and/or national origin, placed at the beginning of the application which may contribute to bias including, but not limited to, the priming effect;²⁻⁶ and

WHEREAS, conscious and unconscious bias, that may influence the selection of a resident, may be associated with many identifiers revealed at the beginning of the ERAS Residency Application including, but not limited to, age, race, religion, national origin, weight, gender, sexual orientation, transgender status, and attractiveness;⁷⁻¹⁰ and

WHEREAS, bias has been associated with school admissions and hiring;⁶,¹⁰ and

WHEREAS, this bias should be minimized to ensure fairness in residency trainee selection; therefore be it

RESOLVED, that our American Medical Association advocate for the formation of an Electronic Residency Application Service (ERAS) Residency Application Bias Minimization Committee to examine the role of bias in the residency training selection process¹¹ (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the modification of the ERAS Residency Application to minimize its bias in accordance with the suggestions of the ERAS Residency Application Bias Minimization Committee. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 09/22/17
References:

RELEVANT AMA POLICY

Gender-Based Questioning in Residency Interviews H-310.976
The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion.
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process.
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants.
Res. 307, A-09

Oppose Discrimination in Residency Selection Based on International Medical Graduate Status D-255.982
Our AMA:
1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants.
2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience.
3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms.
Sub. Res. 305, A-08 Reaffirmation I-11

See also: Eliminating Religious Discrimination from Residency Programs H-310.923
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 956
(I-17)

Introduced by: International Medical Graduates Section
Subject: House Physicians Category
Referred to: Reference Committee K
(L. Samuel Wann, MD, Chair)

Whereas, In order to practice clinical medicine in an unsupervised setting, all physicians (international medical graduates and domestic graduates) must be licensed by the medical licensing board of the state where they plan to practice; and

Whereas, International medical graduates (IMGs) must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and must pass USMLE Steps 1, Step 2 CK and Step 2 CS; and

Whereas, When a physician receives ECFMG certification, he/she may apply for an ACGME accredited residency; and

Whereas, Many ECFMG-certified IMGs are waiting to get into a residency program, but are unable to obtain a residency due to the limited number of residency slots available; and

Whereas, A significant shortage of primary care physicians is predicted ranging between 8,700 and 43,100 physicians by 2030;¹ which will further impact the availability of physicians and health care providers to care for patients in underserved areas of the United States;² and

Whereas, The Florida State Medical Board has implemented policies and laws to allow hospitals to employ physicians who have limited medical licenses as “house physicians” to work under the direct supervision of a physician who has an active Florida medical license and provide care to patients³; therefore be it

RESOLVED, That our American Medical Association work with state legislators and other regulatory organizations to develop the category of “House Physicians” to help address the anticipated physician need and shortfall of available practitioners in underserved areas of the United States. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 09/22/17

References:
Whereas, Current Accreditation Council for Graduate Medical Education (ACGME) guidelines state that accredited obstetrics and gynecology (OB-GYN) residencies are required to provide access to abortion training in their curriculum, which the American Congress of Obstetricians and Gynecologists (ACOG) recognizes is a necessary component of women’s health care; and

Whereas, ACGME requires that all programs be held to the same high standards; however, ACOG reports that programs differ widely in scope and types of training offered; and

Whereas, There are many institutional barriers to medical education surrounding abortion, including legislative, societal, and monetary, all of which contribute to the limited access to family planning training opportunities; and

Whereas, Many institutions do not provide equal access to abortion training during OB-GYN residency training, only 54 percent of OB-GYN residents from 161 programs noted routine integrated abortion training, and 16 percent reported that elective training was not available; and

Whereas, In a 10-year study of Ryan Residency programs—which offer enhanced, integrated family planning education in OB-GYN residencies—there was a demonstrated 97 percent improved competency in abortion and contraceptive care, but they only make up 32 percent of all US OB-GYN residency programs; and

Whereas, Offering comprehensive, integrated training in abortion and family planning has shown to improve residents’ competency and proficiency in abortion, counseling, miscarriage management, and other reproductive care; and

Whereas, ACOG supports expansion of abortion training, and the improvement and integration of abortion education throughout all levels of medical education; and

Whereas, AMA policy supports the opportunity for residents to learn or opt-out of pregnancy termination procedures and opposes program measures aimed to interfere with or restrict the availability of this training; and

Whereas, AMA policy maintains that basic skills and competencies be determined solely by the medical profession; therefore be it
RESOLVED, That our American Medical Association encourage the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the American Congress of Obstetricians and Gynecologists’ recommendations. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 09/29/17

RELEVANT AMA POLICY

Medical Training and Termination of Pregnancy H-295.923
The AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.

Residency Program Responsibility for Resident Education H-295.915
The AMA affirms that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession.
Citation: Res. 313, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16;

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1 Accreditation Council for Graduate Medical Education. "ACGME program requirements for graduate medical education in obstetrics and gynecology." (2013).
Whereas, The cellular biology, gene expression, and hormonal profile differs between sexes and genders, and influence the clinical presentation, progression, and outcome for a variety of diseases; and

Whereas, The Institute of Medicine supports the advent and implementation of sex and gender based medicine in daily practice of patient care due to its multifactorial impact on overall patient health and disease prognosis; and

Whereas, Sex and gender based medical education is a critical component in the pursuit of more personalized medicine; and

Whereas, The majority of current educational materials used in medical education have a gender-bias toward male patients, and educators must make the conscious decision to offer learning materials and teaching that is sex and gender based; and

Whereas, There are demonstrated sex and gender differences in drug responses to therapeutic doses due to variations in gene expression leading to increases in adverse effects disproportionately in the female sex; and

Whereas, Sex and gender-based medicine (SGBM) may not currently be addressed in undergraduate or graduate medical education, and medical students and residents may not fully understand the impact of these differences on patient care; and

Whereas, A recent study shows 96 percent of medical students are aware of differences in SGBM, and 94.2 percent believe including it in the curriculum improves their ability to care for future patients; and

Whereas, Some schools have already adapted their curriculum to include SGBM through integration into existing educational resources, including clinical cases and learning modules; and

Whereas, Over twenty national and international organizations and schools are already addressing sex and gender implications in medical education and continuing medical education curricula; and

Whereas, The AMA has recently expanded the definition of women’s health to be inclusive of all health conditions for which there is evidence that women’s risks, presentations, and/or responses to treatment are different from those of men, and encouraged physicians to use this in their training; and
Whereas, The AMA has previously resolved to encourage the research of sex and gender differences in medicine, and recommends that medical/scientific journals require sex based analysis of data when appropriate; therefore be it

RESOLVED, That our American Medical Association ask the AMA Council on Medical Education and Academic Physician Section to encourage the Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to assure the inclusion of sex and gender based medicine in medical education programs across the spectrum of learners nationwide. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 09/29/17

RELEVANT AMA POLICY

An Expanded Definition of Women’s Health H-525.976,
Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.
Citation: CSAPH Rep. 05, A-16;

See also: Medical Education and Training in Women's Health H-295.890, Sex and Gender Differences in Medical Research H-525.988

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4 Pinn VW. Sex and Gender Factors in Medical Studies: Implications for Health and Clinical Practice. JAMA. 2003;289(4):397-400.
9 Jenkins, Marjorie R., Richard Dickerson, Michael Song, Chwan-Li Shen, Susan Bergeson, Betsy Jones, Simon Williams, Robert Casanova, Texas Tech University Health Sciences Center School of Medicine, and Laura W. Bush Institute for Women’s Health. Direct Connection of Foundational Science Principles to Clinical Care. Texas Tech Sex and Gender-Based Medicine Longitudinal Curriculum Model. N.p., n.d. Web.
11 Sex and Gender Women's Health Collaborative – Collaborators (http://sgwhc.org/participate/collaborators/#sthash.kxbSvcku.dpbs)
Whereas, Four healthy lifestyle factors--never smoking, maintaining a healthy weight, exercising regularly, and following a healthy diet--together appear to be associated with as much as an 80 percent reduction in the risk of developing the most common and deadly chronic diseases, such as cardiovascular disease, cancer, and diabetes; and

Whereas, The Bipartisan Policy Center has called for improving medical education and training in “topics such as nutrition and physical activity that have an important role to play in the prevention and treatment of obesity and chronic diseases,” since “these topics have traditionally received little attention in formal medical school curricula”; and

Whereas, Many physicians and other healthcare providers are not adequately trained in nutrition and physical activity and other lifestyle components in a way that could mitigate disease development and progression; and

Whereas, In a report from 2010, only 25% of medical schools surveyed required a dedicated nutrition course (down from 30% in 2004) and only 27% of schools surveyed met the minimum 25 required hours of nutrition instruction set by the National Academy of Sciences (down from 38% in 2004); and

Whereas, Patients advised to quit smoking by their physicians are 1.6 times more likely to quit than patients not receiving physician advice; however, most smokers do not receive this advice when visiting their physicians; and

Whereas, Just 34% of U.S. adults reported exercise counseling at their last medical visit; and

Whereas, In a study of internal medicine physicians, less than half reported confidence in knowledge of local exercise facilities, American College of Sports Medicine (ACSM) guidelines, and behavior modification techniques; therefore be it

RESOLVED, That our American Medical Association support legislation that incentivizes and/or provides funding for the inclusion of lifestyle medicine education in medical school education, graduate medical education, and continuing medical education, including but not limited to education in nutrition, physical activity, behavior change, sleep health, tobacco cessation, alcohol use reduction, emotional wellness, and stress reduction. (New HOD Policy)
Fiscal Note: Minimal - less than $1,000.

Received: 10/12/17

RELEVANT AMA POLICY

Healthy Lifestyles H-425.972
Our AMA: (1) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (2) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (3) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.

Citation: Res. 423, A-12

E-8.11 Health Promotion and Preventive Care

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physicians role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community. The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patients main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:
(a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.
(b) Educate patients about relevant modifiable risk factors.
(c) Recommend and encourage patients to have appropriate vaccinations and screenings.
(d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.
(e) Collaborate with the patient to develop recommendations that are most likely to be effective.
(f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.
(g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.
(h) Recognize that modeling health behaviors can help patients make changes in their own lives.

Collectively, physicians should:
(i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.
(j) Advocate for healthier schools, workplaces and communities.
(k) Create or promote healthier work and training environments for physicians.
(l) Advocate for community resources designed to promote health and provide access to preventive services.
(m) Support research to improve the evidence for disease prevention and health promotion.
APS nominations/elections
1 Nominations and elections: APS Governing Council and Membership Committee

The officers of the APS are the nine GC members: Chair, Chair-elect, Immediate Past Chair, Delegate, Alternate Delegate, three Members-at-Large, and Liaison to the AMA Council on Medical Education.

For 2018-2019, the APS GC has the following openings:

<table>
<thead>
<tr>
<th>Position</th>
<th>Opening(s)</th>
<th>Term length (years)</th>
<th>Maximum number of terms</th>
<th>Maximum length of service (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair-elect</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1*</td>
</tr>
<tr>
<td>Member-at-Large</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Delegate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Liaison to the Council on Medical Education</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

* Three-year cycle—one year each as chair-elect, chair, and immediate past chair.

In addition, the following positions will be open on the APS Membership Committee, for Regions 3, 4, 6, and 7, as shown below. These are two-year positions, with a maximum of three terms (or six years of service).

<table>
<thead>
<tr>
<th>Region</th>
<th>States</th>
<th>Open for 2018?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington (WWAMI), Wyoming</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Illinois, Iowa, Minnesota, Missouri, Nebraska, Wisconsin</td>
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<tr>
<td>3</td>
<td>Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Alabama, Florida, Georgia, North Carolina, Puerto Rico, South Carolina, Tennessee</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Indiana, Kentucky, Michigan, Ohio, West Virginia</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Delaware, District of Columbia, New Jersey, Maryland, Pennsylvania, Virginia</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The APS nominations committee will be soliciting qualified candidates for GC and Membership Committee openings beginning in January 2018. A proposed slate of candidates will be presented by the committee to the APS Governing Council in April; if approved, this slate will be presented to the APS at its business meeting in June 2018 for voting by APS members.

To learn more about the duties of the GC and the Membership Committee and obtain the application for consideration as a candidate, contact APS staff at fred.lenhoff@ama-assn.org or (312) 464-4635.
2 Opportunities for service on medical education organizations through the AMA

The AMA invites interested and qualified AMA members to apply for nomination for important leadership positions in key medical education organizations. The physicians selected to serve by these organizations demonstrate deep knowledge and passion for the practice of medicine and their specialty.

The AMA nominates AMA member candidates to these organizations, and the organizations make the final appointment decisions.

Timeline of AMA Nomination Decision – Approximately 3 months from AMA application deadline to AMA nomination decision.

Timeline of Organization Appointment Decision – Varies by organization.

Interested individuals are encouraged to submit their contact information and opportunity(ies) of interest to Mary O’Leary, Program Administrator for AMA Council on Medical Education, mary.oleary@ama-assn.org, 312-464-4515, to be notified when the opportunities are announced. Please feel free to contact Ms. O’Leary with any questions.

AMA membership is required for consideration for AMA nomination, and if appointed, nominees must maintain AMA member status throughout the term of appointment. AMA membership does not guarantee a position. Since AMA membership is a requirement, eligible candidates who are not members are encouraged to join in order to be considered for nomination.

Following are anticipated opportunities through 2018. Please note that opportunities and timeframes are subject to change. Current AMA nomination opportunities for medical education organizations can also be found online at Medical Education Leadership Opportunities.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Term Start, Length</th>
<th>Announcement of Opportunities</th>
<th>AMA Application Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Board of Family Medicine</td>
<td>May 2018, 5 yrs</td>
<td>Nov 2017</td>
<td>Dec 2017</td>
</tr>
<tr>
<td>American Board of Radiology</td>
<td>TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACGME RC-Emergency Medicine</td>
<td>Jul 2019, 6 yrs</td>
<td>Nov 2017</td>
<td>Jan 2018</td>
</tr>
<tr>
<td>ACGME RC-Nuclear Medicine</td>
<td>Jul 2019, 6 yrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACGME RC-Pathology</td>
<td>Jul 2019, 6 yrs</td>
<td></td>
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<tr>
<td>ACGME RC-Pediatrics</td>
<td>Jul 2019, 6 yrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACGME RC-Radiology</td>
<td>Jul 2019, 6 yrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Board of Psychiatry and Neurology (Psychiatry Director)</td>
<td>Jan 2019, 4 yrs</td>
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</tr>
<tr>
<td>ACGME Institutional Review Committee</td>
<td>Jul 2018, 6 yrs</td>
<td>Feb 2018</td>
<td>Mar 2018</td>
</tr>
<tr>
<td>Accreditation Review Commission on Education for the Physician Assistant</td>
<td>Jan 2019, 3 yrs</td>
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<tr>
<td>American Board of Orthopaedic Surgery</td>
<td>Oct 2019, 10 yrs</td>
<td></td>
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<tr>
<td>American Board of Allergy and Immunology (Internist Director)</td>
<td>Jan 2019, 6 yrs</td>
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<tr>
<td>Organization</td>
<td>Start Date</td>
<td>End Date</td>
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<tr>
<td>American Board of Emergency Medicine</td>
<td>Jul 2019, 4 yrs</td>
<td>Aug 2018</td>
<td></td>
</tr>
<tr>
<td>American Board of Preventive Medicine</td>
<td>Aug 2019, 3 yrs</td>
<td>Jul 2018</td>
<td></td>
</tr>
<tr>
<td>American Board of Family Medicine</td>
<td>May 2019, 5 yrs</td>
<td>Nov 2018</td>
<td></td>
</tr>
<tr>
<td>American Board of Radiology</td>
<td>TBD</td>
<td>Nov 2018</td>
<td></td>
</tr>
<tr>
<td>National Resident Matching Program</td>
<td>TBD</td>
<td>Dec 2018</td>
<td></td>
</tr>
<tr>
<td>ACGME RC-Emergency Medicine</td>
<td>Jul 2020, 6 yrs</td>
<td>Nov 2018</td>
<td></td>
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<tr>
<td>ACGME RC-Internal Medicine</td>
<td>Jul 2020, 6 yrs</td>
<td>Jan 2019</td>
<td></td>
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<tr>
<td>ACGME RC-Ophthalmology</td>
<td>Jul 2020, 6 yrs</td>
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<tr>
<td>ACGME RC-Orthopaedic Surgery</td>
<td>Jul 2020, 6 yrs</td>
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<tr>
<td>ACGME RC-Preventive Medicine</td>
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<td>ACGME RC-Psychiatry</td>
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<tr>
<td>ACGME RC-Radiology</td>
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<tr>
<td>ACGME RC-Surgery</td>
<td>Jul 2020, 6 yrs</td>
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<tr>
<td>ACGME RC-Urology</td>
<td>Jul 2020, 6 yrs</td>
<td></td>
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<tr>
<td>ACGME Transitional Year Review Committee</td>
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<tr>
<td>American Board of Family Medicine</td>
<td>May 2019, 5 yrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Board of Psychiatry and Neurology (Psychiatry Director)</td>
<td>Jan 2020, 4 yrs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APS and AMA membership
Academic Physicians Section: Membership application form

Instructions:
- Complete all fields below
- Email completed form to Fred Lenhoff, AMA-APS staff, at fred.lenhoff@ama-assn.org. For membership avenue one, below, first email completed form to the dean of your institution for dean review/approval.
- Current AMA membership is required to become an AMA-APS member. Join the AMA or renew your membership now
- The AMA-APS Governing Council will review applications (except for avenue one) and advise applicants of its decision
- Questions? Call (312) 464-4635 or email fred.lenhoff@ama-assn.org

<table>
<thead>
<tr>
<th>First name</th>
<th>Enter First Name</th>
<th>Middle initial</th>
<th>Enter M.I.</th>
<th>Last name</th>
<th>Enter last name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degrees(s)</td>
<td>Enter degree(s)</td>
<td>Title</td>
<td>Enter title(s)</td>
<td>Title 2</td>
<td>Enter second title, if any</td>
</tr>
<tr>
<td>Institution</td>
<td>Enter primary institution</td>
<td>City</td>
<td>Enter city</td>
<td>State</td>
<td>Enter state</td>
</tr>
<tr>
<td>Email(s)</td>
<td>Enter email(s)</td>
<td>Telephone</td>
<td>Enter telephone</td>
<td>Specialty/ subspecialty</td>
<td>Enter specialty/subspecialty</td>
</tr>
<tr>
<td>AMA member?</td>
<td>AMA member?</td>
<td>Y or N</td>
<td>How long have you been an AMA member?</td>
<td>AMA member for X years</td>
<td>AMA delegate?</td>
</tr>
<tr>
<td>Number of AMA-APS meetings attended</td>
<td>Attended X APS meetings</td>
<td>What is your current involvement in medical education?</td>
<td>Current involvement in medical education</td>
<td>Why do you wish to join the AMA-APS?</td>
<td>Reason to join the APS</td>
</tr>
<tr>
<td>How did you learn about the APS?</td>
<td>How did you learn about the APS?</td>
<td>Were you referred to join by an APS member?</td>
<td>Referred to join by an APS member?</td>
<td>Which aspect(s) of medical education is your primary role/interest?</td>
<td>Undergraduate (UME)</td>
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<tr>
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<td>Graduate (GME)</td>
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<td></td>
<td></td>
<td>Continuing (CME)</td>
</tr>
</tbody>
</table>

Membership avenue (choose one):

- **Avenue 1: Dean-appointed**
  - An AMA-member physician appointed by the dean of any United States medical school (with an educational program provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association leading to the MD or DO degree) to represent undergraduate, graduate or continuing medical education at the institution.

- **Avenue 2: Self-nominated, faculty appointment**
  - An AMA-member physician who holds a faculty appointment of any type at a United States medical school with an educational program provided by a college of medicine or osteopathic medicine accredited by the LCME or the AOA leading to the MD or DO degree. *(include a brief biosketch—three pages or fewer—and a copy of your faculty appointment letter)*

- **Avenue 3: Self-nominated, no faculty appointment**
  - An AMA-member physician who does not hold a medical school faculty appointment, but has an active role in undergraduate, graduate, or continuing medical education or who serves in a clinical/research capacity with an academic medical center, community hospital, or other health care setting. *(include a brief biosketch—three pages or fewer)*
The three avenues to APS membership are:

1. Dean-appointed: An AMA-member physician appointed by the dean of any United States medical school (with an educational program provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association leading to the MD or DO degree) to represent undergraduate, graduate or continuing medical education at the institution.

2. Self-nominated (faculty appointment): An AMA-member physician who holds a faculty appointment of any type at a United States medical school with an educational program provided by a college of medicine or osteopathic medicine accredited by the LCME or the AOA leading to the MD or DO degree.

3. Self-nominated (no faculty appointment): An AMA-member physician who does not hold a medical school faculty appointment, but has an active role in undergraduate, graduate, or continuing medical education or who serves in a clinical/research capacity with an academic medical center, community hospital, or other health care setting.

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**Alabama**

**Alabama College of Osteopathic Medicine**

*Craig J. Lenz, DO, Dean/Senior Vice President*

**University of Alabama School of Medicine**

*Selwyn M. Vickers, MD, SVP of Medicine and Dean*

Craig J. Hoesley, MD, Senior Associate Dean for Medical Education

**University of South Alabama College of Medicine**

Jack Di Palma, MD, Professor, internal medicine
Ronald D. Franks, MD, Professor and Acting Chair, Psychiatry
David A. Gremse, MD, Professor and Chair, Pediatrics
Edward A. Panacek, MD, Professor and Chair, Emergency Medicine

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**Arizona**

**University of Arizona College of Medicine**

*Guy L. Reed, III, MD, Dean - Phoenix*

Kevin F. Moynahan, MD, FACP, Deputy Dean for Medical Education

**University of Arizona College of Medicine - Phoenix**

*Kenneth S. Ramos, MD, PhD, Interim Dean*

Michael Grossman, MD, MACP, Special Assistant to the Dean, Professor emeritus, internal medicine and biomedical informatics

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**Arkansas**

**University of Arkansas for Medical Sciences College of Medicine**

James Clardy, MD, Assistant Dean for Graduate Medical Education
Charles James Graham, MD, Associate Dean of Undergraduate Medical Education
Charles W. Smith, Jr., MD, Executive Associate Dean, Clinical Affairs
California Northstate University College of Medicine
Joseph Silva, Jr., MD, Dean

Loma Linda University School of Medicine
H. Roger Hadley, MD, Dean, Executive Vice President, Medical Affairs
Daniel W. Giang, MD, Associate Dean, Graduate Medical Education
June-Anne Gold, Professor, AMA IMG delegate
Sara Marie Roddy, MD
Tamara Shankel, MD, Associate Dean, Clinical Education, Associate Professor, Medical Education
Tamara Lynn Thomas, MD, Vice Dean, Academic Affairs, Associate Dean, Faculty Development
Leonard S. Werner, MD, Senior Associate Dean, Medical Student Education

Stanford University School of Medicine
Lloyd B. Minor, MD, Carl and Elizabeth Naumann Dean, Professor of Otolaryngology, Head & Neck Surgery

Touro University - California College of Osteopathic Medicine
Michael B. Clearfield, DO, Dean

University of California, Davis School of Medicine
Mark E. Servis, MD, Senior Associate Dean for Medical Education, Professor in Psychiatry and Behavioral Sciences

University of California, Irvine School of Medicine
Michael J. Stamos, MD, Dean
Mark Langdorf, MD, MHPE, Professor of Clinical Emergency Medicine
Deena Shin McRae, MD, Associate Dean of Graduate Medical Education and Designated Institutional Official
Danielle M. Perret Karimi, MD, Associate Clinical Professor, Physical Medicine & Rehabilitation and Anesthesiology
Shyrl Sistrunk, MD, FACP, Senior Associate Dean, Medical Education, HS Clinical Professor, Department of Medicine

University of California, Los Angeles David Geffen School of Medicine
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Sarah Wood, MD, Senior Associate Dean for Medical Education

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Laura Shea, MD, Assistant Professor of Clinical Internal
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delegate
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Medical Chief of Staff
Marta Van Beek, MD, Clinical Associate Professor,
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Kansas

University of Kansas School of Medicine

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Kim Templeton, MD, Associate Professor
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Education

Kentucky

University of Kentucky College of Medicine

Toni M. Ganzel, MD, MBA, FACS, Dean
Mary Nan Mallory, MD, Associate Director, Professor &
Chair – Obstetrics & Gynecology

University of Louisville School of Medicine

APS meeting, Nov. 2017
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Fred A. Lopez, MD, Assistant Dean, Student Affairs and Records

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Kevin Krane, MD, FACP, Vice Dean, Academic Affairs

Maryland

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Jessica Bienstock, MD, Professor, Department of Gynecology & Obstetrics

Uniformed Services University of the Health Sciences F. Edward Hebert School of Medicine
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John E. McManigle, MD, COL USAF, MC, former Acting Dean, Asst Dean, Clinical Sciences
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Massachusetts

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Michigan

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James Kleshinski, MD, Senior Associate Dean for Clinical Affiliation
Ronald McGinnis, MD, Associate Dean for COM Student Affairs, Associate Professor, Psychiatry
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Donna Woodson, MD, Professor, Department of Public Health & Preventive Medicine, Director of Women’s Health, Office of Medical education

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Oregon

Oregon Health and Science University School of Medicine

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Oklahoma

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Paul Haidet, MD, MPH, Director of Medical Education Research, Co-Director, Office for Scholarship in Learning and Education Research
Eileen F Henriksen, MD, FACP, FHM, Associate Professor of Medicine, Department of General Internal Medicine
Eileen M. Moser, MD, MHPE, Associate Dean for Clinical Education
Elizabeth H. Sinz, MD, Associate Dean for Clinical Simulation
Mark B. Stephens, MD, CAPT MC USN, Professor of Family and Community Medicine
Daniel Rick Wolpaw, MD, Director, The Doctors Kienle Center for Humanistic Medicine, Vice Chair for Educational Affairs, Dept of Medicine
Therese M. Wolpaw, MD, MHPE, Vice Dean for Educational Affairs

Temple University Lewis Katz School of Medicine

Larry R Kaiser, MD, Dean

Linda M. Famigli, MD, Chief Academic Officer, Geisinger Medical Center, Associate Dean at Geisinger for Temple U SOM
Enrique Hernandez, MD, Chair, OB/Gyn
Stephen R. Permut, MD, Professor and Chair of the Department of Family and Community Medicine, Associate Dean for Academic Affiliations
Michael J. Suk, MD, JD, PhD, Chairman, Orthopaedic Surgery

University of Pittsburgh School of Medicine

Barbara E. Barnes, MD, Associate Vice Chancellor
Rita M. Patel, MD, Professor of Anesthesiology; Vice Chair for Education, Dept of Anesthesiology; Associate Dean for Graduate Medical Education; Designated Institutional Official, UPMC Medical Edu
John P. Williams, MD, Professor

Puerto Rico

Ponce School of Medicine

Olga Rodriguez de Arzola, MD, Dean, Professor of Pediatrics

San Juan Bautista School of Medicine

Yocasta Brugal, MD, President and Dean

University of Puerto Rico School of Medicine

Edgar Colon-Negron, MD, Dean

Rafael Rodriguez-Mercado, MD, FAANS, Professor in Neurosurgery and Endovascular Neurosurgery, Stroke Center Director

Rhode Island

Warren Alpert Medical School of Brown University

Jack A. Elias, MD, Dean

Patrick J. Sweeney, MD, Associate Dean, Continuing Medical Education

South Carolina

Medical University of South Carolina College of Medicine

Leonie Gordon, MD, Senior Associate Dean for Faculty Affairs and Faculty Development, Professor, Department of Radiology
Gerald E. Harmon, MD, Professor, College of Medicine
University of South Carolina School of Medicine
Les Hall, MD, Executive Dean, CEO of Palmetto Health-USC Medical Group
Richard A. Hoppmann, MD, Director, Ultrasound Institute

University of South Carolina School of Medicine - Greenville
Jerry R. Youkey, MD, Founding Dean
Bruce A. Snyder, MD, Vice-Chief Medical Staff Affairs, Greenville Health System Department of Surgery

South Dakota
Sanford School of Medicine of the University of South Dakota
Mary D. Nettleman, MD, MS, MACP, Dean, Vice President Health Affairs
Archana Chatterjee, MD, Senior Associate Dean of Faculty Development, Chair, Department of Pediatrics
Luann Marie Eidsness, MD
Keith Allen Hansen, MD
Rodney R. Parry, MD, Emeritus faculty and former dean
Tim Ridgway, MD, Dean of Faculty Affairs
Matt Edward Simmons, MD, Campus Dean
Timothy Soundy, MD, Chair, Department of Psychiatry
Gary Lee Timmerman, MD

Texas
Baylor College of Medicine
Jennifer G. Christner, Dean
Linda B. Andrews, MD, Senior Associate Dean, Graduate Medical Education

Texas A&M Health Science Center College of Medicine
Paul B. Hicks, MD, PhD, Vice Dean, Temple Campus
Gary C. McCord, MD, Associate Dean for Student Affairs

Texas Tech University Health Sciences Center Paul L. Foster School of Medicine
Jose Manuel de la Rosa, MD, Provost and Vice President for Academic Affairs, Professor of Pediatrics
Manuel Schydlower, MD, Associate Dean for Admission

Texas Tech University Health Sciences Center School of Medicine
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Surendra K. Varma, MD, Executive Associate Dean for Graduate Medical Education & Resident Affairs, Professor and Vice Chairman, Department of Pediatrics

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S. Claiborne Johnston, MD, PhD, Dean, Vice President for Medical Affairs
Virginia

Eastern Virginia Medical School
Richard V. Homan, MD, President and Provost, Dean
Ronald W. Flenner, MD, FACP, Vice Dean for Academic Affairs
Clarence W Gowen, Jr, MD, Professor and Chair, Department of Pediatrics
Shannon M. McCole, MD, Chairman & Residency Program Director, Ophthalmology

Edward Via College of Osteopathic Medicine Virginia Campus
Dixie Tookel-Rawlins, DO, Dean and Executive Vice President, President, Virginia, Carolinas, and Auburn campuses

University of Virginia School of Medicine
Karen S. Rheuban, MD, Senior Associate Dean for Continuing Medical Education and External Affairs

Virginia Commonwealth University School of Medicine
Peter F. Buckley, MD, Dean, Executive Vice President for Medical Affairs
Jonathan Bekenstein, MD, Associate Professor of Neurology
Judy Brannen, MD, MBA, Clinical Director, Undergraduate and Graduate Medical Education, Associate Professor of Internal Medicine, VCU
PonJola Coney, MD, Senior Associate Dean for Faculty Affairs

Virginia Tech Carilion School of Medicine and Research Institute
Cynda Ann Johnson, MD, MBA, President and Founding Dean
Jonathan Carmouche, MD, Undergraduate Academic Activities
Daniel P. Harrington, MD, Senior Dean for Academic Affairs
Patrice Weiss, MD, Graduate Academic Activities

Washington

Pacific Northwest University of Health Sciences
College of Osteopathic Medicine
Sheila Rege, MD, FACRO, Adjunct Clinical Assistant Professor

University of Washington School of Medicine
Paul G. Ramsey, MD, CEO, UW Medicine and Dean
Suzanne M. Allen, MD, MPH, Vice Dean for Academic, Rural and Regional Affairs
Washington State University Elson S. Floyd College of Medicine

John Tomkowiak, MD, MOL, Founding dean

West Virginia

Joan C. Edwards School of Medicine at Marshall University

Joseph I. Shapiro, MD, Dean

Bobby L. Miller, MD, FAAP, Vice Dean for Medical Education

West Virginia School of Osteopathic Medicine

Lorenzo Pence, DO, Dean

West Virginia University School of Medicine

Judie Fern Charlton, MD, Chief Medical Officer, WVU Hospital Administration, and Professor
Alan Marc Ducatman, MD, Professor, Public Health
Norman D. Ferrari, III, MD, Senior Associate Dean for Medical Education Professor, Department of Peds
David Frederick Hubbard, MD
Maria Munoz Kolar, MD, Professor
John Peter Lubicky, MD, FAAOS, FAAP, Professor, Orthopaedic Surgery
Bonhomme Jos Prud'Homme, MD
Rebecca Jane Schmidt, DO, Professor and Section Chief
James Marcus Stevenson, MD

Wisconsin

Medical College of Wisconsin

Joseph E Kerschner, MD, Dean, Executive Vice President

Carlyle H. Chan, MD, Professor
Jose Franco, MD, Discovery Curriculum Director
William John Hueston, MD, Senior Associate Dean for Academic Affairs
Reza Shaker, MD, Senior Associate Dean, Director, Clinical & Translational Science Institute
Kenneth B. Simons, MD, Senior Associate Dean for Graduate Medical Education and Accreditation, Executive Director and DIO, MCWAH, Inc.
Alonzo Patrick Walker, MD

University of Wisconsin School of Medicine and Public Health

Daniel D Bennett, MD, Vice Chair, Associate Professor
Elizabeth M. Petty, MD, Senior Associate Dean, Academic Affairs
1. **Ralitsa Akins, MD**  
   Associate Dean of Faculty Talent, Recognition and Enhancement  
   Washington State University Elson S. Floyd College of Medicine  
   Chief interest: UME

2. **Arthur E. Angove, DO**  
   Retired  
   Chief interest: GME

3. **Peter P. Aran, MD**  
   Medical Director of Population Health  
   Blue Cross and Blue Shield of Oklahoma  
   Chief interest: GME

4. **David Barbe, MD, MHA**  
   Vice president, Regional Operations, Mercy Clinic, and AMA BOT member  
   American Medical Association  
   Chief interest: GME

5. **Veronica M. Catanese, MD, MBA**  
   Co-secretary, and senior director of accreditation services, AAMC  
   Liaison Committee on Medical Education Council  
   Chief interest: UME

6. **Ellen M. Cosgrove, MD, FACP**  
   Vice Dean, Academic Affairs and Education  
   University of Nevada, Las Vegas School of Medicine  
   Chief interest: UME

7. **Louito C. Edje, MD**  
   Program Director  
   Promedica Toledo Hospital  
   Chief interest: GME

8. **Nicky R Holdeman, OD, MD**  
   Professor and Associate Dean for Clinical Education, and Executive Director, University Eye Institute  
   University of Houston University Eye Institute  
   Chief interest: UME
9. **William E. Kobler, MD**  
Medical Director of Health Management, OSF Saint Anthony Medical Center (SAMC), and AMA BOT member  
American Medical Association  
Chief interest: CME

10. **Stanley Kozakowski, MD**  
Director, Medical Education Division  
American Academy of Family Physicians  
Chief interest: GME

11. **Barbara McAneny, MD**  
Oncologist/hematologist, and AMA BOT member  
American Medical Association  
Chief interest: CME

12. **William A. McDade, MD, PhD**  
Executive Vice President & Chief Academic Officer, and AMA BOT member  
Alton Ochsner Medical Foundation  
Chief interest: UME

13. **Frederick Schiavone, MD**  
Vice President for Graduate Medical Education  
HCA West Florida  
Chief interest: GME

14. **Michael Sinha, MD, JD, MPH**  
Post-Doctoral Fellow  
Harvard Medical School  
Chief interest: GME

15. **Sunil Wimalawansa, MD**  
Professor  
Rutgers Robert Wood Johnson Medical School  
Chief interest: UME
Medical schools with no APS members

1. A T Still University School of Osteopathic Medicine in Arizona (AZ)
2. Midwestern University - Arizona College of Osteopathic Medicine (AZ)
3. Keck School of Medicine of the University of Southern California (CA)
4. George Washington University School of Medicine and Health Sciences (DC)
5. Rush Medical College of Rush University Medical Center (IL)
6. Midwestern University - Chicago College of Osteopathic Medicine (IL)
7. Marian University College of Osteopathic Medicine (IN)
8. Des Moines University College of Osteopathic Medicine (IA)
9. University of New England College of Osteopathic Medicine (ME)
10. Kansas City University of Medicine and Biosciences College of Osteopathic Medicine (MO)
11. A T Still University Kirksville College of Osteopathic Medicine (MO)
12. Geisel School of Medicine at Dartmouth (NH)
13. Burrell College of Osteopathic Medicine at New Mexico State University (NM)
14. CUNY School of Medicine Sophie Davis School of Biomedical Education (NY)
15. New York Institute of Technology New York College of Osteopathic Medicine (NY)
16. Weill Cornell Medicine (NY)
17. Campbell University Jerry M. Wallace School of Osteopathic Medicine (NC)
18. Oklahoma State University Center for Health Sciences College of Osteopathic Medicine (OK)
<table>
<thead>
<tr>
<th></th>
<th>Institution</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>19.</td>
<td>Philadelphia College of Osteopathic Medicine (PA)</td>
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<tr>
<td>20.</td>
<td>Lake Erie College of Osteopathic Medicine (PA)</td>
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<tr>
<td>21.</td>
<td>Universidad Central del Caribe School of Medicine (PR)</td>
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<tr>
<td>22.</td>
<td>Lincoln Memorial University DeBusk College of Osteopathic Medicine (TN)</td>
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<tr>
<td>23.</td>
<td>University of North Texas Health Sciences Center College of Osteopathic Medicine (TX)</td>
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<tr>
<td>24.</td>
<td>University of Utah School of Medicine (UT)</td>
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<tr>
<td>25.</td>
<td>Liberty University College of Osteopathic Medicine (VA)</td>
<td></td>
</tr>
</tbody>
</table>
3 APS Governing Council

George Mejicano, MD, MS, FACP
Chair

Infectious Diseases
2017 - 2018

Affiliation: Oregon Health and Science University School of Medicine
Email: mejicano@ohsu.edu

Hal B. Jenson, MD, MBA
Chair-elect

Pediatric Infectious Diseases
2017 - 2018

Affiliation: Western Michigan University Homer Stryker M.D. School of Medicine
Email: hal.jenson@med.wmich.edu

John L. Roberts, MD
Immediate Past Chair

Neonatal-Perinatal Medicine
2017 - 2018

Affiliation: University of Louisville School of Medicine
Email: john.roberts@louisville.edu
Kenneth B. Simons, MD
Delegate

Ophthalmology
2016 - 2018

Affiliation: Medical College of Wisconsin
Email: ksimons@mcw.edu

Donald G. Eckhoff, MD
Alternate Delegate

Orthopedic Surgery
2016 - 2018

Affiliation: University of Colorado School of Medicine

Jose M. de la Rosa, MD, MSc
Member-at-large

Pediatrics
2017 - 2018

Affiliation: Texas Tech University Health Sciences Center Paul L. Foster School of Medicine
Email: jmanuel.delarosa@ttuhsc.edu
Sharon P. Douglas, MD  
Member-at-large  
Pulmonary Medicine  
2017 - 2018  
Affiliation: University of Mississippi School of Medicine  
Email: spdouglas@umc.edu

Cynda Ann Johnson, MD, MBA  
Member-at-large  
Family Medicine  
2017 - 2018  
Affiliation: Virginia Tech Carilion School of Medicine and Research Institute  
Email: CAJohnson1@carilionclinic.org

Surendra K. Varma, MD, DSc (Hon), FAAP, FACE  
Liaison to Council on Medical Education  
Pediatric Endocrinology  
2015 - 2018  
Affiliation: Texas Tech University Health Sciences Center School of Medicine  
Email: surendra.varma@ttuhsc.edu
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The American Medical Association recognizes that academic physicians play a critical role in shaping physician training and practice. Your innovative ideas, leadership and creative energy advance academia, medical education, research and medicine worldwide.

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- Offers a special discounted group membership program for medical school leadership
- Allows additional faculty members to be added at any time at the appropriate dues discount level
- Delivers full AMA membership benefits to each member
- Provides exclusive customized group education opportunities

AMA membership resources

<table>
<thead>
<tr>
<th>AMA leadership opportunities</th>
<th>• Get involved in our AMA Academic Physicians Section and AMA Council on Medical Education. • Assist in setting educational standards by seeking nominations for leadership opportunities in key medical education organizations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA resources supporting medical education</td>
<td>• The Introduction to the Practice of Medicine (IPM) educational series helps residents/program administrators with required ACGME general competencies. • FREIDA Online® with access to more than 10,000 ACGME-accredited residency/fellowship programs. • AMA Journal of Ethics, a forum for medical ethics. • Choosing a specialty: An AMA resource for medical students assists students with their specialty selection. • The AMA Foundation Scholars Fund awarded over $60 million in medical student scholarships and almost $970,000 in Seed Grant Research Programs to students and residents. • AMA Section Involvement Grants provide up to $1,000 for medical student sections to host educational activities. • NEW! Search for volunteer and paid short-term opportunities with the AMA’s Physician Opportunities Portal.</td>
</tr>
<tr>
<td>AMA products and services to help you save money</td>
<td>• AMA Insurance – NEW! Travel benefits with AMA-sponsored Travel insurance, including concierge services and TSA Prev® for physicians and all insured family members. – Save up to 35% on AMA Insurance products and financial services designed exclusively for physicians • AMA Preferred Provider Offers and Services – Access to practice resources and savings on tech products, travel, auto and financial services.</td>
</tr>
<tr>
<td>AMA Representation</td>
<td>Be part of the nation’s leading voice for physicians and receive powerful representation at the federal and state levels on academic-related issues such as GME funding and work force. • In the courtroom, we fight to protect the integrity of hospital medical staffs and challenge abusive litigation against physicians. • In Washington, DC, we are advocating on behalf of physicians and patients during the transition to new payment and delivery models, to ensure the health care system works better for everyone. • In the states, we work alongside lawmakers and policymakers to enact laws that enhance the practice of medicine—and to defeat those laws that would create barriers to high-quality care.</td>
</tr>
</tbody>
</table>

Group Size* | Volume Discount | Dues Per Physician** |
---|---|---|
6 to 50 physicians | 20% | $336 |
51 to 299 physicians | 25% | $315 |
300 to 749 physicians | 30% | $294 |
750 to 999 physicians | 40% | $252 |
1000+ physicians | 50% | $210 |

*Group pricing requires a minimum of six academic leaders, including the medical school dean. **Regular annual physician dues are $420.

To learn more, call (312) 464-5920 or email academicleadership@ama-assn.org
2017 Annual Meeting review
1 APS meeting highlights

AMA policy review, educational sessions and networking opportunities with academic physician colleagues were part of the Academic Physicians Section (AMA-APS) meeting, June 9-10 in Chicago.

Participants—comprising deans and faculty from a wide range of medical schools, graduate medical education programs, and academic health systems nationwide—voiced their opinions and reached decisions on recommendations for several reports and resolutions to be acted upon by delegates at the Annual Meeting of the AMA House of Delegates (HOD), June 10-14. Their work guides the section delegate and alternate delegate in the discussions and voting during the AMA meeting.

Issues covered included immigration, physician workforce, clinical skills testing of medical students, and Maintenance of Certification. In all, the AMA-APS reviewed more than 30 business items (reports and resolutions) to go before the AMA HOD.

Updates on key nationwide medical education activities

After welcome and introductions from John Roberts, MD, the APS chair for 2016-2017 and vice dean for graduate medical education and continuing medical education at the University of Louisville School of Medicine, a number of speakers covered key issues affecting academic physicians (presentations are available on the APS website).

Meeting highlights included the following:

- Greeting from host medical school: Diane B. Wayne, MD, vice dean for education, Feinberg School of Medicine Northwestern University
- Update on the progress of the AMA’s Accelerating Change in Medical Education initiative, by Susan Skochelak, MD, MPH, group vice president, medical education
- Presentation on the work of the Accreditation Council for Graduate Medical Education, by Louis Ling, MD, senior vice president, Hospital-Based Accreditation
- A discussion on best practices for improving your institution’s impact/involvement in organized medicine and the AMA; this is also the topic of a resolution from the APS that went forward to the AMA House of Delegates.
- A demo of the new Graduate Medical Education Competency Education Module (formerly Introduction to the Practice of Medicine).
- Information about leadership opportunities on national medical education organizations/boards, from Jacqueline Bello, MD, chair, Nominations Committee, Council on Medical Education
- AMA and academic physician membership update, from Kristen Tinney, vice president, Physician Engagement, AMA, and Peter Carmel, MD, APS membership committee chair

Related to membership, the APS now comprises more than 560 academic physicians from the majority of U.S. medical schools (allopathic and osteopathic). With the recent development of a membership committee, the APS hopes to build on this number in the coming year.
Election of 2017-2018 APS Governing Council

For the annual elections to the AMA-APS Governing Council, the section’s nine-member leadership body, members in attendance voted to elect the proposed slate put forward by the nomination committee, as follows:

Chair-elect

Hal B. Jenson, MD, MBA
Founding Dean
Western Michigan University Homer Stryker M.D. School of Medicine

Members-At-Large (three total)

1. Cynda Ann Johnson, MD, MBA, President and Founding Dean
   Virginia Tech Carilion School of Medicine and Research Institute

2. Jose Manuel de la Rosa, MD, Msc, Provost and Vice President for Academic Affairs; Founding Dean
   Texas Tech University Health Sciences Center Paul L. Foster School of Medicine

3. Sharon P. Douglas, MD
   Associate Dean for Veterans Administration Education and Professor of Medicine
   University of Mississippi School of Medicine

Educational sessions on apps for academic physicians, medical education funding

The education component of the meeting featured two offerings:

Apps for Academic Physicians: The Hows and Whys
(Cosponsored by the International Medical Graduates Section and Senior Physicians Section)

Speakers were
• George Mejicano, MD, APS Chair-elect
• Michael Hodgkins, MD, MPH, Chief Medical Information Officer, AMA
• A. L. Jones, MD, MS, FACOEM, Young Physicians Section member and AMA HOD delegate, American College of Occupational and Environmental Medicine
• Arjun Gupta, medical student member of the Council on Medical Education, 2017-2018

Funding for Accountability, Sustainability and Transparency in Medical Education: A Proposed Model for Meeting Physician Workforce Needs
(Cosponsored by the International Medical Graduates Section)

Speaking was Kelly Caverzagie, MD, associate dean for educational strategy, University of Nebraska College of Medicine.
## 2 HOD actions on medical education items

<table>
<thead>
<tr>
<th>#</th>
<th>Item</th>
<th>Title</th>
<th>APS Recommendation(s) and notes</th>
<th>Final HOD action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Reference Committee on Amendments to Constitution and Bylaws</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Res 001</td>
<td>Participation of Physicians on Healthcare Organization Boards</td>
<td>Amend</td>
<td>Adopted as amended</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notes: Delete Resolves 1 and 3, keep Resolve 2</td>
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<tr>
<td></td>
<td></td>
<td>RESOLVED: That our American Medical Association advocate for and promote the membership of actively practicing physicians on the boards of healthcare organizations including, but not limited to, acute care providers, insurance entities, medical device manufacturers, and health technology service organizations (New HOD Policy), and be it further RESOLVED: That our AMA promote educational programs on corporate governance that prepare and enable physicians to participate on health organization boards (New HOD Policy); and be it further RESOLVED: That our AMA provide existing healthcare boards with resources that increase their awareness of the value of physician participation in governance matters. (Directive to Take Action)</td>
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<td></td>
<td></td>
<td>Reference Committee B</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td>Res 218</td>
<td>Licensing of Electronic Health Records</td>
<td>Adopt</td>
<td>Referred</td>
</tr>
<tr>
<td>4.</td>
<td>Res 233</td>
<td>Regulation of Physician Assistants</td>
<td>Adopt</td>
<td>Adopted; Amendment B-3 referred for decision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reference Committee C</td>
<td></td>
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<tr>
<td>5.</td>
<td>CME 1</td>
<td>Council on Medical Education Sunset Review of 2007 House Policies</td>
<td>Adopt</td>
<td>Adopted as amended</td>
</tr>
<tr>
<td>6.</td>
<td>CME 2</td>
<td>Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 315-A-16)</td>
<td>Adopt</td>
<td>Adopted as amended</td>
</tr>
<tr>
<td>7.</td>
<td>CME 3</td>
<td>Obesity Education</td>
<td>Adopt</td>
<td>Adopted</td>
</tr>
<tr>
<td>8.</td>
<td>CME 6</td>
<td>Standardizing the Allopathic Residency Match System and Timeline (Resolution 310-A-16)</td>
<td>Adopt</td>
<td>Original Recommendation 1 adopted; Recommendations 2 and 3 referred</td>
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<tr>
<td>9.</td>
<td>CME</td>
<td>7</td>
<td>Expansion of Public Service Loan Forgiveness</td>
<td>Amend</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Notes: Revise Recommendation 1, as noted, and remove Recommendation 4:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>1. That our American Medical Association (AMA) encourage the Accreditation Council for Graduate Medical Education (ACGME) to require request that programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer. (New HOD Policy)</td>
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<td>4. That our AMA advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility. (Directive to Take Action)</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>CME</td>
<td>9</td>
<td>Feasibility and Appropriateness of Transferring Jurisdiction over Required Clinical Skills Examinations to LCME-Accredited and COCA-Accredited Medical Schools</td>
<td>Adopt</td>
</tr>
<tr>
<td>11.</td>
<td>Res</td>
<td>301</td>
<td>Mental Health Disclosures on Physician Licensing Applications</td>
<td>Adopt</td>
</tr>
<tr>
<td>13.</td>
<td>Res</td>
<td>303</td>
<td>Addressing Medical Student Mental Health Through Data Collection and Screening</td>
<td>Not adopt</td>
</tr>
<tr>
<td>14.</td>
<td>Res</td>
<td>304</td>
<td>Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding</td>
<td>Adopt</td>
</tr>
<tr>
<td>15.</td>
<td>Res</td>
<td>305</td>
<td>Reduction of Caregiver Burnout</td>
<td>Amend</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Notes: amend as follows:</td>
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<tr>
<td></td>
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<td></td>
<td>RESOLVED, That our American Medical Association encourage partner organizations, including the AARP, to develop resources to better prepare caregivers in performing medical/nursing tasks (New HOD Policy); and be it further</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>RESOLVED, That our AMA create an online educational module to promote physician understanding of caregiver burnout and develop strategies to support caregivers and their patients. (Directive to Take Action)</td>
<td></td>
</tr>
<tr>
<td>Res 307</td>
<td>Formal Business and Practice Management Training During Medical Education</td>
<td>Not adopt</td>
<td>The APS opposes curricular mandates.</td>
<td></td>
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<tr>
<td>Res 308</td>
<td>Immigration Reform Impacts on International Medical Graduate Training and Patient Access</td>
<td>Adopt</td>
<td>Revised Resolution 308 adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326</td>
<td></td>
</tr>
<tr>
<td>Res 309</td>
<td>Future of the USMLE: Examining Multi-Step Structure and Score Usage</td>
<td>Not adopt</td>
<td>Adopted as amended</td>
<td></td>
</tr>
<tr>
<td>Res 310</td>
<td>Breast Pump Accommodations During Medical Licensing Exams</td>
<td>Adopt</td>
<td>Policy H-295.861 adopted as amended in lieu of Resolution 310</td>
<td></td>
</tr>
<tr>
<td>Res 311</td>
<td>Support of International Medical Students and Graduates</td>
<td>Adopt</td>
<td>Revised Resolution 308 adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326</td>
<td></td>
</tr>
<tr>
<td>Res 312</td>
<td>Supporting International Medical Graduates and Students</td>
<td>Adopt</td>
<td>Revised Resolution 308 adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326</td>
<td></td>
</tr>
<tr>
<td>Res 313</td>
<td>Study of Declining Native American Medical Student Enrollment</td>
<td>Adopt</td>
<td>Adopted</td>
<td></td>
</tr>
<tr>
<td>Res 314</td>
<td>Educating a Diverse Physician Workforce</td>
<td>Amend</td>
<td>Adopted as amended</td>
<td></td>
</tr>
</tbody>
</table>

In Resolve 3, revise use of “underrepresented minority (URM)” to refer instead to “underrepresented in medicine” (see: https://www.aamc.org/initiatives/urm/).

“RESOLVED, That our AMA create and support programs that introduce elementary through high school students, especially those from underrepresented minority groups that are underrepresented in medicine (URM), to healthcare careers”

Also, remove “holistic” from Resolve 5:

“RESOLVED, That our AMA recommend that medical school admissions committees use holistic evaluations of admission applicants,”
<table>
<thead>
<tr>
<th></th>
<th>Resolution Number</th>
<th>Description</th>
<th>Action</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.</td>
<td>Res 315</td>
<td>Inclusion of Developmental Disabilities Curriculum in Undergraduate, Graduate and Continuing Medical Education of Physicians</td>
<td>Adopt</td>
<td>Adopted as amended</td>
</tr>
<tr>
<td>27.</td>
<td>Res 317*</td>
<td>Immigration</td>
<td>No position</td>
<td>Revised Resolution 308 adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326</td>
</tr>
<tr>
<td>28.</td>
<td>Res 318*</td>
<td>Oppose Direct to Consumer Advertising of the ABMS MOC Product</td>
<td>Not adopt</td>
<td>Referred</td>
</tr>
<tr>
<td>30.</td>
<td>Res 320*</td>
<td>Cultural Competence in Standardized Patient Programs Within Medical Education</td>
<td>Not adopt</td>
<td>Adopt</td>
</tr>
<tr>
<td>33.</td>
<td>Res 323*</td>
<td>Exceptions to Medicare GME Cap-Setting Deadlines for Residency Programs in Medically Underserved/Economically Depressed Areas</td>
<td>Adopt</td>
<td>Adopted</td>
</tr>
<tr>
<td>34.</td>
<td>Res 324**</td>
<td>Improve HRSA Projections of the Physician Workforce</td>
<td>Adopt</td>
<td>Adopted as amended</td>
</tr>
<tr>
<td></td>
<td>Res 325**</td>
<td>Ensure an Effective H-1B Visa Program to Protect Patient Access to Care</td>
<td>Adopt</td>
<td>Revised Resolution 308 adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326</td>
</tr>
<tr>
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<td>-------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Res 326**</td>
<td>Supporting International Medical Graduates and Students</td>
<td>Adopt</td>
<td>Revised Resolution 308 adopted in lieu of Resolutions 308, 311, 312, 317, 321, 325, and 326</td>
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</table>

**Reference Committee F**

<table>
<thead>
<tr>
<th></th>
<th>Res 601</th>
<th>Reinstate the AMA Commission to Eliminate Health Care Disparities</th>
<th>Adopt</th>
<th>Referred</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Res 608</td>
<td>Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine</td>
<td>Adopt</td>
<td>Adopted as amended with a change in title</td>
</tr>
</tbody>
</table>

**Reference Committee G**

|   | CMS 5 | Hospital Consolidation (Resolution 216-A-16) | Adopt | Adopted |

**Informational reports**

<table>
<thead>
<tr>
<th></th>
<th>CME 4</th>
<th>Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>CME 5</td>
<td>Options for Unmatched Medical Students</td>
</tr>
<tr>
<td></td>
<td>CME 8</td>
<td>ACCME Proposed Changes in Accreditation with Commendation Continuing Medical Education (CME) Criteria Assessment Methodology</td>
</tr>
</tbody>
</table>
Information items
AMA funds medical student programs for member recruitment, community service, and more

Through the AMA Section Involvement Grant (SIG), the AMA Medical Student Section (MSS) provides an opportunity for local AMA medical student sections to:

- Educate students about the AMA and provide an opportunity for students to get more involved
- Help put AMA policy into action by providing a service to medical school campuses or communities
- Engage in activities that focus on AMA's top priorities

The MSS section at each school is eligible for up to $1,000 in AMA funding each year. Events submitted through the SIG program encompass innovative activities held at medical schools and in the local communities, to include recruitment, community service, education/local section development and national service project events (e.g., the Accelerating Change in Medical Education initiative).

APS and MSS staff are working to increase awareness of the SIG program, help improve the linkages between medical students and the academic physicians that comprise the APS, and highlight to the APS how the AMA is working to support worthwhile medical student projects nationwide.

APS members are also invited to consider volunteering as academic advisors to the MSS section at your institution. To learn more, contact the APS at (312) 464-4635 or fred.lenhoff@ama-assn.org.

The SIG fiscal year began July 1, 2017. Funding has been approved for the following project(s) during the 2017-2018 academic year (through October 15, 2017):

<table>
<thead>
<tr>
<th>St</th>
<th>School</th>
<th>Title of Project</th>
<th>Date</th>
<th>Advisor/Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>Univ of S Alabama COM</td>
<td>AMA Orientation Dinner</td>
<td>8/1</td>
<td></td>
</tr>
<tr>
<td>AZ</td>
<td>Univ of Arizona COM Phoenix</td>
<td>Annual AMA Doctor's Dinner</td>
<td>10/10</td>
<td>Dr. Jennifer Hartmark-Hill</td>
</tr>
<tr>
<td>CA</td>
<td>Univ of California, San Francisco, SOM</td>
<td>AMA Medical Student Section at UCSF Recruitment</td>
<td>8/14</td>
<td>Dr. Benjamin Franc</td>
</tr>
<tr>
<td>CO</td>
<td>Univ of Colorado SOM</td>
<td>Getting to Know the AMA and CMS</td>
<td>8/17</td>
<td>Brandi Ring, MD</td>
</tr>
<tr>
<td>CT</td>
<td>Univ of Connecticut SOM</td>
<td>1st Year Recruitment for AMA Involvement</td>
<td>10/6</td>
<td>Mary Jacobs</td>
</tr>
<tr>
<td>DC</td>
<td>Georgetown Univ SOM</td>
<td>Welcome to Med School: AMA recruitment event</td>
<td>8/9</td>
<td>Dr. David Rabin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advocacy Week 2017: Reversing the Opioid Epidemic Speaker</td>
<td>10/17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>George Washington Univ SOM</td>
<td>Fall Recruitment '17</td>
<td>9/1</td>
<td>Dr. Charles Macri</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Naloxone Administration 101</td>
<td>10/17</td>
<td></td>
</tr>
<tr>
<td>FL</td>
<td>Univ of Florida COM</td>
<td>Lunch with an Expert on the Opioid Epidemic</td>
<td>10/18</td>
<td>Dr. David Winchester</td>
</tr>
<tr>
<td></td>
<td>Univ of Central Florida COM</td>
<td>Opioid Epidemic Lunch with an Expert</td>
<td>10/18</td>
<td>Dr. Edward Ross</td>
</tr>
<tr>
<td>GA</td>
<td>Morehouse SOM</td>
<td>Lunch with an Expert on the Opioid Epidemic</td>
<td>10/24</td>
<td></td>
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<tr>
<td>IL</td>
<td>Loyola Univ Chicago Stritch SOM</td>
<td>Combatting the Opioid Epidemic: Naloxone Training for Medical Students</td>
<td>10/23</td>
<td>Blake E Murphy</td>
</tr>
<tr>
<td></td>
<td>Midwestern Univ Chicago Coll of Osteo Med</td>
<td>Opioid Epidemic Lunch with an Expert</td>
<td>10/18</td>
<td>Dr. Inouye</td>
</tr>
<tr>
<td></td>
<td>Rosalind Franklin Univ Chicago Med Sch</td>
<td>AMA First General Meeting</td>
<td>8/23</td>
<td>Jeanette Morrison</td>
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<tr>
<td></td>
<td></td>
<td>An Expert's Take on the Opioid Crisis</td>
<td>10/17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Southern Illinois Univ SOM Carbondale</td>
<td>AMA and Organized Medicine Book Sale and Pizza Party</td>
<td>9/14</td>
<td>Carol Harms/Executive Director of the Sangamon County Medical Society</td>
</tr>
<tr>
<td></td>
<td>Southern Illinois Univ SOM Springfield</td>
<td>Welcome to Springfield Cookout - Sponsored by the AMA, Illinois State Medical Society, and Sangamon County Medical Society</td>
<td>8/8</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Reversing the Opioid Epidemic</td>
<td>10/16</td>
<td></td>
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<tr>
<td>LA</td>
<td>Louisiana State Univ SOM, Shreveport</td>
<td>Welcome to Med School: AMA Medical Student Section Recruitment Week</td>
<td>7/28</td>
<td>Lee Stevens</td>
</tr>
<tr>
<td>MA</td>
<td>Harvard Med School</td>
<td>Lunch Talk with Dr. Andrew Gurman, Immediate Past President of the AMA</td>
<td>7/20</td>
<td>Colleen Hennessey</td>
</tr>
<tr>
<td>MD</td>
<td>Johns Hopkins Univ SOM</td>
<td>Harm Reduction Policies in the Opioid Era</td>
<td>10/20</td>
<td>Casey Humbyrd, MD</td>
</tr>
<tr>
<td>MN</td>
<td>Univ of Minnesota Med Sch, Minneapolis</td>
<td>Hands On Advocacy Education Day</td>
<td>8/26</td>
<td>Juliana Milhofer/Policy Analyst</td>
</tr>
<tr>
<td>MO</td>
<td>Mayo Med School</td>
<td>Harvest Classic 5K/10K</td>
<td>9/23</td>
<td></td>
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<tr>
<td>MO</td>
<td>Univ of Missouri SOM Columbia</td>
<td>Project Homeless Connect - A MedZou Community Outreach Event</td>
<td>1/25/18</td>
<td>Ted Groshong</td>
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<tr>
<td>MO</td>
<td>Univ of Missouri SOM Kansas City</td>
<td>Understanding the Opioid Epidemic: What We Know, What We Can Do</td>
<td>10/12</td>
<td>Charles VanWay, MD</td>
</tr>
<tr>
<td>NC</td>
<td>East Carolina Univ Brody SOM</td>
<td>Class of 2021 Recruitment Event</td>
<td>8/25</td>
<td>Charles Willson</td>
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<tr>
<td>NC</td>
<td>Wake Forest Univ SOM</td>
<td>Opioid Epidemic Lunch Talk During Advocacy Week Recruitment Event</td>
<td>10/18</td>
<td>Dr. Howerton</td>
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<tr>
<td>NE</td>
<td>Creighton Univ SOM</td>
<td>Welcome to Med School: AMA Recruitment Event</td>
<td>9/27</td>
<td>Peter Silberstein</td>
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<tr>
<td>NE</td>
<td>Univ of Nebraska COM</td>
<td>M1 AMA Recruitment Event</td>
<td>9/14</td>
<td>Kelly Caverzagie</td>
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<td>NJ</td>
<td>Rowan University School of Osteopathic Medicine (Stratford, NJ)</td>
<td>Health Policy Summit</td>
<td>10/28</td>
<td>Neil Jain/President</td>
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<td>NJ</td>
<td>Rutgers, Robert Wood Johnson Medical School (Piscataway)</td>
<td>New Jersey Healthcare Policy Summit</td>
<td>10/28</td>
<td>Dr. Mehan, Assistant Dean of Student Affairs</td>
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<tr>
<td>NV</td>
<td>Univ of Nevada SOM Reno</td>
<td>AMA Recruitment Lunch</td>
<td>7/31</td>
<td>Ranna Nash/Learning Specialist</td>
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<td>NY</td>
<td>Cornell Med College</td>
<td>Information Session: Weill Cornell Medicine American Medical Association Chapter</td>
<td>9/15</td>
<td>Dr. Keith LaScalea</td>
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<td>NY</td>
<td>New York Med College</td>
<td>New first year recruitment event</td>
<td>8/11</td>
<td>Tony Sozzo</td>
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<tr>
<td>NY</td>
<td>SUNY Buffalo SOM</td>
<td>AMA Recruitment Breakfast and Presentation The Buffalo Community’s Response to the Opioid Epidemic</td>
<td>8/7</td>
<td>Dr. David Milling</td>
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<td>NY</td>
<td>SUNY Upstate COM Syracuse</td>
<td>AMA Physician-Student Social SUNY Upstate AMA introductory Meeting with Dr. Andrew Gurman, SUNY Upstate Alumnus and Immediate Past AMA President</td>
<td>9/15</td>
<td>Dr. Anthony P Weiss, Associate Dean for Clinical Affairs</td>
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<td>NY</td>
<td>SUNY Stony Brook SOM</td>
<td>Get Set for BMD/PHD - AMA-MSS Speaker Presentation</td>
<td>10/20</td>
<td>Kelly Garcia</td>
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<td>NY</td>
<td>Univ of Rochester SOM</td>
<td>New Student Orientation Week Dinner Health Reform Education Series</td>
<td>8/22</td>
<td>9/18</td>
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<td>OH</td>
<td>Northeast Ohio Medical Univ</td>
<td>NEOCED AMA/OSMA Welcome Lunch and Meet &amp; Greet Dinner with an Expert on the Opioid Epidemic</td>
<td>8/30</td>
<td>Brian Bachelder, MD</td>
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<tr>
<td>OH</td>
<td>Ohio St Univ COM</td>
<td>Medical Student National Advocacy Week 2017: Experts on the Opioid Epidemic</td>
<td>10/16</td>
<td>Anne Taylor, MD, MPH</td>
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<td>OH</td>
<td>Univ of Cincinnati COM</td>
<td>AMA presents Advocacy Week</td>
<td>9/11</td>
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<td>OH</td>
<td>Univ of Toledo COM</td>
<td>Pressing Advocacy and Policy Issues in Healthcare by Dr. Evangeline Andarsio</td>
<td>10/10</td>
<td>Donna Woodson, MD</td>
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<td>SC</td>
<td>Univ of South Carolina SOM</td>
<td>AMA and the Importance of Health and Physician Advocacy Palmetto Health Children's Hospital Halloween Carnival</td>
<td>9/27</td>
<td>10/31</td>
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<td>SC</td>
<td>Univ of South Carolina SOM, Greenville</td>
<td>New Student Zoo Day and BBQ Social Lunch with an Expert on the Opioid Epidemic</td>
<td>7/14</td>
<td>Dr. Rob Morgan</td>
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<tr>
<td>State</td>
<td>Institution</td>
<td>Event Description</td>
<td>Date</td>
<td>Organizer</td>
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<tr>
<td>TN</td>
<td>East Tennessee St Univ Quillen COM</td>
<td>AMA/TMA Recruitment Banquet</td>
<td>7/20</td>
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<td></td>
<td>Lincoln Mem Univ DeBusk Coll of Osteo Med</td>
<td>LMU-DCOM AMA Recruitment</td>
<td>9/19</td>
<td>Dr. Teresa Campbell, MD</td>
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<td>TX</td>
<td>Baylor COM</td>
<td>Pizza with Professors</td>
<td>9/14</td>
<td>Cedric Dark</td>
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<tr>
<td></td>
<td>Texas A &amp; M Univ COM Temple</td>
<td>Aggie Health Project: Hepatitis C</td>
<td>10/12</td>
<td>Donna Shipp, Coordinator, Student Services</td>
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<tr>
<td></td>
<td>Texas A &amp; M Univ COM College Station</td>
<td>Meet with an Expert on the Opioid Epidemic</td>
<td>10/18</td>
<td>Rachel Hohlt</td>
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<tr>
<td></td>
<td>Univ of N TX Coll of Osteo Med Ft Worth</td>
<td>AMA/TMA Orientation/Recruitment Dinner</td>
<td>7/12</td>
<td>Dr. Siy</td>
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<td></td>
<td>University of Texas Rio Grande Valley</td>
<td>SafeMD</td>
<td>8/16</td>
<td>Adela Valdez</td>
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<tr>
<td></td>
<td>Univ of Texas SOM San Antonio</td>
<td>American Medical Association and Texas Medical Association Happy Hour</td>
<td>9/6</td>
<td>Dr. Ashok Kumar</td>
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<tr>
<td></td>
<td>Univ of Virginia SOM</td>
<td>Political Engagement and Advocacy Panel and Discussion</td>
<td>10/4</td>
<td>Jenny Young</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cells, Tissues, and Mechanisms of Disease Journal Club</td>
<td>10/17</td>
<td></td>
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<td></td>
<td>Virginia Tech Carilion SOM</td>
<td>AMA Annual Welcome and Recruitment Barbecue</td>
<td>8/20</td>
<td>Omar Salman - Co-President</td>
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<tr>
<td>WI</td>
<td>Med Coll of Wisconsin</td>
<td>MCW AMA-MSS Meet and Greet</td>
<td>8/31</td>
<td>Dr. Bill Hueston</td>
</tr>
<tr>
<td>WV</td>
<td>Marshall Univ Edwards SOM</td>
<td>Dr. Sheri Young, DO, VP WVSMA speaking about physician advocacy and the opioid epidemic as part of AMA Advocacy Week</td>
<td>10/17</td>
<td>Amy Smith, Assistant Dean for Student Affairs</td>
</tr>
</tbody>
</table>
The AMA’s GME Competency Education Program

An online educational program to help your residents develop ACGME milestones to meet competency requirements

The American Medical Association created its new GME Competency Education Program with you in mind. Get answers to your questions and learn how this program has been completely reimagined to help make life a little easier … for you and your residents.

How will this improve the education and training of my residents?

• Robust library allows you to select courses to meet individual program year and/or program needs
• Meaningful knowledge checks in each course increase knowledge retention for residents
• Identify outliers in your program(s) with multiple failed course assessment alerts

How will this ease the burden on my staff and program managers?

• System auto-generates reminders for residents to complete coursework
• Dashboard gives a quick, comprehensive look at resident usage
• Allows for easy creation of customized assignments for program year and/or specific program needs

How will this reduce stress on my residents?

• Short, concise courses reduce time needed for education
• Mobile optimization allows for self-paced learning available whenever, wherever
• System-generated reminders keep residents aware of assigned due dates

To learn more about the AMA’s GME Competency Education Program, contact Kathy Hinton at kathy.hinton@ama-assn.org or call (312) 464-5698.
2 AMA online communities and communication resources

Accelerating Change in Medical Education digital community
ace.communities.ama-assn.org

Join the Accelerating Change in Medical Education digital community to discuss topics in medical education and take an active role in creating the medical school of the future. This online forum allows you to take part in an ongoing conversation on important developments in medical education, innovations that will transform how medical students learn and how future physicians practice, and ways to implement those innovations at your institution.

Other AMA online communities include the following; access ama-assn.org/communities to learn more.

- Running Your Practice
- Medical Student
- International Medical Graduates
- Journal of Ethics Discussion Forum
- Physician Innovation Network

AMA Morning Rounds®
A daily newsletter that provides highlights from the AMA, The JAMA Network® and the most relevant news distilled from more than 3,000 major newspapers, magazines and journals.

AMA Morning Rounds® Weekend Edition
A members-only, weekly newsletter that provides top news and information to help physicians and physicians in training know and understand the top issues impacting their profession.

AMA Wire® Alert
Periodic alerts on the latest news and information impacting the medical community.

The JAMA Network® Alerts
Email alerts of the latest content from the 12 journals of The JAMA Network, including the Journal of the American Medical Association (JAMA®), as soon as they are published.

AMA Advocacy Update
A bi-weekly newsletter that offers exclusive advocacy news and information on key national and state issues.

AMA MedEd Update
A monthly newsletter that includes news and information focused on graduate medical education, health care careers, medical schools and continuing physician professional development.
AMA Journal of Ethics®
A monthly email of the top stories from the latest issue of the AMA Journal of Ethics®, as well as a themed podcast and reader poll.

FREIDA Online® News
The latest information on FREIDA Online® The AMA Residency & Fellowship Database™ of accredited graduate medical education programs in the United States and Puerto Rico.

AMA Store News
A newsletter with the latest industry news, exclusive product specials, education and training opportunities and important product updates.

AMA Member and Special Group News
Information on career support and opportunities offered by our member sections and group.

CPT® Updates
Notifications on changes to CPT® codes, including Category II codes, Category III codes, vaccine codes and errata. Also alerts on when registration opens for the CPT Editorial Panel meetings.

Product and Program Updates
Email alerts to stay up to date on the latest AMA products and programs.

Credentialing Updates
Information on physician credentialing verification and qualifications.

Practice Improvement Information
News that helps physicians identify patient care areas for improvement and change their performance.

To learn more and subscribe to these newsletters, see:
ama-assn.org/life-career/email-newsletter-publications
3 Future APS meeting dates

June 8-9, 2018
Chicago, Ill.

November 9-10, 2018
National Harbor, Md.

June 7-8, 2019
Chicago, Ill.

November 15-16, 2019
San Diego, Ca.

June 5-6, 2020
Chicago, Ill.
We're glad you're here!

The American Medical Association is pleased you are joining us for our 2017 Interim Meeting—where all of organized medicine assembles at the same time and place.

As a new participant, this brochure will help you navigate the meeting and better understand the variety of experiences you can take part in while you are here. We encourage you to visit our Information Desk, located outside the Kamehameha Exhibit Hall II, for additional personal assistance.

Visit the Information Desk for personal assistance. (outside the Kamehameha Exhibit Hall II near registration)

AMA exhibit: Stop by to get your free gift and discover what's new for AMA members!

Located just outside the Kalakaua Ballroom, the AMA exhibit is the place to:

- Post your photos on one of the AMA digital communities
- View digital resources and receive personal assistance
- Pick up your free gift!

Download “AMA Meetings” app
(Apple and Android)
WiFi: aloha2017
Password: aloha2017
#AMAmtg

2017 AMA Interim Meeting
Hawai‘i Convention Center, Honolulu

NOV. 9–11
Interest-specific educational sessions, AMA Research Symposium and networking events

NOV. 11–14
AMA House of Delegates (policymaking meetings, open hearings and education)

Aloha new participants!
Orientation

Things to know about the meeting and related events

AMA House of Delegates Interim Meeting
- Officially begins at 2 p.m., Saturday, Nov. 11, and is scheduled to adjourn no later than noon Tuesday, Nov. 14 (note: actual adjournment time and date, which can vary slightly, is determined by when the AMA House of Delegates formally concludes its business)
- Democratic process; forum for robust, respectful debate that establishes AMA policy positions and directs some actions and activities
- 555 delegates represent all 50 U.S. states and territorial medical associations, and nearly 120 medical specialty societies, lifestyle and interest-specific groups, as well as the armed services, Veterans Administration and Public Health Service (note: non-delegate registered attendees will find open seating in the back third of the Kamehameha Exhibit Hall II)

The AMA's 11 interest-specific groups and their respective meetings and activities
- Represent and bring forward the ideas, issues and policy recommendations of their respective constituents
- The following groups conduct and conclude the majority of their official business of the AMA House of Delegates: Academic Physicians Section (APS) – Organized Medical Staff Section (OMSS) – Young Physicians Section (YPS)
- The following councils study and submit recommendations related to the business of the AMA House of Delegates:
  - CCAB (Council on Constitution and Bylaws)
  - CEJA (Council on Ethical and Judicial Affairs)
  - CMS (Council on Medical Service)
  - CLRPD (Council on Long Range Planning and Development)
  - CME (Council on Medical Education)
  - CSAPH (Council on Science and Public Health)

AMA Board of Trustees
- Principal governing and strategic planning body; takes actions based on policy/directives of the AMA House of Delegates
- Twenty-one members (including student, resident, young physician and public member representatives)

Navigation

Finding your way around the hotel and hearings

Open hearings: Reference committee hearings
8:30 a.m.–12:30 p.m., Sunday, Nov. 12
AMA House of Delegates will consider more than 100 resolutions and reports that fit the advocacy theme of the Interim Meeting. If the resolution is accepted, each resolution will be referred to one of the following reference committees that will listen to members’ comments and then recommend how each item should be acted upon by voting delegates.
- Reference Committee on Amendments to Constitution and Bylaws
- Reference Committee B (legislation, legal and regulatory issues)
- Reference Committee F (AMA finance and governance)
- Reference Committee J (advocacy related to medical service, practice and insurance)
- Reference Committee K (advocacy related to medical education, science, public health and related topics)

Closed hearings: AMA councils
The following councils study and submit recommendations related to the business of the AMA House of Delegates:
- CCAB (Council on Constitution and Bylaws), CEJA (Council on Ethical and Judicial Affairs), COL (Council on Legislation), CLRPD (Council on Long Range Planning and Development), CME (Council on Medical Education), CMS (Council on Medical Service) and CSAPH (Council on Science and Public Health)

A few rules for the road
AMA members, guests and observers are welcome to attend:
- All reference council sessions (AMA members have the right to comment; nonmembers or non-physicians may speak with permission of the chair)
- All educational sessions (including those offering CME)
- All open sessions of the AMA House of Delegates and interest-specific groups

Within the AMA House of Delegates sessions:
- Only certified delegates or alternate delegates temporarily credentialed as delegates may speak from the floor or vote

Education sessions
- Numerous, concurrent educational sessions and events offered with many sessions certified for CME credit (sponsored by various entities)
- All sessions and events are open to all meeting attendees unless designated as a “Governing Council,” “Council,” “Executive Session” or “Closed Session” (be sure to check door signage before entering room)
- AMA and medical society staff are present at every session/event to help
- Please check in with staff and sign in if you have not pre-registered for that session; claim CME credit by Dec. 31, 2017
Educational sessions: Sponsored by AMA sections
2017 AMA Interim Meeting • Hawai‘i Convention Center, Honolulu

The American Medical Association designates each live activity for the maximum number of AMA PRA Category 1 Credits™, unless otherwise noted. The deadline to claim credit is Dec. 31, 2017.

**Being present: Physician wellness and mindfulness**
9–10 a.m. Saturday, Nov. 11, Room 320
Physicians are faced with numerous stressors including increasing administrative responsibilities, regulatory pressures and evolving payment and care delivery models. Professional pressures and stress can lead to physician burnout, which can have an impact on organizational productivity, morale, costs and the quality of care being delivered. This session will provide you with an overview of contributing factors associated with physician burnout and ways you can address burnout individually and organizationally.

Track: Practice Sustainability and Satisfaction

**Telemedicine: Improving patient care and health outcomes**
9–10 a.m. Saturday, Nov. 11, Room 310
Telemedicine technology has the potential to transform health care delivery and address many care coordination challenges facing the U.S. health care system. It can facilitate remote, mobile and site-to-site medical care. Telemedicine, a key innovation in support of health care delivery reform, is being used in initiatives to improve access to care, care coordination and quality and when properly used has the potential to reduce the rate of growth in health care spending. Implementing telemedicine in your practice can expand access to care, provide a better patient experience and improve health outcomes when implemented properly.

Track: Advocacy

**Situational leadership for physicians**
9–10 a.m. Saturday, Nov. 11, Room 315
As leaders in your hospital, medical school or practice, you need to understand when, and how, to adjust your leadership style to fit the needs of your staff and to ensure improved patient care and quality outcomes. Join expert faculty for this session to help you develop the required skills to adjust your leadership style, based on the specific situation, including the number and type of health professionals and the needs of the patient.

Track: Leadership

**Advocacy: Tools of the trade**
10:10–11:10 a.m. Saturday, Nov. 11, Room 310
Physician advocates play a vital role in influencing policymakers on matters that affect patient care and outcomes. Despite the importance of such advocacy, physicians rarely receive formal training on how to conduct advocacy activities to achieve goals for their patients and the profession.

This program will introduce tools and skills that every physician should employ when connecting with decision makers, including how to organize your peers, how to build relationships with legislators, and how to effectively communicate an advocacy message.

Track: Advocacy

(Continued on next page)
Generational changes: Managing up, leadership and followership
10:10–11:10 a.m. Saturday, Nov. 11, Room 315
Organized medicine, health care systems, and physician groups have evolved and are designed with the current workforce in mind. In contrast, younger generations are increasingly diverse and have different expectations than their predecessors with regard to work-life balance, lines of authority, technology, privacy, and social media. Current systems are not prepared for what these differences will produce with regards to the future workforce, work environment and patient outcomes. You will learn techniques to help you work more effectively with colleagues from multiple generations.

Track: Leadership

Trends in Academic Medicine: Community preceptors, innovations in pedagogy, and more
10:10–11:10 a.m. Saturday, Nov. 11, Room 320
How can you mentor the future generation of physicians? For community-based practicing physicians, serving as a preceptor to medical student and/or resident/fellow trainees is an excellent way to do just that. Learn more about precepting, and how to balance it with clinical and administrative duties. Both the administrative perspective (i.e., what schools can offer, trends in funding, faculty appointments, etc.) as well as the preceptor viewpoint will be addressed in this session.

Another key trend in medical education is the information explosion and the need for future physicians to move beyond mere memorization to develop critical thinking and problem-solving skills. Learn about the many ongoing innovations in medical education (including those of the AMA’s Accelerating Change in Medical Education consortium) that can help make learning more readily applicable and relevant to future physicians. Also, be sure to bring your own ideas to share during the open forum segment of this session.

Track: Practice Sustainability and Satisfaction

Advocacy: What roles exist for physicians?
11:20 a.m.–12:20 p.m. Saturday, Nov. 11, Room 310
Physicians have an important role to play in health care advocacy. With health care accounting for a large share of the American economy and the current evolutionary state of medicine, physicians are in a prime position to help navigate and influence these discussions.

This program will highlight the experiences of a group of physicians who advocate for their patients and the profession in diverse ways, including a physician legislator and a physician leader of a health system with its own lobbying arm. Join us for a discussion about how you can take an active role in advocacy and the political process.

Track: Advocacy

Achieving health equity through organized medicine as physician leaders
11:20 a.m.–12:20 p.m. Saturday, Nov. 11, Room 315
The implementation of the ACA has closed the gap but disparities in care and health outcomes continue to persist. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health care on the basis of their race, ethnicity, gender, gender identity, socio-economic status, and sexual orientation. It has been noted that a comprehensive, multilevel strategy is needed to eliminate these disparities. After participating in this session, you will learn about how you can integrate effective interventions, new techniques and patient considerations in order to mitigate and eliminate health disparities.

Track: Leadership

Outside of the box: Physician innovators and entrepreneurs
11:20 a.m.–12:20 p.m. Saturday, Nov. 11, Room 320
As a physician, you can shape the future of health care. Through lending your expertise to a tech company or pursuing a career as an entrepreneur, you have options to make a lasting impression on the future of medicine. Join fellow physician-entrepreneurs for a discussion about how you can lend your expertise to influence health care and shape the future of medicine.

Track: Practice Sustainability and Satisfaction

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APS meeting, Nov. 2017 110 of 116
Looking to pay it forward as a mentor?

As part of the AMA Foundation’s new Leadership Development Institute, we are recruiting physicians who would like to mentor students during their final year of medical school.

Information Sessions @ 2017 Interim Meeting

Stop by for more information and a continental breakfast!

Monday, November 13th 7:00-9:00am in Center Room 318B
Tuesday, November 14th 7:00-8:30am in Center Room 323C

RSVP to emily.demko@ama-assn.org
2017 AMA Advisory Committee on LGBTQ Issues Interim Meeting

Walking the walk: How to navigate LGBTQ community engagement and social justice in medicine

5:30 p.m. | Friday, Nov. 10
Room: Tapa 1 | Hilton Hawaiian Village

The American Medical Association Advisory Committee on Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Issues invites you to the following special presentation during its Interim Meeting.

Overview
Panelists will share perspectives on medicine and community engagement as a form of social activism to achieve health justice. They will discuss their decades-long practice of medicine through public health and legal crises (e.g., AIDS epidemic, same-gender marriage) in the Hawaiian LGBTQ community and how it led to improved health and wellness today, as well as for future generations.

Moderator
David McEwan, MD
Family medicine
Private practice

Panelists
Robert Bidwell, MD
Adolescent medicine
J.A. Burns School of Medicine
University of Hawai‘i, Mānoa

Jennifer Frank, MD
Family medicine
University Health Services
University of Hawai‘i, Mānoa

Drew Kovach, MD
Family medicine
J.A. Burns School of Medicine
University of Hawai‘i, Mānoa
Join international medical graduates in Hawaii

20th AMA-IMG Section Interim Meeting
Nov. 10–13
Hawaii Convention Center
Honolulu

You are invited to attend the 20th anniversary American Medical Association International Medical Graduates (IMG) Section’s Interim Meeting. We encourage you to invite a colleague or friend who may be interested in attending the valuable information sessions at the meeting.

Meeting highlights include:

• 14th AMA Research Symposium and reception
  1–7:30 p.m., Friday, Nov. 10
  Hear educational sessions, oral research presentations and view abstracts by our AMA-IMG ECFMG-certified candidates who are awaiting residency. The AMA Medical Student Section and the AMA Resident and Fellow Section will also be part of the AMA Research Symposium.
  AMA-IMG Section podium presentations will be held 4–5 p.m. in Room 319A.

• Joint sections and special group education sessions
  9 a.m.–noon, Saturday, Nov. 11; Rooms 310, 315 and 320
  Participate and earn complimentary CME in the sections’ and special group’s first-ever co-sponsored educational tracks, which include nine educational programs important to physicians. The AMA designates each live activity for the maximum number of AMA PRA Category 1 Credit™, unless otherwise noted. The deadline to claim credit is Dec. 31.

• AMA-IMG Section reception and congress
  5:30–7:30 p.m., Saturday, Nov. 11; Room 316B
  Network with colleagues, hear an NBME Update and discuss policy items for the AMA-IMG Section and AMA House of Delegates reports/resolutions of interest.
  Keynote speaker: Peter J. Katsufrakis, MD, CEO, president, National Board of Medical Examiners

• Busharat Ahmad, MD, Leadership Development Program
  Answering the call to be a physician leader
  2:30–3:30 p.m., Sunday, Nov. 12; Room 317A
  Come and learn about how to be an effective physician leader.
  Keynote speaker: George C. Mejicano, MD, MS

• AMA-IMG Section and AMA Minority Affairs Section delegates caucus
  9–10 a.m., Monday, Nov. 13; Room 314
  Review reference committee reports and discuss strategies for supporting AMA-IMG Section and AMA House of Delegates policy items.

Register at ama-assn.org/sections-meeting-registration today. The deadline for registration is Saturday, Nov. 4. For more information, email img@ama-assn.org or call (312) 464-5397.
You’re invited to participate in an AMA-IMG Section event

Busharat Ahmad, MD, Leadership Development Program

Answering the call to be a physician leader
2:30–3:30 p.m.
Sunday, Nov. 12
Room 317A, Hawaii Convention Center
Honolulu

Busharat “Bush” Ahmad, MD, is one of the most well-known and respected international medical graduates in the United States. A strong advocate for international graduates, Dr. Ahmad’s tireless efforts were instrumental in the formation of the American Medical Association International Medical Graduates (IMG) Section in 1997. This leadership development program commemorates his guidance and commitment to organized medicine.

This year’s program is designed to give individuals interested in becoming dynamic physician leaders an overview of the skills needed to be successful in answering the call to be a physician leader.

Featured speaker

George C. Mejicano, MD, MS, is the current chair of the AMA Academic Physicians Section, as well as the chair of the Continuing Professional Development Section of the AAMC’s Group on Educational Affairs. In 2017 he began his first term on the Liaison Committee on Medical Education.

This event is cosponsored by the AMA Minority Affairs Section.

All 2017 AMA Interim Meeting attendees are welcome to attend this event. For more information, email img@ama-assn.org or call (312) 464-5397.
How family-centered care helps Hawai‘ian health care meet the needs of an extremely diverse patient population

4:30 p.m. | Friday, Nov. 10
Room: Rainbow 3 | Hilton Hawaiian Village

Speaker
Maile Taualii, PhD, MPH
Assistant professor, Native Hawaiian and indigenous health
Hawai‘inuikea, School of Hawaiian Knowledge
University of Hawaii, Manoa

Overview
Hawai‘i’s diverse population requires that health care providers be responsive to cultural diversity and reflexive to a patient’s individual needs, all while embracing the Native Hawaiian values of respect, humility, kindness, patience and aloha.

This presentation will focus on research and recent efforts to develop an “‘ohana-centered” model for health care delivery that is rooted in these values. ‘Ohana in its most literal sense means “family.” This work focuses on moving from patient-centered care to ‘ohana-centered care with the goal of assisting patients in receiving not only the best individual care and disease prevention, but also providing advice and assistance in keeping their entire ‘ohana healthy, from their kupuna (elders) to their unborn keiki (children) and everyone in between. The goal of this culturally respectful delivery model is to prevent disease, maintain health, prepare for the next generation and help the kupuna ease gracefully into the time of hala, or the passing from this life into the next.
2017 AMA Senior Physicians Section Interim Meeting

Educational session: “Keeping your brain fit”
Noon–1:30 p.m. | Saturday, Nov. 11
Room 312 | Hawaii Convention Center

The American Medical Association Senior Physicians Section (SPS), the AMA Academic Physicians Section (APS) and the AMA Organized Medical Staff Section (OMSS) invite you to this joint educational program during the 2017 AMA Interim Meeting.

Moderator
Paul H. Wick, MD
Chair, AMA-SPS Governing Council

Speaker
Allan A. Anderson, MD, MMM
Assistant professor, Johns Hopkins School of Medicine; vice president, Dementia Care Practice, Integrace; medical director, Samuel and Alexia Bratton Memory Clinic, The Gardens at Bayleigh Chase, Easton, Md.

Reaction panelist
Jeremy A. Lazarus, MD
Past president, AMA (2012–2013)

Program description
With the aging of our society we are witnessing an ever-increasing number of individuals who develop mild cognitive impairment and dementia. The American public often turns to their primary care and specialty physicians for support and education as they navigate advertisements supporting brain training products as well as nutritional and other supplements to improve brain function and memory.

It is important for physicians and other clinicians to know the science behind claims for various products and other treatment options. To date, the best evidence supports lifestyle changes to improve cognitive function and possibly prevent dementia, with little data to support other approaches. This presentation will summarize this data and present evidence for physicians to provide to their patients prudent information about ways to “maintain the brain” as their patients age.

Learning objectives
Upon completion of this activity, the physician will be able to:

• Identify the ways our cognitive abilities change with normal aging.
• Describe the potential lifestyle changes that promote optimal brain functioning.
• Recognize the difficulty in translating observational studies to specific recommendations.

Please join us for the AMA-SPS Assembly Meeting where we will discuss AMA House of Delegates business items and future AMA-SPS activities
11:30 a.m.–noon
Saturday, Nov. 11
A light lunch will be offered at 11:30 a.m., first come, first served.

Spread the word! Any physician 65 years of age and above is welcome to attend! Visit ama-assn.org/go/spss to learn more.