AMA-IMG Section 20th Anniversary Congress Meeting
June 10, 2017

Hyatt Regency Chicago
AMA INTERNATIONAL MEDICAL GRADUATES SECTION
20TH ANNIVERSARY CONGRESS AGENDA
Saturday, June 10, 2017
Hyatt Regency - Chicago
5:30 pm – 7:30 pm, Columbus G

I. Networking Reception until 5:45 pm

II. Welcome and Introductions, Bhushan Pandya, MD, Chair

III. AMA-IMG Section Rules of Order
American Institute of Parliamentarians Rules of Order,
Parliamentary Procedures

IV. Featured Speaker
"AMA Washington Update" - Todd Askew

V. Full meeting schedule (informational)

VI. A. Reports & Resolutions
IMGS Resolutions
a) IMG Section Chair’s Report
b) Resolution 306 – U.S. International Medical Graduates in Physician Workforce
c) Resolution 307 – Formal Business and Practice Management Training During Medical Education

B. Minority Affairs Section Resolutions
a. Resolution 007 - Healthcare as a Human Right
b. Resolution 225 - Truth in Advertising
c. Resolution 313 - Study of Declining Native American Medical Student Enrollment
d. Resolution 314 - Educating a Diverse Physician Workforce
e. Resolution 516 - Inflight Emergencies
f. Resolution 517 - Choline Supplementation in Prenatal Vitamins

C. Other HOD Reports/Resolutions
a. Resolution 304 – Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding (MSS)
b. Resolution 308 – Immigration Reform Impacts on International Medical Graduate Training and Patient Access (Various specialties)
c. Resolution 311 – Support of International Medical Graduates (Wisconsin)
d. Resolution 312 – Support of International Medical Graduates and Students (New York)

e. Resolution 317 – Immigration (Michigan)

f. CLRPD Report 2 – Demographic Characteristics of the House of Delegates and AMA Leadership

g. CME Report 4 – Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages

h. CME Report 5 - Options for Unmatched Medical Students

i. CME Report 6 – Standardizing the Allopathic Residency Match System & Timeline

VII. Organizational Reports
A. ECFMG IMG Section Representative – Nyapati Rao, MD
B. AMA Foundation
C. NAAMA – Dr. Basim Dubaybo
D. AAPI – Dr. Ajay Lodha

VIII. Open Discussion/New Business
A. Ideas for I-17 resolutions
B. IMG Physicians Online Community

IX. Announcements/Informational Items
A. Virtual Congress Schedule
B. Monday, June 12 - IMGS & Minority Affairs Section Delegates Caucus, 8:30 am – 9:30 am, Skyway 273, East Tower (review Reference Committee reports)
C. Monday, June 12 - Busharat Ahmad, MD Leadership Development Program, 10:30 am – 11:30 am, Roosevelt 3 A/B
D. Leadership Opportunities Grid
E. 15th Annual Joint Research Symposium, Friday, Nov. 10, 2017
   a. Need volunteer judges*
   b. Research Symposium IMG Section categories: Clinical Vignette, Clinical Medicine, Improving Health Outcomes (cardiovascular disease, diabetes)
   c. Abstract deadline: August 9, 2017
F. Summary of Actions (2016 Interim Meeting)
G. 2017-2018 IMG Governing Council Roster
H. Relevant IMG articles
I. Hotel Map
J. Speakers Letter

X. Sections and Special Groups Fliers
XI. Future IMG Section Meetings
   A. November 9-12, 2017, IMG Section 20th Interim Meeting, Hawaii Convention Center
   B. June 9-11, 2018, IMG Section 21st Annual Meeting, Hyatt Regency
   C. November 9-12, 2018, IMG Section 21st Interim Meeting, National Harbor, Maryland
<table>
<thead>
<tr>
<th>Order of Rank/Precedence¹</th>
<th>Interrupt</th>
<th>Second</th>
<th>Debate</th>
<th>Amend</th>
<th>Vote</th>
<th>Applies to what other motions?</th>
<th>Can have other motions applied?²</th>
<th>Renewable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Privileged Motions</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend, Close Debate, Limit Debate</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend, Close Debate, Limit Debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>3. Question of Privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Subsidiary Motions</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. Table</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Main Motion</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>5. Close Debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable Motions</td>
<td>None</td>
<td>Yes</td>
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<tr>
<td>6. Limit Debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>2/3</td>
<td>Debatable Motions</td>
<td>Amend, Close Debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>7. Postpone to a Certain Time</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main Motion</td>
<td>Amend, Close Debate, Limit Debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>8. Refer to Committee (or Board)</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main Motion</td>
<td>Amend, Close Debate, Limit Debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes³</td>
<td>Yes</td>
<td>Majority</td>
<td>Rerworldable Motions</td>
<td>Close Debate, Limit Debate</td>
<td>No⁵</td>
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<tr>
<td><strong>Main Motions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10a. The Main Motion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
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<tr>
<td>10b. Specific Main Motions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Adopt in-lieu-of</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
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<tr>
<td>Amend a Previous Action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Same Vote</td>
<td>Adopted MM</td>
<td>Subsidiary</td>
<td>No</td>
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<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Same Vote</td>
<td>Adopted MM</td>
<td>Subsidiary</td>
<td>No</td>
</tr>
<tr>
<td>Recall from Committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>No</td>
<td>Majority</td>
<td>Referred MM</td>
<td>Close/Limit Debate</td>
<td>No</td>
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<tr>
<td>Reconsider</td>
<td>Yes⁴</td>
<td>Yes</td>
<td>Yes²</td>
<td>No</td>
<td>Majority</td>
<td>Vote on MM</td>
<td>Close/Limit Debate</td>
<td>No</td>
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<tr>
<td>Rescind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Same Vote</td>
<td>Adopted MM</td>
<td>Subsidiary; not amend</td>
<td>No</td>
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</table>
## Incidental Motions (non-ranking within the classification)

<table>
<thead>
<tr>
<th>Motions</th>
<th>No order of Rank/Precedence</th>
<th>Interrupt</th>
<th>Second</th>
<th>Debate</th>
<th>Amend</th>
<th>Vote</th>
<th>Applies to what other motions?</th>
<th>Can have other motions applied?</th>
<th>Renewable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority⁷</td>
<td>Ruling of Chair</td>
<td>Close/limit debate</td>
<td>No</td>
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<tr>
<td>Suspend the Rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Procedural Rules</td>
<td>None</td>
<td>Yes</td>
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<tr>
<td>Consider Informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main Motion or Subject</td>
<td>None</td>
<td>Yes</td>
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**Requests**

<table>
<thead>
<tr>
<th>Requests</th>
<th>Yes</th>
<th>No</th>
<th>No</th>
<th>No</th>
<th>No</th>
<th>None</th>
<th>Procedural error</th>
<th>None</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of Order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Procedural error</td>
<td>None</td>
<td>No</td>
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<tr>
<td>Inquiries</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None⁶</td>
<td>All motions</td>
<td>None</td>
<td>No</td>
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<tr>
<td>Withdraw a Motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None⁶</td>
<td>All motions</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Division of a Question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None⁶</td>
<td>Main Motion</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Division of Assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None⁶</td>
<td>Indecisive Vote</td>
<td>None</td>
<td>No</td>
</tr>
</tbody>
</table>

**Notes:**

1. Motions are in order only if no motion higher on the list is pending.
2. Restricted
3. Not debatable when applied to undebatable motion
4. Member may interrupt proceedings, but not a speaker
5. Withdraw may be applied to all motions
6. Renewable at discretion of presiding officer (chair)
7. Tie or majority vote sustains the ruling of the presiding officer; majority vote in negative reverses the ruling
8. If decided by assembly (by motion), requires a majority vote to adopt

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American Institute of Parliamentarians
(888) 664-0428
www.aipparl.org
aip@aipparl.org

*American Institute of Parliamentarians Standard Code of Parliamentary Procedure* Motions Table
Todd Askew
American Medical Association
Director of Congressional Affairs

Todd Askew is the Director of the Division of Congressional Affairs for the American Medical Association, a position he has held since 2006. In that capacity, Todd oversees that team of Congressional lobbyists and develops and implements strategies to advance organized priorities before the United States Congress.

Prior to becoming Director, Todd was an Assistant Director for the division, working primarily with House Democratic leadership and the House Committees on Energy and Commerce and Ways and Means, the committees with primary jurisdiction over most health care and public health issues. From 1994-2000, Todd worked for the American Academy of Pediatrics Department of Federal Affairs. In this role, he worked extensively on legislative and regulatory matters dealing with health care financing and public health, including the 1997 enactment of the Children Health Insurance Program. Todd began his career in Washington in the office of then Representative Nathan Deal of Georgia.

Todd has a B.A.in History from Washington and Lee University in Lexington, VA.
# International Medical Graduates Section (IMGS) Meeting Schedule

## 2017 20th Annual Meeting
Hyatt Regency Chicago

**IMGS Meetings: June 9-12**
**House of Delegates Meetings: June 10-14**

<table>
<thead>
<tr>
<th><strong>Friday, June 9</strong></th>
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<tbody>
<tr>
<td>7:00 a.m.-4 p.m.</td>
<td>Registration for all meeting attendees</td>
<td>Across from Grand Ballroom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:00-4:20 p.m.</td>
<td>IMGS &amp; Minority Affairs Section Board Officer Candidates Interviews</td>
<td>Columbus G</td>
<td></td>
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</tr>
<tr>
<td>6:00-7:00 p.m.</td>
<td>AMA Foundation Reception</td>
<td>Crystal Ballroom A</td>
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<table>
<thead>
<tr>
<th><strong>Saturday, June 10</strong></th>
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</thead>
<tbody>
<tr>
<td>6:00 a.m.</td>
<td>Ron Davis Memorial 5K run/walk and other healthful activities</td>
<td>Motor entrance, East Tower</td>
<td></td>
<td></td>
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<tr>
<td>8:00 a.m.</td>
<td>IMGS Emergency Resolutions due</td>
<td>Send to <a href="mailto:img@ama-assn.org">img@ama-assn.org</a></td>
<td></td>
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</tr>
<tr>
<td>9:00-11:45 a.m.</td>
<td>Joint Cosponsored Educational Sessions by Academic Physicians and International Medical Graduates Section</td>
<td>Columbus C/D</td>
<td></td>
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</tr>
<tr>
<td>9:00-10:15 a.m.</td>
<td>1) Apps for Academic Physicians: The Hows and Whys   George Mejicano, MD, APS Chair-elect Michael Hodgkins, MD, MPH, Chief Medical Information Officer, AMA</td>
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</tr>
<tr>
<td>Time</td>
<td>Event</td>
<td>Location</td>
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<tr>
<td>10:30-11:45</td>
<td>2) Funding for Accountability, Sustainability and Transparency in Medical Education: A Proposed</td>
<td>Columbus C/D</td>
<td></td>
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<tr>
<td>a.m.</td>
<td>Model for Meeting Physician Workforce Needs</td>
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<tr>
<td></td>
<td>Kelly Caverzagie, MD, associate dean for educational strategy, University of Nebraska College of</td>
<td></td>
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<tr>
<td></td>
<td>Medicine</td>
<td></td>
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<tr>
<td>2:00–6:00 p.m.</td>
<td>House of Delegates Opening Session (Rules of Order, Speeches, Nominations, Other presentations)</td>
<td>Grand Ballroom</td>
<td></td>
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</tr>
<tr>
<td>5:30–8:00 p.m.</td>
<td>IMGS Congress and Reception</td>
<td>Columbus G</td>
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<tr>
<td></td>
<td>“Washington Update” – AMA Advocacy staff</td>
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<tr>
<td>9:30–11:00 p.m.</td>
<td>IMGS Desserts from Around the World Reception</td>
<td>Crystal Ballroom</td>
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**Sunday, June 11**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>8–8:30 a.m.</td>
<td>House of Delegates Second Opening Session (Business – Introduction of Reports and Resolutions,</td>
<td>Grand Ballroom</td>
</tr>
<tr>
<td></td>
<td>Extraction of Informational Reports, Supplementary Report of Committee on Rules and Credentials)</td>
<td></td>
</tr>
<tr>
<td>8:30 a.m.-noon</td>
<td>Reference Committee A – Medical Service</td>
<td>Regency A</td>
</tr>
<tr>
<td></td>
<td>Reference Committee C – Legislation</td>
<td>Regency C</td>
</tr>
<tr>
<td></td>
<td>Reference Committee E – Public Health</td>
<td>Regency D</td>
</tr>
<tr>
<td></td>
<td>Reference Committee F – Finance/Governance</td>
<td>Grand Ballroom</td>
</tr>
<tr>
<td>1:30–5:00 p.m.</td>
<td>Reference Committee on Constitution and Bylaws</td>
<td>Regency C</td>
</tr>
<tr>
<td></td>
<td>Reference Committee B – Medical Education</td>
<td>Regency B</td>
</tr>
<tr>
<td></td>
<td>Reference Committee D – Science/Technology</td>
<td>Regency D</td>
</tr>
<tr>
<td></td>
<td>Reference Committee G – Medical Practice</td>
<td>Regency A</td>
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### Monday, June 12

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>8–11 a.m.</td>
<td>HOD Ancillary &amp; Education Sessions</td>
<td>Various</td>
</tr>
<tr>
<td>8:30–9:30 a.m.</td>
<td>IMGS Delegates Caucus (to discuss Reference Committee reports)</td>
<td>Skyway 273</td>
</tr>
<tr>
<td>10:30-11:30 a.m.</td>
<td>Busharat Ahmad, MD Leadership Development Program</td>
<td>Roosevelt 3 A/B</td>
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<td>“Physicians as Leaders in An Age of Uncertainty”</td>
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<tr>
<td></td>
<td>Speaker: Peter Angood, MD, CEO/President, American Association of Physician Leadership</td>
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</tr>
<tr>
<td>11:00 a.m.–1:45 p.m.</td>
<td>State/Specialty Caucuses</td>
<td>(various) See Meeting Schedule</td>
</tr>
<tr>
<td>2:00–6:00 p.m.</td>
<td>House of Delegates Business Session</td>
<td>Grand Ballroom</td>
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### Tuesday, June 13

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30–8:45 a.m.</td>
<td>Elections</td>
<td>East Tower</td>
</tr>
<tr>
<td>9:00 a.m.–3 p.m.</td>
<td>House of Delegates Business Session</td>
<td>Grand Ballroom</td>
</tr>
<tr>
<td>5 p.m.</td>
<td>Inauguration of David O. Barbe MD, 172nd AMA President</td>
<td>Crystal Ballroom</td>
</tr>
<tr>
<td>6:30-11:00 p.m.</td>
<td>Inaugural Reception and Dinner Dance</td>
<td>Grand Ballroom</td>
</tr>
</tbody>
</table>

### Wednesday, June 14

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 a.m.–noon</td>
<td>House of Delegates Business Session</td>
<td>Grand Ballroom</td>
</tr>
</tbody>
</table>
To: AMA-IMG Section Members
From: Bhushan Pandya, MD, Chair
IMGS Governing Council
Date: June 1, 2017
Subject: AMA-IMG Section Governing Council Chair’s Report

The following report is submitted on behalf of the AMA-IMGS Governing Council (GC), covering highlights for the 2016-2017 year and provides an overview of current issues affecting IMGs. This report is provided to keep the members of the American Medical Association International Medical Graduates Section (AMA-IMGS) informed on the activities, accomplishments and issues related to international medical graduates and the IMG Section.

Member and GC Involvement

- The IMGS participated in its 5th year of AMA Research Symposiums. Many IMG Section members participated as judges and the research presented by our ECFMG-certified members, awaiting residency continue to be stellar. Our overall winners reported to our Section that they successfully matched in the residency of their choice. The next 15th Annual Research Symposium is scheduled for Friday, November 10 in Honolulu, Hawaii.

- The IMG Section Symposium was held March 23, 2017 at the Marriott Courtyard – East Upper Manhattan in New York. This Symposium entitled “Succeeding in residency and practice” featured a keynote presentation by AMA President-Elect David Barbe and IMG Governing Council speakers. Over 100 participants registered for this event.

- In an effort to connect with our grassroots members, state IMG committees and ethnic medical societies, the AMA IMG Section held its State of the Section teleconference in May, 2016. An interactive question and answer period was also part of the teleconference. The IMG Section is in the process of scheduling its 2017 teleconference during the summer.

- The IMG Section has entered its 5th year of partnering with ECFMG’s ECHO division to plan educational webinars. In May 2017, the IMG Section sponsored a webinar entitled “Alternative Health Care Careers - Genetics” which presented many interesting facts about careers in Genetics which received an overwhelming participation.

- This is the seventh year of the IMGS Committee structure in operations. Committees have been combined to refocus the efforts of the IMG Section. These Committees include: Desserts Reception, Leadership Development Program, Nominating Committee Reports and Resolutions, and Social events. These committees meet quarterly via teleconferences and provide grassroots members with a tangible way to engage with our Section and fulfill the IMGS work plan. Furthermore, the committees provide leadership opportunities (without having to travel) for grassroots members.

- The IMG Section participated in a Kaplan Immigration Panel event entitled “The Future of Immigration in U.S. Health Care” in Chicago which featured attorney Kristen Harris, JD,
the Kaplan Executive Director, Dr. Rashan Raad, of Chicago and AMA-IMG staff. This Kaplan event engaged over 292 participants and additional livestream participants. This event discussed the appropriate visas necessary for the U.S. as well as offered resources for students and potential residents.

- Your GC updated its strategic plan to better align with AMA’s focus areas and address the unique needs of our Section members.

- Your GC held a teleconference with the Chair of the AMA Board, Dr. Patrice Harris, and Dr. Ardis Hoven former Board member, to discuss the possibility of having an Acculturation Forum meeting. The IMG Section Board liaisons, Drs. David Barbe and Stephen Permut also participated in this teleconference. More information to come about the progress on this initiative.

- The 10th Annual Desserts from Around the World Reception was a huge success, with over 400 attendees and entertainment from Chicago. Over a dozen ethnic, state and specialty medical associations contributed to this tasty affair. Proceeds benefitted the AMA Foundation’s IMG Honor Fund. It is never too late to become a sponsor for this event.

**Communications & Resources**

- Over 23,000 subscribers receive the AMA-IMGS portion of the weekly AMA Wire and Morning Rounds electronic newsletter.

- The AMA-IMGS Web site (www.ama-assn.org/go/imgs) was revamped provides comprehensive information on IMG issues, statistics, activities and policies. This year the AMA Web sites were updated to improve its digital presence.

- Your GC meets regularly via teleconference in order to stay connected and apprised about issues of concern that impact the IMG community.

- A pilot Online Physician Community will be launched later this year to provide a forum for AMA-IMG Section members to discuss issues in a closed group environment as well as facilitate sharing of best practices among peers (e.g. licensing issues, residency interviews, where to practice; and successfully navigating the match).

**New AMA Policies**

- The AMA-IMG Section continues to promote its online Virtual Congress to review resolutions and provide comments for its Annual and Interim Section meetings. Five resolutions were made available to Section members to review for 2016. This online member forum is designed to obtain feedback and ratify IMG Section resolutions submitted to the AMA House of Delegates.

**Membership**

- Our Section membership has increased from 38,000 to over 40,000 members which represents over 16% of AMA membership. We will continue to collaborate with the AMA Membership Team to work on new and effective ways to recruit members and retain existing members. We are asking all IMG Section members to become ambassadors and encourage your friends to join the AMA and become a part of the “Born To” campaign.
The ECFMG-certified and awaiting residency membership program created in 2010 has attracted over 1,200 new members to date. Overall IMGS membership increased by 2.4% as of 2016 year-end.

**Top IMG Issues**

**Licensure Parity**

There are 34 states that have separate and unequal GME requirements for US medical graduates and IMGs. Our Section offers a model resolution for states to adopt in order to achieve licensure equality between US medical graduates and IMGs. Several states have adopted this equality policy have been successful in changing their state's licensing laws. The IMG Section is piloting a few states to change the disparities in graduate medical education for licensure. For information, email img@ama-assn.org

**GME Expansion:** Due to adoption of the Affordable Care Act, an ever-increasing number of patients with chronic illnesses and the increased number of physicians retiring, the physician workforce shortage continues to grow. Thousands of qualified IMGs (many who are US citizens or permanent residents) could enter the physician workforce right now, but the number of GME (graduate medical education) positions was capped by Congress in 1994, limiting the ability of qualified IMGs to enter the physician workforce. The Section’s legislative priority continues to be to call for an increase in the number of GME positions in order to alleviate the physician workforce shortage and increase access to care for patients. Additionally, we contributed to the AMA’s testimony before the Institute of Medicine (IOM) GME Financing Committee. Furthermore, our Section authored two resolutions that called for alternate funding mechanisms to expand GME positions. In the 2017 Match, 53.3% of IMGs successfully matched. IMGs who participated in the Match decreased by 435. While the number of IMGs who matched to first-year positions decreased by 47, the percentage of IMGs who matched increased.

**Immigration:** Senators Amy Klobuchar (D-Minn.), Jerry Moran (R-Kan.), Susan Collins (R-Maine) and Heidi Heitkamp (D-N.D.) introduced legislation (S.1189) in May 2015 which amends the Immigration and Nationality Technical Corrections Act of 1994 to make the J-1 visa waiver (Conrad state 30/medical services in underserved areas) program permanent. This bill would allow for expansion of this program beyond 30 slots and better align the visa terms for residents in training and physician practice. In April 2017, the AMA sent letters to Senators Klobuchar, Heitkamp and Collins to support the Conrad 30 program. Our AMA will continue to advocate on behalf of our Section on immigration and other issues that affect IMGs.

**Racial and Ethnic Health Care Disparities:** The diverse cultural, ethnic and linguistic backgrounds of IMGs serve to improve the health care outcomes of racial and ethnic minority patients as well as raise awareness of the need for all physicians to eliminate racial and ethnic disparities. Because of the diversity of the IMGS, our Section is well-positioned to contribute to the overall strategies related to eliminating racial and ethnic health care disparities and improving health outcomes. While the Commission to End Health Care Disparities has been dissolved, the AMA-IMGS is positioned to continue to work on these issues.
Leadership Development: IMG physicians make up a little over 16% of the membership of the AMA, yet IMGs are underrepresented in leadership positions in the practice setting and in organized medicine. The Leadership Development Committee provides our Section members with the tools and resources to be more effective, dynamic leaders. To address the issues related to being an effective leader, the Section created the Busharat Ahmad, MD Leadership Program in 2006. This program is held in conjunction with the AMA Annual and Interim Meetings and the attendance and scope of the topics and audience has grown each year. The November 2016 Busharat Ahmad MD Leadership Development session, “Followership: the other face of leadership” was presented by our AMA-IMG Section member, Nestor Ramirez-Lopez, MD. This year’s Annual Meeting program is titled “Physicians as Leaders in An Age of Uncertainty,” which features Peter Angood, MD, CEO/President, American Association of Physician Leadership, who will provide strategies on how to be a successful leader during an age of uncertainty.

Conclusion
The AMA-IMGS continues to address many issues of importance to IMGs in order to pave the way for continued and effective advocacy and membership involvement with the support of its membership. Our AMA Board of Trustees liaisons: AMA President-Elect, David Barbe, MD and Immediate Past Chair, Stephen Permut, MD, JD, have been very helpful and informative. I want to thank my fellow Governing Council members and our staff (J. Mori and Carolyn) for all of their efforts and support. The AMA-IMGS continues to encourage all of its Section members to participate in their community, hospital, group practice, county society, state and specialty organizations as well as the AMA.

Thank you for being a part of organized medicine. We appreciate your involvement and support.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-17)

Introduced by: International Medical Graduates Section

Subject: U.S. International Medical Graduates in Physician Workforce

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, There are hundreds of U.S. citizens that attend offshore medical schools each year; and

Whereas, In 2017 53% of U.S. IMGs matched and 46.1% of U.S. IMGs did not match in the National Residency Matching program;1 and

Whereas, It is estimated that medical students spend over $800,000 to graduate from medical school, which includes lost opportunities costs;2,3 and

Whereas, It is estimated that half of those medical students may not match into a residency program;3 and

Whereas, Concerns have been raised about the quality of medical education, clinical rotations, and their accreditation requirements; and

Whereas, The challenges of U.S. IMGs impact the quality of health care provided to citizens in the U.S.; and

Whereas, 56.7% of U.S. IMGs choose a primary care specialty and fill in the gaps in the physician workforce;4 therefore, be it

RESOLVED, That the American Medical Association work with the Educational Commission on Foreign Medical Graduates (ECFMG) to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Residency Matching Program (NRMP) and are therefore unable to get a residency or practice medicine. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/28/17

References
1National Residency Matching Program; http://www.nrmp.org
2American Association of Medical Colleges; http://www.aamc.org
RELEVANT AMA POLICY

Foreign Medical Graduates H-255.987
1. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the US regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.
2. Our AMA will: (a) continuously study challenges and issues pertinent to IMGs as they affect our country’s health care system and our physician workforce; and (b) lobby members of the US Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

National Resident Matching Program Reform D-310.977
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP’s policies and procedures and make recommendations for improvements as the need arises;
(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what care/gs are pursued by those with an MD or DO degree who do not enter residency programs;
(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(14) will study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match;
(15) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested Bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions; and
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-17)

Introduced by: International Medical Graduates Section

Subject: Formal Business and Practice Management Training During Medical Education

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, Current training curriculums for physicians are designed to ensure the development of clinical skills necessary to become competent practitioners, yet there is no clearly defined process to encourage and sustain business and practice management skills essential to successful practice across the continuum of medical school, residency, fellowship and independent practice; and

Whereas, Appropriate business skills and knowledge in conjunction with effective leadership are vital to creation and maintenance of an optimal environment for providing high-quality patient care; and

Whereas, Physicians who acquire insufficient understanding and knowledge of business and practice management skills within the clinical, operational and financial spheres of practice may face greater challenges in navigating the ever-changing United States healthcare environment and in maintaining high standards of care while minimizing healthcare disparities; therefore be it

RESOLVED, That our American Medical Association encourage the Liaison Committee for Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), Association of American Medical Colleges (AAMC) and other entities responsible for medical education to advocate for and support the creation of a more standardized process and approach for training and education in business and practice management skills for medical practitioners across the continuum of medical school, residency, fellowship and independent practice (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage LCME, ACGME, AAMC and other entities responsible for the education of future physicians, to provide educational resources and programs on business administration and practice management in their medical education curriculum, (Directive to Take Action)

Fiscal Note: Minimal – less than $1,000

Received: 04/28/17
References:

RELEVANT AMA POLICY

AMA Mission and Vision G-625.010
Mission: To promote the art and science of medicine and the betterment of public health.
Core Values: (1) Leadership; (2) Excellence; and (3) Integrity and Ethical Behavior.
Vision: To be an essential part of the professional life of every physician.

AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs H-225.972
It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible.

See also:
Management and Leadership for Physicians D-295.316
Initiative to Transform Medical Education: Strategies for Medical Education Reform H-295.871
Physician Employment Trends and Principles H-225.947
Physicians’ Ability to Negotiate and Undergo Practice Consolidation H-383.988
Practice Options and Skills Curriculum for Residents H-310.953
Physician Managers H-405.990
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-17)

Introduced by: Minority Affairs Section

Subject: Healthcare as a Human Right

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Michael B. Hoover, MD, Chair)

Whereas, The United States of America voted in favor of the United Nations General
Assembly’s Universal Declaration of Human Rights (UDHR) in 1948, and ratified each
amending covenant that together constitute the encompassing International Bill of Human
Rights;\(^1\),\(^2\) and

Whereas, Article 25 of the UDHR states that “everyone has the right to a standard of living
adequate for the health and well-being of himself and of his family, including...medical care”;\(^1\),\(^2\)
and

Whereas, The United States is also a member state of the World Health Organization (WHO),
which exhorts all member states to “contribute to meeting the needs of the population for health
care”;\(^3\) and

Whereas, The United States makes good on these promises via Medicare and Medicaid
programs, which provide basic levels of medical care for certain vulnerable and low-income
American citizens;\(^4\) and

Whereas, The 115\(^{th}\) Congress of the United States has proposed to withdraw the United States
from both the United Nations and the World Health Organization, endangering these
commitments;\(^5\) and

Whereas, The 115\(^{th}\) Congress of the United States is currently discussing switching the open
entitlement of Medicaid to a per capita or block grant system, which would limit states’ ability to
care for Medicaid populations should healthcare costs or eligible populations increase;\(^6\) and

Whereas, The AMA has repeatedly endorsed the World Medical Association’s Declaration of
Tokyo, which amongst other principles establishes that “A physician must have complete
clinical independence in deciding upon the care of a person for whom he or she is medically
responsible. The physician’s fundamental role is to alleviate the distress of his or her fellow
human beings, and no motive, whether personal, collective or political, shall prevail against this
higher purpose”(H-65.997, H-65.991);\(^7\) and

Whereas, The WMA Declaration of Tokyo further encourages lifelong education on and
furtherance of human rights by physicians and calls on all national medical associations to
promote these endeavors;\(^7\) and

Whereas, The AMA recognizes that its conduct serves a model for health organizations around
the globe, and that participation in these organizations is essential to achieving the AMA’s goals
for public health (G-630.070); and

Whereas, The AMA supports continued funding of the World Health Organization and
participation in international medical organizations (H-250.986, H-250.999, H-250.992); and
Whereas, The AMA has codified a physician's duty to care for, advocate on behalf of, and endeavor to improve future care for all persons, making no exceptions for gender, socioeconomic status, race, origin, or creed (ex. H-140.900, H-140.997, H-140.838, H-160.975, H-140.951); and

Whereas, The AMA recognizes socioeconomic factors and self determination as important components of an individual's health (ex. H-295.874); and

Whereas, An entire body of AMA policy exists under the heading "Civil and Human Rights" with the specific intent to support and define the fundamental concepts of human rights (ex. H-65.997); and

Whereas, The AMA has not yet specifically named healthcare as one such right; and

Whereas, The very mission statement of the AMA is "to promote the art and science of medicine and the betterment of public health"; therefore be it

RESOLVED, That our American Medical Association recognize that a basic level of medical care is a fundamental human right (New HOD Policy); and be it further

RESOLVED, That our AMA support the United Nations' Universal Declaration of Human Rights and its encompassing International Bill of Human Rights as guiding principles fundamental to the betterment of public health (New HOD Policy); and be it further

RESOLVED That our AMA advocate for the United States to remain a member state in the World Health Organization. (New HOD Policy)

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

Received: 05/03/17

References:

RELEVANT AMA POLICY
Human Rights H-65.997: Persecution of Physicians for Political Reasons and Participation by Doctors in Violations of Human Rights H-65.991; International Strategy G-630.070; AMA and Public Health in Developing Countries H-250.988; World Health Organization H-250.999; World Health Organization H-250.992; Collaborative Care H-140.838; A Declaration of Professional Responsibility H-140.900; Professionalism and Medical Ethics H-140.951; Patient Advocacy H-140.997; Planning and Delivery of Health Care Services H-160.975; AMA Principles for Physician Employment H-225.950; Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
American Medical Association House of Delegates

Resolution: 225
(A-17)

Introduced by: Minority Affairs Section
Subject: Truth in Advertising
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

Whereas, A June 2014 study by the American Medical Association found that 22% of patients believe that a chiropractor is a medical doctor. Thirty five percent of patients believe that a doctor of nursing practice is a medical doctor. Thirty percent of patients believe that a psychologist is a medical doctor. Forty-two percent of patients believe that an optometrist is a medical doctor, and seventy-four percent of patients believe a podiatrist is a medical doctor; and

Whereas, There are widespread differences regarding the training and qualifications required to earn specialty and subspecialty certifications. There are differences in training and skills are necessary to correctly detect, diagnose, and treat serious healthcare conditions that are common in specialized care; and

Whereas, The increased public knowledge of board certification has resulted in the creation of 22 fake boards for profit or solely for the creation of credentials; and

Whereas, an April 2012 article in "Forbes" magazine notes that 41 percent of physicians would choose a different specialty if they could make the choice over again, and a lack of professional satisfaction may lead physicians to drastically change their practice specialty, therefore be it

RESOLVED, That our American Medical Association support clarity and truth in advertising by requiring physicians to fully disclose board certification status, medical license restrictions as permitted by law, residency and fellowship status, particularly with vulnerable patients such as those treated in confined settings such as locked mental health institutions and correctional settings and encourage restricting the use of the title "doctor" in closed settings to only medical doctors. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 05/03/17

References:

1 Forbes Magazine (2012) "Why Do So Many Doctors Regret Their Job Choice?"
2 Wisconsin Medical Society Policies:
RELEVANT AMA POLICY

Physician Practice Drift H-410.951
Our AMA will: (1) continue to work with interested state and national medical specialty societies to advance truth in advertising legislation, and (2) continue to monitor legislative and regulatory activity related to physician practice drift.
BOT Rep. 5, A-13

Truthful Specialty Information H-405.985
Our AMA: (1) reaffirms its policy that: (a) individual character, training, competence, experience and judgment be the criteria for granting privileges in hospitals; (b) physicians representing several specialties can and should be permitted to perform the same procedures if they meet these criteria; (c) a physician who acquires new skills as a result of additional education or training should be given individual evaluation and the same consideration as a new physician applying for privileges; and (2) believes that advertising by physicians should comply with ethical opinion 5.02 of the Council of Ethical and Judicial Affairs.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-17)

Introduced by: Minority Affairs Section
Subject: Study of Declining Native American Medical Student Enrollment
Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, The total number of US medical school matriculates has increased by 27% between 2002 and 2016 (4,537 more students), Native American medical school matriculates declined from 156 in 2002 to 142 in 2016;¹ and

Whereas, The AMA House of Delegates has 552 delegates and 552 alternate delegates, or 1104 people, which is 8 times more than Native American medical student matriculates this year; and

Whereas, A 2016 Government Accounting Office reported cited that the Indian Health Service has a 20% vacancy rate for physicians, which is contributing to critical wait times;² and

Whereas, AMA policy supports increasing diversity in the physician workforce, including “broad-based efforts that involve partners within and beyond the medical profession and medical education community” (D-200.985); and

RESOLVED, That our American Medical Association 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. (Directive to Take Action)

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

Received: 05/03/17

References:
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. CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRNP Rep. 2, A-14 Reaffirmation: A-16
Whereas, Our AMA Minority Affairs Section (MAS) membership is composed of physicians and medical students dedicated to addressing the issues and concerns of underrepresented minority (URM) physicians and improving the health of minority populations; and

Whereas, AMA-MAS provides a national forum for advocacy on minority health issues and professional concerns of minority physicians and medical students; and

Whereas, There are health benefits of having physicians from diverse backgrounds; and

Whereas, The Association of American Medical Colleges reports that U.S. physician workforce diversity remains constant with prior years with approximately 8.9 percent of physicians identifying as black or African-American, American Indian or Alaska Native, and Hispanic or Latino, which is not consistent with the nation’s demographic shift; therefore be it

RESOLVED, That our American Medical Association develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population (Directive to Take Action); and be it further

RESOLVED, That our AMA provide on-line educational materials for its membership that address cultural, racial and religious issues in patient care (Directive to Take Action); and

RESOLVED, That our AMA create and support programs that introduce elementary through high school students, especially those from under-represented minority groups, to healthcare careers (Directive to Take Action); and be it further

RESOLVED, That our AMA 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA recommend that medical school admissions committees use holistic evaluation of admission applicants, taking into account the diversity of preparation and the variety of talents that applicants bring to their education (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to race and ethnicity collected from Electronic Residency Application Service (ERAS) applications through the National Residency Matching Program (NRMP) (New HOD Policy); and be it further
RESOLVED, That our AMA continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.3 (Directive to Take Action)

2 ibid

Fiscal Note: Not yet determined

Received: 05/03/17

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.


Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979
Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precolligate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-17)

Introduced by: Minority Affairs Section

Subject: In-Flight Emergencies

Referred to: Reference Committee E
(Rebecca S. Hierholzer, MD, Chair)

Whereas, In-flight conditions such as changes in humidity and cabin pressure may exacerbate medical conditions leading to a risk of exacerbating underlying medical conditions; and

Whereas, Approximately 646 million people traveled on commercial US flights in 2014, with one in every 646 flights or 44,212 passengers involve a reported in-flight medical emergency worldwide every year; and

Whereas, 85% of flights with an emergency have a physician on board; and

Whereas, Physician passengers provided medical assistance in 48.1% of reported in-flight medical emergencies (2013 study); and

Whereas, The Aviation Medical Assistance Act of 1998 was passed to give limited protection to medical personnel who act as “Good Samaritans” and respond to in-flight medical emergencies on domestic flights; and

Whereas, Most in-flight medical emergencies can be successfully managed with timely and appropriate care such that only 7% of in-flight medical emergencies require flight diversion; and

Whereas, FAA regulations require all US commercial airlines weighing 7,500 pounds or more and serviced by a least one attendant to carry a defibrillator and an enhanced emergency medical kit; and

Where’s, There are no international regulations requiring the complete enhanced medical kit to be available on commercial airlines; and

Whereas, Basic equipment on board commercial flights must contain a defibrillator, saline solution, aspirin, antihistamines, epinephrine, and nitroglycerin tablets and other commonly used medications; however the kits vary widely in quality; and

Whereas, When the heart fails, the lack of oxygenated blood can cause brain damage in only a few minutes. A person may die within 8 to 10 minutes & may experience cognitive deficits if deprived of oxygen for greater than 4 minutes; therefore a prolonged period of time to verify credentials can lead to a negative patient outcome; and

Whereas, Lufthansa and partner airlines have successfully initiated a Doctor on Board program that allows physicians to add their name to a list of those willing to be called should there be an in-flight emergency; and
Whereas, Medical assistance at 36,000 feet requires managing atypical environmental conditions such as lower air pressure, cramped quarters, and the roar of an engine; and

Whereas, Many countries in Europe and Australia require physicians to respond during an inflight emergency; and

Whereas, Physicians in training and in practice do not receive routine instructions on handling an in-flight medical emergency; therefore be it

RESOLVED, That our American Medical Association support and advocate for a requirement that all U.S. based commercial carriers consult with the Air Transport Medicine Committee Aerospace Medical Association every six months to determine the minimal medical equipment that should be available on domestics and international commercial flights and provide easy access to that information to passengers in order to aid in responding to likely emergencies such as adding naloxone to target potential opioid overdoses and a glucometer given the increase prevalence of diabetes (New HOD Policy); and be it further

RESOLVED, That our AMA support and advocate for a requirement that medical supplies, equipment, and medications available for an inflight medical emergency are standardized based upon the size and mission of the aircraft across all domestic and international commercial US based airlines with careful consideration of flight crew training requirements (New HOD Policy); and be it further

RESOLVED, That our AMA support and advocate for a requirement that fight crews will no longer be required to verify a medical professional's credentials before allowing that person to assist with an inflight medical emergency (New HOD Policy); and be it further

RESOLVED, That our AMA support and advocate for a requirement that US based commercial carriers develop an online process for health providers to become credentialed in advance of a flight in order to respond to an inflight emergency (New HOD Policy); and be it further

RESOLVED, That our AMA offer medical trainees and physicians medical education courses to prepare for addressing in-flight emergencies during its meetings and/or by strongly encouraging its affiliated state and local branches to offer similar education courses. (Directive to Take Action)

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

Received: 05/03/17

References:
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 517
(A-17)

Introduced by: Minority Affairs Section

Subject: Choline Supplementation in Prenatal Vitamins

Referred to: Reference Committee E
(Rebecca S. Hierholzer, MD, Chair)

Whereas, The effects of neurobehavioral disorder-prenatal exposure to alcohol (fetal alcohol syndrome) begins during the first trimester of pregnancy; and

Whereas, More than over 50% of pregnancies are unplanned; and

Whereas, Adequate levels of choline are necessary to maintain a normal pregnancy including neural development of the fetus and reducing the incidence of birth defects; and

Whereas, The prevalence of neurobehavioral disorder-prenatal exposure (nd-pae) to alcohol is disproportionately high in African-Americans due to the prevalence of liquor stores in low income African-American communities and a mechanism of choline depletion during pregnancy is alcohol consumption; and

Whereas, The effects of nd-pae include learning and behavioral disorders, explosive behavior, and hyperactivity disorders; and

Whereas, The recommended amount of choline intake for pregnant women is 450 mg/day and current vitamins only contain 0-55 mg and 90% of women do not have enough dietary choline; therefore be it

RESOLVED, That our American Medical Association support and advocate for an increase of choline in all prenatal vitamins to 450 mg/day. (New HOD Policy)

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

Received: 05/03/17

References:
RELEVANT AMA POLICY

Fetal Effects of Maternal Alcohol Use H-420.991
The AMA believes that (1) The evidence is clear that a woman who drinks heavily during pregnancy places her unborn child at substantial risk for fetal damage and physical and mental deficiencies in infancy. Physicians should be alert to signs of possible alcohol abuse and alcoholism in their female patients of child-bearing age, not only those who are pregnant, and institute appropriate diagnostic and therapeutic measures as early as possible. Prompt intervention may prevent adverse fetal consequences from occurring in this high-risk group. (2) The fetal risks involved in moderate or minimal alcohol consumption have not been established through research to date, nor has a safe level of maternal alcohol use been established. One of the objectives of future research should be to determine whether there is a level of maternal alcohol consumption below which embroyotoxic and teratogenic effects attributable to alcohol are virtually non-existent. (3) Until such a determination is made, physicians should inform their patients as to what the research to date does and does not show and should encourage them to decide about drinking in light of the evidence and their own situations. Physicians should be explicit in reinforcing the concept that, with several aspects of the issue still in doubt, the safest course is abstinence. (4) Long-term longitudinal studies should be undertaken to give a clearer perception of the nature and duration of alcohol-related birth defects. Cooperative projects should be designed with uniform means of assessing the quantity and extent of alcohol intake. (5) To enhance public education efforts, schools, hospitals, and community organizations should become involved in programs conducted by governmental agencies and professional associations. (6) Physicians should take an active part in education campaigns. In so doing, they should emphasize the often overlooked consequences of maternal drinking that are less dramatic and pronounced than are features of the fetal alcohol syndrome, consequences that are at least indicated, if not sharply delineated, by some of the research that has been conducted in several parts of the world with diverse populations.

Fetal Alcohol Syndrome Educational Program H-420.964

Fetal Alcohol Syndrome Warning Legislation H-420.981

Alcohol and Other Substance Abuse During Pregnancy H-420.976
Our AMA: (1) supports ongoing efforts to educate the public, especially adolescents, about the effects of alcohol abuse on prenatal and postnatal development; (2) favors expanding these efforts to target abuse of other substances; and (3) encourages intensified research into the physical and psychosocial aspects of maternal substance abuse as well as the development of efficacious prevention and treatment modalities. Res. 244, A-89 Reaffirmation A-99 Reaffirmation A-07
Resolution: 304
(A-17)

Introduced by: Medical Student Section

Subject: Support of Equal Standards for Foreign Medical Schools Seeking Title IV Funding

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, Programs authorized under Title IV of the Higher Education Act are the major source of federal student aid and include Federal Family Education Loans, Direct Loans, and Federal Perkins Loans;¹ and

Whereas, In order for a foreign medical school to be eligible for Title IV funding, no more than 40% of its enrollees and graduates may be United States citizens or permanent residents, and at least 75% of its students and graduates who took examinations administered by the Educational Commission for Foreign Medical Graduates must have received a passing score in the preceding year;² and

Whereas, Five foreign medical programs, (American University of the Caribbean School of Medicine, Ross University School of Medicine, St. George's School of Medicine, Saba University School of Medicine, and Universidad Iberoamericana) are exempt from Title IV funding requirements regarding the citizenship and examination pass rates of their students because they were grandfathered under a clause of 20 U.S.C. §1002;³ and

Whereas, Subclauses 1002(a)(2)(A)(i)(II)(aa & bb) of 20 U.S.C. §1002 specify that an American student attending a foreign medical institution is eligible for federal student loans if the institution "has or had a clinical training program approved by a State as of Jan. 1992," and "continues to operate that program that is approved by the State";³ and

Whereas, In the 2011-2012 year, students at three of the exempted schools accepted a total of about $470 million in U.S. government loans;³ and

Whereas, The mean Title IV loan debt incurred by U.S. students who completed medical school in 2015 was $274,985 for American University of the Caribbean School of Medicine, $252,320 for Ross University School of Medicine, and $242,261 for St. George’s School of Medicine;⁴,⁵,⁶ and

Whereas, The bipartisan, bicameral Foreign Medical School Accountability Fairness Act was proposed to eliminate the grandfather provisions that currently exempt these foreign medical schools from the requirements of 20 U.S.C. §1002(a)(2) (A)(i)(I), to “establish consistent eligibility requirements for graduate medical schools operating outside of the United States and Canada in order to increase accountability and protect American students and taxpayer dollars”⁷,⁸ and

Whereas, The Foreign Medical School Accountability Fairness Act had support from many medical organizations, including the Associated Medical Schools of New York, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and the medical school deans of more than 60 U.S. medical schools;⁷,⁹,¹⁰,¹¹ therefore be it

RESOLVED, That our American Medical Association support 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. (New HOD Policy)

Fiscal note: Minimal – less than $1,000

Received: 04/28/17

RELEVANT AMA POLICY:
Graduates of Foreign Health Professional Schools H-255.985
AMA Principles on International Medical Graduates H-255.988
Foreign Medical Graduates H-255.998

Introduction by: American College of Cardiology
American Society of Echocardiography
Heart Rhythm Society
Society of Cardiovascular Angiography and Interventions

Subject: Immigration Reform Impacts on International Medical Graduate Training and Patient Access

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, AAMC's most recent data show that 30% of all US cardiologists are international medical graduates; and

Whereas, 43% of current cardiac electrophysiology fellows are international medical graduates; and

Whereas, A significant portion of residency training spots are filled by international medical graduates; and

Whereas, Many underserved patients are cared for by international medical graduates who obtain a Fast Track H-1B Visa after residency via the Conrad 30 J-1 visa waiver program; and

Whereas, 10500 physicians were employed by H-1B visas nationwide, with many more trainees receiving J visas; and

Whereas, Recent proposed changes to visa issuances, visa acceptances, have had impact on trainees and their program directors' planning; and

Whereas, Recent proposed changes to the H-1B program will impact residency slots, and patients' access to timely medical care; and

Whereas, Existing AMA policy D-255.991, Visa Complications for IMGs in GME states that, Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position; therefore be it

RESOLVED, That our American Medical Association advocate for the timely processing of visas for physicians to fill residency and fellowship training spots (New HOD Policy); and be it further
RESOLVED, That our AMA study the current impact of immigration reform efforts on residency and fellowship training programs, physician supply, and timely access of patients to healthcare throughout the US (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates by the 2017 Interim Meeting such study findings, including appropriate proposals to advocate on behalf of international medical graduate physicians and their patients. (Directive to Take Action)

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

Received: 05/01/17

1 Kahn PA, Gardin TM. Distribution of Physicians With H-1B Visas By State and Sponsoring Employer. JAMA. Published online April 17, 2017. doi:10.1001/jama.2017.4877

RELEVANT AMA POLICY

Visa Complications for IMGs in GME D-255.991
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-17)

Introduced by: Wisconsin

Subject: Support of International Medical Students and Graduates

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, International medical graduates (IMGs) comprise 26% of physicians in practice and 24% of residents in specialty programs;¹ and

Whereas, IMGs receive certification from the Education Commission for Foreign Medical Graduates in order to qualify for U.S. medical education admission;¹ and

Whereas, In addition to certification from the Education Commission for Foreign Medical Graduates, IMGs must also abide by state-specific requirements published by the Federation of State Medical Boards to qualify for U.S. residency programs;² and

Whereas, According to the Association of American Medical Colleges (AAMC), out of the total 88,304 students who are enrolled in medical schools for the 2016-2017 academic year, 1,375 of those students are non-U.S. citizens or are non-permanent U.S. residents;³ and

Whereas, For most minority subgroups, the number of students enrolled in medical schools continually falls short of what the expected number of students would be based upon the demographics of the population surrounding the schools, showing a lack of diversity in medical students;⁴ and

Whereas, The AAMC believes that diversity in healthcare is a critical driver on the path to ensure equitable healthcare for all because minority students choose to serve underserved populations more so than students from other backgrounds;⁵ and

Whereas, Foreign-born physicians will help increase the cultural competency of hospitals and clinics through better communication with non-English speaking patients in addition to being more sensitive to culturally-based medical decisions, which can improve patient satisfaction and positively affect patient outcomes;⁶ and

Whereas, The care provided to patients by IMGs is equal to that of U.S. medical school graduates. When comparing IMGs to U.S. graduates, there is no statistical significance between patient mortality and the length of hospital stay for patients being treated for congestive heart failure and acute myocardial infarction;⁷ and

Whereas, It is estimated that there will be a physician shortage of 125,000 by 2025, and that primary care will experience the largest decline;⁸ and

Whereas, IMGs are more likely to practice in primary care shortage areas outside metropolitan statistical areas (67.8%) than U.S. medical graduates (39.8%);⁹ and

Whereas, Many IMGs entered the U.S. on temporary visas that allowed them residence permitting that they work in an underserved area for three years following residency;⁵ and
Whereas, The Conrad visa program for non-U.S. citizen international medical graduates has directed almost 10,000 physicians into practice in rural and underserved communities across the U.S., including in Wisconsin communities;

Whereas, The number of IMGs on these visas declined by 47% as use of less-restrictive temporary specialized worker visas increased and the decreasing number of IMGs has decreased access to care in underserved areas;

Whereas, The federal government, through presidential executive order on January 27, 2017, issued an order banning nationals of seven countries from entering the United States for at least the following 90 days and has also called for a review into suspending the Visa Interview Waiver Program, which allows travelers from 38 countries to renew travel authorizations without an in-person interview; and

Whereas, This executive order has created hardships for international medical graduates with temporary or permanent visas who need to travel outside of the U.S. and has prevented the return of travelling international medical graduates to the U.S. to continue residency/fellowship training, and thus negatively impacted the ability of healthcare systems to provide patient care without any identified safety risk to the U.S. public; and

Whereas, The Association of American Medical Colleges (AAMC) has reported that 260 IMGs have applied for U.S. medical residency from the seven nations impacted by the order’s 90-day ban and that uncertainty regarding this order is impacting the selection and ranking of these IMGs into the match; and

Whereas, Many physician professional organizations including the American College of Physicians and the American Academy of Family Physicians, and the AAMC have decried the executive order’s impact on and offered support for IMGs and prospective medical students; therefore be it

RESOLVED, That our American Medical Association recognize the unique contributions and affirm our support of international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine (New HOD Policy); and be it further

RESOLVED, That our AMA oppose changes to immigration policies for international and foreign-born medical graduates and students that use country of origin to restrict visa procurement and ability to travel outside of the U.S. and return with a visa. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 05/02/17

References:
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-17)

Introduced by: New York
Subject: Supporting International Medical Graduates and Students
Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

Whereas, On January 27, 2017, President Trump signed Executive Order 13769, which banned citizens/nationals of seven Middle Eastern countries from entering the United States; and

Whereas, The aforementioned executive order prevented many of our colleagues from returning to the United States to practice; and

Whereas, The order was issued in the middle of residency application season after most interviews were complete, ruining the chances of many international medical graduates from entering residencies and fellowships for the foreseeable future and potentially resulting in unfilled residency spots which will decrease the quality of care for our patients; and

Whereas, According to studies performed by the Association of American Medical Colleges (AAMC) there is currently a shortage of physicians in America, which will likely be worsened if fewer IMGs are allowed to immigrate to the USA; and

Whereas, Several other medical societies including the American College of Physicians and AAMC have come out in opposition to Executive Order 13769; and

Whereas, On March 6, 2017, President Trump rescinded Executive Order 13769, and replaced it with Executive Order 13780, which still bans the issuance of new visas for citizens/nationals of six Middle Eastern countries; therefore be it

RESOLVED, That our American Medical Association oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion (New HOD Policy); and be it further

RESOLVED, That our AMA oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. (New HOD Policy)

Fiscal Note: Minimal — less than $1,000

Received: 05/01/17

Sources:
https://www.acponline.org/acp-newsroom/acp-comprehensive-statement-us-immigration-policy
AMERICAN MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution: 317
(A-17)

Introduced by: Michigan
Subject: Immigration
Referred to: Reference Committee C
(Kenneth M. Cerfa, MD, Chair)

Whereas, The recent Immigration Executive Order temporarily banning immigration from six
countries has created chaos, fear and uncertainty among physicians and their patients; and

Whereas, This threatens the free exchange of medical ideas, experience and perspectives; and

Whereas, International Medical Graduates have a crucial impact on internal medicine, making
up more than 50 percent of the residency slots in 2016, filling gaps through care provided to
underserved residents and veterans and serving as faculty in top internal medicine programs
across the US; and

Whereas, Twenty-four percent of all practicing physicians in the US in 2015 were international
medical graduates; and

Whereas, Restrictions on immigration for physicians would adversely affect patient care in the
US for years to come; and

Whereas, Over the past 50 years, the US biomedical research enterprise has benefited greatly
from the ideas, creativity, ingenuity and drive of international medical graduates and other non-
US nationals engaged in biomedical research; and

Whereas, An immigration policy that blocks the best and brightest from coming to work and train
in the United States and blocks our trainees, physicians and faculty from traveling to other
countries is a step backward that will harm our patients, our colleagues, and America's position
as a world leader in health care and innovation; therefore be it

RESOLVED, That our American Medical Association lobby the US Congress and other
appropriate US government officials to exempt physicians from any current or future ban or
suspension impacting immigration or the issuance of a J1 Visa or H1-B Visa. (Directive to Take
Action)

The topic of this resolution is currently under study by the Council on Medical Education.

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

Received: 05/11/17
RELEVANT AMA POLICY

Visa Complications for IMGs in GME D-255.991
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Conrad 30 - J-1 Visa Waivers D-255.985
1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.
3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.
4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.
5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.
REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRDP Report 2-A-17

Subject: Demographic Characteristics of the House of Delegates and AMA Leadership

Presented by: Mary T. Herald, MD, Chair

This informational report, “Demographic Characteristics of the House of Delegates and AMA Leadership,” is prepared biennially in odd numbered years by the Council on Long Range Planning and Development (CLRDP), with an abbreviated version created in even numbered years by the American Medical Association (AMA) Board of Trustees (BOT), pursuant to AMA Policy G-600.035, “The Demographics of the House of Delegates.” This policy states:

1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. 2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and our AMA physician membership every other year. (3) Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations.

This demographic report will survey the current demographic makeup of AMA leadership in accordance with AMA Policy G-600.030, “Diversity of AMA Delegations,” which states that, “Our AMA encourages...state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity...” and AMA Policy G-610.010, “Nominations,” which states in part:

Guidelines for nominations for AMA elected offices include the following... (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity...

Similar to previous reports, this document compares AMA leadership with the entire AMA membership and with the overall U.S. physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. Resident/fellow physicians endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA leadership includes delegates, alternate delegates, the BOT, and councils, sections and special groups (hereinafter referred to as CSSG; see detailed listing in Appendix A).

Additionally, this report includes information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations, pursuant to part 3 of Policy G-600.035.
DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of HOD Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2016 delegation rosters. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2016 Masterfile, after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the 552 allotted at the 2016 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment.

Race and ethnicity information, which is provided directly by physicians, is missing for slightly under one-sixth of AMA members and just over one-fifth of the total U.S. physician population, limiting the ability to draw firm conclusions. BOT Report 24-I-06, “Improving Collection of AMA Race/Ethnicity Data,” described efforts to improve AMA data on race and ethnicity, and such improvements have resulted in a decline in unknown race/ethnicity information in some of the leadership groups and overall AMA membership.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic characteristics of AMA Leadership, AMA members, and all physicians and medical students. Raw counts for tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to the previous CLRPD Demographic Report (2-A-15). The following observations, unless otherwise stated, refer to changes since CLRPD Report 2-A-15:

- Among delegates, increases of greater than two percentage points were observed in both the under 40 (+2.0 percentage points) and the 60-69 (+2.0) age groups.
- Female delegates increased by 2.0 percentage points; since 2010, the percentage of female delegates has increased from 20.6% to 26.4%.
- Asian/Asian American representation in CSSG increased by 4.2 percentage points.
- The percentage of AMA members under age 40 increased 3.3 percentage points to 49.2%. That percentage has increased by at least 1.7 percentage points over every two-year period since 2006, and will likely surpass 50% this year.
- White non-Hispanic representation decreased by at least two percentage points among alternate delegates (-2.0), the BOT (-5.0), CSSG (-2.8), and AMA members (-3.4).
- Black non-Hispanic representation in the BOT increased 5.0 percentage points.
### Table 1. Basic Demographic Characteristics of AMA Leadership

<table>
<thead>
<tr>
<th></th>
<th>Delegates</th>
<th>Alternate Delegates</th>
<th>Board of Trustees</th>
<th>Councils and Leadership of Sections and Special Groups</th>
<th>AMA Members</th>
<th>All Physicians and Medical Students</th>
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</thead>
<tbody>
<tr>
<td><strong>Count</strong></td>
<td>545</td>
<td>440</td>
<td>20</td>
<td>165</td>
<td>240,498</td>
<td>1,283,477</td>
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<tr>
<td><strong>Mean age (years)</strong></td>
<td>57.4</td>
<td>51.8</td>
<td>56.0</td>
<td>52.4</td>
<td>47.3</td>
<td>51.6</td>
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<tr>
<td><strong>Age Distribution</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Under age 40</td>
<td>14.1%↑</td>
<td>24.1%</td>
<td>15.0%</td>
<td>29.1%↓</td>
<td>49.2%↑</td>
<td>29.6%</td>
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<tr>
<td>40-49 years</td>
<td>9.0%↓</td>
<td>15.2%</td>
<td>10.0%</td>
<td>11.5%</td>
<td>10.5%</td>
<td>19.0%</td>
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<tr>
<td>50-59 years</td>
<td>22.9%</td>
<td>23.6%</td>
<td>25.0%</td>
<td>14.5%↑</td>
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</tr>
<tr>
<td>60-69 years</td>
<td>36.0%↑</td>
<td>28.0%</td>
<td>45.0%</td>
<td>30.3%</td>
<td>11.2%</td>
<td>16.9%</td>
</tr>
<tr>
<td>70 or more</td>
<td>18.0%</td>
<td>9.1%</td>
<td>5.0%</td>
<td>14.5%</td>
<td>17.9%</td>
<td>16.2%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>73.6%↓</td>
<td>71.6%↓</td>
<td>70.0%↑</td>
<td>61.8%</td>
<td>65.7%</td>
<td>66.0%</td>
</tr>
<tr>
<td>Female</td>
<td>26.4%↑</td>
<td>28.4%↑</td>
<td>30.0%↓</td>
<td>38.2%</td>
<td>34.3%</td>
<td>33.9%</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>72.8%</td>
<td>67.5%↓</td>
<td>75.0%↓</td>
<td>59.4%↓</td>
<td>56.1%↓</td>
<td>52.2%</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>4.6%</td>
<td>3.4%</td>
<td>15.0%↑</td>
<td>7.9%</td>
<td>4.7%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2.2%</td>
<td>4.8%</td>
<td>0.0%</td>
<td>4.8%</td>
<td>5.2%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Asian/Asian American</td>
<td>7.7%</td>
<td>12.0%</td>
<td>10.0%</td>
<td>16.4%↑</td>
<td>14.9%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Native American</td>
<td>0.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Other</td>
<td>1.1%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>0.6%</td>
<td>2.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>11.4%</td>
<td>11.1%</td>
<td>0.0%</td>
<td>10.9%</td>
<td>16.7%</td>
<td>20.5%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US or Canada</td>
<td>93.8%</td>
<td>89.1%</td>
<td>100.0%</td>
<td>89.1%</td>
<td>83.2%</td>
<td>76.9%</td>
</tr>
<tr>
<td>IMG</td>
<td>6.2%</td>
<td>10.9%</td>
<td>0.0%</td>
<td>10.9%</td>
<td>16.8%</td>
<td>23.1%</td>
</tr>
</tbody>
</table>

Table 2 displays life stage, present employment and self-designated specialty of AMA leadership.

- Increases of at least two percentage points occurred among young physician delegates (+2.0 percentage points), alternate delegates (+4.7), and all physicians and medical students (+2.5).
- Representation among physicians employed by government hospitals increased by at least two percentage points among delegates (+3.2), alternate delegates (+3.6), and CSSG (+5.4).
- The percentage of resident AMA members increased by 4.1 percentage points, and over the past decade has increased by 12.7 percentage points; students and residents now combine to make up 44.9% of all AMA members.
- Group practice physicians decreased in representation among alternate delegates (-4.3) CSSG (-6.2), and AMA members (-2.7).

1 Numbers do not include the public member of the Board of Trustees, who is not a physician.
2 Numbers do not include non-physicians on the Council on Legislation and AMPAC. In addition, Appendix A contains a listing of the AMA councils, sections, and special groups.
3 Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
4 Age as of December 31. Mean age is the arithmetic average.
5 Includes other self-reported racial and ethnic groups.
6 Indicates an increase of at least two percentage points compared with 2014.
7 Indicates a decrease of at least two percentage points compared with 2014.
### Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Count</th>
<th>Delegates</th>
<th>Alternate Delegates</th>
<th>Board of Trustees</th>
<th>Councils and Leadership of Sections and Special Groups</th>
<th>AMA Members</th>
<th>All Physicians and Medical Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>5.9%</td>
<td>8.6%</td>
<td>5.0%</td>
<td>10.9%</td>
<td>23.2%</td>
<td>7.9%</td>
<td></td>
</tr>
<tr>
<td>Resident</td>
<td>5.0%</td>
<td>7.5%</td>
<td>5.0%</td>
<td>12.7%</td>
<td>21.7%</td>
<td>10.4%</td>
<td></td>
</tr>
<tr>
<td>Young (Under age 40 or first eight years of practice)</td>
<td>5.5%↑</td>
<td>14.3%↑</td>
<td>5.0%</td>
<td>10.3%</td>
<td>9.8%</td>
<td>20.0%↑</td>
<td></td>
</tr>
<tr>
<td>Mature (Age 40-64)</td>
<td>49.9%</td>
<td>48.6%↓</td>
<td>60.0%</td>
<td>37.6%</td>
<td>22.6%</td>
<td>38.0%↓</td>
<td></td>
</tr>
<tr>
<td>Senior (Age 65 or more)</td>
<td>33.8%</td>
<td>20.9%</td>
<td>25.0%</td>
<td>28.5%↑</td>
<td>22.8%</td>
<td>23.8%</td>
<td></td>
</tr>
</tbody>
</table>

### Present Employment

<table>
<thead>
<tr>
<th>Private Practice</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-employed solo practice</td>
<td>15.6%</td>
<td>12.7%</td>
<td>20.0%↑</td>
<td>13.3%</td>
<td>8.8%</td>
<td>9.3%</td>
<td></td>
</tr>
<tr>
<td>Two physician practice</td>
<td>2.6%</td>
<td>2.3%</td>
<td>5.0%</td>
<td>1.8%</td>
<td>1.7%</td>
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<td></td>
</tr>
<tr>
<td>Group practice</td>
<td>39.4%</td>
<td>36.1%↓</td>
<td>35.0%</td>
<td>27.3%↓</td>
<td>23.7%</td>
<td>40.9%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employed Physicians</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-government hospital</td>
<td>4.6%</td>
<td>6.4%</td>
<td>0.0%</td>
<td>6.1%</td>
<td>2.3%</td>
<td>2.8%</td>
<td></td>
</tr>
<tr>
<td>State or local government</td>
<td>6.4%</td>
<td>9.4%↑</td>
<td>11.4%↑</td>
<td>15.0%↓</td>
<td>11.5%↑</td>
<td>4.7%</td>
<td>6.9%</td>
</tr>
<tr>
<td>HMO</td>
<td>0.6%</td>
<td>0.7%</td>
<td>0.0%</td>
<td>0.6%</td>
<td>0.1%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>Medical School</td>
<td>6.6%</td>
<td>3.9%↓</td>
<td>10.0%↓</td>
<td>7.3%</td>
<td>1.3%</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>U.S. Government</td>
<td>4.8%</td>
<td>4.3%</td>
<td>0.0%</td>
<td>1.8%</td>
<td>1.2%</td>
<td>2.1%</td>
<td></td>
</tr>
<tr>
<td>Locum Tenens</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.2%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>Retired/Inactive</td>
<td>5.3%</td>
<td>5.0%</td>
<td>0.0%</td>
<td>6.1%</td>
<td>10.1%</td>
<td>11.0%</td>
<td></td>
</tr>
<tr>
<td>Resident/Intern/Fellow</td>
<td>5.0%</td>
<td>7.5%</td>
<td>5.0%</td>
<td>12.7%</td>
<td>21.7%</td>
<td>10.4%</td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>5.9%</td>
<td>8.6%</td>
<td>5.0%</td>
<td>10.9%</td>
<td>23.2%</td>
<td>7.9%</td>
<td></td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>0.4%</td>
<td>1.1%</td>
<td>5.0%</td>
<td>0.6%</td>
<td>0.9%</td>
<td>4.8%</td>
<td></td>
</tr>
</tbody>
</table>

### Self-designated Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>12.1%</td>
<td>8.9%↑</td>
<td>20.0%</td>
<td>9.1%</td>
<td>8.9%</td>
<td>11.8%</td>
<td></td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>19.3%</td>
<td>20.2%</td>
<td>20.0%</td>
<td>18.2%</td>
<td>19.1%</td>
<td>23.0%</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>23.7%</td>
<td>19.3%</td>
<td>20.0%↑</td>
<td>17.6%</td>
<td>14.2%</td>
<td>13.5%</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td>3.9%</td>
<td>3.0%</td>
<td>0.0%↓</td>
<td>7.9%</td>
<td>5.0%</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>OB/GYN</td>
<td>6.2%</td>
<td>6.4%</td>
<td>0.0%↓</td>
<td>6.1%</td>
<td>5.4%</td>
<td>4.7%</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>4.2%</td>
<td>6.1%</td>
<td>0.0%</td>
<td>6.1%</td>
<td>3.5%</td>
<td>4.5%</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>5.5%</td>
<td>5.0%</td>
<td>5.0%</td>
<td>7.9%</td>
<td>3.9%</td>
<td>5.3%</td>
<td></td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>4.0%</td>
<td>3.2%</td>
<td>10.0%↑</td>
<td>3.6%</td>
<td>3.7%</td>
<td>4.7%</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>2.2%</td>
<td>1.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.7%</td>
<td>2.3%</td>
<td></td>
</tr>
<tr>
<td>Other specialty</td>
<td>13.0%</td>
<td>17.5%</td>
<td>20.0%</td>
<td>12.7%</td>
<td>11.4%</td>
<td>13.6%</td>
<td></td>
</tr>
</tbody>
</table>

1 For further data, including information on state medical associations and national medical specialty societies, please see Appendix A.

2 Students and residents are so categorized without regard to age.
3 Age delineation reflects section/group definition of its membership.
4 Indicates an increase of at least two percentage points compared with 2014.
5 Indicates a decrease of at least two percentage points compared with 2014.
PROMOTING DIVERSITY AMONG DELEGATIONS

Pursuant to Part 3 of AMA Policy G-600.035, CLRDP utilized several methods to query state and specialty societies, and AMA sections and special groups on initiatives to encourage diversity, particularly by age, among their delegations. In 2015, CLRDP queried 118 medical specialty societies and 54 geographic medical associations and societies asking them to identify potential best practices-successful initiatives to promote diversity among their delegations. From those queries the Council received only 14 responses. During the 2016 Annual Meeting of the HOD, CLRDP hosted a forum to provide members of the Federation with an opportunity to contribute their thoughts, ideas, and concerns on diversity among state and specialty delegations to the HOD. Additionally, the Council established a virtual forum to solicit input on diversity from stakeholders.

These efforts yielded the following suggestions:

- Term restrictions/slotted seats: CLRDP Report 1-I-15 suggested restrictions on delegate terms as a potential method of increasing opportunities for involvement in the HOD. Contributors at the A-16 forum offered this suggestion as well. Though the data in CLRDP Report 1-I-15 showed only modest decreases in the average age of delegations with restrictions on the number of consecutive years that delegates serve, more frequent delegate rotation would increase the opportunities for society members to participate in the HOD. A structured system of delegate transition encourages improved mentorship of younger and “up and coming” leaders as each delegation will be self-motivated to keep their voice strong in the HOD. Slotting seats for members of specific sections and life stages was frequently mentioned as a method of increasing diversity. The American College of Radiology (ACR) fills some of their open delegate and/or alternate delegate seats at each AMA meeting with local radiology residents/young physicians whom their program directors recommend. According to ACR, this system has helped to increase gender, age and ethnic diversity within the delegation, and provide young physicians with exposure to the political process and a better understanding of the role ACR plays in the HOD.

- Improved data collection: Many stakeholders cited the need for comprehensive demographic data collection as a vital first step in assessing and responding to shortcomings in diversity. In terms of HOD delegates and alternates, information on age and gender is complete, and ethnic information has improved, but gaps still exist. In 2002, ethnic information on 30% of delegates and 38.5% of alternate delegates was unknown. Those figures fell to 11.4% and 11.1%, respectively as of 2016. Additionally, the AMA Nominations Form includes a new diversity and demographics section to measure and evaluate diversity and provide the Awards and Nominations Committee with this information to assess nominees. The AMA Masterfile, the source of demographic data of HOD members, does not collect information on sexual orientation and gender identity; however, the Gay and Lesbian Medical Association (GLMA) uses tools to collect demographic information inclusive of sexual orientation and gender identity, which they have offered to share with the AMA.

- Listening/open dialogue: In order to increase diversity, it is imperative to understand the reasons diversity is lacking, and to understand the concerns and needs unique to particular generations and social groups. This is essential when considering an organization such as the HOD, which is comprised of independent societies. An initiative that may be successful in a large delegation may not be suitable for one represented by a few or a single member. For this reason, once data are gathered, and diversity gaps are identified, societies may benefit from reaching out to members and non-members of specific demographic groups to determine what actions might be taken to increase their involvement. Several societies and sections, including
the Resident Fellow Section (RFS) through their “50 States 1 Voice” initiative, have appointed ambassadors to engage in dialogues with current and potential members to gain insight into barriers to involvement.

- Diversity and inclusion initiatives: Stressing the importance of inclusion, especially of underrepresented groups, recognizing unconscious biases, and improving cultural competencies demonstrate an organization’s commitment to diversity, and that the organization values input from all of its members. Additionally, broad diversity among delegations and in organizational leadership roles demonstrates to prospective members that they will have opportunities to advance into such roles. In 2016, The American College of Emergency Physicians (ACEP) published an article entitled, “Why Diversity and Inclusion Are Critical to the American College of Emergency Physicians’ Future Success,” which stressed the importance of diversity, inclusion and cultural sensitivity to the success of the College and the specialty. The AMA Women Physicians Section (WPS) suggests the creation of an AMA diversity advisory committee that would work toward developing actionable steps to increase diversity in the HOD.

- Formal guidance and mentorship programs: While mentorship and leadership training programs were often cited as among the most productive ways of encouraging student and young physician involvement in organized medicine, the lack of formal programs was cited as a concern and impediment to the success of such initiatives. In societies that lack formal programs, situations may arise where long-term informal mentorship breaks down—the mentor leaves the organization, is no longer willing to participate, etc.—leaving those formerly being mentored without support. As such, formal programs should be encouraged. Additionally, by consulting individually with current/prospective delegates, delegation leadership can gain an understanding of members’ desired career trajectories, and work to tailor delegate terms with those trajectories. The Texas Medical Association (TMA) launched the TMA Leadership College (TMALC) in 2010 as part of its effort to ensure strong and sustainable physician leadership within organized medicine.

- Use of social media: Virtual communication can allow participation without necessitating physical presence. During the A-16 forum, a suggestion was made to proactively invite and involve non-delegate members of state and specialty societies to participate in the work of their respective delegations prior to, and even perhaps during HOD meetings, by reviewing reports and resolutions within the HOD Handbook and participating in reference committee workgroups. Forum attendees cited the use of social media tools as viable options for this type of involvement. These tools may be especially useful for young and early-career physicians and trainees, whose time is often constrained by the rigorous demands of residency, challenges of early career development, and personal obligations. Additionally, several forum speakers, attendees, and a member of CLRPD cited the Physician Moms Group (PMG) as an example of a network that connects over 65,000 female, parent physicians from all specialties to collaborate, support, and share medical knowledge.

The data in this report suggest that some progress has been made in increasing diversity among delegations. However, for that trend to continue, the delegations that comprise the HOD must continuously seek ways to expand opportunities for participation to all of their members. Much of what the Council heard from stakeholders was a desire for increased opportunities for leadership and involvement; these initiatives demonstrate a variety of ways in which organizations are attempting to expand such opportunities to larger and more diverse groups of people. The Council applauds those efforts already underway, and encourages delegations to consider strategies to promote diversity and inclusion among their leadership.
Appendix A

Table 3. Basic Demographic Characteristics of AMA Leadership

<table>
<thead>
<tr>
<th></th>
<th>Delegates</th>
<th>Alternate Delegates</th>
<th>Board of Trustees</th>
<th>Councils and Leadership of Sections and Special Groups</th>
<th>AMA Members</th>
<th>All Physicians and Medical Students</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean age (years)</strong></td>
<td>57.4</td>
<td>51.8</td>
<td>56.0</td>
<td>52.4</td>
<td>47.3</td>
<td>51.6</td>
</tr>
<tr>
<td><strong>Age Distribution (total counts)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>77</td>
<td>106</td>
<td>3</td>
<td>48</td>
<td>118,281</td>
<td>380,104</td>
</tr>
<tr>
<td>40-49 years</td>
<td>49</td>
<td>67</td>
<td>2</td>
<td>19</td>
<td>25,146</td>
<td>244,265</td>
</tr>
<tr>
<td>50-59 years</td>
<td>125</td>
<td>104</td>
<td>5</td>
<td>24</td>
<td>27,152</td>
<td>234,151</td>
</tr>
<tr>
<td>60-69 years</td>
<td>196</td>
<td>123</td>
<td>9</td>
<td>50</td>
<td>26,924</td>
<td>216,925</td>
</tr>
<tr>
<td>70 or more</td>
<td>98</td>
<td>40</td>
<td>1</td>
<td>24</td>
<td>42,995</td>
<td>208,032</td>
</tr>
<tr>
<td><strong>Gender (total counts)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>401</td>
<td>315</td>
<td>14</td>
<td>102</td>
<td>158,007</td>
<td>847,095</td>
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<tr>
<td>Female</td>
<td>144</td>
<td>125</td>
<td>6</td>
<td>63</td>
<td>82,491</td>
<td>436,382</td>
</tr>
<tr>
<td><strong>Race/ethnicity (total counts)</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>397</td>
<td>297</td>
<td>15</td>
<td>98</td>
<td>134,961</td>
<td>670,569</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>25</td>
<td>15</td>
<td>3</td>
<td>13</td>
<td>11,212</td>
<td>53,412</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12</td>
<td>21</td>
<td>0</td>
<td>8</td>
<td>12,500</td>
<td>68,752</td>
</tr>
<tr>
<td>Asian/Asian American</td>
<td>42</td>
<td>53</td>
<td>2</td>
<td>27</td>
<td>35,834</td>
<td>194,872</td>
</tr>
<tr>
<td>Native American</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>841</td>
<td>3,246</td>
</tr>
<tr>
<td>Other</td>
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<td>5</td>
<td>0</td>
<td>1</td>
<td>4,924</td>
<td>28,992</td>
</tr>
<tr>
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<td>49</td>
<td>0</td>
<td>18</td>
<td>40,226</td>
<td>263,634</td>
</tr>
<tr>
<td><strong>Education (total counts)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>US or Canada</td>
<td>511</td>
<td>392</td>
<td>20</td>
<td>147</td>
<td>200,057</td>
<td>987,628</td>
</tr>
<tr>
<td>IMG</td>
<td>34</td>
<td>48</td>
<td>0</td>
<td>18</td>
<td>40,441</td>
<td>295,849</td>
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</tbody>
</table>

---

1 Numbers do not include the public member of the Board of Trustees, who is not a physician.
2 Numbers do not include non-physicians on the Council on Legislation and AMPAC.
3 Age as of December 31. Mean age is the arithmetic average.
4 Includes other self-reported racial and ethnic groups.
Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

<table>
<thead>
<tr>
<th>Life Stage (total counts)</th>
<th>Delegates</th>
<th>Alternate Delegates</th>
<th>Board of Trustees</th>
<th>Councils and Leadership of Sections and Special Groups</th>
<th>AMA Members</th>
<th>All Physicians and Medical Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student¹</td>
<td>32</td>
<td>38</td>
<td>1</td>
<td>18</td>
<td>55,863</td>
<td>100,896</td>
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<tr>
<td>Resident</td>
<td>27</td>
<td>33</td>
<td>1</td>
<td>21</td>
<td>52,191</td>
<td>132,982</td>
</tr>
<tr>
<td>Young (Under age 40 or first eight years of practice)²</td>
<td>30</td>
<td>63</td>
<td>1</td>
<td>17</td>
<td>23,473</td>
<td>256,202</td>
</tr>
<tr>
<td>Mature (Age 40-64)</td>
<td>272</td>
<td>214</td>
<td>12</td>
<td>62</td>
<td>54,233</td>
<td>488,216</td>
</tr>
<tr>
<td>Senior (Age 65 or more)</td>
<td>184</td>
<td>92</td>
<td>5</td>
<td>47</td>
<td>54,738</td>
<td>305,181</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present Employment (total counts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice</td>
</tr>
<tr>
<td>Self-employed solo practice</td>
</tr>
<tr>
<td>Two physician practice</td>
</tr>
<tr>
<td>Group practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employed Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-government hospital</td>
</tr>
<tr>
<td>State or local government hospital</td>
</tr>
<tr>
<td>HMO</td>
</tr>
<tr>
<td>Medical School</td>
</tr>
<tr>
<td>U.S. Government</td>
</tr>
<tr>
<td>Locum Tenens</td>
</tr>
<tr>
<td>Retired/Inactive</td>
</tr>
<tr>
<td>Resident/Intern/Fellow</td>
</tr>
<tr>
<td>Student</td>
</tr>
<tr>
<td>Other/Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-designated Specialty (total counts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
</tr>
<tr>
<td>Internal Medicine</td>
</tr>
<tr>
<td>Surgery</td>
</tr>
<tr>
<td>Pediatrics</td>
</tr>
<tr>
<td>OB/GYN</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Anesthesiology</td>
</tr>
<tr>
<td>Pathology</td>
</tr>
<tr>
<td>Other specialty</td>
</tr>
<tr>
<td>Student</td>
</tr>
</tbody>
</table>

¹ Students and residents are so categorized without regard to age.
² Age delineation reflects section/group definition of its membership.
Table 5. Characteristics of Specialty Society Delegations, December 2016

<table>
<thead>
<tr>
<th>Specialty Society Delegations</th>
<th>Mean Age</th>
<th>Median Age</th>
<th>% Female</th>
<th>% IMG</th>
<th>% Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA Members (n = 240,498)</td>
<td>47.3</td>
<td>40</td>
<td>34.3%</td>
<td>16.8%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Specialty Society Delegates and Alternates (n = 383)</td>
<td>56.2</td>
<td>57</td>
<td>28.7%</td>
<td>5.5%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Family Medicine Delegations (n = 23)</td>
<td>53.5</td>
<td>57</td>
<td>43.5%</td>
<td>0.0%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Internal Medicine Delegations (n = 67)</td>
<td>60.7</td>
<td>63</td>
<td>17.9%</td>
<td>6.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Surgery Delegations (n = 92)</td>
<td>56.3</td>
<td>54.50</td>
<td>15.2%</td>
<td>4.3%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Pediatrics Delegations (n = 15)</td>
<td>58.9</td>
<td>60</td>
<td>46.7%</td>
<td>0.0%</td>
<td>6.7%</td>
</tr>
<tr>
<td>OB/GYN Delegations (n = 26)</td>
<td>55.6</td>
<td>55.50</td>
<td>57.7%</td>
<td>3.8%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Radiology Delegations (n = 27)</td>
<td>57.7</td>
<td>59</td>
<td>22.2%</td>
<td>3.7%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Psychiatry Delegations (n = 26)</td>
<td>56.8</td>
<td>57.50</td>
<td>34.6%</td>
<td>11.5%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Anesthesiology Delegations (n = 13)</td>
<td>57</td>
<td>60</td>
<td>30.8%</td>
<td>7.7%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Pathology Delegations (n = 13)</td>
<td>50.8</td>
<td>53</td>
<td>38.5%</td>
<td>15.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other specialty Delegations (n = 81)</td>
<td>52.7</td>
<td>52</td>
<td>34.6%</td>
<td>6.2%</td>
<td>2.5%</td>
</tr>
<tr>
<td>State</td>
<td>Total AMA Members in State</td>
<td>Mean Age of AMA Members</td>
<td>Median Age of AMA Members</td>
<td>Total Number of Delegates and Alternate Delegates</td>
<td>Mean Age of AMA Delegates and Alternate Delegates</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Alabama</td>
<td>3,035</td>
<td>51.1</td>
<td>51</td>
<td>8</td>
<td>56.8</td>
</tr>
<tr>
<td>Alaska</td>
<td>333</td>
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<td>53</td>
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<td>†</td>
</tr>
<tr>
<td>Arizona</td>
<td>4,537</td>
<td>53.1</td>
<td>52</td>
<td>9</td>
<td>59.9</td>
</tr>
<tr>
<td>Arkansas</td>
<td>2,059</td>
<td>51.0</td>
<td>50</td>
<td>6</td>
<td>63.3</td>
</tr>
<tr>
<td>California</td>
<td>21,310</td>
<td>53.9</td>
<td>52</td>
<td>41</td>
<td>57.8</td>
</tr>
<tr>
<td>Colorado</td>
<td>4,068</td>
<td>51.6</td>
<td>50</td>
<td>8</td>
<td>58.8</td>
</tr>
<tr>
<td>Connecticut</td>
<td>3,572</td>
<td>51.7</td>
<td>51</td>
<td>9</td>
<td>67.6</td>
</tr>
<tr>
<td>Delaware</td>
<td>685</td>
<td>54.0</td>
<td>53</td>
<td>2</td>
<td>†</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>1,828</td>
<td>44.5</td>
<td>38</td>
<td>3</td>
<td>†</td>
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<td>13,366</td>
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<td>55</td>
<td>27</td>
<td>56.1</td>
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<td>10</td>
<td>62.8</td>
</tr>
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<td>48</td>
<td>23</td>
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</tr>
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<td>48.6</td>
<td>47</td>
<td>10</td>
<td>65.9</td>
</tr>
<tr>
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<td>64.3</td>
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<td>52</td>
<td>2</td>
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<td>18</td>
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<td>60.5</td>
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<td>25</td>
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<td>48</td>
<td>4</td>
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<td>2</td>
<td>†</td>
</tr>
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<td>4,768</td>
<td>50.8</td>
<td>50</td>
<td>10</td>
<td>62.9</td>
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<td>33</td>
<td>58.1</td>
</tr>
<tr>
<td>State</td>
<td>Total AMA Members in State</td>
<td>Mean Age of AMA Members</td>
<td>Median Age of AMA Members</td>
<td>Total Number of Delegates and Alternate Delegates</td>
<td>Mean Age of AMA Delegates and Alternate Delegates</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
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<td>4</td>
<td>57.0</td>
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<td>†</td>
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<td>62</td>
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<td>-</td>
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<td>6,610</td>
<td>51.2</td>
<td>50</td>
<td>14</td>
<td>62.9</td>
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<td>51</td>
<td>10</td>
<td>56.1</td>
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<td>227</td>
<td>56.7</td>
<td>56</td>
<td>2</td>
<td>†</td>
</tr>
<tr>
<td>APO/FPO/Foreign</td>
<td>662</td>
<td>64.5</td>
<td>63</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>240,498</td>
<td>52.1</td>
<td>51</td>
<td>508</td>
<td>57.4</td>
</tr>
</tbody>
</table>

† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall totals.

This table does not include regional student delegates or alternate delegates. It also does not include resident sectional delegates or alternate delegates.
Table 7. Women and International Medical Graduates on State Association Delegations, December 2016

<table>
<thead>
<tr>
<th>State</th>
<th>Total AMA Members in State</th>
<th>Total Number of Delegates and Alternate Delegates</th>
<th>Total Women AMA Members in State</th>
<th>Number of Women Delegates and Alternate Delegates</th>
<th>Total IMG Members in State</th>
<th>Number of IMG Delegates and Alternate Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>3,035</td>
<td>8</td>
<td>874</td>
<td>2</td>
<td>383</td>
<td>-</td>
</tr>
<tr>
<td>Alaska</td>
<td>333</td>
<td>2</td>
<td>121</td>
<td>1</td>
<td>30</td>
<td>-</td>
</tr>
<tr>
<td>Arizona</td>
<td>4,537</td>
<td>9</td>
<td>1,468</td>
<td>1</td>
<td>823</td>
<td>-</td>
</tr>
<tr>
<td>Arkansas</td>
<td>2,059</td>
<td>6</td>
<td>636</td>
<td>-</td>
<td>242</td>
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</tr>
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<td>41</td>
<td>7,169</td>
<td>10</td>
<td>3,365</td>
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</tr>
<tr>
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<td>4,068</td>
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<td>1,489</td>
<td>5</td>
<td>193</td>
<td>-</td>
</tr>
<tr>
<td>Connecticut</td>
<td>3,572</td>
<td>9</td>
<td>1,285</td>
<td>-</td>
<td>644</td>
<td>2</td>
</tr>
<tr>
<td>Delaware</td>
<td>685</td>
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<td>188</td>
<td>2</td>
<td>159</td>
<td>-</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>1,828</td>
<td>3</td>
<td>904</td>
<td>-</td>
<td>207</td>
<td>-</td>
</tr>
<tr>
<td>Florida</td>
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<td>27</td>
<td>3,935</td>
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<td>3,400</td>
<td>4</td>
</tr>
<tr>
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<td>4,967</td>
<td>10</td>
<td>1,659</td>
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1 Alaska, Delaware, Guam, Idaho, Montana, Virgin Islands, and Wyoming do not have a medical school.
2 The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.
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1 Alaska, Delaware, Guam, Idaho, Montana, Virgin Islands, and Wyoming do not have a medical school.

2 The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.
American Medical Association Councils, Sections, and Special Groups.

AMA Councils
Council on Constitution and Bylaws
Council on Ethical and Judicial Affairs
Council on Legislation
Council on Long Range Planning and Development
Council on Medical Education
Council on Medical Service
Council on Science and Public Health
American Medical Political Action Committee

Sections
Academic Physicians Section
Integrated Physician Practice Section
International Medical Graduates Section
Medical Student Section
Minority Affairs Section
Organized Medical Staff Section
Resident and Fellow Section
Senior Physicians Section
Young Physician Section
Women Physicians Section

Special Groups
Advisory Committee on Gay, Lesbian, Bisexual and Transgender Issues
Appendix B

Specialty classification using physicians' self-designated specialties.

<table>
<thead>
<tr>
<th>Major Specialty Classification</th>
<th>AMA Physician Masterfile Classification</th>
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<td>Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology</td>
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<tr>
<td>Pediatrics</td>
<td>Pediatrics, Pediatric Allergy, Pediatric Cardiology</td>
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<td>Diagnostic Radiology, Radiology, Radiation Oncology</td>
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<td>Psychiatry, Child Psychiatry</td>
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<td>Anesthesiology</td>
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<td>Pathology</td>
<td>Forensic Pathology, Pathology</td>
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<td>Other Specialty</td>
<td>Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified</td>
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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-17

Subject: Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages

Presented by: Patricia Turner, MD, Chair

Policy D-350.986, “Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages,” directs our American Medical Association (AMA) to study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates. This report is in response to that directive.

This policy was adopted at the 2015 Annual Meeting of the AMA House of Delegates. Unanimous supportive testimony at A-15 before Reference Committee C asserted that many Deferred Action for Childhood Arrivals (DACA)-eligible medical students want to meet the health care needs of their communities and have the potential to increase the physician workforce, particularly for underserved populations and in underserved areas. DACA allows individuals who came to the U.S. illegally as minor children, and who meet several guidelines, to apply for deferred deportation and be eligible for a renewable work authorization and Social Security number. While the ethnicity of eligible individuals varies by region, 77 percent of all DACA applicants by 2014 were of Mexican origin; individuals of Mexican, El Salvadoran, Guatemalan, Korean, and Honduran origin accounted for 87 percent of all applicants.\(^1\)

This report offers background information regarding the DACA program; provides estimates of the number of medical students and resident trainees eligible for these opportunities; discusses their potential impact on the physician workforce; and reviews how the current political climate and the results of the 2016 presidential election may affect or eliminate this initiative. All information is current as of March 17, 2017.

DEFERRED ACTION FOR CHILDHOOD ARRIVALS

In June 2012, then-Secretary of Homeland Security Janet Napolitano issued a memorandum to U.S. Customs and Border Protection, U.S. Citizenship and Immigration Services, and U.S. Immigration and Customs Enforcement to set forth “now, in the exercise of our prosecutorial discretion, the Department of Homeland Security (DHS) should enforce the Nation’s immigration laws against certain young people who were brought to this country as children and know only this country as home.”\(^2\) The memorandum explains the criteria these federal agencies should use when considering whether or not to remove non-citizens from the country. Later that day, then-President Barack Obama addressed this new inter-agency policy, remarking that “it makes no sense to expel talented young people, who, for all intents and purposes, are Americans—they’ve been raised as Americans; understand themselves to be part of this country—to expel these young people who want to staff our labs, or start new businesses, or defend our country simply because of the actions of their parents—or because of the inaction of politicians.”\(^3\) This policy action, which has become known as DACA, had been approved for almost 730,000 qualifying individuals by March 2016.\(^4\)

Despite the protections the memorandum appears to offer, however, it ends with a warning that

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“[t]his memorandum confers no substantive right, immigration status or pathway to citizenship. Only the Congress, acting through its legislative authority, can confer these rights. It remains for the executive branch, however, to set forth policy for the exercise of discretion within the framework of the existing law.”

In November 2014, President Obama issued an executive action titled Immigration Accountability, which would have expanded the original DACA policy action and introduced a new initiative—Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA). These two actions were intended to keep families united and simultaneously increase tax revenue. In February 2015, the actions were blocked by a federal judge in Texas, effectively preventing the programs from being implemented. That decision was reaffirmed by the 5th Circuit Court of Appeals in New Orleans. The case ultimately was heard by the U.S. Supreme Court, which handed down a split decision in June 2016, preventing these programs from being implemented during the remainder of President Obama’s term. The injunction did not affect the original DACA initiative, and beneficiaries of that program remained—as of June 2016—“low priorities for enforcement.”

DACA-ELIGIBLE TRAINEES IN UNDERGRADUATE MEDICAL EDUCATION

Medical schools traditionally may have been unwilling to offer admission to individuals who might not have been able to complete their training due to the uncertainty of their immigration status. DACA status is therefore key to opening doors to medical school for qualified non-citizen applicants, as achieving such status also secures work authorization—necessary for any individual who wants to eventually enter residency/fellowship training. According to the Association of American Medical Colleges (AAMC), 61 U.S. allopathic medical schools reported that they considered applications from students with DACA status for the 2016/2017 academic year. In 2016, 108 students with DACA status applied to U.S. allopathic medical schools, and 34 of those individuals matriculated, bringing total allopathic medical school enrollment of DACA-eligible individuals to approximately 70 students.

While DACA status might provide opportunities for entry into higher education, it does not confer eligibility for federal financial aid. This financial barrier has implications for students and schools. Like others, undocumented medical students may find the average cost of a medical school education out of reach: the AAMC estimates the median cost of attending four years of medical school for the class of 2017 at $240,351 for public school and $314,202 for private school.

Loyola University Chicago Stritch School of Medicine—the first U.S. medical school to accept DACA-eligible applicants—has taken steps to address financial barriers by working with local partners to create a program similar to public health service loans. No taxpayer funds are used, and recipients are required to dedicate one year of service to underserved populations/areas in the state of Illinois for each year of training during which the loans are used.

California has pursued another pathway that seeks to assist undocumented individuals as they pursue training in health care (not limited to physician training). A 2016 bill signed into law permits individuals to apply for multiple sources of state training funding regardless of citizenship status, and further prohibits medical school and residency training programs from denying admission to individuals solely based on this status.
DACA-ELIGIBLE TRAINEES IN GRADUATE MEDICAL EDUCATION

While the Accreditation Council for Graduate Medical Education (ACGME) does not currently track numbers of medical school graduates with DACA status who have entered ACGME-accredited residency training programs, the AAMC is currently aware of four DACA resident trainees at four different institutions.11 Overall numbers of current DACA-eligible resident trainees/fellows therefore appear quite small; however, several impediments that might previously have prevented medical school graduates from entering residency training programs recently have been addressed. One barrier was removed in 2014, and strengthened in 2016, when the Veterans Health Administration (VA) agreed to allow DACA-eligible trainees to rotate through VA facilities, a required rotation for many residency training programs.12 Also, the Electronic Residency Application System (ERAS)—the online application tool medical school graduates use to apply to most ACGME-accredited residency training programs—recently added a DACA category, thereby allowing DACA-eligible residency applicants to participate in this process.13 The renewable work authorization granted under DACA allows recipients to be hired using customary I-9 verification.14 Therefore, payment barriers are alleviated, and DACA recipients with work authorization are protected from employment discrimination as well.15

STATE LICENSURE

Eligibility for medical licensure of undocumented, U.S.-educated physicians who have completed residency training varies by state, and the Federation of State Medical Boards (FSMB) does not maintain a centralized repository of this information. While some states specifically allow medical licensure for qualified DACA-eligible individuals, others are silent on this issue.16

POTENTIAL PHYSICIAN WORKFORCE IMPLICATIONS

Because of a lack of data, due in large part to the relative youth of the DACA program, little is known about the potential impact of DACA-eligible medical students and trainees on the U.S. physician workforce. The Migration Policy Institute projected that of the 1.2 million immediately DACA-eligible youth in 2014, four percent had completed a bachelor’s (three percent) or advanced degree (one percent).17 This would imply that only a small number of individuals would be prepared to even consider application to medical school. Another model, however, predicts that the DACA initiative could introduce 5,400 previously ineligible physicians into the U.S. health care system in the coming decades (although “coming decades” is not defined).18 Nevertheless, even if this projection is accurate, speculation regarding both specialty choice and practice location, and extrapolation regarding patient populations served, would be rash at this time.

IMPACTS OF THE 2016 PRESIDENTIAL ELECTION

All of the foregoing information is, of course, subject to any policy action taken by President Donald Trump and the 115th Congress. In the lead-up to the election, Mr. Trump referred to the DACA initiative as “one of the most unconstitutional actions ever undertaken by a president,” and spoke of immediately expelling all undocumented immigrants.19 As of the writing of this report, however, no official actions have been taken by the new administration to abolish DACA or punitively identify and deport individuals covered by the initiative, and comments offered during the administration’s first official White House Press Briefing suggest that there will be no immediate effort to terminate DACA.20 While the President generally has been expanding immigration enforcement efforts, he still has not taken any action to rescind or roll back the DACA program. Furthermore, the recently issued executive orders and guidance memoranda do not address the DACA program.
A number of different groups have expressed concern for the status of DACA-eligible medical students and resident trainees. At the 2016 Interim Meeting, the House adopted a resolution in support of current U.S. health care professionals, including medical students and resident/fellow trainees, who are DACA recipients. In December 2016, the AAMC sent a letter to then President-Elect Trump “strongly” encouraging him not to eliminate the protections conferred by the DACA initiative. The AMA expressed its concerns about the future of the DACA initiative in a letter to Department of Homeland Security Secretary John F. Kelly in February 2017, which urged the administration to carefully consider any future action related to individuals with DACA status. The AMA stated its strong support for medical students and physicians with DACA status and advocated that the administration retain the current DACA initiative until a permanent solution on lawful immigration status for DACA participants could be implemented.

Legislators also are addressing this concern. In January 2017, a bipartisan group of six senators—Lindsey Graham (R-SC), Richard Durbin (D-IL), Lisa Murkowski (R-AK), Dianne Feinstein (D-CA), Jeff Flake (R-AZ), and Charles Schumer (D-NY)—reintroduced the BRIDGE Act (Bar Removal of Individuals who Dream and Grow our Economy), S. 128. Provisions of this legislation—at the time of this report’s writing—would amend Chapter 4 of Title II of the Immigration and Nationality Act to offer DACA-eligible individuals “provisional protected presence,” which also includes employment authorization. The AMA subsequently sent a letter of support to Senators Graham and Durbin in February, which noted that DACA-eligible medical students “help contribute to a diverse and culturally responsive physician workforce, which in turn helps benefit not only traditionally underserved patients, but all patients as well.” This bill also was introduced in the House of Representatives as H.R. 496 by Representatives Mike Coffman (R-CO), Luis Gutiérrez (D-IL), and 18 cosponsors from both sides of the aisle. The AMA sent an additional letter of support to Representatives Coffman and Gutiérrez.

If DACA status were to be eliminated, previously DACA-eligible medical students might not be able to continue in their programs, and DACA-eligible medical school graduates would not be eligible to enter residency training in the United States. These individuals’ status also would preclude them from entering residency training as international medical graduates (IMGs), a category officially recognized by U.S. residency and fellowship training programs. In order to qualify as an IMG, an applicant is required to have a certificate from the Educational Commission for Foreign Medical Graduates (ECFMG). An individual who has graduated from a Liaison Committee on Medical Education (LCME)- or Commission on Osteopathic College Accreditation (COCA)-accredited medical school is not eligible to receive an ECFMG certificate. While the ECFMG does sponsor J-1 visas for non-IMGs (often graduates of Canadian medical schools), individuals pursuing this route would need to leave the country and reenter with a valid visa; this seems an unlikely path for individuals with current DACA status.

SUMMARY AND AREAS FOR FURTHER STUDY

Extensive AMA policy and previous Council on Medical Education reports support a diverse, well-distributed physician workforce and promote access to care for underserved populations; for these reasons, our AMA should promote policies that enable individuals from diverse backgrounds to complete medical school and residency training and enter into U.S. practice. At this time, DACA-eligible individuals are not likely to have a significant impact on physician workforce shortages, and the effects of their entry into the workforce on physician misdistribution are unknown. Regardless, the practice patterns of DACA-eligible medical school graduates and trainees in residency training programs should be studied to better understand their future potential relationship to medically underserved areas and populations. The Council on Medical Education will continue to monitor this issue and its implications and report back as needed.
APPENDIX: RELEVANT AMA POLICIES

H-350.970, Diversity in Medical Education
Our AMA will: 1. Request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; 2. Support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and 3. Encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion.

D-200.982, Diversity in the Physician Workforce and Access to Care
Our AMA will: 1. Continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; 2. Continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and 3. Continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

H-295.874, Educating Medical Students in the Social Determinants of Health and Cultural Competence
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students in the social determinants of health and cultural competence.

H-310.919, 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
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; and 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.

H-295.897, Enhancing the Cultural Competence of Physicians
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula; 2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings; 3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database; 4. Our AMA will assist physicians in
obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; 5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice; and 6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.

D-350.986. Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages
I. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates; and 2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations: 1. Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care; 2. Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities; and 3. Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

H-200.950. Retraining Refugee Physicians
Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories.

D-200.985. Strategies for Enhancing Diversity in the Physician Workforce
I. 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; and 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.

H-350.960, Underrepresented Student Access to US Medical Schools
Our AMA: 1. Recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and 2. Supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

H-200.954, US Physician Shortage
Our AMA: 1. Explicitly recognizes the existing shortage of physicians in many specialties and areas of the US; 2. Supports efforts to quantify the geographic maldistribution and physician shortage in many specialties; 3. Supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US; 4. Encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations; 5. Encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations; 6. Encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations; 7. Will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas; 8. Will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification; 9. Will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need; 10. Continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and 11. Continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
REFERENCES


6 Geoff Young, Senior Director, Student Affairs and Programs, Association of American Medical Colleges. Personal communication. January 9, 2017.

7 Ibid.


9 Kuczewski MG, Brubaker L. Equity for “DREAMers” in Medical School Admissions. AMA Journal of Ethics. 2015;17(2):152-156.


11 Geoff Young, Senior Director, Student Affairs and Programs, Association of American Medical Colleges. Personal communication. January 9, 2017.


REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-17

Subject: Options for Unmatched Medical Students

Presented by: Patricia Turner, MD, Chair

Policy D-310.977 (15), “National Resident Matching Program Reform,” directs our American Medical Association (AMA) to “discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.” This report is in response to that directive.

This policy was adopted at the 2015 Annual Meeting of the AMA House of Delegates. Testimony at A-15 before Reference Committee C reflected growing concern over the issue of unmatched medical students, with the continued growth in enrollments in medical schools. The AMA is committed to continued study and close monitoring of this issue—through the efforts of the Council on Medical Education and Academic Physicians Section, among others—to ensure the highest possible return on the nation’s investment in our future physician workforce.

This report focuses primarily on those Match participants who are U.S. medical school seniors at allopathic, MD-granting programs accredited by the Liaison Committee on Medical Education. Graduates of osteopathic medical schools (DOs) can participate in both the osteopathic Match as well as the NRMP Match, and as such the data available on match rates of DOs versus MDs are not directly comparable. That said, we have included segments in this report noting some of the Match issues specific to DOs as well as to International Medical Graduates (IMGs).

BACKGROUND: THE HISTORICAL STABILITY OF MATCH RATES

Council on Medical Education Report 3-A-16, “Addressing the Increasing Number of Unmatched Medical Students,” was adopted as amended by the AMA House of Delegates at its 2016 Annual Meeting (see Policy D-310.977). This report responded to Policy D-310.977 (14), “National Resident Matching Program Reform,” which calls for the AMA to “study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match.” Some of the information in that report is relevant to this document and is incorporated where appropriate.

A key point is the historical stability in Match rates for U.S. allopathic medical school seniors. As noted by the authors of research published in the December 8, 2015 issue of JAMA,1 “The percentage of US MD graduates entering GME the year of graduation has remained stable during the past decade despite an increase in the number of graduates.”

These conclusions were highlighted in an interview with the article’s lead author, Henry Sondheimer, MD.2 “[I]n spite of the growth in U.S. MD graduates, the percent of graduates not beginning their GME the year they graduated has remained very stable around 3%.” He adds that, after following the graduates for eight to 10 years after graduation, “more than 99% enter GME or

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begin practice in some other way”—for example, those with a joint medical/dental degree may obtain a dental residency slot versus a similar position in a medical residency.

WHY STUDENTS FAIL TO MATCH

Data provided by medical schools to the Liaison Committee on Medical Education (LCME) offer insight into the reasons students did not match into a residency program. The LCME Part II Annual Medical School Questionnaire from 2015-2016 (with responses from 142 schools; 100 percent response rate) shows that academic shortcomings and inadequate Match preparation are two key reasons for failure to match.

The LCME data show that 18,442 potential 2016 graduates accepted appointments to first-year residency programs. An additional 473 potential 2016 graduates did not enter residency training in 2016-2017, for the following reasons:

<table>
<thead>
<tr>
<th>#</th>
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<tr>
<td>273</td>
<td>57.7%</td>
<td>Did not find a residency position</td>
</tr>
<tr>
<td>75</td>
<td>15.9%</td>
<td>Research/pursuing additional degree or training</td>
</tr>
<tr>
<td>75</td>
<td>15.9%</td>
<td>Other</td>
</tr>
<tr>
<td>45</td>
<td>9.5%</td>
<td>Changing careers</td>
</tr>
<tr>
<td>5</td>
<td>1.1%</td>
<td>Family responsibilities/maternity/child care</td>
</tr>
</tbody>
</table>

Of these 473 potential 2016 graduates, medical schools provided data on the 332 individuals who sought but did not find a residency position:

Students who did not find a residency position:

<table>
<thead>
<tr>
<th>#</th>
<th>%</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>203</td>
<td>61.1%</td>
<td>The student’s academic performance (eg, clinical grades) and/or USMLE scores were below the norm</td>
</tr>
<tr>
<td>55</td>
<td>16.6%</td>
<td>The applications were limited to one specialty and did not include backup plans (“plan B” specialty)</td>
</tr>
<tr>
<td>24</td>
<td>7.2%</td>
<td>The number of applications was (relatively) limited</td>
</tr>
<tr>
<td>21</td>
<td>6.3%</td>
<td>There were nonacademic flags in the MSPE (eg, professional behavior)</td>
</tr>
<tr>
<td>29</td>
<td>8.7%</td>
<td>Reason not reported or unknown to school</td>
</tr>
</tbody>
</table>

Not having a backup plan (“plan B” specialty) may result from candidates’ failure to fully and realistically evaluate their chances for matching into a given specialty field and/or residency program. Students who have not achieved high United States Medical Licensing Examination (USMLE) scores or class ranking may not be competitive applicants for such programs, and are likely to remain unmatched if their rank order lists include only highly competitive specialties. Indeed, as the authors of a recent study in Academic Medicine note, “U.S. seniors’ Match outcomes may be affected by applicant characteristics that negatively influence their selection for interviews, and their difficulties may be exacerbated by disadvantageous ranking behaviors.”

3
FUTURE PLANS OF STUDENTS WHO FAIL TO MATCH

As to the plans of the 332 students who were unmatched in 2016, the LCME Questionnaire provides additional insight, as shown below (Note: One or more options could be marked for an individual student; total responses were 553):

<table>
<thead>
<tr>
<th>#</th>
<th>%</th>
<th>Future Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>246</td>
<td>44.4%</td>
<td>Will search for a residency position for entry in 2017</td>
</tr>
<tr>
<td>120</td>
<td>21.7%</td>
<td>Will continue searching for a residency position in 2016</td>
</tr>
<tr>
<td>120</td>
<td>21.7%</td>
<td>Will seek employment, such as a research position</td>
</tr>
<tr>
<td>32</td>
<td>5.8%</td>
<td>Will seek an additional degree</td>
</tr>
<tr>
<td>5</td>
<td>0.1%</td>
<td>Will seek a career outside of medicine</td>
</tr>
<tr>
<td>30</td>
<td>5.4%</td>
<td>Plans unknown by school</td>
</tr>
</tbody>
</table>

For these unmatched students, the odds of a future successful Match are not favorable. Historically, fewer than 50 percent of U.S. medical school graduates who did not match in their initial attempt obtained a position in a succeeding year’s Match. This finding reinforces the need for individualized counseling by medical schools as well as rational and realistic decisions by medical students prior to entering their first match.

The 2016 GME compendium from the AMA outlines options for unmatched medical students to consider, as well as the challenges/opportunities that these options may entail. These include a program-specific fifth year of medical school or research/clinical program or pursuing a master’s degree. Other potential options are seeking employment in a research, clinical, or teaching environment; obtaining volunteer work; or pursuing a nonclinical career in such fields as public health and service, public policy and government, communications and journalism, informatics, pharmaceutical research, and consulting. Some unmatched medical school graduates turn to other health professions, to become a nurse, nurse practitioner, or physician assistant.

Finally, an often unstated truism is that the Match serves as an additional filter for those medical school graduates who, due to poor academic performance or concerns about professional behavior, are not well-equipped to become competent, caring health care professionals. These numbers are small, to be sure—which reflects well on the medical school admissions process—but they represent a beneficial outcome, in that a given individual who may not be suitable to become a fully licensed practicing physician is removed from the system.

DOs AND THE MATCH

The American Association of Colleges of Osteopathic Medicine (AACOM) has been tracking Match rates for graduates of osteopathic medical schools (DOs) and communicating with its colleges on responses to the issue (personal communication, December 2016). Much of the discussion in the DO profession centers around Commission on Osteopathic College Accreditation (COCA) Standard 8 on GME Outcomes, which requires an osteopathic medical college to provide a retrospective GME accountability report on GME placement. Specifically, Standard 8.3 requires osteopathic medical colleges to report on:

... the number of graduates entering GME, the positions available in the COM’s affiliated OPTI [Osteopathic Postdoctoral Training Institution], the historic percentage of match participation (AOA, NRMP, military, etc.), final placement, the number/percentage of eligible students unsuccessful in the matches, and the residency choices of its graduates.
Guideline: COMs should strive to place 100% of their graduates into GME programs and devote the necessary resources to obtain that goal.

Further, Standard 8.5.a requires colleges to “annually report publicly, beginning with the 2013-2014 academic year, from the previous four academic years, the following data...on its website, in its catalog, and in all COM promotional publications that provide information about the COM’s education for prospective students.... The number of students from each graduating class who applied to and obtained or were offered placement in a graduate medical education program accredited by the American Osteopathic Association or the Accreditation Council for Graduate Medical Education or the military, and the number of students from each graduating class who applied to and were unable to obtain placement in an accredited graduate medical program.”

COCA policy also states that, if an osteopathic medical school does not match 98 percent of students on its three-year rolling average, it will not be granted the same average allowance for class sizes.

IMGs AND THE MATCH

IMGs face additional challenges in securing a residency program placement. Foreign national IMGs, in particular, must surmount visa and immigration hurdles, aside from the need to obtain a residency slot. Furthermore, as they lack the institutional support and counsel of a domestic medical school’s student affairs office, IMGs may have additional difficulties in learning about and employing successful Match strategies.

Helping to fill this gap are programs like the IMG Advisors Network (IAN) of the Educational Commission for Foreign Medical Graduates (ECFMG) and the AMA International Medical Graduates Section (AMA-IMGs). The AMA-IMGs, for example, advocates for the interests of IMGs and helps minimize the time it takes for IMGs to obtain visas and obtain credentials verification from educational and training programs in other countries. The section also provides model guidelines for establishing observership programs, to assist IMGs who wish to observe clinical practice in a U.S. setting as a preparatory step for residency application and placement. The AMA-IMGs has also collaborated with the ECFMG on webinars related to aiding IMGs as they seek a residency program slot.

The work of the AMA in this regard is important, in that the health workforce impact of IMGS vis-à-vis the Match cannot be understated. Foreign national IMGs, for example, are more likely to practice in underserved urban and rural communities. If the increasing numbers of U.S. graduates displace IMGs from the Match over the next 10 or more years, current health workforce shortages affecting underserved populations could be exacerbated.

TOOLS AND INITIATIVES TO SUPPORT INFORMED MATCH CHOICES

As noted previously, the available data regarding unmatched medical students demonstrate that student behaviors likely contribute to the problem. In this regard, students bear the responsibility to make good choices before and during the match process, and medical schools and medical education organizations bear the responsibility to ensure that students are well-prepared and well-informed about realistic career path options and strategies for success.

At the organizational level, the AMA has been a leader in providing data/information to medical students and medical schools to inform Match decisions. One AMA tool for helping ensure a more successful match (not just to residency but to one's career as a physician) is the AMA's Career
Planning Resource, which includes guidance on applying for residency, choosing a specialty, interviewing for residency, writing a C.V., and finding residency programs (through the AMA Residency and Fellowship Database, FREIDA Online).

Another useful tool is the AAMC’s Careers in Medicine (CiM) online guide, which helps students make strategic decisions about residency training and beyond, and provides self-assessment tools and specialty-specific data to inform those decisions.

The AAMC has also embarked on its Optimizing Graduate Medical Education initiative, which encompasses development of resources and tools to support all parties involved in a learner’s transition to residency. Goals of the Transition to Residency component of the initiative (aamc.org/initiatives/optimizinggme/phase-two) include helping residency program applicants, program directors, and medical school advisors make more strategic decisions. Some of the specific projects supporting the Transition to Residency effort include the following:

• Development of a research study to evaluate the use of a standardized video interview as a potential tool in the residency application and selection process.
• Analysis of a national survey of residency program directors to understand their applicant evaluation and selection process, and pain points experienced in that process.
• Creation of an overview of interview practices and processes, to support program directors and allow a more efficient and informative interview for applicants and interviewers.
• Recommendations for a new format for the Medical Student Performance Evaluation (MSPE), which allows for a holistic approach to both evaluating and reviewing an applicant.

Meanwhile, the key theme for the May 2017 meeting of the National Resident Matching Program (NRMP) was “The Unmatched Applicant,” intended to generate discussion about the medical education continuum (http://nrmpconference.org/themes.html). Themes covered include the following:

• Does the MSPE meet program director needs?
• How can the Match be flexible in accommodating competency-based programming?
• Ensuring readiness for residency: Innovations from the field.
• Goodness of fit: How can medical schools and GME programs quell application overload?
• What applicants need to inform specialty/program selection.
• Program director panel to explore criteria used to interview and rank applicants.
• What tools do program directors need/want to improve the selection process?
• Enhancing unmatched students’ applications for next year’s Match.
• Alternatives to clinical medicine: What options exist?
• Candid career counseling: When and how to guide academically underachieving students toward non-medical professions.
• IMG success rate: Trends over time and impact on training programs.
• Workforce: Current status and future trends.
• Resident resilience: Tips and tools to keep young physicians engaged for a long career.

SUMMARY AND POTENTIAL FUTURE RESEARCH

This report outlines a number of key points related to unmatched medical students, including the long-term stability of Match rates, common reasons for an unsuccessful match, options for students who do not match, the special Match concerns of DOs and IMGs, and tools/initiatives from medical schools and medical organizations (including the AMA) that are essential to ensuring an
effective, efficient, and equitable Match process that balances the interests of applicants and
programs and promotes rational, strategic decision making by all parties.

In general, medical students need up-front disclosures on Match potential and a realistic assessment
of career possibilities. Students should be provided accurate data about graduation and Match rates,
as well as projected Match rates for the institution, when they apply to a given medical school.
From a systemic perspective, according to the authors of a 2016 article in Academic Medicine,
potential improvements to the residency application and Match process include limiting the number
of applications as well as “increasing the amount and/or types of information provided by
applicants and by residency programs; shifting to holistic review, with standardization of metrics
for important attributes; and fundamental reanalysis of the residency application process.”

A number of variables contribute to the complex supply/demand equation of Match rates, physician
workforce, and the need for health care services; these areas offer important venues for research:

- The continued growth in the number of U.S. medical schools (both allopathic and osteopathic)
  and increased enrollments in existing schools.
- Limited growth in graduate medical education due to caps in federal funding, and the potential
  for further reductions in government funding levels, particularly with calls on the rise for more
  transparency in and accountability for public funding of GME.
- Growth in the number of U.S. citizen international medical graduates (IMGs) who graduate
  from non-LCME-accredited medical schools and seek to enter residency programs in the
  United States—along with foreign national IMGs.
- Increased competition among medical students for certain specialty fields of medicine that
  offer attractive compensation and “controllable lifestyle.”
- The large and increasingly burdensome debt load many medical graduates face, which may
  affect students’ decisions.
- Changes in medical practice (for example, increased use of electronic medical records) and
  new clinical and administrative developments and technologies (i.e., telemedicine), which can
  lead to greater (or, reduced) efficiencies.
- Physician practice patterns, including the move towards employee settings (versus practice as a
  solo practitioner); cessation of and reentry into clinical practice, due to raising a family or other
  personal concerns; and earlier (or later) retirement from clinical practice.
- Increases in the number of non-physician clinicians (physician assistants, nurse
  practitioners) that are providing health care and other services.
- The number of people seeking health care services, and the services needed—particularly as
  our population ages and the burden of chronic diseases and conditions grows.
- The health workforce impacts of students’ specialty and program choices in the Match.
- The geographic distribution of physicians and the availability of health care services in
  underserved areas, both rural and urban.
- The impact of applicants’ race/ethnicity on Match outcomes.

The Council on Medical Education will continue to monitor this issue and report back to the HOD
as needed, and to work with other key stakeholders, as noted in this report, to ensure that our
nation’s investment in the future physician workforce is fully realized.
APPENDIX: RELEVANT AMA POLICIES

D-310.977, National Resident Matching Program Reform
Our AMA:
(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;
(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
(4) will continue to review the NRMP’s policies and procedures and make recommendations for improvements as the need arises;
(5) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
(6) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
(7) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
(8) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
(9) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
(10) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
(11) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
(12) will study, in collaboration with the Association of American Medical Colleges, the National Resident Matching Program, and the American Osteopathic Association, the common reasons for failures to match; and
(13) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions.

H-200.955, Revisions to AMA Policy on the Physician Workforce
It is AMA policy that; (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and
REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-17)
Standardizing the Allopathic Residency Match System and Timeline
(Resolution 310-A-16)
(Reference Committee C)

EXECUTIVE SUMMARY

This report is in response to Resolution 310-A-16, “Standardizing the Allopathic Residency Match System and Timeline,” which asks that the American Medical Association (AMA) support the movement toward a single United States residency match system and notification timeline for all non-military allopathic specialties, and work with the Association of University Professors in Ophthalmology, American Academy of Ophthalmology, Society of University Urologists, American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program (NRMP).

The specialties of ophthalmology and urology have had their own match programs for many years, primarily because both specialties require a preliminary year of training (GY1). The matches occur earlier in the academic year than for specialties in the NRMP, which allows applicants successfully matched into GY2 positions to then attempt to match into GY1 positions in the NRMP. For some applicants, this system can be advantageous.

For example, successful applicants to early match programs will have resolved some or all of the guesswork involved in finding a GY1 position. Receiving interview offers for a GY2 position in a particular geographic area can help in application and interview strategies for a GY1 position, and once the match has occurred, the applicant can submit a tailored rank order list for the GY1 position. Potentially unsuccessful candidates who do not receive interview offers from early match programs will still have time to apply to programs in other specialties.

The limitations of the early match process, however, include additional planning, a drawn-out application and interview season, and substantial financial costs for the applicant (especially for ophthalmology applicants), without the advantages available through the NRMP. Since 1988 the NRMP has had the capability to match applicants simultaneously into GY1 and GY2 positions—the same process for many applicants to radiology programs that require a preliminary GY1 position. Furthermore, the NRMP allows two applicants to link their rank order lists in such a way as to maximize their opportunity to match into programs in the same geographic area—the so-called “couples match.” Neither of these more sophisticated matching processes is available in the early match programs. Finally, the NRMP offers far more detailed match analyses and statistics that can assist applicants and their advisors in crafting match strategy.

The two specialties that hold early matches are the primary beneficiaries of the current system. Ophthalmology and urology are able to control their own matches; peruse, interview, and claim future residents before other specialties; and earn income from the process. To unduly burden the approximately 1,100 applicants annually to these two specialties during the already stressful period of attempting to enter GME, without a commensurate benefit, seems unwarranted.

Accordingly, the Council’s recommendations include encouraging the specialty stakeholders to move their matches into the NRMP and encouraging the NRMP to consider developing sequential matches to accommodate specialties that require preliminary training.
REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-17

Subject: Standardizing the Allopathic Residency Match System and Timeline (Resolution 310-A-16)

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C (Kenneth M. Certa, MD, Chair)

INTRODUCTION

Resolution 310-A-16, “Standardizing the Allopathic Residency Match System and Timeline,” introduced by the Michigan Delegation and referred by the American Medical Association (AMA) House of Delegates, asks that our AMA: 1) support the movement toward a single United States residency match system and notification timeline for all non-military allopathic specialties; and 2) work with the Association of University Professors in Ophthalmology, American Academy of Ophthalmology, Society of University Urologists, American Urological Association, and any other appropriate stakeholders to switch ophthalmology and urology to the National Resident Matching Program (NRMP).

Testimony heard by Reference Committee C at the 2016 Annual Meeting was largely in support of Resolution 310, despite some opposition. Testimony focused on such issues as: 1) the difficulties of couples attempting to navigate two different match systems, i.e., one run by the NRMP, and the other, taking place prior to the NRMP match, run by a specialty organization; 2) the relative transparency and quantity of data provided by the NRMP versus the specialty organizations, which allows individuals in the NRMP match to better gauge their competitiveness than individuals participating in a specialty match; and 3) concerns that the specialties that run their own matches have a potential financial conflict of interest.

Testimony in opposition to the resolution came mostly from the affected specialties, which expressed satisfaction with the current system and a reluctance to switch to a shared match and timeline. In addition, it was noted that applicants in these specialty match programs are afforded the opportunity to participate in an “early match.”

Due to the conflicting testimony and the complexity of these issues, the resolution was referred for a report back to the House of Delegates and assigned to the Council on Medical Education. This report includes: 1) the history and processes of the urology match and the ophthalmology match; 2) the advantages of a separate, early match or a single match; and 3) examples of specialties that successfully left an early matching process to join the NRMP.

BACKGROUND

Currently, the vast majority of allopathic specialties use the application and matching services provided by the Electronic Residency Application Service (ERAS) and the NRMP. Urology and ophthalmology, however, do not, in part or wholly. In addition, the match process for these two specialties can be significantly different.
specialties occurs earlier in the year than for the NRMP. (Note: While the resolution referred to an
“allopathic” match system, all programs participating in the ophthalmology match, urology match,
and the NRMP are accredited by the Accreditation Council for Graduate Medical Education
[ACGME]. As osteopathic-focused programs become ACGME-accredited they will join these
match systems.)

History and Process of the Ophthalmology Match

Training in ophthalmology requires three years of the field, preceded by one year of general
medical training, typically while in a preliminary position. The ophthalmology residency matching
program was established in 1977 by the Association of University Professors of Ophthalmology
(AUPO), and is part of the San Francisco Match (SF Match).1 Ophthalmology was the first
specialty with a matching algorithm created by August Colenbrander, MD, who created matches
for other specialties that eventually became the SF Match.2 Applicants apply to ophthalmology
programs through a common application system (CAS), also maintained by the SF Match. The SF
Match matches applicants to graduate year 2 (GY2) positions in ophthalmology programs. This
match occurs each January; therefore, successfully matched applicants will be able to tailor their
applications in ERAS and rank order lists (ROLS) in the NRMP for a preliminary (GY1) position
for the NRMP main match, which occurs in March.3 Thus, students interested in ophthalmology
must submit applications through two different application services and match services. This
system was created before the NRMP added the process of creating a supplemental ROL in 1988,
which allows for two simultaneous matches (GY1 and GY2) for one applicant.

Scheduling. The CAS for the SF Match opens in June. The first week of September is considered a
good target date for applicants to have completed their application and uploaded documents. Some
international medical graduates and all graduates of Canadian medical schools have to mail some
of their documentation. The CAS only allows three letters of recommendation, and all three are
distributed to the programs that the applicant is applying to; specifically tailored letters to
individual programs are not possible. Meanwhile, medical schools are responsible for uploading
the Medical Student Performance Evaluation (MSPE) for U.S. seniors of osteopathic and allopathic
medical schools. It may take up to two weeks for CAS to distribute complete applications to
programs. In December, programs and applicants may begin submitting their ROLS; the deadline is
the first week in January. The following week, match results are available to medical schools,
programs, and applicants, and vacancies (unfilled positions) are posted on the SF Match website.1

In conjunction with the SF Match scheduling, an applicant interested in ophthalmology training
must find a GY1 position, most likely through ERAS and the NRMP, with different calendars and
deadlines, which are described later in this report.

Fees for the SF Match. A $100 registration fee for applicants covers registration and matching. In
addition, the CAS charges fees for the initial distribution of applications:

<table>
<thead>
<tr>
<th>Number of CAS Distributions</th>
<th>Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 10</td>
<td>$60 total</td>
</tr>
<tr>
<td>11 - 20</td>
<td>$10 per program</td>
</tr>
<tr>
<td>21 - 30</td>
<td>$15 per program</td>
</tr>
<tr>
<td>31 - 40</td>
<td>$20 per program</td>
</tr>
<tr>
<td>41 or more</td>
<td>$35 per program</td>
</tr>
</tbody>
</table>

Subsequent distributions of applications (after the initial distribution) cost $35 per program.
The registration fee for new ophthalmology programs is $325, which includes the membership fee for the current year. An annual membership fee for programs is $125, regardless of the number of positions the program offers.1

Match statistics. The SF Match website posts statistics for the ophthalmology match for the past 11 matches. Although these data are not as comprehensive as those provided by the NRMP, the viewer can get an estimate of the competitiveness of the ophthalmology match. For example, in the 2016 match, U.S. seniors (presumably both osteopathic and allopathic) made up 92% of those who matched. All but two of the 469 positions were filled, the average USMLE Step 1 score of matched applicants was 244 (average score of unmatched applicants was 229), the average number of applications per applicant was 68 (with approximately 110 programs participating), and the average number of interview offers received was 4.4 per applicant.5

History and Process of the Urology Match

Originally, students and urology residency programs did not use a centralized system of pairing up. In 1985, however, the American Urological Association (AUA) created the urology match, with advice from August Colenbrander, MD, who created the ophthalmology match; like ophthalmology, urology requires a prior year of training before a resident begins urology training in GY2. The AUA elected not to use the services of the NRMP, since at that time the NRMP did not manage simultaneous matches of GY1 and GY2 years, nor did it choose the services of the SF Match, as the AUA and the American Board of Urology desired to more closely monitor resident training from entry into the match through to board certification.3 Applicants intending to match into a urology program must register with the Urology Residency Match Program (Urology Match) on the AUA’s website. The AUA does not have its own application services; students are directed to ERAS to apply to urology programs. This match occurs each January. Successfully matched applicants must then obtain GY1 positions, generally in surgery. Unlike ophthalmology, urology programs tend to have arrangements for GY1 positions with local surgical programs. Students are advised that “applicants matched with certain urology training programs will have adequate time to go through the NRMP match for the general training which is required prior to beginning urological training. This is a formality required by some surgery department/divisions and they will provide the code to submit on the preference form for the NRMP match.”6

Scheduling. In June, students register with the Urology Match on the AUA’s website. Students must then apply to programs of interest; although most urology programs participate in ERAS, it is not a requirement of the AUA Match that they do so. Programs and students can submit their ROLs in November. The deadline occurs during the first week of January. During the second week, the match is held, and the results are announced to students, medical schools, and programs during the third week. Those matching into urology programs that do not have a GY1 surgical position “built-in” then need to register with the NRMP and submit their ROL.6

Fees for the Urology Match. Students registering with the Urology Match pay a $75 fee. Programs pay a $100 fee to register for the match, and $25 per position posted in the match.

Match statistics. The AUA website posts match statistics for six years, with more detailed statistics available for 2016.7 Again, as with ophthalmology, the statistics provided are not as detailed as what the NRMP offers, but the viewer can get an estimate of the competitiveness of the Urology Match. For example, in the 2016 match, 77% of the 356 U.S. seniors (presumably both osteopathic and allopathic) who submitted a ROL matched into a program, and 51% of whom got their first or second choice. U.S. seniors made up 85% of those who matched. All but one of the 295 positions was filled, the average number of applications per applicant was 65 (with 124 programs
participating), the average number of interviews taken by applicants was 10, and the average
number of programs ranked by applicants who matched was 14.

ADVANTAGES OF SEPARATE AND COMBINED MATCHES

Advantages of a Separate Specialty Match System

Presumably many successful applicants to ophthalmology and urology programs are relieved to
learn the news of their match earlier than their peers, and to have some or all of the guesswork
involved in finding a GY1 position removed by an early match. Receiving interview offers for a
GY2 position in a particular geographic area can help in application and interview strategies for a
GY1 position. Once the match has occurred, submitting a precisely tailored ROL for the GY1
position reduces potential conflict in choices. Potentially unsuccessful candidates who do not
receive interview offers from early match programs still have time to apply to programs in other
specialties through ERAS. It is generally assumed, however, that the two specialties operating the
matches are the main beneficiaries of an early match, both in the scheduling and in the ownership,
which provide financial benefits as well.

The early match allows the two specialties to get an early view and pick of applicants who could
also be successful candidates for other specialties, particularly other surgical specialties. Owning
the process of the match can be financially remunerative as well, especially in the case of the SF
Match, as it runs its own application service. The AUPO owns the SF Match, which runs several
other matches as well, such as for plastic surgery (independent programs), and 23 fellowships.
Revenue generated for the AUPO from the SF Match in 2014 was $1.4 million. The
ophthalmology match is by far the biggest match for the SF Match. There were 726 CAS
registrants in the 2016 ophthalmology match. At the average number of 68 applications per
applicant, those fees would have generated close to $1.1 million.

The AUPO could retain the CAS for ophthalmology programs but have the match run by the
NRMP; unlike ERAS, which requires 80% of programs in a specialty to participate, the NRMP
does not have minimum proportion of programs within a specialty to agree to use their matching
services. Any number of ophthalmology programs could use the NRMP for matching.

Besides the Urology Match, the AUA also administers matches for five urology fellowships. Since
the AUA does not manage the applications for the Urology Match or for the fellowships, the
income generated by running the matches is not comparable to what the AUPO can realize. For
example, there were 468 registrants in the 2015 Urology Match, paying $75 each, totaling $35,100.
Program participation would have generated nearly $20,000 for registration and fees per vacancy.
The main value of the match for the AUA is likely its stated interest in more closely monitoring
resident training from entry into the match through to fellowship training.

Advantages of Moving to a Single Match

The primary impetus of the early match for ophthalmology and urology, as well as other specialties
that once had an early match (and do no longer), was the need to interview and match applicants
for their GY2 year. There was still time after the early match for the applicant who did not match
into one of these specialties to attempt to find a GY1 position in another specialty through the
NRMP. For the applicant who did match into one of these specialties, there was adequate time to
tailor an application for a GY1 position, apply through ERAS, and match into a GY1 position
through the NRMP.
In 1988, however, the NRMP began offering GY2 positions through its match, and in turn providing the opportunity for applicants to create a supplemental ROL to match into a GY1 position. For every program with GY2 positions that an applicant is interested in pursuing, the applicant can pair preferences for programs that have GY1 positions. Applicants thus have the possibility of simultaneously securing GY1 and GY2 positions. It is possible to match into a GY2 position and not the corresponding GY1 position, in which case the applicant needs to obtain a GY1 position in the Supplemental Offer and Acceptance Program (SOAP). The NRMP matching algorithm will not place an applicant in a GY1 position until the applicant has matched into a GY2 position.  

In addition, beginning in 1984, the NRMP included another sophisticated match process that enables two applicants to link their ROLs. Commonly called the “couples match,” the two applicants’ ROLs form pairs of program choices that are considered in the algorithm. A match only occurs when both members of the couple match into a linked pair of programs; i.e., if partner A matches into a rank 1 program, but partner B does not match into a rank 1 program, a match does not occur, and the algorithm will continue processing until both partners are matched into similarly ranked programs.

In contrast, neither the SF Match nor the Urology Match can process linked ROLs. Applicants to urology or ophthalmology using the NRMP for matching into GY1 positions may link their ROLs with a partner. For couples in which one member is matching into a GY2 NRMP position, such as for radiology, and the other into a GY1 position, the “couples match” can aid the process, but only insofar as linking the primary ROL, not the supplemental ROL. For example, partner A ranks a radiology advanced program (GY2) in Boston as rank 1, with a supplemental ROL for a GY1 position in the Boston area. Partner B ranks a GY1 in the Boston area as rank 1. Both partners may match into their rank 1 programs, but there is no corresponding guarantee of partner A matching into the rank 1 GY1 position on the supplemental ROL. Partner A may match into a GY1 position farther down the ROL. To prepare for such possibilities, paired ROLs can be become fairly complicated and lengthy, particularly in cases of GY2 positions and supplemental ROLs.  

Nonetheless, despite this complexity, participants in the “couples match” are generally successful in the NRMP match. Match rates have been above 90 percent since the NRMP starting linking ROLs, and in 2016 the match rate was 95.7% for one or both members of the couple, the highest ever.

In addition, the greater size and sophistication of the NRMP as a matching organization may protect it (and applicants) from error. In 2005, the Urology Match had to be re-run. Several programs found themselves unexpectedly unfilled. After review, it was found that one of the criteria in the match was not applied correctly, skewing the outcome; namely, the ROLs of program directors had been considered more heavily than the ROLs of applicants. ROLs of applicants were always to be prioritized over the ROLs of program directors. The match was run again, and four days later new results were announced. Upon further review, it was found that the misapplication of the matching algorithm was secondary to human error, coupled by a lack of review of the results. More safeguards were applied, and no problems have been reported since.

Additional benefits of the NRMP and ERAS over the Urology Match and the SF Match include the availability of additional data for review and consideration by students, program directors, and medical school advisors. The NRMP releases annual or semi-annual reports based on analysis of NRMP match data, as well as of surveys of program directors and applicants. Historical statistics and reports are posted on the NRMP website as well. ERAS also has available statistics going back several years. Although both the AUA and the SF Match post statistics on their website,
what is available is not nearly as comprehensive and potentially helpful to applicants and their
advisors as what is offered by the NRMP and ERAS.

The fact that these two specialties interview and match earlier than all other specialties may affect
the ability of students to best utilize their 3rd and 4th years. Scheduling electives, sub-internships,
etc., in ophthalmology or urology in the 3rd or 4th year may mean displacement of some fields into the 4th
year. Some faculty have observed that the 4th year of medical school for many students appears
squandered after the NRMP match; this period of “senioritis” starts even earlier for those
successfully matched into urology or ophthalmology.15

Probably the most compelling advantages to applicants of standardizing the match process are cost
and convenience. Ophthalmology applicants use two separate application and matching services. A
few ophthalmology programs have an integrated GY1 year, but most do not. Therefore, applicants
need to apply using ERAS, and match using the NRMP, for that position. It is recommended that
ophthalmology applicants apply to 10 to 15 preliminary/transitional year programs.16 Below are the
application fees for ERAS. The registration fee for the NRMP of $75 covers the costs of ranking 20
different programs, including 20 on the primary ROL and 20 on the supplemental ROL. The
NRMP charges $30 additional per program beyond the 20.

<table>
<thead>
<tr>
<th>Programs Per Specialty</th>
<th>Application Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 10</td>
<td>$99</td>
</tr>
<tr>
<td>11 - 20</td>
<td>$12 each</td>
</tr>
<tr>
<td>21 - 30</td>
<td>$16 each</td>
</tr>
<tr>
<td>31 or more</td>
<td>$26 each</td>
</tr>
</tbody>
</table>

For the average applicant in the 2016 SF Match applying to 68 ophthalmology programs, the fees
paid to the SF Match would be $1,590 (match registration plus application distribution). If that
applicant then applied to 15 programs with GY1 preliminary positions (and not another specialty),
the ERAS fee would be $239 (application distribution plus USMLE transcript fee). Adding in the
NRMP fee of $75, the total paid for applying and matching for the average ophthalmology
applicant would be $1,904.

If this process were housed within ERAS and the NRMP, and assuming the applicant applied to the
same number of programs, and created a primary and supplemental ROL of 15 programs, the costs
would be $1,447 to ERAS, and $75 to NRMP, for a total of $1,522.

Urology applicants use ERAS for applying to urology programs. Presumably they do not apply to
programs for their GY1 training, as that is typically arranged through the urology residency
program. The average number of applications submitted to programs in 2016 was 65 in the
Urology Match. The ERAS fee would be $1,369 (application distribution plus USMLE transcript
fee). Adding in the $75 Urology Match fee and the NRMP fee of $75 for matching into one
program for the GY1, the total paid for applying and matching for the average urology applicant
would be $1,519. The cost difference for a urology applicant if the urology match was run by the
NRMP would be only $75, the Urology Match fee paid to the AUA.

Aside from costs, convenience is another factor, not only for medical students but also for student
affairs deans and residency program directors and coordinators. The appendix shows a partial
timeline covering residency application dates and events for rising 4th year medical students at one
medical school. Not only are there additional deadlines and processes that early match students
must follow, their student affairs deans must also be aware of the same deadlines in their efforts to
keep their students on track. One calendar for all specialties would greatly lessen confusion and anxiety.

PRECEDENT: SPECIALTIES THAT LEFT AN EARLY MATCH

Otolaryngology was in the SF Match until 2006, at which point it joined the NRMP. The specialty had decided to eliminate the required general surgery intern year and integrate that training into the otolaryngology program; thus, separate matching processes for surgery and otolaryngology were no longer necessary. Some expressed concern that by leaving the early match, the specialty may have lessened its ability to attract highly competitive applicants, who might have found the chance of two matches (to include the NRMP, if not initially successful in the SF Match) a risk worth taking. A counterpoint to that concern was the NRMP option for applicants to attempt to match into otolaryngology and be part of the “couples match,” thus attracting a different type of applicant, possibly more committed to the locale of the program. Analysis of the number of applicants, the match rate, and the Step 1 scores of successfully matched applicants before and after the switch from the SF Match to the NRMP shows no statistically significant differences that may be attributed to the different match, except that non-U.S. senior applicants had a lower match rate (34% vs. 21%). In short, the match for prospective otolaryngology trainees and otolaryngology programs has become simplified, with minor effects.

Child neurology has several GME entry possibilities; one can enter a five-year training program that combines pediatrics and neurology training; a three-year program after having completed two years in pediatrics; or a three-year program after one year in pediatrics, plus one year in internal or family medicine or one year in neuroscience research. The SF Match had managed the child neurology match as an early match for years, but in 2010 the new software for SF Match could not manage a “three-tier match.” The specialty switched in 2012 to the NRMP, which has managed the three types of positions in the main match (categorical, advanced, and reserved positions).

Matching for neurosurgery had been managed by the SF Match as an early match until it joined the NRMP and ERAS for the 2009 match. A major impetus for the move to the NRMP was the full integration of the GY1 year into neurosurgery programs, rather than as preliminary training in general surgery programs. Other rationales provided by the Society of Neurological Surgeons included financial considerations and the ease with which other specialties had made the switch. The majority of programs experienced an increase in the number of applications received, but also an increase in the quality of applicants. One perceived drawback is that students now select a “back-up” specialty in the circumstance of not matching into neurosurgery; this precludes them from participating in the SOAP for an unfilled position in neurosurgery. Given the competitiveness of neurosurgery, however, there are very few unfilled positions after the match. Overall, the transition has been considered successful.

CURRENT AMA POLICY

Currently, the AMA has several policies or directives that relate to matching into training programs, including the following, which speak to the advantages of Match process standardization:

D-310.977, “National Resident Matching Program Reform”— “Our AMA … (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including supplication timelines and requirements; (8) will work with the NRMP and other external bodies to
develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant."

H-310.925, “National Residency Matching Program Reform”—“Our AMA supports the National Resident Matching Program as an efficient and effective placement system for filling positions in graduate medical education in the US.”

H-310.910, “Preliminary Year Program Placement”—“Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.”

D-310.958, “Fellowship Application Reform”—“Our AMA will (1) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training.”

SUMMARY AND RECOMMENDATIONS

The two specialties that hold early matches are the primary beneficiaries of the current system. Ophthalmology and urology are able to control their own matches; peruse, interview and claim future residents before other specialties; and earn income from the process. Applicants may achieve an earlier sense of relief (if successfully matched) or dismay (if not) compared to their peers, and unsuccessful applicants have the opportunity to apply and match into another specialty, but all early match participants must undergo an overly long, complicated process that no longer is necessary. The NRMP successfully manages simultaneous matches into GY1 and GY2 positions for many specialties—some of which were previously with the SF Match. Applicants entering the ophthalmology and urology matches do not have the opportunity to fully participate in the NRMP “couples match,” nor do they benefit from insight provided by the sophisticated data analysis and reports prepared by the NRMP. Furthermore, especially in the case of ophthalmology, the applicant faces added costs. To unduly burden the approximately 1,100 applicants annually to these two specialties during the already stressful period of attempting to enter GME, without a commensurate benefit, seems unwarranted.

The Council of Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 310-A-16 and the remainder of this report be filed.

1. That our American Medical Association (AMA) support the movement toward a unified and standardized residency application and match system for all non-military residencies. (New HOD Policy)

2. That our AMA encourage the Association of University Professors of Ophthalmology, the American Urological Association, and other appropriate stakeholders to move ophthalmology and urology to the National Resident Matching Program. (Directive to Take Action)

3. That our AMA encourage the National Resident Matching Program to develop a process by which sequential matches could occur for those specialties that require a preliminary year of training, allowing a match to the GY2 position, followed later in the year by a match to a GY1 position, thus reducing application and travel costs for applicants. (Directive to Take Action)

Fiscal Note: $1,000
# APPENDIX

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Residency timeline for all rising 4th year students.</td>
</tr>
<tr>
<td></td>
<td><strong>Ophthalmology is bold. Urology is underlined.</strong></td>
</tr>
<tr>
<td>April 15th</td>
<td>MyERAS site opens to applicants to register and begin working on their applications.</td>
</tr>
<tr>
<td>April-May</td>
<td><strong>Review SF Match site for general information about the early match process.</strong></td>
</tr>
<tr>
<td>April-June</td>
<td><strong>Urology Residency Match information is available online,</strong></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.auanet.org">http://www.auanet.org</a></td>
</tr>
<tr>
<td></td>
<td>Investigate on-line sources for specialty and program information, requirements</td>
</tr>
<tr>
<td></td>
<td>and deadlines</td>
</tr>
<tr>
<td>April-July</td>
<td>Begin submitting application for USMLE Step 2 CS &amp; CK. Must have Step 2 CS</td>
</tr>
<tr>
<td></td>
<td>completed by end of December; Step 2 CK by the end of January. Register early!</td>
</tr>
<tr>
<td></td>
<td>Put final touches on CV and personal statement</td>
</tr>
<tr>
<td>April-Sept</td>
<td>Begin residency program applications. Note: Individual programs set the deadlines.</td>
</tr>
<tr>
<td></td>
<td>You should contact programs directly for their deadlines.</td>
</tr>
<tr>
<td>April-Oct</td>
<td>Track LoRs through ERAS Applicant Document Tracking System</td>
</tr>
<tr>
<td>May-June</td>
<td><strong>Gather SF Match CAS materials (LoRs, transcript, personal statement, application, CV)</strong></td>
</tr>
<tr>
<td>June</td>
<td><strong>Urology registration is available through the AUA site at</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Early match registration is available through the SF Match site at</strong></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.SFMatch.org">http://www.SFMatch.org</a></td>
</tr>
<tr>
<td>July 1st</td>
<td>Applicants may start searching for and selecting programs in MyEras.</td>
</tr>
<tr>
<td>July 15th</td>
<td>ERAS PostOffice opens. Residency Programs can start receiving applications.</td>
</tr>
<tr>
<td>July 18th</td>
<td><strong>An overview of the application process for early match. This session is REQUIRED.</strong></td>
</tr>
<tr>
<td>August 8th</td>
<td><strong>An overview of the application process for regular match. This session is REQUIRED.</strong></td>
</tr>
<tr>
<td>Aug-Sept</td>
<td>Early match students mock interviews</td>
</tr>
<tr>
<td>September</td>
<td>Student review draft of MSPF (online) and review transcript</td>
</tr>
<tr>
<td></td>
<td>Target date for ERAS applicants to register and have entered all MyERAS</td>
</tr>
<tr>
<td></td>
<td>information.</td>
</tr>
<tr>
<td>Sept 1st</td>
<td><strong>CAS Target Date for Ophthalmology. Note: This is not a deadline. It's the</strong></td>
</tr>
<tr>
<td></td>
<td><strong>target date to have your application submitted for central distribution.</strong></td>
</tr>
<tr>
<td>Sept 3rd</td>
<td>NRMP registration and applicant user guide for the NRMP available at</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.nrmp.org">http://www.nrmp.org</a></td>
</tr>
<tr>
<td></td>
<td><strong>Note: Students going through early match and need to secure a GY1</strong></td>
</tr>
<tr>
<td></td>
<td><strong>position must register with the NRMP.</strong></td>
</tr>
<tr>
<td>Sept 12th</td>
<td>Transcripts will be loaded to ERAS.</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>September 15th</td>
<td>ERAS PostOffice opens. Applicants may begin applying to ACGME accredited residency programs. Programs may begin contacting the ERAS PostOffice to download your application. This is also a target date to submit your application.</td>
</tr>
<tr>
<td>Oct-Jan</td>
<td>Interview at residency programs</td>
</tr>
<tr>
<td>Oct 1st</td>
<td>MSPE release date for ERAS and CAS</td>
</tr>
<tr>
<td>November</td>
<td>Begin submitting rank order lists for AUA (Urology).</td>
</tr>
<tr>
<td>Nov 30th</td>
<td>11:59 PM Deadline to register for NRMP. Applicants who register after Nov 30th must pay an additional $50 late registration fee.</td>
</tr>
<tr>
<td>Dec-Jan</td>
<td>Early match students go over RoL with advisor SF Match applicants submit RoL</td>
</tr>
<tr>
<td>December</td>
<td>Complete Step 2 CK and CS</td>
</tr>
<tr>
<td>December 12th</td>
<td>Urology registration deadline</td>
</tr>
<tr>
<td>January 5th</td>
<td>Deadline for submitting rank order lists for AUA (Urology).</td>
</tr>
<tr>
<td>January 6th</td>
<td>Deadline for submitting rank order lists for Ophthalmology</td>
</tr>
<tr>
<td>January 13th</td>
<td>Match results for Ophthalmology made available</td>
</tr>
<tr>
<td>January 15th</td>
<td>Begin to enter rank order lists for NRMP.</td>
</tr>
<tr>
<td>January 21st</td>
<td>Match results for Urology made available</td>
</tr>
<tr>
<td>February 25th</td>
<td>Deadline for registration and ROL certification. NRMP ROL must be certified by 8:00 PM CST. NRMP staff will be available to answer questions during the final hours.</td>
</tr>
<tr>
<td>March 16th</td>
<td>Unmatched information posted on the NRMP Web site at 11:00 AM CST. Individual counseling will be available for all unmatched students.</td>
</tr>
<tr>
<td>March 20th</td>
<td>Match Day!</td>
</tr>
</tbody>
</table>
REFERENCES


18 Singer, HS. The child neurology match: where have we been and we are we going? Pediatric Neurology. 2014;50: 443-446.

Join the international medical graduate community

You're invited to join the American Medical Association international medical graduate community, the new online platform focused on the unique needs and interests of international medical graduates, including licensure, residency and more!

In this AMA-member forum you'll share curated content, insights from experts, stay on top of important meetings and events, and go deep into current issues and trends in medicine with your peers.

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- **Blog**—experts post and share your thinking on health care topics that matter, like avoiding burnout
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Accelerating change in medical education community—medical education professionals and students can connect with colleagues in medical education to learn about new innovations emerging across the country and how to implement the “Accelerating Change in Medical Education” Consortium’s initiatives at your institution. Email ace.community@ama-assn.org to join.

Watch for more communities coming throughout 2017.
INTERNATIONAL MEDICAL GRADUATES SECTION
PRELIMINARY TIMELINE FOR RESOLUTIONS/REPORTS REVIEW
INTERIM MEETING – NOVEMBER 2017
HONOLULU, HI

DUE DATES

Deadline for Receipt of Resolutions
August 1

Extended Deadline
August 11

Virtual Congress—review reports/resolutions
Provide email testimony to img@ama-assn.org
August 31 – Sept. 8

Governing Council teleconference
September 11

Virtual Congress final ratification of Reports and
Resolutions via email
September 12–18

House of Delegates Handbook Deadline for Resolutions
September 22

House of Delegates Handbook Addendum deadline
October 6

Deadline at I–17 meeting site:
Saturday, Nov. 11 – 8 am
(emergency resolutions only)
You’re invited to participate in an AMA-IMG Section event

Busharat Ahmad, MD, Leadership Development Program

10:30–11:30 a.m.
Monday, June 12
Roosevelt 3 A/B
Hyatt Regency Chicago
Chicago

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.

The leadership development program, which commemorates Dr. Ahmad’s guidance and commitment to organized medicine, consistently brings dynamic speakers to the AMA Annual and Interim Meetings.

Featured presentation and speaker

“Physicians as leaders in an age of uncertainty”
Peter Angood, MD, CEO/president
American Association of Physician Leadership

All 2017 American Medical Association Annual Meeting attendees are welcome to attend this program designed to develop individuals who aspire to be leaders during these uncertain times in health care.

For more information, email img@ama-assn.org or call the AMA-IMG Section at (312) 464-5397.

This event is cosponsored by the AMA Minority Affairs Section.
<table>
<thead>
<tr>
<th>Entity</th>
<th>Council Members (Expiration Dates)</th>
<th>Appointed by</th>
<th>Length of Term/Maximum</th>
<th>BOT Review Date</th>
<th>Nomination Deadline</th>
<th>IMGs Interested</th>
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</thead>
<tbody>
<tr>
<td>CPT Editorial Panel</td>
<td>BOT</td>
<td>Four Years/One or Two Terms</td>
<td>June</td>
<td>2018</td>
<td>Jayesh Shah, MD</td>
<td></td>
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<tr>
<td>CPT Advisory Committee</td>
<td>BOT</td>
<td>Two Years</td>
<td>November</td>
<td></td>
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<tr>
<td>Residency Review Committees (28)</td>
<td>BOT</td>
<td>Two Years/Three Terms</td>
<td>April/As Needed</td>
<td>March 1, 2018</td>
<td>Ved Gossain, MD (IM)</td>
<td></td>
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<tr>
<td>American Boards (19 of 24)</td>
<td>BOT</td>
<td>Varied</td>
<td>As Needed</td>
<td>March 1, 2018</td>
<td>Milton Kramer, MD</td>
<td></td>
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<tr>
<td>AAHC/URAC Board of Directors</td>
<td>BOT</td>
<td>Three-Years</td>
<td>June</td>
<td></td>
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<tr>
<td>Accreditation Council for Graduate Medical Education</td>
<td>Nominated by BOT, Elected by ACGME</td>
<td>Three Years/Two Terms</td>
<td>June</td>
<td>March 1, 2018</td>
<td>Drs. Kiran Shah, Jayesh Shah, Milton Kramer</td>
<td></td>
</tr>
<tr>
<td>National Patient Safety Foundation</td>
<td>BOT</td>
<td>Three Years</td>
<td>June</td>
<td></td>
<td>Kiran Shah, MD</td>
<td></td>
</tr>
<tr>
<td>Practice Expense Advisory Committee (subcommittee of the RUC)</td>
<td>BOT</td>
<td>Four Years</td>
<td>June</td>
<td></td>
<td>Drs. Niranjan Rao, Jose David</td>
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<tr>
<td>AMA/Specialty Society RVS Update Committee (subcommittee of the RUC)</td>
<td>BOT</td>
<td>Three Years/Two Terms</td>
<td>June/December</td>
<td></td>
<td>Deepak Kumar, MD</td>
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<tr>
<td>AMA Foundation</td>
<td>BOT</td>
<td>Three Years/Two Terms</td>
<td>June/October</td>
<td>Jayesh Shah, MD</td>
<td></td>
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</tr>
<tr>
<td>Accreditation Coun. for Contin. Med. Educ.</td>
<td>BOT</td>
<td>One Year/Six Terms</td>
<td>October</td>
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<tr>
<td>Accreditation Council for Continuing Medical Education Review Committee</td>
<td>BOT</td>
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For additional information, please contact Carolyn Carter-Ellis, Sr. Group Manager, IMGS, LGBTQ Adv. Committee & Minority Affairs Section; carolyn.carter-ellis@ama-assn.org; (800)262-3211, Ext. 5397
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| Council on Constitution and Bylaws          | Patricia L. Austin, MD (2018)*  
Madelyn E. Butler, MD (2018)*  
Jerome C. Cohen, MD, Vice Chair (2017)*  
Pino D. Colone, MD (2020)  
Joy Lee (Student) (2017)*  
Cyndi Yag-Howard, MD (2018)  
Nalim S. Ali MD (Resident) (2018)  
Susan Rudd Bailey, MD (ex officio) (2017)*  
Bruce A. Scott, MD (2017)*  
Collette R. Willins, MD, Chair, (2019)* | Candidates approved by BOT/Elected by HOD | Four Years/Two Terms | February | March 15, 2018     |                 |
| Council on Ethical & Judicial Affairs        | Dennis S. Agliano, MD, Vice Chair (2018)  
Ronald J. Clearfield, MD, Chair (2017)  
Marc Mendelsohn, MD (Resident) (2018)  
Kathryn L. Moseley, MD,MPH,FAAP (2020)  
Alexander Rosenau, DO,CPE (2022)  
James E. Sabin, MD (2019)  
Peter A. Schwartz, MD (2023)  
Kimberly Swartz, (Student) (2017)  
Monique A. Spillman, MD, (2021) | President/Elected by HOD                        | Seven Years/One Term | June               | March 15, 2018     |                 |
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| Council on Legislation             | Seyed H. Aleali, MD (2017)*  
Jack J. Beller, MD (2017)  
Edgar Scott Ferguson, MD, Vice Chair (2017)*  
Jacob R. Burns (Student) (2017)  
Mary S. Carpenter, MD (2017)*  
John Robert Corker, MD, Resident (2017)*  
Marilyn J. Heine, MD (2017)*  
E. Coy Irvin, MD, Chair (2017)  
Jerry D. Kenneth, MD (2017)*  
Elizabeth A. Irish, Alliance Representative  
Linda B. Ford, MD, AMPAC Board Observer (2020)  
Heather Ann Smith, MD (2017)*  
David T. Tayloe, Jr., MD (2017)*  
Willie Underwood, MD III (2017)* | BOT           | One Year/Eight Terms | April            | March 15, 2018        | Drs. S. Jayasankar, Appareddy Deepak Kumar, MD |
Kira A. Geraci-Ciardullo, MD (2018)*  
Noel Deep, MD (2019)  
Alexander Ding, MD (2020)*  
Adam P. Dougherty, MD (Resident) (2017)  
Robert A. Gilchick, MD, MPH, FACP, Chair-Elect (2018)  
Christina Kratschmer, Student (2017)  
Ilse R. Levin, MD, (2017)  
Michael M. Miller, MD (2018)*  
S. Bobby Mukkamala, MD, Chair (2017)  
Bruce M. Smoller, MD (2019)*  
David J. Welsh, MD (2020)* | BOT           | Four Years/Two Terms | April            | March 15, 2018        |                                                             |
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<td>American Medical Political Action Committee</td>
<td>Grayson W. Armstrong, MD (Resident), 9/18* Brook M. Buckley, MD, 9/18* Steven J. Fleishman, MD, 11/18* Linda B. Ford, MD*, 11/18* Benjamin Z. Galper, MD, 11/18* Dev. A. GnanaDev, MD, 11/18* Ashtin B. Jeney, (Student), 11/18 Stephen A. Imbeau, MD, 11/18* Vidya Kora, MD, Chair, 11/18 James L. Milam, MD*, 11/18 Michael Suk, MD, 9/18* Lyle S. Thorstenson, MD (Secretary), 11/18*</td>
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AMA RESEARCH SYMPOSIUM

Showcase your original research! All American Medical Association member residents, fellows, medical students and ECFMG-certified candidates who are awaiting residency are invited to submit abstracts.

Abstract deadline: Aug. 9

Hawaii Convention Center • Honolulu
Reference Committee C

1. Resolution 306 – Formal Leadership Training During Medical Education

Resolution 306 asked: 1) That our American Medical Association advocate for and support the creation of programs and curricula that emphasize experiential and active learning models which are inclusive of leadership knowledge, skills and the qualities utilized in the clinical setting through direct observation and which foster a shared learning environment with the entire interdisciplinary care team (Directive to Take Action);

2) That our AMA advocate for and support the creation of programs and curricula to develop the leadership competencies and foundational skills for medical practitioners necessary to effectively understand and navigate current and future policy changes from the Center for Medicare and Medicaid Services, while continuing to maintain said practitioners fiduciary responsibility and high-quality patient care. (Directive to Take Action), and

3) That our AMA advocate with the Liaison Committee for Medical Education (LCME), Association of American Medical Colleges (AAMC) and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership capabilities, so that all doctors obtain a minimum standard of leadership and management skills. (Directive to Take Action)

HOD Action: Adopted as amended.

RESOLVED, That our American Medical Association advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to leading interprofessional team care, in the spirit of the AMA’s Accelerating Change in Medical Education initiative. (Directive to Take Action)
RESOLVED, That our AMA advocate for and support the creation of programs and curricula to develop the leadership competencies and foundational skills for medical practitioners necessary to effectively understand and navigate current and future policy changes from the Center for Medicare and Medicaid Services, while continuing to maintain said practitioners’ fiduciary responsibility and high-quality patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership capabilities, so that all doctors obtain a minimum standard of leadership and management skills. (Directive to Take Action)

Reference Committee K

2. Resolution 908 – Faith and Mental Health

Resolution 908 asked: 1) That the American Medical Association advocate and support mental health and faith community partnerships that will provide a platform for faith leaders to get educated about psychiatric and substance abuse disorders and mental health providers understand the role of faith in recovery (Directive to Take Action); and

2) That the AMA study and support a partnership to foster respectful, collaborative relationships between psychiatrists, other mental health providers and the faith-based community to improve quality care for individuals and families with mental health and substance abuse problems. (Directive to Take Action)

HOD Action: Alternate Resolution adopted as amended in lieu of Resolution 908.

RESOLVED, That our American Medical Association advocate for and support mental health and faith community partnerships that foster improved education and understanding for faith leaders regarding culturally competent, medically accepted, and scientifically proven methods of care for psychiatric and substance abuse disorders (Directive to Take Action); and be it further

RESOLVED, That our AMA support better understanding on the part of mental health providers of the role of faith in mental health and
addiction recovery for some individuals, (Directive to Take Action); and be it further

RESOLVED, That our AMA support efforts of mental health providers to create respectful, collaborative relationships with local religious leaders to improve access to scientifically sound mental health services. (Directive to Take Action)

Other House Of Delegates Reports And Resolutions Of Interest


CLRPD Report 1 analyzed information from the letter requests submitted by the Minority Affairs Section and Integrated Physician Practice Section for renewal of their delineated Section status.

HOD Action: CLRPD report 1 adopted with renewal of delineated Section status for the Minority Affairs Section and the Integrated Physician Practice Section.

4. Resolution 308 – Promoting and Reaffirming Domestic Medical School Clerkship Education

Resolution 308 asked that our American Medical Association 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.

HOD Action: Resolution 308 referred.

5. Resolution 309 – Development of Alternative Competency Assessment Models

Resolution 309 asked Resolution 309 asks that our American Medical Association amend AMA Policy H-8 275.936, Mechanisms to Measure Physician Competency, by addition and deletion to 9 read as follows:

Our AMA (1) continues to works with the American College of Graduate Medical Education, American Board of Medical Specialties, and other relevant organizations to develop and explore alternative and more accurate evidence-based-methods to of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing
medical education, and teaching experience; and (2) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.

**HOD Action: Resolution 309 adopted as amended.**

6. Resolution 311 – Prevent Maintenance of Certification Licensure and Hospital Privileging

Resolution 307 – Inappropriate Uses of Maintenance of Certification

Resolution 307 asked that our AMA, through legislative, regulatory, and collaborative efforts, advocate that Maintenance of Certification not be a requirement for: 1) medical staff membership, privileging, or credentialing; (2) insurance panel participation; or (3) state medical licensure.

Resolution 311 asked that our AMA, 1) consistent with Policy H-275.924, vigorously advocate by legislation, regulation, or other appropriate activity to prevent the use of maintenance of certification as a licensing requirement in any state, and amend Policy H-275.924, “Maintenance of Certification,” Bullet No. 15, by addition to read as follows:

15. The MOC program should not be a mandated requirement for licensure, credentialing, hospital privileging, reimbursement, network participation or employment.

**HOD Action: Alternate resolution adopted in lieu of Resolutions 307 and 311; Resolve 1 amended by addition and deletion, to read as follows:**

RESOLVED, That our American Medical Association, through legislative, regulatory, and other interested parties to advocate by creating model state legislation and model medical staff bylaws while advocating collaborative efforts, work with interested state medical societies that Maintenance of Certification not be a requirement for: (1) medical staff membership, privileging, credentialing, or recredentialing; (2) insurance panel participation; or (3) state medical licensure. (Directive to Take Action)
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<td>Sameer Avasarala, MD</td>
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<td>Guillermo Godoy, MD</td>
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<td>Ved Gossain, MD, FRCP (c), MACP, FACE, Chair</td>
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<tr>
<td>Kevin King MD, FACE, AACE</td>
<td><a href="mailto:Kevin.King2@HCAhealthcare.com">Kevin.King2@HCAhealthcare.com</a></td>
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<td>Bhushan Pandya, MD, Immediate Past Chair</td>
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<td>Colonel Ronit Katz, MD</td>
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Office: (312) 464-5678 |
| Carolyn Carter-Ellis, MBA, Senior Group Manager, (IMGS, MAS & LGBT Advisory Committee) | Email: carolyn.carter-ellis@ama-assn.org  
Office: (312) 464-5397 |
Reassessing the Data on Whether a Physician Shortage Exists

Does the United States have enough physicians?—Yes.

For decades, experts have bemoaned a lack of sufficient primary care physicians in the United States. These fears came to a head during debate over the Affordable Care Act (ACA), when critics suggested that the millions of US residents gaining coverage under the ACA would further exacerbate the existing physician shortage. A 2011 American College of Surgeons report asserted that "even before [this] health care reform, the nation was headed for serious physician shortages and reform has only made it worse."1 According to the updated report of the Association of American Medical Colleges (AAMC), released March 14, 2017, the AAMC still predicts a shortage of between 40 800 to 104 900 physicians by 2030.2

Some have questioned the accuracy of these projections. Yet the ominous forecast of a physician shortage has already motivated significant reforms. During the last 15 years, the number of medical schools in the United States—including those with provisional or preliminary accreditations—has increased from 125 to 145. Concomitantly, medical school enrollment has increased from 16 488 to 21 030 students, an increase of 28% since 2002, and is expected to increase even further by 2018.3 Additionally, over the last 5 years, the number of Accreditation Council for Graduate Medical Education programs has increased from 9022 to 9977, an increase of 10.6%, and the number of active residents (currently enrolled in a program) has increased from 115 293 to 124 409, an increase of 7.9%.4

Since passage of the ACA, 22 million US residents have gained health care coverage and thousands of newly trained physicians have begun practicing.5 Given these changes, it is worth reassessing the data on whether a physician shortage really exists.

Are Wait Times Longer?

As millions gained coverage under the ACA, many argued that the time to get a physician appointment would increase. A 2013 Commonwealth Fund survey found that 52% of adults could not get a same-day or next-day appointment with their physician.6

However, long wait times for physician appointments predate the ACA. The average time to an appointment with a US family practice physician in 2009 was 20 days; today, it is 19.5 days.7 Since the 2006 implementation of "RomneyCare" (the ACA’s predecessor) in Massachusetts, serial surveys have shown that wait times for appointments with Massachusetts primary care physicians have increased and declined without statistically significant differences. Specialist appointment wait times in Massachusetts have remained stable or decreased for all groups except orthopedic surgeons. Therefore, it is difficult to attribute longer wait times solely to an expansion of health coverage.

For Medicaid beneficiaries, data suggest that appointment availability has improved under the ACA. A study of 295 primary care practices in Michigan found that appointment availability for new Medicaid patients increased from 49% to 55% before vs after the state’s Medicaid expansion, probably due to improved Medicaid funding under the ACA.8 The study noted that even as more beneficiaries became eligible, “wait times for new Medicaid and new privately insured [patients] did not significantly increase.”8 Although US residents do wait a long time to get a physician appointment, this time has not increased since the ACA.

Does the US Have Enough Physicians?

On the supply side, are there too few physicians? A simple calculation estimating the number of physicians needed to care for all US residents suggests no physician shortage. The United States currently has more than 900 000 active physicians. Of these, 441 735 are primary care physicians and 484 384 are specialists.9 Approximately 12% of primary care physicians work part time, leaving slightly more than 388 000 full-time primary care physicians. Of these, nearly 80 000 are pediatricians.

According to recommendations from the Agency for Healthcare Research and Quality, the average physician panel size—the number of unique patients under the care of an individual physician—should be between 1500 and 2000. A recent Medical Group Management Association survey of primary care physicians found that the median panel size was 1906 and the average was 2184.10

Conservatively, if each of the 388 000 full-time primary care physicians cares for an average of 1500 patients, they could care for an estimated 583 million people. Today, there are 240 million adults in the United States. Even at the low panel size of 1500 patients, all adults could be cared for by 160 000 primary care physicians; at a panel size of 2000 patients, the United States would require an estimated 120 000 full-time primary care physicians. Similarly, the 73 million US children younger than 18 years could be cared for by an estimated 49 000 pediatricians, assuming that each provides care for 1500 patients, or by an estimated 36 500 pediatricians with panel sizes of 2000 patients. Add to these conservative calculations the care provided by the more than 50 000 part-time primary care physicians and there seems a significant surplus, rather than a shortage, of full-time primary care physicians.

Can Physicians Care for All Patients in the United States?

Another way of determining if there are enough physicians is to approach the issue from the demand side. Each...
year, there are 930 million US physician visits, 54.6% (507 million) of them to primary care physicians. If each primary care physician sees patients in 30-minute appointments for 6 hours a day (12 appointments per day) to ensure patients are thoroughly examined and visits are not rushed, then 43 million primary care physician workdays per year are needed (507 million visits divided by 12 visits per day). If physicians work an average of 200 days per year, then an estimated 215 000 active, full-time primary care physicians would be needed for all the primary care office visits in the United States. That number is nearly identical to the estimated 209 000 internists, family physicians, and pediatricians (160 000 + 49 000) needed based on the conservative panel size calculations.

From either a supply or a demand perspective, enough physicians are available for all US patients. Given this balance, and assuming these estimates are accurate, there is no obvious physician shortage.

Why Is There a Projected Shortage?
The AAMC report predicts a physician shortage based on 3 factors: declining physician working hours, impending physician retirements, and aging of the population.

The report suggests that physicians younger than 35 years are expected to work 13% fewer hours per week relative to earlier cohorts. This seems accurate considering that physicians who are aged 46 to 55 years work more hours than younger physicians.

Yet even if physicians are now choosing to work fewer hours, there are still enough physicians. An estimated 215 000 primary care physicians are needed to care for all US residents, then millennial physicians could still work fewer hours and the 388 000 full-time primary care physicians in the United States could together cover all patients.

The report also suggests that a third of all currently active physicians will be of retirement age within the next decade, risking a significant decline in the number of available physicians. Most US adults nearing retirement age, however, are delaying retirement, so the number of retirement-eligible physicians who choose to leave the workforce will likely be lower than the projected. Additionally, even if a third of all current physicians retire, there will still be approximately 260 000 full-time primary care physicians (0.67 × 388 000) with no replacements, which should be more than enough.

The AAMC report also suggests that the aging population is likely to increase volume of care. Even though older patients do on average have higher health care demands, there are more efficient ways to address their health needs than simply increasing the supply of physicians. Health services that do not require a physician—such as annual wellness examinations, follow-up visits, closing of care gaps, and support for medication adherence—could be provided by nurse practitioners, care coordinators, and medical assistants. By reorganizing clinicians’ responsibilities, physician time could be used more effectively.

What Are the Problems in Obtaining a Timely Appointment?
Why are patients experiencing long wait times and rushed office visits? The short answer is inefficiency. Many physicians control their schedules, often resulting in ineffective office scheduling and high rates of patient no-shows. To address this, physician practices should implement open-access scheduling, in which 20% to 50% of appointment slots are left open for same-day or walk-in patients. This strategy can increase office efficiency and reduce time to an appointment.

Wait times may also be decreased through utilization of virtual medicine for follow-up appointments. Text messaging, apps, and video calls can allow patients to quickly access routine, follow-up care without having to schedule an in-person appointment. In addition to enhancing patient convenience, virtual medicine also frees up office time for patients with emergent issues.

Although there appears to be an abundance of physicians in the United States, the system is still characterized by a maldistribution of physicians. Nearly a fifth of US residents live in rural areas, yet less than a tenth of primary care physicians practice there. Training more physicians will not solve this issue. Instead, it will be important to consider how physicians are incentivized to encourage more to pursue underserved areas, such as in rural health care.

There are many assumptions in these projections, as there are in projections by those who suggest a physician shortage. These calculations suggest that there are more than enough primary care physicians to care for the US population. Long delays in getting an appointment are due to system inefficiencies rather than supply. This is a management problem that should not be addressed by adding more physicians; doing so will only drive up health care costs and increase inefficiency.

REFERENCES
Addressing the Physician Shortage
The Peril of Ignoring Demography

Does the United States have enough physicians?—No.

The United States faces a serious physician shortage that is likely to worsen in the coming decade without multifaceted intervention. At the same time, the US health care system is in a period of marked uncertainty, and many questions are on the horizon—from the future of health insurance coverage to how scientific discoveries will revolutionize medicine in the coming decades. With multiple variables affecting how the health needs of the United States will evolve in the next few years, physician workforce projections must consider this complex and dynamic landscape.

Demographic Changes
Of the many challenges that US health care faces, demographic change is foremost among factors contributing to workforce shortages. Arguably, it is also the variable about which the facts are clearest. The population of the United States both is increasing in number and is aging. Current projections indicate that between 2015 and 2030, the US population will increase by 12% to 359 million, with the population aged 65 years or older projected to increase by 55%. With 10 000 individuals in the United States turning 65 years old every day, this older population will drive increased demand for health services over the next few decades. Not only is the population as a whole aging, but more than one-third of all currently active physicians will be aged 65 years or older within the next 10 years, and the retirement decisions of those physicians will have a significant effect on physician supply.1

Physician Workforce Projections
Beyond demographic change, uncertainty about future policy regarding health insurance and the financing of care, the potential implications of integrated care delivery models, and new developments in technology complicate the picture of the future physician workforce. Considering all these factors, the annual physician workforce projections commissioned by the Association of American Medical Colleges (AAMC) take a multivariable approach. The method analyzes a number of assumptions and determines variable outcomes to assess the nation’s current situation and future needs.

The recently released 2017 update1 of annual physician workforce projections indicates that under likely scenarios, the United States will face a shortage of between 40 800 and 104 900 physicians by 2030. Workforce projections for surgical specialties are an area of particular concern, with a projected shortfall of between 19 800 and 29 000 surgical specialists by 2030. While some contend that repealing the Affordable Care Act (ACA) will help resolve the physician shortage, these projections indicate that if the ACA is replaced with policies and programs that reduce current coverage to pre-ACA levels, future demand would decrease by only 6000 to 10 000 physicians.1 Regardless of the future of the ACA, shortages in the numbers of physicians, especially in certain specialties, are likely to persist.

The data also indicate shortages in both specialty and primary care and in both urban and rural communities. In fact, many individuals in US urban and rural underserved communities are already feeling the effects of the shortage—wait times for physician visits are long, and the most vulnerable people often have difficulty accessing a physician when they need one. Some suggest that simply correcting maldistribution—too many physicians in suburban areas, too few in certain urban and rural areas—will solve the issue. However, an analysis based on 2015 population data indicates that if underserved populations had full access to physicians and utilized health care at the same rate as the rest of the population, an additional 34 800 to 96 800 physicians would be required immediately to meet that demand.1 Thus, even if it were mandated, redistributing physicians would still result in shortages.

Nonphysician Clinicians
Some who argue that the United States does not have a serious physician shortage contend that it can meet this growing need and expand the capacity currently provided by physicians by using nonphysician health care professionals such as physician assistants or advanced practice nurses. Creating a culture of true team-based care, with these professionals as integral members of the health care team, will result in more effective and efficient care and may help mitigate shortages to a certain point. Current AAMC projections consider the reality of an expanded role for nonphysician health care professionals. But the presence of these practitioners cannot be expected to wholly take over for needed physician services. These health care professionals deliver important additional services, not exactly the same ones as physicians. Moreover, as care and technology advance, novel treatments and complex tools will create new demands for physicians to implement these interventions as other functions may be taken on by other caregivers.

Technological Advances
Those who claim that the current and future needs of the United States do not demand increasing the supply of physicians may also argue that technological advances
Solving the Physician Shortage

Given the many years required to train a physician, it is essential to acknowledge the current and increasing physician shortage now. Solving the physician shortage will require a multifaceted approach over time. The US health care system is in a transformational moment, representing an important opportunity to develop better practice models, create a culture of interprofessional team-based care, advance medical technology, and develop a diverse health care workforce that serves all individuals in the United States.

In addition, medical schools and residencies must also train enough physicians to meet the needs of the population. United States medical schools are already responding by increasing medical student matriculation—since 2002, MD degree enrollment has increased by 27.5%, from 16,488 matriculants in 2002 to 21,030 matriculants in 2016 (unpublished data, AAMC Data Warehouse: Applicant Matriculant File, October 6, 2016)—and there are record numbers of applicants to medical school. However, caps placed on federal Medicare funding for residency training nearly 2 decades ago limit the current ability to expand graduate medical education, thereby limiting use of a key tool for meeting the nation’s need for physicians. Congress needs to increase these caps if the United States is to expand its overall supply of physicians.

As the size of the US population increases, the ratio of physicians to the population is declining. Ignoring demographic change will be perilous for the US health care system. Relying on unrealistic assumptions—for example, that political uncertainty will evaporate or that changing health care delivery methods will be seamless and immediately eliminate inefficiencies—is not a prudent strategy for addressing physician supply and the health needs of the nation.
Introduction

Ensuring an adequate supply of physicians is a top concern of health care policy workers in the United States. Physicians’ gender is an important component in analyzing how male and female physicians are contributing to the health care supply. To date, however, little attention has been given to how the international medical graduate (IMG) community, and more specifically the IMG female community, has grown and helped provide a supply of physicians in the United States. According to the 2014 FSMB Census of Licensed Physicians, 32% of actively licensed physicians are female. Less attention, however, has been given to the location of medical school graduation and its association with the growing population of female physicians. This study examines physicians who were issued their first license in the United States by gender and by where they graduated from medical school.

Using data from the Federation of State Medical Boards’ (FSMB) Physician Data Center, the authors measured the percentage of first-time licenses issued between 1990 and 2014 by gender and by where they graduated from medical school — that is, either a United States medical graduate (USMG) or an international medical graduate (IMG). Key findings indicate that between 1990 and 2014, first-time licenses issued to IMG females have increased from 25% to 45% (31% to 47% for USMG females). Furthermore, the percentage of first-time licenses issued to female IMGs increased among international regions with the highest number of licensed physicians in the U.S. The findings support that a greater percentage of first-time licenses issued to IMGs have been to females over the past two and half decades. Analyzing the trend of first-time licenses issued to physicians by gender and location of medical school graduation adds to better understanding the physician pipeline and physicians’ transition from medical school to the practicing medical community in the United States.

Background

Over the past few decades, there has been a distinct increase in the number of female physicians providing care in the United States. According to the 2014 FSMB Census of Licensed Physicians, 32% of actively licensed physicians are female and 23% are IMGs. The goal of this research is to analyze the growth of first-time licenses issued to female physicians in the United States, with a particular focus on IMG females. Using data from the FSMB’s Physician Data Center (PDC), we analyzed the percentage of physicians who received their first license between 1990 and 2014 by gender and where they graduated from medical school. Furthermore, we examined the percentage of first-time licenses issued to females who graduated from international regions with the largest populations of licensed physicians in the United States (India, the Caribbean, the Philippines, Pakistan, Mexico and all other international countries). Tracking the percentage of first-time licensed physicians by gender and where they graduated from medical school provides valuable information on how these physicians contribute to the physician pipeline.
by 2011. The rise of women in medicine parallels the rise of women in other professional fields. An examination of selected professional fields, including dentistry, optometry, pharmacy, podiatry, veterinary medicine, chiropractic, law, theology, medicine and osteopathic medicine, shows that 49% of graduates from institutions granting these professional degrees in 2011 were females.

Just as female physicians from U.S. medical schools fill the need for physicians in the United States, the growth of IMG physicians has also helped with increasing health care demands. In 2014, IMGs constituted approximately a quarter of all licensed physicians in the U.S. According to the American Medical Association (AMA), between 1970 and 1994 the overall physician population increased by more than 105%; the USMG population grew by 91% and the IMG population grew at almost twice the rate (170%). The female population among IMG physicians providing patient care grew from 17% in 1981 to 26% in 2001. While research has shown growth in the IMG female population, less is known about trends in the percentage of females from the IMG population who have been issued their first license in the United States.

Growth among IMG physicians can encourage better care among certain areas and populations in the U.S. First, IMGs may be able to help alleviate the maldistribution of primary care physicians in rural and underserved areas. According to the 2002 AMA physician data, IMG primary care physicians were more likely to practice in rural areas than USMGs in 18 states, while USMG primary care physicians were more likely to practice in rural areas in 16 states. Second, IMGs are more likely to be sensitive to cross-cultural issues as they relate to the medical field. In summary, an appropriate distribution of male and female physicians from U.S. and international medical schools helps ensure a physician population that can better respond to health care demands...

Method

Data used for this analysis were from the FSMB’s PDC, including license data provided by the U.S. and District of Columbia state medical boards that regulate allopathic and osteopathic physicians. Physician records are created in the PDC when U.S. medical school students or IMGs register for the United States Medical Licensing Examination (USMLE). For physicians who do not take the USMLE, the PDC uses license files from state boards to create an initial physician record. Physician records in the PDC are updated on a regular basis, including all medical licenses issued by state boards.

Over their career, physicians are often issued several licenses, either from renewing their license in the same state or applying for licenses in multiple states. Each physician’s licenses were ordered by their issue date to identify the earliest and first license issued. If physicians had licenses with missing issue dates, we were unable to accurately determine the first license and therefore excluded these physicians from our analysis. With these criteria, a total of 605,424 physicians were issued their first license between 1990 and 2014. With the assumptions that most physicians receive their first license within five years after graduating medical school, we estimated the number of missing physicians who may have been issued their first license between 1990 and 2014. It is estimated that 6% or less of physicians who were issued their first license were missing from our study population.

Location of where physicians graduated from medical school was divided into two categories of either USMGs or IMGs. USMGs included physicians who graduated from medical schools in the United States or Canada. Physicians who graduated from medical schools outside of the United States and Canada were categorized as IMGs.

First-time licenses issued by gender were also analyzed by international countries or regions with the highest number of graduates with licenses in the United States, according to the 2014 FSMB.
In 2014, there were 48,377 actively licensed physicians who graduated from medical schools in India, 30,895 physicians from the Caribbean, 14,211 physicians from the Philippines, 11,651 physicians from Pakistan, 10,213 physicians from Mexico and 92,493 physicians who graduated from other international countries. The exact numbers of graduates by country of medical school graduation may be slightly under-represented due to 2% of the 2014 actively licensed physicians in the United States who had an unknown location for their medical school.¹

Among the 605,424 physicians who were issued their first license between 1990 and 2014, 593,035 physicians had a recorded gender (corresponds to Figure 1). When including where physicians graduated from medical school, 584,291 first-time licensed physicians were known to be either USMGs or IMGs (corresponds to Figure 2). This represents our study population, which includes physicians with valid first-time license issue dates, a recorded gender, and where applicable, location of medical school graduation.

Results

Between 1990 and 2014, 347,146 male and 245,889 female physicians were issued their first license to practice medicine, accounting for 59% and 41% of first-time licenses issued, respectively. The percentage of first-time licensed physicians who were females increased from 30% in 1990 to slightly under half (47%) in 2014 (see Figure 1). Using a simple linear regression analysis to investigate the change each year from 1990 to 2014 in the percentage of first-time licenses to female physicians, we found that the rise in the percentage of first-time licenses to female physicians was statistically significant (p < 0.001) and increased by an average of 0.773% for each year.

The gender of first-time licensed physicians was also segmented by whether they were USMGs or IMGs. From the 431,470 first-time licenses issued to USMGs between 1990 and 2014, 58% of these licenses were issued to males and 42% to females. Among IMGs during this time period (n = 152,821),
61% of licenses were issued to males, compared to 39% of licenses issued to females.

When looking at the trend of licenses issued by year, 31% of first-time licenses to USMGs were issued to females in 1990. The percentage grew to 47% by 2014 (see Figure 2). A linear regression analysis confirmed that the rise in the percentage of first-time licenses to USMG female physicians was statistically significant ($p < 0.001$) and increased by an average of 0.769% for each year.

Similarly, females represented 25% of first-time licenses issued to IMGs in 1990 and the percentage grew to 45% by 2014 (see Figure 2). A linear regression analysis confirmed that the rise in the percentage of first-time licenses to IMG female physicians was statistically significant ($p < 0.001$) and increased by an average of 0.856% for each year.

Overall, a greater proportion of first-time licenses issued to USMGs were females, compared to IMG females between 1990 and 2014. There has been, however, a greater percentage increase of first-time licenses issued to female IMGs (82%), compared to 53% for USMG females.

Lastly, we looked at the gender composition by international regions with the highest number of medical graduates with active U.S. medical licenses in 2014. The total number of first-time licenses issued between 1990 and 2014 to physicians by their country of medical school graduation were as follows: 34,004 first-time licenses were issued to graduates from India, 27,794 to graduates from the Caribbean, 10,082 to graduates from Pakistan, 7,479 to graduates from the Philippines, 4,016 to graduates from Mexico and 69,446 first-time licenses were issued to graduates from all other international schools. While an increasingly greater percentage of first-time licenses were issued to female physicians between 1990 and 2014 based on the location of their international medical graduation, the increase varied by region (see Figure 3). Physicians who graduated from the Philippines had the highest percentage of first-time licenses issued to females (39% in 1990 and 59% in 2014). Comparatively, physicians who graduated...
from Mexico had the lowest percentage of first-time licenses issued to females (17% in 1990 and 41% in 2014). The percentage of first-time licenses issued in 2014 to females who graduated from Mexico and other international counties were relatively close by comparison; 49%, 48%, 44% and 43% of first-time licenses issued to graduates from Pakistan, India, the Caribbean and other international countries were, respectively, female.

**Discussion**

Defining trends for first-time licensed physicians by gender and where they graduated from medical school adds an important piece in measuring the physician pipeline and physicians’ transition from medical school training to being part of the established U.S. medical community. Based on our analysis, first-time licenses are being issued in an increasingly more equal distribution for male and female physicians who graduated from U.S. and international medical schools. In 1990, USMG and IMG female physicians constituted 31% and 25%, respectively, of first-time licenses issued. Comparatively, USMG and IMG female physicians represented 47% and 45%, respectively, of first-time licenses issued in 2014. While a smaller proportion of first-time licenses were issued to IMG females compared to USMG females between 1990 and 2014, there was a greater increase in the percentage of first-time licenses issued to IMG females than USMG females during this time period. Furthermore, an analysis looking at medical school graduates from India, the Caribbean, the Philippines, Pakistan, Mexico and all other international countries also confirmed that the percentage of first-time licenses issued to females has increased since 1990 to 2014, although to varying degrees.

Our analysis summarizing physician characteristics based on gender and location of medical school graduation helps provide a link between the physician population and research looking at quality of care provided based upon physician demographics. International medical graduates tend to serve patients in traditionally underserved areas.7,8

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**Figure 3**

*Percentage of First Licenses Issued to IMG Females by Year and Region*
International medical graduates are also likely to be more culturally sensitive when communicating with their patients.9

When analyzing physician contributions by gender, male and female physicians also tend to contribute to the medical profession in different ways. For example, when comparing patient-physician encounters by gender, male physicians tend to report more patient encounters and write out more prescriptions compared to female physicians.10, 11 Female primary care physicians, however, tend to engage in more patient-centered communication, spend a longer time and address a greater number of patient issues per visit compared to their male primary care counterparts. 10, 12

Availability of both male and female physicians also helps address patients’ preferences for a particular physician gender. For example, female patients tend to prefer female obstetricians and gynecologists.13, 14 It should be noted, however, that preference for physician experience, communication, quality of care and competency tends to be stronger than the preference for female obstetricians or gynecologists.13-15

Regarding workforce capacity, male physicians tend to work more hours each week, and male and female physicians tend to be more active in their careers at different ages.11, 16 Using the U.S. Census Bureau Current Population Survey data from 1979 to 2008, Staiger, Auerbach and Buerhaus examined physician work activity across ages and by gender. Both males and females peak work years are between 45 to 54 years. Relative to their own peak activity, females tend to be less active than males between ages 25 to 34 years. Females, however, are 98% as active relative to their peak work years when they are 55 to 64 years while male physicians at this age are 83% as active relative to their peak work years.16

While male and female physicians both contribute to the medical field in their respective ways, evidence remains that females tend to hold less visible and lower compensated roles than males. For example, even though females are more likely to have roles in science and medical research experiments, males are more likely to be published authors.17 Similarly, male physicians tend to have higher incomes than females even after accounting for several characteristics, including specialty, hours worked and geographical location.18 The persistence of gender biases calls for further research to study the role of male and female physicians in the workforce.

In addition to our analysis, which helps link the rise of first-time licensed females and IMG physicians with established literature stating this same population can provide increased quality care to certain patients’ preferences, our study also helps link health workforce studies in understanding the gender and age distribution in the physician pipeline.

FEMALE PRIMARY CARE PHYSICIANS...TEND TO ENGAGE IN MORE PATIENT-CENTERED COMMUNICATION, SPEND A LONGER TIME AND ADDRESS A GREATER NUMBER OF PATIENT ISSUES PER VISIT COMPARED TO THEIR MALE PRIMARY CARE COUNTERPARTS.

For example, there was a greater percentage of actively licensed female physicians who were 39 years and younger in 2014 compared with male physicians (30% vs. 16%),1 which can be explained by the greater increase in the percentage of first-time licenses issued to females over past decades. While our analysis establishes a distinct trend in the rise of IMG female physicians from 1990 to 2014, a limitation of our analysis is that it does not provide a direct link as to why the trend exists. There are many reasons why IMGs want to practice in the United States, including the prestige of practicing abroad, working in technologically-advanced environments, having a higher standard of living, personal freedom and living in the environment of a stable government.19 Even though IMGs may help alleviate physician shortages in the United States, some question the ethics of relying on IMGs in the U.S. health care workforce, because it decreases the supply of physicians in their native countries.20 Future research is needed to explore how the increase in IMGs, particularly female IMGs, in the United States influences physician workforce patterns worldwide. Further research should also examine the intersections of gender, country of medical school graduation and other physician
attributes, such as specialty certification, and their relationship to how the health workforce responds to U.S. health care demands and preferences.

In summary, while a great deal of attention has been given to the increase in female medical school acceptance rates, medical school graduation rates and actively practicing physicians,1-3 less attention has been given to how female IMGs have contributed to the physician supply in U.S. health care. This analysis affirms the growth in the percentage of first-time licenses issued to IMG females and their sizeable contribution to health care in the United States.

About the Authors

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Ethical approval

This study was determined to be exempt from further human subjects review by The American Institutes for Research on September 13, 2016, reference number EX00404.

References


Welcome to Hyatt Regency Chicago. Meeting rooms, ballrooms, restaurants and guest amenities are listed in alphabetical order and color coded by floor. For help, dial Guest Services at Extension 4460.

EAST TOWER
- East Tower, Blue Level
- East Tower, Bronze Level
- East Tower, Green Level
- East Tower, Gold Level
- East Tower, Silver Level

WEST TOWER
- West Tower, Blue Level
- West Tower, Bronze Level
- West Tower, Green Level
- West Tower, Gold Level
- West Tower, Silver Level

ESCALATORS, ELEVATORS AND RESTROOMS are indicated on each floor. Elevators are conveniently located throughout the hotel for guests with disabilities or where no escalator is present.

CROSSING BETWEEN TOWERS: Cross between towers via the Blue Level Skybridge or the Concourse on the Bronze Level. You may also cross on the Green Level via the crosswalk on Stetson Drive.
Speakers’ Letter
2017 Annual Meeting of the AMA House of Delegates
June 10–14, 2017
Hyatt Regency Chicago

Ladies and Gentlemen:

The following information is provided to aid your planning for the upcoming Annual Meeting in Chicago. We would particularly like to call your attention to childcare services that will be available in Chicago (see page 2), the elections (see page 3), and a call for respectful behavior (see page 3).

Please call 312.464.4463, send an email to hod@ama-assn.org or visit ama-assn.org/annual-meeting if you have questions regarding any of the following items or questions on American Medical Association (AMA) policy. Watch the Annual Meeting website for updates to this Speakers’ Letter.

Susan R Bailey, MD, Speaker
Bruce A Scott, MD, Vice Speaker

House of Delegates schedule

The 2017 Annual Meeting of the AMA House of Delegates (HOD) will meet June 10–14 at the Hyatt Regency Chicago. The AMA-HOD will convene at 2 p.m. Saturday, June 10 in the Grand Ballroom, and your speakers ask that delegates be seated by 1:50 p.m. The opening session will start promptly at 2 p.m. and recess by 6 p.m.

On Sunday, June 11, the “Second Opening” of the AMA-HOD will be in session 8–8:30 a.m. to receive items of business, consider acceptance of late resolutions, and extract informational reports and items from the reaffirmation consent calendar. Reference committee hearings will follow.

The four following reference committees will convene their open hearings from 8:30 a.m. to noon Sunday:

Reference Committee A
Regency Ballroom A
Reference Committee C
Regency Ballroom B
Reference Committee E
Regency Ballroom D
Reference Committee F
Grand Ballroom

The remaining reference committees will hold hearings from 1:30 to 5 p.m.

Reference Committee on Amendments to Constitution & Bylaws
Regency Ballroom C
Reference Committee B
Regency Ballroom B
Reference Committee D
Regency Ballroom D
Reference Committee G
Regency Ballroom A

Additional business sessions of the AMA-HOD will convene at 2 p.m. Monday, June 12, and 9 a.m. Tuesday and Wednesday, June 13 and 14. The AMA-HOD will adjourn by noon on Wednesday. Your speakers ask delegates to schedule departures for the afternoon of Wednesday so that they can give full consideration to the business debated that day.

Delegates and alternate delegates may request special accommodations (eg, an assistive listening device) by contacting the Office of House of Delegates Affairs by email at hod@ama-assn.org or phone 312.464.4344.

Note: All events are at the Hyatt Regency Chicago unless otherwise indicated.
Meeting details and reminders

Handbook distribution
The initial Handbook will be posted on the Annual Meeting website by May 12 as a single large document as well as in a set of smaller documents collated by reference committee. The Addendum will be posted about May 19, and when it is posted, the original Handbook and Addendum will be available separately along with a combined document that interleaves the Addendum with the Handbook. An abridged Handbook containing only the recommendations from reports and the resolve clauses from resolutions will also be available as a Word document.

Hardcopy Handbooks will be mailed by May 19 to delegates and alternate delegates who have previously received paper copies, with the Addendum scheduled to go out on or about May 25. Primary distribution of the Handbook and Addendum will be by download from the Annual Meeting website.

Registration
Registration for the AMA-HOD will be located in the Grand Foyer, which adjoins the Grand Ballroom. For security purposes, all attendees will be required to provide photo identification at the AMA Registration Desk in order to receive their credentials and other materials. Registration will open daily at 7 a.m. and run from Friday, June 9 through Wednesday, June 14.

Delegates and alternate delegates should check with their sponsoring society to ensure that their names have been submitted to the Office of House of Delegates Affairs prior to this meeting. Under AMA bylaws all delegates and alternate delegates must be credentialed by the society that they will represent. Individuals whose credentials have not been confirmed prior to the Annual Meeting will have to be accompanied to the AMA Registration Desk by an officer of their society in order to register.

Recording of AMA-HOD meetings
Proceedings of AMA meetings may be recorded by audiotape, videotape or otherwise, for use by the AMA. Participation in/attendance at a meeting shall be deemed to confirm the participant’s consent to recording and to the AMA’s use of such recording.

Childcare services
Following House action last June, a pilot test of childcare will be initiated at A-17. The service will be available from 7 a.m. to 7 p.m. starting on Thursday, June 8 and running through Tuesday, June 13; availability on Wednesday will run from 7 a.m. to noon. Reservations are required to ensure a spot and may be made through the meeting website. Hours and prices are as follows:

<table>
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<tr>
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<th>Age up to 36 months</th>
<th>Age 3 years and older</th>
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<td>Half day (7 a.m. to 1 p.m. or 1 p.m. to 7 p.m.)</td>
<td>$60</td>
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<tr>
<td>Full day (7 a.m. to 7 p.m.)</td>
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<td>Wednesday</td>
<td>$45</td>
<td>$40</td>
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There is a $10 per child registration fee, and prices do not include meals.

The vendor, Accent on Children, is fully licensed, and caregivers have considerable experience in working with children. Staff to child ratios range from 1:2 for infants to 1:8 for school-age children.

The same service will be available in Honolulu for the 2017 Interim Meeting and is planned for 2018.

Airline and airport transportation discounts
An airline discount is available on United Airlines, valid for 3 days prior to and 3 days after the official meeting dates. To obtain the discount when booking online at United.com, click on All Search Options and enter your origin, destination and travel dates. Then enter ZY3G795513 in the Promotions and Certificates offer code box. Available flights will be displayed, and the discounted fare will automatically be calculated after flights are selected.
To obtain the discount over the phone, call United Airlines Meetings at 800.426.1122 and mention Z code ZY3G and agreement code 795513. A service fee will apply for phone transactions.

GO Airport Express offers airport shuttle services between O’Hare and Midway Airports and downtown Chicago hotels, with fares of $21 each way from O’Hare and $17 each way from Midway. These fares are only available through the link on the meeting website or visit airportexpress.hudsonltd.net/res and enter “ama” in the Frequent User Login box.

Meeting attire
Your speakers have determined that business casual dress is appropriate for the Annual Meeting, although business attire is requested for those seated on the dais during HOD business sessions. Business attire is also proper for the inaugural and dinner-dance, with formal attire (black tie) optional.

Respectful behavior
At the first session of each AMA-HOD meeting, as provided in the HOD Reference Manual, delegates are asked to ratify a code of conduct that reaffirms a commitment to be courteous, respectful and collegial in the conduct of HOD business. Courteous and respectful dealings in all interactions with other delegates and with AMA staff are expected of all attendees at HOD meetings—including social events apart from HOD meetings themselves. Instances of unwelcome or inappropriate behavior should be brought to the attention of the Speakers. Hugs and embraces, while not always inappropriate, are not universally accepted. Delegates are reminded of their personal responsibility, while greeting others, to consider how the recipient of their greeting is likely to interpret it.

Distribution of nonbusiness items
The “not-for-official-business” bag contains campaign literature, small gifts and other informational material approved by your Speakers. It is distributed at the Opening Session. Material for distribution to the AMA-HOD in the not-for-official-business bag should be delivered to the production area of the AMA Headquarters Office at the Hyatt Regency Chicago by 5 p.m. Thursday, June 8. As a general rule, 1300 copies of items are required for distribution throughout the AMA-HOD. For campaign gifts, at least 700 items are required for distribution in the delegates’ seating area; distribution throughout the ballroom requires 1300 items. The decision as to the number of gifts is up to the candidate, but the $2,775 cap on expenditures for campaign memorabilia applies regardless.

Nominations and elections
The 2017 Election Manual lists previously announced candidates for officer positions along with candidates for various council seats who were nominated by the Board of Trustees. A link to candidates’ conflict of interest information also appears in the election manual. The election manual is freely accessible, but conflict of interest disclosures are available only to members, who must login to obtain access.

Elections at A-17
For this year’s elections the announced candidates for president-elect are sitting trustees whose terms do not expire until 2018, and one at-large trustee’s term terminates at the conclusion of the 2017 Annual Meeting, but he is eligible for another term and is seeking re-election. While the election manual lists current nominees, nominations from the floor are possible during the opening session.

On Tuesday morning electronic balloting will be used and delegates will vote:

- For one candidate in the race for president-elect
- For one candidate in the race for an at-large trustee position
- For one candidate in the race for resident and fellow trustee
- In multiple council races

After the initial results are announced, paper ballots will be used in runoffs and elections for newly created vacancies, if any. Runoffs for officer slots would be completed before new vacancies are handled.
If either of the currently announced candidates for president-elect is elected, a vacancy will be created for an at-large trustee seat.

That vacancy will be treated as a new election, which means:
- Unsuccessful candidates in the earlier at-large trustee election will automatically be nominated; AND
- Nominations from the floor shall be accepted (Bylaws, §3.4.2.2).
- In the event of nominations from the floor, all nominees will be permitted to give a two-minute speech. Otherwise, the election will proceed without additional speeches.

House policy requires that all nominees complete a conflict of interest form prior to election. Individuals who anticipate the possibility of a nomination from the floor are urged to contact Roger Brown in the Speakers’ Office (roger.brown@ama-assn.org, or phone 312.464.4344). Inquiries will be maintained in confidence.

Balloting at A-17

The elections for officer and council positions will be held 7:30–8:45 a.m. Tuesday, June 13 in Columbus K–L. Elections are conducted under the supervision of the chief teller, the assistant election tellers and the Committee on Rules and Credentials. The polls will close 15 minutes before the AMA-HOD reconvenes that morning, and eligible delegates must be in line by 8:45 a.m. in order to vote.

Only duly credentialed delegates are permitted to cast a ballot. An alternate delegate who is seated for a delegate must first be properly re-credentialed as a delegate at the AMA Registration Desk in order to vote in an election. The change from alternate delegate to delegate must be approved by a duly authorized officer of the society in question; see bylaws 2.10.4 and 2.10.4.1.

In the event that a new vacancy arises or a runoff election is required, paper ballots will be distributed to credentialed delegates seated in the House at the time ballots are distributed. Anyone considering a possible run for a newly created vacancy is again reminded of the need to complete a conflict of interest disclosure and is encouraged to contact Roger Brown well ahead of time.

CEJA nominations

President-elect David O. Barbe, MD, will nominate two members for seats on the Council on Ethical and Judicial Affairs during the Opening Session on Saturday, June 10. One nomination will be for a full term on the Council, and the other will be for the student seat. Both nominees’ conflict of interest disclosures will be posted on the AMA website in the week preceding the opening of the House. This will allow the election to proceed on Saturday following the formal nomination by Dr Barbe. Please watch the meeting website or the candidate page in the days leading up to the AMA-HOD meeting.

Announcements of future candidacy

Individuals who intend to seek election at the 2018 Annual Meeting are reminded that printed announcements may no longer be distributed in the meeting venue. Announcements provided to us by noon, Monday, June 12 will be projected on the last day of the meeting. An electronic announcement should be submitted to Roger Brown (roger.brown@ama-assn.org) in the Speakers’ Office; the preferred format is JPG, but a PDF or PowerPoint slide (16:9 format) are also acceptable. Submissions will be maintained in confidence until posted. Announcements will be posted online on an updated candidate page after the meeting.

Inauguration of David O. Barbe, MD

The inaugural ceremony for President-elect David O. Barbe, MD, will take place on Tuesday, June 13 at 5 p.m. in the Crystal Ballroom, with a reception and dinner dance starting at 6:30 p.m. in the Grand Ballroom. Tickets are required for the dinner dance. Individuals should coordinate reservations, payment and seating with their sponsoring organization but may visit the meeting website to register online, or contact Registration Services in the AMA’s Department of Meeting Services at 312.464.4582. Business or formal attire is requested for the evening.
Online member forums
As mentioned in the meeting information memo, each reference committee includes an online member forum. The forums can be accessed directly at ama-assn.org/forums/house-delegates or via the meeting website. The site will be up no later than when the Handbook is posted, and items from the Addendum will be added as they become available. Instructions are found on the site. All members of the House with email addresses will have been sent an announcement when the online forum is launched. If you do not receive such a notice, please send an email to that effect to patti.wargo@ama-assn.org.

The forums will remain open for commenting up to the opening of the House, but comments posted after Sunday, June 4 are unlikely to be captured in the summary reports that are prepared and posted on the meeting website.

Proceedings of the 2016 Interim Meeting
The draft of the Proceedings of the House of Delegates for the 2016 Interim Meeting (I-16) has been posted in downloadable format on the AMA website. Approval of the minutes from I-16 is an action item on Sunday morning.

PolicyFinder has been updated to reflect actions from I-16.

Conflict of interest policy
Sponsors of resolutions are reminded that the AMA-HOD has established policy (G-600.060) calling on delegates introducing an item of business to declare any commercial or financial conflict of interest at the time the resolution is submitted and that any such conflict of interest be included with the resolution.

Your Speakers have determined that this policy also applies to resolutions introduced by delegations. The sponsoring delegation must disclose the identity of any delegate or alternate delegate who has a commercial or financial interest with respect to matters addressed in the resolution. If a conflict is disclosed, the notation on the resolution will not contain an individual delegate’s name, but will state in substance that, “In accordance with House policy regarding disclosure of conflicts of interest, the delegation has notified the Speaker that one or more delegates has a commercial or financial conflict of interest with respect to the matters addressed in this resolution.” For resolutions already submitted, please notify the AMA Office of House of Delegates Affairs. A revised resolution containing the conflict of interest statement will be distributed.

HOD Reference Manual

2017 Interim Meeting planning
The 2017 Interim Meeting, with its focus on advocacy and legislation, will be held at the Hawaii Convention Center in Honolulu, Nov. 11–14. Delegates and alternate delegates who are willing to serve on a reference committee at the Interim Meeting are asked to contact the Office of House of Delegates Affairs by stopping in the Headquarters Office or emailing hod@ama-assn.org to let us know about your preferences for a reference committee assignment. Six reference committees will convene at the Interim Meeting:

- Reference Committee on Amendments to Constitution and Bylaws: Ethics, bylaws
- Reference Committee B: Legislative advocacy
- Reference Committee C: Advocacy related to medical education
- Reference Committee F: AMA governance and finance
- Reference Committee J: Advocacy related to medical service, medical practice, insurance and related topics
- Reference Committee K: Advocacy related to science and public health
Reference Committee C met in Orlando, and we tentatively plan to assemble the committee in Honolulu. The volume of business will be the determining factor. If business is limited, these items will be considered in Reference Committee K.

Insofar as possible, we rely on volunteers to serve on the reference committees, and we strive to place volunteers on reference committees of their choosing. New appointments to Reference Committee F will be made just a few weeks after the Annual Meeting adjourns.

In addition, as is our custom, we will be holding a speaker-to-speaker session, which is open to anyone interested in discussing meeting processes. Suggestions for the agenda are always welcome and can be sent to hod@ama-assn.org.

Meetings and caucuses

OSMAP
The Organization of State Medical Association Presidents (OSMAP) will hold its semi-annual membership meeting and general session 2–5 p.m. Friday, June 9 Grand Ballroom A. All state medical association presidents, presidents-elect, past presidents and executive directors (past and present) are encouraged to attend. A program agenda for the general session will be posted at the OSMAP web site (www.osmapandtheforum.org) in advance of the meeting. At 5 p.m., immediately following the OSMAP meeting, a reception will be held in Grand Ballroom B. All OSMAP members, their spouses and invited guests are welcome to attend.

Questions regarding OSMAP should be directed to Brian O. Foy, Executive Director, at bfoy11@yahoo.com.

Surgical Caucus Handbook review
The Surgical Caucus of the AMA will meet from 7 to 9:30 a.m. Saturday, June 10 in the Comiskey Room (breakfast available at 6:30) for a combined Business Meeting and Handbook review session. Specialties participating in the Caucus are encouraged to send at least one representative to this meeting.

Council on Ethical and Judicial Affairs – Open house on aid in dying
The Council on Ethical and Judicial Affairs will host an open house from 10 to 11:30 a.m. Saturday, June 10 in Columbus I–J. During this informal session CEJA invites delegates and members to share information regarding physician aid in dying to supplement the council’s review of published literature and data.

Academic Medicine Caucus
Delegates and alternate delegates with an academic appointment are invited to attend the AMA Academic Medicine Caucus, 5-6 p.m. Saturday, June 10 in the Water Tower Room and again from 9:30 to 10 a.m. Monday, June 12 in Columbus H. Attendees will discuss issues of mutual concern and interest pertaining to academic medicine and discuss HOD items of business in Reference Committee C. This is an opportunity to network with colleagues and share ideas on how the AMA can continue to provide leadership in medical education.

Visit the section’s website to learn more about the AMA Academic Physicians Section, which serves as the voice of academic physicians to the AMA House of Delegates.

Private Practice Physician Congress
The Private Practice Physician Congress will meet from 10 to 11:30 a.m. Monday, June 12 in Columbus I–J. All AMA members including young physicians, residents, fellows and medical students are invited to join the meeting. The group includes primary care and specialty care physicians. The meeting will include a presentation on “The independent Physician: Dinosaur or Reality” by Dr. Eppes. For questions or comments please contact Zuhdi Jasser, MD, Chair at zuhdi@jasserim.com or 608.721.7186; Tim McAvoy, MD, Vice-Chair at timothymcavoy@yahoo.com or 414.573.0751; or Barb Hummel, MD, Secretary at hummelb@ameritech.net or 414.690-6352.
Several education programs will be offered during the 2017 Annual Meeting. All members are welcome to attend any of the education sessions listed below, many of which are sponsored by the sections and special groups. These sessions will be offered between Friday, June 9 and Monday, June 12.

Sessions certified by the AMA for CME credit are indicated by an asterisk (*).

The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The American Medical Association designates each live activity for the maximum number of AMA PRA Category 1 Credits™ reflected with each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Some sessions are certified for credit by other CME providers, and those sessions are indicated with a dagger (†). Those sessions are not available on the AMA Education Center.

The deadline to claim credit for sessions certified by the AMA is July 31, 2017. The AMA Education Center can be accessed at cme.ama-assn.org/Education.aspx. Click on “Sign In” in the upper right hand corner of the screen, and enter your AMA username and password or create an account. Follow the instructions and complete the evaluation for each activity attended. Physicians will receive a CME certificate; non-physicians will receive a Certificate of Participation. Certificates will be saved in the “My Profile” section.

Attendees who have questions will find the AMA Education Center booth near the Grand Ballroom, where staff can assist learners in claiming credit or printing certificates. You may also contact the AMA Unified Service Center at 800.262.3211.

*Emerging issues in medical staff affairs (1.5 AMA PRA Category 1 Credits™)
8-9:30 a.m. Friday, June 9, Crystal Ballroom B
Hosted by the AMA Organized Medical Staff Section (AMA-OMSS)

This session, the second in an ongoing series on current topics in medical staff affairs, will address some of the most pressing issues facing medical staffs today. Presented from the perspectives of a medical staff leader, a medical staff services professional, and a medical staff attorney, the session will provide background information, insight, and practical solutions on common medical staff challenges such as threats to self-governance, National Practitioner Data Bank (NPDB) reporting, telehealth, and assessing senior physician competency.

*When the dust settles, what’s new and what’s not? (1 AMA PRA Category 1 Credits™)
9-10 a.m. Friday, June 9, Crystal Ballroom A
Hosted by the AMA Integrated Physician Practice Section (AMA-IPPS)

Speakers Robert Nesse, MD, senior medical advisor, Healthcare Policy and Payment Reform for Mayo Clinic and Richard Deem, senior vice president, AMA Advocacy look beyond the partisan rhetoric and media hype for a candid, enlightening discussion about the current state of health system reform under the current administration. What has changed, what hasn’t, and what are the implications for the future of health care delivery? Dr. Nesse brings his perspective from a distinguished career in leadership at the Mayo Clinic and Mr. Deem draws on his work leading the AMA’s renowned advocacy efforts. Attendees will be encouraged to engage speakers in a dialogue following the presentation.
*Emails, texts and social media: What physicians need to know (1 AMA PRA Category 1 Credits™)
9:45-10:45 a.m., Friday, June 9, Crystal Ballroom B
Hosted by the AMA Organized Medical Staff Section (AMA-OMSS)

Using actual cases, this session will explore how physicians’ use of digital communications, such as email, text messaging, and social media, to communicate with and about patients can cause headaches for health care providers, from HIPAA violations to ruined reputations. The session will also present strategies for how you and your practice staff can safely use these tools.

*Where health systems are looking for profitable growth (2.25 AMA PRA Category 1 Credits™)
10 a.m.-12:15 p.m., Friday, June 9, Crystal Ballroom A
Hosted by the AMA Integrated Physician Practice Section (AMA-IPPS)

As policy continues to drive and advance value based care, health systems need to effectively develop access points, manage channels and deliver high quality, cost-effective care across diverse care sites. Guest speaker, John Becker, senior vice president at Sg2, encourages system leaders to understand local market demand for services and identify their strengths and gaps across the system of care. Armed with this information, systems can find new potential opportunities with a holistic view of their delivery network. In this program, Mr. Becker will present case studies to illustrate new strategies health systems can use to drive profitable growth to meet better the needs of patients.

*Health system consolidation: How big is big enough (or too big)? (1.25 AMA PRA Category 1 Credits™)
2:30-3:45 p.m., Friday, June 9, Crystal Ballroom A
Hosted by the AMA Integrated Physician Practice Section (AMA-IPPS)

Health systems are on the verge of rapid consolidation because of regulatory changes, technological innovations, financial pressures and market dynamics. In a recent *JAMA*® Forum on health care marketplace consolidation, Harvard-based Ashish Jha, MD, MPH suggests consolidation is one of the key underlying problems of the dysfunctional health care market. However, he cites evidence that ACOs established under the ACA and run by independent physician-led practices, show potential for cost savings and quality improvement. On the flip side, a recent white paper funded by the American Hospital Association offers evidence that hospital mergers are transforming health care by laying a foundation for value-based care. These are just two of the many conflicting perspectives on health system consolidation that will be represented during the program.

*Council on Medical Education Stakeholders’ Forum —Leadership in Medical Education (2.0 AMA PRA Category 1 Credits™)
3-5:30 p.m. Friday, June 9, Toronto Room
Hosted by the Council on Medical Education

This Stakeholders’ Forum will engage medical education stakeholders in a discussion of the importance of leadership in medical education.

Speakers will address how leadership skills can be identified, fostered, and taught across the continuum; which different leadership models physicians should be familiar with; and what physicians can learn about leadership from other industries. In addition to panelists, leaders from national medical organizations have been invited to share their perspectives regarding this issue. The Council welcomes you to take part in this forum and to contribute to the discussion. For more information, or to reserve a seat (space is limited), please contact Karen Heins at karen.heins@ama-assn.org.
*Advancing patient-provider communication: Improving care, decreasing risk, and increasing joy at work (1 AMA PRA Category 1 Credits™)
8-9 a.m. Saturday, June 10, Crystal Ballroom B
Hosted by the AMA Organized Medical Staff Section (AMA-OMSS)

This session will present the key evidence that supports an increased institutional focus on patient-provider communication, share proven strategies to improve your practice, and give a brief overview of program designs that you can implement to educate providers within your organization.

*Responding to the impact of the opioid epidemic on women (1.5 AMA PRA Category 1 Credits™)
8:30-10 a.m. Saturday, June 10, Columbus I–J
Hosted by the AMA Women Physicians Section (AMA-WPS)

Deaths from prescription painkiller overdoses among women have increased more than 400% since 1999, compared to 265% among men. Biological differences and social factors may influence susceptibility to substance abuse in women, which could have implications for prevention and treatment. Learning how to recognize these differences will prepare you to identify at-risk patients and implement interventions to address opioid use disorder in women across various age, race, and socioeconomic spectrums.

Attendees will learn to differentiate between variables that increase the risk of addiction to prescription opioids in women; describe trends related to opioid prescribing, opioid use disorder, and unintentional overdose among adolescent girls and women; and identify ways to effectively manage pain and reduce opioid-related harm.

Featured speakers include Melinda Campopiano, MD, chief medical officer, Substance Abuse and Mental Health Services Administration; Mishka Terplan, MD, MPH, FACOG, FASAM, professor, Virginia Commonwealth University; Mary Anne McCaffree, MD, professor of pediatrics, University of Oklahoma; and Patrice Harris, MD, chair, AMA Board of Trustees. Claudia Reardon, MD, associate professor, University of Wisconsin School of Medicine and Public Health, will moderate the session.

*Apps for academic physicians: The hows and whys (1.25 AMA PRA Category 1 Credits™)
9-10:15 a.m. Saturday, June 10, Columbus C–D
Co-hosted by the AMA Academic Physicians Section (AMA-APS), the AMA International Medical Graduates Section (AMA-IMGS), and the AMA Senior Physicians Section (AMA-SPS)

Mobile devices have become commonplace in everyday life. The health care setting is no different, with a proliferation of medical software applications (apps) for physicians, patients, and medical students/trainees. This session will consider the development of innovations in medical education as well as apps and tools for academic physicians to help them better prepare students and residents to practice in a changing health care environment. In addition, participants will learn ways to integrate patient apps and data resulting from these apps into their practices and improve patient care, compliance, and communication. This session is aligned with the work of the AMA’s Accelerating Change in Medical Education initiative as well as AMA’s Professional Satisfaction and Practice Sustainability initiative, both of which seek to improve innovation and efficiency in medical education and medical practice, respectively.

Featured speakers include George Mejicano, MD, APS chair-elect; Michael Hodgkins, MD, MPH, AMA chief medical information officer; A. L. Jones, MD, MS, FACOEM, Young Physicians Section member and AMA HOD delegate, American College of Occupational and Environmental Medicine; and Arjun Gupta, medical student member of the Council on Medical Education.
*Are you leaving, too? Combating burnout (2.0 AMA PRA Category 1 Credits™)
9:15-11:15 a.m. Saturday, June 10, Crystal Ballroom B
Hosted by the AMA Organized Medical Staff Section (AMA-OMSS)

This session will describe the root causes of physician burnout and the prevalence of burnout at different career stages. The session will also examine how burnout may contribute to physician impairment and ultimately affect patient care. Finally, the session will teach you how to create a culture of prevention and wellness within your organization.

Health equity and the intersectionality of LGBTQ and minority health
10 a.m.-Noon, Saturday, June 10, Randolph 3
Co-hosted by the AMA Advisory Committee on Lesbian, Gay, Bisexual, Transgender, and Queer Issues (AMA-LGBTQ), the AMA Minority Affairs Section (AMA-MAS), and the AMA Medical Student Section (AMA-MSS) Minority Issues Committee

This forum will feature health professionals and advocates from Chicago who will discuss the intersectionality of minority and LGBTQ health. Divided into two sessions, the topics will focus on addressing housing, health disparities, and social determinants through public health and advocacy initiatives to achieve health equity.

Carl Streed, Jr., MD, AMA-LGBTQ chair will moderate the first session. Panelists will include David E. Munar, president and CEO of Howard Brown Health; Abbas Hyderi, MD, MPH, associate dean for curriculum and associate professor of clinical family medicine at the University of Illinois-Chicago College of Medicine; and Mona Noriega, MBA, MPH, commissioner for human relations, City of Chicago.

The second session will be moderated by Frank Clark, MD, AMA-MAS chair. Panelists will include Kim Hunt, executive director of Pride Action Tank; Maxx Boykin, community advocacy and social justice manager with the AIDS Foundation of Chicago; and Julie Morita, MD, commissioner of the Chicago Department of Public Health.

*Funding for accountability, sustainability and transparency in medical education: A proposed model for meeting physician workforce needs (1.25 AMA PRA Category 1 Credits™)
10:30-11:45 a.m. Saturday, June 10, Columbus C–D
Co-hosted by the AMA Academic Physicians Section (AMA-APS) and the AMA International Medical Graduates Section (AMA-IMGS)

As policy-makers and educators debate at national and state levels the structure and funding for graduate medical education, a wide-ranging new model for funding for GME holds promise. This all-payer system proposal, developed in Nebraska, encompasses funding for both undergraduate and graduate medical education, while increasing transparency and enhancing accountability, to meet the workforce needs of patients, both now and in the future. This approach provides a potential example for further innovation in GME funding.

Kelly Caverzagie, MD, associate dean for educational strategy, University of Nebraska College of Medicine, will outline the details of this model and describe its potential implications for availability of GME slots, meeting service needs of current patients, and addressing future workforce needs.

AMA Medical Specialty Showcase and Clinical Skills Workshop
11:30 a.m.-1:30 p.m. Saturday, June 10, Riverside Exhibit Hall
Hosted by the AMA Medical Student Section (AMA-MSS)

Over 45 of the specialties represented in the AMA House of Delegates will be in attendance to offer medical students an opportunity to speak with residents and physicians about various medical specialties and sub-
specialties, and to practice essential medical skills, such as suturing, casting, ultrasound, and airway management.

*Mindfulness interventions: A workshop to foster resiliency (1.5 AMA PRA Category 1 Credits™)
Noon-1:30 p.m. Saturday, June 10, Columbus K–L
Hosted by the AMA Senior Physicians Section (AMA-SPS)

Mindfulness—the process of bringing one’s attention to internal and external experiences occurring in the present moment—can be developed through the practice of meditation. Recent research has indicated a correlation between mindfulness and improved well-being, suggesting mindfulness can even help alleviate many mental and physical conditions. This session will explore how incorporating mindfulness interventions into your daily life can be effective in developing a healthy state of active and open attention to the present.

The featured speaker is Philip Cass, PhD, consultant, TLP Group Inc., Columbus, Ohio. The program will be introduced by Claire V. Wolfe, MD, delegate, AMA-SPS Governing Council, and moderated by Paul H. Wick, MD, chair-elect, AMA-SPS Governing Council.

Employment contracts: What you need to know
12:30-1:30 p.m. Saturday, June 10, Crystal Ballroom C
Hosted by the AMA Organized Medical Staff Section (AMA-OMSS)

Presented by a leading health law attorney, this session will help you understand the most important components of physician employment contracts, including how to structure your contract to maximize your future practice options.

†Current concepts in obesity medicine (1.5 AMA PRA Category 1 Credits™)
8–9:29 a.m. Monday, June 12, Regency Ballroom C
Hosted by the Obesity Medicine Association

Although our AMA recognized obesity as a disease in 2013, obesity rates continue to climb. Our AMA is in a unique position to leverage the evidence base about obesity and contribute to halting and reversing this epidemic. Dr. Ethan Lazarus is a nationally recognized expert in obesity treatment and is a diplomate of the American Board of Obesity Medicine. In this 90-minute presentation, learn how to perform an obesity assessment (beyond just calculating BMI), gain an understanding as to how the body resists weight loss and review the evidence on different treatment approaches including nutrition, physical activity, behavioral therapy, pharmacotherapy and surgery.

The Obesity Medicine Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Obesity Medicine Association designates this live activity for 1.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

*Physician Workforce and Immigration: Educational, Scientific, Institutional, and Patient Access Implications (1.5 AMA PRA Category 1 Credits™)
8-9:29 a.m. Monday, June 12, Crystal Ballroom A
Hosted by the AMA Council on Medical Education and cohosted by the AMA Academic Physicians Section, Council on Science and Public Health, Integrated Physician Practice Section, and Medical Student Section

The new administration’s recently issued executive orders regarding limitations on immigration have introduced great uncertainty into the lives of physicians in training, physician scientists, and administrators. Furthermore, while public understanding of the implications of these orders is not comprehensive, access to care would also be compromised in the short and long term should the orders be implemented as written.
This session aims to educate AMA members and leadership regarding the multiple implications of the proposed executive orders.

*Litigation Center Open Meeting (2.0 AMA PRA Category 1 Credits™)
9-11 a.m. Monday, June 12, Regency Ballroom A
Hosted by the Litigation Center of the American Medical Association and State Medical Societies

The meeting will discuss Freedom of Speech for physicians and how that freedom can be protected or infringed through litigation. A moot court panel will dramatize the legal arguments surrounding the Anthem/Cigna health insurance company merger. Also, updates will be provided on several ongoing AMA cases.

*The physician’s role in providing solutions to the opioid epidemic (1 AMA PRA Category 1 Credits™)
9-9:59 a.m. Monday, June 12, Regency Ballroom D
Hosted by the AMA Opioid Task Force

Even though the rate of opioid prescribing has declined, the misuse of prescription opioid medications continues to be associated with a high rate of emergency department visits, unintentional overdoses and deaths, and patients suffering from opioid use disorder and addiction. This program will address the physician’s role in providing solutions to what has been called the “opioid epidemic.” Attention has recently been devoted to associations between certain medical interventions, as well as the dose and duration of opioid prescriptions for acute pain, and the transition to long term opioid use in some patients.

One speaker, David Dickerson, MD, Director of the Acute Pain Service at The University of Chicago Medicine, will highlight how the university hospital is characterizing opioid prescribing across practice settings in the institution, positively influencing physician behavior in the use of opioids for pain management, and effectively encouraging patient disposal of unused prescription opioid supplies. With respect to patients with opioid use disorder, Sarah Wakeman, MD, Director of the Substance Use Disorder Initiative at Massachusetts General Hospital, will review evidence demonstrating the effectiveness of treatments for opioid use disorder, and offer practical guidance on how physicians can provide solutions to the opioid epidemic through treatment, across various practice settings. Patrice A. Harris, MD, MA, Chair of the AMA Opioid Task Force and the AMA Board of Trustees will serve as moderator.

*DPP Easy as 1-2-3? 21st Century options for implementing diabetes prevention in practice (1.5 AMA PRA Category 1 Credits™)
9:30-11 a.m. Monday, June 12, Regency Ballroom C
Hosted by the AMA’s Improving Health Outcomes unit

Eighty-six million American adults have prediabetes, but only 10 percent are aware of it. Patients with prediabetes are at high risk for progressing to type 2 diabetes. There is a need to increase awareness among health care providers about diabetes prevention, the importance of identifying patients with prediabetes, and the value of implementing a process for referring patients to evidence-based lifestyle change programs. CDC-recognized diabetes prevention programs have been proven to reduce the incidence of patients developing type 2 diabetes by 58 percent. There are more than 1300 community-based and virtual programs available, and yet physicians are unaware of the availability or how to identify their eligible patients. If prediabetes is not addressed in the clinical practice, there will be a 32 percent increase of patients with type 2 diabetes by 2020.

Get an up-close look inside a virtual diabetes prevention program and learn how you can implement strategies in your practice to prevent the incidence of type 2 diabetes within your patient population. At this session, you will be able to put yourself in the patient’s shoes. Through smartphone technology, Carolyn Bradner Jasik, MD, Medical Director at Omada, will take you through a virtual diabetes prevention program module to see first-hand what patients experience as they adopt new lifestyle habits to help them live
healthier lives. Participants will also learn how they can create their own diabetes prevention program within their practice from Robert Jackson, MD, family physician at Western Wayne.

For additional information, contact Stephanie Johnson at stephanie.johnson@ama-assn.org or 312.464.5921.

*CEJA Open Forum (1.5 AMA PRA Category 1 Credits™)
9:30-11 a.m. Monday, June 12, Crystal Ballroom A
Hosted by the Council on Ethical and Judicial Affairs

The Open Forum will be open to all AMA members, interested non-members, other guests, and the press. The first hour will cover judicial function and medical records. Attendees will participate in an engaging exercise where they will “adjudicate” two example cases of lapses in medical record keeping. For the last half hour, attendees are invited to introduce emerging ethical issues that may warrant attention from CEJA and inclusion in the AMA Code of Medical Ethics.

Learning Objectives
- Explain the different actions CEJA can take against a physician who does not maintain good patient records
- Describe the nature and scope of CEJA’s role in disciplinary action in adjudicating fitness for membership of physicians who do not maintain good patient records
- Identify key questions for assessing alleged ethical lapses related to record-keeping
- Clarify how poor record-maintenance is a form of professional misconduct and an ethical issue that can pose harms to patients

†Cultivating and protecting your digital presence: Do’s and don’ts of social media (1 AMA PRA Category 1 Credits™)
10-11 a.m. Monday, June 12, Regency Ballroom B
Hosted by the Surgical Caucus of the AMA

This program will describe the value of personal and professional branding through social media for the practicing physician; discuss the importance of strong cybersecurity processes to protect both physician and patient data; and examine practical methods for building and protecting a social media reputation.

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The American College of Surgeons designates this live activity for a maximum of 1 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

*Health systems science: The emerging third pillar of physician education (1 AMA PRA Category 1 Credits™)
10-11 a.m. Monday, June 12, Regency Ballroom D
Hosted by the AMA Accelerating Change in Medical Education Consortium

The need for physicians, including those currently in practice, to understand health systems science has emerged from the work of the AMA Accelerating Change in Medical Education Consortium. This session will serve as an introduction to health systems science, describing the selection of curricular topics such as value-based care, quality improvement, teamwork, leadership, and population health along with other topics that can improve physician practice, system performance and patient outcomes. In addition, presenters will describe novel experiential opportunities for medical students to learn health systems science, as well as the need for faculty development and continuing education for practicing physicians in this subject area. Presenters will outline the role of the consortium in preparing medical students to become systems-ready physicians engaged in lifelong learning. For additional information contact Victoria Stagg Elliott at 312.464.4459 or victoria.elliott@ama-assn.org.
Section and special group events

Section-sponsored events during the 2017 Annual Meeting
Annual Meeting participants are welcome to attend AMA section and special group meetings and events. For additional information on these member group activities, visit ama-assn.org/about-us/member-sections-group.

Doctors Back to School™—Improving health outcomes together
7:45-11:45 a.m. Friday, June 9. Roundtrip bus transportation to a local high school departs from the East Tower Lobby of the Hyatt Regency Chicago.
Hosted by the AMA Minority Affairs Section (AMA-MAS)

AMA Young Physicians Section (AMA-YPS) assembly meeting
8:30 a.m.-5 p.m. Friday, June 9, Crystal Ballroom C

AMA International Medical Graduates Section (AMA-IMGs) and AMA Minority Affairs Sections (AMA-MAS) candidates’ forum
3-4:20 p.m. Friday, June 9, Columbus G

AMA Minority Affairs Section (AMA-MAS) reception and business meeting
4:30-6 p.m. Friday, June 9, Columbus K–L

AMA Advisory Committee on Lesbian, Gay, Bisexual, Transgender, and Queer Issues (AMA-LGBTQ) and Allies caucus and reception
5:30-7 p.m. Friday, June 9, Plaza B

AMA Senior Physicians Section (AMA-SPS) luncheon and business meeting
11:30 a.m.-Noon Saturday, June 10, Columbus K–L

AMA International Medical Graduates Section (AMA-IMGs) congress and reception
5:30-7:30 p.m. Saturday, June 10, Columbus G

AMA Women Physicians Section (AMA-WPS) business meeting and reception
5:30-7:30 p.m. Saturday, June 10, Columbus E–F

11th annual Desserts from Around the World reception
9:30-11 p.m. Saturday, June 10, Crystal Ballroom A–B
Hosted by the AMA International Medical Graduates Section (AMA-IMGs)

AMA Young Physicians Section (AMA-YPS) caucus
6-7 p.m. Sunday, June 11, San Francisco

AMA International Medical Graduates Section (AMA-IMGs) and AMA Minority Affairs Section (AMA-MAS) delegates caucus
8:30-9:30 a.m., Monday, June 12, Skyway 273

AMA Medical Student Section (AMA-MSS), AMA Resident and Fellow Section (AMA-RFS), and AMA Young Physicians Section (AMA-YPS) joint caucus
9:30–11 a.m. Monday, June 12, Crystal Ballroom B–C

Busharat Ahmad, MD, leadership development program
10:30-11:30 a.m. Monday, June 12, Roosevelt
Hosted by the AMA International Medical Graduates Section (AMA-IMGs)
AMA Women Physicians Section (AMA-WPS) Associates luncheon and business session
11:30 a.m.-1 p.m. Monday, June 12, Columbus H

Exhibits

AMA exhibits
Visit the AMA exhibit area outside the Grand Ballroom for 15 minute demos on exciting new programs and digital resources available to AMA members. You can also pick up a free gift and share feedback with AMA staff.

Enjoy your free coffee on the following days and times:
- Saturday, June 10: 10 a.m. to 6 p.m.
- Sunday, June 11: 7:30 a.m. to 11:30 a.m.
- Monday, June 12: 10 a.m. to 6 p.m.
- Tuesday, June 13: 7:30 a.m. to 12 p.m.

AMA Foundation booth
Please visit the AMA Foundation booth to learn how the Foundation is building an engaged network of physicians and communities to collaborate on creating community health programs that provide targeted, measurable improvements to our health. Last year, the Foundation distributed nearly $1 million in grants and scholarships to outstanding medical students and public health initiatives.

Today, the AMA Foundation is working to identify the best models of health care practice and education, which can be taken to scale throughout the country, while developing the physician leaders who can guide the future of their profession and provide the highest-quality care to our most underserved communities. Support their mission to bring together physicians and communities to improve the nation’s health by making a gift. For additional information, please call 312.464.4200.

Special Events

AMA Foundation Excellence in Medicine Awards dinner
The AMA Foundation’s Excellence in Medicine Awards program recognizes physicians who exemplify the highest values of volunteerism, leadership, and dedication to underserved populations. The awards include The Jack B. McConnell, MD, Award for Excellence in Volunteerism, the Pride in the Profession Award, the Dr. Debasish Mridha Spirit of Medicine Award, and the Dr. Nathan Davis International Award in Medicine. The Excellence in Medicine Program is made possible in part through the generous support of Pfizer, PhRMA, and Novo Nordisk.

The dinner is from 7:30 to 9 p.m. Friday, June 9 in the Ivy Room at 12 East Ohio Street. Tickets are available for purchase for $160 per person or a table of 10 for $1500. To purchase, please contact Katherine Perkins by email at katherine.perkins@ama-assn.org or phone 312.464.4218.

AMA Foundation donor reception to celebrate and honor donors
The AMA Foundation Annual Donor Reception recognizes and thanks the generous supporters who made a new gift or pledge in 2016 or 2017. Last year, you made it possible for the AMA Foundation to award scholarships to almost forty outstanding medical students, support grassroots public health projects in underserved communities around the country, and provide seed grants for nearly thirty research projects in the areas of cardiovascular/pulmonary diseases, HIV/AIDS, pancreatic cancer, and neoplastic diseases.

Please join the Foundation in celebration 6–7 p.m. Friday, June 9 in Crystal Ballroom A. If you’ve not already done so, please renew your annual support today, and join your friends and colleagues at this special reception.
If you received an invitation by mail, RSVP by June 1. If you did not receive an invitation but wish to attend the event, email amafoundation@ama-assn.org or call 312.464.4200 to make a donation and RSVP for the reception.

**Ron Davis Memorial 5K run/walk**
The 7th Annual Ron Davis Memorial 5K run/walk will take place at 6 a.m. Saturday, June 10. Interested parties should meet near the motor entrance on the Gold Level in the East Tower of the Hyatt Regency Chicago. This is a self-guided event along the lake shore.

**Catholic Mass**
Father Dan Costello will celebrate Catholic Mass at 6:30 p.m. Saturday, June 10 in Columbus I–J.

**AMA Foundation Student Ambassador Raffle**
The AMA Foundation Student Ambassadors will conduct a raffle during the annual meeting with the proceeds benefiting the AMA Foundation. The winner will receive a Hawaii-themed package that would be ideal for redemption during the AMA Interim Meeting. Look for their tropical attire to purchase tickets, which will be sold throughout the meeting and during the Annual Donor Reception. The winner will be announced prior to the meeting’s close.

NOTES
The following list is provided for your convenience.

All items mentioned in the Speakers’ Letter are included.

(Items listed in bold are official AMA-HOD sessions, reference committees or programs.)

All events are at the Hyatt Regency Chicago unless indicated by italics.

Activities offering continuing medical education credit are preceded by an asterisk (*) or dagger (†).

### Thursday, June 8

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location†</th>
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<tbody>
<tr>
<td>7 a.m.–7 p.m.</td>
<td>Childcare availability</td>
<td>Reservations required</td>
</tr>
<tr>
<td>5 p.m.</td>
<td>Deadline for receipt of not-for-official-business items</td>
<td>AMA staff area</td>
</tr>
</tbody>
</table>

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<tr>
<td>7 a.m.–7 p.m.</td>
<td>AMA-HOD registration</td>
<td>Grand Foyer</td>
</tr>
<tr>
<td>7 a.m.–7 p.m.</td>
<td>Childcare availability</td>
<td>Reservations required</td>
</tr>
<tr>
<td>7:45–11:45 a.m.</td>
<td>Doctors Back to School™</td>
<td>Depart East Tower Lobby</td>
</tr>
<tr>
<td>8–9:30 a.m.</td>
<td>Emerging issues in medical staff affairs</td>
<td>Crystal Ballroom B</td>
</tr>
<tr>
<td>8 a.m.–5 p.m.</td>
<td>AMA-yps Assembly</td>
<td>Crystal Ballroom C</td>
</tr>
<tr>
<td>9–10 a.m.</td>
<td>*When the dust settles, what’s new and what’s not?</td>
<td>Crystal Ballroom A</td>
</tr>
<tr>
<td>9:45–10:45 a.m.</td>
<td>*Emails, texts and social media: What physicians need to know</td>
<td>Crystal Ballroom B</td>
</tr>
<tr>
<td>10 a.m.–12:15 p.m.</td>
<td>*Where health systems are looking for profitable growth</td>
<td>Crystal Ballroom A</td>
</tr>
<tr>
<td>2–5 p.m.</td>
<td>OSMAP membership meeting and general session</td>
<td>Crystal Ballroom A</td>
</tr>
<tr>
<td>2:30–3:45 p.m.</td>
<td>*Health system consolidation: How big is big enough (or too big)?</td>
<td>Crystal Ballroom A</td>
</tr>
<tr>
<td>3–4:20 p.m.</td>
<td>AMA-IMGS &amp; AMA-MAS candidate forum</td>
<td>Columbus G</td>
</tr>
<tr>
<td>3:50 p.m.</td>
<td>*Council on Medical Education Stakeholders’ Forum – Leadership</td>
<td>Toronto</td>
</tr>
<tr>
<td>4:30–6 p.m.</td>
<td>AMA-MAS reception and business meeting</td>
<td>Columbus K–L</td>
</tr>
<tr>
<td>5 p.m.</td>
<td>OSMAP reception</td>
<td>Plaza B</td>
</tr>
<tr>
<td>7:30–9 p.m.</td>
<td>AMA Foundation Excellence in Medicine Awards Dinner</td>
<td>Ivy Room, 12 East Ohio</td>
</tr>
</tbody>
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### Friday, June 9

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<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>6 a.m.</td>
<td>Ron Davis Memorial run/walk</td>
<td>Motor entrance, east tower</td>
</tr>
<tr>
<td>7–9:30 a.m.</td>
<td>Surgical Caucus Handbook review</td>
<td>Comiskey Room</td>
</tr>
<tr>
<td>7 a.m.–6 p.m.</td>
<td>AMA-HOD registration</td>
<td>Grand Foyer</td>
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<tr>
<td>7 a.m.–7 p.m.</td>
<td>Childcare availability</td>
<td>Reservations required</td>
</tr>
<tr>
<td>8–9 a.m.</td>
<td>Advancing patient-provider communication: Improving care, decreasing risk, and increasing joy at work</td>
<td>Crystal Ballroom B</td>
</tr>
<tr>
<td>8:30–10 a.m.</td>
<td>*Responding to the impact of the opioid epidemic on women</td>
<td>Columbus I–J</td>
</tr>
<tr>
<td>9–10:15 a.m.</td>
<td>*Apps for academic physicians: The hows and whys</td>
<td>Columbus C–D</td>
</tr>
<tr>
<td>9:15–11:15 a.m.</td>
<td>*Are you leaving, too? Combating burnout</td>
<td>Crystal Ballroom B</td>
</tr>
<tr>
<td>10–11:30 a.m.</td>
<td>CEJA open house</td>
<td>Columbus I–J</td>
</tr>
<tr>
<td>10 a.m.–noon</td>
<td>Health equity and the intersectionality of LGBTQ and minority health</td>
<td>Randolph 3</td>
</tr>
<tr>
<td>10:30–11:45 a.m.</td>
<td>*Funding for accountability, sustainability and transparency in medical education: A proposed model for meeting physician workforce needs</td>
<td>Columbus C–D</td>
</tr>
<tr>
<td>11:30 a.m.–1:30 p.m.</td>
<td>AMA Medical Specialty Showcase and Clinical Skills Workshop</td>
<td>Riverside Exhibit Hall</td>
</tr>
<tr>
<td>Noon–1:30 p.m.</td>
<td>*Mindfulness interventions: A workshop to foster resiliency</td>
<td>Columbus K–L</td>
</tr>
<tr>
<td>11:30 a.m.–1:30 p.m.</td>
<td>Employment contracts: What you need to know (time change)</td>
<td>Crystal Ballroom C</td>
</tr>
<tr>
<td>2–6 p.m.</td>
<td>HOD opening session; president-elect debate</td>
<td>Grand Ballroom</td>
</tr>
<tr>
<td>5–6 p.m. (after HOD)</td>
<td>Academic Medicine Caucus</td>
<td>Water Tower</td>
</tr>
<tr>
<td>5:30–7:30 p.m.</td>
<td>AMA-IMGS Congress and reception</td>
<td>Columbus G</td>
</tr>
<tr>
<td>5:30–7:30 p.m.</td>
<td>AMA-yps business meeting and reception</td>
<td>Columbus E–F</td>
</tr>
<tr>
<td>6:30 p.m.</td>
<td>Catholic Mass</td>
<td>Columbus I–J</td>
</tr>
<tr>
<td>9:30–11 p.m.</td>
<td>AMA-IMGS desserts from around the world</td>
<td>Crystal Ballroom A–B</td>
</tr>
</tbody>
</table>

### Saturday, June 11

<table>
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<tr>
<th>Time</th>
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<td>Columbus I–J</td>
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<td>9–10:15 a.m.</td>
<td>*Apps for academic physicians: The hows and whys</td>
<td>Columbus C–D</td>
</tr>
<tr>
<td>9:15–11:15 a.m.</td>
<td>*Are you leaving, too? Combating burnout</td>
<td>Crystal Ballroom B</td>
</tr>
<tr>
<td>10–11:30 a.m.</td>
<td>CEJA open house</td>
<td>Columbus I–J</td>
</tr>
<tr>
<td>10 a.m.–noon</td>
<td>Health equity and the intersectionality of LGBTQ and minority health</td>
<td>Randolph 3</td>
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<tr>
<td>10:30–11:45 a.m.</td>
<td>*Funding for accountability, sustainability and transparency in medical education: A proposed model for meeting physician workforce needs</td>
<td>Columbus C–D</td>
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<td>Riverside Exhibit Hall</td>
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<tr>
<td>Noon–1:30 p.m.</td>
<td>*Mindfulness interventions: A workshop to foster resiliency</td>
<td>Columbus K–L</td>
</tr>
<tr>
<td>11:30 a.m.–1:30 p.m.</td>
<td>Employment contracts: What you need to know (time change)</td>
<td>Crystal Ballroom C</td>
</tr>
</tbody>
</table>

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</tr>
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<tbody>
<tr>
<td>7 a.m.–6 p.m.</td>
<td>AMA-HOD registration</td>
<td>Grand Foyer</td>
</tr>
<tr>
<td>7 a.m.–7 p.m.</td>
<td>Childcare availability</td>
<td>Reservations required</td>
</tr>
<tr>
<td>8–8:30 a.m.</td>
<td><strong>HOD second session</strong></td>
<td><strong>Grand Ballroom</strong></td>
</tr>
<tr>
<td>8:30 a.m.–noon</td>
<td>Reference Committee A</td>
<td>Regency Ballroom A</td>
</tr>
<tr>
<td>8:30 a.m.–noon</td>
<td>Reference Committee C</td>
<td>Regency Ballroom C</td>
</tr>
<tr>
<td>8:30 a.m.–noon</td>
<td>Reference Committee E</td>
<td>Regency Ballroom D</td>
</tr>
<tr>
<td>8:30 a.m.–noon</td>
<td>Reference Committee F</td>
<td>Grand Ballroom</td>
</tr>
<tr>
<td>1:30–5 p.m.</td>
<td>Reference Committee on Amendments to Constitution and Bylaws</td>
<td>Regency Ballroom C</td>
</tr>
<tr>
<td>1:30–5 p.m.</td>
<td>Reference Committee B</td>
<td>Regency Ballroom B</td>
</tr>
<tr>
<td>1:30–5 p.m.</td>
<td>Reference Committee D</td>
<td>Regency Ballroom D</td>
</tr>
<tr>
<td>1:30–5 p.m.</td>
<td>Reference Committee G</td>
<td>Regency Ballroom A</td>
</tr>
<tr>
<td>6–7 p.m.</td>
<td>AMA-YPS caucus</td>
<td>San Francisco</td>
</tr>
</tbody>
</table>

**Monday, June 12**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location†</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 a.m.–6 p.m.</td>
<td>AMA-HOD registration</td>
<td>Grand Foyer</td>
</tr>
<tr>
<td>7 a.m.–7 p.m.</td>
<td>Childcare availability</td>
<td>Reservations required</td>
</tr>
<tr>
<td>8–9:29 a.m.</td>
<td><strong>Physician Workforce and Immigration: Educational, Scientific, Institutional, and Patient Access Implications</strong></td>
<td>Regency Ballroom C</td>
</tr>
<tr>
<td>8:30–9:30 a.m.</td>
<td>AMA-IMGS delegate caucus</td>
<td>Skyway 273</td>
</tr>
<tr>
<td>9–11 a.m.</td>
<td>*Litigation Center Open Meeting</td>
<td>Regency Ballroom A</td>
</tr>
<tr>
<td>9–9:59 a.m.</td>
<td>*The physician’s role in providing solutions to the opioid epidemic</td>
<td>Regency Ballroom D</td>
</tr>
<tr>
<td>9:30–10 a.m.</td>
<td>Academic Medicine Caucus</td>
<td>Columbus H</td>
</tr>
<tr>
<td>9:30–11 a.m.</td>
<td>*CEJA Open Forum</td>
<td>Crystal Ballroom A</td>
</tr>
<tr>
<td>9:30–11 a.m.</td>
<td>AMA-MSS, AMA-RFS &amp; AMA-YPS joint caucus</td>
<td>Crystal Ballroom B–C</td>
</tr>
<tr>
<td>10–11 a.m.</td>
<td>*Cultivating and protecting your digital presence: Do’s and don’ts of social media</td>
<td>Regency Ballroom B</td>
</tr>
<tr>
<td>10–11 a.m.</td>
<td>*Health systems science: The emerging third pillar of physician education</td>
<td>Regency Ballroom D</td>
</tr>
<tr>
<td>10–11:30 a.m.</td>
<td>Private Practice Physician Congress</td>
<td>Columbus I–J</td>
</tr>
<tr>
<td>10:30–11:30 a.m.</td>
<td>Busharat Ahmad, MD, leadership development program</td>
<td>Roosevelt</td>
</tr>
<tr>
<td>11:30 a.m.–1 p.m.</td>
<td>AMA-WPS Associates luncheon and business session</td>
<td>Columbus H</td>
</tr>
<tr>
<td>2–6 p.m.</td>
<td><strong>HOD business session</strong></td>
<td><strong>Grand Ballroom</strong></td>
</tr>
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**Tuesday, June 13**

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>7 a.m.–6 p.m.</td>
<td>AMA-HOD registration</td>
<td>Grand Foyer</td>
</tr>
<tr>
<td>7 a.m.–7 p.m.</td>
<td>Childcare availability</td>
<td>Reservations required</td>
</tr>
<tr>
<td>7:30–8:45 a.m.</td>
<td>Elections</td>
<td>Columbus K–L</td>
</tr>
<tr>
<td>9 a.m.–3 p.m.</td>
<td><strong>HOD business session</strong></td>
<td><strong>Grand Ballroom</strong></td>
</tr>
<tr>
<td>5 p.m.</td>
<td>Inaugural, David O. Barbe, MD</td>
<td>Crystal Ballroom</td>
</tr>
<tr>
<td>6:30 p.m.</td>
<td>Inaugural reception</td>
<td>Grand Ballroom Foyer</td>
</tr>
<tr>
<td>7 p.m.</td>
<td>Inaugural dinner dance</td>
<td>Grand Ballroom</td>
</tr>
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</table>

**Wednesday, June 14**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location†</th>
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</thead>
<tbody>
<tr>
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<td>7 a.m.–noon</td>
<td>Childcare availability</td>
<td>Reservations required</td>
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<tr>
<td>9 a.m.–noon</td>
<td><strong>HOD business session</strong></td>
<td><strong>Grand Ballroom</strong></td>
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</tbody>
</table>
Join us at the American Medical Association International Medical Graduates (IMG) Section Annual Meeting. This meeting commemorates the 20th year of the AMA-IMG Section. We encourage you to invite a colleague or friend to attend and share in the AMA-IMG Section’s valuable information sessions.

**Meeting highlights include:**

- **AMA-IMG and AMA Minority Affairs sections candidates forum**
  3 p.m., Friday, June 9—Columbus G
  Meet the candidates who are running for an AMA Board of Trustees position. The candidate’s forum is cosponsored by the Minority Affairs Section.

- **Cosponsored educational sessions by the AMA Academic Physicians and AMA-IMG sections**
  9–11:45 a.m., Saturday, June 10—Columbus C/D
  Come learn about the “Apps for Academic Physicians: The Hows and Whys” and “Funding for Accountability, Sustainability and Transparency in Medical Education: A Proposed Model for Meeting Physician Workforce Needs.”

- **AMA-IMG Section reception and congress**
  5:30–7:30 p.m., Saturday, June 10—Columbus G
  Join us as we celebrate the 20th anniversary of the AMA-IMG Section and hear a Washington Update by AMA’s Government Affairs staff. Additional discussions will include organizational reports and resolutions being considered at the 2017 AMA Annual Meeting. Don’t miss the opportunity to share your comments on those resolutions being considered for the meeting.

- **11th annual “Desserts From Around the World” reception**
  9:30–11 p.m., Saturday, June 10—Crystal Ballroom
  Each year this event gets bigger and tastier! Join us and try new and exciting ethnic desserts. You are also welcome to be a sponsor for this event. For more information, contact img@ama-assn.org.

- **Reference Committee hearings**
  8:30 a.m.—5 p.m., Sunday, June 11
  Participate and hear reference committee deliberations on AMA House of Delegates reports and resolutions.

- **AMA-IMG and AMA Minority Affairs sections delegates caucus**
  8:30–9:30 a.m., Monday, June 12—Skyway 273
  Meet your respective section delegates and discuss the strategies for deliberations on various reference committee reports and resolutions.

- **Busharat Ahmad, MD, Leadership Development Program**
  10:30–11:30 a.m., Monday, June 12—Roosevelt 3 A/B
  Learn how to improve your leadership skills to become an effective leader in your organization.

**Make plans to attend today!** To register, visit ama-assn.org/sections-meeting-registration. Email img@ama-assn.org or call the AMA-IMG Section at (312) 464-5397 if you have questions.
2017 AMA International Medical Graduates Section Annual Meeting

June 9–12
Hyatt Regency Chicago
Chicago

Join us at the American Medical Association International Medical Graduates (IMG) Section Annual Meeting. This meeting commemorates the 20th year of the AMA-IMG Section. We encourage you to invite a colleague or friend to attend and share in the AMA-IMG Section's valuable information sessions.

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Learn how to improve your leadership skills to become an effective leader in your organization.

Make plans to attend today! To register, visit ama-assn.org/sections-meeting-registration.
Email img@ama-assn.org or call the AMA-IMG Section at (312) 464-5397 if you have questions.

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Tasty desserts with an international flair and live entertainment!

Hosted by the AMA International Medical Graduates (IMG) Section

9:30 p.m.
Saturday, June 10

Crystal Ballroom
Hyatt Regency Chicago

Email img@ama-assn.org with questions.
2017 AMA Minority Affairs Section Annual Meeting

**Addressing intentional violence through a public health lens**
Room: Columbus K/L
4:30–6 p.m. | Friday, June 9
Reception and business meeting

*Selwyn Rogers, MD, MPH*
University of Chicago Medicine Trauma Center

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**Health equity and the intersectionality of minority and LGBTQ health**
Room: Randolph 3
10 a.m.–noon | Saturday, June 10

**Session 1 (10–11 a.m.)**
Moderator
*Carl G. Streed Jr., MD*
AMA Advisory Committee on LGBTQ Issues

Panelists
*Abbas Hyderi, MD, MPH*
University of Illinois at Chicago College of Medicine
*David Ernesto Munar*
Howard Brown Health
*Mona Noriega, MBA, MPA*
Chicago Commission on Human Relations

**Session 2 (11 a.m.–noon)**
Moderator
*Frank A. Clark, MD*
Governing Council, AMA-MAS

Panelists
*Maxx Boykin*
AIDS Foundation of Chicago
*Kim Hunt*
Pride Action Tank
*Julie Morita, MD, MPH*
Chicago Department of Public Health

---

Co-sponsors
AMA Minority Affairs Section
AMA Advisory Committee on LGBTQ Issues
AMA Medical Student Section Minority Issues Committee
Plan to attend!

2017 AMA Senior Physicians Section Annual Meeting

Saturday, June 10
Hyatt Regency
Chicago
Columbus K/L

The American Medical Association Senior Physicians Section (SPS) invites you to our assembly and educational program held in conjunction with the 2017 AMA Annual Meeting. We hope you can join us and enjoy the fellowship of your senior physician colleagues.

Noon–1:30 p.m.
Mindfulness interventions: A workshop to foster resiliency
Approved for 1.5 AMA PRA Category 1 Credits™

 Introduced by: Claire V. Wolfe, MD, AMA-SPS Governing Council
Speaker: Philip Cass, PhD, consultant, TLP Group Inc., Columbus, Ohio
Moderator: Paul H. Wick, MD, chair-elect, AMA-SPS Governing Council

Program description
Mindfulness—the process of bringing one's attention to internal and external experiences occurring in the present moment—can be developed through the practice of meditation. Recent research has indicated a correlation between mindfulness and improved well-being, suggesting mindfulness can even help alleviate many mental and physical conditions. This session will explore how incorporating mindfulness interventions into your daily life can be effective in developing a healthy state of active and open attention to the present.

Objectives
• Review the latest understanding of the effects that mindfulness meditation has on the brain.
• Assess the implications mindfulness meditation has for physicians in their practice of medicine.
• Evaluate how to incorporate mindfulness techniques in daily life.
• Practice three easy-to-implement mindfulness techniques.

Assembly meeting
The AMA–SPS extends an open invitation to all physicians 65 years of age and above to attend our business meeting right before the mindfulness workshop. The AMA-SPS will discuss AMA House of Delegates' business items and future AMA-SPS activities.

A light lunch will be offered at 11:30 a.m. – first come, first served!
Visit ama-assn.org/senior-physicians-section to learn more.

*The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The American Medical Association designates this live activity for a maximum of 1.5 AMA PRA Category Credits™. Physicians should claim only the credit commensurate with the extent of their participation in this activity.
Plan to attend!

2017 AMA Women Physicians Section Annual Meeting

Saturday, June 10
Hyatt Regency Chicago

The American Medical Association Women Physicians Section (AMA-WPS) Annual Meeting offers a unique opportunity to network with physicians from across the country and meet leaders from state societies, specialty societies and the AMA. Please plan to attend.

8:30–10 a.m.
Responding to the impact of the opioid epidemic on women
Approved for 1.5 AMA PRA Category 1 Credits™
Columbus I/J room
Moderator: Claudia Reardon, MD, Associate Professor, University of Wisconsin School of Medicine
Speakers:
• Melinda Campopiano, MD, Chief Medical Officer, Substance Abuse and Mental Health Services Administration
• Mishka Terplan, MD, MPH, FACOG, FASAM, Professor, Virginia Commonwealth University
• Mary Anne McCaffree, MD, Professor of Pediatrics, University of Oklahoma College of Medicine
• Patrice Harris, MD, Chair, AMA Board of Trustees

Program description:
Attendees will learn to: differentiate between variables that increase the risk of addiction to prescription opioids in women; describe trends related to opioid prescribing, opioid use disorder, and unintentional overdose among adolescent girls and women; and identify ways to effectively manage pain and reduce opioid-related harm.

5:30–7:30 p.m.
Business meeting and reception
Columbus E/F room

The meeting will feature dynamic presentations and a review of the AMA House of Delegates Handbook.

Monday, June 12
Columbus H room
11:30 a.m.–1 p.m.

AMA-WPS Associates lunch and business meeting

Participants will discuss current and emerging issues impacting the professional lives of women physicians and women’s health issues. The discussion will also include details on Women in Medicine Month, taking place in September.
You’re invited to participate in an AMA-IMG Section event

Busharat Ahmad, MD, Leadership Development Program

10:30–11:30 a.m.
Monday, June 12
Roosevelt 3 A/B
Hyatt Regency Chicago
Chicago

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.

The leadership development program, which commemorates Dr. Ahmad’s guidance and commitment to organized medicine, consistently brings dynamic speakers to the AMA Annual and Interim Meetings.

Featured presentation and speaker

“Physicians as leaders in an age of uncertainty”
Peter Angood, MD, CEO/president
American Association of Physician Leadership

All 2017 American Medical Association Annual Meeting attendees are welcome to attend this program designed to develop individuals who aspire to be leaders during these uncertain times in health care.

For more information, email img@ama-assn.org or call the AMA-IMG Section at (312) 464-5397.

This event is cosponsored by the AMA Minority Affairs Section.