2001 ANNUAL REPORT

Accreditation
Council
for
Graduate
Medical
Education

The ACGME members are:

American Board of Medical Specialties
American Hospital Association
American Medical Association
Association of American Medical Colleges
Council of Medical Specialty Societies

The Accreditation Council for Graduate Medical Education is responsible for evaluating and accrediting residency programs in the United States. We are a private-sector council operating under the aegis of five medical organizations.

Most importantly we act as a catalyst, bringing together knowledgeable healthcare practitioners, educators and administrators to resolve critical issues concerning graduate medical training.

The volunteers who participate in our Residency Review Committees are key to the efficacy of our process. Through their work we directly influence the quality of graduate medical education, the quality of healthcare institutions and, ultimately, the quality of medicine in America. Because of them the ACGME is improving the pattern of medical education and the course of patient care.

From left to right: Computer Information Services staff: John Nylen, COO & Director of Computer Information Services; Kathleen Colella, Data Administrator; Herbert Gentry, Network Administrator; David Leach, M.D., Executive Director of the ACGME; Brenda Trevino, Help Desk Specialist.

ACGME Mission Statement

The mission of the ACGME is to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians in training. The ACGME establishes national standards for graduate medical education by which it approves and continually assesses educational programs under its aegis. It uses the most effective methods available to evaluate the quality of graduate medical education programs. It strives to improve evaluation methods and processes that are valid, fair, open and ethical.

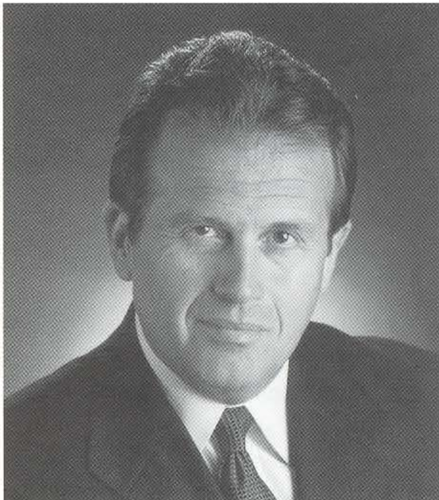
In carrying out these activities the ACGME is responsive to change and innovation in education and current practice, promotes the use of effective measurement tools to assess resident physician competency, and encourages educational improvement.

ACGME Vision Statement

The ACGME will:

- Be a source of inspiration, encouragement, support and assistance to all who strive for educational excellence;
- Incorporate educational outcomes into accreditation decisions;
- Be data and evidence driven;
- Encourage the development of core competencies across all disciplines, including knowledge of quality improvement;
- Explore a more comprehensive role in GME policy;
- Become a world leader in accreditation efforts;
- Maintain objectivity and independence while continuing its interorganizational relationships;
- Develop a consultative role and encourage innovation.
- Be the spokesperson for GME

MESSAGE FROM THE CHAIR



The events of last September have caused many of us to re-examine various salutary elements of our society that we have heretofore taken for granted. Those of us involved in Graduate Medical Education are certainly not immune from this reflective imperative...Indeed, the chilling reality is that the destruction of the World Trade Center and the shattering of our peaceful paradigm occurred at the very time the ACGME board was meeting in Chicago.

In the pensive days since, it has occurred to me that the self-regulatory approach we have historically enjoyed to promote the highest quality of Graduate Medical Education is under siege, at least metaphorically, in much the same way those twin pillars of freedom in New York City were under attack. These attacks, while less blatant, originate from within our community as well as from outside forces, and, in my judgment, are certain to escalate in the months and years ahead.

To be sure, society has long entrusted to medicine the responsibility of training and monitoring, and even disciplining its own members. This ethos has not only resulted in unparalleled academic and professional freedom for American Medicine, but also inherently vests a substantial public obligation. But as we enter the new millennium, vocal sectors of our society appear to now be questioning that vaunted position and calling for expanded oversight of the professional development of physicians.

Perhaps a harbinger of this awakened interest was the controversial and challenging report issued by the Institute of Medicine on the safety of patient care in America. This report not only gave rise to generic concerns about the performance of our nation's health-care system, but also challenged the very credentials of those whom society has asked to care for them. This sentinel report was followed shortly by the National Labor Relations Board determination that resident physicians in private hospitals were subject to NLRB regulations and thus are to be seen more as employees than as learners.

Most recently federal legislation has now surfaced that is intended to limit or restrict residents' duty hours. This initiative, if enacted as proposed, would doubtless have wide-sweeping implications not only for the clinical experience of our trainees, but also for the very core and fabric of Graduate Medical Education and the institutions that sponsor this training.

Viewed in the collective, our public accountability and indeed, our very esteem are being questioned in unprecedented ways, demanding a swift and decisive response from Academic Medicine. In fact, all of us engaged in the provision, coordination or oversight of Graduate Medical Education shoulder a shared responsibility to critically reexamine associated structures, processes and communications to assure that the expectations and ideals of the various publics we serve are fully accommodated.

As we embrace this challenge, it is incumbent upon those of us who are ultimately accountable for Graduate Medical Education to be truly versed in the commitments necessary to assure high-quality GME in the training of tomorrow's health-care professionals. Development of such knowledge simply cannot be delegated. Today's leaders of teaching institutions must, more than ever, be fully cognizant of the requirements and obligations of Graduate Medical Education.

Lastly, and perhaps most importantly, we must cast a beacon on the support given to those engaged in Graduate Medical Education. By this statement, I am not simply referencing our repeated call for enhanced federal funding. But rather, available resources must be effectively deployed to support, recognize, and advance Graduate Medical Education within our home institutions. Our residency program directors must be valued for their critical contributions to our training programs and our rank and file clinician educators must be rewarded for their service as role models for the next generation of aspiring physicians.

Certainly, these institutional commitments are not facile. However, it is imperative that academic medicine cast off the perceived complacency and arrogance that has cloaked our ivory towers and be visibly responsive to these public obligations. Without such dedicated action, on a collective front, I fear that the self-governance and self-regulation of our Graduate Medical Education programs may, in fact, perish from our landscape just as certainly as the twin towers of New York exist now only as a memory.

R. Edward Howell
Chair
Accreditation Council for Graduate Medical Education

EXECUTIVE DIRECTORS REPORT

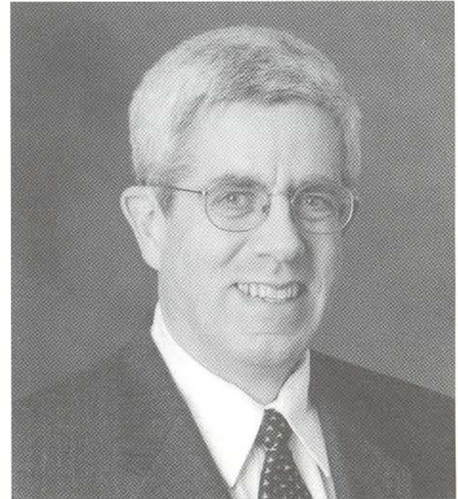
Two thousand and one was an important year for the ACGME. Many academic health centers are doing more with less. Recognition of this fact led the ACGME to: freeze its fees for the third consecutive year; to establish the Parker J. Palmer "Courage to Teach Award," an award designed to acknowledge acts of courage on the part of program directors who are true to their values and who maintain quality educational programs in a very harsh environment; and to continue to pursue an accreditation system based more on educational outcomes and less on process and structure measures. The need for program flexibility is apparent and can be better accommodated in an outcome- based system. Additionally the ACGME and Residency Review Committees (RRCs) solicited and responded to over 70 "RFPs" Requests for Permission from programs seeking permission to conduct innovative educational experiments and to enable a deeper understanding of "Good Learning for Good Health Care." This initiative, supported by the Commonwealth Fund, has resulted in several interesting opportunities to enhance learning.

The ACGME engaged several graduate students at the Dartmouth Medical School's Center for Evaluative Clinical Sciences to assist the ACGME in its attempts to improve its work with the forty organizations that appoint to the Residency Review Committees. The results, published under the title "Six Competencies in Search of a Community: Reports from the Appointing Organizations" reviews the various appointment processes, identifies the common and diverse purposes designed to support GME, and identifies opportunities for the ACGME to enhance dialogue with the very broad community of talented and individuals and organizations committed to GME.

For the second consecutive year the ACGME published the frequency of citations related to work hour violations. This issue is symptomatic of three related phenomena: there is more work to be done; in less time; and with less help. Hospitalized patients are sicker, are discharged sooner, and hospitals are experiencing shortages of other types of health care professionals and financial resources. There is no quick fix to the problem. Fundamental redesign of the way work is done will need to be developed. However, the ACGME will be inexorable in its attempts to focus on educational approaches that maximize good education and safe patient care. Programs that consistently violate accreditation standards will sustain adverse accreditation actions. A work group on Duty Hours and the Learning Environment was established in September and will clarify ACGME's responsibilities, identify opportunities to collaborate with other organizations in the medical community, and develop a generic template for ACGME requirements that will address this problem.

The Accreditation Data System (ADS) became fully functional in 2001. This system gathers data over the internet for accreditation purposes, clearly identifies the Designated Institutional Official (DIO) accountable for the accredited programs in a given sponsoring institution, allows for e-mail communication between RRCs and programs, preloads institutional data as part of the accreditation process, and supports comparisons that can build knowledge about good GME. A public site on www.acgme.org identifies accredited programs, their accreditation status and cycle length.

The ACGME Outcome and Competency Initiative has entered its first operational phase: Forming the Initial Response. This one-year phase is designed to allow RRCs and programs to respond to the challenge of using assessment of six general competencies: patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills, professionalism; and system-based practice as a measure of a program's success at teaching its residents. The larger community has been very supportive of this effort. Some of the boards have developed global assessment instruments that are being applied to all residents in their discipline; portfolios are being developed to record a resident's clinical experience, focused observations of clinical skills are being offered, and many programs are beginning to use some form of 360 degree evaluation to capture the perceptions of peers, patients and colleagues of a given resident.



Program directors are at the heart of good learning. Their efforts have long gone unrecognized. The ACGME has this year established the Parker J. Palmer "Courage to Teach" Award offering public acknowledgment of the power of effective teaching in a harsh environment. Each of the awardees has demonstrated unusual commitment and talent in the education of residents. They offer all of us a model of the power of aligning internal values and external behaviors. A retreat supported by the Fetzer Institute in Kalamazoo and facilitated by Parker J. Palmer himself will explore this in greater depth. Stay tuned.

The ACGME attracts some of the best physicians in America to serve as volunteers on its RRCs and on the ACGME itself. The strength of the organization is dependent on this talent and their ability and willingness to create standards, review programs in their discipline, and make judgments about compliance with those standards. This is a lot of work. The ACGME remains a private, voluntary, accreditation system. It is the profession's best attempt to regulate its own GME programs. The ACGME and the public owes these individuals a great debt.

David C. Leach, MD
Executive Director,
Accreditation Council for Graduate Medical Education

MILESTONES FOR 2001

The primary responsibility of the ACGME is accreditation of residency programs. One of the most important measures of annual activity, therefore, is the number of programs reviewed. Of the 7,805 programs accredited by the end of 2001, a full 3,555 appeared on Residency Review Committee agendas during the year, including 2,151 that were scheduled for regular accreditation status reviews. In addition, the ACGME processed 162 applications for new programs.

As a result, 45.5 percent of all programs were examined and 24.6 were subject to routine accreditation actions.

SCOPE OF RESPONSIBILITY

ACGME-accredited programs	7,805
ACGME-accredited specialties	27
ACGME-accredited training areas	83
Residents affected by ACGME accreditation	99,761

ACGME field staff conducted 1,708 surveys, including 86 institutional surveys, 787 surveys of programs in the basic disciplines, and 835 surveys of sub-specialty programs. Volunteer physician specialists conducted an additional 110 surveys.

During regular accreditation reviews, RRCs proposed adverse evaluations for 119 programs, or 6.7 percent. Accreditation was withheld upon application in 13 cases and withdrawn in 15 cases. Sixty one programs were placed on probation, and one reduction in resident complement were mandated. Six programs were administratively withdrawn, and 84 programs withdrew voluntarily.

The ACGME considered 7 appeals after formal hearings by specially constituted Boards of Appeals.

Another indicator of ACGME's 2001 activity is the number of people and tasks necessary to accomplish this vital process. The staff of ACGME surveyors spent approximately 570 weeks on the road. In addition, volunteer surveyors made 110 trips to visit programs. RRCs held 60 meetings; the Institutional Review Committee met two times; and the entire ACGME council met three times.

All told, volunteer physicians and administrators contributed an estimated 40,000 hours in 2001. The ACGME staff of 76 employees supported their invaluable work.

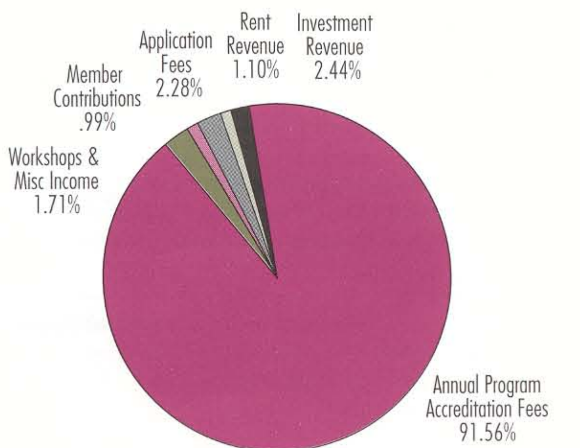
EVALUATION ACTIVITY

Total agenda items	3,555
Regular accreditation status reviews	1,920
Adverse actions	
Withheld	13
Withdrawn	15
Probation	61
Appeals	7
Sustained	5
Reversed	2

2001 FINANCIAL HIGHLIGHTS

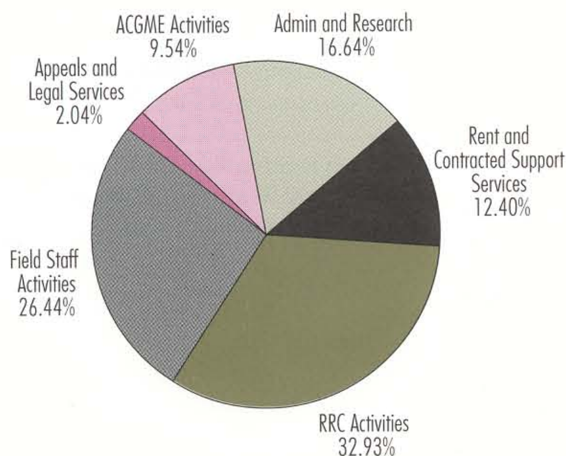
The ACGME's 2001 fees came primarily from annual fees charged to all accredited programs. Programs with more than 4 residents are charged $2,500 annually and programs with fewer than 5 residents are charged $2000. The current rates have been frozen since the 2000-2001 academic year. ACGME reserves, defined as cash and investments, totaled $16 million at year end

REVENUES



Investment Revenue	$	468,114
Rent Revenue	$	210,116
Application Fees	$	437,025
Member Contributions and Appeals Fees	$	174,029
Workshops & Miscellaneous Income	$	327,099
Annual Program Accreditation Fees	$	17,531,807
Total	**$**	**19,148,190**

EXPENSES



Administration and Research	$	2,716,079
Rent and Contracted Support Services	$	2,023,714
RRC Activities	$	5,373,714
Field Staff Activities	$	4,314,866
Appeals and Legal Services	$	333,107
ACGME and General Activities	$	1,557,158
Total	**$**	**16,318,638**

Each of the 26 Residency Review Committees is sponsored by the two or three organizations listed below. The sponsoring organizations are the medical specialty boards, the American Medical Association (AMA), and in many instances an appropriate major specialty organization. Members of the Residency Review Committees, which vary in size from six to 15 persons, are appointed in equal numbers by the sponsoring organizations. In addition to the specialty area which forms the name of the committee, other specialized training areas accredited by the committee are also indicated.

In addition to programs in these areas, the ACGME accredits special one-year general clinical programs called Transitional Year Programs. The ACGME also provides for an Institutional Review Committee, which evaluates sponsoring institutions for compliance with the ACGME Institutional Requirements.

Committee	Specialized Area	Sponsoring Organizations
Allergy and Immunology	**Specialized Area:** • Clinical and Laboratory Immunology	• American Board of Allergy and Immunology (A Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics) • AMA Council on Medical Education
Anesthesiology	**Specialized Area:** • Critical Care Medicine • Pain Management • Pediatric Anesthesiology	• American Board of Anesthesiology • AMA Council on Medical Education • American Society of Anesthesiologists
Colon and Rectal Surgery		• American Board of Colon and Rectal Surgery • AMA Council on Medical Education • American College of Surgeons
Dermatology	**Specialized Area:** • Dermatopathology	• American Board of Dermatology • AMA Council on Medical Education
Emergency Medicine	**Specialized Area:** • Medical Toxicology • Pediatric Emergency Medicine • Sports Medicine	• American Board of Emergency Medicine • AMA Council on Medical Education • American College of Emergency Physicians
Family Practice	**Specialized Area:** • Geriatric Medicine • Sports Medicine	• American Board of Family Practice • AMA Council on Medical Education • American Academy of Family Physicians
Internal Medicine	**Specialized Area:** • Cardiovascular Disease • Clinical Cardiac Electrophysiology • Critical Care Medicine • Endocrinology, Diabetes, and Metabolism • Gastroenterology • Geriatric Medicine • Hematology • Hematology and Oncology • Infectious Disease • Interventional Cardiology • Nephrology • Oncology • Pulmonary Disease • Pulmonary Disease & Critical Care Medicine • Rheumatology • Sports Medicine	• American Board of Internal Medicine • AMA Council on Medical Education • American College of Physicians

Specialty	Specialized Area	Organizations
Medical Genetics		• American Board of Medical Genetics • AMA Council on Medical Education • American College of Medical Genetics
Neurological Surgery	**Specialized Area:** • Endovascular Neuroradiology	• American Board of Neurological Surgery • AMA Council on Medical Education • American College of Surgeons
Neurology	**Specialized Area:** • Child Neurology • Clinical Neurophysiology • Pain Management	• American Board of Psychiatry and Neurology • AMA Council on Medical Education • American Academy of Neurology
Nuclear Medicine		• American Board of Nuclear Medicine • AMA Council on Medical Education • Society of Nuclear Medicine
Obstetrics and Gynecology		• American Board of Obstetrics and Gynecology • AMA Council on Medical Education • American College of Obstetricians and Gynecologists
Ophthalmology		• American Board of Ophthalmology • AMA Council on Medical Education • American Academy of Ophthalmology
Orthopaedic Surgery	**Specialized Area:** • Adult Reconstructive Orthopaedics • Foot & Ankle Orthopaedics • Hand Surgery • Musculoskeletal Oncology • Orthopaedic Sports Medicine • Orthopaedic Surgery of the Spine • Orthopaedic Trauma • Pediatric Orthopaedics	• American Board of Orthopaedic Surgery • AMA Council on Medical Education • American Academy of Orthopaedic Surgeons
Otolaryngology	**Specialized Area:** • Otology-Neurotology • Pediatric Otolaryngology	• American Board of Otolaryngology • AMA Council on Medical Education • American College of Surgeons
Pathology – Anatomic and Clinical	**Specialized Area:** • Blood Banking/Transfusion Medicine • Chemical Pathology • Cytopathology • Dermatopathology • Forensic Pathology • Hematology • Immunopathology • Medical Microbiology • Neuropathology • Pediatric Pathology	• American Board of Pathology • AMA Council on Medical Education

Specialty	Specialized Areas	Organizations
Pediatrics	**Specialized Area:** • Adolescent Medicine • Neonatal-Perinatal Medicine • Pediatric Cardiology • Pediatric Critical Care Medicine • Pediatric Emergency Medicine • Pediatric Endocrinology • Pediatric Gastroenterology • Pediatric Hematology/Oncology • Pediatric Infectious Disease • Pediatric Nephrology • Pediatric Pulmonology • Pediatric Rheumatology • Pediatric Sports Medicine	•American Board of Pediatrics •AMA Council on Medical Education •American Academy of Pediatrics
Physical Medicine and Rehabilitation	**Specialized Area:** • Spinal Cord Injury Medicine • Pain Management	• American Board of Physical Medicine and Rehabilitation • AMA Council on Medical Education • American Academy of Physical Medicine and Rehabilitation
Plastic Surgery	**Specialized Area:** • Craniofacial Surgery • Hand Surgery	• American Board of Plastic Surgery • AMA Council on Medical Education • American College of Surgeons
Preventive Medicine	**Specialized Area:** • Medical Toxicology	• American Board of Preventive Medicine • AMA Council on Medical Education
Psychiatry	**Specialized Area:** • Addiction Psychiatry • Child and Adolescent Psychiatry • Forensic Psychiatry • Geriatric Psychiatry • Pain Management	• American Board of Psychiatry and Neurology • AMA Council on Medical Education • American Psychiatric Association
Radiology-Diagnostic	**Specialized Areas:** • Abdominal Radiology • Endovascular Neuroradiology • Musculoskeletal Radiology • Neuroradiology • Nuclear Radiology • Pediatric Radiology • Vascular and Interventional Radiology	• American Board of Radiology • AMA Council on Medical Education • American College of Radiology
Radiation Oncology		• American Board of Radiology • AMA Council on Medical Education • American College of Radiology
Surgery	**Specialized Areas:** • General Vascular Surgery • Hand Surgery • Pediatric Surgery • Surgical Critical Care	• American Board of Surgery • AMA Council on Medical Education • American College of Surgeons
Thoracic Surgery		• American Board of Thoracic Surgery • AMA Council on Medical Education • American College of Surgeons
Urology	**Specialized Area:** • Pediatric Urology	• American Board of Urology • AMA Council on Medical Education • American College of Surgeons
Transitional Year		• ACGME Standing Committee

LIST OF PARTICIPANTS

Residency Review Committee Members

The ACGME's volunteers come from the membership of national medical societies and specialty boards across the country. They are the innovators, the pioneers, the respected experts. Each has a demonstrated history of involvement and commitment to excellence. With the ongoing support of these volunteers, the ACGME will continue to be a leader in assuring the quality of medicine in the United States. It is with considerable pride and gratitude that we acknowledge their contribution.

Allergy and Immunology

John A. Anderson, M.D.
Tucson, AZ

A. Wesley Burks, M.D.
Arkansas Children's Hospital
Little Rock, Arkansas

Paula J. Busse, M.D.
Mount Siani School of Medicine
New York, New York
Resident

Gary B. Carpenter, M.D.
Quincy Medical Group
Quincy, Illinois

Theodore M. Freeman, M.D.
San Antonio, Texas
Vice-Chair

James T. Li, M.D.
Mayo Graduate School of Medicine
Rochester, Minnesota

Dean D. Metcalfe, M.D.
National Institutes of Health/NIAID/LAD
Bethesda, Maryland
Chair

Dennis R. Ownby, M.D.
Medical College of Georgia
Augusta, Georgia

William T. Shearer, M.D., Ph.D.
Texas Children's Hospital
Houston, Texas

Abba I. Terr, M.D.
San Francisco, California

John W. Yunginger, M.D.
Mayo Graduate School of Medicine
Rochester, Minnesota
Ex-Officio

Anesthesiology

J. Jeffrey Andrews, M.D.
University of Alabama
Birmingham, Alabama

James F. Arens, M.D.
University of Texas Medical Branch
Galveston, Texas
Chair

David L. Brown, M.D.
University of Iowa College of Medicine
Iowa City, Iowa

Bruce F. Cullen, M.D.
Harborview Medical Center
Seattle, Washington

Wayne K. Jacobsen, M.D.
Loma Linda University Medical Center
Loma Linda, California
Vice-Chair

M. Jane Matjasko, M.D.
American Board of Anesthesiology
Raleigh, North Carolina
Ex-Officio

Philip D. Lumb, M.D.
Penn State University
Milton S. Hershey Medical Center
Hershey, Pennsylvania

Susan J. Polk, M.D.
University of Chicago
School of Medicine
Chicago, Illinois

Stephen J. Thomas, M.D.
Cornell University
School of Medicine
New York, New York
Chair

Steve Zgleszewki, M.D.
Penn State University
Milton S. Hershey Medical Center
Hershey, Pennsylvania
Resident

Colon and Rectal Surgery

Herand Abcarian, M.D.
American Board of Colon & Rectal Surgery
Detroit, Michigan
Ex-Officio

Alan Abrams, M.D.
Greater Baltimore Medical Center
Baltimore, Maryland

James W. Fleshman, M.D.
Washington University
School of Medicine
St. Louis, Missouri

Ann Lowry, M.D.
University of Minnesota
Minneapolis, Minnesota

Jennifer K. Moldovan, M.D.
Washington Hospital Center
Washington, D.C.
Resident

Richard Nelson, M.D.
University of Illinois
School of Medicine
Chicago, Illinois
Chair

Frank Padberg, M.D.
American College of Surgeons
Chicago, Illinois
Ex-Officio

Alan G. Thorson, M.D.
Creighton, University
Omaha, Nebraska

Steven Wexner, M.D.
Cleveland Clinic
Weston, Florida
Vice-Chair

Dermatology

Terry L. Barrett, M.D.
Johns Hopkins University
Baltimore, Maryland
Vice-Chair

Paul R. Bergstresser, M.D.
University of Texas Southwestern Medical Center
Dallas, Texas

Jeffrey P. Callen, M.D.
University of Louisville
Louisville, Kentucky

Kenneth E. Greer, M.D.
University of Virginia Medical Center
Charlottesville, Virginia
Chair

Antoinette Hood, M.D.
Indiana University
School of Medicine
Indianapolis, Indiana
Ex-Officio

Thomas D. Horn, M.D.
University of Arkansas for Medical Sciences
Little Rock, Arkansas

Lee T. Nesbitt, M.D.
Louisiana State University
New Orleans, Louisiana

Jeanne Osborn, M.D.
Naval Medical Center
San Diego, California
Resident

Abel Torres, M.D.
Brigham and Women's Hospital
Boston, Massachusetts

Duane C. Whitaker, M.D.
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Emergency Medicine

G. Richard Braen, M.D.
Buffalo General Hospital
Buffalo, New York

Joseph E. Clinton, M.D.
Hennepin County Medical Center
Minneapolis, Minnesota

Francis Counselman, M.D.
Norfolk, Virginia

Marjorie Geist, Ph.D.
American College of Emergency Physicians
Irving, Texas
Ex-Officio

Gary Katz, M.D.
Fairlawn, Ohio
Resident

Jo Ellen Linder, M.D.
Altadena, California

Debra Perina, M.D.
University of Virginia Health Science Center
Charlottesville, Virginia

Mary Ann Reinhart, Ph.D.
American Board of Emergency Medicine
East Lansing, Michigan
Ex-Officio

Douglas Rund, M.D.
Ohio State University
Columbus, Ohio

Arthur Sanders, M.D.
Arizona Health Science Center
Tucson, Arizona

Corey M. Slovis, M.D.
Vanderbilt University
School of Medicine
Nashville, Tennessee

Robert Strauss, M.D.
Emergency Treatment Associates
Poughkeepsie, New York
Chair

Family Practice

Robert Avant, M.D.
American Board of Family Practice
Lexington, Kentucky
Ex-Officio

Diane Kaye Beebe, M.D.
University of Mississippi Medical Center
Jackson, Mississippi
Vice-Chair

Edward T. Bope, M.D.
Riverside General Hospital
University Medical Center
Columbus, Ohio
Chair

Charles Driscoll, M.D.
Centra Health Program
Lynchburg, Virginia

Margaret Hayes, M.D.
Oregon Health Sciences University
Portland, Oregon
Alternate

Warren Heffron, M.D.
University of New Mexico
School of Medicine
Albuquerque, New Mexico

James R. Little, Jr., M.D.
Oregon Health Sciences University
Portland, Oregon
Resident

Perry A. Pugno, M.D.
American Academy of Family Physicians
Kansas City, Missouri
Ex-Officio

Mary Elizabeth Roth, M.D.
Providence Hospital and Medical Centers
Southfield, Michigan

John W. Saultz, M.D.
Oregon Health Sciences University
Portland, Oregon

Susan Schooley, M.D.
Henry Ford Health System
Detroit, Michigan

J. Lewis Sigmon, Jr., M.D.
Charlotte Office of Regional Care Education
Charlotte, North Carolina

Mary Willard, M.D.
West Jersey Health System
Voorhees, New Jersey

Internal Medicine

Thomas Blackwell, M.D.
University of Texas Medical Branch
Galveston, Texas
Chair

Bruce Brundage, M.D.
Bend Medical Clinic
Bend, Oregon

Sidney Cohen, M.D.
Thomas Jefferson University
Philadelphia, Pennsylvania

F. Daniel Duffy, M.D.
American Board of Internal Medicine
Philadelphia, Pennsylvania
Ex-Officio

Suzanne Gebhart, M.D.
Emory University
Atlanta, Georgia

Allan H. Goroll, M.D.
Massachusetts General Hospital
Boston, Massachusetts

Mark Klempner, M.D.
Boston University School of Medicine
Boston, Massachusetts

Capt. Angeline Lazarus, MC, USN
National Naval Medical Center
Bethesda, Maryland

Richard F. LeBlond, M.D.
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Thomas Nasca, M.D.
Thomas Jefferson University Hospital
Philadelphia, Pennsylvania
Vice-Chair

Paul Rockey, M.D.
Southern Illinois University
Springfield, Illinois

Geraldine Schechter, M.D.
Veterans Affairs Medical Center
Washington, DC

Barbara Schneidman, M.D.
American Medical Association
Chicago, Illinois
Ex-Officio

Stanley R. Shane, M.D.
Veterans Affairs Medical Center
Reno, Nevada

James Simon, M.D.
Brooke Army Medical Center
Fort Sam Houston, Texas
Resident

Carl Sirio, M.D.
University of Pittsburgh Medical Center
Pittsburgh, PA

Valerie Stone, M.D.
Massachusetts General Hospital
Boston, Massachusetts

Herbert Waxman, M.D.
American College of Physicians
Philadelphia, Pennsylvania
Ex-Officio

Robert Wright, M.D.
Mercy Hospital
Scranton, Pennsylvania

Medical Genetics

Katrina Dipple, M.D.
UCLA Medical Center
Los Angeles, California
Resident

Mark I. Evans, M.D.
Wayne State University
School of Medicine
Detroit, Michigan

Gerald Feldman, M.D., Ph.D.
Wayne State University
School of Medicine
Detroit, Michigan

Lewis B. Holmes, M.D.
Massachusetts General Hospital
Boston, Massachusetts
Chair

Capt. Charles J. Macri, M.D.
Armed Forces Institute of Pathology
Rockville, M.D.

Hope Northrup, M.D.
University of Texas at Houston
School of Medicine
Houston, Texas
Vice-Chair

Georgia D. Wiesner, M.D.
University Hospitals of Cleveland
Cleveland, Ohio

Neurological Surgery

Howard Eisenberg, M.D.
University of Maryland
School of Medicine
Baltimore, Maryland

Steven Giannotta, M.D.
American Board of Neurological Surgery
Houston, Texas
Ex-Officio

Karen Guice, M.D.
American College of Surgeons
Chicago, Illinois
Ex-Officio

Edward Laws, M.D.
University of Virginia
School of Medicine
Charlottesville, Virginia
Vice-Chair

Lawrence Marshall, M.D.
University of California-San Diego
San Diego, California

Donald Quest, M.D.
Columbia University
School of Medicine
New York, New York

William Shucart, M.D.
Tufts University
School of Medicine
Boston, Massachusetts

Robert Tibbs, M.D.
University of Mississippi
Medical Center
Jackson, Mississippi
Resident

John Van Gilder, M.D.
University of Iowa
College of Medicine
Iowa City, Iowa
Chair

Neurology

David Anderson, M.D.
University of Minnesota
School of Medicine
Minneapolis, Minnesota
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