EXECUTIVE SUMMARY

In May 2015 Lois Margaret Nora, MD, JD, MBA, ABMS President and Chief Executive Officer, commissioned the Special Committee on Physician Executives/Administrative Leaders and Continuing Certification* (the Committee) to advise ABMS and its 24 Member Boards on ways to make ABMS' process for continuous professional development (CPD), known as the ABMS Program for MOC (ABMS MOC®), more meaningful and relevant to Board Certified medical specialists in executive and/or administrative leadership positions. The Committee's charter is to:

• Explore how implementation of MOC has and will affect Board Certified medical specialists in executive/administrative roles.

• Recommend for consideration by the ABMS Member Boards Community opportunities to make MOC more relevant, meaningful, and valuable to this diplomate population.

During the course of its deliberations, the Committee identified a number of important questions foundational to its discussion about improving MOC's value to Board Certified medical specialists in executive/administrative roles. These included:

• Whether Member Boards' expectations for MOC participation should be different for medical specialists in executive/administrative positions than for specialists who provide direct patient care;

• Whether the competencies needed by medical specialists to carry out executive/administrative leadership responsibilities are different from those needed to care for patients;

• Whether certification should be considered a clinical or professional credential;

• Whether the interpretation of clinically active should be broadened beyond direct patient care to encompass physicians and other medical specialists who have a primary responsibility to the larger context and system of health care, and who are principally engaged in activities that impact the health care delivery system's capacity to provide optimal patient care;

• Whether there are types of activities that could make MOC more relevant to Board Certified medical specialists employed in executive/administrative roles.

This report provides an overview of changes in the health care system's expectations of physicians as they assume leadership roles, examines issues that need to be considered as the Member Boards Community determines how to make MOC more meaningful to medical specialists in executive/administrative positions, and offers recommendations for short- and long-term strategies to improve the value of MOC to Board Certified physician executives/administrative leaders.

*The report of the Special Committee on Physician Executives/Administrative Leaders and Continuing Certification provides guidance to the American Board of Medical Specialties (ABMS) and its Member Boards regarding opportunities to improve the relevance and value of Board Certification and Maintenance of Certification (MOC) for the physician executive/administrative leader community. The Committee report and recommendations are advisory and do not represent the policy of ABMS or its Member Boards.
KEY FINDINGS

Regarding the many issues related to improving the relevance and value of MOC for Board Certified medical specialists in executive/leadership roles, the Committee found the following:

- **Duty to patients:** A Board Certified physician executive/administrative leader who provides any amount of direct patient care, however limited or focused, has a responsibility to maintain the same level of clinical knowledge, skill, and competence as a medical specialist who provides patient care on a full-time basis.

- **Certification as a professional credential:** Board Certification should be considered a professional credential as well as a clinical credential. Committee members believe there is an opportunity to evolve MOC so that it supports the CPD of all Board Certified medical specialists as they transition through various professional pathways during the course of their careers whether from patient care to research, teaching, or organizational leadership.

- **What it means to be clinically active:** The term *clinically active* traditionally has been interpreted as providing direct patient care, and most ABMS Member Boards’ MOC Part IV Improvement in Medical Practice (IMP) requirements reflect this interpretation. Given the considerable diversity in how Board Certified medical specialists today are influencing the delivery of health care, the Committee believes there is a need to broaden the interpretation to include professional activities that directly or indirectly impact the provision of care to an individual or community of patients, including those that contribute to improvement in systems of care and delivery of medical education.

- **Competencies required for effective organizational leadership:** Board Certified physicians and other health care professionals in executive/administrative leadership positions should be proficient in the six core competencies established by ABMS and the Accreditation Council for Graduate Medical Education (ACGME), as well as have a depth of leadership knowledge and management skills in areas such as, but not limited to, quality improvement (QI), change management, and data analytics.

- **Obtaining competencies for effective leadership:** There is an opportunity to position the ABMS Program for MOC as a valued resource that supports Board Certified physician executives/administrative leaders in a manner that is relevant and meaningful to their day-to-day work. This will necessitate Member Boards recognizing and accepting for MOC credit, participation in programs and services offered by third parties that enhance proficiency in the competencies required to perform both executive/administrative duties as well as patient care related duties.

- **Evaluation of knowledge and skills required for effective leadership:** To make MOC more relevant to physician executives/administrative leaders, Member Boards should consider balancing the content of the MOC Part III requirements for the Assessment of Knowledge, Judgment, and Skills so that the examination reflects the core knowledge of a given specialty as well as the knowledge required to be an effective physician executive/administrative leader.

- **Consistency in MOC program requirements:** Given that the knowledge and skills required to perform executive/administrative functions are generalizable across specialties, the ABMS Member Boards Community should strive to implement consistent requirements for Board Certified physicians and other health care professionals holding such positions.

- **Re-entry:** Board Certified physician executives/administrative leaders who wish to return to direct patient care should have access to Board-approved re-entry programs to facilitate their resuming patient care responsibilities.
DEFINITIONS

For purposes of its work, the Committee identified and adopted the following terms and definitions:

Physician Executive/Administrative Leader:
A physician or non-physician medical specialist certified by an ABMS Member Board, whose scope of work primarily involves:

1. Both direct patient care and substantial administrative functions. For example, a chief medical officer (CMO) who sees patients, or a residency program director who provides patient care and also performs administrative duties;

2. The direct oversight or management of systems of care or populations of patients, but not the provision of direct patient care. For example, a CMO of an insurance organization or a Chief Executive Officer (CEO) in a clinical delivery system who does not see patients;

3. Activities that influence the delivery of patient care but do not involve oversight of individual patient care or systems of care. Examples include physicians and other health care professionals in health policy positions, regulatory organizations, medical professional organizations, or in health care organizations such as pharmaceutical or device companies; and

4. Responsibility for overseeing, developing, leading, and/or delivering the pedagogy of medical education.

Clinically Active:
For purposes of this report, the Committee has interpreted the phrase clinically active to include a scope of professional practice that has the potential to directly or indirectly impact the provision of care to an individual or community of patients. Examples include a CMO who oversees the clinical quality of a community hospital, a medical school faculty member who directs educational programs for students or residents, or a policy maker or regulator who sets or enforces standards that impact public health.
Table 1 provides examples of the types of executive/administrative leadership positions the Committee envisioned when developing its recommendations. The Committee specifically excluded from its definition, physicians and other health care professionals who have left medicine to pursue careers in areas unrelated to health care, such as an investment banking or financial planning.

<table>
<thead>
<tr>
<th>Position</th>
<th>Scope of duties</th>
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<tr>
<td>CEO, CMO, Chief Medical Information Officer, Chief Quality Officer, Patient Safety Officer, or similar positions that directly influence the delivery of care to a patient or patient populations</td>
<td>Direct oversight of and involvement in ensuring and improving the quality of patient care provided by a system of care (e.g., a hospital, an insurer, etc.).</td>
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<tr>
<td>Clinical Educator</td>
<td>Significantly or primarily involved in the system processes for clinical education of other health care providers.</td>
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<tr>
<td>Medical Regulator</td>
<td>Oversees or manages aspects of regulatory or accreditation organizations that set standards which influence physician practice. Examples of such organizations include The Joint Commission, State Medical Boards, ACGME, or Specialty Certifying Boards.</td>
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<tr>
<td>Medical Organization Leader</td>
<td>Oversees or manages aspects of an organization that establishes policy influencing medical professionalism, such as a medical society, the American Medical Association (AMA), Federation of State Medical Boards, Association of American Medical Colleges, or American Hospital Association.</td>
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BACKGROUND

Medical practice has changed significantly during the past 30 years, becoming both increasingly specialized and diversified in terms of the professional pathways available to clinicians interested in influencing patient care through channels such as health policy, medical education, or health systems leadership or management.

Simultaneously, in response to public calls for regulatory bodies to ensure the continuing competence of the health professions, the 24 ABMS Member Boards have evolved medical specialty certification from a point-in-time verification of a physician’s training and knowledge in a medical specialty to what today is known as the Program for MOC. MOC is a continuing certification process comprising four elements: professionalism and professional standing; lifelong learning and self-assessment; external assessment of knowledge, judgment, and skills; and improvement in medical practice.

The transition from lifetime certification to continuous certification has impacted both the medical specialty boards and the health care professionals they certify. The ABMS Member Boards recognize and are committed to understanding the full impact of this transition in order to make continuing certification more relevant, meaningful, and valuable to individuals who participate in the program while upholding the high standards for assessment expected by the public.

To assist Member Boards in this reflective process, Dr. Nora commissioned a series of special committees to examine issues facing three cohorts of Board Certified medical specialists as they engage with certification and continuing certification processes: those in the military, research positions, and executive/administrative leadership roles.

This report represents the work of the Special Committee on Physician Executives/Administrative Leaders and Continuing Certification. Composed of ABMS Member Board representatives as well as individuals representing key external stakeholders, the Committee examined a variety of issues foundational to improving MOC’s value proposition to Board Certified physician executives/administrative leaders, including to what extent Member Boards should expect physician executives/administrative leaders to engage in MOC, whether Member Boards’ expectations for lifelong learning and professional development for medical specialists in executive or leadership roles should be different than for those who provide direct patient care, whether certification should be considered a clinical or professional credential, and whether Board Certified medical specialists holding such positions should be considered clinically active.

Throughout its deliberations, the Committee was mindful of the fact that while all Member Boards certify MD and DO physicians, two Boards – the American Board of Medical Genetics and Genomics and American Board of Radiology – also certify non-physician professionals. The Committee presents its report and recommendations for consideration by the Member Boards Community and the health professionals they certify.

THE EVOLVING PRACTICE CONTEXT FOR PHYSICIAN EXECUTIVE/ADMINISTRATIVE LEADERS

Health care organizations traditionally have separated clinical care management from business operations – physicians and other health care professionals were responsible for the former and business leaders for the latter. This is changing, however, as health care professionals increasingly are playing a critical role in delivery system redesign, influencing the care of both individuals and communities of patients. The emergence of positions such as Vice President of Medical Affairs, Patient Safety Officer, Chief Quality Officer, Chief Information Officer, and Chief Technology Officer are illustrative of the surging interest on the part of health care institutions to engage health care professionals in delivery system redesign. In fact, many health systems now employ physicians in their CEO positions.
The roles and responsibilities of physician executives/administrative leaders can be quite diverse, impacted by factors such as the individual’s place of employment (e.g., academic institution, insurance company, hospital/provider organization), the position he or she holds (e.g., Dean, CEO, or senior leader of a health care organization), the scope of work in which the individual engages (e.g., population health management, medical regulation), the point of time in the individual’s professional career, and the degree to which the individual’s scope of work impacts patient care (e.g., educates future providers of care, sets policy that impacts systems of care or patient populations).

Many medical specialists currently employed in executive/administrative leadership positions spent the first part of their professional careers providing direct patient care. At some point along their career paths, they transitioned to executive/administrative leadership positions and found that the education and training they received in medical school had not prepared them for these new roles. This is changing, however, as the medical education community increasingly is recognizing there is a unique body of knowledge related to health systems science and is incorporating this knowledge into undergraduate and graduate medical education. AMA, which began an initiative in 2013 aimed at accelerating transformation of undergraduate medical education, describes this new discipline as “understanding how to improve health care quality, increase the value of care provided, enhance patient safety, deliver population-based medical care and work collaboratively in teams.” One outcome from the AMA’s initiative is a study published in the October 2015 issue of Academic Medicine entitled Educating for the 21st-Century Health Care System: An Interdependent Framework of Basic, Clinical, and Systems Sciences. It makes the argument that an explicit focus on systems sciences as a vital and equal component of physician education will be necessary to prepare physicians for practice in the 21st century.

Board Certified medical specialists who currently are in executive/administrative roles rely on the knowledge and skills inherent in the ABMS/ACGME core competencies. However, they manifest these competencies differently than health care professionals who provide direct patient care. For example, to be effective in their roles, physician executives may need knowledge and skills in areas such as team-based care, QI science, organizational development, health resources management, and health care finance — all of which arguably are facets of professionalism, interpersonal communication, practice-based learning and improvement, and systems-based practice.

Finally, many health care organizations view Board Certification as a marker of quality and competence and accordingly require physician executives/administrative leaders to have the credential. For example, it is common for institutions that require their medical staffs to be Board Certified to also require their CMOs to have the clinical knowledge, skills, and professional standing associated with Board Certification and MOC to ensure that the medical staffs view the executives/administrators as credible leaders.
STAKEHOLDER NEEDS AND EXPECTATIONS

The Committee considered its charge from the perspective of four key stakeholders: 1) physician executives/administrative leaders; 2) Member Boards; 3) consumers of the credential (e.g., hospitals and insurers), and 4) the public. Issues identified as important to the targeted stakeholders include:

Physician Executives/Administrative Leaders

- Board Certified physician executives/administrative leaders who are interested in improving their knowledge and skills through participation in MOC face challenges in doing so because MOC programs – as currently designed – have limited application to their scope of practice. In particular, MOC content requirements are generally oriented to medical specialists who provide direct patient care.

- Physician executives/administrative leaders apply the knowledge and skills associated with the ABMS/ACGME core competencies differently than do medical specialists who provide direct patient care.

- Many physician executives/administrative leaders who are required by their employers to maintain Board Certification often have difficulty identifying MOC Part IV IMP activities they view as relevant to their day-to-day work.

- Physician executives/administrative leaders may experience difficulty obtaining MOC credit from their certifying boards for specific types of continuing medical education (CME) and QI activities relevant to their scope of activities.

- Physician executives who no longer provide direct patient care still identify themselves as physicians, and for many, medical specialty certification serves as the imprimatur of that identity or requirement for the job as in the case of an Executive Director of a specialty society or ABMS Member Board.

Member Boards

- The majority of Member Boards define the phrase clinically inactive based on whether or not a medical specialist provides direct patient care and the length of time away from such duties. Some Member Boards offer or recognize limited MOC offerings for medical specialists who do not provide direct patient care.

- Some Member Boards may not have the capacity needed to develop assessment tools for use in fostering acquisition of leadership skills and behaviors.

- Smaller and mid-sized Member Boards have limited resources, impacting the extent to which they may be able to adapt their MOC programs and policies to make them more relevant to physician executives/administrative leaders.

- Member Boards benefit by maintaining strong relationships with Board Certified physicians and other health care professionals in executive/administrative leadership positions.

- There is value in creating consistency across the Member Boards as it relates to program requirements that are relevant to physician executives/administrative leaders.

Consumers of the Credential (e.g., hospitals, insurers, credentialers, state medical boards)

- While consumers of the credential expect Board Certified medical specialists to be evaluated in the core knowledge relevant to a given specialty, there is increasing expectation for accountability in knowledge and skills in areas such as QI, patient safety, and appropriate use of resources.

- Because clinical and business enterprises are integrated, consumers of the credential often expect physician executives/administrative leaders to have both the clinical knowledge and experience related to their discipline as well as the leadership or management expertise necessary to contribute to improving care delivery, and ultimately, patient care outcomes.
The Public

• The public expects the certification process to ensure Board Certified physicians and other health care professionals in executive/administrative leadership roles maintain the competencies needed to effectively carry out their roles.

• The public expects accurate and transparent information from the Member Boards Community regarding a medical specialist’s qualifications to engage in patient care duties.

DISCUSSION

In considering the many issues associated with making MOC more relevant and meaningful to Board Certified medical specialists in executive/administrative leadership roles, the Committee early on took the position that first and foremost, public accountability is best served when medical specialists who provide any amount of direct patient care, however limited or focused, are held to the same standard for maintaining the level of knowledge, skill, and competence as specialists who provide patient care full time.

Committee members agreed that the knowledge and skills needed by physician executives/administrative leaders are embodied in the ABMS/ACGME core competencies of systems-based practice, interpersonal communications, practice-based learning and improvement, and professionalism. However, because of their day-to-day responsibilities physician executives/administrative leaders demonstrate these competencies differently than medical specialists who provide direct patient care, however limited or focused, are held to the same standard for maintaining the level of knowledge, skill, and competence as specialists who provide patient care full time.

Given that a significant number of physician executives/administrative leaders no longer engage in patient care yet are required by their employers to maintain medical specialty certification, Committee members expressed support for viewing Board Certification as both a clinical and professional credential. The reasons for this are two-fold. First, while medical specialists in executive/administrative leadership roles may not be actively engaged in direct patient care, they do routinely make decisions that affect or influence systems of clinical care and patient care outcomes. Secondly, medical specialists who transition from clinical practice to leadership or management positions often experience difficulty meeting MOC Part IV IMP requirements in ways that are meaningful and relevant to their day-to-day professional practices. The Committee believes that by positioning certification as both a clinical and professional credential, ABMS will encourage Member Boards to broaden their criteria for acceptable MOC activities to include learning and assessment activities that foster the development of leadership knowledge and skills.

In discussing whether physician executives/administrative leaders are clinically active, Committee members acknowledged that the phrase traditionally has been defined as caring for patients, and in fact, Member Boards with policies that define clinically inactive use time away from patient care as the benchmark for determining an individual’s clinical status. The Committee agreed that while Board Certified medical specialists in executive/administrative leadership roles may not provide direct patient care, they are engaged in clinical work by virtue of the fact that their day-to-day responsibilities influence systems of clinical care as well as the quality of care patients receive. The Committee believes broadening the interpretation of clinically active to encompass professional activities that improve systems of care or the care of patient populations will create more opportunities for physician executives/administrative leaders to use health systems-related learning and QI activities to meet their certifying board’s MOC requirements.
While the Committee believes expanding the interpretation of clinically active has merit, it recognizes doing so is a source of ongoing discussion within the Boards Community and thus encourages further dialogue about this recommendation.

In reflecting on stakeholder needs/expectations, the Committee noted that in some instances, stakeholders could have different views about the purpose of Board Certification and its role in advancing the knowledge and skills of medical specialists in executive/administrative leadership roles. Acknowledging this tension, the Committee believes that transparency is critical to ensuring the public is informed about the degree to which a Board Certified medical specialist is engaged in the direct care of patients. While the Committee understands that further conversation is needed within the Boards Community about these tensions, it encourages ABMS and its Member Boards to recognize that changes in health care delivery and patient/population care mandate a broader acknowledgement of medical specialists’ impact and influence on individuals and communities.

The Committee reviewed the 2015 Standards for the ABMS Program for MOC and discussed the relevance of each component for the physician executive/administrative leader community. The Committee agreed on the following:

- The MOC component pertaining to Professionalism and Professional Standing is essential to the physician executive/administrative leader.
- The MOC component pertaining to Lifelong Learning and Self-Assessment is also applicable to the physician executive/administrative leader, and Member Boards should be encouraged to accept CME activities that focus on competencies associated with effective leadership and management skills for MOC credit. Consistent with the 2015 MOC Standards, leadership development activities may include accredited CME as well as other offerings that meet similar standards of quality programming.
- The MOC component pertaining to Assessment of Knowledge, Judgment, and Skills could be made more relevant to physician executives/administrative leaders if Member Boards were to weight the content of the examination based on the individual’s practice profile. The examination could balance knowledge core to the specialty, with content that reflects the knowledge and skills needed to be an effective leader and/or manager. Member Boards that provide modular exams could offer a module with content that is specifically relevant to physician executives/administrative leaders.
- The MOC IMP component could be made more inclusive of medical specialists in executive/administrative leadership roles if it were designated Improvement in Professional Practice. The diversity of projects appropriate for physician executives/administrators could include traditional QI projects as well as institutional and educational projects designed to improve the care of individual patients, populations of patients, or the health care delivery system.

In considering physician executives/administrative leaders who have not been engaged in the direct care of patients and wish to resume such duties, the Committee determined that active engagement with MOC could help to ease their return to clinical practice. The Committee agreed that medical specialists who wish to return to direct patient care duties will need access to Board-approved re-entry programs to facilitate their return. This is consistent with the MOC Standards for Professionalism and Professional Standing, which call for each Member Board to establish and maintain a process that provides former Board Certified health care professionals an opportunity to regain Board Certification.
The Committee received information about programs offered by ABMS and select Member Boards that could be leveraged to better support the Board Certified physician executive/administrative leader. Programs submitted for review included the:

• American Board of Family Medicine’s IMP Practice Improvement Module for Board Certified physician specialists who are clinically inactive,

• American Board of Preventive Medicine’s Aerospace Medicine Practice Assessment Protocol,

• American Board of Internal Medicine’s Clinical Supervision Practice Improvement Module,

• ABMS MOC Directory, powered by the Association of American Medical Colleges’ MedEdPORTAL, and

• ABMS Multi-Specialty Portfolio Program.

The Committee observed that the MOC Directory, in particular, was positioned to provide physician executives/administrative leaders access to resources aimed at fostering the development of the knowledge and skills required to be effective health care leaders/managers. Numerous organizations, including specialty societies, academic institutions, and physician organizations, have submitted accredited CME offerings relevant to physician executives for posting on the MOC Directory website. Specifically in the arena of MOC Part II Lifelong Learning and Self-Assessment requirements, Member Boards could accept for credit the leadership development programming and offerings available either directly from these organizations or via the MOC Directory. In addition, Member Boards should consider accepting for MOC Part IV IMP credit, organizational-related QI activities submitted by physician executives/administrative leaders.

RECOMMENDATIONS

The Special Committee on Physician Executives/Administrative Leaders and Continuing Certification offers the following recommendations for consideration by ABMS and its Member Boards:

Clinical Activity

Adopt a statement articulating the position that Board Certified medical specialists who provide direct patient care, however limited or focused, have a responsibility to maintain the same clinical knowledge, judgment, and skill as a specialist who provides patient care on a full-time basis.

• Member Boards should have the purview to set criteria for the minimum amount of patient care activity needed to maintain competence in their specific discipline.

• Member Boards that designate medical specialists as clinically inactive on their public-facing websites should consider using the phrase not currently active in direct patient care.

Broaden the interpretation of the phrase clinical activity to include professional activities that directly or indirectly impact the provision of care to a patient or community of patients, including those that contribute to improvement in systems of care and delivery of medical education.

Broaden the MOC Standards for Improvement in Medical Practice to Improvement in Professional Practice, so that physician executives/administrative leaders who contribute to improving the care of patients or patient populations through mechanisms other than direct patient care may engage meaningfully in their certifying board’s MOC program.
Application of MOC Standards
Support the career path of physician executives/administrative leaders and embrace a pathway to MOC for this population.

Establish MOC requirements for physician executives/administrative leaders that are flexible, relevant, and consistent across specialties.

Relevance
Accept accredited or equivalent CME activities that foster the knowledge and skills needed by Board Certified medical specialists to be effective in their particular scope of health care-related responsibilities.

Weight the content of the MOC Part III Assessment of Knowledge, Judgment, and Skills so that it balances knowledge core to the specialty with content that reflects the knowledge and skills needed to be an effective leader/manager.

• Member Boards should consider whether a common, shared bank of multiple-choice questions pertaining to leadership knowledge and skills could be a cost-effective way to enhance their Part III examinations.

• Member Boards that offer modular examinations could consider developing a module with content reflecting the competencies required to be an effective health care executive/administrative leader.

Establish flexible criteria for use in determining the acceptability of organizational-related QI activities submitted by physician executives/administrative leaders for MOC Part IV IMP credit. For example, QI activities that are intended to improve the health care delivery system or the quality of care delivered to a patient or a community of patients should be acceptable for MOC Part IV IMP credit.

Resources
Assist physician executives/administrative leaders in accessing CPD resources that are relevant to their scope of activities and acceptable for MOC credit.

• Member Boards should clearly communicate to physician executives/administrative leaders what types of CME and IMP activities are acceptable for purposes of meeting MOC Part II Self-Assessment and Lifelong Learning and MOC Part IV IMP requirements.

• Member Boards should encourage specialty societies and other physician leadership organizations to develop educational and mentoring tools and resources aimed at building executive or administrative knowledge and management skills for MOC credit.

• ABMS and its Member Boards should collaborate with organizations that are positioned to help increase access to practice-relevant CPD resources for physician executives/administrative leaders.
CONCLUSION

Understanding the complex and diverse environments in which Board Certified physicians practice is critical to delivering a high quality, relevant, and meaningful continuing certification program. Many Board Certified medical specialists began their careers in clinical medicine, transitioned to health care executive/administrative positions, and are now leading the effort to improve the quality of patient care in their workplaces. The Committee encourages the Member Boards Community to seek ways to enable these medical specialists to engage with MOC in a meaningful and relevant fashion. The Committee appreciates the opportunity to contribute to efforts aimed at improving the value of Member Board MOC programs for Board Certified physician executives/administrative leaders.
APPENDIX I
AMERICAN BOARD OF MEDICAL SPECIALTIES SPECIAL COMMITTEE ON PHYSICIAN EXECUTIVES/ADMINISTRATIVE LEADERS & CONTINUING CERTIFICATION

Peter B. Angood, MD, FRCS(C), FACS, MCCM
President and Chief Executive Officer
American Association for Physician Leadership

David Bjorkman, MD, MSPH
Former Dean and Executive Director of Medical Affairs
Charles E. Schmidt College of Medicine
Florida Atlantic University

Miriam G. Blitzer, PhD
Chief Executive Officer
American Board of Medical Genetics and Genomics

Christopher C. Colenda, MD, MPH (Co-chair)
President and Chief Executive Officer
West Virginia University United Health System

John R. Combes, MD
Chief Medical Officer & Senior Vice President
American Hospital Association
President
Center for Healthcare Governance

W. Bryan Gamble, MD, FACS
Former President and Chief Executive Officer
Florida Hospital Medical Group

Trent Haywood, MD, JD
Senior Vice President, Office of Clinical Affairs, and
Chief Medical Officer
BlueCross BlueShield Association

Diane Magrane, MD
Executive Director
International Center for Executive Leadership in Academics
Drexel University

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James T. McDeavitt, MD  
Professor and Chairman  
Department of Physical Medical and Rehabilitation  
Baylor College of Medicine

Lois Margaret Nora, MD, JD, MBA (Co-chair)  
President and Chief Executive Officer  
American Board of Medical Specialties

Susan E. Northrup, MD, MPH  
Southern Regional Flight Surgeon  
Federal Aviation Administration

Barbara S. Schneidman, MD, MPH  
Clinical Professor  
Department of Psychiatry and Behavioral Sciences  
University of Washington

Robert W. Strauss, MD, FACEP  
Senior Director  
American Board of Emergency Medicine

Stephen I. Wasserman, MD  
President  
American Board of Allergy and Immunology

ABMS Staff Support  
Carol Clothier, Vice President, State Health Policy & Public Affairs  
Hannah Williams, Manager, Policy Operations
American Board of Allergy and Immunology
American Board of Anesthesiology
American Board of Colon and Rectal Surgery
American Board of Dermatology
American Board of Emergency Medicine
American Board of Family Medicine
American Board of Internal Medicine
American Board of Medical Genetics and Genomics
American Board of Neurological Surgery
American Board of Nuclear Medicine
American Board of Obstetrics and Gynecology
American Board of Ophthalmology

American Board of Orthopaedic Surgery
American Board of Otolaryngology
American Board of Pathology
American Board of Pediatrics
American Board of Physical Medicine and Rehabilitation
American Board of Plastic Surgery
American Board of Preventive Medicine
American Board of Psychiatry and Neurology
American Board of Radiology
American Board of Surgery
American Board of Thoracic Surgery
American Board of Urology

The American Board of Medical Specialties (ABMS) is a leading not-for-profit organization overseeing physician certification in the United States. It assists its 24 Member Boards in their efforts to develop and implement educational and professional standards for the evaluation, assessment and certification of physician specialists. ABMS Member Boards provide certification and ongoing professional development programs for more than 840,000 physicians across 37 specialties and 85 subspecialties.