The Political and Advocacy Issue

10 Reasons to #VoteKids this Election Season

By Rachel Nash, MPH

As the presidential election season intensifies, you may be wondering, “Why should I, as a medical student, even care?” Well, I can empathize with that feeling. I admit that I was a bit indifferent at the beginning. After all, we have exams, clinical duties, and residency interviews on the horizon, keeping us all busy. However, after watching the debates and following the media coverage over the past few months (check out The Skimm, it’s amazing), I have come to realize that my vote really does matter.

Children can’t vote, but pediatricians and those who care for children can. It is our civic duty, as future healthcare providers, to consider the issues which matter most to our patients and families, in order to make an informed choice in November.

The American Academy of Pediatrics (AAP) has developed a Get Out the Vote campaign website, which includes a variety of helpful resources to keep you informed. Several prominent pediatricians, including current AAP President, Dr. Benard Dreyer, and AAP Chief Executive Officer, Dr. Karen Remley, have shared why they will be #VotingKids in this powerful YouTube video. I would like to encourage you to join the AAP’s exciting social media campaign for the election by changing your profile picture banner and using the hashtag #VoteKids in posts you share.
For sample social media posts, you can check out the awesome Social Media Toolkit from the AAP. The more we spread the word, the better. Every vote counts!

*Disclaimer: The AAP is a non-partisan organization and does not endorse any single candidate or party.

If you still need some convincing, I have broken-down the top 10 reasons why you should get out and #VoteKids this November:

1. **Higher turnout makes our democracy more representative.** In the most recent national election, the US had the 9th-lowest voting rate among the 35 countries in the Organization for Economic Cooperation and Development. Further, many Americans who are directly impacted by important social and economic policies, do not vote. People of color, lower incomes, and younger ages all turn out in lower numbers to vote. By becoming an informed voter and choosing individuals who represent our diverse nation, democracy can begin to work for everyone.

2. **Young people (18-29) make up nearly 21% of the voting population.** According to the Pew Research Center, 69 million millennials are eligible to vote this year— a number rivaling the Baby Boomers. However, only 19.9 percent of 18-29-year olds cast ballots in the 2014 elections which was the lowest youth turnout rate ever recorded in a federal election. Most medical students fall into this potentially influential age bracket, making it extremely important for medical students to cast their vote this election!

3. **It’s not just the president on the ballot.** When I was in graduate school, it was drilled into my head that change happens at the local level. With so much media coverage focused on the presidential election, it is easy to forget how your vote can impact every day life. Attend a town hall meeting or read your city’s newspaper in order to learn more about the issues and candidates in your local community. Further, read about referenda and initiatives on state ballots across the country and learn where the AAP stands. You can also visit Vote Smart to get free, factual, unbiased, information on candidates and elected officials.

4. **The margin of victory can be important.** Even if the candidate you loathe is destined to win, you can make a dent in their margin of victory. The margin limits how much of a “mandate” they can claim once in office, encouraging them to promote more moderate policies in order to not jeopardize re-election. Conversely, even if you know that your preferred candidate will win, adding to their margin of victory can help him/her advance their agenda in office.

5. **Enable yourself to complain with integrity.** Don’t be that person who has strong opinions, but doesn’t act on them in a meaningful way. If you choose not to vote, you lose the right to complain about the outcome and the possible consequences. As President Abraham Lincoln once said, “Elections belong to the people. It’s their decision. If they decide to turn their back on the people and burn their behinds, then they will have to sit on their blisters.”

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6. The presidential candidates have an opinion and a national agenda that will impact kids. The American Academy of Pediatrics asked both presidential candidates to answer four questions focused on child health. These questions represent important issues, such as poverty, gun violence, and affordable health insurance. Hillary Rodham Clinton’s responses can be found here. Donald J. Trump’s responses can be found here.

7. It’s good advocacy training for your future career as a pediatrician. Pediatrics is unique in its commitment to not only meet the needs of children in the clinic/hospital, but to also work systemically to change the environment which contributes to the health and wellbeing of all children. Through advocacy efforts at the individual, community, state, and federal level, pediatricians can move from treating one patient at a time, to working with a broader network of advocates. As a medical student, it is time to start thinking about advocacy as it will be an important part of your career if you choose pediatrics! To learn more about what you can do as a student to advocate for kids this election, see the AAP’s guide for engagement.

8. You get a free sticker! If you’ve spent a day in the pediatric clinic, you know there is nothing better than a free sticker. Enough said.

9. Americans have fought and died for the right to vote. Many Americans take their right to vote for granted. It wasn’t that long ago when certain populations in the US were denied that right to vote. Women gained suffrage in 1919, meaning that many of our grandmothers were, for a time, prohibited from casting a ballot. At various times since the era of women’s suffrage, African-Americans, Asians, Latinos and Native Americans have all faced obstacles to voting. Additionally, accessibility issues continue to disenfranchise citizens with disabilities of every age and race.

10. #PutKids1st: be the voice for those who can’t vote. While children cannot vote or speak up for themselves, we can. We must use our voices to make sure that their needs are prioritized by our elected leaders in state legislatures, governors’ offices, Congress, and the White House.

Now that I’ve convinced you – what’s the next step? Well, make sure you’re registered to vote! You can check your voter registration status in 30 seconds here. If you are not registered yet, get registered in 2 minutes here. It is important to be aware of your state’s voter ID requirements and voter registration deadlines. Most states have deadlines 30 days or less before the election.

As a medical student, you may be living in a different state than you were previously registered. Further, you may be unsure if you can get out of class or clinical duties on November 8th to vote. Luckily, you can vote absentee and get your ballot sent directly to your current address. How convenient! Sign up here for an Absentee Ballot or check out Rock the Vote to learn how to vote by mail from your home state.

There’s a lot at stake this election. One in five children lives in poverty, one in five children lives in households where food is scarce, and seven children die from gun violence every day. The AAP represents 66,000 voices for children. Will you be one of them this November?

References:
Why is it important for medical students to get involved in advocacy?

Medical students are at the very beginning of their career in medicine; they will become increasingly more specialized in their focus as they advance in their training. Learning what they’re passionate about and how to turn that passion into real progress for their patients and profession, is a powerful tool. The earlier they start, the better and more effective they will become as they continue their education and career. By the time they’re in practice, they’ll be training other medical students how to advocate—and peer-to-peer mentorship is one of the most effective ways to learn.

How can medical students promote advocacy at their own medical schools?

By giving advocacy talks to their class, working to help make advocacy part of the curriculum, or simply being a student with an active eye—applying what they are learning outside the classroom to what they are learning in it, and vice versa. For example, they can be picking up anecdotes about the cost of medical school and student debt which can be used to advocate for loan forgiveness. Additionally, they can share advocacy opportunities with their colleagues, lead efforts to join together to push for a bill, write something in the media, work to get time off to vote on election day, and educate their institution about our #VoteKids campaign.

How can medical students get involved in causes relevant to the upcoming presidency and state elections?

1. By voting on November 8th! 2. By downloading the AAP’s Blueprint for Children and sharing it with their institutions. 3. By participating in our #VoteKids campaign leading up to the election. Our website includes resources that are intended to be used for advocacy: (1) responses from both presidential campaigns to questions the AAP asked each candidate about children’s health, (2) guidelines for writing op-ed s on why it’s important to #VoteKids, (3) a prescription to vote, (4) information on changing your social media profile photo to our I #VoteKids message, (5) a social media toolkit on the campaign, (6) our #VoteKids video, featuring AAP leaders and pediatric residents, (7) soon, state specific infographics on when polls are open in each state, state ballot initiatives AAP is tracking.

How can medical students get involved in advocacy with the AAP on a national level?

The best way to get involved in federal advocacy is to just go to DC and meet with members of Congress and their staff. We offer an annual legislative conference with advocacy trainings for pediatricians of every experience level. There are scholarships available for medical students. It’s a wonderful way for students to network with other pediatricians, learn skills such as using social media to craft an effective message, and hear from speakers like cabinet secretaries and members of Congress. Attendees also go to the Hill during the conference to advocate for a specific issue that is relevant at the time of the conference. Visit the website to learn more about this year’s conference, taking place April 23-25, 2017.
The AAP Department of Federal Affairs in Washington, DC, offers an internship for 4th year medical students interested in learning about the legislative process and federal advocacy. To learn more, read below and visit their website.

What does a typical day look like for a medical student doing the DC internship with the AAP?

Every day is different in Washington, and the same is true for medical student interns. We treat interns like an extension of our DC office staff, who lobby and communicate every day to make sure that legislators and decision-makers in the highest ranks of the federal government are thinking about children the right way, and prioritizing them. One day, an intern may be at a congressional hearing where a pediatrician is testifying. Another day, there might be a briefing on child nutrition or a press conference at the Capitol on the Affordable Care Act. It’s a wonderful way for medical students

What kinds of projects or activities do medical students work on during their DC internship?

All kinds of different ones; we have had medical students do in-depth analysis of complex federal regulations, write op-eds in their hometown newspapers, help write issue briefs on key policy topics, support preparation for advocacy conferences, and much more. It’s really up to the intern to look for opportunities where their interests align with the demands of the legislative agenda. That’s where the most exciting outcomes can happen.

What kind of impact can medical students make during their advocacy rotation in DC? Are there any specific examples that come to mind?

We’ve had medical student and resident interns that have made a tremendous impact during their short time in DC. One example is where a resident worked with staff in DC to write and publish an op-ed about early literature, who then got a call on his cell phone from his member of Congress wanting to learn more about the article. The member of Congress ended up reading to the children at the resident’s institution! Another example is when an intern developed sophisticated methodology for us to analyze data and feedback from pediatrician leaders to inform our recently launched Blueprint for the next administration on how to prioritize children. We’ve had medical students and residents get to meet members of Congress during their internships, go on Hill visits to offer a firsthand perspective on how policies help or hurt their patients, and the list goes on. There really are so many ways the short internship can have a lasting impact.

What types of skills do medical students learn during this internship?

How to distill research and data and evidence into sound bites and stories to tell legislators. How to think on their feet, make the most of every minute infront of a Hill staffer (even if it means lobbying them while walking down a hallway), and to seek out opportunities without waiting to be told. Students learn how to think creatively to get to the right solution.
Medical-Legal Partnerships: Screening For Legal Needs as a Social Determinant of Health

By: Zuhair M. Haleem

As our healthcare system shifts toward value-based reimbursement, we must focus more on population health management initiatives. In order to accomplish this transition, it will require the implementation of a different type of healthcare delivery system where screening for the social determinants of health is essential.¹

More specifically, this new system must have a greater focus on population health management initiatives which involve clinical integration and care coordination.² A patient’s social history must be an important consideration for clinicians as 60% of an individual’s health is determined by social and environmental factors.²,³

Medical-legal partnerships (MLPs) can be an effective tool to identify patients, especially children, who are disproportionately affected by socioeconomic and environmental conditions and require legal assistance to address their health conditions. The legal needs of patients can often act as a barrier to positive health outcomes when patients do not receive the benefit of laws intended to address the social determinants of health. For example, underserved children in particular are disproportionately affected with regards to access to food, housing, education and security.⁴,⁵,⁶,⁷

In order to address such issues, MLPs function within five domains of medically related legal needs and use the assessment tool I-HELP (Income, Housing, Education/Employment, Legal Status, and Personal and Family Stability and Safety).⁸ The utilization of MLPs results in increased access, return on investment, and improved health outcomes.⁴,⁵,⁶,⁷

The first formal model for MLPs was developed in 1993 by the Department of Pediatrics at Boston Medical Center and Boston University School of Medicine where a three-pronged approach was set forth to apply preventative law to improve health outcomes.⁸ The first component involved providing legal advice to patients with the goal of early detection of legal problems and the prevention of legal crises. The second component focused on improving health care systems by educating clinicians on legal needs and implementing tools to identify and address legal needs that impact health. The third component involved MLPs advocating for proper enforcement of existing laws that address the social determinants of health and supporting new legislation meant to benefit vulnerable populations.

Another example of a successful MLP is the Cincinnati Child Health- Law Partnership (Child HeLP). A joint venture between Cincinnati Children’s Hospital Medical Center (CCHMC) and the Legal Aid Society of Greater Cincinnati (LASGC), Child HeLP, was launched in 2008 with the goal of screening 90% of its patients for social determinants of health. The subsequent increase of legal referrals led to 1,742 (89%) positive legal outcomes, affecting nearly 6,000 children and adults, which translated into nearly $200,000 in recovered benefits over the course of 35 weeks.⁴

The Children’s Hospital of Virginia along with the Massey Cancer Center are currently partnered with the Legal Information Network for Cancer (LINC), the Legal Aid Justice Center (LAJC), and the Central Virginia Legal Aid Society (CVLAS) to provide pro bono legal help to patients identified as having legal needs affecting their health.⁹ Since the MLP began in 2015, $740,750 worth of legal services have been given to 251 families and $84,000 worth of financial benefits were returned to patients as a result of successful Medicaid and Social Security Disability appeals.¹⁰ Clinicians at the Children’s Hospital of Virginia describe how patients were able to force landlords to make needed repairs to housing with the proper legal assistance.¹² Often times, it is substandard living conditions that cause severe pediatric asthma and other preventable health conditions.⁴,⁵,⁶,⁷
In order to transition to a population-focused healthcare system and comprehensively address the social determinants of health, a healthcare team needs to be equipped with the knowledge of how to identify, treat, and prevent health-harming legal needs in patients, clinics, and populations. Pediatricians in particular should be trained to recognize common situations in which their patients’ health might be aggravated by legal needs which are not being addressed. Clinicians can play a key role in shaping the strategy to address the complex factors that influence health and equity by encouraging interprofessional cooperation and promote a “health in all policies” throughout the community.

To find out more about MLPs and to learn about how you can get involved, click here.

References

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Choosing a Residency Program

Q&A By: Pattie Quigley, MD, MME, FAAP

Small programs versus large programs, what do I need to consider?

Whether you prefer a small or a large program depends a lot on your personality and preferred learning environment. One is not better than the other. Personally, I wanted to know everyone in my program. I noticed at large programs that some of the residents were meeting each other for the first time on my interview day. I didn’t think that would be a good learning environment for me. I wanted to know my attendings and co-residents well because that felt like a safer learning environment. Ultimately I chose a program that was 13 residents and it was the right size for me.

With a larger program comes more specialized care and perhaps busier services (NICU, PICU, wards). Very often the largest programs are quaternary care centers and take care of patients with very rare diseases. This is not a bad thing. But it might not be the best fit for you if you love bread and butter general pediatrics. The most common fear about smaller programs is what might happen if someone gets sick or has a baby. It is worth asking about this. Especially in smaller programs you want to know if their services are resident dependent or if they can function without a resident on the team. If they are resident dependent and someone gets sick, you want to know who covers that service.

Fellows versus no fellows, what do I need to consider?

There are two main benefits that come to my mind. The first is related to teaching. Often, fellows are more available than attendings and they can be great teachers. Because they are closer to residency, they may better remember what your knowledge base is, which can really inform their teaching. In addition, if you think you know what specialty you are interested in pursuing, doing your residency in a hospital with that particular fellowship is likely to better inform your decision. It can also make for an easy transition into fellowship—it is common for people to do residency and fellowship in the same hospital.

The most commonly cited disadvantages of being in a hospital with fellows is that you may compete for procedures. This is something worth asking the residents about—especially when it comes to their PICU and NICU experiences. The other complaint is you only ever talk to the fellow and don’t get direct teaching from the attending. Again, this is very program specific. In really large institutions that have large residencies and large fellowships, that may very well be the case. Most hospitals do not have fellowships in every specialty or do not have fellowships in every specialty, so you can still get plenty of time with the attending.

What should medical students factor in when they are trying to decide which programs to rank highly?

First and foremost, do not rank a program where you would not be happy. If you don’t like the program, don’t take the chance of ending up there. And, don’t rank a program #1 just because it has a strong reputation. If you didn’t feel at home there on interview day, you won’t get the best training there, even if it is the best pediatrics program in the world. When it comes to choosing a residency program, there is no right or wrong. It is really about what feels like the best program for you and your situation. Life during residency is stressful and you want the rest of your life outside of residency to be as simple as possible. Where do you want to live? For the adventurous, residency can be a great time to move to a new part of the country. On the other hand, if you have family needs to consider, place a very high priority on those needs—a happy, employed (if so desired), spouse makes for a happier home life. Your life outside of work is as important to the decision as the quality of the program. There are many, many ways to consider how to rank programs. You will hear different advice from every person you talk to. Personally, I wanted to attend a program where I could admit “I don’t know” and ask for help without shame. I also looked for programs where I already had friends and family—I wanted life outside of work to be easy. In the end, as is true for many pediatricians, I went with my gut instinct. I was very happy with my decision.

Dr. Pattie Quigley, MD, MME, FAAP, is a pediatric hospitalist at All Children’s Hospital Johns Hopkins Medicine and the Director of Undergraduate Medical Education at Johns Hopkins.
The Chronic Cough- A Case Study

By: Pooja Jaeel, B.A., Ernesto Casillas, B.S., Shazia Khan, M.D.

Case Presentation:
A previously healthy, 19-year-old, Hispanic, girl presents with new onset of cough and shortness of breath for the past four months. The patient describes a progressive, productive cough, which is worse with exertion and at night. Further, she is increasingly affected by her shortness of breath which now limits her daily activities which include doing chores and attending her college classes. She reports an involuntary weight loss of 16 pounds over the past four months.

Since the onset of these symptoms, she has been evaluated three times in the emergency department (ED) and treated twice with empiric ceftriaxone and azithromycin without any improvement in symptoms.

Previous medical and surgical history is negative. Family history is only significant for hypertension in both parents. She denies any recent travel, sick contacts, exposure to animals, tobacco, alcohol or drug use. Medications include IM medroxyprogesterone acetate and PRN benzonatate for her cough.

Hospital Course:
The patient is admitted and her O2 saturation is found to be 93% at rest. Her symptoms improve on 2L of oxygen via nasal canula. Her physical exam is significant for diffuse crackles throughout both lung fields anteriorly and posteriorly. CBC, CMP, metabolic profile and liver studies are all within normal limits. Sputum cultures are negative for organisms. Her chest x-ray demonstrates bilateral reticular opacities and small bilateral plural effusions in the lower lung fields. Pulmonary function studies reveal a restrictive lung disease with an increased FEV1/FVC. Right lung biopsy demonstrates a necrotizing granulomatous inflammation and vasculitis. A working diagnosis of granulomatosis with polyangiitis (GPA) is proposed. This diagnosis is confirmed via auto-immune serologies which are positive for anti-neutrophil cytoplasmic antibodies (ANCA) Myeloperoxidase (MPO) and negative for ANCA proteinase 3 (PR3).

Management and Outcome:
Once the diagnosis of GPA is made, the patient is started on a 3-day course of high dose (1gm) IV methylprednisolone and receives her first dose of rituximab. As GPA also presents with a syndrome of upper airway and renal vasculitis, an MRI of the head and urinalysis are performed. MRI demonstrates maxillary sinus disease, but urinalysis is normal. After the patient is started on methylprednisolone and rituximab therapy, the patient’s shortness of breath improves within days. She is discharged from the hospital and continues to be followed by outpatient rheumatology. Seven months after hospital discharge, the patient is doing well overall. She achieved remission six months after initiating induction therapy and is now on maintenance therapy with azathioprine. She continues to have complaints of sinus congestion and has recently started to complain of tinnitus and mild right-sided hearing loss. She is followed by outpatient rheumatology and otolaryngology.
Discussion:
GPA is a rare small vessel vasculitis which is classically diagnosed in patients between 40-65 years old with equal prevalence in males and females. According to the European Medicines Agency, diagnosis is based on involvement of upper airways (sinusitis, otitis media or mastoiditis), lower airways (pulmonary infiltrates, nodules or cavitations), and/or kidneys (glomerulonephritis) with a positive ANCA test (Falk, 1997). GPA usually presents with a positive PR3-ANCA however, but up to 20% of patients have a positive MPO-ANCA instead.

The patient presented here is not a classic case of GPA. At 19 years old, this patient is much younger than the typical patient with GPA. At presentation, her clinical symptoms were mostly limited to diffuse damage to the lower airways with no upper airway or renal complaints. Further, her urinalysis was normal at diagnosis and continues to be normal after seven months. Studies show that only 18% of patients initially present with renal damage however, up to 85% of patients develop renal complications within two years of initial diagnosis (Hoffman, 1992). Therefore, close monitoring of this patient’s kidney function is warranted. This patient presents with atypical serologies as she is MPO-ANCA positive.

It has been suggested that the type of ANCA is a good prognostic indicator of remission and relapse (Watts, 2007). In 2005, Hogan et al. (2005) found that PR3-ANCA seropositivity, upper respiratory tract involvement, and lung damage were risk factors for relapse after achieving remission. As our patient is MPO-ANCA positive, she may be at a lower risk of relapse now that she has achieved remission.

This case demonstrates a rare presentation of GPA. From this patient, we have learned to keep a high index of suspicion of an autoimmune vasculitis in young patients with repeated ED presentations despite normal labs and a relatively benign presentation. Though it is invasive, obtaining a lung biopsy sooner in the disease course could have prevented several courses of unnecessary antibiotic therapy and radiation exposure from multiple x-rays. It remains to be seen how her disease course will be influenced by her relatively young age and presenting clinical symptoms.

References:
Update from the Medical Student Subcommittee

By: Ali Mols, MD, Chair

Medical student involvement within the AAP has achieved a major milestone this year as now medical students are considered national members of the AAP. With this recognition, there are now more resources for students than ever before. From the AAP News online to Pediatrics online to the Federal Advocacy Action Network, the opportunities are endless to advocate on behalf of children and their families. Furthermore, we are engaging students through promoting leadership opportunities on the national and local level. From our 21-member Medical Student Subcommittee (MSSC) to expanding our program representative position on medical student campuses, we hope to continue to improve communication between the AAP, MSSC and pediatric interest groups across the country.

We are continuing our annual Pediatric Interest Group of the Year Award to recognize groups going above and beyond to make medical students feel welcome in pediatrics. Each year, the winning group is recognized at the AAP National Conference. At the National Conference, the MSSC organizes a half-day program focused on medical student needs and interests. Included in this free event is a keynote address given by a child health advocate and an interactive residency panel where students can have their questions answered by three pediatric residency program directors to learn how to become a successful residency applicant.

Ali Mols, MD
Medical Student Subcommittee Chair

#VoteKids and learn more here: www.aap.org/votekids
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