REPORTS OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

The following reports, 1–3, were presented by Clifford Moy, MD, Chair:

1. INTERNATIONAL MEDICAL GRADUATES SECTION AND ORGANIZED MEDICAL STAFF SECTION, FIVE-YEAR REVIEWS

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED
See Policy G-615.003

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, only with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

The Council analyzed information from letters of application submitted by the International Medical Graduates Section (IMGS) and the Organized Medical Staff Section (OMSS) for renewal of delineated section status.

APPLICATION OF CRITERIA TO THE IMGS

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

Established in 1997, the IMGS facilitates the development of information and policies for physicians who graduated from medical schools outside the United States or Canada. The IMGS is the only group within the AMA to represent international medical graduate physicians (IMGs). All AMA members who are IMGs are automatically members of the IMGS. The IMGS enhances AMA outreach, communication, and interchange with IMGs by advocating on their key issues through resolutions, educational sessions, open forums, employment contract guidelines, and immigration webinars. Some of the unique professional issues raised by IMGs include the following: unequal treatment with regard to state licensing criteria, disparities in the minimum United States Medical Licensing Examination (USMLE) test scores, and J-1 visa issues related to delays, denials, and caps. Additionally, the IMGS recommends the development of amicus briefs on behalf of its constituency.

CLRPD assessment: The IMGS provides the only formal structure for physicians who graduated from medical schools outside the United States and Canada to participate directly in the deliberations of the House of Delegates (HOD) and the activities of the AMA.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.
The IMGS has pursued closer working relationships with other AMA sections and departments as well as member societies of the Federation to create educational resources and leadership development programs for IMGs. Additionally, the IMGS has collaborated with the Council on Medical Education on graduate medical education and licensure initiatives.

Initiated in 2008, the Busharat Ahmad, MD, Leadership Development Program, held at each AMA Annual and Interim Meeting, offers education sessions for improving the skills of IMGs who aspire to be in leadership positions. These leadership development sessions have resulted in members building relationships with national IMG leaders who serve as mentors to program committee members and have yielded excellent attendance and evaluations among participants.

CLRPD Assessment: The IMGS serves its constituents by bringing professional issues unique to them to the forefront of organized medicine and by providing targeted educational and policy resources.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

The IMGS convenes an eight-member governing council (GC) to direct the section's agenda and strategies, carry out the policies and actions adopted by the IMGS Congress, endorse section members for various leadership positions within the AMA and other organizations, develop resources for IMGs, and interact with AMA leaders to ensure alignment with the AMA strategic plan. The Federation and the IMGS nominate candidates for the GC. The IMGS members use an electronic voting system to elect GC members. The IMGS has established eight committees to implement the mission and goals of the section.

Members of the IMGS participate in the AMA Accelerating Change in Medical Education (ACE) strategic focus area by attending ACE Consortium events and providing appropriate feedback to the ACE team. As a complement to the work carried out by the AMA's Enhancing Professional Satisfaction and Practice Sustainability strategic focus area, the IMGS Research and Development Committee is planning a project to determine whether there are unique factors related to IMGs' professional satisfaction compared to US medical graduates. The GC is conducting research on physicians awaiting residency placement to elucidate basic demographics of this little known cohort.

CLRPD Assessment: The IMGS convenes a GC from its members and established eight committees, which offer additional leadership opportunities for non-GC members. The section has established business meetings that are open to its members and provide venues for sharing concerns and identifying opportunities for IMGs, which is consistent with the objectives of this section.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

The IMGs who join the AMA are automatically enrolled in the IMGS. Between 2008 and 2014, membership in the IMGS grew from 30,000 to more than 37,000 members. The potential membership of the IMGS is approximately 278,000 members, according to the AMA Physician Characteristics and Distribution in the US, 2015 edition.

According to BOT Report 7-A-14, Demographic Report of the House of Delegates and AMA Membership, twenty-three percent of all physicians and medical students are IMGs. Nearly eight percent of delegates and alternate delegates of the HOD are IMGs, while IMGs comprise sixteen percent of AMA members.

CLRPD Assessment: The IMGS is comprised of members from an identifiable segment of AMA membership and the general physician population. This group is able to represent a minimum of 1,000 AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

Approximately 15 percent or nearly 5,000 IMGS members participate in some aspect of the business of the IMGS, including participation in meetings, webinars, teleconferences, committees and surveys. Outcomes of IMGS meetings include forwarding resolutions to the HOD; identifying gaps in resources and policies, future AMA leaders and mentors, and future program topics; providing mock residency interview program volunteers, judges for the AMA Research Symposium, eligible nominees for ECFMG, the National Resident Matching Program, the Accreditation Council for Graduate Medical Education, and the Council on Graduate Medical Education; and disseminating regulatory information about new immigration laws, ECFMG certification changes and requirements, and updates from the Federation of State Medical Boards and National Board of Medical Examiners.

CLRPD Assessment: The IMGS has a long history with the AMA, which benefits from having the distinct voice of the IMGS in the HOD. Since its inception, the IMGS has taken numerous steps to align its structure with the policymaking activities of the AMA.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the AMA HOD.

The IMGS serves as a conduit for communication between grassroots IMGs and the AMA. A call for resolutions is sent to all IMGS members, the chairs of state IMG groups, and the leadership of ethnic societies prior to HOD meetings. Discussions of pending resolutions occur at each HOD meeting during the IMGS Congress business meeting and strategy sessions. The IMGS Resolutions Committee also convenes teleconferences four to six times per year to maintain open lines of communication with members of the section. The IMGS has authored more than 90 resolutions in the past 15 years, of which the HOD has adopted approximately 70 percent as policy.

CLRPD Assessment: The IMGS provides numerous opportunities for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the HOD policymaking process.

CONCLUSION

The CLRPD has determined that the IMGS meets all criteria; therefore, it is appropriate to renew the delineated section status of the section, which will allow members of the IMGS to continue to have focused representation in the HOD.

APPLICATION OF CRITERIA TO THE OMSS

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the broader, general issues that face medicine. A demonstrated need exists to deal with these matters, as they are not currently being addressed through an existing AMA group.

The OMSS is the sole constituent group that provides a direct and ongoing relationship between the AMA and physicians who are members of medical staffs. The section actively addresses issues of medical staffs, which include credentialing; privileging; peer review; physician protections such as due process rights, hospital accreditation standards and other hospital-related regulatory and legislative matters; hospital management models such as co-management service line agreements and other joint management arrangements; physician employment and contracting in the hospital setting; and relationships between independent and employed members of medical staffs.

CLRPD assessment: The OMSS provides the only formal structure for physicians on hospital and health system medical staffs to participate directly in the deliberations of the HOD and the activities of the AMA.

Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The OMSS has initiated or contributed substantially to the development of AMA policy on a variety of vital topics, including medical staff self-governance, physician employment, physician-hospital relations, accountable care organizations, and physician leadership of inter-professional care teams.

Over the past five years, the OMSS, working in consultation with various segments of the AMA, has developed or significantly revised a wide range of substantive resources addressing issues of interest to medical staffs and physicians practicing in the hospital setting. These resources include numerous educational webcasts on a variety of topics; Physician’s Guide to Medical Staff Organization Bylaws; Model Medical Staff Code of Conduct; Guidelines for Hospital Compliance Program Audits and Investigations; Annotated Model Physician-Hospital Employment Agreement; AMA Principles for Physician Employment; and AMA Physician Assistance Service.

Last year, the Centers for Medicare & Medicaid Services published a final rule revising the Conditions of Participation for hospitals, which permits a multi-hospital health system to have a unified, system-wide medical staff, rather than a separate medical staff at each hospital, provided the medical staff at each hospital votes to accept a unified staff structure. The final rule also eliminates a requirement that the hospital governing body include a member of the medical staff. The governing body must now consult at least two times per year with the medical

staff. Since 2011, the AMA and its OMSS have strongly advocated to protect and enhance the role of the medical staff throughout various iterations of these regulations. The OMSS ensured that the issue was brought to the attention of medical staff leaders and members of medical staffs. Additionally, the OMSS contributed to the development of resources to assist medical staffs in implementing the rule in a physician-friendly manner.

CLRPD Assessment: The OMSS is the only group within the AMA dedicated to advocacy on issues affecting physicians on hospital and health system medical staffs. The OMSS serves its constituents by bringing professional issues unique to them to the forefront of organized medicine and by providing targeted educational and policymaking resources.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

While policymaking activities are a core component of OMSS activities, in recent years, the OMSS has shifted some of its energies to the development of educational and other resources for medical staffs and their members. In particular, the structure of OMSS meetings has been adjusted to allow for increased educational programming. OMSS meetings are now conducted over a two-and-a-half day period, which allows equal time for policymaking and business activities, and educational programming.

The OMSS Assembly elects the GC members of the section through a democratic process. The AMA Bylaws and OMSS internal operating procedure require that members of the GC be certified OMSS representatives, who are selected by the members of the hospital/health system medical staffs they represent, each of which may establish its own qualifications.

CLRPD Assessment: The OMSS elects a GC from its voting members. The section's business meetings are open to its members and provide venues for sharing concerns and identifying opportunities for physicians on hospital and health system medical staffs. This is consistent with the objectives of this section.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

OMSS membership is limited to physicians who have been selected and certified by their medical staffs as official representatives. Individual physicians who are not certified OMSS representatives are not included in OMSS membership figures, even if they are members of medical staffs.

As of the June 2014 OMSS Assembly, 346 OMSS representatives had been certified as official representatives of medical staffs. Assuming an average medical staff size of 125 physicians, that 15 percent of practicing physicians are AMA members, and that there is minimal staff membership overlap between represented hospitals, approximately 6,500 AMA member physicians are directly represented in the OMSS through their staffs' OMSS representatives.

The total number of AMA member physicians who could potentially be represented by the OMSS is unclear, as no data exist on the number of members who have been appointed to at least one hospital/health system medical staff.

CLRPD Assessment: The OMSS is comprised of members from an identifiable segment of AMA membership and the general physician population. This group is able to represent a minimum of 1,000 AMA members.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body.

Approximately one-third of OMSS representatives (100-125) attend and are credentialed to vote at any given OMSS Assembly. Nearly 80 percent of all OMSS members have attended at least one meeting in the last two years. In addition to OMSS representatives, 25 to 50 guests, e.g., medical staff members who are not yet certified representatives, and individuals from stakeholder organizations such as The Joint Commission and the National Association of Medical Staff Services attend any given meeting. The impact of each OMSS Assembly reaches far

beyond the members in attendance, as OMSS representatives are expected to provide feedback on the outcomes of meetings and ongoing activities of the OMSS to the medical staffs they represent.

CLRPD Assessment: The OMSS has a long history with the AMA, which benefits from having the distinct voice of the OMSS in the HOD. Since its inception, OMSS has taken numerous steps to align its structure with the policymaking activities of the AMA.

Criterion 6: Accessibility - Provides opportunity for members of the constituency who are otherwise underrepresented to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

Although supporting data are not available, it is reasonable to surmise that a large proportion of the members of the HOD are members of at least one medical staff. Moreover, many OMSS representatives also serve as AMA delegates for their state or specialty medical societies. It would appear, at least on paper, medical staff members and their concerns are well represented in the HOD. However, it can be difficult to usher medical staff-related resolutions through the policymaking processes of state and specialty medical societies, primarily because many of these organizations lack the time, resources and expertise necessary to develop solutions to what are frequently specific, complex and nuanced medical staff problems. The OMSS serves as an entry point to the HOD for most AMA resolutions addressing medical staff and hospital matters, even though such issues directly affect a large majority of AMA delegates. In this sense, the OMSS provides opportunity for "underrepresented" members to introduce issues of concern and to participate in the AMA policy-making process.

On average, the OMSS submits five to seven resolutions for consideration by the HOD at each meeting. More than 90 percent of these resolutions are adopted in some form.

CLRPD Assessment: Frequently, medical staff physicians' concerns are topics of discussion in reference committees and HOD sessions; consequently, having the perspective and expertise of the OMSS is important to the AMA when creating policy.

CONCLUSION

The CLRPD has determined that the OMSS meets all criteria; therefore, it is appropriate to renew the delineated section status of this section, which will allow members of the OMSS to continue to have focused representation in the HOD.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the International Medical Graduates Section and the Organized Medical Staff Section through 2020 with the next review no later than the 2020 Annual Meeting and that the remainder of this report be filed.

2. DEMOGRAPHIC CHARACTERISTICS OF THE HOUSE OF DELEGATES AND AMA LEADERSHIP

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

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

> (1) A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our

> AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and our AMA physician membership every other year. (3) Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations.

Pursuant to part 3 of the aforementioned policy, the Council prepared CLRPD Report 3-A-15, "Best Practices and Successful Efforts to Increase Diversity, by Age, of AMA Delegates and Alternate Delegates."

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

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

Similar to previous reports, this document compares AMA leadership with the entire AMA membership and with the overall US physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. Resident/fellow physicians endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA leadership includes the following groups:

- Delegates
- Alternate Delegates
- The AMA Board of Trustees
- AMA councils and the sections and special groups (hereinafter referred to as CSSG; see detailed listing in Appendix A).

Some comparisons are made separately for state and specialty society delegations, in which case delegates and alternate delegates are combined for the states or specialties.

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect delegation rosters as of year-end 2014. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of US medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2014 Masterfile, after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. First, members of the Board of Trustees, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Second, vacancies in delegation rosters mean the total number of delegates is fewer than the 527 allotted at the 2014 Interim Meeting. The number of alternate delegates is nearly always less than the full allotment. Third, race and ethnicity information, which is provided directly by physicians, is missing for slightly under one-sixth of AMA members and just over one-fifth of the total US physician population, limiting the ability to draw firm conclusions. Board of Trustees Report 24-I-06 described efforts to improve AMA data on race and ethnicity, and improvements have been made resulting in a decline in reporting race/ethnicity as unknown in some of the leadership groups and overall AMA membership.

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

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 presents basic characteristics of AMA leadership along with corresponding information for the total AMA membership and the entire US physician population. On the whole, numbers are not significantly different from two years ago (see CLRPD Report 2-A-13). The average ages of both delegates and alternate delegates declined .8 years. Delegates, alternate delegates, and the Board are all somewhat older than the average member or physician (including medical students). The average age for the councils, sections and special groups (CSSG) is 3.1 years older than the average AMA member and equal to that of the average physician.

An ongoing trend that has emerged over the past 10 years of data is the increasing percentage of House of Delegates (HOD) representation by those under the age of 40. Currently, 12.1% of delegates and 23.9% of alternate delegates are under the age of 40. Those figures have risen 1.4% and 2.9%, respectively, over the past two years, and 5.3% and 10.5% over the past 10 years. This can largely be attributed to the increasing proportions of resident delegates and alternate delegates, which have increased by 4.5% and 4.6%, respectively, over the same 10 year period.

Other characteristics shown in Table 1 indicate that female physicians remain relatively underrepresented among delegates and alternate delegates. Since 2012, the percentage of female delegates rose 4.2%, and the percentage of female alternate delegates rose 1.7%. As indicated in Figure 1, this reflects the continuation of an ongoing trend over the last 10 years, during which the percentage of female delegates has risen 7.8% and the percentage of female alternate delegates has risen 5.9%. Over that time frame, the percentage of females in the overall physician population rose 4.6%. The percentage of female delegates is 8.6% less than that of all physicians.

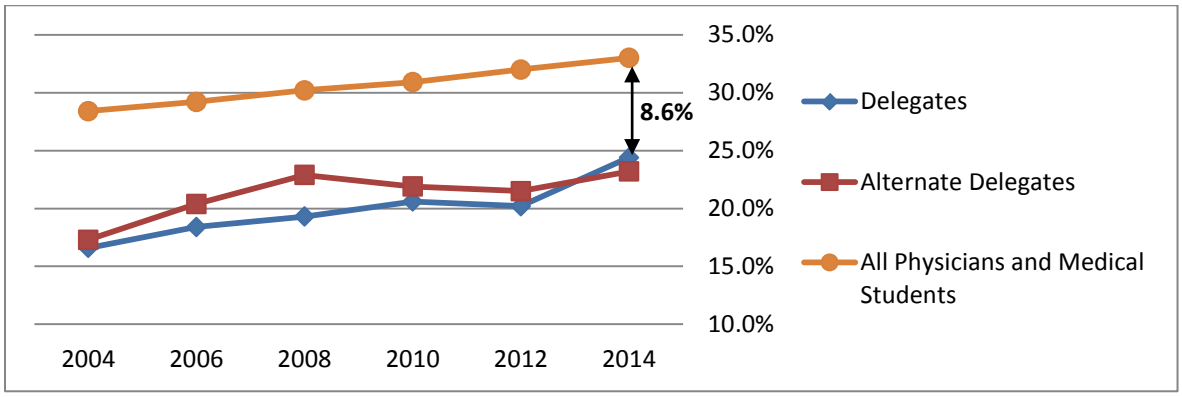


Figure 1. Female Representation in the HOD and Overall Physician and Medical Student Populations. 2004-2014

Figure 2 shows that IMGs make up another proportionally underrepresented group in the HOD. IMGs make up 22.9% of all physicians, yet make up only 7.9% of delegates.

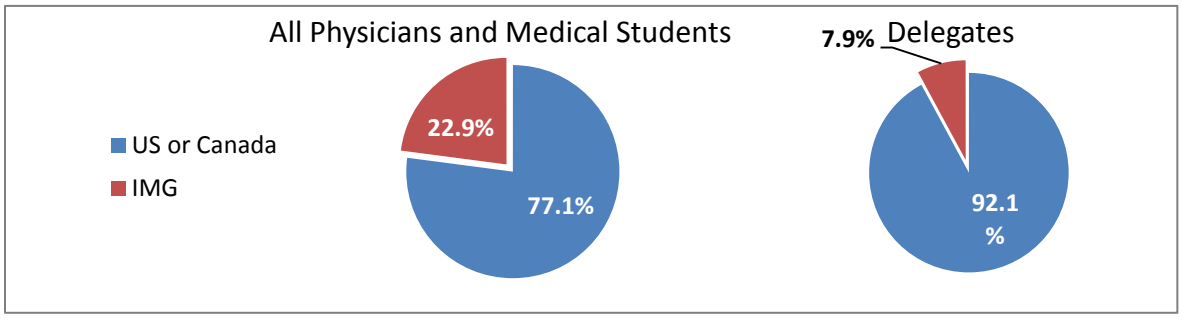


Figure 2. IMG Proportion of All Physicians and Medical Students vs. Delegates.

Comparisons across race and ethnicity categories are complicated by the large proportion of physicians for whom data are missing. Except for the Board and CSSG, for whom it is comparatively easy to solicit information, data are

missing for approximately 11% to 20% of the groups arrayed in Table 1. Nonetheless, for all four leadership groups, at least 60% are white, non-Hispanic. In three of the four leadership categories—delegates, alternate delegates, and CSSG—the percentage of members who identified as white, non-Hispanic fell, by 3.3%, 1.7% and 6.9%, respectively, while the percentage of white, non-Hispanic Board members grew by 5%.

Additionally, Table 1 includes data on medical education, which show that more than 89% of each leadership group has graduated from medical schools in the United States or Canada. This compares to 83.6% of AMA membership and 77.1% of the US physician population.

Data on physicians' and students' current activities appear in Table 2. The "life stage" classifications correspond with the membership criteria for specific AMA groups such as young (under age 40 or in first eight years of practice), mature (age 40-64), and senior (age 65 or more).

Over twenty-three percent (23.6%) of AMA members are students, compared to roughly eight percent (8.1%) of the US physician population. Approximately one in 20 (4.8%) delegates and one in 12 (8.7%) alternate delegates are medical students. The total number of regional medical student delegates and alternate delegates is 47. Nearly eighteen percent (17.6%) of AMA members are resident/fellow physicians, compared to roughly ten percent (10.1%) of the US physician population. Approximately one in 20 (5.2%) delegates and one in 13 (7.6%) alternate delegates are resident/fellow physicians. The data include 37 sectional resident delegates and alternate delegates.

Young physicians, those under the age of 40 or in their first 8 years of practice, remain one of the most consistently underrepresented groups in the HOD. Just 3.5% of delegates and 9.6% of alternate delegates qualify as young physicians, compared to 17.5% of all physicians and 9.0% of AMA members. Just over twelve percent (12.2%) of CSSG leaders are classified as young physicians.

Overall, more than half of the delegates and alternate delegates are mature physicians, defined as 40-64 years of age. More than one-third of delegates and one-fifth of alternate delegates are senior physicians, which is defined as over the age of 65.

Table 2 also includes data on present employment patterns for the leadership groups as well as AMA members and the total US physician population. Students and residents/interns/fellows have been called out as two separate categories under present employment.

The self-designated specialties of AMA leadership appear in the lower panel of Table 2. Except for a slight overrepresentation of surgical specialists among delegates and alternate delegates, the distribution of specialties is consistent with AMA membership and reasonably similar to the entire physician population.

Specialty Delegations to the AMA House of Delegates

While the preceding comparisons examined demographic attributes of AMA leadership, the stated goal of the demographic report is to offer data that encourages state and specialty delegations to increase diversity. The Council acknowledges most delegations are too small to exhibit true diversity within their ranks, but hopes diversity will be apparent within the composition of the HOD.

In this regard, Table 3 presents data on specialty society delegations. Because individual delegations are too small to analyze separately, the data are presented by specialty discipline rather than delegation. The self-designated specialties and specific specialty designations contained within each are found in Appendix B. The totals for the delegates and alternate delegates are combined.

At the end of 2014, there were 374 delegates and alternate delegates representing specialty societies in the HOD. The mean age of AMA specialty society delegates and alternate delegates is 56.4 years and the median age is 58 years, significantly higher than the mean age for AMA members of 48.1 and the median age of 50 years.

Resident/fellow physicians and IMGs are uniformly underrepresented across the specialty disciplines. At the same time, because most specialty disciplines have relatively few slots, a change of only one more or one less

resident/fellow physician or IMG would dramatically change the proportions. These data must be interpreted cautiously.

Female representation across all specialty society groups has increased from 20.4% to 24.1% since 2012, with the biggest increases coming from family medicine (11.1%), ob/gyn (10.9%) and pediatrics (10.3%).

State Delegations to the AMA House of Delegates

Table 4 presents data on the mean and median age of AMA members by state as well as the mean and median age of each state delegation. The mean age of AMA members across states is 48.1 years, and the median age is 50 years. Most state delegations are, on average, older than the average for the state's AMA members. The mean age for state delegations is 59.7, or 11.6 years greater than the mean age of AMA members.

Table 5 provides state-by-state figures on the numbers of female and IMG physicians per state and per state delegation. Similar information for resident/fellow physicians and students is presented in Table 6.

Key findings include:

- Both women and IMG physicians are underrepresented on state delegations.
  - Women physicians make up 32.7% of AMA members across the states; however, only 21.9% of delegates and alternates are female.
  - IMG physicians comprise 16.4% of AMA members across the states, while making up 10.3 % of the delegates and alternate delegates.

- Students and resident/fellow physicians have fewer slots on delegations than would be representative of their overall numbers among AMA membership.
  - Students comprise 22.2% of AMA members, but hold only 11.6% of positions in state delegations.
  - Resident/fellow physicians hold 6.2% of the slots in state society delegations even though they constitute 17.0% of AMA members across the states.

CHARACTERISTICS OVER TIME SINCE 2004

Figures 3 through 5 present data related to age of the groups of interest. The average age of all physicians and medical students grew significantly in comparison to 2004, while the age of AMA members, delegates and alternate delegates held fairly steady. The AMA Board has become notably younger, while the average age of CSSG increased.

In 2004, the average age of physicians and medical students was 48.4 years old, but in 2014 that number had risen to 51.2. The average AMA member age decreased slightly from 49.7 years in 2004 to 48.1 in 2014. The average age of delegates declined from 59.1 years in 2004 to 57.5 in 2014, and alternate delegates went from 53.3 in 2004 to 52.5. The average age of AMA Board members went from 57.7 in 2004 to 55.5 in 2014. CSSG went from an average age of 51.1 years in 2004 to 51.2 in 2014.

Present employment is detailed in Table 2 and Figure 6. Significant changes that occurred since the 2013 report include:

- Group Practice Employment Setting:
  - After a large jump from 2010 to 2012, during which the percentage of group practice physicians grew from 30.8% of all physicians to 42.6%, that number fell slightly to 42.0% in 2014. The proportion of group practice physicians among AMA members fell slightly as well, from 27.7% in 2012 to 26.4% in 2014, while the percentage of group practice physicians among delegates fell from 45.1% to 40.2%, representing the largest single demographic shift in the HOD over the past two years.

- Mature Physicians:
  - The percentage of physicians in the mature life stage—those aged 40-64—declined among delegates, alternate delegates and CSSG, by 2.2%, 4.1% and 7.3%, respectively. The percentage of mature physicians also declined by 1.5% among AMA Members and 2.1% among all physicians.

Figure 7 illustrates the gender composition for AMA leadership, AMA membership and the US physician population. Figure 8 shows representation of women physicians over time. The representation of women physicians has generally improved since 2004. The proportion of delegates who are female increased from 16.6% in 2004 to 24.4% in 2014. Among alternate delegates, the numbers went up from 17.3% in 2004 to 23.2% in 2014. The AMA Board was 10.0% female in 2004, but 35% female in 2014. CSSG was 27.3% female in 2004, but this number grew to 38.4% in 2014.

Race and ethnicity of AMA leadership groups, AMA membership, and the US physician population are illustrated in Figure 9. Compared to the US physician population, white, non-Hispanic physicians continue to be generally overrepresented in AMA leadership and membership.

Figure 10 depicts similar information on IMG physicians. The proportion of physicians and medical students who are IMGs grew from 21.7% in 2004 to 22.9% in 2014. The percentage of AMA members who are IMGs grew from 14.2% to 16.4%. Trends among AMA leadership groups show only slight changes for IMGs, with small increases among delegates, alternate delegates, and CSSG. In addition, no IMGs have held a position on the AMA Board in the past decade.

APPENDIX A

Table 1. Basic Demographic Characteristics of AMA Leadership, December 2014

	AMA Delegates (n = 520)[2]	AMA Alternate Delegates (n = 436)[2]	AMA Board[3] (n = 20)	AMA Councils and Leadership of Sections and Special Groups[4] (n = 164)	AMA Members (n =232,126)	All Physicians and Medical Students (n = 1,235,246)
Mean age (years)[5]	57.5	52.5	55.5	51.2	48.1	51.2
Age distribution (percent)						
Under age 40	12.1%	23.9%↑	15.0%↑	32.3%↑	45.9%↑	29.8%
40-49 years	11.5%	13.8%	10.0%↑	10.4%	11.3%	19.4%
50-59 years	24.0%	22.9%↓	25.0%↓	17.7%↓	12.9%	19.3%
60-69 years	34.0%	29.6%	45.0%↑	27.4%	11.4%	16.3%
70 or more	18.3%	9.9%	5.0%↓	12.2%↓	18.6%	15.2%
Gender (percent)						
Male	75.6%↓	76.8%	65.0%↑	61.6%↓	67.3%	67.0%
Female	24.4%↑	23.2%	35.0%↓	38.4%↑	32.7%	33.0%
Race/ethnicity (percent)						
White non-Hispanic	73.5%↓	69.5%	85.0%↑	62.2%↓	59.5%↓	53.3%
Black non-Hispanic	4.8%	2.8%	5.0%	9.1%↑	4.5%	4.1%
Hispanic	2.3%	3.4%	0.0%	3.0%	4.6%	5.1%
Asian/Asian American	6.3%	10.6%	10.0%↓	12.2%	14.7%	15.1%
Native American	0.2%	0.2%	0.0%	0.6%	0.3%	0.2%
Other[6]	1.3%	1.1%	0.0%	0.6%	1.5%	1.8%
Unknown	11.5%	12.4%	0.0%	12.2%↑	14.9%	20.4%
Education (percent)						
US or Canada	92.1%	91.1%	100.0%	89.0%↓	83.6%	77.1%
IMG	7.9%	8.9%	0.0%	11.0%↑	16.4%	22.9%

[2] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[3]Numbers do not include the public member of the Board of Trustees, who is not a physician.
[4]Numbers do not include non-physicians on the Council on Legislation and AMPAC. In addition, Appendix A contains a listing of the AMA councils, sections, and special groups.
[5] Age as of December 31. Mean age is the arithmetic average.
[6] Includes other self-reported racial and ethnic groups.
↑ Indicates an increase of at least two percentage points compared with 2012; see text.
↓ Indicates a decrease of at least two percentage points compared with 2012; see text.

Table 2. Life Stage, Present Employment and Self-Designated Specialty[1] of AMA Leadership, December 2014

	AMA Delegates (n = 520)[2]	AMA Alternate Delegates (n = 436)[2]	AMA Board (n = 20)	AMA Councils and Leadership of Sections and Special Groups (n = 164)	AMA Members (n =232,126)	All Physicians and Medical Students (n = 1,235,246)
Life Stage (percent)						
Student[2]	4.8%	8.7%	5.0%	11.6%	23.6%	8.1%
Resident[2]	5.2%	7.6%	5.0%	12.2%	17.6%	10.1%
Young (Under age 40 or first eight years of practice)[3]	3.5%	9.6%	5.0%↑	12.2%↑	9.0%	17.5%
Mature (Age 40-64)[3]	51.7%↓	52.3%↓	60.0%	39.0%↓	26.4%	41.9%↓
Senior (Age 65 or more)[3]	34.8%	21.8%	25.0%↓	25.0%↑	23.4%	22.4%
Present Employment						
Private Practice						
Self-employed solo practice	16.7%	12.4%↓	10.0%↓	12.8%↓	9.8%	9.9%
Two physician practice	4.2%	3.0%	5.0%↑	3.0%	2.2%	2.2%
Group practice	40.2%↓	40.4%↑	35.0%↓	33.5%	26.4%	42.0%
Employed Physicians						
Non-government hospital	4.4%	5.5%	0.0%↓	4.9%↑	2.6%	3.0%
State or local government hospital	6.2%	7.8%	20.0%↑	6.1%	4.3%	6.2%
HMO	0.6%	0.5%	0.0%	0.0%	0.1%	0.2%
Medical School	7.1%	6.4%	15.0%↑	9.1%	1.6%	2.0%
US Government	4.2%	3.4%	0.0%	1.2%	1.4%	2.4%
Locum Tenens	0.0%	0.2%	0.0%	0.6%	0.2%	0.2%
Retired/Inactive	5.4%	3.7%	0.0%	4.3%	9.4%	9.9%
Resident/Intern/Fellow	5.2%	7.6%	5.0%	12.2%	17.6%	10.1%
Student	4.8%	8.7%	5.0%	11.6%	23.6%	8.1%
Other/Unknown	1.0%	0.5%	5.0%↑	0.6%	0.7%	3.9%
Self-designated specialty						
Family Medicine	11.3%	11.9%	20.0%↑	9.8%	9.2%	12.0%
Internal Medicine	20.0%	19.7%	20.0%	19.5%	18.6%	22.9%
Surgery	23.8%↓	20.4%	15.0%	17.7%↓	14.6%	13.7%
Pediatrics	3.8%	3.4%	5.0%	6.1%	4.9%	8.7%
OB/GYN	7.3%	5.3%	5.0%	7.3%↑	5.8%	4.8%
Radiology	4.0%	6.7%	0.0%↓	4.9%	3.8%	4.5%
Psychiatry	4.8%	4.8%	5.0%↓	9.8%↑	3.8%	5.4%
Anesthesiology	4.6%	3.4%	5.0%	4.3%	3.8%	4.7%
Pathology	2.1%	2.5%	0.0%	0.0%	1.8%	2.3%
Other specialty	13.3%	13.1%	20.0%↑	9.1%	10.2%	12.9%
Student	4.8%	8.7%	5.0%	11.6%	23.6%	8.1%

[1]See Appendix B for a listing of specialty classifications.
[2] Students and residents are so categorized without regard to age.
[3] Age delineation reflects section/group definition of its membership.
↑ Indicates an increase of at least two percentage points compared with 2012; see text.
↓ Indicates a decrease of at least two percentage points compared with 2012; see text.

Table 3. Characteristics of Specialty Society Delegations, December 2014

	Mean Age*	Median Age*	% Female	% IMG	% Resident
AMA Members (n =232,126)	48.1	43	32.7%	16.4%	17.6%
Specialty Society Delegates and Alternates (n =374)	56.4	58	24.1%	6.7%	3.2%
Family Medicine Delegations (n =22)	54.8	59	27.3%	4.5%	9.1%
Internal Medicine Delegations (n =69)	59.8	62	18.8%	8.7%	2.9%
Surgery Delegations (n =90)	55.4	54.5	16.7%	6.7%	3.3%
Pediatrics Delegations (n =15)	60.9	59	33.3%	6.7%	0.0%
OB/GYN Delegations (n =23)	61	60.5	60.9%	4.3%	0.0%
Radiology Delegations (n =26)	58.1	58	15.4%	0.0%	0.0%
Psychiatry Delegations (n =22)	55.1	54	18.2%	13.6%	4.5%
Anesthesiology Delegations (n =17)	54.4	58	35.3%	11.8%	0.0%
Pathology Delegations (n =14)	54.5	54	35.7%	7.1%	0.0%
Other specialty Delegations (n =76)	53.2	54.5	23.7%	5.3%	5.3%

* The mean age is the arithmetic average age. The median age is the age at which 50% of the group is older and 50% is younger

Table 4. Mean and Median Age of AMA Members and Delegations by State, December 2014*

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
Alabama	3,001	50.7	51	6	51.5	52
Alaska	361	53.5	53	2	†	†
Arizona	3,819	52.4	51	7	61.9	64
Arkansas	2,117	50.4	50	6	61.3	62.5
California	20,764	53.5	52	40	57.5	61.5
Colorado	3,805	51.4	50	8	56.8	59.5
Connecticut	3,404	51.4	50	8	69.5	71.5
Delaware	658	53.4	52	2	†	†
District of Columbia	1,611	44.4	38	4	64.0	61
Florida	12,845	54.6	54	25	57.3	59
Georgia	4,798	50.6	49	10	60.9	60.5
Guam	26	54.6	51	1	†	†
Hawaii	1,082	54.0	53	2	†	†
Idaho	631	54.3	53	2	†	†
Illinois	10,972	49.3	47	24	60.9	66.5
Indiana	4,810	50.9	50	9	62.7	62
Iowa	2,356	50.2	49	6	56.7	61
Kansas	2,232	50.9	50	7	58.4	61
Kentucky	3,014	50.1	49	8	62.1	63
Louisiana	3,288	48.8	47	8	58.0	64
Maine	1,208	53.1	53	4	61.8	61.5
Maryland	4,279	51.6	50	9	63.1	64
Massachusetts	7,708	49.3	47	13	53.4	52
Michigan	9,952	50.2	49	23	54.9	58
Minnesota	4,623	50.5	49	11	57.3	62

Mississippi	2,160	51.4	51	6	54.0	53.5
Missouri	5,150	48.1	46	11	62.4	67
Montana	696	54.7	55	2	†	†
Nebraska	1,615	47.3	45	4	59.0	62.5
Nevada	1,268	52.7	52	4	66.0	65.5
New Hampshire	847	52.5	52	2	†	†
New Jersey	6,410	53.1	53	14	61.6	60.5
New Mexico	1,387	53.1	53	4	59.3	61.5
New York	18,744	50.6	49	30	57.7	59
North Carolina	5,767	50.2	49	9	58.9	59
North Dakota	771	48.8	47	2	†	†
Ohio	10,159	49.0	47	22	52.2	56
Oklahoma	3,330	51.6	51	8	60.8	65
Oregon	1,893	53.3	52	4	59.3	58.5
Pennsylvania	11,884	50.1	49	25	60.0	59
Puerto Rico	1,442	52.3	53	4	68.8	72.5
Rhode Island	1,026	49.5	48	2	†	†
South Carolina	3,483	50.0	49	8	64.0	64.5
South Dakota	967	50.4	50	3	†	†
Tennessee	4,790	50.3	50	10	64.7	65
Texas	16,245	49.0	47	36	56.9	59
Utah	1,629	50.9	49	4	53.3	51
Vermont	430	51.6	51	2	†	†
Virgin Islands	43	60.8	61			
Virginia	6,445	50.8	49	14	63.1	63
Washington	3,558	53.6	53	7	56.3	57
West Virginia	1,542	50.0	49	4	68.8	68.5
Wisconsin	4,170	50.9	50	9	59.7	63
Wyoming	225	56.0	55	2	†	†
APO/FPO/ Foreign	686	63.7	62			
TOTAL	232,126	48.1	50	497	59.7	61

* The mean age is the arithmetic average age. The median age is the age at which 50% of the group is older and 50% is younger.
† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall totals.

This table does not include regional student delegates or alternate delegates. It also does not include resident sectional delegates or alternate delegates.

Table 5. Women and International Medical Graduates on State Association Delegations, December 2014

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	3,001	6	825	2	358	0
Alaska	361	2	123	1	26	0
Arizona	3,819	7	1,171	1	577	0
Arkansas	2,117	6	612	0	260	2
California	20,764	40	6,749	9	3,123	2
Colorado	3,805	8	1,361	5	191	0
Connecticut	3,404	8	1,115	0	572	2
Delaware	658	2	173	2	148	0
District of Columbia	1,611	4	763	2	122	1
Florida	12,845	25	3,594	2	3,211	4
Georgia	4,798	10	1,567	3	740	1
Guam	26	1	8	0	12	0

Hawaii	1,082	2	329	0	133	0
Idaho	631	2	127	2	27	1
Illinois	10,972	24	3,698	6	2,309	6
Indiana	4,810	9	1,489	0	717	1
Iowa	2,356	6	693	1	307	0
Kansas	2,232	7	682	1	272	0
Kentucky	3,014	8	893	0	392	0
Louisiana	3,288	8	1,141	1	373	1
Maine	1,208	4	478	1	108	0
Maryland	4,279	9	1,462	2	784	1
Massachusetts	7,708	13	3,143	3	953	1
Michigan	9,952	23	3,236	6	2,304	5
Minnesota	4,623	11	1,568	2	610	0
Mississippi	2,160	6	554	1	186	0
Missouri	5,150	11	1,789	0	564	2
Montana	696	2	233	1	21	0
Nebraska	1,615	4	531	0	130	0
Nevada	1,268	4	343	2	191	1
New Hampshire	847	2	259	1	129	0
New Jersey	6,410	14	2,056	3	1,940	4
New Mexico	1,387	4	508	1	158	0
New York	18,744	30	6,540	5	5,115	4
North Carolina	5,767	9	1,821	2	615	0
North Dakota	771	2	265	1	114	0
Ohio	10,159	22	3,326	9	1,570	1
Oklahoma	3,330	8	926	3	432	1
Oregon	1,893	4	554	1	155	0
Pennsylvania	11,884	25	3,800	4	1,591	0
Puerto Rico	1,442	4	541	1	330	2
Rhode Island	1,026	2	405	1	131	0
South Carolina	3,483	8	1,220	0	224	0
South Dakota	967	3	324	2	106	0
Tennessee	4,790	10	1,513	0	495	1
Texas	16,245	36	5,569	7	2,427	4
Utah	1,629	4	394	1	89	0
Vermont	430	2	152	0	24	0
Virgin Islands	43	0	14	0	16	0
Virginia	6,445	14	2,285	4	934	1
Washington	3,558	7	1,073	4	443	1
West Virginia	1,542	4	484	0	272	1
Wisconsin	4,170	9	1,337	3	596	0
Wyoming	225	2	48	0	23	0
APO/FPO/Foreign	686	0	76	0	407	0
TOTAL	232,126	497	75,940	109	38,057	51

Table 6. Medical Students and Resident Physicians on State Association Delegations, December 2014

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Medical Student AMA Members in State[1]	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[2]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates
Alabama	3,001	6	577	0	0	482	0	0
Alaska	361	2	2	0	0	33	0	0

Arizona	3,819	7	868	0	0	712	0	0
Arkansas	2,117	6	626	1	1	257	0	0
California	20,764	40	3,036	6	4	5,314	5	2
Colorado	3,805	8	1,429	1	1	384	0	0
Connecticut	3,404	8	864	1	1	465	1	1
Delaware	658	2	6	0	0	71	1	1
District of Columbia	1,611	4	837	0	0	290	0	0
Florida	12,845	25	2,333	5	5	1,907	1	0
Georgia	4,798	10	1,058	1	1	705	2	2
Guam	26	1	0	0	0	6	0	0
Hawaii	1,082	2	225	0	0	123	0	0
Idaho	631	2	7	0	0	52	0	0
Illinois	10,972	24	2,626	3	2	1,457	6	5
Indiana	4,810	9	869	1	1	1,276	1	1
Iowa	2,356	6	508	0	0	273	0	0
Kansas	2,232	7	388	1	1	374	0	0
Kentucky	3,014	8	680	1	1	386	0	0
Louisiana	3,288	8	947	2	1	923	0	0
Maine	1,208	4	536	0	0	131	0	0
Maryland	4,279	9	937	2	2	692	4	4
Massachusetts	7,708	13	2,878	4	3	1,331	7	6
Michigan	9,952	23	2,062	3	2	1,898	1	0
Minnesota	4,623	11	589	0	0	1,378	2	2
Mississippi	2,160	6	465	0	0	187	0	0
Missouri	5,150	11	1,735	3	2	977	0	0
Montana	696	2	295	0	0	16	0	0
Nebraska	1,615	4	573	0	0	200	0	0
Nevada	1,268	4	362	0	0	98	0	0
New Hampshire	847	2	121	0	0	98	0	0
New Jersey	6,410	14	1,152	3	3	990	0	0
New Mexico	1,387	4	439	0	0	170	0	0
New York	18,744	30	4,461	4	3	4,482	5	4
North Carolina	5,767	9	1,101	0	0	1,238	1	1
North Dakota	771	2	322	0	0	129	0	0
Ohio	10,159	22	2,834	3	2	1,906	3	1
Oklahoma	3,330	8	655	1	1	656	1	1
Oregon	1,893	4	233	0	0	206	0	0
Pennsylvania	11,884	25	3,120	3	2	1,587	2	2
Puerto Rico	1,442	4	632	0	0	193	0	0
Rhode Island	1,026	2	373	1	1	166	0	0
South Carolina	3,483	8	1,320	1	1	459	0	0
South Dakota	967	3	293	1	1	111	0	0
Tennessee	4,790	10	1,328	0	0	658	1	1
Texas	16,245	36	4,252	3	2	2,536	2	1
Utah	1,629	4	189	0	0	215	0	0
Vermont	430	2	139	0	0	55	1	1
Virgin Islands	43	0	0	0	0	2	0	0
Virginia	6,445	14	2,066	1	1	1,010	0	0
Washington	3,558	7	159	0	0	439	0	0
West Virginia	1,542	4	455	1	1	212	0	0
Wisconsin	4,170	9	774	1	1	981	1	1
Wyoming	225	2	0	0	0	10	0	0
APO/FPO/								
Foreign	686	0	0	0	0	35	0	0
TOTAL	232,126	497	54,736	58	47	40,942	48	37

[1] Alaska, Delaware, Guam, Idaho, Montana, Virgin Islands, and Wyoming do not have a medical school.

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

Figure 3. Age Makeup of AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.

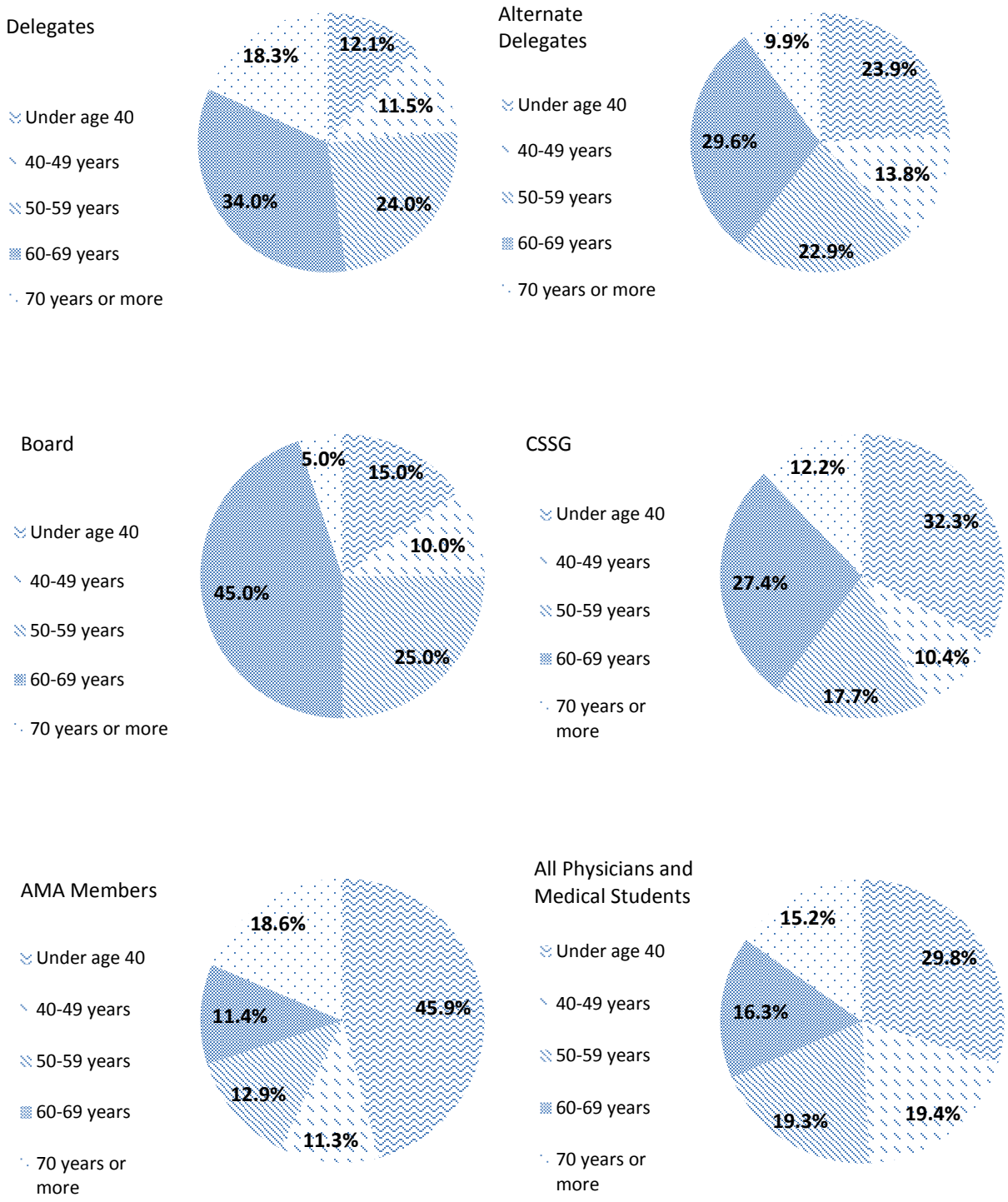


Figure 4. Average Age of AMA Leadership Groups, AMA Members, and US Physician Population, including Medical Students. 2004-2014

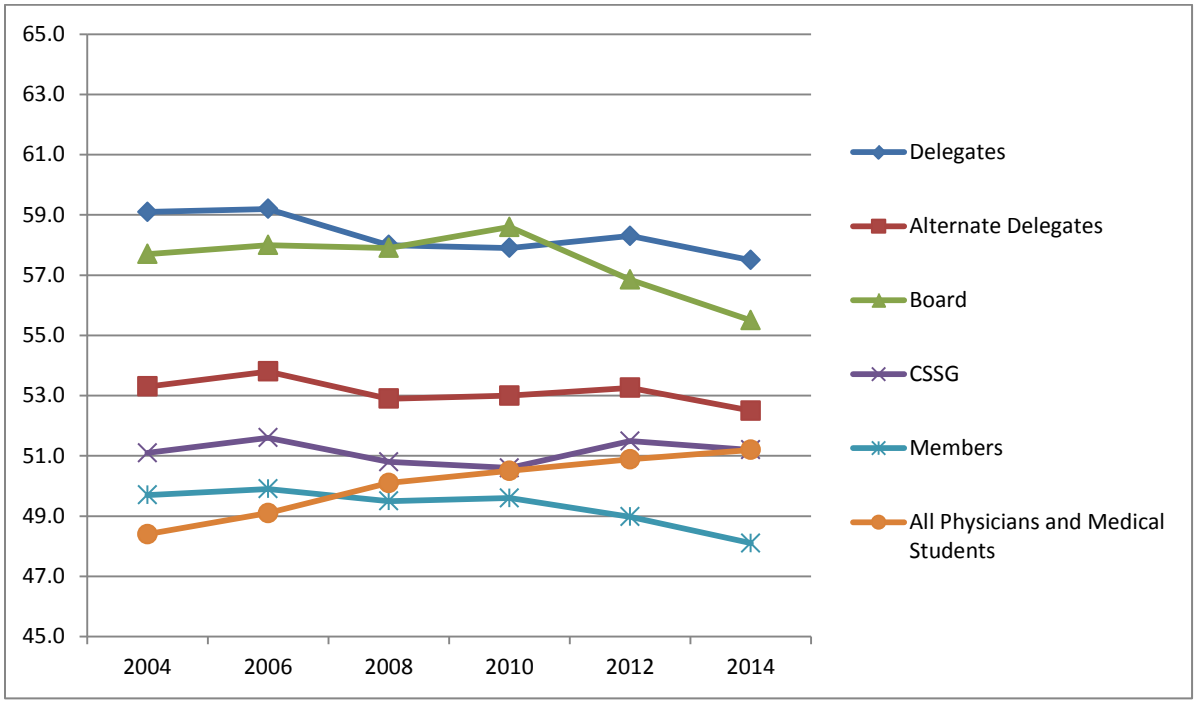
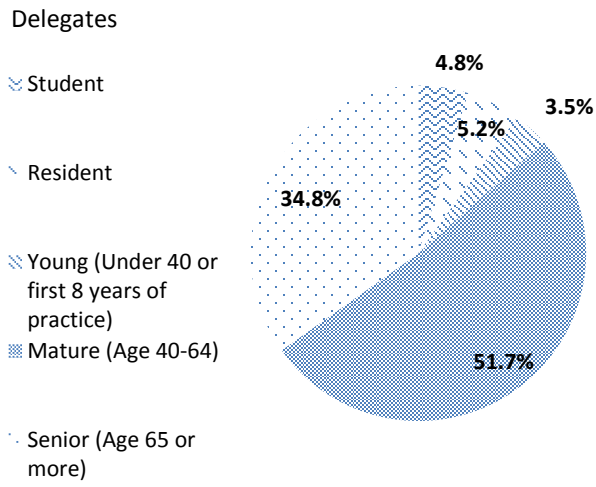
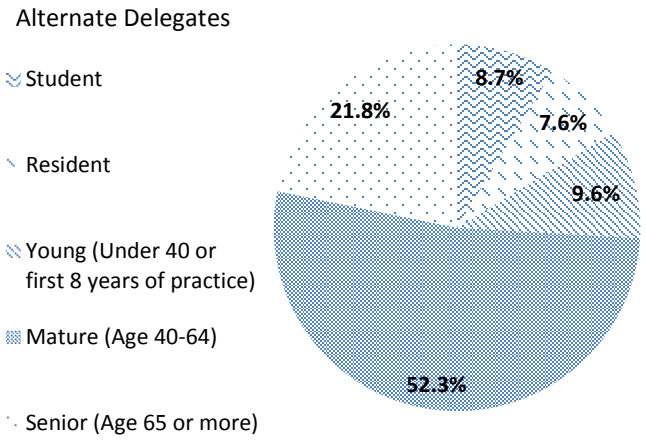


Figure 5. Life Cycle Data for AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.





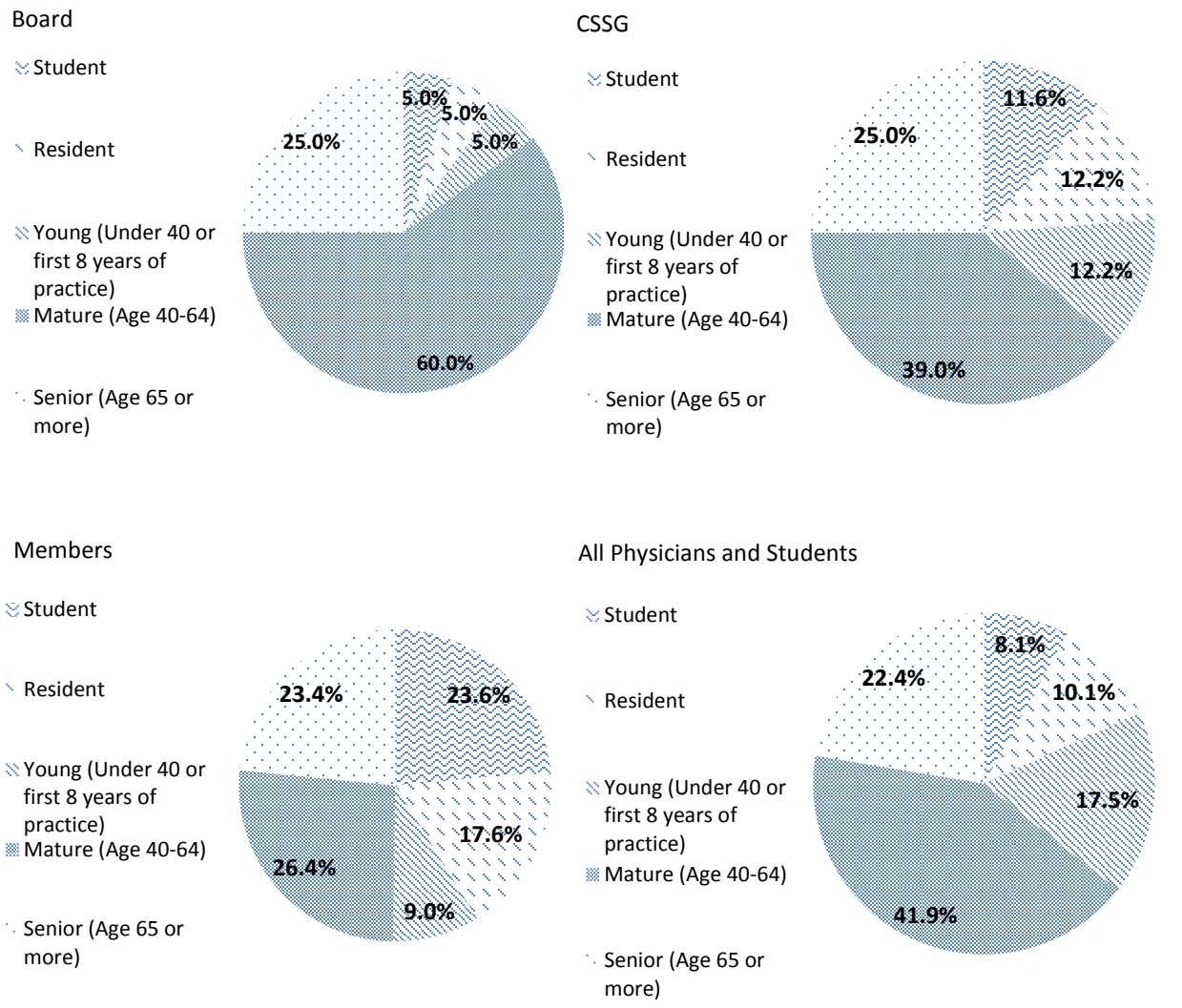
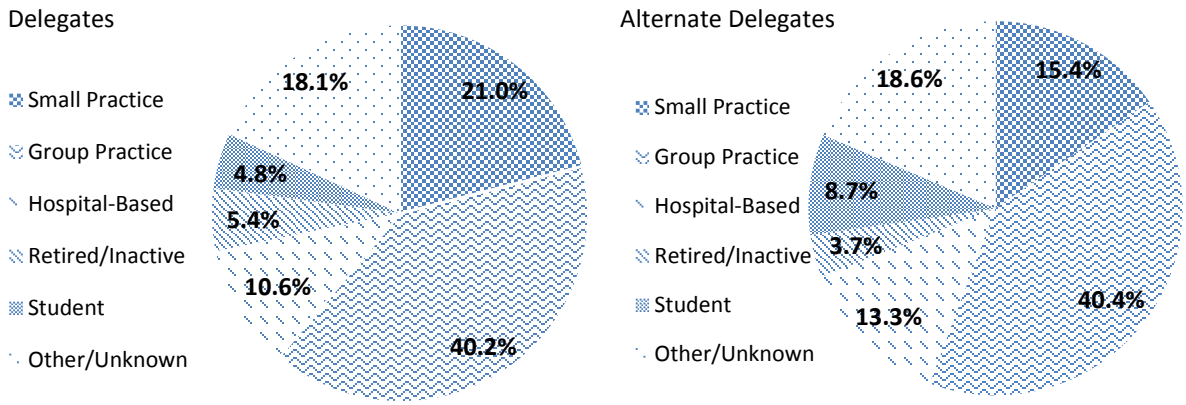


Figure 6. Select Categories of Present Employment of AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.



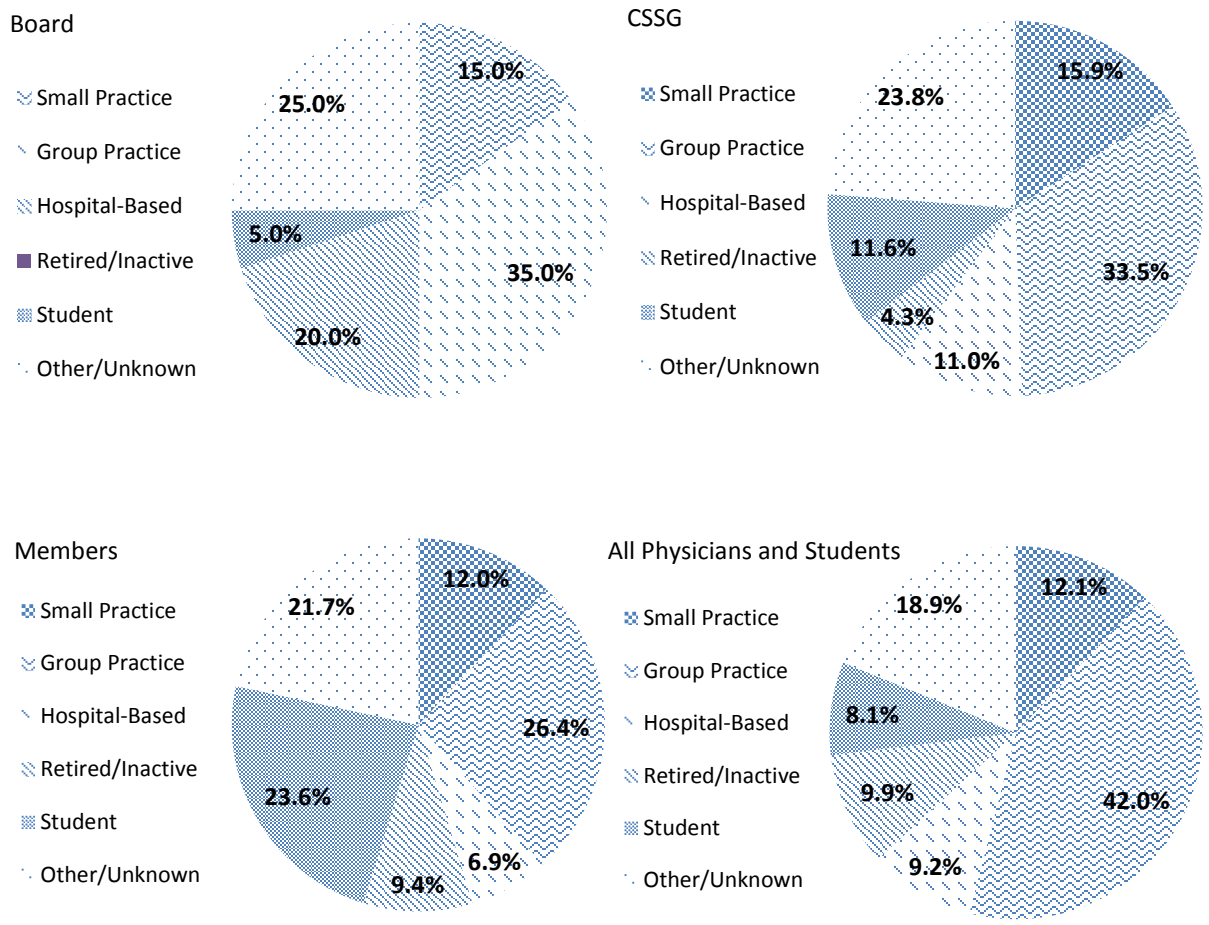


Figure 7. Gender Makeup of AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.

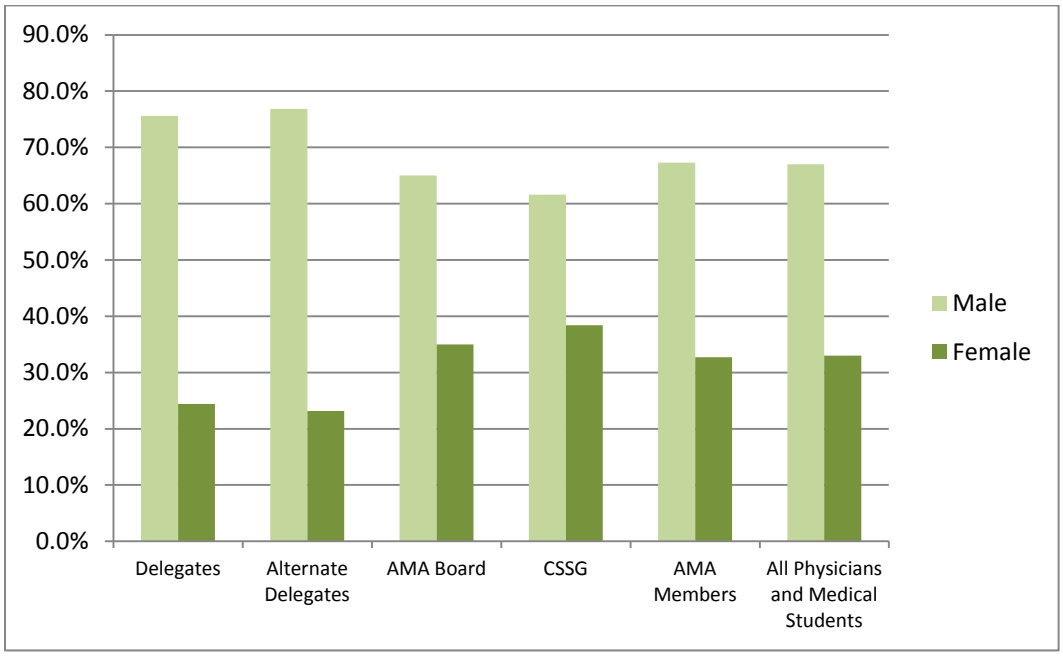


Figure 8. Proportion Female Among AMA Leadership Groups, AMA Members, and U.S. Physician Population, including Medical Students. 2004-2014

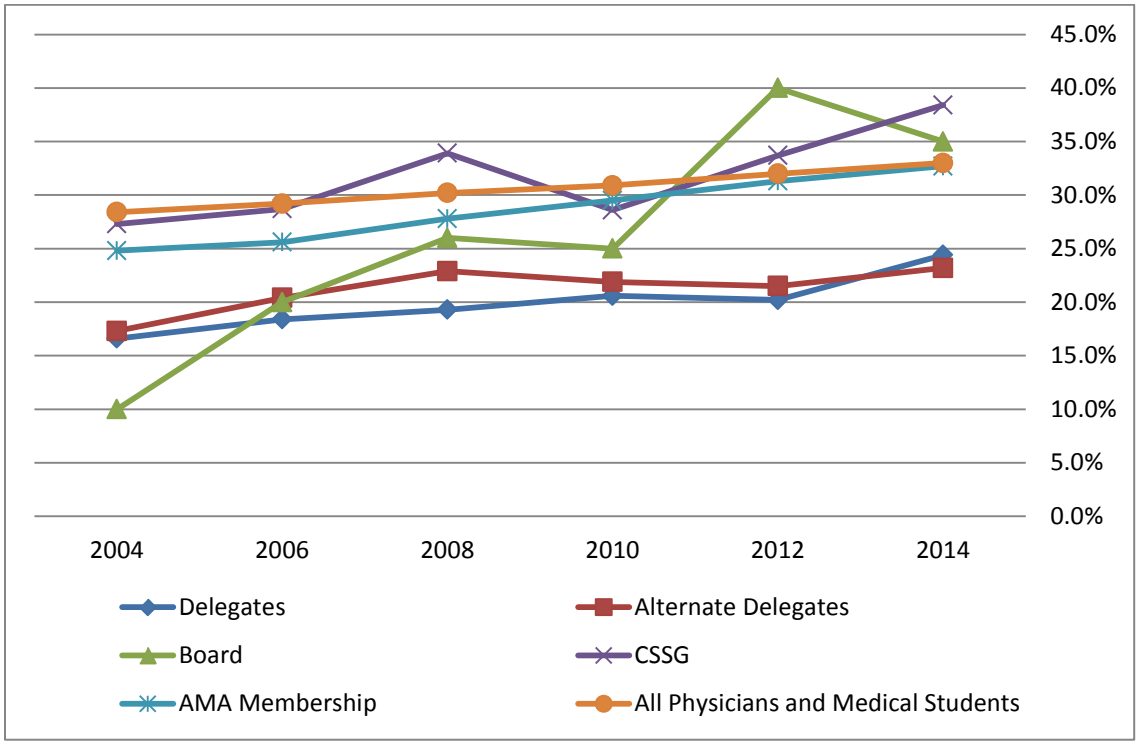


Figure 9. Race and Ethnicity of AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.

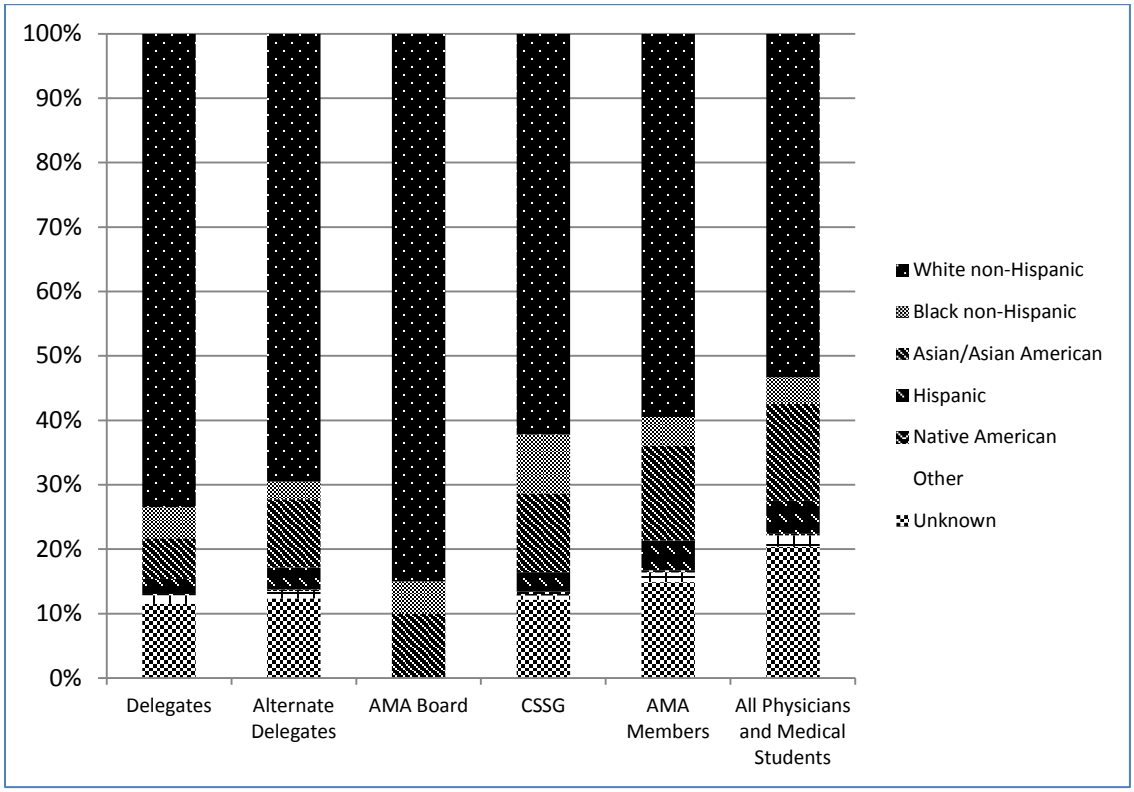
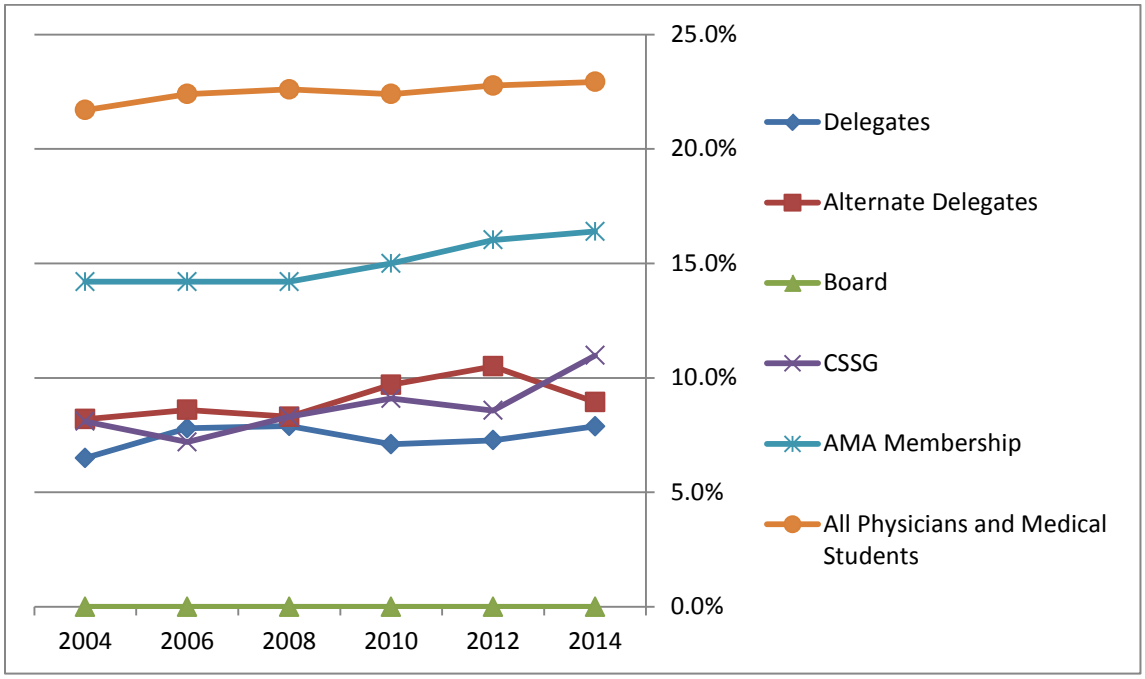


Figure 10. Proportion of IMGs in AMA Leadership Groups, AMA Members, and US Physician Population, including Medical Students. 2004-2014



American Medical Association Councils, Sections, and Special Groups.

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

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

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

APPENDIX B - Specialty classification using physician's self-designated specialties.

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition,

	Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

3. BEST PRACTICES AND SUCCESSFUL EFFORTS TO INCREASE DIVERSITY, BY AGE, OF AMA DELEGATES AND ALTERNATE DELEGATES

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

The Council on Long Range Planning and Development (CLRPD) has prepared this report pursuant to part 3 of American Medical Association (AMA) Policy G-600.035, "The Demographics of the House of Delegates."

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

This report examines the current state of age diversity among the AMA House of Delegates (HOD), ongoing efforts to promote diversity, and barriers that exist to improving age diversity among state and specialty delegations that make up the HOD, while making recommendations for action aimed at enhancing diversity, particularly by age, among the HOD.

PROMOTING DIVERSITY IN THE HOUSE OF DELEGATES

Our AMA recognizes that organizational diversity and inclusion are integral and inherent parts of its mission to promote the art and science of medicine and the betterment of public health. To that end, the AMA has begun developing and instituting an organization-wide diversity strategy that will help bridge currently disparate diversity initiatives, support the success of the AMA strategic plan, and further build and strengthen the One AMA brand.

An impediment the AMA faces to enhancing diversity in the HOD specifically is that the HOD is comprised of representatives from autonomous geographic and specialty delegations, each with the authority to select its own delegates. In addition, since each geographic society is proportionally represented in the HOD based on the number

of AMA members in the geographic area, there is a wide disparity amongst delegations of the number of delegate seats allotted and the number of potential candidates.

AMA Policy G-600.030, "Diversity of AMA Delegations," includes recommendations to aid state and specialty societies in enhancing diversity among their delegations and encourages:

> …(2) State medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity; (3) specialty and state societies to develop training and/or mentorship programs for their student, resident and fellow and young physician section representatives, and current HOD delegates for their future activities and representation of the delegation; (4) specialty and state societies to include in their delegations physicians who meet the criteria for membership in the Young Physicians Section…

In addition, CLRPD prepares biennially in odd-numbered years the informational report, "Demographic Characteristics of the House of Delegates and AMA Leadership." (See CLRPD Report 2-A-15.) The report examines the demographic makeup of the HOD and AMA leadership, and highlights opportunities for increasing all types of diversity, including, but not limited to age. Pursuant to part 2 of AMA Policy G-600.035, the report contains, "…a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and our AMA physician membership…" to encourage greater awareness and responsiveness to diversity among delegations.

Therefore, while the AMA encourages diversity through policy, organizational philosophy and strategy, the demographic makeup of the HOD exists as a summation of its constituent parts, which the AMA cannot control.

THE DEMOGRAPHICS OF THE HOUSE OF DELEGATES WITH RESPECT TO AGE

As of year-end 2014, the average age of delegates was 57.5 and the average age of alternate delegates was 52.5. Neither of these figures has changed substantially over the past decade.

The proportions of delegates and alternate delegates under the age of 40, however, have grown by a significant margin. In 2004, 6.8% of delegates and 13.4% of alternate delegates were under age 40. Those figures have risen to 12.1% and 23.9%, respectively. These increases can largely be attributed to the increasing proportions of resident delegates and alternate delegates over that same period, during which the percentage of resident delegates increased by 5.3% and the percentage of resident alternate delegates increased by 10.5%.

Figure 1 shows the proportional representation by age of the HOD compared with AMA membership. Figure 2 shows the proportional representation of the HOD compared with AMA membership classified by "life stage." These classifications correspond with the membership criteria for specific AMA groups, such as: young (under age 40 or in first eight years of practice), mature (age 40-64), and senior (age 65 or more).

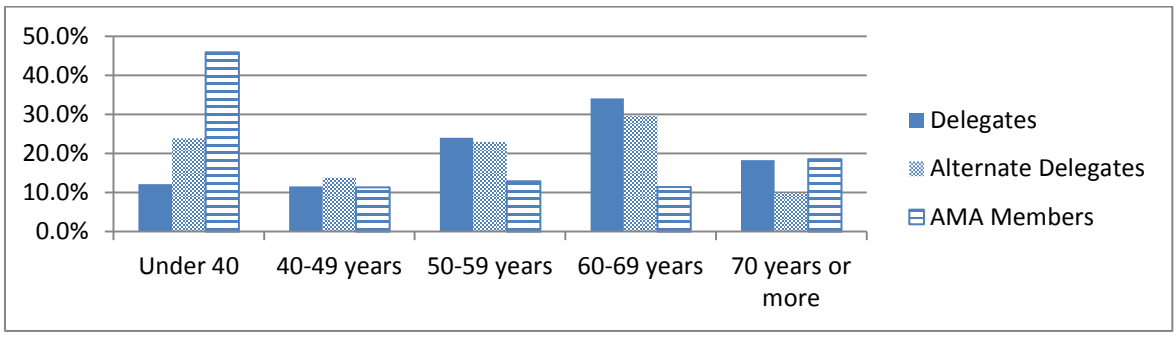


Figure 1. Proportional Representation by Age in the HOD and AMA Membership.

Figure 1 demonstrates that physicians under the age of 40, including medical students, are significantly underrepresented among delegates and alternate delegates compared to the overall percentage of AMA members who fall into that age group. By contrast, physicians aged 50-59 and 60-69 are overrepresented. To some degree, however, it should be expected that older physicians would hold more seats as delegates than their younger colleagues. Many physicians spend a great deal of time waiting for delegate seats to become available, especially

given the fact that most seats across delegations have either no term limit or an effective limit of over 10 years. During this time it is expected that younger physicians will contribute on the local level while developing skills that will serve them if and when they become delegates to the AMA HOD.

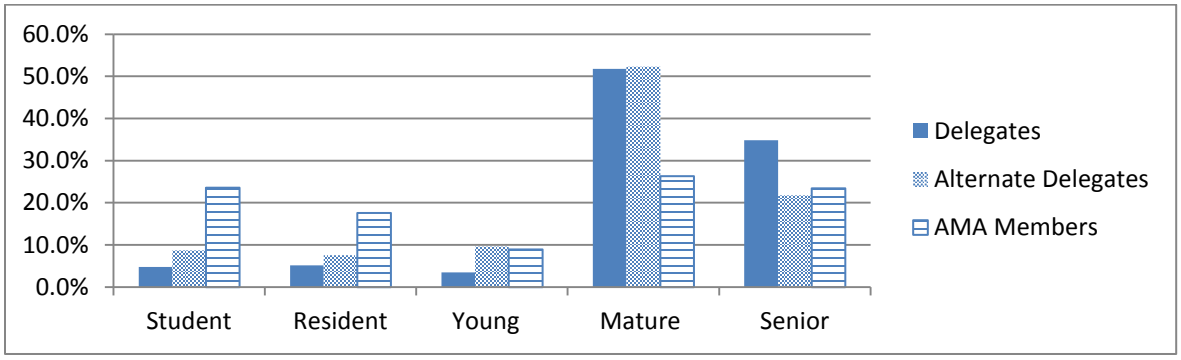


Figure 2. Proportional Representation by Life Stage in the HOD and AMA Membership.

Figure 2 indicates that students, residents and young physicians are underrepresented among delegates, while mature and senior physicians are overrepresented. Among alternate delegates, students and residents are underrepresented while mature physicians hold a disproportionately large number of seats. The distributions of young physicians and senior physicians among alternate delegates are consistent with AMA membership. In addition, it should be noted that young physicians make up the smallest proportion of AMA members, and attempts to increase young physician representatives in the HOD might begin with increased efforts to recruit young physician members.

INITIATIVES TO ENCOURAGE AGE DIVERSITY AMONG DELEGATIONS

In attempting to identify successful practices for encouraging age diversity among HOD representation, queries were made to 51 geographic societies (50 states and Washington, DC) and over 120 specialty societies. In those queries, representatives from each association were asked:

- What, if any, strategies has your organization implemented in order to promote age diversity among your elected representatives?
- Have you found any of these strategies to be successful?
- Do you consider diversity in age among representatives to be a priority? Why or why not?

From those queries, CLRPD received a total of 17 responses from a variety of state and specialty societies. A few general patterns emerged:

- Most societies consider age diversity to be a priority to at least some degree, even if they have no formal initiatives in place to encourage it. Some societies pointed out that age diversity is one of a variety of types of diversity they work to encourage.

- Larger societies, i.e., those with more AMA members and subsequently greater HOD representation, are more likely to have implemented strategies to promote age diversity among their delegates.

- Societies struggling with declining membership or lack of competition for delegate seats are less likely to institute policies that restrict delegate seats to certain age groups or life stages.

These patterns suggest that while successful strategies have been implemented for increasing age diversity among delegations, and while there is general agreement that age diversity is important, the ability of societies to institute formal initiatives toward that goal is largely dependent on factors such as membership size and the pool of potential delegates. Thus, the labelling of initiatives that have been successful for certain delegations as best practices may be inaccurate, in that many societies may be unable, given their unique circumstances, to institute them.

The following initiatives were identified through the questionnaire and additional analysis as potentially successful ways to promote age diversity among delegations.

Leadership Colleges/Training Programs

Encouraged by part 3 of AMA Policy G-600.030, leadership colleges and training programs provide education to prepare younger physicians and physicians in training to hold leadership positions in the future. Alumni are then considered a primary talent pool for their respective societies as potential committee members, board members and delegates. This resulting "feeder system" seems to have the effect of decreasing the average age of delegates and potentially increasing diversity in general. Societies that have instituted these kinds of programs have reported positive results in increasing and maintaining engagement with young physicians who have participated in them.

Sections

Similarly, the development of sections for students, residents and young physicians gives young physicians and physicians in training opportunities to network, hold leadership roles and acquire skills that may prepare them to assume delegate positions in the future. Sections act as formal groups of physicians or medical students representing unique interests related to the professional lifecycle. At the AMA each section is assigned one delegate. While this practice could not be actionable among all societies due to restrictions on the number of delegates apportioned to each, some societies reported slotting delegate and/or alternate delegate seats to members of specific groups.

Term Restrictions

Of the geographic societies for which information was available, 25 have instituted a term limit of some kind for delegates and alternate delegates, while 21 have not. These term limits fall into three categories:

- Fixed limit on the number of years served (n=3)
- A fixed term (usually two years) with no limit on the number of terms served (n=13)
- A fixed term (usually two years) and a limit on the number of terms served (generally five to eight consecutive terms) (n=11)

Figure 3 shows the average and median ages of delegates and alternate delegates in states with term limits compared to those without them, classified by the type of term restriction in place.

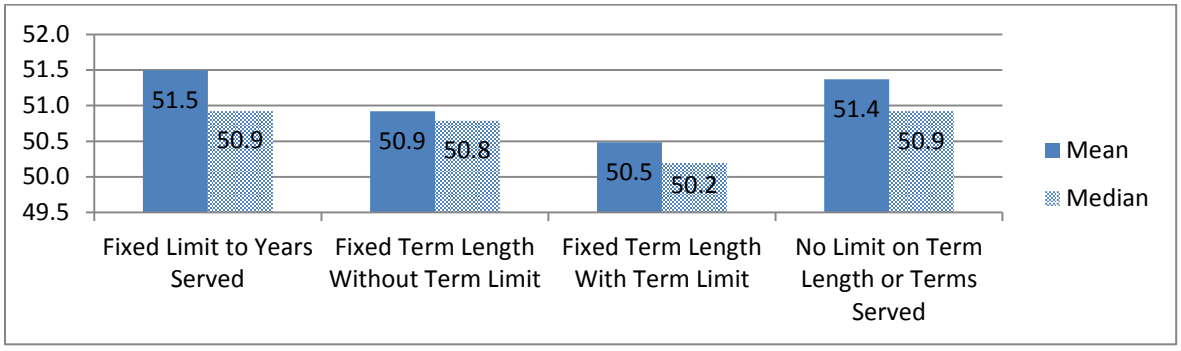


Figure 3. Mean and Median Ages of State Delegations Classified by Restrictions on Delegate and Alternate Delegate Terms of Service.

The sample size for this data is too small to draw any definitive conclusions, but it does appear that limiting the length of delegate terms and restricting the number of consecutive terms allowed to each delegate may have some effect on reducing the average age of delegations. It should be noted, however, that the difference between the average age of the youngest classification (fixed term length with fixed term limit) and the average age of those delegations with no restrictions of any kind is only 0.9 years, with an even smaller dispersion between the medians. These figures do not exist in a vacuum, and other circumstances or initiatives among individual societies will affect these data. Additionally, societies currently struggling to attract and retain members, and those that have limited pools of interested delegates, reported being less inclined to impose restrictions on the terms of their delegates.

Slotted Seats

Designating delegate and/or alternate delegate seats to specific age groups, life stages or sections guarantees that there will be at least a minimum amount of representation for that given group.

The greatest impediment to the implementation of slotted seats was mentioned previously: the limitations of delegate seats based on AMA membership in the delegation. AMA Bylaw 2.1.1, "Apportionment," stipulates:

> The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association…

Therefore, a state with 650 AMA members will be apportioned one delegate and one alternate delegate. In such a case, slotting seats with the intention of increasing diversity of any type becomes impossible. As of year-end 2014, of the 53 geographic societies represented in the HOD, 20 (37.7%) are represented by four or fewer delegates and alternate delegates, while the majority of specialty societies are apportioned one delegate. These figures suggest that the potential breadth of the implementation of this strategy is limited.

SUMMARY

While there has been some progress in increasing age diversity among delegates and alternate delegates, the representation of younger physicians and medical students in the HOD remains disproportionate to their membership figures, and the basic age characteristics of the HOD have remained largely unchanged over the past ten years. Potential delegates often must wait a great deal of time for seats to become available, and tend to be older by the time they assume positions in the HOD. In addition, delegates tend to hold their seats for long, often uncapped periods of time. Due to these facts, and the limited number of seats available, it is conceivable that to some degree older physicians will hold proportionally greater number of seats compared directly to membership data. Physicians classified under the young physician life stage make up the smallest percentage of AMA members by a significant margin, and efforts to increase HOD representation among that specific group should likely begin with concerted efforts to recruit young physicians as AMA members.

Though strategies have been implemented to increase age diversity among delegations, the term "best practices" when referring to delegations that comprise the HOD is a misnomer, since initiatives that have been effective for one delegation may be implausible for another to implement. Additionally, given the slow pace of delegate turnover, the length of time required to determine whether or not an initiative is successful, and the limited data with which to judge the sustained success of such efforts, an annual review of successful initiatives is inadvisable.

RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that the following statements be adopted and that the remainder of this report be filed.

1. That our American Medical Association Young Physician Section engage with young physicians to encourage AMA membership and successful initiatives to promote diversity, by age, among delegations.

2. That part 3 of Policy G-600.035, "The Demographic Characteristics of the House of Delegates," be amended by addition and deletion to read as follows:

   … (3) Every five years, a report will be prepared ~~Future reports on the demographic characteristics of the House of Delegates will~~ to identify ~~and include information on~~ successful initiatives ~~and best practices~~ to promote diversity, particularly by age, of state and specialty society delegations.

3. That our American Medical Association encourage young physicians to work with their local state associations and medical specialty societies to promote diversity among delegations.