REPORTS OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

The following reports, 1–2, were presented by Mary T. Herald, MD, Chair.

1. DELEGATE ALLOCATION FOR SPECIALTY SOCIETIES

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy G-600.027

At the American Medical Association's (AMA) 2016 Interim Meeting the House of Delegates (HOD) adopted Policy G-600.027, "Designation of Specialty Societies for Representation in the House of Delegates," which created a new specialty society delegation allocation system. Under this new system, the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent (i.e., geographic) societies under section 2.1.1 (and subsections thereof) of the AMA bylaws. A companion report by the Council on Constitution and Bylaws (CCB Report 2-A-17) proposes bylaws changes related to this policy.

This report by the Council on Long Range Planning and Development (CLRPD) proposes two additions to Policy G-600.027 for the consideration of the HOD. These additions relate to two situations not explicitly addressed by the policy as written but raised during debate in the HOD. These situations occur (1) when new specialty societies are granted representation to the HOD, and (2) when specialty societies lose representation in the HOD.

Additionally, during review of AMA policy in conjunction with this report, the Council has determined that, pending bylaws changes to enact the new delegate allocation system, the following AMA policies should be reviewed and may require action to reflect these changes: G-600.021, G-600.023 and G-600.135. These policy changes can be addressed following necessary bylaws changes, as the new apportionment mechanism will not come into effect until January 2018.

Apportionment when Specialty Societies Gain or Lose Representation in the HOD

Per section 8.4.2 of the AMA Bylaws, any eligible specialty society seeking representation in the HOD will submit an application through the AMA to the Specialty and Service Society (SSS) for consideration. These societies must submit their letters of application and supporting data for SSS review in November, at which point SSS will determine whether those societies have met the criteria for representation. The SSS makes its recommendations to the Board of Trustees (BOT) the following spring and to the HOD at that year's Annual Meeting in June. The final decision to admit these societies is determined by the voting process of the HOD, and societies whose applications are accepted gain representation immediately.

Since apportionment of delegates occurs each year in January, and remains in effect for the entire year, per section 2.1.1.1 of the AMA Bylaws, delegate allocation necessarily takes place after the SSS has determined which, if any, specialty societies have met the criteria for representation, but before those societies are formally admitted to the HOD. CLRPD believes the most prudent method of allocating delegates to these societies is to apportion their delegates in January in anticipation of their formal admittance at the subsequent Annual Meeting. Should the HOD decline to admit a specialty society, the delegate seat(s) apportioned to those societies should remain vacant for the duration of the year.

The inverse of this situation occurs when specialty societies fail to meet requirements for continued representation in the HOD set forth by AMA Bylaws and do not retain representation in the HOD. Such situations may occur at any meeting of the HOD. CLRPD recommends handling these situations in a similar fashion. In cases where specialty societies lose representation in the HOD, the delegate seat(s) that were apportioned to those societies in January of that year should remain vacant for the duration of the year.

These procedures will ensure equal apportionment of delegates to specialty and constituent societies each January, as called for by Policy G-600.027. They will also ensure that the maximum possible number of specialty society

delegates will be apportioned for any given year; when new specialty societies are admitted to the HOD, the total number of specialty society delegates will not exceed the number of delegates apportioned to constituent societies. Additionally, research of previous meetings of the AMA HOD failed to uncover instances in which the HOD voted not to admit specialty societies recommended for representation by the SSS. Therefore, the only situations likely to result in a minor shortage of specialty society delegates (in relation to constituent society delegates) at any given meeting will occur if specialty societies lose representation in the HOD. Thus, these procedures will also guarantee that the most accurate possible number of specialty society delegates will be apportioned each year.

RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that AMA Policy G-600.027 be amended by addition to read as follows and the remainder of the report be filed:

1. The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request.

2. Specialty society delegate allocation will be determined annually, based on the latest available membership data, using a two-step process:

   (a) First, the number of delegates per specialty society will be calculated as one delegate per 1,000 AMA members in that society, or fraction thereof.

      (i) At the time of this calculation, any specialty society that has applied for representation in the HOD, and has met SSS criteria for representation, will be apportioned delegates in anticipation of its formal acceptance to the HOD at the subsequent Annual Meeting. Should the society not be accepted, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

   (b) Second, the total number of specialty society delegates will be adjusted up or down to equal the number of delegates allocated to constituent societies.

      (i) Should the calculated total number of specialty society delegates be fewer than the total number of delegates allocated to constituent societies, additional delegates will be apportioned, one each, to those societies that are numerically closest to qualifying for an additional delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.

      (ii) Should the calculated total number of specialty society delegates be greater than the number of delegates allocated to constituent societies, then the excess delegates will be removed, one each, from those societies numerically closest to losing a delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.

      (iii) In the case of a tie, the previous year's data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate.

3. The Council on Constitution and Bylaws will investigate the need to change any policy or bylaws needed to implement a new system to apportion national medical specialty society delegates.

4. This new specialty society delegate apportionment process will be implemented at the first Annual Meeting of the House of Delegates following the necessary bylaws revisions.

5. Should a specialty society lose representation during a meeting of the HOD, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

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 (BOT), pursuant to AMA Policy G 600.035, "The Demographics of the House of Delegates." This policy states:

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

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

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

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

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

DATA SOURCES

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

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

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee (AMPAC) and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the 552 allotted at the 2016 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for slightly under one-sixth of AMA members and just over one-fifth of the total U.S. physician population, limiting the ability to draw firm conclusions. BOT Report 24-I-06, "Improving Collection of AMA Race/Ethnicity Data," described efforts to improve AMA data on race and ethnicity, and such improvements have resulted in a decline in unknown race/ethnicity information in some of the leadership groups and overall AMA membership.

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

CHARACTERISTICS OF AMA LEADERSHIP

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

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

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

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

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

Table 1. Basic Demographic Characteristics of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees[1]	Councils and Leadership of Sections and Special Groups[2]	AMA Members	All Physicians and Medical Students
Count[3]	545	440	20	165	240,498	1,283,477
Mean age (years)[4]	57.4	51.8	56.0	52.4	47.3	51.6
Age Distribution						
Under age 40	14.1%↑	24.1%	15.0%	29.1%↓	49.2%↑	29.6%
40-49 years	9.0%↓	15.2%	10.0%	11.5%	10.5%	19.0%
50-59 years	22.9%	23.6%	25.0%	14.5%↓	11.3%	18.2%
60-69 years	36.0%↑	28.0%	45.0%	30.3%	11.2%	16.9%
70 or more	18.0%	9.1%	5.0%	14.5%	17.9%	16.2%
Gender						
Male	73.6%↓	71.6%↓	70.0%↑	61.8%	65.7%	66.0%
Female	26.4%↑	28.4%↑	30.0%↓	38.2%	34.3%	33.9%
Race/ethnicity						
White non-Hispanic	72.8%	67.5%↓	75.0%↓	59.4%↓	56.1%↓	52.2%
Black non-Hispanic	4.6%	3.4%	15.0%↑	7.9%	4.7%	4.2%
Hispanic	2.2%	4.8%	0.0%	4.8%	5.2%	5.4%
Asian/Asian American	7.7%	12.0%	10.0%	16.4%↑	14.9%	15.2%
Native American	0.2%	0.0%	0.0%	0.0%	0.3%	0.3%
Other[5]	1.1%	1.1%	0.0%	0.6%	2.0%	2.3%
Unknown	11.4%	11.1%	0.0%	10.9%	16.7%	20.5%
Education						
US or Canada	93.8%	89.1%	100.0%	89.1%	83.2%	76.9%
IMG	6.2%	10.9%	0.0%	10.9%	16.8%	23.1%

Notes:
1. Numbers do not include the public member of the Board of Trustees, who is not a physician.
2. Numbers do not include non-physicians on the Council on Legislation and AMPAC. In addition, Appendix A contains a listing of the AMA councils, sections, and special groups.
3. Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
4. Age as of December 31. Mean age is the arithmetic average.
5. Includes other self-reported racial and ethnic groups.

↑ Indicates an increase of at least two percentage points compared with 2014.
↓ Indicates a decrease of at least two percentage points compared with 2014.

Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	545	440	20	165	240,498	1,283,477
Life Stage						
Student[1]	5.9%	8.6%	5.0%	10.9%	23.2%	7.9%
Resident[1]	5.0%	7.5%	5.0%	12.7%	21.7%↑	10.4%
Young (Under age 40 or first eight years of practice)[2]	5.5%↑	14.3%↑	5.0%	10.3%	9.8%	20.0%↑
Mature (Age 40-64)[2]	49.9%	48.6%↓	60.0%	37.6%	22.6%	38.0%↓
Senior (Age 65 or more)[2]	33.8%	20.9%	25.0%	28.5%↑	22.8%	23.8%
Present Employment						
Private Practice						
Self-employed solo practice	15.6%	12.7%	20.0%↑	13.3%	8.8%	9.3%
Two physician practice	2.6%	2.3%	5.0%	1.8%	1.7%	1.8%
Group practice	39.4%	36.1%↓	35.0%	27.3%↓	23.7%↓	40.9%
Employed Physicians						
Non-government hospital	4.6%	6.4%	0.0%	6.1%	2.3%	2.8%
State or local government hospital	9.4%↑	11.4%↑	15.0%↓	11.5%↑	4.7%	6.9%
HMO	0.6%	0.7%	0.0%	0.6%	0.1%	0.2%
Medical School	6.6%	3.9%↓	10.0%↓	7.3%	1.3%	1.7%
U.S. Government	4.8%	4.3%	0.0%	1.8%	1.2%	2.1%
Locum Tenens	0.0%	0.0%	0.0%	0.0%	0.2%	0.2%
Retired/Inactive	5.3%	5.0%	0.0%	6.1%	10.1%	11.0%
Resident/Intern/Fellow	5.0%	7.5%	5.0%	12.7%	21.7%↑	10.4%
Student	5.9%	8.6%	5.0%	10.9%	23.2%	7.9%
Other/Unknown	0.4%	1.1%	5.0%	0.6%	0.9%	4.8%
Self-designated specialty						
Family Medicine	12.1%	8.9%↑	20.0%	9.1%	8.9%	11.8%
Internal Medicine	19.3%	20.2%	20.0%	18.2%	19.1%	23.0%
Surgery	23.7%	19.3%	20.0%↑	17.6%	14.2%	13.5%
Pediatrics	3.9%	3.0%	0.0%↓	7.9%	5.0%	8.7%
OB/GYN	6.2%	6.4%	0.0%↓	6.1%	5.4%	4.7%
Radiology	4.2%	6.1%	0.0%	6.1%	3.5%	4.5%
Psychiatry	5.5%	5.0%	5.0%	7.9%	3.9%	5.3%
Anesthesiology	4.0%	3.2%	10.0%↑	3.6%	3.7%	4.7%
Pathology	2.2%	1.8%	0.0%	0.0%	1.7%	2.3%
Other specialty	13.0%	17.5%↑	20.0%	12.7%↑	11.4%	13.6%
Student	5.9%	8.6%	5.0%	10.9%	23.2%	7.9%

Notes:
1. Students and residents are so categorized without regard to age.
2. Age delineation reflects section/group definition of its membership.

↑ Indicates an increase of at least two percentage points compared with 2014.
↓ Indicates a decrease of at least two percentage points compared with 2014.

PROMOTING DIVERSITY AMONG DELEGATIONS

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

These efforts yielded the following suggestions:

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

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

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

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

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

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

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

APPENDIX A

Table 3. Basic Demographic Characteristics of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees[1]	Councils and Leadership of Sections and Special Groups[2]	AMA Members	All Physicians and Medical Students
Mean age (years)[3]	57.4	51.8	56.0	52.4	47.3	51.6
Age Distribution (total counts)						
Under age 40	77	106	3	48	118,281	380,104
40-49 years	49	67	2	19	25,146	244,265
50-59 years	125	104	5	24	27,152	234,151
60-69 years	196	123	9	50	26,924	216,925
70 or more	98	40	1	24	42,995	208,032
Gender (total counts)						
Male	401	315	14	102	158,007	847,095
Female	144	125	6	63	82,491	436,382
Race/ethnicity (total counts)						
White non-Hispanic	397	297	15	98	134,961	670,569
Black non-Hispanic	25	15	3	13	11,212	53,412
Hispanic	12	21	0	8	12,500	68,752
Asian/Asian American	42	53	2	27	35,834	194,872
Native American	1	0	0	0	841	3,246
Other[4]	6	5	0	1	4,924	28,992
Unknown	62	49	0	18	40,226	263,634

Education (total counts)						
US or Canada	511	392	20	147	200,057	987,628
IMG	34	48	0	18	40,441	295,849

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

Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Life Stage (total counts)						
Student[1]	32	38	1	18	55,863	100,896
Resident[1]	27	33	1	21	52,191	132,982
Young (Under age 40 or first eight years of practice)[2]	30	63	1	17	23,473	256,202
Mature (Age 40-64)[2]	272	214	12	62	54,233	488,216
Senior (Age 65 or more)[2]	184	92	5	47	54,738	305,181
Present Employment (total counts)						
Private Practice						
Self-employed solo practice	85	56	4	22	21,218	119,505
Two physician practice	14	10	1	3	4,139	23,317
Group practice	215	159	7	45	56,971	525,014
Employed Physicians						
Non-government hospital	25	28	0	10	5,604	35,532
State or local government hospital	51	50	3	19	11,271	88,277
HMO	3	3	0	1	233	2,318
Medical School	36	17	2	12	3,066	22,321
U.S. Government	26	19	0	3	2,912	27,586
Locum Tenens	0	0	0	0	477	2,661
Retired/Inactive	29	22	0	10	24,355	141,809
Resident/Intern/Fellow	27	33	1	21	52,191	132,982
Student	32	38	1	18	55,863	100,896
Other/Unknown	2	5	1	1	2,198	61,259
Self-designated Specialty (total counts)						
Family Medicine	66	39	4	15	21,438	151,669
Internal Medicine	105	89	4	30	45,886	295,248
Surgery	129	85	4	29	34,134	173,514
Pediatrics	21	13	0	13	12,024	112,250
OB/GYN	34	28	0	10	12,920	60,859
Radiology	23	27	0	10	8,509	58,057
Psychiatry	30	22	1	13	9,290	67,884
Anesthesiology	22	14	2	6	8,911	60,117
Pathology	12	8	0	0	4,179	28,927
Other specialty	71	77	4	21	27,344	174,056
Student	32	38	1	18	55,863	100,896

Notes:
1. Students and residents are so categorized without regard to age.
2. Age delineation reflects section/group definition of its membership.

Table 5. Characteristics of Specialty Society Delegations, December 2016

	Mean Age	Median Age	% Female	% IMG	% Resident
AMA Members (n = 240,498)	47.3	40	34.3%	16.8%	21.7%
Specialty Society Delegates and Alternates (n = 383)	56.2	57	28.7%	5.5%	3.4%
Family Medicine Delegations (n = 23)	53.5	57	43.5%	0.0%	8.7%
Internal Medicine Delegations (n = 67)	60.7	63	17.9%	6.0%	3.0%
Surgery Delegations (n = 92)	56.3	54.5	15.2%	4.3%	1.1%
Pediatrics Delegations (n = 15)	58.9	60	46.7%	0.0%	6.7%
OB/GYN Delegations (n = 26)	55.6	55.5	57.7%	3.8%	7.7%
Radiology Delegations (n = 27)	57.7	59	22.2%	3.7%	0.0%
Psychiatry Delegations (n = 26)	56.8	57.5	34.6%	11.5%	7.7%
Anesthesiology Delegations (n = 13)	57.0	60	30.8%	7.7%	7.7%
Pathology Delegations (n = 13)	50.8	53	38.5%	15.4%	0.0%
Other specialty Delegations (n = 81)	52.7	52	34.6%	6.2%	2.5%

Table 6. Mean and Median Age of AMA Members and Delegations by State, December 2016

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	3,035	51.1	51	8	56.8	59.0
Alaska	333	53.9	53	2	†	†
Arizona	4,537	53.1	52	9	59.9	63.0
Arkansas	2,059	51.0	50	6	63.3	64.5
California	21,310	53.9	52	41	57.8	62.0
Colorado	4,068	51.6	50	8	58.8	61.5
Connecticut	3,572	51.7	51	9	67.6	72.0
Delaware	685	54.0	53	2	†	†
District of Columbia	1,828	44.5	38	3	†	†
Florida	13,366	54.9	55	27	56.1	57.0
Georgia	4,967	51.2	50	10	62.8	62.5
Guam	25	55.8	53	1	†	†
Hawaii	1,069	54.5	54	4	64.0	65.0
Idaho	593	54.6	54	2	†	†
Illinois	10,352	50.0	48	23	58.6	61.0
Indiana	4,733	51.5	51	9	60.3	61.0
Iowa	2,241	50.8	50	6	55.8	55.0
Kansas	2,107	51.3	50	7	60.4	59.0
Kentucky	2,858	50.6	50	10	60.0	58.5
Louisiana	3,337	49.2	47	7	59.7	61.0
Maine	1,331	52.9	53	4	63.8	63.5
Maryland	4,092	52.3	51	10	58.9	60.0
Massachusetts	11,309	49.6	47	18	53.3	55.0
Michigan	11,154	49.9	48	23	56.5	60.0
Minnesota	4,407	51.1	49	10	60.4	62.5
Mississippi	2,167	51.4	51	6	54.2	55.5
Missouri	4,644	48.6	47	10	65.9	69.5
Montana	697	55.4	56	2	†	†
Nebraska	1,703	47.6	45	4	55.8	56.0
Nevada	1,346	53.2	52	4	64.3	67.0
New Hampshire	935	53.1	52	2	†	†
New Jersey	6,781	53.5	53	15	63.5	63.0
New Mexico	1,344	53.7	54	4	62.0	63.5
New York	18,952	50.9	49	30	57.3	58.5
North Carolina	5,432	50.8	49	9	60.9	61.0
North Dakota	785	49.0	47	2	†	†
Ohio	10,448	49.4	47	18	53.7	57.5
Oklahoma	3,424	51.6	51	8	60.5	66.5
Oregon	1,904	53.8	52	4	57.8	57.5

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
Pennsylvania	12,986	50.5	49	25	57.6	59.5
Puerto Rico	1,467	53.0	54	4	70.0	70.5
Rhode Island	1,026	49.5	48	4	52.3	54.0
South Carolina	3,691	50.4	50	9	61.3	66.0
South Dakota	927	50.8	50	2	†	†
Tennessee	4,768	50.8	50	10	62.9	62.0
Texas	16,378	49.4	47	33	58.1	61.0
Utah	1,603	51.2	49	4	57.0	53.0
Vermont	501	51.9	52	2	†	†
Virgin Islands	47	61.9	62	-	-	-
Virginia	6,610	51.2	50	14	62.9	63.5
Washington	3,725	53.8	53	8	52.6	55.0
West Virginia	1,651	50.1	49	4	70.8	70.5
Wisconsin	4,299	51.3	51	10	56.1	62.0
Wyoming	227	56.7	56	2	†	†
APO/FPO/ Foreign	662	64.5	63	-	-	-
Total	240,498	52.1	51	508	57.4	61

† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall totals.
This table does not include regional student delegates or alternate delegates. It also does not include resident sectional delegates or alternate delegates.

Table 7. Women and International Medical Graduates on State Association Delegations, December 2016

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	3,035	8	874	2	383	-
Alaska	333	2	121	1	30	-
Arizona	4,537	9	1,468	1	823	-
Arkansas	2,059	6	636	-	242	2
California	21,310	41	7,169	10	3,365	2
Colorado	4,068	8	1,489	5	193	-
Connecticut	3,572	9	1,285	-	644	2
Delaware	685	2	188	2	159	-
District of Columbia	1,828	3	904	-	207	-
Florida	13,366	27	3,935	3	3,400	4
Georgia	4,967	10	1,659	3	823	1
Guam	25	1	9	-	13	1
Hawaii	1,069	4	343	1	132	-
Idaho	593	2	121	2	30	1
Illinois	10,352	23	3,546	5	2,244	8
Indiana	4,733	9	1,517	1	732	2
Iowa	2,241	6	693	1	292	-
Kansas	2,107	7	645	1	278	1
Kentucky	2,858	10	893	-	368	-
Louisiana	3,337	7	1,207	1	393	1
Maine	1,331	4	552	1	102	-
Maryland	4,092	10	1,479	4	808	4
Massachusetts	11,309	18	4,945	8	1,589	1
Michigan	11,154	23	3,871	5	2,438	6
Minnesota	4,407	10	1,532	3	600	-
Mississippi	2,167	6	616	2	190	1
Missouri	4,644	10	1,682	-	476	1
Montana	697	2	274	1	31	-

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
Nebraska	1,703	4	608	-	124	-
Nevada	1,346	4	385	1	236	1
New Hampshire	935	2	309	-	139	-
New Jersey	6,781	15	2,248	3	1,954	3
New Mexico	1,344	4	500	1	135	-
New York	18,952	30	6,795	6	5,063	4
North Carolina	5,432	9	1,732	2	591	-
North Dakota	785	2	284	1	116	-
Ohio	10,448	18	3,684	8	1,712	1
Oklahoma	3,424	8	1,016	3	427	-
Oregon	1,904	4	605	2	170	-
Pennsylvania	12,986	25	4,385	4	2,068	1
Puerto Rico	1,467	4	580	-	306	2
Rhode Island	1,026	4	419	2	144	-
South Carolina	3,691	9	1,327	-	247	-
South Dakota	927	2	334	1	85	-
Tennessee	4,768	10	1,545	-	475	1
Texas	16,378	33	5,608	8	2,552	3
Utah	1,603	4	384	1	103	-
Vermont	501	2	194	-	31	-
Virgin Islands	47	-	17	-	16	-
Virginia	6,610	14	2,431	3	892	1
Washington	3,725	8	1,233	3	497	2
West Virginia	1,651	4	549	-	336	1
Wisconsin	4,299	10	1,455	4	608	1
Wyoming	227	2	48	-	19	-
APO/FPO/ Foreign	662	-	66	-	410	-
Total	240,498	508	82,394	116	40,441	59

Table 8: Medical Students and Resident Physicians on State Association Delegations, December 2016

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	3,035	8	659	1	1	520	-	-
Alaska	333	2	2	-	-	39	-	-
Arizona	4,537	9	773	2	2	1,510	-	-
Arkansas	2,059	6	599	-	-	297	-	-
California	21,310	41	3,053	7	5	5,739	5	3
Colorado	4,068	8	1,576	-	-	484	1	1
Connecticut	3,572	9	1,038	1	-	666	-	-
Delaware	685	2	12	-	-	92	1	1
District of Columbia	1,828	3	863	1	1	488	-	-
Florida	13,366	27	2,473	4	4	2,236	-	-
Georgia	4,967	10	970	-	-	824	-	-
Guam	25	1	-	-	-	3	-	-
Hawaii	1,069	4	233	-	-	140	-	-
Idaho	593	2	7	-	-	48	-	-
Illinois	10,352	23	2,470	2	1	1,508	3	2
Indiana	4,733	9	820	1	1	1,363	1	1
Iowa	2,241	6	484	-	-	303	-	-

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
Kansas	2,107	7	386	-	-	302	-	-
Kentucky	2,858	10	694	1	1	386	-	-
Louisiana	3,337	7	1,002	2	2	906	-	-
Maine	1,331	4	550	-	-	266	-	-
Maryland	4,092	10	704	1	1	811	1	1
Massachusetts	11,309	18	3,320	6	5	4,584	7	6
Michigan	11,154	23	2,130	2	1	3,380	2	1
Minnesota	4,407	10	571	1	1	1,356	1	1
Mississippi	2,167	6	568	1	1	218	-	-
Missouri	4,644	10	1,595	3	2	761	-	-
Montana	697	2	293	-	-	35	-	-
Nebraska	1,703	4	642	1	1	240	-	-
Nevada	1,346	4	357	1	1	206	-	-
New Hampshire	935	2	173	-	-	117	-	-
New Jersey	6,781	15	1,344	2	2	1,234	-	-
New Mexico	1,344	4	469	-	-	142	-	-
New York	18,952	30	4,436	5	4	4,825	7	6
North Carolina	5,432	9	1,041	-	-	1,060	1	1
North Dakota	785	2	350	-	-	138	-	-
Ohio	10,448	18	2,720	4	3	2,644	2	1
Oklahoma	3,424	8	909	2	2	624	-	-
Oregon	1,904	4	260	-	-	261	-	-
Pennsylvania	12,986	25	2,776	3	2	3,456	2	1
Puerto Rico	1,467	4	680	-	-	207	-	-
Rhode Island	1,026	4	346	-	-	209	2	2
South Carolina	3,691	9	1,459	2	2	506	-	-
South Dakota	927	2	318	1	1	127	-	-
Tennessee	4,768	10	1,442	1	1	625	-	-
Texas	16,378	33	4,124	4	3	2,768	3	2
Utah	1,603	4	183	-	-	228	-	-
Vermont	501	2	160	1	1	96	1	1
Virgin Islands	47	-	1	-	-	-	-	-
Virginia	6,610	14	2,258	2	2	1,064	2	2
Washington	3,725	8	195	-	-	613	1	1
West Virginia	1,651	4	494	-	-	339	2	2
Wisconsin	4,299	10	879	1	1	1,157	2	2
Wyoming	227	2	1	-	-	13	-	-
APO/FPO/Foreign	662	-	1	-	-	27	-	-
Total	240,498	508	55,863	66	55	52,191	47	38

Notes:
1. Alaska, Delaware, Guam, Idaho, Montana, Virgin Islands, and Wyoming do not have a medical school.
2. The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.

American Medical Association Councils, Sections, and Special Groups

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

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

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

APPENDIX B - Specialty classification using physicians' 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