Reference Committee F

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Subject: Data Used to Apportion Delegates  
(Resolution 604-A-18)

Presented by: Jack Resneck, Jr., MD

Referred to: Reference Committee F  
(Greg Tarasidis, MD, Chair)

At the 2018 Annual Meeting, Georgia introduced Resolution 604-A-18, “AMA Delegation Entitlements,” which reads as follows:

RESOLVED, That our American Medical Association continue to provide a count of AMA members for AMA delegation entitlements to the House of Delegates as of December 31 and also provide a second count of AMA members within the first two weeks of the new year and that the higher of the two counts will be used for state and national specialty society delegation entitlements during the current year; and be it further

RESOLVED, That the Council on Constitution and Bylaws prepare appropriate language to add a second period of time to determine AMA delegation entitlements to be considered by the AMA House at its earliest opportunity.

The resolution was referred.

The reference committee reported that testimony was largely supportive. Some suggested the opportunity to increase representation in our AMA House of Delegates is used by many delegations in membership recruitment, and delegations believe that seeing the results of their membership recruitment efforts reflected in their delegate counts sooner would further support those efforts.

Following discussion the reference committee was unable to develop a means to implement the method proposed in the resolution and recommended referral to allow a review that focuses on the impact on our entire House of Delegates.

AMA MEMBERSHIP AND DELEGATE APPORTIONMENT BACKGROUND & HISTORY

Article III of the Constitution, “Members,” declares “The American Medical Association is composed of individual members who are represented in the House of Delegates through state associations and other constituent associations, national medical specialty societies and other entities, as specified in the Bylaws.” Individual members are recruited through the efforts of both our AMA and societies in the Federation as well as by current members who solicit their colleagues. The number of individual AMA members in a given society determines the number of delegates under the aforementioned representation in the House of Delegates. (This is true for nearly all societies in the House of Delegates. Under the bylaws, professional interest medical associations and a handful of national societies have a single delegate.)
The modern House of Delegates traces to the work of the Committee on Reorganization, which was established in 1900 and eventuated in the adoption of a new constitution and bylaws in 1901, redefining and modernizing the House of Delegates (Campion, 1984). Current membership became the basis for apportioning delegates, as the Committee’s work established a House of Delegates based on proportional representation in which constituent associations were represented on the basis of one delegate for 500 members. The following year, in June 1902, the House adopted a resolution stating “That state associations or societies in counting members for a basis of delegate representation in this House shall count only members in good standing, who pay regular dues to the state association, either directly or indirectly through county societies.”

While the ratio of members per delegate has been adjusted over the last 100 plus years to accommodate growth in the physician population and membership, delegate apportionment has always been based upon the number of current members. The current ratio of one delegate per 1000 AMA members dates from 1946. The 1948 constitution prescribed that the “number of delegates from the constituent associations shall be proportional to the number of active members in the respective associations,” and that year saw the start of the annual apportionment process.

Two significant changes were effected in the early 1950s. At the December 1950 meeting, the members to be counted were explicitly defined to be AMA members: “The apportionment of delegates from each constituent association shall be one delegate for each thousand (1,000) or fraction thereof, dues paying active members of the American Medical Association (emphasis added).” Whereas before this time counts focused on members of the constituent associations, now the relevant population was specified to be AMA members.* At the 1952 Annual Meeting, December 31 was set as the cutoff date for counting members to maximize the time allowed for societies to add members, with the effective date for apportionment January 1 (Proceedings of the House of Delegates, 1952).

Irrespective of how or when members join our AMA, under our current bylaws delegates are apportioned to constituent societies and national medical specialty societies at the rate of one delegate per 1000, or fraction thereof, AMA members as of December 31.† That is, one must be a member on December 31 to be counted for apportionment purposes. The apportionment is effective January 1 of the following year and is effective for one year. (See bylaws 2.1.1 and 2.2.1 and subsections.) Thus, for example, if a society has 1000 AMA members on December 31, it will be apportioned one delegate for the following year. A society with 1001 members will be apportioned two delegates. (Although they are endorsed by and seated with constituent and national medical specialty societies seated in the House of Delegates, separate bylaws provisions address the regional medical student and sectional resident delegates who are apportioned differently.)

Because of differences in data availability and because delegate apportionment for constituent societies determines the overall delegate apportionment for national medical specialty societies, characterizations below are couched in terms of constituent societies. Figures for those societies are also more easily captured in real time.

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* To be clear, under the 1901 constitutional revision, AMA membership was granted to all members of local medical societies affiliated with state medical societies who applied for membership, supplied certification and paid the annual fee. In 1899, the annual dues were $10 (Caring for the Country, 1997, pages 40-41).
† Member counts for constituent (ie, geographic) societies are determined annually. The overall number of delegates apportioned to constituent societies determines the total number of delegates apportioned to national medical specialty societies, with the number of delegates apportioned to any particular specialty society generally tied to that society’s most recent five-year review.
APPORTIONMENT UNDER RESOLUTION 604

As written, Resolution 604-A-18 calls for two enumerations of AMA membership, with the first being the usual year-end calculation and the second being a count of members in approximately mid-January. The larger of the two figures would be used for delegate apportionment. Unspecified is who would be counted in the mid-January enumeration. While the count should clearly include those whose current year’s dues have been paid, it should properly exclude individuals who have not paid their appropriate dues by mid-January, as knowing who will (or will not) renew their membership is not possible. A substantial number of members unfortunately do not renew annually, and many members pay their current year dues after mid-January. Given these factors it seems likely that a mid-January count of current year dues paying members would almost certainly be lower than the year end count.

Calculations by AMA’s Membership Group suggest that the magnitude of the difference of the two counts would depend on the date of the second count. The largest number of AMA members is recruited through AMA’s own direct channel, and in any given year the vast majority of current year members have typically joined by February. Consequently, one might advocate for a count in early March or later, but even such a later count would exclude members who join later in the year, particularly the large number of medical students and residents who typically join in summer or fall. Pushing the count to a later date would also shorten the time for societies to adjust their delegation size when necessary.

In light of the ambiguity regarding who would be counted, prior to June’s House of Delegates meeting Georgia, the sponsor of Resolution 604-A-18, proposed that the first resolve would be implemented by counting for apportionment purposes current nonmembers who join the AMA for the succeeding year during the current year. That discussion as well as comments during the reference committee hearing suggested a revision of the first resolve to call for “the number of new AMA members who have already paid their dues for a membership that officially begins on January 1 of the following year will be included in the annual year-end count of AMA members, for the purposes of AMA Delegation entitlements for state and national specialty societies for that following year.” For example, a nonmember in 2018 who during calendar year 2018 joins (and pays dues) for the 2019 membership year would be counted as a member in apportioning delegates for the 2019 calendar year. Hereinafter these are referred to as “pending members,” as their active membership is still pending on December 31.

Whether any particular society would benefit from such a change would depend on whether the inclusion of pending members would carry it over a one thousand threshold. For those societies that gain a delegate, the increased representation would, other things being equal, be a one-time increase. That is because each year some current members choose not to renew their memberships. While they factor into the annual delegate apportionment process as current members, they drop out of the calculations at the end of the subsequent year, and unless the pending members consistently outnumber the non-renewing members, the gain would likely be a one-time event.

Data from year-end 2017, which were used for delegate allocation in 2018, indicate that five states would have gained a delegate this year if pending members had been included. The states that would gain in the future, however, depend on whether the addition of pending members pushes them across the threshold for an additional delegate. For example, only two of the four states currently needing fewer than 100 pending members to gain a delegate position would benefit, while among the 10 states that had the largest number of pending members (range 261–691) at the end of 2017, only the first and third largest would have picked up a delegate. The other three states that would have added a delegate using this method at the end of 2017 did not have the largest number of pending members, but the figure would push them over the additional delegate threshold. In other words, it would be the
combination of pending members and actual members that determines which states would benefit from the change, adding an element of chance to the apportionment process.

DISCUSSION

Other than changes due to the inclusion of more societies in the House of Delegates (and discounting freezes), the rules for apportioning delegates to constituent societies have remained essentially unchanged since 1952. For over a century, the apportionment rules have been based on current membership, and for seventy years it has been recognized that apportionment should be conducted annually to address membership fluctuations.

Another issue related to the counting of members warrants further discussion. Counting pending members, individuals who “join” our AMA at the end of a current year but whose memberships are not effective until the following year, means that one membership for AMA purposes effectively counts for two years membership for delegate allocation purposes. In addition, this could result in counting members for apportionment purposes that subsequently request a refund and are therefore never actual dues paying members in either year. Gaming of such a system would be possible, with for example panels of one-year members joining in alternate years or signing up for membership and then requesting a refund, which is generally provided upon request in the first half of a calendar year.

Membership accounting can only allocate the membership to the year for which dues are paid, so membership figures used for apportionment figures that include pending members would be inconsistent with figures reported in our AMA’s annual report. Both the apportionment figures and the official membership numbers are publicly available on the AMA website, which would require the divergent apportionment figures to include an explanatory note. It might also be noted that adjustments are not made during the year for losses such as deaths, resignations or CEJA actions that remove an individual from the membership rolls.

While no effort to recruit members to our AMA should be discounted, among current members the most often cited reason for belonging to our AMA is advocacy on behalf of the profession. This has been true for many years, and although the value of enhanced representation in the House of Delegates is often promoted to prospective members, little evidence supports the idea that physicians join our AMA because of the House of Delegates per se. Rather, the advocacy that stems from House actions is the more valued commodity. Indeed, the average physician—member or not—knows little about the House of Delegates and AMA policymaking processes. The prospect of enhanced representation may be a serviceable argument in the member recruitment quiver, but more successful appeals address current AMA activities dealing with critical matters of public health, medical education, practice sustainability and advocacy. Our AMA’s current Members Move Medicine™ campaign is based on this well-established foundation. The current apportionment system occurring at the end of the year recognizes the recruitment that occurs throughout the year, including the significant recruitment of medical students and residents that typically occurs well into the year.

Finally, some costs would be associated with the change. Our AMA would incur the expense of rebuilding the counting procedures and maintaining the distinct records necessary for membership accounting and apportionment processes. The associated complexity and expense would be greater if the selected methodology demanded counting pending and current members rather than a simple change in date of apportionment. Societies in the House of Delegates could incur the intangible cost of some uncertainty in the number of delegates, which would depend on the counting scheme actually adopted, along with the real expense of supporting additional delegates. None of these costs are easily quantified.

RECOMMENDATION
The decision to count pending members for delegate apportionment purposes is clearly within the purview of the House. It would require revisions of the bylaws before it can be implemented with issues of how to handle those who join and those who no longer are AMA members during a calendar year after a fixed point in time of deciding HOD apportionment has occurred. The apparent concern about disenfranchising a new AMA member whose membership is effective after apportionment is readily addressed through the online member forums. With access to online member forums before HOD meetings, that AMA member can have active voice and influence in AMA policymaking.

The House of Delegates has for over a century counted only current members (ie, dues paid and received by AMA) in determining delegate apportionment. The idea that pending members should be added to the current membership seems unwarranted. It effectively double counts individuals, counts members who may or may not rejoin, artificially increases the size of the House of Delegates by including nonmembers in determining representation among Federation societies, and creates opportunities for abuse. Insofar as these pending members will be counted for apportionment purposes for the next cycle when they are actually members, arguments about fairness and representation seem overstated. Finally, under current bylaws any constituent society that may lose a delegate based upon the previous year final count is given a full year to recruit and retain members to retain their delegate count. For these reasons, the Board of Trustees recommends that Resolution 604-A-18 not be adopted and the remainder of this report be filed.

Fiscal note: None

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‡ Some bylaws issues are not clear cut. Bylaw 2.1.1.1.1, for example, allows a constituent society to retain a delegate in the event of a loss of AMA members. Whether so called “pending members” should be allowed to offset losses in “actual members” certainly merits discussion.
REFERENCES


At the 2018 Annual Meeting, the House of Delegates referred Resolution 606 as introduced by the delegation from New Jersey to the Board of Trustees, to investigate a proposal that the AMA should “establish a program for training physicians in the art and science of conducting public forums in order to ensure that the public is well informed on the health care system of our country.”

Within the reference committee, there was considerable supportive testimony about the need to improve physicians’ ability to speak publicly. Several who testified believed that the resources needed to undertake training in public speaking are already available throughout the Federation and could be utilized instead of creating new training materials. However, others believed that developing the ability of physicians to positively present themselves in the public arena is too important to leave to other organizations, and that training in public speaking could be offered as a valuable AMA member benefit.

In evaluating the goal and the desired outcome, it is important to survey the existing landscape of resources available to physicians to help inform AMA’s approach.

The leading organization that assists individuals with public speaking and leadership development is Toastmasters International. Individuals can improve their speaking and leadership skills by attending one of the 16,400 clubs worldwide. By regularly giving speeches and receiving feedback, individuals can learn to tell their stories and leverage their voices.

AMPAC, the bipartisan political action committee of the American Medical Association, provides high level training to physicians who are considering pursuit of elected office. For those who want to campaign for public office and advocate for issues important to patients and physicians, this is a premiere training program and valuable resource for physicians.

Other general communication resources available by the AMA include STEPS Forward modules on topics like “Conducting Effective Team Meetings” and “Implementing a Daily Team Huddle.”

Within the Federation, several physician groups provide opportunities for training on effective communications, including the American College of Physicians, American Academy of Family Physicians, and the American Medical Women’s Association.
Perhaps the leader in providing this training to physicians is the American Association of Physician Leadership (AAPL). Training topics offered by this organization include: “Present like a Pro,” “Delivering Effective Feedback,” “Fundamentals of Physician Leadership: Communication,” and “Improving Communication and Feedback in Healthcare Leadership.” Courses are offered online or in-person. Many of the self-study courses offer the option to watch the video lectures or attend the sessions. A majority of the courses are accessible for up to three years after purchase. The organization also offers live education courses that allow physicians to network with their peers. There are also faculty-led courses that allow physicians to participate in discussions and case studies throughout a six-week class session.

RECOMMENDATION

Physicians who want to learn more about public speaking can leverage existing resources both within and outside the AMA. AMA can make public speaking tips available through online tools and resources that would be publicized on our website. Physicians and physicians-in-training who want to publicly communicate about the AMA’s ongoing work are invited to learn more through the AMA Ambassador program.

Meanwhile, STEPS Forward provides helpful tips to physicians wanting to improve communication within their practice and AMPAC is available for physicians who want to advocate and communicate about the needs of patients and physicians in the pursuit of public office. There are also resources provided to physicians at various Federation organizations and through AAPL to support those who are interested in training of this nature.

Because public speaking is a skill that is best learned through practice and coaching in a small group or one-on-one setting, we also encourage individuals to pursue training through their state or specialty medical society or through a local chapter of Toastmasters International.

The Board of Trustees recommends that the AMA’s Enterprise Communications and Marketing department work to develop online tools and resources that would be published on the AMA website to help physicians learn more about public speaking in lieu of Resolution 606-A-18 and the remainder of the report to be filed. (Directive to Take Action)

Fiscal Note: $20,000 for professional fees for external support and capacity to develop these tools and resources.
Subject: Women Physicians Section Five-Year Review

Presented by: Alfred Herzog, MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

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, 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 the letter of application submitted by the Women Physicians Section (WPS) for renewal of delineated section status.

APPLICATION OF CRITERIA TO THE WOMEN PHYSICIANS SECTION

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 WPS is the only AMA group that is dedicated to advocacy on women physician policy issues, providing leadership development and educational opportunities for women, and monitoring trends and issues that affect women in medicine and women’s health. Currently, the WPS represents more than 82,000 AMA women members. According to 2017 data from the Association of American Medical Colleges, the number of women enrolling in U.S. medical schools has exceeded the number of men. Since 2015, the number of female matriculants has grown by 9.6%, while the number of male matriculants has declined by 2.3%.

The WPS addresses three major concerns: 1) women in medicine professional issues, which include discrimination, e.g., gender bias and income disparity; 2) under-representation of women physicians in leadership positions in organized medicine and academic medicine, which includes disproportionate representation of women physicians in the AMA House of Delegates (HOD); and 3) health issues that disproportionately or uniquely affect women patients.

CLRPD assessment: The mission of the WPS is to provide a dedicated forum within the AMA to increase discussion of and advocacy on women physician issues and strengthen the AMA’s ability to represent this physician constituency. The WPS provides advice and counsel to the Association on policy and program issues of interest to women physicians, and offers suggestions for activities that best meet the needs of this physician segment. No other groups or sections within the AMA specifically address the unique issues of concern of women physicians and patients.
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.

Over the past five years, the WPS has aligned its strategic goals with the AMA to find ways to promote the efforts of the three strategic arcs. The Section’s educational programs were in support of topics that highlighted AMA priority issues such as physician burnout, continuing education, and the opioid epidemic. Overall, the WPS supports the AMA’s objectives by reviewing new AMA products and services, providing insights on policy and advocacy positions, and creating new ways to reach out to members and potential members.

The WPS collaborates with other groups to help improve the impact of the Section’s key goals. During the 2017 Annual Meeting of the HOD, the WPS collaborated with the Medical Student Section to offer two programs: 1) a session that allowed medical students to connect with WPS Governing Council (GC) members to discuss such topics as choosing a residency, communicating with patients, developing leadership skills, critical decision making, careers in academic medicine, and contract negotiation; and 2) “Occupational Health through a Gender-Conscious Lens.” The WPS has collaborated with other AMA sections on educational offerings: the WPS, Integrated Physician Practice Section, and Organized Medical Staff Section program, “Transforming Roles in Healthcare Leadership: How physicians can effectively communicate with non-physician leaders”; and the multi-sections’ program, “Gun Violence: What do we know? What can physicians do?”

Additionally, the WPS leads the AMA’s Women in Medicine Month each September. During this time, the WPS implements two major programs:

1. Inspirational Physicians Recognition Program (formerly the Physician Mentor Recognition Program). The WPS provides an opportunity for physicians to express appreciation to the special men and women who have offered time, wisdom and support throughout their professional journeys.

2. Joan F. Giambalvo Fund for the Advancement of Women (formerly the Giambalvo Memorial Scholarship Fund). The AMA Foundation in association with the WPS established the Fund with the goal of advancing the progress of women in the medical profession, and strengthening the ability of the AMA to identify and address the needs of women physicians and medical students.

In 2016, the WPS hosted its Women in Medicine Symposium at AMA headquarters, which included presentations, panel discussions and breakout sessions covering physician resiliency and burnout, overcoming obstacles in daily practice, and physician wellness techniques.

Over the last five years, the Section has worked collaboratively with various physician groups to expand the influence of the WPS. Some of these efforts have included strong working relationships with the leadership of other sections, representation on the AMA Alliance’s Women in Medicine Task Force, and the renaming and expansion of the liaisons program to the WPS Associates Program.

CLRPD Assessment: The WPS serves its constituents by bringing professional issues unique to women physicians to the forefront of organized medicine, and by providing targeted educational programs and resources for the policymaking process.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.
The WPS GC is structured as an eight-member group elected by the WPS membership. Designated positions on the GC are delegate, alternate delegate, member-at-large (2), Medical Student Section representative, Resident and Fellow Section representative, Young Physicians Section representative, and American Medical Women’s Association representative.

All members of the WPS are eligible to be elected to any office, except the member at-large positions that may not be assumed by medical students. If a candidate is serving on a HOD delegation, they must be willing to resign from their respective HOD delegation position if elected as the WPS delegate or alternate delegate. Lastly, the GC elects its chair and vice chair for the upcoming year in a closed session at each Annual HOD Meeting.

The WPS is developing a five-year strategic plan to assess the progress that the Section has made in advancing women in the medical profession, strengthening the ability of the AMA to address the needs of women physicians and medical students, and what WPS hopes to achieve by 2023.

CLRPD Assessment: The WPS convenes a GC from its members and holds strategic planning meetings to plot its annual and long-term goals, and ensure alignment with the goals of the AMA. All Section members have opportunities throughout the year to contribute to the deliberations of the WPS either in person or by virtual means such as HOD Online Forums, listservs, Twitter and special interest Facebook groups.

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.

According to CLRPD Report 1-A-07, Demographic Characteristics of the House of Delegates and AMA Leadership, in 2006, 309,617 (29%) of U.S. physicians and medical students were female, and comprised 25.6% of AMA members. When the Women Physicians Congress became a section in 2013, CLRPD Report 2-A-13 indicated a growing number of female physicians and medical students (380,050), which comprised 31.3% of AMA members. According to CLRPD Report 2-A-17, there are 82,491 female AMA members (34.3% of AMA membership) and women make up 34.0% of all U.S. physicians and medical students. According to the same CLRPD report, there are 435,099 women physicians and medical students in the United States. Thus, WPS membership comprises 19% of this physician segment.

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CLRPD Assessment: The WPS is comprised of members from an identifiable segment of AMA membership and the general physician population, and represents a substantial number of members. AMA Physician Masterfile data indicate that the number of women physicians has grown steadily for a decade, highlighting the alignment of WPS with potential AMA membership growth.

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.

AMA Bylaw 7.10.1 states, “All female physicians and medical students who are active members of the AMA shall be eligible to be members of the Women Physicians Section. Other active members of the AMA who express an interest in women’s issues shall be eligible to join the Section.”

Based on AMA Physician Engagement’s analysis, the WPS unit experienced a 5% increase of interactions with women physicians and medical students from 2015 to 2016. Overall, the following changes drove improvement:

1. The Women Physicians Congress transitioned from an advisory group to the WPS in 2013.
2. WPS members have the ability to create policy and have a voice in the HOD.
3. The AMA increased communication directed at women physicians.
4. All WPS members with a valid email address in the AMA’s database receive a monthly newsletter from the Section.
5. WPS members are encouraged to contribute to the policymaking processes of the Section and provide input into programs and products.

Additionally, the WPS developed a social media plan to further member engagement efforts. During the 2016 Women in Medicine month:

- Facebook posts totaled 1,186,889 impressions and 14,950 acts of engagement, reflecting 31% and 25% increases over 2015 numbers, respectively.
- Twitter posts totaled 287,665 impressions, reflecting a 21% increase over 2015 numbers.
- The WPS webpage experienced a 34% increase in traffic compared to the previous year. Similarly, there was a 16% increase in traffic to the Women In Medicine webpage in 2016.

In the 2017 GC elections, 1,732 WPS members voted. The number of voters has increased every year. During the first WPS election in 2015, 936 WPS members took part in the election. Nominations for leadership positions were also up by 35% over last year. This increase was driven by promotional efforts in AMA Wire, targeted outreach to the Federation, and the identification of new communication channels such as the Women in Otolaryngology Listserv and special interest Facebook groups.

CLRPD Assessment: WPS meetings, elections, and educational sessions are well attended, and demonstrate increasing engagement, while strategies are in place to further grow participation. The population of potential WPS members continues to expand. The AMA has benefited from an increased voice of WPS members within the policymaking body of the Association.
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.

From 2008 to 2016, the percentage of female delegates increased from 19.3% to 26.4%. While this increase is important, in 2016, women represented 34% of all U.S. physicians and medical students, and 34.3% of all AMA members. However, just 26.4% of delegates and 28.4% of alternate delegates were female, which indicates this segment is under-represented in the HOD.

The WPS policymaking process begins with an open call to the Section’s membership for resolutions. Concurrently, the WPS policy committee works to identify topics for potential resolutions. Resolutions are vetted by WPS staff and the AMA legal team. Accepted resolutions are presented to the Section’s membership for comment via an online forum. The WPS GC reviews the comments and approved resolutions are placed online for ratification. Ultimately, the ratified resolutions are submitted to the HOD.

The WPS convenes a HOD Handbook Review Committee prior to each HOD meeting. The process involves several members of the WPS who evaluate all resolutions and reports under consideration. The Committee usually reaches consensus on 95% of the items and the GC determines the Section’s position on the remaining 5%. During the WPS business meeting, the delegate and alternate provide an open forum to discuss the Section’s active positions on HOD items of business. All attendees are welcome to participate and provide insights on reports and resolutions. The process allows for discussion and development of a position, to support, monitor or oppose, which guides the delegate and alternate delegate as they testify on behalf of the Section. The WPS typically submits 3-4 resolutions to the HOD per meeting. Over the past four years, the Section has introduced 20 resolutions to the HOD.

Over the past four years, the Section has submitted resolutions related to WPS topics of concern: Tubal Ligation and Vasectomy Consents, Impact of Pharmaceutical Advertising on Women’s Health, A New Definition of “Women’s Health,” Off-Label Use of Hormone Therapy, Heart Disease and Women, Medical Necessity of Breast Reconstruction and Reduction Surgeries, Women and Alzheimer's Disease, Women and Pre-exposure prophylaxis (PrEP), Women and Mental Health, Research into Preterm Birth and Related Cardiovascular (CV) and Cerebrovascular
Risks (CVD) in Women, and Care of Women and Children in Family Immigration Detention. Fifty-two percent of WPS submitted resolutions resulted in development of new AMA policy or amendment of existing policy. The WPS provides its members with an opportunity to become involved in the Section’s HOD activities, such as delivering testimony on behalf of the Section during reference committee hearings.

Overall, the WPS presents the AMA with the unique policy perspective of its women physician members. The Section brings to the forefront key areas of need in relation to women physicians and women’s health concerns. For example, the WPS introduced and the HOD adopted the resolution, Interventions for Opioid Dependent Pregnant Women (A-16). During the 2017 Annual Meeting, the Section hosted an educational session, “Responding to the Impact of the Opioid Epidemic on Women” and is supporting the efforts of the AMA’s Task Force to Reduce Opioid Abuse. During the 2015 Annual Meeting, the WPS submitted the resolution, Human Trafficking Reporting and Education, that the HOD adopted, and the AMA used to provide testimony for a Congressional Committee.

CLRPD Assessment: The WPS provides numerous opportunities for members of the constituency to introduce issues of concern and participate in the HOD policymaking process. The WPS has continually pursued ways to improve member communications and the resolution process; thereby, encouraging member involvement. The WPS provides a formal structure for women physicians to participate directly in the deliberations of the HOD and impact policy.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Women Physicians Section through 2023 with the next review no later than the 2023 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500
REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Comp. Comte. Report I-18

Subject: Report of the House of Delegates Committee on Compensation of the Officers

Presented by: Marta J. Van Beek, MD, Chair

Referred to: Reference Committee F
(Greg Tarasidis, MD, Chair)

This report by the Committee at the 2018 Interim Meeting presents one recommendation. It also documents the compensation paid to Officers for the period July 1, 2017 thru June 30, 2018 and includes the 2017 calendar year IRS reported taxable value of benefits, perquisites, services, and in-kind payments for all Officers.

BACKGROUND

At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on Trustee Compensation, currently named the Committee on Compensation of the Officers, (the “Committee”). The Officers are defined in the American Medical Association’s (AMA) Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among whom are President, President-Elect, Immediate Past President, Secretary, Speaker of the HOD and Vice Speaker of the HOD, collectively referred to in this report as Officers.) The composition, appointment, tenure, vacancy process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaws 2.13.4.5 provides:

The Committee shall present an annual report to the House of Delegates recommending the level of total compensation for the Officers for the following year. The recommendations of the report may be adopted, not adopted or referred back to the Committee, and may be amended for clarification only with the concurrence of the Committee.

At A-00, the Committee and the Board jointly adopted the American Compensation Association’s definition of total compensation which was added to the Glossary of the AMA Constitution and Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an individual for work performance including: (a) all forms of money or cash compensation; (b) benefits; (c) perquisites; (d) services; and (e) in-kind payments.

Since the inception of this Committee, its reports document the process the Committee follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-effective compensation practices as derived from research and use of independent external consultants, expert in Board compensation. Reports beginning in December 2002 documented the principles the Committee followed in creating its recommendations for Officer compensation.

At A-08, the HOD approved changes that simplified compensation practices with increased transparency and consistency. At A-10, Reference Committee F requested that this Committee
recommend that the HOD affirm a codification of the current compensation principle, which
occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
its recommendations for Officer compensation on the principle of the value of the work performed,
consistent with IRS guidance and best practices as recommended by the Committee’s external
independent consultant, who is expert in Board compensation.

At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
with that of all other Officers (excluding Presidents and Chair) because these positions perform
comparable work.

Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
Group, to update his 2007 research by providing the Committee with comprehensive advice and
counsel on Officer compensation. The updated compensation structure was presented and
approved by the HOD at I-11 with an effective date of July 1, 2012.

The Committee’s I-13 report recommended and the HOD approved the Committee’s
recommendation to provide a travel allowance for each President to be used for upgrades because
of the significant volume of travel in representing our AMA.

At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
Huddleston, an expert in Board Compensation with Willis Towers Watson, the Committee
recommended and the HOD approved modest increases to the Governance Honorarium and Per
Diems for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. A-
17’s report, approved by the HOD, modified the Governance Honorarium and Per Diem definition
so that Internal Representation, in excess of eleven days, receives a per diem.

At A-18, based on a compensation review focused on the Presidents’ and Chairs’ compensation,
the Committee recommended and the House approved a modest increase to their Honoraria, the
first increase in ten years.

CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as
compensation reported annually on the AMA’s IRS Form 990 because Form 990s are based on a
calendar year. The total cash compensation in the summary is compensation for the days these
Officers spent away from home on AMA business approved by the Board Chair. The total cash
compensation in the summary includes work as defined by the Governance Honorarium and Per
Diem for Representation including conference calls with groups outside of the AMA, totaling 2
hours or more per calendar day as approved by the Board Chair. Detailed definitions are in the
Appendix.
### The summary covers July 1, 2017 to June 30, 2018

<table>
<thead>
<tr>
<th>AMA Officers</th>
<th>Position</th>
<th>Total Compensation</th>
<th>Total Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maya A Babu, MD, MBA</td>
<td>Resident Officer</td>
<td>$5,400</td>
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<tr>
<td>Susan R Bailey, MD</td>
<td>Speaker, House of Delegates</td>
<td>$96,850</td>
<td>50.5</td>
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<tr>
<td>David O Barbe, MD, MHA</td>
<td>President</td>
<td>$279,000</td>
<td>161</td>
</tr>
<tr>
<td>Willarda V Edwards, MD, MBA</td>
<td>Officer</td>
<td>$67,600</td>
<td>48</td>
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<tr>
<td>Jesse M Ehrenfeld, MD, MD, MBA</td>
<td>Secretary &amp; Young Physician Officer</td>
<td>$131,650</td>
<td>90</td>
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<tr>
<td>E Scott Ferguson, MD</td>
<td>Officer</td>
<td>$ -</td>
<td>2.5</td>
</tr>
<tr>
<td>Sandra A Fryhofer, MD</td>
<td>Officer</td>
<td>$ -</td>
<td>4</td>
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<tr>
<td>Andrew W Gorman, MD</td>
<td>Immediate Past President</td>
<td>$274,000</td>
<td>98</td>
</tr>
<tr>
<td>Gerald E Harmon, MD, MD</td>
<td>Chair</td>
<td>$269,500</td>
<td>91.5</td>
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<tr>
<td>Patrice A Harris, MD, MA</td>
<td>Immediate Past Chair</td>
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<td>120.5</td>
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<td>William E Kobler, MD, MD</td>
<td>Officer</td>
<td>$92,950</td>
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<tr>
<td>Russell WH Kridel, MD, MD</td>
<td>Officer</td>
<td>$70,200</td>
<td>47</td>
</tr>
<tr>
<td>Barbara L McAneny, MD, MD</td>
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<td>135</td>
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<tr>
<td>William A McDade, MD, PhD</td>
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<tr>
<td>Mario E Motta, MD</td>
<td>Officer</td>
<td>$ -</td>
<td>2</td>
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<tr>
<td>S Bobby Mukkamala, MD, MD</td>
<td>Officer</td>
<td>$65,000</td>
<td>43.5</td>
</tr>
<tr>
<td>Albert J Osbahr, III, MD</td>
<td>Officer</td>
<td>$78,000</td>
<td>54.5</td>
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<tr>
<td>Stephen R Permut, MD, JD</td>
<td>Officer</td>
<td>$89,050</td>
<td>68</td>
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<tr>
<td>Jack Resneck, Jr, MD, MD</td>
<td>Chair-Elect</td>
<td>$199,500</td>
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<tr>
<td>Ryan J Ribeira, MD, MPH, MD</td>
<td>Resident Officer</td>
<td>$66,300</td>
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<tr>
<td>Karthik V Sarma, MS, MD</td>
<td>Medical Student Officer</td>
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<td>Bruce A Scott, MD</td>
<td>Vice Speaker, House of Delegates</td>
<td>$78,650</td>
<td>55.5</td>
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<td>Carl A Sirio, MD, MD</td>
<td>Officer</td>
<td>$106,600</td>
<td>78.5</td>
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<tr>
<td>Georgia A Tuttle, MD, MD</td>
<td>Officer</td>
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<td>60.5</td>
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<tr>
<td>Kevin W Williams, MSA, MD</td>
<td>Public Board Member Officer</td>
<td>$65,000</td>
<td>43.5</td>
</tr>
</tbody>
</table>

1. President, President-Elect, Immediate Past President and Chair
2. In 2017-2018, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 485.5 days on approved Assignment and Travel, or 121.4 days each on average.
3. Chair-Elect
4. This position received a Governance Honorarium of approximately 75% of the Governance Honorarium provided to the Chair.
5. All other Officers
6. All other Officers received cash compensation, which included a Governance Honorarium of $65,000 paid in monthly installments. The remaining cash compensation is for Assignment and Travel Days that are approved by the Board Chair to externally represent the AMA. These days were compensated at a per diem rate of $1,300.
7. Assignment and Travel Days
8. The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President and Chair) were 1110.5; this includes reimbursement for telephonic representation meetings for external organizations that are 30 minutes or longer during a calendar day and total 2 or more hours. These are reimbursed at ½ of the current per diem rate. During this reporting period, there were 18 reimbursed calls, representing 9 per diem days.
EXPENSES

Total expenses paid for the period, July 1, 2017 – June 30, 2018, $798,212 compared to $844,506 for the previous period, representing a 5.5% decrease. This includes $1,907 in upgrades for Presidents’ travel per the approved Presidential Upgrade Allowance of $2,500 per position per term.

BENEFITS, PERQUISITES, SERVICES AND IN-KIND PAYMENTS

Officers are able to request benefits, perquisites, services and in-kind payments, as defined in the “AMA Board of Trustees Standing Rules on Travel and Expenses.” These non-taxable business expense items are provided to assist the Officers in performing their duties:

- AMA Standard laptop computer or iPad
- iPhone
- American Express card (for AMA business use)
- Combination fax/printer/scanner
- An annual membership to the airline club of choice offered each year during the Board member’s tenure
- Personalized AMA stationery, business cards and biographical data for official use.

Additionally, all Officers are eligible for $305,000 term life insurance and are covered under the AMA’s $500,000 travel accident policy and $10,000 individual policy for medical costs arising out of any accident while traveling on official business for the AMA. Life insurance premiums paid by the AMA are reported as taxable income. Also, travel assistance is available to all Officers when traveling more than 100 miles from home or internationally.

Secretarial support, other than that provided by AMA’s Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000; $5,000 each for the President-Elect, Chair, Chair-Elect and Immediate Past president per year. Secretarial expenses incurred by other Officers in connection with their official duties are paid up to $750 per year per Officer. This is reported as taxable income.

Travel expenses incurred by family members are not reimbursable, except for the family of the incoming President at the Annual Meeting of the HOD.

Calendar year taxable life insurance and taxable secretarial fees reported to the IRS totaled $28,791 and $28,750 respectively for 2017. An additional $5,750 was paid to third parties for secretarial services during 2017.

METHODOLOGY

Periodically, the issue of health insurance for the Presidents has been brought to this Committee’s attention. Specifically, what our AMA can do to assist our President(s) when replacement health insurance is needed because he/she loses health insurance coverage at his/her practice, university or hospital (collectively referred to as “Employer”) when they reduce their work schedule to fulfill their responsibilities as President, President-Elect or Immediate Past President. While this has occurred infrequently, the Committee wanted our AMA to be prepared going forward. In researching possible solutions, the Committee’s objective was to arrive at a solution that was fiscally responsible to the AMA, require the President to have some responsibility for the premium
cost and provide flexibility to address each President’s health insurance needs based on his/her family demographics. An annual stipend to assist the President(s) seemed to meet this goal.

To determine the amount of the stipend, premiums were obtained from the Health Insurance Marketplace (“Exchange”) established under the Patient Protection and Affordable Care Act of 2010 to obtain the specific amounts of 2018 premiums. The Committee reviewed the Plan designs offered on the Exchange and determined that the Gold Plan would be the basis for the stipend. The Gold Plan’s actuarial value is that the plan covers 80% of expenses. Gold Plan design can vary by state but the actuarial equivalent of the design must be to cover 80% of expenses. In addition, insurance carriers, plan availability, premium amounts and the scope of the network varies state to state down to county level within a state. Premiums are individually determined based on the home zip code of the family and the demographics of each covered family member.

Demographics of the full Board were used to obtain a broader cross-section of Gold Plan premiums across the country. Board members who qualify for Medicare were excluded from the analysis and would not be eligible for a stipend. With the assistance of AMA’s external employee benefits broker, premiums were anonymously obtained based on each Board member’s state of residence, and demographics.

The range of the premiums was significant which demonstrated the need for a “customized” stipend. The Committee determined that the stipend would reflect a “cost-sharing” of the premium for the President and covered family members. Premiums would also change annually. Medicare-eligible President(s) would not be eligible to receive a stipend.

President(s) who lose his/her employer insurance would substantiate his/her eligibility for an annual stipend by written notice to the Board Chair detailing the effective date of the loss and listing covered family members. The amount of the stipend will be reported as taxable income for the President each calendar year and will be included in this Committee’s annual report to the House, which documents compensation paid to Officers and the IRS reported taxable value of benefits, perquisites, services and in-kind payments.

FINDINGS

The Committee notes that the President-Elect, President and Immediate Past President responsibilities require a significant time commitment in supporting our AMA in governance and representation functions. Our A-18 report noted that this level of responsibility results in a time commitment well above that required by other not-for-profit boards. The level of commitment needed in supporting our AMA may necessitate a President reduce his/her work schedule with his/her employer to a part-time status which may result in a President losing his/her eligibility for employer’s health insurance coverage.

This Committee considers health insurance a necessity. As such, this Committee recommends that Presidents who are not Medicare-eligible receive a stipend based on 70% of the then current Gold Plan premium for the President and his/her covered family members once the President provides written notice to the Board Chair about the loss of coverage. The stipend would be reported as taxable income to the President(s).
RECOMMENDATIONS

The Committee on Compensation of the Officers recommends the following recommendations be adopted and the remainder of this report be filed:

1. That there be no change to the current Definitions effective July 1, 2018 as they appear in the Travel and Expenses Standing Rules for AMA Officers for the Governance Honorarium, Per Diem for External Representation and Telephonic Per Diem for External Representation.

2. Annual Health Insurance Stipend (Stipend)
   The purpose of this payment is to provide a Health Insurance Stipend (Stipend) to compensate the President, President-Elect and Immediate Past President under age 65, when the President(s) loses his/her employer-provided medical insurance coverage during his/her term. President(s) who lose his/her employer insurance will substantiate his/her eligibility for the Stipend by written notice to the Board Chair detailing the effective date of the loss of coverage and listing covered family members. The President receiving the Stipend will have the sole discretion to determine the appropriate health insurance coverage for the himself/herself and the family, and provide proof of purchasing such coverage to the Board Chair.

   The amount of the Stipend will be 70% of the then current Gold Plan premium in the President(s) state/county of residence for each covered family member. If there are multiple Gold Plans in the state/county, the Stipend will be based on the average of the then current Gold Plan premiums. The amount of the Stipend will be updated January 1 of each Plan year based on then Gold Plan premiums and covered family members. Should a President reach age 65 during his/her term(s), the Stipend will end the month Medicare coverage begins. In all cases the Stipend will end the sooner the President(s) obtains other health insurance coverage, reaches age 65 or the month following the end of his/her term as Immediate Past President.

   The Stipend will be paid monthly. The amount of the Stipend will be reported as taxable income for the President each calendar year and will be included in this Committee’s annual report to the House which documents compensation paid to Officers and the IRS reported taxable value of benefits, perquisites, services and in-kind payments.

3. Except as noted above, there will be no other changes to the Officers’ compensation for the period beginning January 1, 2019. (Directive to Take Action)

Fiscal Note: The maximum annual stipend is estimated at $87,000. This is based on 70% of the highest 2018 Gold Plan Premium based on current Board demographics and assumes all three Presidents and spouses/partners would receive the stipend in the same year.
APPENDIX

<table>
<thead>
<tr>
<th>POSITION</th>
<th>GOVERNANCE HONORARIUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td>$290,160</td>
</tr>
<tr>
<td>Immediate Past President &amp; President-Elect</td>
<td>$284,960</td>
</tr>
<tr>
<td>Chair</td>
<td>$284,960</td>
</tr>
<tr>
<td>Chair-Elect</td>
<td>$280,280</td>
</tr>
<tr>
<td>Other Officers</td>
<td>$207,480</td>
</tr>
</tbody>
</table>

Definition of Governance Honorarium Effective July 1, 2017:
The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation day.

Definition of Per Diem for Representation effective July 1, 2017:
The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is $1,300 per day.

Definition of Telephonic Per Diem for External Representation effective July 1, 2017:
Officers, excluding the Board Chair and the Presidents, who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem rate for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for these meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem or $650.
Whereas, The Indian Health Service is a federal agency with a multi-billion dollar budget that provides health care to American Indian and Alaska Native members of federally recognized Tribes; and

Whereas, The basis of this health care provision is a special government-to-government relationship established in 1787, by Article 1, Section 8 of the United States Constitution; and

Whereas, The director of the Indian Health Service is a political appointment that requires confirmation by the United States Senate; and

Whereas, In consideration of the unique demands for the Indian Health Service Director, the Association of American Indian Physicians adopted “Desired Qualifications for the Director of the Indian Health Service”, as follows:

1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.
6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans/Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs; therefore be it

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1 AAIP “Desired Qualifications for the Director of the Indian Health Service”
http://files.constantcontact.com/82ca0b6a001/17d8e3c8-755a-4644-8814-bb60ce9c667c.pdf?ver=1512063577000
RESOLVED, That our American Medical Association support the “Desired Qualifications for the Director of the Indian Health Service” set forth by the Association of American Indian Physicians. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/03/18

RELEVANT AMA POLICY

Indian Health Service H-350.977
The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)
Improving Health Care of American Indians H-350.976

Our AMA recommends that:

1. All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

2. The federal government provide sufficient funds to support needed health services for American Indians.

3. State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

4. American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

5. Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

6. Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

7. A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

8. Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

9. State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

10. Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

11. Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)