Reference Committee F

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-I-18

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 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 now 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 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

[‡] 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

Campion FD. *The AMA and US Health Policy since 1940*. Chicago: Chicago Review Press. 1984. See especially Chapter 7.

Caring for the Country: A History and Celebration of the first 150 years of the American Medical Association. American Medical Association, Chicago 1997

Proceedings of the House of Delegates, One Hundred and First Annual Session. Chicago: American Medical Association. 1952.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-18

Subject:	Training Physicians in the Art of Public Forum (Resolution 606-A-18)
Presented by:	Jack Resneck, Jr., MD, Chair
Referred to:	Reference Committee F (Greg Tarasidis, MD, Chair)

INTRODUCTION

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.

BACKGROUND

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.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-18

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.

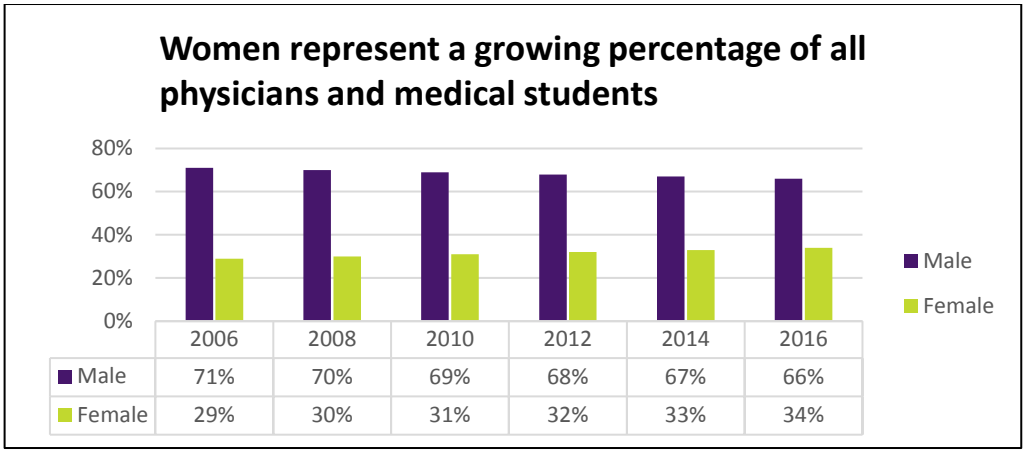
All members of the WPS are eligible to be elected to any office, except the member at-large positions that may not be assumed by medical students. If a candidate is serving on a HOD delegation, they must be willing to resign from their respective HOD delegation position if elected as the WPS delegate 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.



	2006	2008	2010	2012	2014	2016
Male	71%	70%	69%	68%	67%	66%
Female	29%	30%	31%	32%	33%	34%

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:

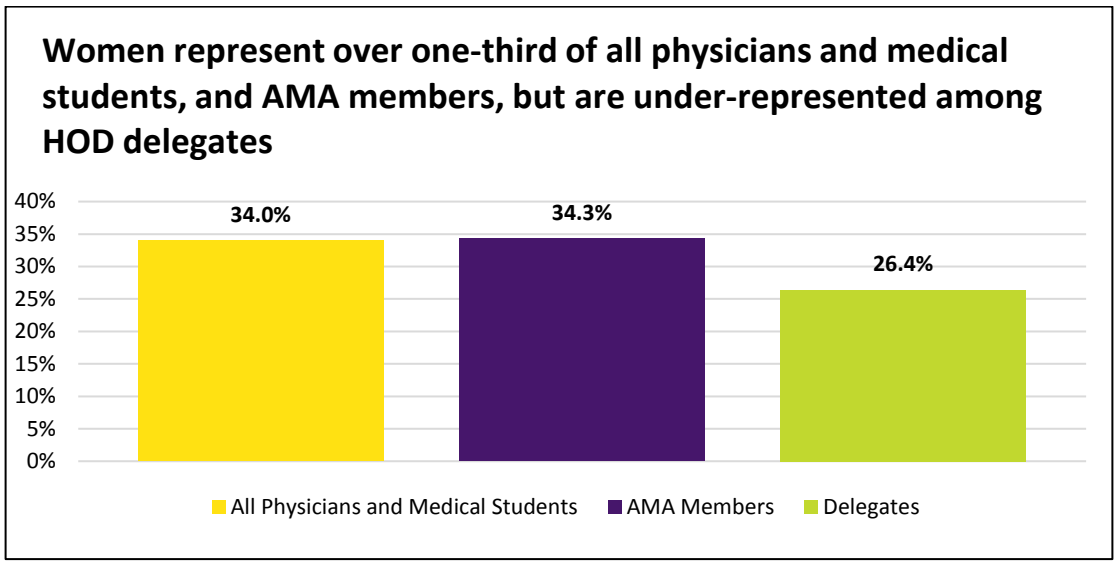
- Facebook posts totaled 1,186,889 impressions and 14,950 acts of engagement, reflecting 31% and 25% increases over 2015 numbers, respectively.
- Twitter posts totaled 287,665 impressions, reflecting a 21% increase over 2015 numbers.
- The WPS webpage experienced a 34% increase in traffic compared to 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. Eighty-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