REPORTS OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

The following reports were presented by Michelle Berger, MD, Chair:

1. INTERNATIONAL MEDICAL GRADUATES SECTION FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee F.

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

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted in June 2024 from the International Medical Graduates Section (IMGS) for renewal of delineated section status and representation in the American Medical Association (AMA) House of Delegates (HOD). The letter focuses on activities beginning in June 2019.

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 five 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."

APPLICATION OF CRITERIA

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.

Since its transition from the IMG Advisory Committee to a Section in 1997, The IMGS has worked to fulfill the objectives of its mission statement:

1. Increase the impact of IMG viewpoints in organized medicine
2. Promote IMG participation and visibility at all levels of organized medicine
3. Establish two-way communication between grassroots IMGs and organized medicine
4. Represent the views of IMGs in the AMA HOD

The IMGS is the only group within the AMA that represents and promotes the interests of physicians who have graduated from medical schools outside the United States or Canada. The IMGS serves its constituents by bringing critical IMG professional issues to the forefront of organized medicine and by providing targeted educational and policy resources.

Over the past five years, the Section has focused on core issues affecting IMGs in the United States including licensure parity, immigration, graduate medical education expansion and discrimination. The IMGS collaborates with the AMA Advocacy unit to work toward uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating disparity in the years of GME required for licensure and a uniform standard for the allowed number of administrations of licensure examinations. The IMGS works with the AMA Washington D.C. office to stay abreast of the immigration issues that affect the J-1 Visa Waiver and Conrad 30 Waiver programs for IMGs practicing in underserved areas. IMGS members contributed to the AMA's testimony before the National Academy of Medicine Graduate Medical Education (GME) Financing Committee on the issue of GME expansion. Discriminatory issues have been addressed by the IMGS through policy initiatives, educational sessions, open forums, immigration webinars, employment contract guidelines, amicus briefs, and advocacy for equity in leadership positions. Some professional issues addressed include the Bachelor of Medicine, Bachelor of Surgery (MBBS) degree equivalent, licensure disparity, disparities in the residency selection process, and visa issues related to delays, denials, caps and green card backlogs. The IMGS has worked with AMA Washington D.C. office staff to communicate to the United States Citizenship Immigration Services, U.S. Senators and Representatives regarding these issues. Additionally, the Section has identified and worked to affect the following issues of concern for IMGs:

Providing ongoing support on issues affecting IMGs

The IMGS receives many inquiries regarding immigration, J-1 visa issues, licensure, residency positions, observerships, and mentoring. In response to these requests, in addition to providing direct support, the Section developed an IMG Toolkit, which is posted on the AMA website and is updated regularly. Staff of the Section keep track of all inquiries and work with the Governing Council (GC) on how to best provide the appropriate resources to assist IMGs.

Mentorship

The Section regularly receives communications from its members requesting mentors or a mentorship program. IMG students and early residents are often unfamiliar with the requirements and challenges of practicing medicine in the United States. In response, the IMGS has developed a listing of over 65 volunteer mentors to assist in this regard. IMG staff have also worked with the Governance and Policy Group Committee to determine how to develop an AMA mentorship program.

IMG representation in leadership positions

IMGs have historically been underrepresented in leadership positions in organized medicine, and the IMGS consistently encourages its core members to apply for leadership positions. The Section has also included a Section on Board/Council Endorsements in its Internal Operating Procedures (IOP), which was approved in 2022, as an offering to those IMGs who are interested in applying for an endorsement.

Inclusion of IMGs in the AMA's Equity Strategic Plan

The IMGS collaborated with the Center for Health Equity (CHE) to integrate IMG issues into the AMA's Organizational Strategic Plan to Advance Health Equity. This led to a pull-out section on IMGs in the Strategic Plan and participation in the A-24 Health Equity forum panel discussion. The IMGS GC and staff work with CHE on a regular basis to provide IMG insights for the Center's work.

Many IMGs in the United States are still unaware that the AMA has an IMGS and subject matter experts to assist them. Once they became aware of this information, many IMG physicians and residents have joined the AMA as demonstrated by the increased membership numbers in the past five years. There are also U.S. citizens attending Caribbean medical schools that have an interest in joining the AMA; however, current AMA policy and bylaws prohibit this until they have become ECFMG-certified, an issue the IMGS hopes to address.

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

The IMGS works with its GC to align its work with the AMA's and the Section's Strategic Plan and to inform members and non-members how the AMA has worked to remove obstacles that interfere with patient care, confront chronic disease and eliminate health disparities, and drive the future of medicine by reimagining medical education. The IMGS has collaborated with the Council on Medical Education, CHE, Advocacy and other units, sections and special groups on its priority issues to maximize impact and avoid duplicative effort. Since its inception, the IMGS has submitted more than 125 resolutions to the HOD, including 19 since 2019, on topics relevant to IMGs, while also contributing and providing input to HOD reports when appropriate. The IMGS also reviews and revises its strategic plan on an annual basis to ensure relevance and alignment with AMA priorities.

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

Each year the Section works with its GC to develop its Strategic Plan to focus on priority initiatives. GC and committee meetings are held on a regular basis. In 2024, the Section began "Conversation Circles" on topics of interest suggested by its IMGS membership. To date, the Section has held two sessions attended by over 30 participants. The GC meets four to six times a year. Committees meet quarterly and as needed to address issues of immediate concern. Email inquiries received via the IMG mailbox deemed important to address are shared with the GC. Issues addressed and success stories are shared via the IMGS communication vehicles, including newsletters, email, Facebook and LinkedIn.

The IMGS provides direct opportunities for its members to participate in the policymaking process twice a year. These opportunities are announced in advance of annual and interim meetings to allow members time for comment and ratification of reports and resolutions via the Section's online member forum. The Section makes the resolution guidelines and checklist available to members via its newsletters, website and Facebook group. All resolutions are vetted by the Section's Delegates, the Resolution and Policy Committee, followed by the GC and Congress Assembly.

The IMGS GC election is held annually, with calls for nominations announced in December and accepted through February 22. Nominations are reviewed and scored by the IMGS Nominating Committee members, who discuss all candidate nomination materials and perform category rankings to build the slate of candidates for each election. An election announcement is sent via all communication vehicles to Section members, allowing opportunities for all members to consider running for open positions. IMGS members are also invited to participate in IMG Committees including the diversity, equity and inclusion Committee, social media, resolutions & policy, the IMG Bylaws Committee, IMGS Leadership Development; United States International Medical Graduate Liaison Committee and other ad hoc committees as deemed appropriate.

The most recent changes to the Section's IOP were made in 2021 to include the Section's policy on the GC's role in endorsing AMA Board of Trustees and Election Council Candidates each year.
The IMGS GC believed this was important for inclusivity and offering support to IMGs and other candidates. In 2023, the Section and its assigned Bylaws Committee members began working on a complete review and update of its IOP. Once this IOP has completed its revisions, it will be reviewed and approved by Section members, provided to the Council on Constitution and Bylaws and subsequently provided for the Board of Trustees' approval.

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

The IMGS is comprised of graduates of medical schools outside the United States or Canada as identified in the AMA Masterfile. IMGs who join the AMA automatically become members of the IMGS. The core members of the Section are those that participate in the IMGS Congress and online member forum. IMG physicians represent approximately 25 percent of the U. S. physician workforce, and the Section has a potential membership of over 324,000 physicians

Involvement in the IMGS GC, committees, meetings and events, requires that a physician be a current AMA member. Membership of the IMGS increased from 43,554 in 2019 to 53,023 when the letter of application was submitted in June 2024.

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.

The IMGS was established in 1997 and has demonstrated consistent growth in membership and engagement. From the 2019 Annual Meeting to the 2024 Annual Meeting the IMGS averaged 153 attendees at each IMGS meeting. From 2015 to 2019 attendance at the same meetings averaged 77 members; the last five years have shown a nearly 100 percent increase in attendance over the five years prior. This substantial increase means that the deliberations of the HOD and resulting AMA policy incorporates the perspectives of a significantly increased number of IMGs.

The IMGS attributes this increased participation to continuous communication with current and potential members via newsletters, the IMGS Facebook page, surveys, emails, and specific campaigns, e.g. IMGS Recognition Week and Research Challenge, state IMG Chair Groups and ethnic societies. The Section has also collaborated with other organizations to increase engagement and membership and attended special meetings such as Project IMG—an exclusive network connecting, resourcing and supporting international medical students and graduates—to assist in this effort. This outreach has increased engagement, promoted more interest in the Section as well the AMA.

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

IMGs make up 7.9 percent of delegates in the AMA HOD and 10.5 percent of Alternate Delegates. Comparatively, according to CLRPD Report 1-A-23, IMGs make up 18.1 percent of AMA members and 22.3 percent of all physicians and medical students, demonstrating a significant level of underrepresentation in the AMA's policymaking body.

Through the Section, IMGs can participate in the AMA's policymaking process during business meetings, reference committee hearings and IMGS caucuses, as well as making use of the IMGS online member forum to debate and ratify resolutions submitted to annual and interim meetings. Other opportunities to contribute to AMA policymaking include participation in the Resolutions & Policy Committee, the IMGS GC (including delegate and alternate delegate positions) and other committee/webinar discussions. The IMGS also provides an opportunity for other sections and councils to provide input on resolutions being considered by the Section for annual and interim meetings, which are shared with the IMGS GC.

The Section identifies its active core members through participation in Section meetings, webinars, Facebook discussions, the AMA Members Move Medicine campaign, and others that engage in committees and mentoring activities. Additional core members include those who participate in newsletter review, online member forums, and vote in the annual GC elections, which at the time of application consisted of over 105 members and 63 mentors.

The IMGS ensures accessibility through a transparent process that aligns with the principles of equity, enhanced decision-making through diverse perspectives, addressing systemic barriers of participation and strengthening governance and policy. The Section is committed to offering a positive member experience, while increasing member engagement on IMG issues, developing new AMA resources and working with new and present partners to increase the AMA Section value and obtain actionable insights.

DISCUSSION

The IMGS continues to focus on issues pertaining to international medical graduates not only within the AMA but throughout the United States. No other existing group within the AMA specifically focuses on these issues, and the Section collaborates with other AMA units when appropriate. Over the past five years, the Section has participated, often in collaboration with other AMA units, in substantial outreach to legislative and regulatory bodies on issues and legislation relevant to all IMGs, including both houses of Congress, the Department of Homeland Security, and the Department of State, demonstrating the Section's role as an important advocate for IMGs in the United States. These efforts have contributed to a number of successes including the creation of pathways and alternative methods to ensure that IMGs receive equitable access to patient care, the addition of one thousand Medicare-funded residency slots through the Inpatient Prospective Payment System, ensuring that IMGs maintained their immigration status during the COVID-19 pandemic, and obtaining licensure parity in several states including Louisiana, Minnesota and Pennsylvania.

The initiatives of the IMGS are consistent with those of the AMA, in particular, IMGS activities focus on practice sustainability and satisfaction for IMG physicians and the patients they serve. Of equal significance, with IMGs making up approximately one-quarter of physicians in the United States, the IMGS provides the AMA with a necessary pipeline for obtaining insight on the challenges and needs of a major segment of the U.S. health care delivery system, which can then be incorporated into AMA policy and strategic planning.

The structure of the Section enables its constituents to participate in both policymaking activities and section leadership; IMGS members have numerous opportunities to actively participate in the resolution development and review to affect changes on issues significant to members of the Section. As the IMG population continues to grow, the Section provides valuable support to its members and IMGs across the country. The IMGS membership has grown by 11 percent since its previous review in 2020, and average meeting participation has nearly doubled, demonstrating both the effectiveness of the Section's outreach efforts and the need for its continued role in AMA activities and member support. Additionally, it should be reiterated that IMGs remain significantly underrepresented when compared with all members of the HOD, demonstrating even further the need for the Section's continued voice in the AMA policymaking process to ensure that the issues of concern of IMGs have a forum to be deliberated and addressed.

The Council appreciates the thorough work of IMGS leadership and staff in completing this letter of application and follow-up communications, as well as the deliberation of the Section as it looks to improve upon its already commendable work in the future.

CONCLUSION

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

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the International Medical Graduates Section through 2030 with the next review no later than the 2030 Annual Meeting and that the remainder of this report be filed.

Fiscal Note: Less than $500

2. ORGANIZED MEDICAL STAFF SECTION FIVE-YEAR REVIEW

Reference committee hearing: see report of Reference Committee F.

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

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted in September 2024 from the Organized Medical Staff Section (OMSS) for renewal of delineated section status and representation in the American Medical Association (AMA) House of Delegates (HOD). The letter focused on activities beginning in June 2019.

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 five 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."

APPLICATION OF CRITERIA

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

The OMSS is the recognized center of expertise within the AMA and the house of medicine for matters concerning hospital and health system medical staffs and issues facing physicians practicing within the hospital setting. Medical staff leaders, other physician members of the medical staff, hospital/health system administrators, health care law attorneys, medical staff professionals, state/specialty medical society leadership and staff, and other stakeholders look to the OMSS for guidance on these and other issues. OMSS works closely with the National Association of Medical Staffing Services (NAMSS) on credentialing and privileging issues to ensure that physician and resident interests are protected and the processes become as streamlined as possible. Colleague medical societies like the American College of Surgeons regularly seek the OMSS' advice on issues impacting OMSS members and their medical staff colleagues.

Over the past five years, OMSS has identified and worked to affect the following issues of concern:

<u>Medical staff unification and systematization</u>

Since 2014, the Medicare Conditions of Participation have permitted unification of multiple medical staffs across multi-hospital systems. The OMSS has provided comprehensive education and resources on this topic going back to 2014. In 2021, OMSS updated its Guide to Medical Staff Organization Bylaws, re-publishing the guide in its seventh edition. The Guide contains new sections on gender-neutral language, pandemic preparedness, right to practice, exclusion from Medicare, criminal clearance and background checks, Board certification and equivalency, and many

others. The updated guide also comes with a variety of toolkits developed to provide practical illustrations of the new concepts and guidelines.

Physician-hospital relations

The OMSS has worked to reframe the relationship between physicians and hospitals as one of partners rather than adversaries, while explicitly advocating for medical staff self-governance. The AMA Guide to Medical Staff Bylaws incorporates several previously adopted OMSS resolutions designed to strengthen these perspectives as well as toolkits to help guide physicians around topics such as gender disparity, pandemic preparedness, and others. In 2022, the OMSS revised its model physician-hospital employment contract and made these available to members. The OMSS Plans to revise an additional model contract for group practices within the next two to three years.

Physician voice in development of accreditation standards

OMSS leadership regularly communicates with AMA-appointed representatives to The Joint Commission (e.g., AMA-appointed members of the Joint Commission Board of Commissioners), as well as with Joint Commission senior staff leadership. Through these interactions, the OMSS has influenced key decisions on Joint Commission hospital accreditation matters. OMSS has also worked to expand physician influence in accreditation matters by engaging AMA members in Joint Commission field reviews and related opportunities.

Support for physicians during hospital closures

When Philadelphia's Hahnemann University Hospital closed in September of 2019, it left more than five hundred residents and fellows without an accredited program they could use to continue their medical education. The OMSS was a key player in drafting policy and resolutions to protect physicians affected by Hahnemann's closure and establish a playbook for the closure or significant reduction in services of hospitals in the future. Those actions included working with other stakeholder organizations to develop proactive processes in the event of sudden teaching hospital closures and promoting funds from health care facilities that ensure professional liability coverage in the event of closures.

Connecting physicians to the personal protective equipment they needed during Covid-19

As the COVID-19 pandemic surged in 2020, physicians across the country were left with substandard options for obtaining and maintaining personal protective equipment. The OMSS was the key initiator of a partnership with a non-profit, Project N95, to coordinate efforts to provide physicians with the masks, face shields, and other products they needed to maintain their safety in the face of the pandemic.

Support for physician collective action

Unionization and collective action have grown as areas of interest for OMSS members, partially spurred on by the COVID-19 pandemic. OMSS members have expressed a desire to better understand how collective action can be accomplished relative to the obligations of the practice of medicine. Since 2022, the Section has sponsored two webinars focused on developing a critical understanding of how collective bargaining and action works in a medical setting and has advanced two resolutions directing the AMA to develop policies and procedures around physician collective action. The efforts to provide education and perspective building are ongoing.

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.

OMSS aligns its focus areas and activities with AMA's strategic priorities. The OMSS has a two-fold mission: To improve the practice experience, and, by doing so, to positively impact patient outcomes. OMSS advocates for physicians and medical staff by removing obstacles to patient care and improving engagement, while also reporting key challenges to the AMA. Medical staff feedback has led to the creation of multiple resolutions adopted by the Section and advanced to the HOD on better compensation for time spent on prior authorization, creating stronger protections against adverse effects from corporate buyouts of practices, and fighting scope creep by improving patient awareness of care delivered through non-physician extenders. In all, the OMSS has sponsored nearly forty resolutions since its last review in 2019, making significant impact on AMA policy and the Association's strategic direction.

OMSS-member medical staffs and their physicians will continue to be significant players in determining how the transition from a volume-based to a value-based care delivery and payment system is managed in the United States. Chronic disease is tailor-made for a value-based environment because it is managed rather than cured. As the entities responsible for patient care quality and safety within health facilities, medical staffs and their physicians are positioned to substantially and positively impact a patient's long-term health status in the management of one or more chronic diseases, while input from OMSS-member medical staff representatives will continue to assist in guiding the AMA's work in this critical area.

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

Section members have a wide range of opportunities to participate in the activities of the OMSS. Although annual and interim meetings are the most obvious of these opportunities, the Section actively promotes that one need not attend meetings to contribute to the work of the Section and provides a variety of opportunities for engagement between meetings, including:

- OMSS committees (e.g., Education Committee, Policy Committee, Membership and Engagement Committee)
- The online member forum enables all representatives to contribute to the policymaking activities of the Section, regardless of whether they can attend meetings.
- Participation in the Section's Reference Committee and Late Resolution Committee for both annual and interim meetings
- Surveys to gauge representatives' interest in potential topics for future education programs and provide a voice to representatives in the Section's strategic planning activities
- Peer-to-peer outreach program for representatives who wish to contribute to the Section's recruitment efforts
- Calls to action on vital legislative and regulatory issues (e.g., Joint Commission field reviews)
- Monthly newsletters (sent to approximately 1,400 subscribers) with relevant medical staff news and announcements.

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.

Since the Section's last renewal of delineated section status, the OMSS has seen an increase of 17 representatives, reaching 178 by September 2024, an increase of 10.6 percent from the 161 OMSS representatives certified in 2019. The Section estimates that it now directly represents approximately 4,000 AMA member physicians based on the following assumptions:

- Approximately 15 percent of practicing physicians are currently AMA members,
- The average medical staff size is 150, and
- There is minimal staff membership overlap between represented hospitals.
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By comparison, using the same calculation, OMSS covered 3,600 AMA member physicians in 2019, showing a steady increase in participation.

The total number of AMA member physicians who could potentially be represented in OMSS is uncertain, as the AMA has no robust data on how many members have been appointed to at least one hospital/health system medical staff. However, using a conservative estimate that 60 percent of all practicing physicians (i.e., not including medical students, residents, or retired physicians) are part of at least one medical staff, and referencing CLRPD's 2023 demographic report, the total potential representation in the OMSS is approximately 88,543 AMA practicing physician members.

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

Since its inception in 1983, the OMSS has played a vital role in helping the AMA address matters concerning hospital and health system medical staffs and issues facing physicians, whether employed or in private practice, who practice within the hospital setting.

Since its last five-year review, OMSS meetings held in conjunction with AMA annual and interim meetings have averaged 37 credentialed representatives and 68 total attendees. OMSS measures meeting participation with two metrics: (1) Section members credentialed to vote at the meeting, and (2) all meeting attendees, regardless of member/voting status. This distinction is made because OMSS typically draws non-OMSS-member attendees to its education programs and other non-business activities at each annual and interim meeting (e.g., individuals from stakeholder organizations such as The Joint Commission, the NAMSS, federation staff, health law attorneys, etc.). OMSS meeting participation has fluctuated over the last five years, due in large part to the effects of the COVID public health emergency.

The OMSS traditionally has communicated with its members and other individuals interested in medical staff topics through a monthly email newsletter with approximately 1,400 subscribers. In 2017, the OMSS launched a Facebook group and continues to post updates on joining, running for the Governing Council (GC) and promoting webinars. Facebook currently has 289 members, up from 210 from the 2019 report and provides a platform for members to discuss relevant topics, stay connected personally, and provides another communication link for AMA announcements. Finally, the Section created a GroupMe chat allowing members to discuss important topics including activities by peers not in the OMSS.
Criterion 6: Accessibility - Provides opportunity for members of the constituency, who are otherwise under-represented, to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

The OMSS offers a unique perspective on the relationship between physicians (whether independent or employed) and the health systems in which they provide services and provides a crucial link between physicians and the facilities where they practice, filling a niche that might not be available to physicians elsewhere. The OMSS serves as an entry point for most resolutions addressing medical staff and hospital issues, which directly affect a large percentage of AMA delegates. On average, the OMSS submits five to seven resolutions for the consideration of the HOD at each meeting, greater than 90 percent of which are eventually adopted in some form. Most OMSS resolutions are introduced by individual Section representatives who, through the experiences of the medical staffs they represent, have identified pressing needs for AMA policy or action. Additionally, resolutions are introduced by OMSS representatives acting on behalf of their state level OMSS groups whose medical societies are not well positioned to address the identified problem.

At the beginning of 2023, the OMSS established an Employed Physicians Caucus to provide advice and counsel to the OMSS and to AMA staff on policy matters that bear directly on employed physicians and their patients. The current roster has an active population of 28 physicians who add to the potential representation of the OMSS. The Caucus convenes two meetings per year, held in conjunction with the annual and interim meetings of the HOD, with additional meetings scheduled throughout the year as necessary. Starting at the 2024 Interim Meeting, the Employed Physician Caucus joined the OMSS Policy Committee for its handbook review.

In addition to providing an opportunity for members to introduce issues of concern, the Section reviews resolutions and reports under consideration at each meeting and, in a democratic process led by the GC, determines which items the Section should take positions on, and what those positions should be. Additionally, the OMSS provides its members with an opportunity to become involved in the Section's HOD activities, such as providing testimony on behalf of the Section at reference committee hearings. The OMSS holds a briefing/strategy session before the Sunday-morning HOD reference committee hearings and a post-reference committee hearing debriefing, both of which are open to all OMSS representatives and other AMA members interested in medical staff matters.

DISCUSSION

The OMSS provides a voice for staff physician interests, as the evolution of staff structures and functions continues to change the landscape of hospital medical staffs. The Section is uniquely focused on addressing the needs and issues of physicians on medical staffs. Through wide-ranging activities, the OMSS strives to improve medical staff relations and empower physicians to lead, direct, and ensure the success of those staffs. The OMSS is in alignment with the AMA's strategic foci, evidenced by the Section's efforts to remove barriers to patient care and joy in medical practice,

treat chronic diseases and remove inequities in health care, and provide opportunities for its members to enhance their participation in AMA activities and deliberations.

As physician modes of practice continue to evolve, it is increasingly vital for the AMA to have a conduit to employed physicians, who are now the majority stakeholder in the physician population. The Section's development and incorporation of its Employed Physicians Caucus established a direct path for the needs and priority issues of employed physicians to be incorporated into OMSS, and, subsequently, the AMA's policy and strategic decision-making. This development also demonstrated the Section's desire and ability to evolve within the changing landscape of health care delivery and willingness to adapt to the needs of its constituents. In addition to the fact that a majority of AMA members are likely to be members of at least one medical staff, the OMSS representatives themselves represent thousands of AMA members in their own medical staffs. The OMSS has demonstrated strong continuity since its founding over 40 years ago.

The unique relationship between physician staffs and organizations incorporates many issues and the OMSS is an appropriate means for members to focus on and address these topics in a holistic fashion and create needed policy. The OMSS provides a crucial link between physicians and the facilities where they practice, and the Section provides the necessary perspective for members to address critical issues related to physician and hospital matters.

The Council appreciates the thorough work of OMSS leadership and staff in completing this letter of application and follow-up communications, as well as the deliberation of the Section as it looks to improve upon its already commendable work in the future.

CONCLUSION

The CLRPD has determined that the OMSS meets all required criteria; therefore, it is appropriate to renew the delineated section status of the OMSS.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Organized Medical Staff Section through 2030 with the next review no later than the 2030 Annual Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500

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

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational report is prepared in odd numbered years by the Council on Long Range Planning and Development (CLRPD), pursuant to American Medical Association (AMA) Policy G-600.035, "The Demographics of the House of Delegates." This policy states:

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

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

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

Like previous reports, this document compares AMA leadership with the entire AMA membership and with the overall U.S. physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. For the purposes of this report, AMA leadership includes delegates; alternate delegates; the Board of Trustees (BOT); and councils and leadership of sections and special groups (hereafter referred to as CSSG; see detailed listing in Appendix A).

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

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates (HOD) Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect year-end 2024 delegation rosters. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all graduates of U.S. medical schools and international medical graduates (IMGs) who have undertaken residency training in the United States. Data on AMA members and the total physician population are taken from the year-end 2024 Masterfile after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. Members of the BOT, the American Medical Political Action Committee and the Council on Legislation who are not physicians or medical students are not included in any tables. Vacancies in delegation rosters mean the total number of delegates is fewer than the number allotted at the 2024 Interim Meeting, and the number of alternate delegates is nearly always less than the full allotment. Race and ethnicity information, which is provided directly by physicians, is missing for nearly one-fourth of AMA members (24.0 percent) and the total U.S. physician population (23.6 percent), limiting the ability to draw firm conclusions.

Readers are reminded that most AMA leadership groups considered herein designate seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of age-related groups, namely the student, resident, and young physician sections. To provide further clarity on this point, an additional table has been included in the appendix illustrating demographic characteristics and career stage breakdowns of section governing councils.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 displays the basic demographic characteristics of AMA leadership, AMA members, and all physicians and medical students. Raw counts for Tables 1 and 2 can be found in Appendix A. Upward- and downward-pointing arrows indicate an increase or decrease of at least two percentage points compared to CLRPD Report 1-A-23, “Demographic Characteristics of the House of Delegates and AMA Leadership”; the following observations refer to changes since CLRPD Report 1-A-23. Changes are not highlighted for the BOT due to the small number of Board members. Between year-end 2022 and year-end 2024, AMA membership increased by 16,080 members, a 5.9 percent increase.

- Among alternate delegates, an increase of 3.9 percentage points was observed in the 40-49 age group, while a decrease of 2.3 percentage points was observed in the 60-69 age group. Among leadership of AMA councils, sections and special groups, an increase of 3.0 percentage points was seen in the under 40 age group, while representatives aged 50-59 and 70 and over decreased by 2.0 and 2.2 percentage points respectively.
- Female representation in the HOD increased once again, a continuation of a steady trend of more than a decade. Delegates identifying as female made up 37.2 percent of delegates (a 2.9 percentage point increase

since 2022) and 49.5 percent of alternate delegates (a 5.8 percentage point increase). Likewise, female representation among all AMA members increased by 2.1 percentage points.

- Delegates, alternate delegates, and CSSG identifying as white non-Hispanic declined by 2.1 percentage points, 4.5 percentage points and 3.8 percentage points, respectively. Asian/Asian American representation increased among alternate delegates by 3.4 percentage points.

Table 1. Demographic Characteristics of AMA Leadership, December 2024

	Delegates[1]	Alternate Delegates[1]	Board of Trustees[2]	Councils and Leadership of Sections and Special Groups[3]	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Mean age (years)[4]	56.5	50.2	55.5	49.9	46.5	52.9
Age Distribution						
Under age 40	14.7%	28.6%	10.0%	33.5%↑	53.1%	30.7%
40-49 years	16.2%	21.6%↑	15.0%	14.0%	11.5%	17.1%
50-59 years	21.5%	18.4%	35.0%	19.6%↓	9.5%	15.5%
60-69 years	26.3%	20.0%↓	35.0%	20.1%	8.6%	15.2%
70 or more	21.3%	11.4%	5.0%	12.8%↓	17.3%	21.5%
Gender						
Male	62.8%↓	50.2%↓	50.0%	52.5%	57.7%↓	61.4%
Female	37.2%↑	49.5%↑	50.0%	47.5%	41.6%↑	37.8%
Unknown	0.0%	0.2%	0.0%	0.0%	0.7%	0.8%
Race/Ethnicity						
White non-Hispanic	63.7%↓	52.8%↓	45.0%	53.1%↓	47.7%	49.0%
Black non-Hispanic	5.9%	6.3%	10.0%	5.0%	5.2%	4.5%
Hispanic	3.1%	4.2%	5.0%	6.1%	4.0%	4.4%
Asian/Asian American	13.5%	19.3%↑	30.0%	20.1%	17.1%	16.6%
Native American	0.3%	0.5%	0.0%	0.6%	0.2%	0.2%
Other[5]	1.8%	1.6%↓	0.0%	1.7%↓	1.8%↓	1.7%
Unknown	11.8%	15.3%↑	10.0%	13.4%↑	24.0%↑	23.6%↑
Education						
US or Canada	90.3%	88.8%	95.0%	87.7%	80.8%	77.2%
IMG	9.7%	11.2%	5.0%	12.3%	19.2%	22.8%

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

- Limited changes were observed to the life stage, employment, and specialty characteristics of delegates to the HOD. Among delegates, an increase of 2.3 percentage points was observed among established physicians, and the share of group practice physicians decreased by 2.2 percentage points. Among alternate delegates, representation of internal medicine specialists increased by 4.2 percentage points.
- Among CSSG, increases were observed among students (2.1 percentage points), group practice physicians (4.4 percentage points), and radiologists (2.6 percentage points), while decreases were observed among established physicians (-2.8 percentage points), self-employed solo practice physicians (-2.4 percentage

[1] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[2] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[3] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[4] Age as of December 31. Mean age is the arithmetic average.
[5] Includes other self-reported racial and ethnic groups.

points), retired/inactive physicians (2.7 percentage points) and internal medicine specialists (-4.9 percentage points).

- The percentage of intern/resident/fellow AMA members increased by 3.0 percentage points.

Table 2. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2024

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Life Stage						
Student[6]	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%
Resident[6]	6.3%	8.4%	5.0%	12.3%	29.2%↑	11.5%
Young (Under age 40 or first eight years of practice)[7]	6.0%	15.1%	0.0%	12.8%	10.2%	15.4%
Established (Age 40-64)[7]	47.4%↑	45.3%	65.0%	38.5%↓	20.9%	36.1%
Senior (Age 65 or more)[7]	35.9%	21.2%	25.0%	24.6%	21.5%	29.1%
Present Employment						
Self-employed solo practice	11.9%	7.2%	30.0%	8.4%↓	5.4%	6.8%
Two physician practice	1.6%	1.6%	0.0%	0.6%	1.3%	1.7%
Group practice	37.6%↓	38.1%	30.0%	39.1%↑	23.9%	38.7%
Non-government hospital	8.8%	8.4%	10.0%	7.3%	3.0%	4.3%
State or local government hospital	9.7%	9.3%	10.0%	7.8%	3.2%	5.3%
HMO	1.0%	0.7%	0.0%	0.6%	0.2%	0.1%
Medical School	4.0%	2.6%	5.0%	2.8%	0.8%	1.2%
U.S. Government	2.6%	1.4%	5.0%	1.7%	0.7%	1.4%
Locum Tenens	0.3%	0.2%	0.0%	1.7%	0.1%	0.2%
Retired/Inactive	9.6%	5.8%	0.0%	3.9%↓	10.7%	12.9%
Resident/Intern/Fellow	6.3%	8.4%	5.0%	12.3%	29.2%↑	11.5%
Student	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%
Other/Unknown	2.2%	6.3%	0.0%	2.2%	3.3%	8.0%
Self-designated Specialty[8]						
Family Medicine	12.9%	9.8%	0.0%	10.1%	8.8%	11.3%
Internal Medicine	21.8%	19.3%↑	10.0%	17.3%↓	21.4%	23.0%
Surgery	21.3%	17.7%	40.0%	15.1%	13.0%	13.0%
Pediatrics	4.0%	5.3%	5.0%	6.7%	5.8%	8.6%
OB/GYN	6.3%	7.0%	15.0%	8.9%	4.9%	4.4%
Radiology	5.3%	3.7%	10.0%	5.0%↑	3.5%	4.3%
Psychiatry	3.7%	5.6%	0.0%	5.6%	4.4%	5.2%
Anesthesiology	3.5%	3.3%	5.0%	2.8%	4.1%	4.9%
Pathology	1.6%	4.0%	0.0%	0.6%	1.7%	2.1%
Other specialty	15.2%	14.4%	10.0%	16.2%	14.2%	15.3%
Student	4.4%	10.0%	5.0%	11.7%↑	18.2%	7.9%

[6] Students and residents are so categorized without regard to age.
[7] Reflects section/group definition of its membership.
[8] See Appendix B for a listing of specialty classifications.

For further data, including information on state medical associations and national medical specialty societies, raw counts of the above tables, and detailed state and specialty society data, please see the appendices.

This year, the Council added another metric to the report with the inclusion of a diversity index. The index provides a balanced and robust assessment of diversity and has been widely applied across demographic and clinical research contexts. The Council utilized the Gini-Simpson Diversity Index (GSI) which measures the probability that two individuals selected at random will represent different identities; it is measured from 0 to 1, where 0 represents an absence of diversity and 1 represents the greatest possible diversity. CLRPD assessed diversity trends within the AMA HOD and AMA leadership from 2014 to 2024, specifically focusing on member age, gender, and race/ethnicity. The Council intends to include this metric in future reports on the demographic characteristics of the HOD and AMA leadership as another means of encouraging greater awareness and responsiveness to diversity. To view data on the GSI of the HOD and AMA leadership, please view graphics 1-3 in Appendix A.

PROMOTING DIVERSITY AMONG DELEGATIONS

Policy G-600.035 stipulates that "(f)uture reports on the demographic characteristics of the House of Delegates should, whenever possible, identify and include information on successful initiatives and best practices to promote diversity within state and specialty society delegations."

In 2024, the AMA Center for Health Equity (CHE) surveyed the AMA Federation of Medicine for its annual Health Equity in Organized Medicine (HEIOM) survey, which queried members of the Federation with the goal of developing a shared understanding of health equity initiatives. This report highlights some key findings of that survey related to diversity among delegations, but the Council encourages members of the HOD to access the report in its entirety to view the breadth of efforts being undertaken by organizations within the Federation to improve health equity and increase organizational diversity. The Council plans to collaborate with CHE to include queries about best practices to increase diversity among state and specialty delegations in future HEIOM surveys to improve collaboration and knowledge sharing, and to avoid duplication of effort.

Of the 81 organizations that responded, the HEIOM survey found that nearly one in four had taken at least one action to identify opportunities for improvement. Approximately half of responding organizations said that they had achieved or were working toward collecting and stratifying quantitative data regarding organizational leadership and staff to identify inequities, and a similar number said they had undertaken or were in the process of undertaking similar efforts about their organization's membership. Additionally, nearly three in four had taken at least one action to make equity a strategic priority which included ensuring that senior leadership and board members reflected the diversity of the community served by the organization.

The report highlighted an illustrative initiative undertaken by the Tennessee Medical Association (TMA), which recognized the need for younger and more diverse members to better reflect the state's physician demographics. To work toward this goal, TMA created a leadership portfolio to assess diversity in leadership across various demographics, environments, and experiences to develop an understanding of diversity within the organization. The Association built on this work by developing a "leadership scorecard," which defines representation and tracks progress on diversity in leadership roles, including its AMA delegation. The initiative aims to identify key areas lacking diversity and guide the nominating committee when selecting candidates for leadership roles.

Another initiative highlighted in the report came from the American Academy of Orthopaedic Surgeons (AAOS), which developed a publicly shared Governance Diversity Report to provide an analysis of the composition of the organization's volunteer structure, member engagement and applicant selection. The report has helped AAOS understand baseline diversity within its governance, raise awareness of diversity with councils and committees, and increase the number of female and underrepresented minority members holding positions within the AAOS governance structure. Additionally, public sharing of the report has allowed for increased transparency, trust-building, and accountability.

APPENDIX A

Table 3. Demographic Characteristics of AMA Leadership, December 2024

	Delegates[9]	Alternate Delegates[1]	Board of Trustees[10]	Councils and Leadership of Sections and Special Groups[11]	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Mean age (years)[12]	56.5	50.2	55.5	49.9	46.5	52.9
Age Distribution						
Under age 40	100	123	2	60	154413	476983
40-49 years	110	93	3	25	33442	265681
50-59 years	146	79	7	35	27626	240822
60-69 years	179	86	7	36	25008	236161
70 or more	145	49	1	23	50308	334043
Gender						
Male	427	216	10	94	167789	953966
Female	253	213	10	85	120971	587295
Unknown	0	1	0	0	2036	12430
Race/Ethnicity						
White non-Hispanic	433	227	9	95	138710	761308
Black non-Hispanic	40	27	2	9	15121	69916
Hispanic	21	18	1	11	11632	68362
Asian/Asian American	92	83	6	36	49726	257913
Native American	2	2	0	1	582	3107
Other[13]	12	7	0	3	5234	26413
Unknown	80	66	2	24	69791	366671
Education						
US or Canada	614	382	19	157	234963	1199449
IMG	66	48	1	22	55833	354241

[9] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[10] Numbers do not include the public member of the Board of Trustees, who is not a physician.
[11] Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. In addition, Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[12] Age as of December 31. Mean age is the arithmetic average.
[13] Includes other self-reported racial and ethnic groups.

Table 4. Life Stage, Present Employment and Self-Designated Specialty of AMA Leadership, December 2024

	Delegates	Alternate Delegates	Board of Trustees	Councils and Leadership of Sections and Special Groups	AMA Members	All Physicians and Medical Students
Count	680	430	20	179	290,796	1,553,690
Life Stage						
Student[14]	30	43	1	21	52925	122742
Resident[1]	43	36	1	22	84912	178674
Young (Under age 40 or first eight years of practice)[15]	41	65	0	23	29661	239268
Established (Age 40-64)[2]	322	195	13	69	60776	560882
Senior (Age 65 or more)[2]	244	91	5	44	62521	452124
Present Employment						
Self-employed solo practice	81	31	6	15	15703	105651
Two physician practice	11	7	0	1	3780	26413
Group practice	256	164	6	70	69500	601278
Non-government hospital	60	36	2	13	8724	66809
State or local government hospital	66	40	2	14	9305	82346
HMO	7	3	0	1	582	1554
Medical School	27	11	1	5	2326	18644
U.S. Government	18	6	1	3	2036	21752
Locum Tenens	2	1	0	3	291	3107
Retired/Inactive	65	25	0	7	31115	200426
Intern/Resident/Fellow	43	36	1	22	84912	178674
Student	30	43	1	21	52925	122742
Other/Unknown	15	27	0	4	9596	124295
Self-designated Specialty[16]						
Family Medicine	88	42	0	18	25590	175567
Internal Medicine	148	83	2	31	62230	357349
Surgery	145	76	8	27	37803	201980
Pediatrics	27	23	1	12	16866	133617
OB/GYN	43	30	3	16	14249	68362
Radiology	36	16	2	9	10178	66809
Psychiatry	25	24	0	10	12795	80792
Anesthesiology	24	14	1	5	11923	76131
Pathology	11	17	0	1	4944	32627
Other specialty	103	62	2	29	41293	237715
Student	30	43	1	21	52925	122742

[14] Students and residents are so categorized without regard to age.
[15] Reflects section/group definition of its membership.
[16] See Appendix B for a listing of specialty classifications.

Table 5. Demographic Characteristic Cross Sections of AMA Members, December 2024

	White non-Hispanic	Black non-Hispanic	Hispanic	Asian/Asian American	Native American	Other[17]
Count	138,771	15,016	11,703	49,758	466	75,084
Mean age (years)[18]	51.2	42.0	46.4	41.0	41.9	42.5
Under age 40	44.1%↑	57.0%	47.8%	60.7%	49.1%↓	64.8%
40-49 years	10.8%	15.5%	13.6%	15.0%	19.3%↓	9.3%
50-59 years	10.1%	12.2%	15.8%↑	11.6%	23.0%↑	5.5%
60-69 years	10.9%	8.1%	10.0%	5.3%	7.5%↑	6.1%
70 or more	24.0%	7.1%	12.9%	7.5%	1.1%	14.3%
Male	63.5%	43.6%	58.0%	51.5%	50.0%↓	54.0%↑
Female	36.4%	56.3%	41.9%	48.3%	50.0%↑	43.6%↓
Unknown	0.0%	0.0%	0.1%	0.1%	0.0%	2.4%
Student[19]	13.0%↓	19.4%↓	17.9%↓	16.9%↓	17.8%↓	28.4%↑
Resident[3]	24.4%↑	33.3%↓	24.6%	35.3%↑	24.5%↓	34.0%↓
Young (Under age 40 or first eight years of practice)[20]	10.4%	11.8%	7.9%↑	13.2%	13.5%↑	8.0%
Mature (Age 40-64)[4]	22.8%	25.0%	31.9%	25.2%	40.3%	12.0%
Senior (Age 65 or more)[4]	29.5%	10.4%	17.7%	9.5%	3.9%↑	17.6%
US or Canada	91.2%	80.6%↓	75.8%↑	65.7%↓	92.9%	72.5%
IMG	8.8%	19.4%↑	24.2%↓	34.3%↑	7.1%	27.5%

[17] Includes other self-reported racial and ethnic groups.
[18] Age as of December 31. Mean age is the arithmetic average.
[19] Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.
[20] Reflects section/group definition of its membership.

Table 6. Demographic Characteristics of AMA Section Governing Councils, December 2024

	APS	IPPS	IMGS	LGBTQ+	MSS	MAS	OMSS	PPPS	RFS	SPS	WPS	YPS
Mean Age (years)	60.2	53.4	42.5	38.1	26.7	49.9	64.6	53.8	31.4	72.0	40.8	38.4
Student	0.0%	0.0%	0.0%	22.2%	100.0%	12.5%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%
Resident	0.0%	0.0%	12.5%	11.1%	0.0%	25.0%	0.0%	0.0%	100.0%	0.0%	25.0%	0.0%
Young (Under age 40 or first eight years of practice)[1]	11.1%	12.5%	62.5%	33.3%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	25.0%	85.7%
Mature (Age 40-64)[1]	44.4%	75.0%	25.0%	33.3%	0.0%	50.0%	50.0%	37.5%	0.0%	14.3%	25.0%	14.3%
Senior (Age 65 or over)[1]	44.4%	12.5%	0.0%	0.0%	0.0%	12.5%	50.0%	37.5%	0.0%	85.7%	12.5%	0.0%
Male	77.8%	75.0%	37.5%	55.6%	33.3%	25.0%	50.0%	25.0%	62.5%	71.4%	0.0%	57.1%
Female	22.2%	25.0%	62.5%	44.4%	66.7%	75.0%	50.0%	75.0%	37.5%	28.6%	100.0%	42.9%
Unknown	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
White non-Hispanic	55.6%	62.5%	37.5%	66.7%	11.1%	0.0%	75.0%	62.5%	75.0%	71.4%	12.5%	85.7%
Black non-Hispanic	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%
Hispanic	11.1%	12.5%	12.5%	11.1%	0.0%	37.5%	12.5%	0.0%	12.5%	0.0%	0.0%	0.0%
Asian/Asian American	33.3%	25.0%	37.5%	22.2%	55.6%	0.0%	12.5%	12.5%	12.5%	14.3%	37.5%	14.3%
Native American	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other[2]	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Unknown	0.0%	0.0%	12.5%	0.0%	33.3%	25.0%	0.0%	25.0%	0.0%	14.3%	25.0%	0.0%
US or Canada	66.7%	62.5%	0.0%	100.0%	100.0%	100.0%	87.5%	75.0%	100.0%	100.0%	100.0%	100.0%
IMG	33.3%	37.5%	100.0%	0.0%	0.0%	0.0%	12.5%	25.0%	0.0%	0.0%	0.0%	0.0%

[1] Reflects section/group definition of its membership.
[2] Includes other self-reported racial and ethnic groups.

Table 7. Characteristics of Specialty Society Delegations, December 2024

	Mean Age[1]	Median Age[1]	% Female	% IMG	% Resident
AMA Members (n = 290,796)	46.5	38	41.6%	19.2%	29.2%
Specialty Society Delegates and Alternates (n = 433)	55.1	54	44.3%	9.7%	2.3%
Family Medicine Delegations (n = 28)	54.9	54	53.6%	10.7%	0.0%
Internal Medicine Delegations (n = 106)	58.4	59	44.3%	17.0%	1.9%
Surgery Delegations (n = 99)	53.7	52	35.4%	8.1%	4.0%
Pediatrics Delegations (n = 11)	52.1	45	81.8%	0.0%	0.0%
OB/GYN Delegations (n = 29)	57.3	58	65.5%	6.9%	0.0%
Radiology Delegations (n = 30)	57.1	60	36.7%	6.7%	0.0%
Psychiatry Delegations (n = 26)	53.4	54	53.8%	3.8%	0.0%
Anesthesiology Delegations (n = 17)	50.9	52	17.6%	5.9%	11.8%
Pathology Delegations (n = 19)	53.5	53	52.6%	10.5%	0.0%
Other specialty Delegations (n = 66)	54.0	52	42.4%	7.6%	3.0%

The specialty delegations listed above contain the following delegations:

Family Medicine: General Practice, Family Medicine
Internal Medicine: Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery: General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics: Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology: Obstetrics and Gynecology
Radiology: Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry: Psychiatry, Child Psychiatry
Anesthesiology: Anesthesiology
Pathology: Forensic Pathology, Pathology
Other Specialty: Aerospace Medicine, Dermatology, Emergency Medicine,
General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

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

Table 8. Mean and Median Age of AMA Members and Delegations by State, December 2024

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
Alabama	3,838	43.7	34	7	62.1	68
Alaska	327	55.2	53	0	0.0	0
Arizona	4,136	48.7	39	9	63.1	65
Arkansas	1,926	46.2	37	4	69.3	70
California	36,006	50.6	46	63	55.2	55
Colorado	5,152	45.6	40	9	61.7	67
Connecticut	3,098	47.9	38	9	61.2	67
Delaware	855	54.9	53	2	†	†
District of Columbia	1,843	40.8	32	2	†	†
Florida	15,970	49.2	40	37	60.1	62
Georgia	6,098	47.8	42	10	57.6	57
Guam	19	59.7	58	0	0.0	0
Hawaii	1,081	53.7	48	3	†	†
Idaho	844	47.8	41	3	†	†
Illinois	11,110	48.8	37	21	62.4	66
Indiana	4,950	43.8	33	9	61.0	68
Iowa	3,224	46.8	40	6	60.0	60
Kansas	2,821	43.4	32	7	63.1	66
Kentucky	4,282	44.1	36	9	62.9	64
Louisiana	5,988	41.2	35	9	55.6	57
Maine	1,250	44.3	34	3	†	†
Maryland	5,267	52.1	48	13	59.5	61
Massachusetts	12,806	38.9	32	16	57.6	61
Michigan	13,136	44.4	35	24	57.7	59
Minnesota	4,683	48.5	40	9	61.8	62
Mississippi	2,748	45.2	36	6	58.5	58
Missouri	5,369	41.4	32	7	58.9	63
Montana	620	49.3	40	2	†	†
Nebraska	1,684	42.3	32	3	†	†
Nevada	1,896	44.9	35	4	67.8	66
New Hampshire	853	52.1	50	3	†	†
New Jersey	8,440	49.0	42	14	64.3	68
New Mexico	1,254	51.0	44	3	†	†
New York	22,864	44.9	34	38	58.4	62
North Carolina	5,395	48.4	40	10	57.9	58
North Dakota	1,315	44.1	41	2	†	†
Ohio	10,750	44.0	33	20	52.5	49
Oklahoma	3,393	42.7	32	7	59.4	56
Oregon	3,294	50.6	46	7	57.0	58
Other	786	81.3	89	1	†	†
Pennsylvania	14,059	48.7	40	26	57.2	61
Puerto Rico	1,460	44.5	31	2	†	†
Rhode Island	1,070	44.6	34	5	59.4	62

† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall total.

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
South Carolina	3,392	44.0	34	8	62.9	67
South Dakota	1,316	44.4	40	4	61.5	61
Tennessee	5,132	44.7	34	8	63.3	64
Texas	21,053	43.3	34	31	59.3	60
Utah	2,093	45.0	36	3	†	†
Vermont	522	48.0	37	1	†	†
Virgin Islands	28	73.5	73	1	†	†
Virginia	6,776	47.0	40	15	56.5	57
Washington	5,779	51.7	48	10	49.9	45
West Virginia	1,820	42.0	33	2	†	†
Wisconsin	4,733	47.2	38	10	57.9	55
Wyoming	192	60.5	58	2	†	†
TOTAL	290,796	46.5	38	539	58.9	60

Table 9. Women and International Medical Graduates on State Association Delegations, December 2024

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	3,838	7	1,532	2	563	0
Alaska	327	0	130	0	39	0
Arizona	4,136	9	1,557	3	685	1
Arkansas	1,926	4	729	0	277	0
California	36,006	63	15,575	25	6,983	5
Colorado	5,152	9	2,362	5	292	0
Connecticut	3,098	9	1,293	4	778	2
Delaware	855	2	295	1	252	0
District of Columbia	1,843	2	953	0	242	0
Florida	15,970	37	5,926	12	4,732	6
Georgia	6,098	10	2,671	3	1,208	1
Guam	19	0	5	0	11	0
Hawaii	1,081	3	406	2	155	0
Idaho	844	3	261	2	45	1
Illinois	11,110	21	4,588	8	2,425	4
Indiana	4,950	9	1,955	5	714	2
Iowa	3,224	6	1,266	3	561	1
Kansas	2,821	7	1,126	3	276	0
Kentucky	4,282	9	1,717	2	603	0
Louisiana	5,988	9	2,643	3	967	2
Maine	1,250	3	618	1	102	0
Maryland	5,267	13	2,346	6	1,338	4
Massachusetts	12,806	16	6,438	5	1,981	1
Michigan	13,136	24	5,277	8	3,027	3
Minnesota	4,683	9	1,835	4	780	0
Mississippi	2,748	6	988	2	333	1
Missouri	5,369	7	2,265	3	720	2
Montana	620	2	236	1	29	0
Nebraska	1,684	3	702	1	143	0
Nevada	1,896	4	699	1	391	1
New Hampshire	853	3	322	1	151	0
New Jersey	8,440	14	3,387	5	2,528	4
New Mexico	1,254	3	525	2	185	0
New York	22,864	38	9,750	13	6,712	6
North Carolina	5,395	10	2,093	6	734	0
North Dakota	1,315	2	510	1	264	0
Ohio	10,750	20	4,429	8	1,855	4
Oklahoma	3,393	7	1,354	3	387	0
Other	786	1	124	1	425	0
Oregon	3,294	7	1,475	2	297	0
Pennsylvania	14,059	26	5,428	4	2,666	5
Puerto Rico	1,460	2	660	0	284	1
Rhode Island	1,070	5	491	2	205	0
South Carolina	3,392	8	1,449	1	325	0
South Dakota	1,316	4	543	1	187	0
Tennessee	5,132	8	2,055	2	562	2
Texas	21,053	31	9,085	10	3,787	3
Utah	2,093	3	610	1	101	0
Vermont	522	1	242	0	45	0

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Virgin Islands	28	1	9	1	8	0
Virginia	6,776	15	2,911	7	1,219	1
Washington	5,779	10	2,428	6	942	2
West Virginia	1,820	2	707	0	389	0
Wisconsin	4,733	10	1,939	5	797	1
Wyoming	192	2	57	0	20	0
TOTAL	290,796	539	120,977	197	55,727	66

Table 10. Medical Students and Resident Physicians on State Association Delegations, December 2024

State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
Alabama	3,838	7	606	2	2	1,644	0	0
Alaska	327	0	6	0	0	24	0	0
Arizona	4,136	9	858	0	0	1,052	1	0
Arkansas	1,926	4	531	1	1	403	0	0
California	36,006	63	3,231	7	5	7,485	6	4
Colorado	5,152	9	1,523	1	1	691	1	1
Connecticut	3,098	9	474	6	6	963	1	1
Delaware	855	2	21	0	0	128	0	0
District of Columbia	1,843	2	613	0	0	515	0	0
Florida	15,970	37	2,397	3	3	5,098	1	1
Georgia	6,098	10	1,076	0	0	1,430	0	0
Guam	19	0	0	0	0	1	0	0
Hawaii	1,081	3	148	0	0	237	0	0
Idaho	844	3	162	0	0	209	0	0
Illinois	11,110	21	2,462	2	1	2,872	5	4
Indiana	4,950	9	1,037	2	2	1,733	0	0
Iowa	3,224	6	403	1	1	948	0	0
Kansas	2,821	7	1,140	2	2	476	0	0
Kentucky	4,282	9	945	0	0	1,144	0	0
Louisiana	5,988	9	1,225	0	0	1,957	0	0
Maine	1,250	3	481	0	0	200	0	0
Maryland	5,267	13	421	1	1	1,036	1	0
Massachusetts	12,806	16	3,362	3	2	5,778	3	2
Michigan	13,136	24	1,775	2	1	5,267	3	3
Minnesota	4,683	9	388	0	0	1,563	0	0
Mississippi	2,748	6	640	1	1	771	1	1
Missouri	5,369	7	1,541	2	1	1,757	1	1
Montana	620	2	239	0	0	34	0	0
Nebraska	1,684	3	704	1	1	231	1	1
Nevada	1,896	4	401	1	1	620	0	0

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

[2] Resident sectional delegates and alternate delegates endorsed by specialty societies were not included in this table. The following specialty societies endorsed sectional resident delegates and alternate delegates: American Academy of Dermatology Association, American Academy of Neurology, American Academy of Ophthalmology, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American College of Chest Physicians (CHEST), American College of Emergency Physicians, American College of Nuclear Medicine, American College of Obstetricians and Gynecologists, American College of Radiology, American College of Surgeons, American Psychiatric Association, American Society of Anesthesiologists, American Urological Association, Association for Clinical Oncology, College of American Pathologists, Society of Interventional Radiology, and Undersea and Hyperbaric Medical Society.

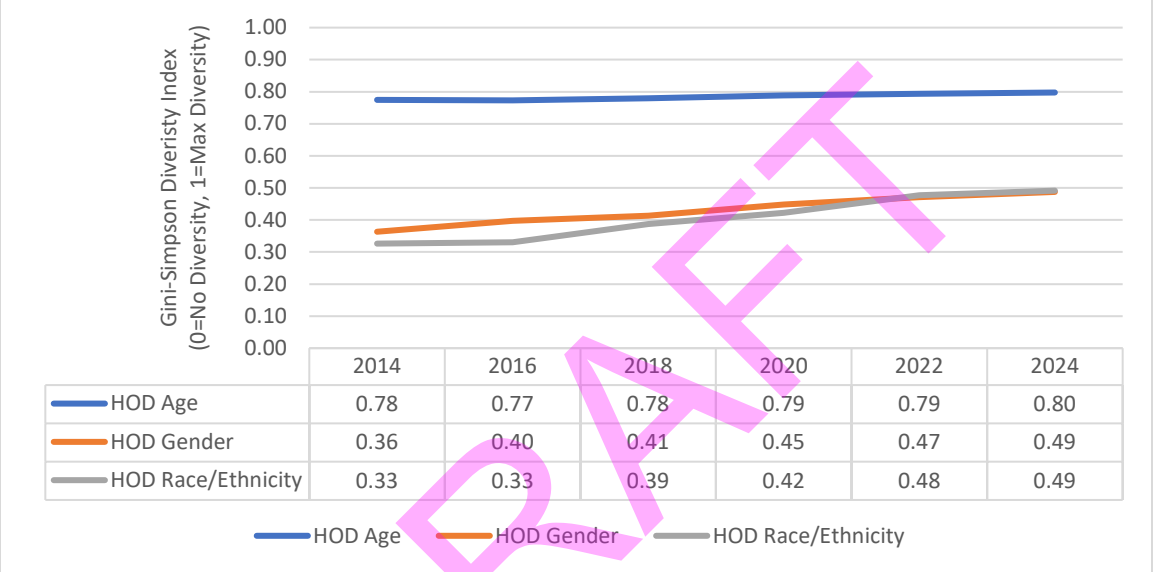
State	Total AMA Members in State	Number of State Delegates and Alternate Delegates	Total Medical Student AMA Members in State	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[1]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates	Number of Sectional Resident Delegates and Alternate Delegates[2]
New Hampshire	853	3	96	0	0	170	0	0
New Jersey	8,440	14	1,172	2	2	2,275	1	1
New Mexico	1,254	3	278	0	0	209	1	1
New York	22,864	38	3,699	3	2	10,101	2	1
North Carolina	5,395	10	673	1	1	1,608	0	0
North Dakota	1,315	2	356	0	0	98	0	0
Ohio	10,750	20	2,299	3	3	3,936	2	2
Oklahoma	3,393	7	1,036	1	1	1,036	3	3
Other	3,294	7	401	1	1	473	0	0
Oregon	786	1	22	0	0	48	0	0
Pennsylvania	14,059	26	2,072	3	1	3,670	1	0
Puerto Rico	1,460	2	597	0	0	306	0	0
Rhode Island	1,070	5	251	0	0	341	2	2
South Carolina	3,392	8	1,014	1	1	737	0	0
South Dakota	1,316	4	355	0	0	140	0	0
Tennessee	5,132	8	1,477	1	1	1,330	0	0
Texas	21,053	31	4,468	4	3	7,300	5	4
Utah	2,093	3	718	0	0	336	0	0
Vermont	522	1	119	0	0	119	0	0
Virgin Islands	28	1	0	0	0	0	0	0
Virginia	6,776	15	1,379	2	2	1,572	1	1
Washington	5,779	10	465	0	0	747	0	0
West Virginia	1,820	2	385	0	0	708	0	0
Wisconsin	4,733	10	735	2	2	1,413	1	0
Wyoming	192	2	4	0	0	11	0	0
TOTAL	290,796	539	52,881	62	52	84,951	44	34

Gini-Simpson Diversity Index (GSI) of the House of Delegates and AMA Leadership

A diversity index is a probabilistic measure that two individuals selected at random will represent different identities. The index provides a balanced and robust assessment of diversity and has been widely applied across demographic and clinical research contexts. The Council utilized the Gini-Simpson Diversity Index (GSI) which is the probability that two individuals selected at random will represent different identities; it is measured from 0 to 1, where 0 represents an absence of diversity and 1 represents the greatest possible diversity. CLRPD assessed diversity trends within the AMA HOD and AMA Leadership from 2014 to 2024, specifically focusing on member age, gender, and race/ethnicity.

From 2014 to 2024, the HOD demonstrated gradual but consistent increases in gender and racial/ethnic diversity, rising from 0.36 to 0.49 for gender, and 0.33 to 0.49 for race/ethnicity, while age diversity remained stable around 0.78. The total diversity index for HOD consequently improved from 0.49 to 0.59 over this period.

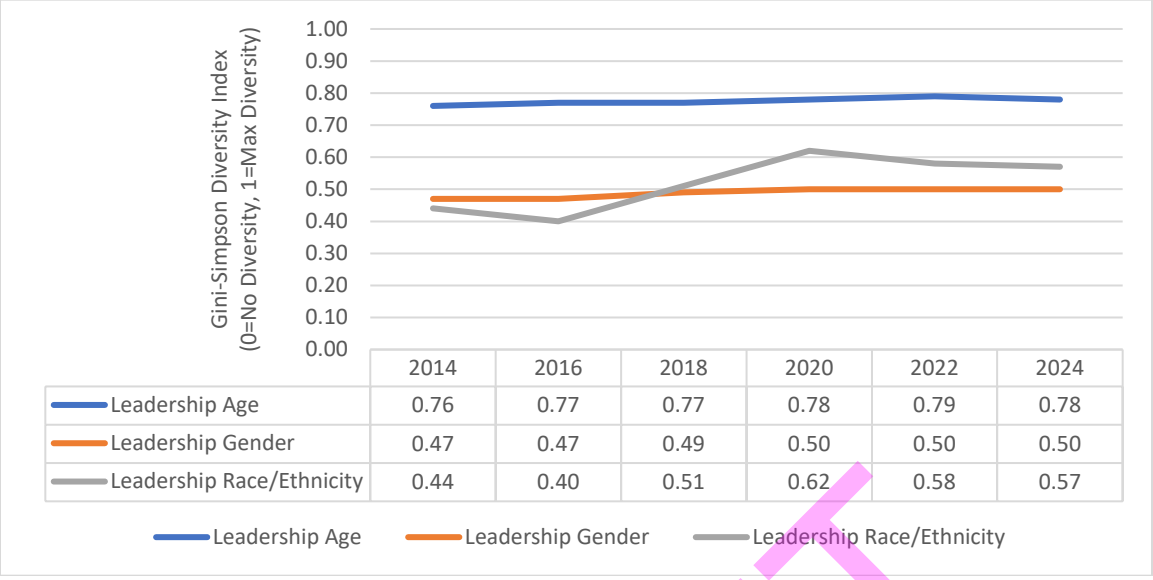
Graphic 1. Trends in Diversity in the AMA House of Delegates, 2014-2024



	2014	2016	2018	2020	2022	2024
HOD Age	0.78	0.77	0.78	0.79	0.79	0.80
HOD Gender	0.36	0.40	0.41	0.45	0.47	0.49
HOD Race/Ethnicity	0.33	0.33	0.39	0.42	0.48	0.49

Among AMA Leadership, a similar trajectory was observed. Gender diversity increased from 0.47 to approximately 0.50, and racial/ethnic diversity rose notably from 0.44 in 2014 to a peak of 0.62 in 2020 before slightly adjusting to 0.57 in 2024. Age diversity remained relatively constant around 0.77. The overall leadership diversity improved from 0.56 in 2014 to 0.62 in 2024, reflecting positive, though modest, gains.

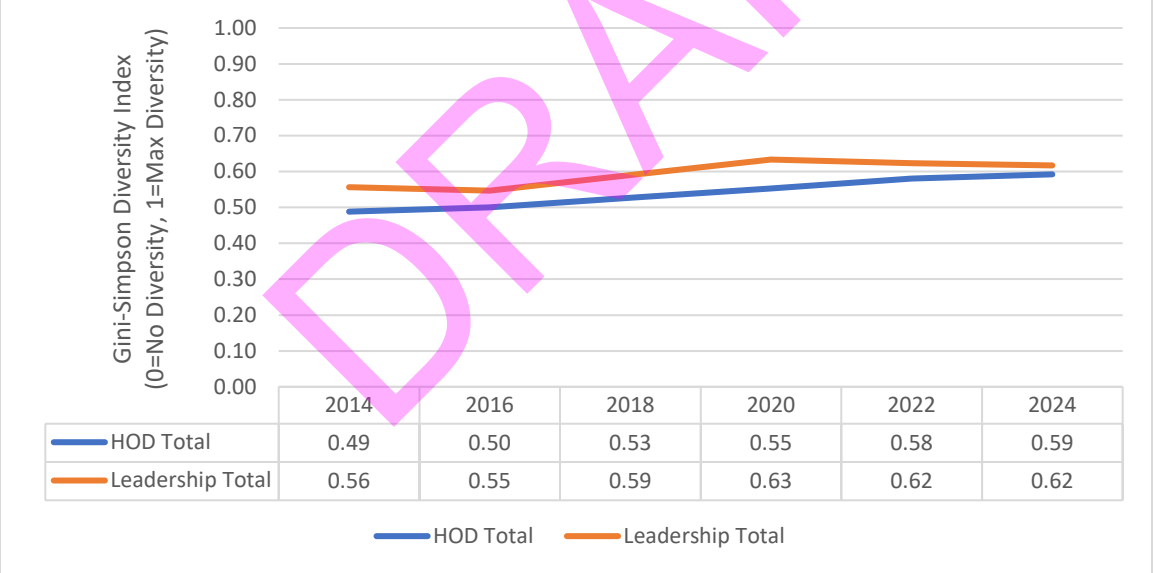
Graphic 2. Trends in Diversity among AMA Leadership, 2014-2024



	2014	2016	2018	2020	2022	2024
Leadership Age	0.76	0.77	0.77	0.78	0.79	0.78
Leadership Gender	0.47	0.47	0.49	0.50	0.50	0.50
Leadership Race/Ethnicity	0.44	0.40	0.51	0.62	0.58	0.57

The GSI illustrates that while diversity has gradually increased within AMA leadership and delegates, continuous efforts are necessary to foster further improvements, particularly in the representation of diverse gender and racial/ethnic identities.

Graphic 3. Overall Trends in Total Diversity at the AMA, 2014-2024



	2014	2016	2018	2020	2022	2024
HOD Total	0.49	0.50	0.53	0.55	0.58	0.59
Leadership Total	0.56	0.55	0.59	0.63	0.62	0.62

APPENDIX B

Specialty classification using physicians' self-designated specialties

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

American Medical Association Councils and Sections

COUNCILS

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

SECTIONS

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