REPORTS OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

The following reports were presented by Jan Kief, MD, Chair:

1. UPDATE ON CLRPD EVALUATION OF THE STRUCTURE OF THE HOUSE OF DELEGATES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

BACKGROUND

As it continues its evaluation of the size and structure of the American Medical Association (AMA) House of Delegates (HOD), the Council on Long Range Planning and Development (CLRPD) wished to provide the House and Board of Trustees (BOT) with an update on its progress, processes, and key takeaways to date.

CLRPD continues to vet all potential solutions; no decisions on final recommendations have been made at this juncture. The council welcomes feedback from the board on all these proposals and will continue to seek ways to present these proposals to an ever-widening group of stakeholders for its feedback and to work together toward consensus. Throughout this process, the council has emphasized objectivity, impartiality, transparency and collaboration as it works toward a future HOD based on the principles of efficiency, effectiveness and fair representation. Any significant changes to HOD processes will require bylaws changes and a supermajority vote. Therefore, while identifying viable solutions is an important part of the equation, providing education on the necessity for action and building consensus on the identified recommendations will be a priori to this project's ultimate success.

TIMELINE AND PROCESS

BOT Report 27-A-25, "AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates" tasked CLRPD to comprehensively study and report back on potential changes to the length, format and structure of future AMA HOD meetings for report at the 2026 Interim Meeting. The charge to CLRPD was further refined to studying possible solutions to address the issue of the rapid growth of the HOD while preserving its representative nature and improving efficiency and effectiveness.

CLRPD Report 2-I-25 provided a detailed timeline and summary of the policy decisions that led to the current state of HOD delegate apportionment and recommended a one year pause on delegate growth so that these policies could be thoroughly evaluated and potential solutions could be offered. This report was not adopted by the HOD.

Also at the 2025 Interim Meeting, the council hosted a listening session open to all meeting attendees to provide background information on the causes of the rapid growth of the HOD and asked a series of questions to attendees to obtain initial reactions to the ideas presented. The session was attended by hundreds of AMA members and staff, and around thirty members offered their perspectives during the one-hour session. A follow-up survey containing the same questions using a Likert scale was made available to all meeting attendees to obtain further feedback, to which 191 members responded. Analysis of those responses was conducted in collaboration with AMA's Strategic Insights team and can be found in Appendix B of this memo.

Since January 2026, the council has been meeting on average every two weeks to continue this effort. In January, BOT Chair David Aizuss MD issued a call for volunteers to participate in a focus group related to CLRPD's ongoing HOD work. Of over 100 applicants, 15 were selected and they participated in three focus groups facilitated by CLRPD to help vet and identify the most viable potential solutions. Throughout those sessions, the council has obtained invaluable feedback and begun to refine its eventual recommendations. The focus group has agreed to potentially reconvene as the report submission approaches. The focus group also received a follow-up survey to collect in-depth personalized feedback on potential HOD proposals.

Prior to and during the February meetings of CLRPD, the council received input from staff to understand organizational capabilities with respect to declaring state and specialty affiliations and insight into the group membership space, which included proprietary data. As will be discussed below, certain capabilities are still being explored with the appropriate AMA business units as the council continues its due diligence.

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Further events and outreach efforts are still under consideration as the council works toward I-26. As noted previously, the council hopes to engage with as many members of the HOD and AMA as possible to ensure that its ultimate recommendations are both thoroughly understood and sensible to increase the likelihood for acceptance by two-thirds of voting delegates. While we all recognize the challenge of reaching this high bar of acceptance, the process so far has been encouraging in that, at least from the perspective CLRPD, it has become apparent that when presented with data and clear, concise accompanying visualizations outlining the realities of recent HOD growth, and when given the opportunity for open and respectful discussion about those challenges and potential solutions, members engage and consider possibilities that they may have initially opposed.

In advance of I-26, and taking in feedback from AMA business units, CLRPD board liaisons, and the CLRPD's April BOT presentation, a final update will be presented to the BOT during its September meeting in which the council will outline its complete list of suggested proposals for consideration and feedback.

KEY THEMES AND CONSIDERATIONS

Before discussing specific proposals under consideration, the council would like to highlight some key themes and ideas that are continually informing its work.

Apportionment of Delegates in the Strictest Sense Based Upon AMA Members' Geographic and Primary Specialty Designations

As the most basic of a contextual perspective, at the current 1:1000 apportionment for a delegate seat, if based upon the current total AMA membership of ~300,000, theoretically, there would be 300 delegate seats. Allowing for all AMA members to be counted twice, once by geographic demography and a second time by their primary specialty, there would be 300 x 2 = 600 Delegate Seats. This is further extrapolated under "Multiplicative Counting."

Urgency

The council understands the importance of finding a viable solution to addressing HOD growth. Appendix A contains three graphics that CLRPD has developed to demonstrate the scope of this issue, both in the present and future. Graphic 1 shows a timeline of HOD growth through this year along with various policy decisions that have led to the HOD's current size, and graphic 3 shows the current breakdown of delegates by category. Graphic 2 presents growth scenarios based on four possible compound annual growth rates (CAGR). Since current apportionment practices were last modified in 2016, the HOD has grown at an average CAGR of 4.0 percent annually. Were that to continue, the HOD would eclipse 1,000 members by 2032. At a more modest 2.0 percent CAGR, the HOD would eclipse 1,000 delegates by 2037. Graphic 2 also demonstrates that the issue is accelerating; the more the HOD grows, the faster it will grow in the future due to current apportionment policies. The council has investigated and benchmarked other similar bodies within the United States as requested by focus group members. These examples display organizations with similar governing bodies, and the council has been unable to identify any other representative bodies with similar HOD sizes as the AMA. In fact, as the AMA HOD approaches 800 voting members, CLRPD was unable to identify another professional interest association with more than 600 members of its policymaking body. The council considers these other organizations as benchmarking examples since an oversized HOD impacts the efficiency of its deliberations.

Organization	**Membership**	**Policymaking Body Size**
American Academy of Family Physicians	~124,500	~120-130
American Bar Association	~227,000	~550-600
American Nurses Association	~200,000	~400
American Institute of CPAs	~428,000	~265
American Osteopathic Association	~207,000	564 (2025)

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State and Specialty Parity

No single policy decision has more significantly contributed to the recent, rapid growth of the House than the decision made at I-16, which established Policy G-600.027, which stated that "…specialty society allocation in the House of Delegates be determined so that the total number of specialty society delegates shall be equal to the number of delegates apportioned to constituent societies…" This decision was made in response to a desire within the HOD for equal representation between states and specialties, a simple mechanism to do so, and the ineffectiveness of the ballot system that asked members to select a specialty society to represent them because few members completed the ballot. Referring again to Graphic 1 in Appendix A, since the establishment of that policy, the HOD has grown by 44 percent in the last ten years, after being nearly stable in size for the previous fifteen. Introducing parity between state and specialty societies without simultaneously adjusting the delegate apportionment ratio has directly led to the dramatic increase in delegates over the past decade.

The question has been raised frequently as to whether this policy is necessary, or whether the unintended consequences of its adoption might suggest that a recommendation to rescind G-600.027 would in and of itself solve the HOD's growth problem. It is likely that such a policy change would lead to a quick reduction in the size of the HOD, but the council has strong doubts about the likelihood of such a proposal being accepted by two-thirds of the House.

Multiplicative Counting

As noted in BOT Report 6-I-16, "Designation of Specialty Societies for Representation in the House of Delegates," which established Policy G-600.027, "…every AMA member should be represented by both a constituent association and a specialty society in the HOD—the stated goal since 1996…" However, it has become apparent that many AMA members are counted more than two times for the purposes of delegate apportionment. Some examples include:

- A physician who is a member of multiple specialty societies will be counted for his/her state as well as any specialty society in which they are a member.
- Residents are counted for apportionment of the state in which they reside, for the apportionment of resident sectional delegates, and for the apportionment of any specialty to which they belong.
- Delegates are apportioned to state medical associations for any physicians and medical students residing in a state whether or not the individual is a member of that state association. E.g., a physician member of the AMA and AAFP will count toward the apportionment of the Florida Medical Association (FMA) even if he/she is not a member of FMA.
- CLRPD analysis found that as of 2025, students and residents made up approximately 47.5 percent of state AMA membership populations, with some states as high as 60-70 percent. However, as very few delegations are represented by those groups at such high proportions, state delegation growth is driven in large part by groups that may not be appropriately represented among their ranks.

This multiplicative counting combined with the parity policy (and without any adjustment being made to apportionment ratios) has led to a situation of compounding growth of delegations. On the state side, any member residing within a state will contribute to delegate growth among state medical associations, even if those members do not belong to those respective associations. This increase in the total state delegation apportionment then increases the total number of specialty delegates per the previously referenced parity policy. On the specialty side, members can and will be counted as part of any specialty or subspecialty to which they belong, and the increasing number of subspecialties in the HOD (135 total specialty societies in 2026) increases the likelihood of an individual member being counted across multiple specialties. Additionally, residents and students are counted for the purposes of resident sectional and student regional delegates. As a result, individual members, under current practices, are being counted multiple times, artificially inflating delegate count.

The council identified this issue early in its deliberations, and it is one that has resonated with those with whom the council has discussed it, including members of the BOT and the CLRPD focus group, attendees of the HOD listening session and survey respondents. The council has had numerous discussions with AMA management concerning the issue, and to this point, has been advised that determining the prevalence of this multiplicative counting may be exceptionally challenging, if not impossible. Multiple methods have been discussed, including instituting a modernized ballot system to require all AMA members to declare both a state and single specialty affiliation for the purposes of apportionment, and cross-referencing delegation rosters to identify overlapping membership. The former, the council has been advised, presents a series of both technological and logistical challenges, including that (1) for the numbers to be usable, a one hundred percent response rate would be required and (2) in some cases, particularly

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due to evolving group membership practices, physicians do not sign-up for or renew their AMA memberships themselves, and those completing those steps on their behalf would be unlikely to accurately capture their appropriate specialty affiliations.

The council has also been advised that cross-referencing members across specialties is not within the AMA's current capabilities given that the AMA only analyzes specialty member data every five years (on a rotating basis) and looks at overall AMA membership percentages from each organization, not individual physicians. These ideas are still being explored; as noted previously, and all possibilities are being considered. However, from the information obtained from AMA management that the council has received, solutions are unlikely feasible.

Dues/group membership

The idea has been raised by several stakeholders that consideration should be given to how members join the AMA, and, more specifically, whether the dues members pay should have an impact on delegates are apportioned in relation to their membership. This issue is also related to the increasing proportion of AMA members who join through health systems and other group membership programs like the GME Competency Education Program (GCEP) for residents and the UME Curricular Enrichment Program (UCEP) for students and therefore often pay less in dues than their colleagues who are individual members.

Within the council and the focus group, this concept faced a great deal of skepticism, largely due to perception that such a recommendation would be viewed as a "pay-to-play" policy in which influence is tied to payment and at odds with the AMA's commitment to a democratic process. Such a model is also complicated by the fact that even among individual members there is a wide range of dues paid depending on career stage and other factors. For instance, among post-residency physicians, dues in 2026 range from $60/year for physicians in their first year in practice to $315/year in their fourth before reaching the full $420/year. Semi-retired physicians pay $210/year, while fully retired physicians pay $84/year. Different fee structures are also in place for members of the military/veterans affairs, students, and resident physicians and fellows. These factors suggest that implementing an apportionment process related to dues paid would be a logistical challenge. Given that the idea was generally not well received by members of the focus group or CLRPD, the council believes that, at this time, any proposal tying dues to apportionment is unlikely to gain approval from two-thirds of the HOD.

DRAFT TIMELINE FOR APPORTIONMENT CHANGES

A consistent theme raised throughout discussions among the council and the focus group was the preference for a gradual, phased-in implementation process for any policy changes to allow state and specialty societies to adjust to new practices. As noted previously, however, CLRPD recognizes that to avoid major disruption during HOD business sessions, some level of change must be implemented as soon as possible.

Another recurring theme during discussions among the council, board liaisons, and the focus group was a preference for simple solutions over more complex overhauls of current practices. This echoes the previously referenced BOT Report 6-I-16—when the last significant changes were made to HOD apportionment practices—which noted that during debate on the issue of parity at A-16, a desire emerged for a simple method of allocation. The council sees the wisdom in this approach, as any proposal to decrease the size of the HOD will already be viewed as a disruption, introducing and attempting to explain and create buy-in for complex structural change will likely add to the challenge. Given the need for two-thirds of the House to support any of these proposed measures, the council believes that simple, progressive and equitable measures are more likely to be accepted than more drastic or conceptual changes. These conversations are ongoing.

What follows is an illustrative timeline of potential policy changes that the council believes could balance the need for immediate action with a phased implementation that would allow the HOD's component groups time to adjust to a new approach. The recommendations presented below have been discussed at length among the council and focus group, and based on feedback received, were perceived most positively and were identified as those most likely to be acceptable to the HOD.

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Timeline

2026 Interim Meeting:

1. Pause delegate growth for two years (2027-2028) while changes are phased in.
2. Eliminate the language "…and fraction thereof" from bylaws and policy related to delegate apportionment.

As was noted during the board's April meeting in discussion of this topic, a potential issue that may have led to non-adoption of a proposed pause at I-25 was a lack of specifics on how such a pause would be implemented and who would be impacted. Those details would be addressed were this solution to be proposed in a future report. For instance, new societies that have gained representation to the HOD through current policy could still be granted membership despite the suggested pause.

The elimination of "…and fraction thereof…" would, using data from this year's apportionment, decrease the size of the HOD by 94 delegates from state and specialty delegations (via a reduction of 47 delegates from state medical associations and the associated parity adjustment). During discussions among the focus group, this was overall viewed as a fair and reasonable measure. Using current practices, a delegation with membership of 1,001 is apportioned the same number of delegates as one with a membership of 1,999. It was also noted that member numbers for states and specialties are readily available within the first three weeks in January, so this rounding is no longer necessary and artificially elevates delegate numbers.

An alternative proposal is to institute standard rounding practices (rounding half up) so that an additional delegate would be granted to a state or specialty society once they reached the halfway point to the next delegate, e.g., using current apportionment ratios an association would receive a second delegate once they reached 1,500 members. Using 2026 figures, this would result in a reduction of 48 state and specialty delegates.

2027 Annual Meeting:

3. CLRPD will issue a revised report on meeting venues for HOD meetings.

As the question of meeting venues is regularly discussed in relation to the discussion of HOD sizing, CLRPD will revise its previous report on meeting venues for submission to the HOD. In addition to geographic considerations, this report can also address the logistics and costs required for relocating future meetings to larger venues, including convention centers, and would add transparency to the process.

2027 Interim Meeting:

4. Implement a revised apportionment ratio so that societies will be allocated one delegate for every 1,250 AMA members. An Association would receive its next delegate seat at 2,500 members, and so forth.
5. Revise student and resident apportionment so that student regional delegates and resident sectional delegations will be allocated one delegate per 2,500 AMA members. The next delegate seat would be allocated at 5,000 members, and so forth.

Using 2026 figures this would decrease the size of the HOD by 130 state and specialty delegates, five student regional delegates and eight resident sectional delegates. When combined with the previous recommendations this would lead to an HOD of approximately 556 delegates for 2028 (without considering potential future membership growth). Overall, this was viewed as a reasonable proposal by both the council and the focus group. In general, the proposals that received the most support were those viewed as impacting all component groups equitably.

A recommendation of adjusting apportionment ratios to one delegate per 1,500 members and one student/resident delegate per 3,000 members is still under consideration as well. This would reduce the number of state/specialty delegates by 210, student regional delegates by nine and resident sectional delegates by fourteen. The council also considered adjusting the ratios to one delegate per 2,000 members and one delegate per 4,000 student/resident members but determined that adjustment to be too extreme.

2028 Interim Meeting:

6. Establish an HOD with a fixed size of 600.

Under this proposal, the size of the House would be fixed, with 261 delegates apportioned to states, 261 to specialty societies, and 78 to students, residents, sections and other groups. CLRPD has considered methods of apportionment that could "future-proof" the HOD for future membership fluctuations. Mathematical models (such as the Method of

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Equal Proportions (MEP), or Huntington-Hill Method, used by the U.S. House of Representatives) are used worldwide to organize representative bodies and would help our HOD avoid regularly running into issues related to sizing. The MEP and other similar models assign seats based on mathematically neutral priority values rather than arbitrary thresholds. Adopting the MEP would modernize AMA representation and align it with long-standing, globally accepted apportionment standards. Appendix C contains a document outlining the processes involved in such a model.

While this solution is more complex than those previously presented, its adoption would set a clear direction for the HOD that would be transparent to all members and would not fluctuate with membership changes. Specifics of this proposal are still being considered within the council and in consultation with AMA staff.

Other recommendations for consideration:

- The Speakers and BOT will continue to evaluate cost-saving considerations, efficiencies, length and locale of HOD meetings.
- During implementation and into the future, CLRPD will regularly poll members of the HOD on its structure and operations to create a culture of continual assessment.
- Specialty society membership numbers will be obtained every three years as opposed to every five years for increased accuracy.

CONCLUSION

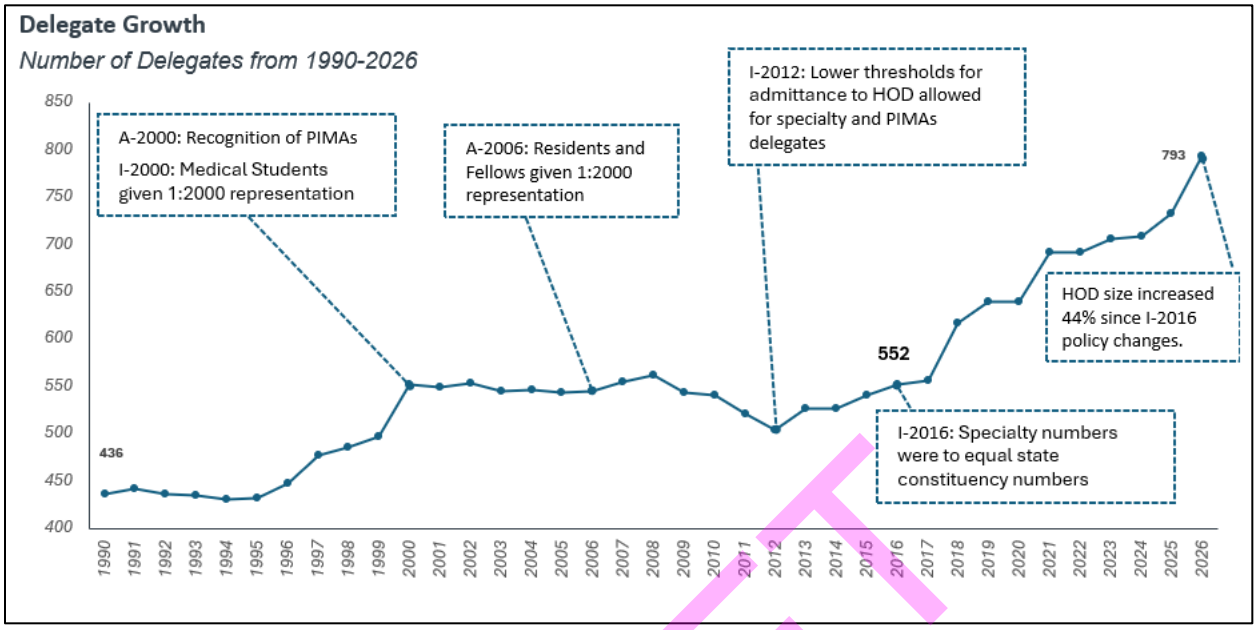
As noted previously, CLRPD has not ruled out any potential recommendations and is still gathering information and investigating potential solutions related to multiplicative counting and state/specialty parity. The solutions contained in the timeline above have been most favorably received by members of the council and the convened focus group and seem most likely to obtain the two-thirds vote required for implementation. As the council works towards its final recommendations, it will continue to consider the expert opinions of the HOD, BOT and AMA executive leadership and welcomes all feedback on the ideas and proposals contained in this report. As noted previously, the council also recognizes that it will be essential to provide education for members of the HOD to make it clear why change is needed and to build consensus on recommendations.

The council's focus will remain on identifying solutions that enhance efficiency, effectiveness and fairness within the HOD, while honoring tradition and working toward future sustainability. The council appreciates the guidance and partnership the BOT and members of the House have offered throughout this process and looks forward to continued collaboration as the process moves forward.

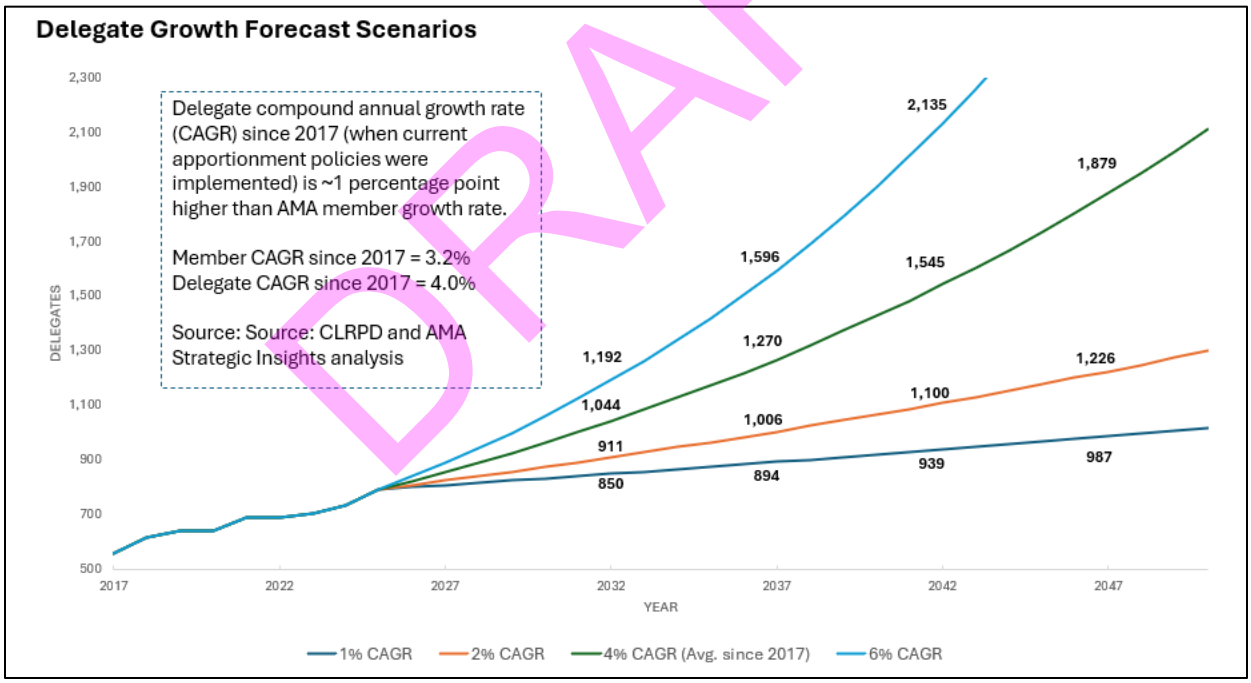
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APPENDIX A



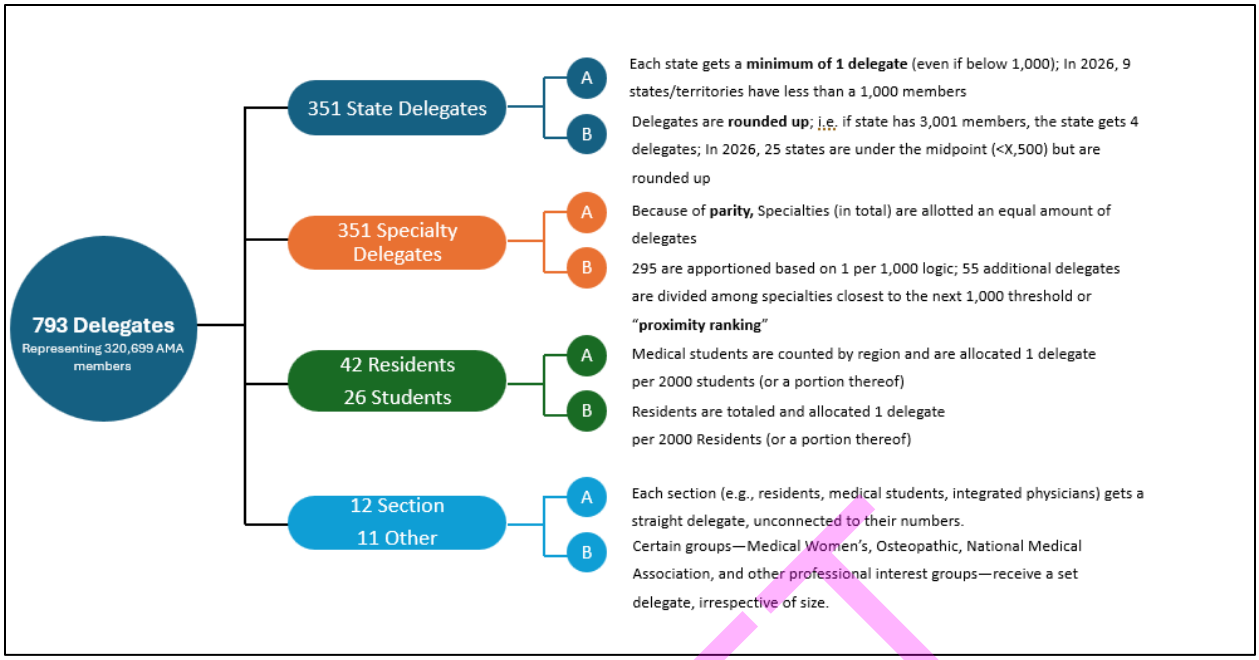
Graphic 1. Delegate Growth Timeline and Related Policy Decisions 1990-2026



Graphic 2. Delegate Growth Forecast Scenarios

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Graphic 3. Delegate Allocation (2026)

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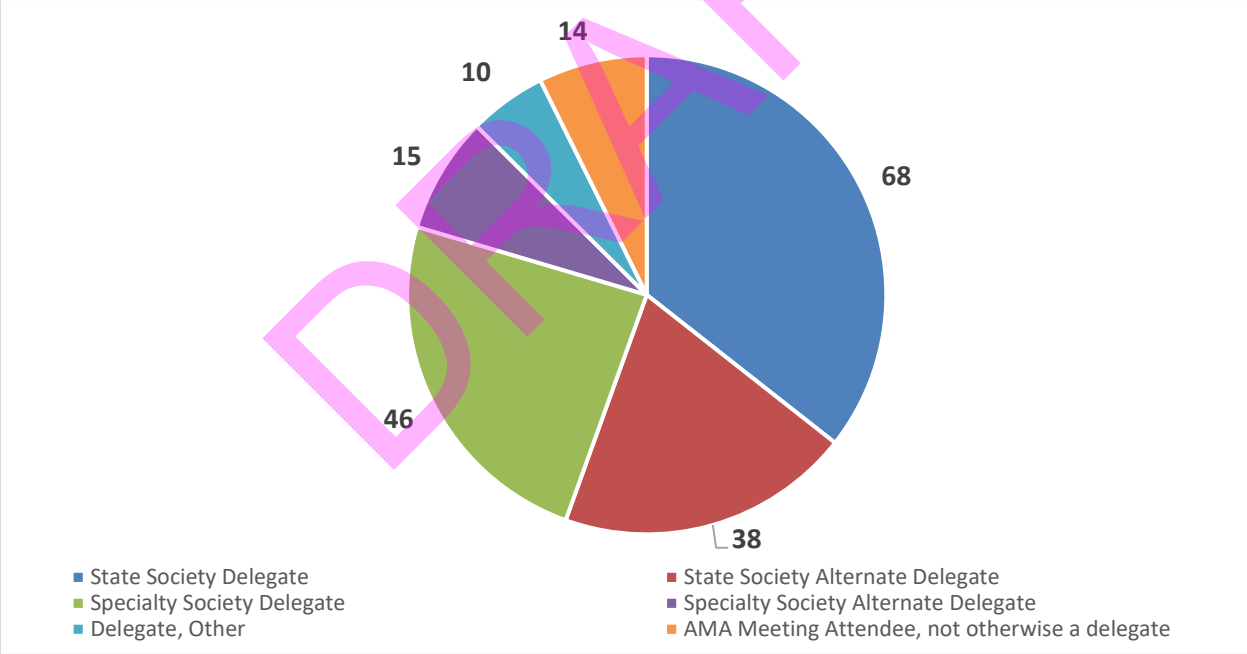
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APPENDIX B

Summary of Survey of AMA Meeting Attendees on Size of HOD
Developed in part using AMA AI

Summary of Respondents by Role

Role	Number	Percent
State Society Delegate	68	36%
State Society Alternate Delegate	38	20%
Specialty Society Delegate	46	24%
Specialty Society Alternate Delegate	15	8%
Delegate, Other	10	5%
AMA Meeting Attendee, not otherwise a delegate	14	7%
Total	**191**	**100%**



Sentiment Descriptions for the Questions Presented at I-25 Open Forum and Follow-Up Survey

- **Positive**: Constructive, supportive, or forward-looking suggestions/remarks.
- **Somewhat Positive**: Mild positivity, constructive with some reservations/conditions.
- **Neutral**: Pure questions, factual statements, or comments without discernible sentiment.
- **Somewhat Negative**: Mild criticism or concern, not strongly worded.
- **Negative**: Strong opposition, criticism, or clear negativity about current structure/issues.

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Q2: Could a House of Delegates with a fixed size help to address the cost, venue, and efficiency challenges?

Sentiment	Count	Percent	Description
Positive	4	2.14%	Enthusiastic support for fixed size, focus on benefits
Somewhat Positive	20	10.70%	Supportive, but often with caveats about diversity or flexibility
Neutral	91	48.66%	States ("Maybe," "It depends," asks for data, or provides balanced pros/cons)
Somewhat Negative	56	29.95%	Concerned about loss of representation/diversity, but not absolute opposition
Negative	16	8.56%	Strong opposition, e.g. "fixed size is a bad idea," prefer growth/expansion

Q2: Common Themes

- Those in favor highlight efficiency, administrative manageability, and cost/venue flexibility.
- Those opposed emphasize the need for inclusiveness, diversity, growth, and the risk of disenfranchising small groups or young/trainee voices.
- Growth & Policy: Strong opinions both for and against fixed, capped, or reduced size. Calls to balance state/specialty representation and apportionment formulas.
- Many “neutral” responses caution about unintended consequences or say "yes, but only with safeguards for representation/engagement/etc."
- Some suggest alternate reforms: hybrid/virtual options for participation, changes/expansion of venues, or incremental reforms rather than a strict cap.

Q3: How would our House of Delegates be impacted if the number of duplicative apportionments were reduced?

Sentiment	Count	Percent	Description
Positive	11	6.15%	Strong endorsement of reduction, believe it would improve fairness/efficiency
Somewhat Positive	68	37.99%	Generally supportive, express some reservations (e.g., want careful implementation)
Neutral	45	25.14%	Factual/informational or very balanced/mixed effects, sometimes "depends"
Somewhat Negative	26	14.53%	Express concern for engagement/small group participation, not total opposition
Negative	29	16.20%	Strong worry about loss of voices/diversity, pipeline, smaller specialties harmed

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Q3: Common Themes

- Many favor reforms to reduce duplicative counting (especially for multiple specialties), reduce delegate inflation, and improve efficiency, but urge data-driven, carefully phased implementation to avoid unintended exclusion of smaller or marginalized groups.
- Some favor requiring/re-evaluating minimum society size for delegate eligibility.
- Some respondents suggest considering a process for members to pick one state and one specialty society and some suggest re-examining/limiting growth formulas or delegate allocation ratios (e.g., is 1/1000 members still an appropriate ratio?).
- Key recommendations include regularly reviewing apportionment, reducing number of alternate delegates, and allowing hybrid/virtual engagement and alternative forums for non-delegates or underrepresented voices.
- Most agree changes should be flexible, with exceptions or protections for key sections and ongoing monitoring to rebalance as needed.

Q4: Is the current structure of our House of Delegates representative and proportional to our membership?

Sentiment	Count	Percent	Description
Positive	3	1.66%	Strong assertions that the structure is representative/proportional
Somewhat Positive	8	4.42%	Vague or qualified positivity ("sort of," "more or less")
Neutral	93	51.38%	Factual, ambiguous, or "it depends" responses
Somewhat Negative	48	26.52%	Mild criticism, "not really," or "needs tweaking"
Negative	29	16.02%	Strongly believes it's not representative or proportional

Q4: Common Themes

- Many believe the current structure is not truly proportional, with duplicative counting and overrepresentation of small specialties, subspecialties, students, and residents diluting the voice of practicing physicians.
- There is widespread concern about whether delegate apportionment accurately reflects true membership, and several call for using real membership numbers or dues when considering apportionment.
- Some wish for more seats for underrepresented groups, mid-career, individual physicians, and states.
- Most respondents seek recalibration rather than status quo, with frequent suggestions to cap or reduce the size of the House.
- A minority value increased seats for broadening diversity, but overall, there are strong calls for greater transparency and clearer data on delegate allocation.

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Q5: What other topics or questions related to the size and structure of our HOD have not been addressed yet by CLRPD, but should be?

Sentiment	Count	Percent	Description
Positive	53	43.09%	New constructive suggestions, affirmations, solution-seeking
Somewhat Positive	8	6.50%	Mildly constructive, positive with reservations
Neutral	38	30.89%	Factual or general "other questions," unclear sentiment
Somewhat Negative	7	5.69%	Mild critique of process, e.g. "should have addressed..."
Negative	17	13.82%	Strongly critical of "missed" issues by CLRPD

Q5: Common Themes

- Greater emphasis on the HOD's mission, long-term vision, and representative function—not just logistics.
- Calls for re-examination of venue policies, i.e., larger/more diverse and flexible venues (including convention centers), hybrid/remote options for participation, accessibility issues related to current venues.
- Concerns about delegate allocation: over-representation of certain groups (e.g., small specialties, medical students, and residents), duplicative counting, and the need for fair and periodically reviewed apportionment formulas.
- Support for diversity, equity, and leadership opportunities for all specialties, trainees, and underrepresented groups, including consideration of term limits.
- Calls to streamline meeting structure and duration, utilize remote participation, and reduce redundancies (e.g., virtual and in-person reference committee sessions)
- Improved accessibility for disabilities and more practical solutions for cost, member engagement, and transparency—especially regarding delegate numbers, allocation, venues, and costs.
- Stronger outreach and engagement with mid-career physicians, trainees, and non-AMA members.

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APPENDIX C

Seat Allocation Methods for the American Medical Association House Of Delegates Using Mathematical Models

SUMMARY
This report outlines the process involved with transitioning the AMA House of Delegates (HOD) from the current delegate apportionment rule—one delegate per 1,000 AMA members or fraction thereof—to the Method of Equal Proportions (MEP).

While the current system is simple, it creates distortions in representation. A constituency with 1,001 members receives two delegates, the same as a constituency with 1,999 members, despite nearly double the membership. This produces "cliffs" in representation and inconsistent proportionality.

The Method of Equal Proportions, used by the U.S. House of Representatives since 1941, assigns seats based on mathematically neutral priority values rather than arbitrary thresholds. It is fair, transparent, and eliminates stepwise distortions.

Adopting MEP would modernize AMA representation and align it with a long-standing, nationally accepted apportionment standard.

BACKGROUND

The AMA's current apportionment rule awards one delegate per 1,000 AMA members, with upward rounding for any partial thousand. This distorts proportional representation and can advantage or disadvantage constituencies purely depending on where their membership falls relative to threshold lines.

Historical Origin of the Method of Equal Proportions

In the early 20th century, Congress faced similar representational inconsistencies when apportioning U.S. House seats among states after each Census. Earlier apportionment methods—Jefferson, Webster, Adams—each had biases favoring either large or small states. To solve these problems, Joseph A. Hill (U.S. Census Bureau statistician) and Edward V. Huntington (Harvard mathematician) developed the Method of Equal Proportions, a purely mathematical, bias-minimized system.

Congress adopted MEP in 1941, and it has remained the federal standard for more than 80 years because:

- It is mathematically neutral
- It prevents disproportionate representation
- It does not systematically advantage large or small groups
- It ensures smooth scaling of representation without threshold cliffs
- The same benefits would apply within the AMA HOD.

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HOW THE METHOD OF EQUAL PROPORTIONS WORKS

The priority value used to decide who receives the next available delegate seat is:

$$\text{Priority} = \frac{\text{Membership}}{\sqrt{n(n+1)}}$$

Where:

- **Membership** = constituency's total AMA members
- **n** = number of seats already assigned
- **sqrt(n(n+1))** = geometric mean of the next two seat numbers

Plain-Language Explanation

- Every constituency begins with 1 seat.
- Additional seats become progressively harder to earn, unless membership increases proportionally.
- Each potential new seat is evaluated using the formula above.
- The next delegate seat goes to the constituency with the highest priority value.
- This is repeated until all HOD seats are assigned.

This prevents the abrupt "cliffs" caused by the current 1:1000 system.

WORKED EXAMPLE: THREE GROUPS, TEN TOTAL SEATS

Membership:

- Group A: **6,000 members**
- Group B: **3,000 members**
- Group C: **1,000 members**

Each group begins with **1 seat**.

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Compute priority values:

$$A = \frac{6000}{\sqrt{1 \times 2}} = 4243$$

$$B = \frac{3000}{\sqrt{1 \times 2}} = 2121$$

$$C = \frac{1000}{\sqrt{1 \times 2}} = 707$$

Group A receives the next seat.
Recompute for A's third seat:

$$A = \frac{6000}{\sqrt{2 \times 3}} = 2449$$

Repeat until all 10 seats are assigned.
The final distribution closely tracks proportional membership.

Constituency	Members	Current Seats (1:1000)	Seats Under MEP
California Medical Assoc.	21,000	21	20
Texas Medical Assoc.	16,500	17	17
ACOG (OB/GYN)	10,500	11	11
Emergency Physicians	7,200	7	8
Small State Society (mock)	1,500	2	2
Dermatology Society	2,150	2	3

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FRAMEWORK FOR A FULL MEP SIMULATION USING AMA MEMBERSHIP DATA

To conduct the complete apportionment calculation, AMA staff will need to:

1. Compile membership totals for all AMA constituencies:
    - State medical associations
    - National medical specialty societies
    - Sections, PIMAs, and other seated groups
2. Enter all membership numbers into the AMA MEP Excel Seat Calculator.

Use this calculator as an example:
https://btror.github.io/apportionment.github.io/huntingtonhill.html
(Jefferson's, Adam's, Webster's, Hamilton's, and Hill's Equal Proportions methods)

3. The calculator automatically computes priority values using:

$$\frac{\text{Membership}}{\sqrt{n(n+1)}}$$

4. Seats are awarded to the highest remaining priority value until all seats are assigned.
5. Staff compare MEP-generated seats to current allocations to identify representation shifts.

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