Reference Committee F

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REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-25

Subject: Private Practice Physicians Section Five-Year Review

Presented by: Jan Kief, MD, Chair

Referred to: Reference Committee F

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted before November 2024 from the Private Practice Physicians Section (PPPS) 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 November 2020 special meeting of the HOD, when the Private Practice Physicians Caucus became the PPPS.

AMA Bylaw 7.0.9 states, "A delineated section must reconfirm its qualifications for continued delineated section status and associated representation in the House of Delegates by demonstrating at least every 5 years that it continues to meet the criteria adopted by the House of Delegates." AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and Development (CLRPD) is "to evaluate and make recommendations to the House of Delegates, through the Board of Trustees, with respect to the formation and/or change in status of any section. The Council will apply criteria adopted by the House of Delegates."

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.

During its first five years the PPPS placed particular focus on the following issues:

Leveling the Economic Playing Field

PPPS advanced a resolution calling for a report illustrating the decades of fiscal losses and inequities that practices without facility fees have endured because of the site of service differential. The AMA produced and posted this analysis on its website for 18 months, increasing awareness of the inequities in reimbursement structures and providing a visual advocacy tool for policymakers and the public.

Pharmacy Benefit Manager Control of Treating Disease States

In response to growing concern over pharmacy benefits managers (PBMs) diverting patients to designated care teams, PPPS led development of AMA policy opposing this practice and called for immediate legal and policy measures to prevent it. Outcomes included AMA advocacy for network adequacy standards that prevent steerage of patients to certain physicians or other providers, the

development of "any willing provider" state model legislation and recognizing the need for federal oversight of relationships between PBMs and insurers. This issue remains a cross-sectional priority shared with the Organized Medical Staff Section (OMSS) and the Integrated Physician Practice Section (IPPS).

Prior Authorization and Patient Autonomy

PPPS successfully introduced a resolution directing the AMA to advocate for electronic prior authorization systems with transparent monitoring capabilities. The measure was incorporated into the AMA policy compendium, supporting broader advocacy to streamline prior authorization and reduce administrative burdens on physicians and patients.

Proper Use of Virtual Overseas Assistants in Medical Practice

The PPPS sponsored a resolution affirming that properly trained overseas virtual assistants are a legitimate administrative staffing option, while calling for AMA guidance to ensure patient, physician, and community protection. This led to the creation of a Board of Trustees report and a widely attended "Private Practice Simple Solutions" educational webinar. The virtual assistant tool is now used across multiple AMA sections.

The PPPS has provided expertise and undertaken efforts to address issues facing private practice physicians and those interested in independent practice. These included participating in an educational session at A-25 on the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule and the role of HL7, a not-for-profit standards-developing organization for electronic health information. HL7 sought input from the PPPS members to provide real-life solutions on the final rule operationalization. Additionally, recognizing the challenges involved in starting an independent, physician-owned medical practice, PPPS has collaborated with AMA business units, particularly Professional Satisfaction and Practice Sustainability (PS2), on the design of a private practice incubator, a free-of-charge, 12-month program covering business planning, legal and regulatory considerations, contracting, human resources and patient acquisition. The program is designed to directly address the sustainability of independent practice models, and upon completion, participants will have developed a final business proposal for an independent practice.

The Section has placed a particular focus on improving the business climate for independent physicians who must, by necessity, possess expertise in the fundamentals of operating small businesses in addition to providing care and attention to patients. The PPPS has introduced resolutions that included efforts to roll back targeted components of Stark laws, which may interfere with an independent physician's business prospects, developing resources to optimize practice sustainability, and pioneering guidelines for ethical and appropriate use of offsite assistance. While the Section remains open to a variety of policy concerns as identified by independent physicians, its primary concern is ensuring the viability of private, independent physician practices.

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 PPPS has engaged in numerous efforts that support the AMA's strategic arcs. The Section has worked to address key issues impeding physicians' ability to deliver care including advocating for preserving private practice options in corporate health care environments, promoting continuity of care across diverse medical challenges, supporting physician reimbursement for interpreter

services, and addressing financial conflicts in corporate medicine. By leading educational programming, the Section has addressed emerging issues such as physician burnout, workplace violence, and cybersecurity. Other sessions have focused on empowering physicians through practice growth strategies, navigating employment contracts, and fostering success in private practice. These initiatives underscore the Section's commitment to reimagining medical education and lifelong learning to meet modern health care demands.

Each year, the PPPS Governing Council (GC) and staff collaborate to refine a comprehensive strategic plan for the Section. This plan outlines key initiatives with timelines that span monthly, biannual, and long-term actions. Strategic priorities include governance, such as internal operating procedures (IOPs) and the resolution development timeline, as well as efforts to expand membership and strengthen partnerships with other sections.

The Section works closely with the Marketing and Member Experience (MMX) business unit to identify shared goals and areas of mutual interest for private practice physicians. Notably, the PS2 business unit has been highly engaged, partnering with the Section to launch initiatives such as the Private Practice Boot Camp and the new Private Practice Physician Incubator, designed to support aspiring independent physicians.

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

The PPPS is structured to allow for open participation by any member on nearly all functions of the Section, while the GC is tasked with managing the operational functions of the Section through monthly virtual meetings. Major directional planning for the Section is put toward the general membership for discussion, debate, and approval.

The PPPS relies heavily on its GroupMe and Google Group email list, both of which are open to PPPS members, to hear concerns from membership and to share new educational, policy, or experiential opportunities. Town halls are also structured for members to bring attention to issues related to their practices or to Section functioning.

Any PPPS member in good standing may submit a resolution for consideration at an annual or interim meeting of the HOD. All resolutions are accepted provided they pass a review from the AMA Office of the General Counsel. The PPPS Reference Committee reviews resolutions and makes recommendations, however that committee's review and conclusions are shared with the Section and the PPPS Assembly makes final determinations on amendments and whether resolutions are adopted by PPPS.

The only major change to the Section's operations since its inception five years ago is the adoption of the use of a PPPS online forum as a primary avenue for policy debate. The online forum was initially used as an emergency mechanism for policy discussion during the first years of the COVID-19 pandemic when face-to-face meetings were replaced by virtual meetings. Since the return of in-person meetings, the Section has found maintaining the online forum to be advantageous as it allows a greater number of members to review and comment on policy without requiring them to leave their practices to travel to an annual or interim meeting.

Since obtaining section status, much of the PPPS leadership has been comprised of legacy leadership from its time as a caucus, with the first two Chairs and the first and current Delegate comprised of longtime Private Practice Physician Caucus leadership. Members of the next generation of leaders have been identified through personal connections with existing GC members

or risen through involvement with Section committees or other organizing events. The Section has carefully employed mechanisms like voluntary committee service as a potential recruitment pipeline for developing future PPPS leadership and plans to continue to generate similar opportunities to open multiple pathways to future leadership.

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 IOPs for PPPS state that Section members are AMA members in a physician-owned private practice. A physician-owned private practice shall be defined as a practice comprising 50 or fewer physicians in which those physicians, in the aggregate, own a controlling interest.

According to the 2024 AMA physician benchmark survey, 35.4 percent of physicians held an ownership stake in their practice, and 42.2 percent of physicians worked in practices that were wholly owned by physicians. In that study, the estimated eligible physician population was 737,195, meaning that 260,967 physicians in the United States held an ownership stake in their practice and 311,096 physicians worked in practices that were wholly owned by physicians. If the AMA's market share of active physicians is approximately 15 percent, approximately 39,145 AMA member physicians may hold an ownership stake in their practice, and approximately 46,664 AMA members may work in practices wholly owned by physicians. Additionally, per CLRPD Report 3-A-25, 15,703 AMA members practiced in self-employed solo practice and 3,780 physicians worked in two physician practices. While this total (19,483) does not represent all private practice physician members of the AMA, it is significantly higher than the 1,000 AMA member threshold required for delineated section status.

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.

Membership in the PPPS has steadily increased since its founding in 2020. Starting with an initial membership of 191 members, in 2025 the membership totaled 387. Average growth over the past four years is approximately 20 percent, however growth slowed from year to year following an initial burst in new membership interest, likely due to the novel nature of the Section.

This membership represents physicians from solo practices and multi-physician practices. Among physicians in multi-physician practices, only the physician that applied to PPPS is credentialed by the Section and counts toward Section membership. An analysis of the PPPS membership roster revealed 40 members with double digit physician representation. Adding the number of private practice physicians in each of those 40 practices yielded a total of 1,062 physicians. In addition to those physicians in solo practice, a conservative estimate is that 1,409 private practice physicians are directly represented in the PPPS through their Section membership.

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.

The PPPS is one of three AMA sections that advocate through the lens of practice setting rather than demographics or career stage. While the OMSS and the IPPS represent employed physicians

or those whose income is largely tied to corporate or contractual arrangements, PPPS is unique in its representation of independent physicians who own or co-own small practices and retain operational and financial control. Without PPPS, there would be no formalized structure within the AMA to identify issues unique to private practice physicians, develop policy solutions tailored to small-scale, independent practice realities and ensure these issues reach the HOD for consideration. PPPS offers multiple avenues for members to introduce issues and engage in policymaking including the opportunity to develop resolutions for all members in good standing. Open forums and virtual town halls give members opportunities to discuss practice-specific challenges and shape resolutions collaboratively and allow members to work with elected Section leadership to refine policy language and prepare for HOD advocacy. All proposed resolutions are accepted as items of business following legal review from the AMA Office of the General Counsel. Resolutions are reviewed by a reference committee composed of PPPS members, or, in the event of late or emergency resolutions, by the PPPS Chair and Chair-Elect. The Section maintains a Resolution Writing Committee that serves as a peer resource for members who request assistance in drafting their resolutions. These processes ensure that solo and small-group physicians have a direct pipeline to influence AMA policy at the national level.

The Section develops consensus on policy and advocacy activities through its annual and interim business meetings and through virtual town halls held typically at least twice per year at times separate from the annual and interim meetings. The Section utilizes an online forum for all proposed resolutions that is open to any AMA member and serves as a mechanism for delivering testimony when a member may otherwise be unable to attend a face-to-face or virtual meeting. All policy is presented to the Section Assembly for amendment and approval before being forwarded to the HOD. Likewise, operational changes such as updating of IOPs can be devised by Section leadership or select committees, however approval of any recommended changes is presented to the Section Assembly for approval and ratification.

DISCUSSION

PPPS addresses issues uniquely impacting independent, physician-owned practices, concerns not fully addressed by other AMA groups. Their successes since obtaining section status include advancing policy on the site of service differential, PBM control of treating disease states, prior authorization reform, and guidance on overseas virtual assistants. Current initiatives, such as influencing the operationalization of CMS technology standards and launching a private practice incubator, show responsiveness to evolving member needs. This targeted focus ensures that AMA policymaking includes perspectives essential to sustaining small, independent practices.

The Section’s structure fosters open participation: any member in good standing can submit resolutions, engage in policy debate via online forums and meetings, and join committees. GC oversight is balanced by member-driven direction. The use of virtual communications and tools like the PPPS Newsletter, GroupMe, and a Google Group listserv expands access and feedback opportunities. While structural changes have been minimal, the adoption of online policy forums has enhanced inclusivity and efficiency.

Since its founding in 2020, PPPS has maintained a membership growth averaging approximately 20 percent annually; consistent meeting attendance, with at least 50 members participating at major meetings; and robust asynchronous communication strategies. These tools facilitate rapid mobilization, as seen in the Change Healthcare cyberattack response when the Department of Justice (DOJ) looked to connect with physicians who were directly affected by the attack. The PPPS was able to connect members to DOJ efforts to provide relief to practices as well as build a

case for legal action and protection. Regular programming including town halls, webinars, and educational sessions supports continuous engagement and policy advancement.

Private practice physicians are now a minority in U.S. medicine, and the PPPS ensures the perspectives of independent physicians are represented in organized medicine through open resolution submission, transparent debate, and multiple participation channels. This structure enables members, many of whom are unable to leave their practices for extended travel, to influence AMA and HOD agendas. The Section's culture values autonomy, reflecting its members' practice environments.

PPPS amplifies the critical, underrepresented perspective of physicians who both provide care and manage small businesses. Their dual clinical and operational expertise informs policy on payment equity, regulatory burden, and practice viability, issues that are central to preserving patient access outside large corporate systems. The Section's targeted advocacy complements the AMA's broader efforts, avoids redundancy through structured collaboration, and drives innovative solutions like the Private Practice Boot Camp and the Private Practice Physician Incubator. By sustaining and growing independent practice representation, PPPS strengthens the diversity, credibility, and reach of AMA policymaking.

The Council appreciates the thorough work of PPPS 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 build on its first five successful years of delineated section status.

CONCLUSION

The CLRPD has determined that the PPPS meets all criteria; therefore, it is appropriate to renew the delineated section status of the section, allowing the continued focused representation of PPPS 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 Private Practice Physicians Section through 2030 with the next review no later than the 2030 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Minimal

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-I-25

Subject: Evaluation of the Structure of the AMA House of Delegates

Presented by: Jan Kief, MD, Chair

Referred to: Reference Committee F

As noted in Board of Trustees (BOT) Report 27-A-25, "AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates," the Council on Long Range Planning and Development (CLRPD) has been asked to comprehensively study and report back on potential changes to the length, format and structure of future AMA House of Delegates (HOD or House) meetings. The charge to CLRPD has been further defined 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.

This report highlights major events that have led to the current delegate apportionment procedure for the HOD and proposes placing a temporary pause on increases to delegate apportionment to allow your AMA HOD, the Council and the Board of Trustees time to thoughtfully consider the current structure of the House. The Council wishes to emphasize that this is just one step in what it hopes will be an open and collaborative process to determine the best course for the future of the HOD. To that end, the Council will be hosting a listening session at the 2025 Interim Meeting and hopes that all delegates and members present will attend and share their thoughts on the current function and structure of the HOD, and what changes they think would lead to the most optimal performance of the body moving forward.

HOD APPORTIONMENT

The history of the AMA's HOD is important context for understanding current challenges and potential paths forward. The following highlights key events since the formation of the HOD in 1901 that led to the current apportionment model for the HOD. The initial model of the House was limited to delegates from constituent societies (U.S. states and territories), initially at a ratio of one delegate per every 500 members in the state, and since 1946 at a ratio of 1:1000.

With the adoption of Council on Long Range Planning and Development Report A-I-77, "Specialty Society Representation," pathways for direct specialty society representation were created. From 1978 to 1996, each specialty society, 50 at the outset, was apportioned one delegate regardless of the number of AMA members in that specialty. The recognition of the increasing number of smaller and more narrowly focused specialty organizations wishing to participate in the HOD led to the adoption of CLRPD Report D-I-90, "Representation of Specialty Organizations in the House of Delegates," which created alternative pathways with reduced membership thresholds for organizations wishing to join the HOD. In 1996, the House adopted recommendation 8 of BOT Report 2-A-96, "Transmission of the Report of the Study of the Federation," by which specialty societies would be apportioned one delegate for every 2,000 AMA members. Three years later, the representation ratio was reduced to one delegate for every 1,000 AMA members. At the 2016

Interim Meeting BOT Report 6-I-16, "Designation of Specialty Societies for Representation in the House of Delegates," modified the specialty society delegate allocation system so that the total number of national specialty society delegates would be equal to the total number of delegates apportioned to constituent societies, leading to an immediate and significant increase in the number of HOD delegates.

CLRPD Report 1-A-99, "Admission of Professional Interest Medical Associations," created a process through which Professional Interest Medical Associations (PIMAs) could be admitted to the HOD and be apportioned a single delegate each, as is the case with the federal services, AMA sections, American Medical Women's Association, American Osteopathic Association, and the National Medical Association. PIMAs represented in the HOD in 2025 were the American Association of Physicians of Indian Origin, American Medical Group Association, and GLMA: Health Professionals Advancing LGBTQ+ Equality.

To be represented in the HOD, specialty organizations and PIMAs must meet one of three criteria: have 1,000 AMA members; have 100 AMA members with 20 percent of eligible physicians in the AMA; or have had HOD representation at the 1990 Annual Meeting and have 20 percent AMA membership among its constituents. Groups must also be members of the Specialty and Service Society (SSS) for at least three years and are evaluated by the SSS Rules Committee using publicly available criteria. BOT Report 30-A-05, "Representation of Specialty Societies in the AMA House of Delegates" includes a history of HOD's delegate apportionment.

Student and resident/fellow representation were added in 1969 and 1971, respectively, to the HOD, with one delegate for each section. The adoption of BOT Report 19-I-00, "Medical Student Representation in the AMA House of Delegates," and BOT Report 20-A-06, "Resident and Fellow Representation in the AMA House of Delegates" led to the apportionment of one medical student delegate for every 2,000 medical student members in each of the seven regions defined in the Medical Student Section (MSS) Regional Section Structure, and one Resident and Fellow Section (RFS) delegate and for every 2,000 resident members, respectively.

Current allocation numbers as of January 1, 2025, consist of the following: constituent delegates 322; specialty delegates 322; section delegates 12; PIMA and other national society delegates 6; armed services 5; medical student delegates 25; and resident and fellow sectional delegates 41.

CHALLENGES ASSOCIATED WITH HOD GROWTH

Continual increases in membership, driven in large part by the successful initiatives of the Marketing and Member Experience (MMX) unit, have resulted in recent increases in the delegate count of the HOD.

CLRPD's analysis finds the size of the HOD since 1990 has increased from 435 delegates to 733, a 68 percent increase (see graphic 1 in Appendix A). In recent years the growth in the number of delegates has accelerated even further, and in the last ten years alone, the HOD has increased in size by nearly 200 delegates, an increase of 35.7 percent. In its current structure, the HOD is projected in 2026 to add 55 additional delegates for an approximate total of 780. Membership growth has increased the number of constituent delegates, and due to parity between state and specialty apportionment established in 2016, has similarly increased the number of specialty delegates. The recent growth in the number of delegates has created pain points associated with logistics, cost and the deliberations of the HOD.

Duplicative apportionment tallies: Constituent associations use the total number of physicians, residents and medical students residing in the state or territory when reporting membership numbers, which then apply towards not only their allocation but also towards specialty allocations due to state/specialty parity. Additionally, specialty organizations and PIMAs include residents and fellows and sometimes medical students towards their total AMA membership. AMA members may be members of more than one of the 132 specialties represented in the HOD, and therefore, count towards each organization's membership. All of these factors can lead to members being counted multiple times to determine HOD apportionment.

Disproportional representation and membership: While the total number of AMA members is similar in 2024 compared to 1999, the HOD's size has significantly increased, due to specialty/state delegate parity, the addition of smaller specialty societies due to lowering of thresholds for representation, the addition of RFS and MSS delegations, and group memberships for physicians and residents. In 1999, the ratio of members to delegates was 591:1; in 2024, the ratio has been reduced to 441:1. (See graphic 2 in Appendix A).

Venues: Collaborating with AMA Meeting Services, CLRPD found only four venues nationwide that can accommodate the HOD's current size while meeting AMA's policy requirements. This was reported to the BOT in 2024. According to the Chicago Fire Marshall, A-25 exceeded the capacity of the ballroom at the Hyatt Regency Chicago (and would have also exceeded the capacities for all other scheduled venues). This situation created a safety issue and made it physically difficult for delegates and alternate delegates to carry out deliberations. This creates an obstacle to participation and limits the House's ability to debate and develop policy.

Cost: A larger HOD incurs greater costs for the AMA and federation societies, as well as for attendees. Convention centers are significantly more expensive than hotels and their usage may inadvertently create pressure to grow the HOD even more in order to reduce the per person cost. Additionally, few if any convention centers offer enough small meeting spaces needed for section, delegation, and caucus activities, while creating new accessibility challenges for attendees. The AMA's Emergency Assistance Pilot Program (EAP) was established in 2024 for two years (four meetings) as a temporary measure to help support federation members and ends in I-26. The EAP provided partial reimbursement to societies meeting its criteria for the attendance of 300 delegates and alternates at its first meeting, A-25. While the EAP helped with some attendance costs, physicians additionally face lost income from time away from their practice at a time when physician payments are already strained, and federation societies continue to face significant financial challenges. A cost savings plan to shorten each meeting by one day was ultimately paused for 2025 until further cost saving considerations could be evaluated. Efficiencies in this area that help decrease costs should still be considered as the cost savings would be significant for not only the AMA but also the federation and all attendees.

AMA I-25 CLRPD EDUCATION AND LISTENING SESSION AND NEXT STEPS

CLRPD encourages all delegations to attend an important session on Sunday, November 16th from 11 a.m. – noon Eastern Time. During this 60-minute session, CLRPD will review key information presented in this report and facilitate a conversation for members to share ideas for setting the HOD on a course that is sustainable, equitable, and representative of AMA's diverse membership. The council is interested in learning all potential solutions to the problems with the size and function of our HOD. CLRPD will compile and analyze the data from this listening session, additional stakeholder surveys, and research into governance best practices. It will also convene several virtual meetings for the HOD. A comprehensive report on the Council's findings will be presented at the 2026 Interim Meeting.

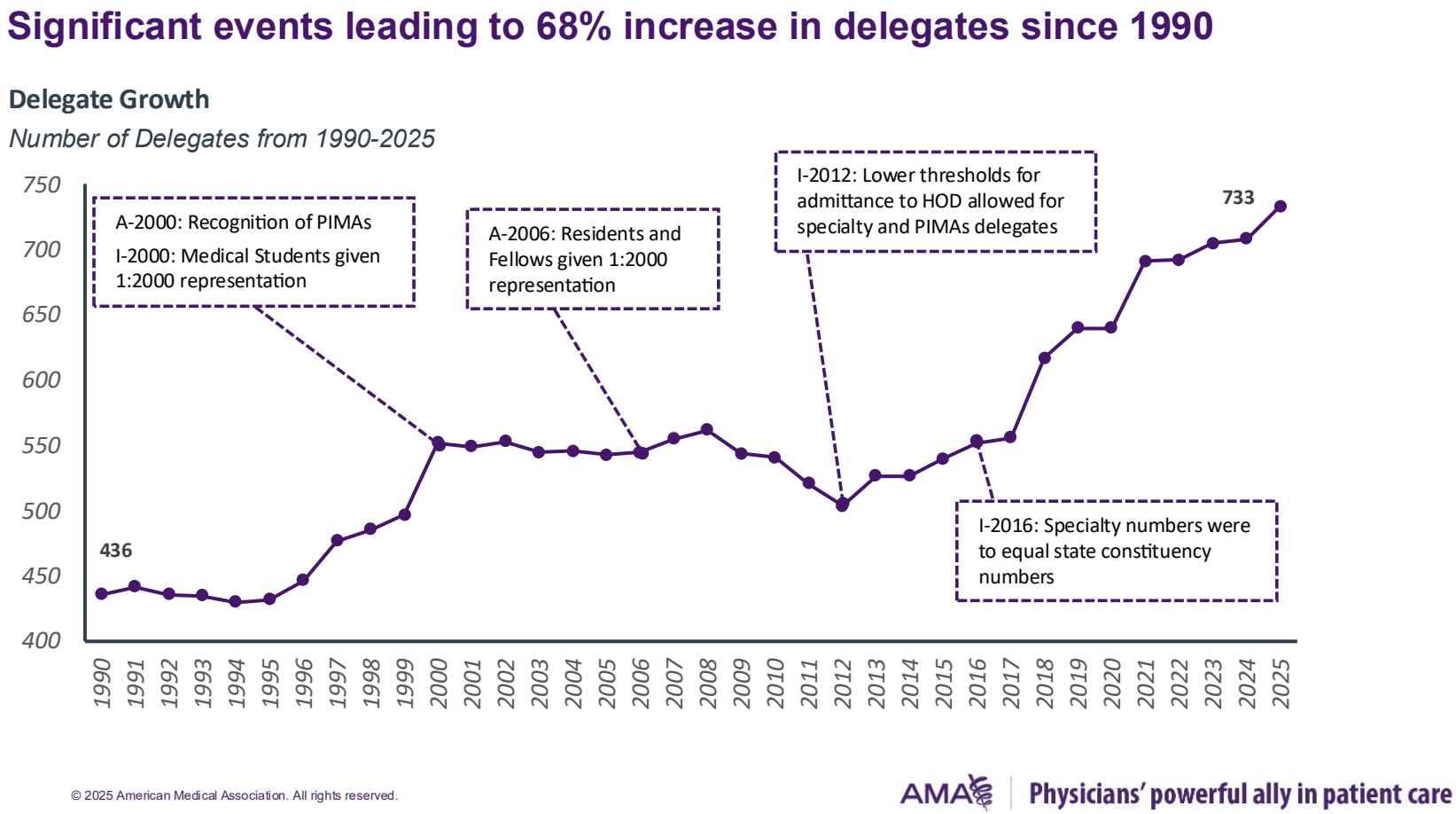
While this work takes place, the Council believes that instituting a temporary pause on increases to delegate allocation will allow the House to avoid further logistical disruption that would likely accompany the addition of 50-plus additional delegates to next year's apportionment.

RECOMMENDATION

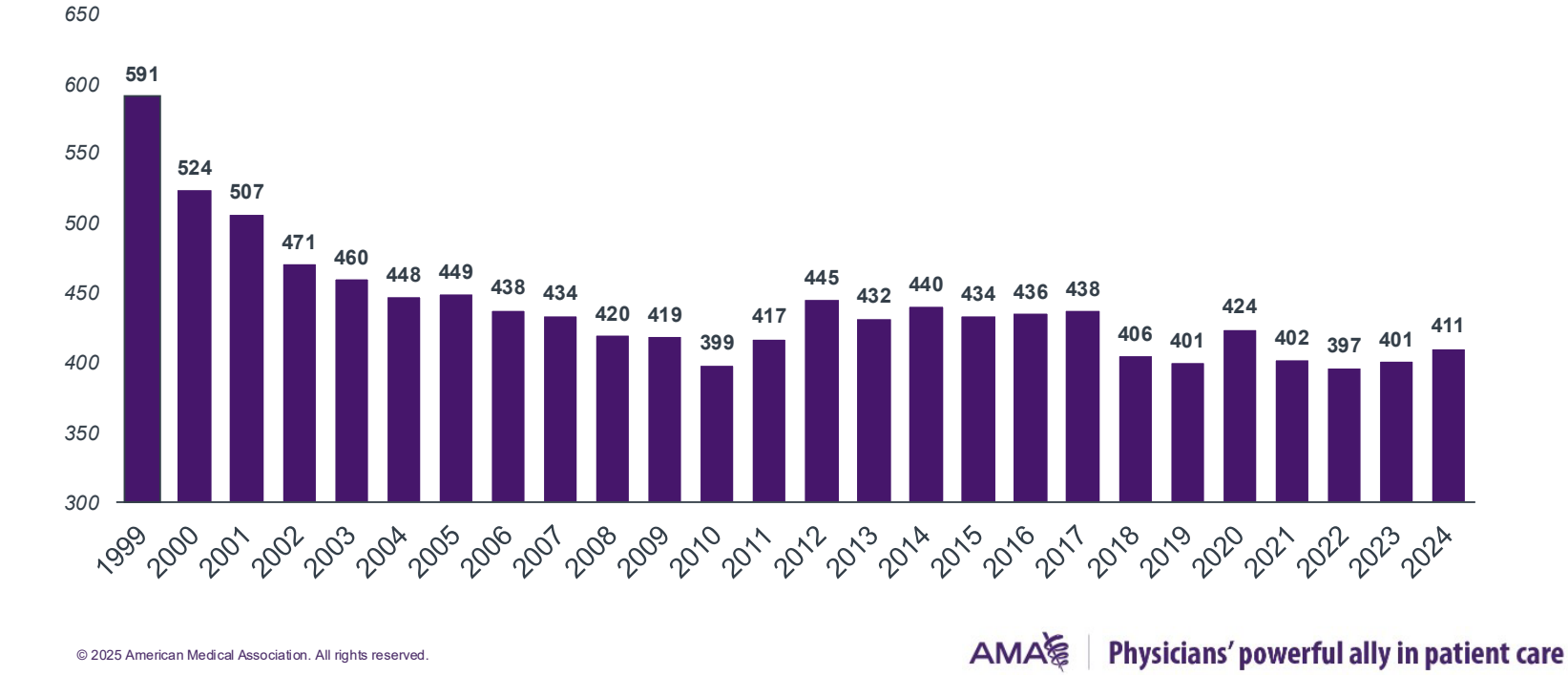
The Council on Long Range Planning and Development recommends that the delegate apportionment for the AMA House of Delegates be paused at 2025 levels through year-end 2026 and that this report be filed.

Fiscal Note: Minimal

Appendix A



Graphic 1. Significant events leading to 68% increase in HOD delegates, 1990-2025.



Graphic 2. Ratio of members represented by HOD Delegates 1999-2024.

APPENDIX B: RELATED AMA POLICIES

Statement of Collaborative Intent G-620.030

Designation of Specialty Societies for Representation in the House of Delegates G-600.027

Delegate Apportionment and Pending Members G-600.959

Specialty Organizations Seated in our AMA House of Delegates D-600.984

Admission of Professional Interest Medical Associations to our AMA House G-600.022

AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates D-600.951

Composition and Representation. B-2.0.1

Constituent Associations. B-2.1

Meetings of the House of Delegates. B-2.12

Committee on Rules and Credentials. B-2.13.2

National Medical Specialty Organizations. B-2.2

Medical Student Regional Delegates. B-2.3

Delegates from the Resident and Fellow Section. B-2.4

Speaker and Vice Speaker Additional Delegate. B-2.5

Other Delegates. B-2.6

Alternate Delegates. B-2.8

Delegate and Alternate Delegate. B-7.0.5

Representation in the House of Delegates. B-8.1

Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. B-8.2

Specialty and Service Society. B-8.3

Application for Representation in the House of Delegates. B-8.4

Periodic Review Process. B-8.5

REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, I-2025

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

Presented by: Jessica Krant, MD, Chair

Referred to: Reference Committee F

This report by the committee at the November 2025 Interim Meeting documents the compensation paid to Officers for the period July 1, 2024, through June 30, 2025, including 2024 calendar year IRS reported taxable value of benefits, perquisites, and services for all Officers.

BACKGROUND

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

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

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

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

CASH COMPENSATION SUMMARY

The cash compensation of the Officers shown in the following table will not be the same as compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a calendar year. The total cash compensation in the summary is compensation for the days these officers spent away from home on AMA business approved by the Board Chair. The total cash compensation in the summary includes work as defined by the Governance Honorarium, Per Diem for Representation and Telephonic Per Diem for External Representation.

The summary covers July 1, 2024, to June 30, 2025.

AMA Officers	Position	Total Compensation	Total Days
David H Aizuss, MD	Chair-Elect	$211,630	73
Toluwalase A. Ajayi, MD	Secretary	$92,200	72
John H. Armstrong, MD	Vice Speaker, House of Delegates	$74,700	68
Geralyn R. Breig	Officer	$67,000	34.5
Madelyn E. Butler, MD	Officer	$76,800	53.5
Alex Ding, MD, MS, MBA	Officer	$76,100	59.5
Lisa Bohman Egbert, MD	Speaker, House of Delegates	$133,500	102.5
Jesse M. Ehrenfeld, MD, MPH	Immediate Past President	$290,659	111.5
Scott Ferguson, MD	Officer	$75,400	45.5
Sandra Adamson Fryhofer, MD	Officer	$98,500	72.5
Melissa J. Garretson, MD	Officer	$72,600	47.5
Marilyn Heine, MD	Officer	$92,200	66.5
Pauline P. Huynh, MD	Officer	-	3
Lynn Jeffers, MD, MBA	Officer	$71,900	55.5
Pratistha Koirala, MD, PhD	Officer	$67,000	36.5
Ilse R. Levin, DO, MPH & TM	Officer	$83,100	56
Justin W. Magrath, PhD	Officer	-	2
Bobby Mukkamala, MD	President-Elect	$290,659	118
Sheila Rege, MD	Officer	-	3.5
Bruce A. Scott, MD	President	$298,865	146
Aliya Siddiqui, MS	Officer	$83,800	63.5
Michael Suk, MD, JD, MPH, MBA	Chair	$285,886	122.5
Willie Underwood, III, MD, MSc, MPH	Immediate Past Chair	$113,200	100.5
Marta J. Van Beek, MD	Officer	-	2
David Welsh, MD, MBA	Officer	$82,400	52

President, President-Elect, Immediate Past President, and Chair
In 2024-2025, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 498 days on approved Assignment and Travel, or on average, 124.5 days each.

Chair-Elect
This position received a Governance Honorarium of approximately 74% of the Governance Honorarium provided to the Chair.

All Other Officers
All other Officers received cash compensation, which included a Governance Honorarium of $67,000 paid in monthly installments and per diems for approved assignment days.

Assignment and Travel Days
As defined, these are Assignment and Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal Representation above 11 days. These days were compensated at a per diem rate of $1,400. The total Assignment and Travel Days for all Officers (excluding the President, President-Elect, Immediate Past President, and Chair) were 1,069.5.

EXPENSES

Total expenses paid for period, July 1, 2024 – June 30, 2025, was $1,061,975.

BENEFITS, PERQUISITES AND SERVICES

Officers are able to request benefits, perquisites and services, as defined in the "AMA Board of Trustees Standing Rules on Travel Expenses." These non-taxable business expenses are provided to assist the Officers in performing their duties.

- AMA Standard laptop computer or iPad
- American Express card (for AMA business use)
- Combination fax/printer/scanner (reimbursable up to $250)
- An annual membership to the airline club of choice offered each year during the Board member's tenure
- Personalized AMA stationery, business cards, and biographical data for official use
- Airline upgrade allowances of up to $5,000 per term for Presidents and $2,500 per term for all other Officers.

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

Secretarial support, other than that provided by the AMA's Board office, is available up to defined annual limits as follows: President, during the Presidential year, $15,000, and $5,000 each for the President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses incurred by other Officers in conjunction with their official duties are paid up to $750 per year per Officer. This is reported as taxable income to the recipient. Calendar year taxable life insurance and taxable secretarial fees included in the 2024 compensation reported to the IRS for the above individuals totaled $15,732 and $26,875 respectively. An additional $16,500 was paid to third parties for secretarial services during 2024.

Officers are also eligible to participate in a service provided to AMA employees by Care@Work through Care.com. This service offers referral services at no cost and back-up care for children and

adults up to 10 days a calendar year at a subsidized rate. If a Board member uses back-up care, it will be reported to the IRS as taxable income.

METHODOLOGY

In June 2024, the Committee commissioned Ms. Becky Glantz Huddleston, a consultant expert in board compensation with WTW, to update the 2019 research on compensation of non-leadership Officers. The purpose of the review was to ensure non-leadership roles are compensated appropriately for their work performed on behalf of the AMA. As a result of this analysis, the Committee recommended increases to the maximum secretarial support reimbursement for non-leadership Board Officers. The HOD approved an increase to the maximum secretarial support reimbursement from $750 to $1,125, effective January 1, 2025.

In November 2024, the Committee further recommended an increase to the honorariums and per diems for non-leadership Board Officers. The following recommendations were approved by the HOD effective July 1, 2025: the Governance Honorarium for non-leadership Board Officers increased by $1,500 to $68,500, the Per Diem for Representation increased by $150 to $1,550 and the Telephonic Per Diem increased by $75 to $775.

In June 2025, the Committee commissioned Ms. Becky Glantz Huddleston to review the compensation of the Speaker and Vice Speaker of the HOD. As a result of this analysis, the Committee recommended increases to the Governance Honorariums for the Speaker and Vice Speaker and the elimination of Per Diems for Internal Representation for all Officers. The following recommendations were approved by the HOD effective July 1, 2025: the Governance Honorariums for the Speaker and Vice Speaker increased to $125,000 and $115,000 respectively and Per Diems were eliminated in their entirety for those two positions. Additionally, Internal Per Diems were eliminated for non-leadership Officers.

FINDINGS

The Committee notes that Officers continue to make significant time commitments in supporting the AMA in governance and representation functions. Given the amount of time required by Board members, it is important that individuals seeking a position on the Board be aware of the scope of the commitment and the related compensation.

Based on the Committee's review of Officer compensation and recent changes to Officer compensation approved effective January 1, 2025, and July 1, 2025, the Committee recommends no additional changes to Officer compensation at this time.

The Committee thanks our Officers for their representation of the AMA.

RECOMMENDATION

1. That there be no additional changes to the Officers' compensation for the period beginning July 1, 2025, through June 30, 2026. (Directive to Take Action.)

2. That the remainder of the report be filed.

Fiscal Note: $0

APPENDIX

Board Leadership Honoraria during the Period of July 1, 2024, to June 30, 2025

POSITION	**GOVERNANCE HONORARIUM**
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630

REPORT OF THE SPEAKERS

Speakers' Report 1-I-25

Subject: Online Reference Committee

Presented by: Lisa Bohman Egbert, MD, Speaker and John H. Armstrong, MD, Vice Speaker

Referred to: Reference Committee F

The American Medical Association Policy G-600.045, "Online Reference Committee Hearings in the House of Delegates," asks that our AMA:

> Convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for 21 days.

DISCUSSION

The 21-day window for Online Reference Committees (ORCs) to be open for comment was established by Speakers' Report 1-A-24, "Report of the Resolution Modernization Task Force Update." Utilization data from the 2024 Interim Meeting and 2025 Annual Meeting show that the majority of comments are made during the first several days of the ORCs being open followed by a flurry of activity the last few days and hours prior to the close of the ORCs. After reviewing this data, your Speakers have determined that reducing the window that ORCs are open to 14 days, would allow more time for reference committees to develop and post Preliminary Reference Committee reports while providing delegations and caucuses with a similar timeframe to comment that has been previously utilized and more time to review the preliminary recommendations.

RECOMMENDATION

Your Speakers recommend that Policy G-600.045, "Online Reference Committee Hearings in the House of Delegates," be amended by addition and deletion and the remainder of the report be filed:

1. Our American Medical Association will convene Online Reference Committee Hearings prior to each House of Delegates meeting. These hearings shall open 10 days following the resolution submission deadline and remain open for ~~21~~ 14 days.

Fiscal note: Minimal

REPORT OF THE SPEAKERS

Speakers' Report 2-I-25

Subject: Election Committee Review of Election Rules for Clarification

Presented by: Lisa Bohman Egbert, MD, Speaker and John H. Armstrong, MD, Vice Speaker

Referred to: Reference Committee F

The American Medical Association's (AMA) policy G-610.090, "AMA Election Rules and Guiding Principles," has undergone significant changes over the last several years. Much of this work was done by Election Task Forces 1 and 2. The feedback on the elections rules changes has been positive. However, there are a few areas that have elicited questions over the last several election cycles. Therefore, your Speakers asked the Election Committee to identify areas within the rules in need of clarification. After careful consideration, the Election Committee recommended several clarifications.

DISCUSSION

Election complaint process

Although the necessary elements of an election complaint and to whom it must be reported are clearly delineated in policy, the formal complaint filing process is not stated in policy. Election monitoring uses a complaint-based process to identify allegations of election rule violations. Your Speakers and the Office of General Council are available for queries from candidates in interpreting the rules. Such queries are not formal complaints. The Election Committee recommends additional clarity regarding who has standing to file an election complaint for HOD elections and what the statute of limitations for filing should be. Further, clarification should include that a formal complaint must be made in writing, with receipt acknowledged within twenty-four hours.

The Elections Committee suggests that a formal complaint may only be made using the form on the AMA election website with the contents of the form submitted to the Speaker, Vice Speaker and/or the Office of General Counsel by a voting member of the HOD. Further, per House rules, action on a substantiated complaint that is announced to the HOD is ultimately adjudicated by the electorate. Therefore, the Election Committee recommends that all formal complaints must be submitted prior to the start of the election session at which the candidate is on the ballot.

Campaign-related presentations

Individuals running for an AMA office participate in a multitude of activities at AMA sponsored meetings and can be members of many different groups, formal and informal. Election rules do not preclude candidates from active involvement in these various activities and groups. However, questions have been raised regarding what is meant by a campaign-related presentation, as discussed under the interview rules, particularly regarding appearances before groups of which a candidate is a member. Candidates should not be impeded from actively participating in any group of which they are a member.

The Election Committee recommends clarification that a campaign-related presentation is a written or verbal presentation about a campaign or a solicitation of votes for an AMA election during a non-sponsoring group meeting. This allows candidates to make a general introduction and to further participate in non-sponsoring group meetings.

Sponsoring group

While a sponsoring group is clearly defined in our election policy, your Election Committee provides this clarification of sponsoring groups: a delegation, not a caucus, is the only group that may sponsor a candidate.

CONCLUSION

AMA election policy promotes fairness across campaigns. Your Election Committee has offered several clarifications.

RECOMMENDATION

Your Speakers recommend that the following clarifications be made to the AMA election policies and the remainder of the report be filed:

1. A formal election complaint must be filed in writing by a HOD delegate or alternate delegate via the election website before the commencement of the election session at which the candidate is currently seeking election.
2. A campaign presentation is a written or verbal presentation about a campaign or a solicitation of votes for an AMA election during a non-sponsoring group meeting.

Fiscal note: Minimal

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-25)

Introduced by: New England Delegation

Subject: Reimagining and Modernizing the U.S. Healthcare Delivery System

Referred to: Reference Committee F

Whereas, the U.S. healthcare delivery system is increasingly failing patients, with persistent inequities in access, affordability, and outcomes, and insufficient investment in prevention and public health; and

Whereas, the Medicare Physician Fee Schedule (MPFS), established in the early 1990s, has become increasingly disconnected from the realities of modern medical practice, with annual updates constrained by legislative budget caps and default cuts and failing to keep pace with inflation and practice costs, and the volume-based system undervaluing essential physician work such as prevention, care coordination, and the management of patients with complex chronic or acute conditions; and

Whereas, as a result, physician reimbursement has declined significantly in real terms, undermining the long-term sustainability of medical practices, accelerating consolidation, reducing resources for patient care improvements, and contributing to physician burnout through administrative and financial pressures, with disproportionate impacts on independent practices, underserved communities, and specialties that rely heavily on cognitive services rather than procedures; and

Whereas, the MPFS was created following the 1989 enactment of Medicare payment reform legislation built on the Harvard resource-based relative value scale (RBRVS), a process in which the AMA played a central role through congressional testimony, policy advocacy, development of the CPT coding system, and the subsequent creation of the Relative Value Scale Update Committee (RUC) to inform CMS updates;[1] and

Whereas, given its historic role in shaping and maintaining public healthcare program reimbursement frameworks, the AMA has both a unique responsibility and opportunity to lead in reimagining a healthcare delivery system that now requires comprehensive reform; and

Whereas, rising patient cost-sharing through regressive copays and co-insurance create significant financial barriers to medically necessary services, even for insured individuals, and contribute to worsening disparities in care delivery; and

Whereas, even among insured patients, high deductibles and cost-sharing obligations contribute to widespread underinsurance, forcing patients to delay or forego needed care and exacerbating inequities in outcomes;[2] and

Whereas, the cumulative effect of administrative burdens—such as prior authorization, step therapy, arbitrary quality metrics, audits, and excessive documentation—erodes the physician-patient relationship, delays care, increases costs, and contributes significantly to physician burnout and patient harm; and

Whereas, the increasing prevalence of complex administrative requirements and burdensome prior authorization protocols imposed by commercial payers and Managed Care Organizations (MCOs), including entities that manage public program benefits, diverts physician time and resources from direct patient care and erects barriers to timely and appropriate access for patients; and

Whereas, the accelerating trend of vertical integration within the healthcare industry, including large insurers acquiring provider groups, pharmacy benefit managers, and other healthcare entities, creates conflicts of interest, stifles competition, drives up costs (including drug prices), and threatens patient choice and physician autonomy;[3] and

Whereas, current drug pricing mechanisms, particularly in Medicare Part B and Part D, have distorted incentives across the system and inadequately support the true costs of delivering complex therapies, with evaluation and management, pharmacy, and infusion services chronically underpaid and forcing many practices to rely on drug margins to cover these unmet costs, as Medicare Part B reimbursement based on Average Sales Price plus a percentage add-on provides only a 4.3 percent markup to physicians, which is insufficient to sustain the infrastructure necessary for safe delivery of high-cost drugs;[4,5] and

Whereas, pharmacy benefit managers (PBMs) have promoted higher drug costs and created intentionally obscure methods of pricing, purchasing, selling, and rebate arrangements in Medicare Part D and commercial markets, making the three largest PBMs among the most profitable corporations in America while driving many patients into financial distress or bankruptcy; and

Whereas, in some value-based care models, incentives tied to regimen cost or utilization benchmarks may pressure physicians to select lower-priced therapies even when newer, more expensive options may provide greater benefit, creating a conflict between patient outcomes and practice financial performance; and

Whereas, the Medicare Hospital Insurance (HI) Trust Fund, which finances inpatient hospital services, skilled nursing facilities, hospice, and some home health care for more than 65 million Americans, is projected to become insolvent within the next decade; and absent Congressional intervention, revenue from payroll taxes and other sources will be insufficient to cover scheduled benefits, threatening older Americans' access to care and destabilizing hospitals and physician practices that rely on Medicare, underscoring the urgent need to plan proactively for systemic reform rather than waiting for crisis-driven patches;[6] and

Whereas, recent federal legislation has imposed deep cuts to Medicaid—including work requirements, eligibility restrictions, and reduced provider funding—that threaten coverage for millions, destabilize safety-net providers, and reduce access to behavioral health and rural services; and

Whereas, Medicare Advantage plans, while expanding rapidly, have cost substantially more per beneficiary than traditional Medicare due to risk coding practices, impose high administrative burdens, restrict networks, and increasingly shift control of care away from physicians, further eroding access and practice sustainability;[7,8] and

Whereas, deeply entrenched structural flaws across both public programs (e.g., Medicare, Medicaid, ACA, VA, CHAMPVA) and private insurance render the healthcare delivery system increasingly unsustainable, and cannot be addressed through incremental adjustments alone, requiring an urgent and comprehensive reimagining of both care delivery and financing; and

Whereas, the AMA Council on Medical Service has previously produced health policy, approved by the House of Delegates, supporting a health system built on advanceable, refundable tax credits inversely related to income and administered by health plans that do not profit from the sale of insurance but from the efficient administration of care, which would maximize coverage, provide sufficient payment to sustain independent practices, avoid forcing patients to remain in jobs solely to maintain health insurance, minimize uncompensated care, and ensure access to the physician-led care team of the patient's choice; and

Whereas, politicization of evidence-based medical decision-making—such as restrictions on reproductive, gender-affirming, or end-of-life care—undermines the physician-patient relationship and threatens equitable access to medically necessary care;[9] and

Whereas, a redesigned healthcare delivery system must ensure equitable care for all patients, embed ethical standards in coverage and access decisions, protect the integrity of physician-patient decision-making free from political interference, and proactively prevent new inequities across socioeconomic, racial, ethnic, geographic, tribal, gender, and sexual identity groups; and

Whereas, past policymaking in healthcare delivery and financing has too often been reactive, negotiating patches only after crises, rather than guided by a clear vision for a sustainable, patient-centered, equitable system; and

Whereas, any financing mechanism within a reimagined system must facilitate access to care rather than maximize profit, with cost-sharing minimized or eliminated where it creates barriers to high-value care, particularly for low-income and underserved populations; and

Whereas, the absence of standardized, transparent reporting of the actual cost of care across payers and delivery settings impedes patients, physicians, and policymakers from identifying value and implementing reforms that reward high-quality, efficient care; and

Whereas, the AMA, as the nation's most representative physician organization, possesses unique expertise not only in physician payment systems but also in public health, prevention, and medical ethics, and has the convening power to unite diverse voices in developing viable, patient-centered solutions; and

Whereas, while the AMA has extensive existing policy on health system reform, proactively integrating and communicating that policy in a unified, evidence-based framework is essential to give physician members clarity of a shared vision for the future of healthcare and to effectively influence policy debates when political will emerges, ensuring that future systems benefit patients, support practice sustainability, and reflect the realities of clinical care; therefore be it

RESOLVED, that our American Medical Association will convene a multidisciplinary Task Force, under the direction of the Board of Trustees, that may include physicians and trainees, allied health professionals, leaders from hospitals and health systems, public and private payers, health economists, ethicists, patient advocates, and other relevant parties from across the health sector, to develop a legislative roadmap to reform the U.S. healthcare delivery system, drawing from and building upon existing AMA policy, and positioning our AMA as a convener of a broader national coalition to advance this vision; and that this roadmap will be structured around the following components:

1. Foundational Principles: The roadmap will specifically incorporate the following principles:
    a. Equitable access to affordable, high-quality healthcare for all as a basic human right;

b. Physician autonomy and the primacy of the patient-physician relationship;
c. Physician-led care as the foundation of clinical decision-making and healthcare delivery;
d. Freedom of patients and physicians to choose care settings and models of practice;
e. Physician practice sustainability through fair and predictable payment;
f. Science-based innovation that improves healthcare value and efficiency; and
g. Prevention, public health, and health equity as central pillars of a sustainable healthcare system;

2. Scope of Review: In developing the roadmap, the task force will consider issues related to healthcare delivery and financing, including, but is not limited to, the following systemic problems and potential solutions:
    a. Physician payment and workforce sustainability;
    b. Comprehensive valuation of physician work;
    c. Incentives that support timely, patient-centered care and uphold clinical judgment;
    d. Administrative, financial, and clinical interference by intermediaries;
    e. Uninsurance, underinsurance, and other cost-sharing issues;
    f. Universal coverage, including preventive services and public health;
    g. Equity in care delivery;
    h. Protection of physician-patient shared decision-making;
    i. Market consolidation, vertical integration, and profiteering;
    j. Drug pricing and access to evidence-based therapies; and
    k. Transparency and reporting of the true cost of care;
3. Environmental Scan: To inform the roadmap, the task force will conduct a comprehensive review of existing global and domestic healthcare programs and reform proposals to evaluate their strengths and weaknesses based on how each framework centers patients, upholds clinical judgment, and promotes healthcare system and physician practice sustainability; and
4. Reporting and Engagement: The task force will:
    a. Report at least annually to the AMA House of Delegates on its findings and progress;
    b. Provide recommendations to the AMA Board of Trustees on areas requiring further policy development to support this work;
    c. Regularly convene focus groups within and outside of the AMA House of Delegates to review draft elements of the roadmap as they are being developed; and
    d. Deliver a final comprehensive legislative roadmap to reform the U.S. healthcare delivery system for consideration by the AMA House of Delegates.

(Directive to Take Action)

Fiscal Note: $240,365 - Convene task force (similar expected for subsequent years).

Received: 9/18/25

References:

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4. https://jamanetwork.com/journals/jama/fullarticle/2836859
5. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun17_ch2.pdf
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8. https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-25)

Introduced by: American Academy of Family Physicians

Subject: Standardizing the Appointment Process for AMA Councils

Referred to: Reference Committee F

Whereas, the American Medical Association currently utilizes a hybrid structure for populating its councils, with some councils comprised of members elected by the House of Delegates and others appointed by the AMA Board of Trustees; and

Whereas, sound governance principles in nonprofit organizations emphasize that functional and advisory bodies, such as councils and committees, should be structured to ensure alignment with the organization's strategic goals and fiduciary obligations; and

Whereas, the work of the AMA Election Task Force was essential in structuring fair and streamlined election processes which should continue to be used for elected officer and board positions; and

Whereas, board-appointed council members are more likely to be selected based on expertise, experience, diversity, and alignment with institutional priorities rather than social recognition or political considerations, leading to more effective council performance; and

Whereas, allowing elections for only some councils introduces inconsistency and may lead to misalignment between councils and the Board of Trustees, complicating accountability and strategic execution; and

Whereas, nearly all major professional and nonprofit organizations vest appointment authority in their boards for internal working groups and advisory bodies, intended to streamline governance, ensure role clarity, and optimize representation of needed skillsets; and

Whereas, the current process for running a candidate for an elected council position often requires significant financial resources, which can create barriers for smaller organizations and societies; and

Whereas, the economic impact of this process can disproportionately affect these smaller entities, limiting their ability to participate fully in the democratic process; and

Whereas, creating a more equitable system would enable these organizations and societies to have a fair opportunity to nominate candidates, thereby enhancing the diversity and representation within the council; and

Whereas, such changes could lead to more inclusive decision-making that better reflects the needs and interests of all community members, particularly those from underrepresented groups; and

Whereas, large geographic and specialty-based caucuses are important in ensuring representation in political races, Councilors should be selected on the basis of qualification and diversity of thought regardless of state, specialty, or caucus alliance within the House of Delegates; and

Whereas, moving to a fully appointed council structure utilizing a blinded and objective process of selection would modernize AMA governance, reduce unnecessary politicization, and enable the Board of Trustees to better steward the mission and long-term vision of the AMA; and

Whereas, the utility of a Nominating Committee mitigates the risk for politicization and enables an objective process of evaluation and selection; and

Whereas, a diverse and rotating set of Nominating Committee members carrying vast institutional knowledge, may also have served previously on Councils or Board, and could be elected by the House of Delegates to serve in this term-limited capacity; and

Whereas, a process outlined by a task force would return to the House of Delegates a plan with necessary bylaws changes for implementation, allowing for delegates to review and amend the process prior to its finalization; therefore be it

RESOLVED, that our American Medical Association develop a phased implementation plan – including selection criteria, procedural steps, and necessary bylaw amendments – to establish a House of Delegates-elected Nominating Committee responsible for the appointment and reappointment of all Council members, subject to final approval by the Board of Trustees. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/23/25