

Reference Committee F

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 01-I-26

Subject: Study of Grading Systems in AMA Board Reports

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee F

Resolution 520-A-25, “Study of Grading Systems in AMA Board Reports” was referred. It asked that our American Medical Association (AMA):

study the use of a system for assessing the quality of evidence and the strength of recommendations in board reports when appropriate.

BACKGROUND

Per the Constitution and Bylaws of the AMA, a report is a formal account providing the rationale for conclusions drawn relying upon experts in a specialized field of knowledge or philosophy that can be informational only or include recommendations for action by a deliberative body.¹ These reports may present recommendations for House of Delegates (HOD) action or provide information in response to existing policy directives. Reports of the Board of Trustees (BOT Reports), specifically, move through an established, deliberative process in which meeting materials are submitted, posted for review, assigned to a reference committee or online reference committee for testimony and comment, and then acted upon by the HOD through adoption, amendment, referral, or filing.

The development of these reports typically draws on the expertise of AMA physician leadership and professional staff across relevant subject areas, including health policy, advocacy, public health, science, ethics, governance, finance, and operations, depending on the topic of the report. Recent BOT Reports, for example, have addressed advocacy analysis, public health strategy, technology and AI, and annual organizational and financial matters. This process is longstanding and deeply embedded in AMA governance. The HOD meets twice each year to establish policy. The HOD Reference Manual serves as the standing procedural guide for our policy-development process, and the AMA maintains public archives of HOD proceedings and BOT Reports.

DISCUSSION

Evidence-based approaches emphasize the importance of systematically assessing the quality and strength of information used to inform decisions. As a result, there is growing interest in applying grading frameworks to policy-relevant documents, such as Board of Trustees reports, to better understand the rigor and transparency of the evidence they provide. However, these reports often incorporate expert judgment, contextual considerations, and other factors that may not be fully captured by traditional evidence-grading schemes. As a key component of clinical decision-making and embedded in medical education, the HOD frequently raises the importance of using EBM concepts and practices in policy development and analysis.

Evidence-Based Medicine for Clinical Decision-Making

Evidence-based medicine (EBM) is the cornerstone of clinical decision making in medical practice to provide the best patient outcomes. EBM utilizes rigorous scientific method and critical appraisal to organize and systematize the application of research and data to ground health care decisions.^{2,3} By utilizing EBM, physicians are able to implement the most up-to-date scientific information into their practice while also building confidence in medical decisions and discussions with patients.

Grading systems translate the level of evidence into a commonly understood alphabetic system for hierarchical consumption and application (Figure 1 and Table 1).⁴⁻⁶ Clinical guidelines often utilize grading systems to demonstrate the strength of their recommendations based on the level of evidence used for their recommendations.^{7,8} Multiple evidence-leveling and grading systems are used in evidence-based medicine (EBM), each with inherent limitations and challenges, particularly in the way some frameworks may disadvantage certain study designs.⁵ By understanding these levels, practitioners can ensure that their clinical decisions are grounded in the most reliable and rigorous evidence available. These grading systems help to provide transparency in recommendations and support communication between patients and their physicians and ensure clear understanding of evidence-based practice for high-quality care. Evidence grading systems also vary in how they classify the quality of evidence and the strength of recommendations. There are a wide variety of grading systems for EBM (Table 2). While these systems work well for clinical practice, policymaking has different leadership and decision-making outcomes.

Evidence to Decision Frameworks for Public Health Decisions

Evidence-to-decision frameworks (EtD) are structured, multicriteria tools that guide panels of experts in moving transparently from a body of synthesized evidence to a health recommendation or decision.^{12,13} Rather than leaving the reasoning behind a recommendation implicit, they force explicit judgments on a defined set of criteria, such as benefits and harms, certainty of evidence, values, resource use, equity, acceptability, and feasibility. EtD frameworks document those judgments so users can see how and why a recommendation was reached.¹³ Empirically, using an EtD framework is associated with more comprehensive consideration of decision criteria, especially including values, equity, and acceptability as key measures and outcomes, and generating guidelines of higher quality and more credible, transparent, implementable recommendations for public health policy.¹⁴

The most widely adopted EtD framework is the GRADE EtD framework, which is structured into three components: the background with the public health question, assessment and conclusions.¹³ Typical GRADE EtD frameworks include twelve criteria and are flexible, having been adapted to different public health decision types.¹⁵ Assessment criteria for GRADE EtD frameworks include: priority of the problem, benefits and harms, certainty of the evidence, values and preferences patients place on outcomes, balance of effects, cost-effectiveness, equity, acceptability to stakeholders, and feasibility of implementation.¹⁵ Conclusions utilizing this framework for public health decisions captures the recommendation, its strength and direction, justification, implementation considerations, monitoring/evaluation, and research priorities, even with capabilities of incorporating decision thresholds for judging the magnitude of benefits and harms for public health recommendations.^{16,17}

Policymaking and Board Reports

Policymaking board reports typically do not use grading systems because board-level decisions require the consideration of multiple, often competing factors that cannot be accurately captured by

a single score, rating, or application.^{18,19} Boards are responsible for evaluating evidence, weighing risks and benefits, considering strategic and operational implications, and exercising independent judgment.¹⁸ As a result, governance guidance emphasizes the importance of balanced, decision-oriented reporting rather than simplistic rankings. A well-designed report from a board should provide a balanced assessment of principal risks and sufficient information to support effective decision-making, underscoring the need for context and analysis rather than summary grades alone.¹⁹ The objective of a board report is typically not to rate a policy, but to equip decision-makers with the information necessary to make an informed and accountable choice. For the AMA, this also includes consideration of the current medical, legal, political and health policy landscape as well as the vast policy developed by the HOD.

Key Challenges to Grading in Board Reports

The GRADE framework and similar grading systems are highly technical and have grown increasingly complex over time. Many organizations charged with developing policy lack the methodological expertise, time, and financial resources to properly implement them.²⁰⁻²² GRADE requires independent, systematic reviews for each important clinical outcome associated with each question, a standard that exceeds even the highest trustworthiness criteria and is beyond the capacity of many guideline and policy efforts.²² A qualitative study of experienced systematic review authors found that even experts struggle with specific domains such as imprecision and indirectness, and cite inadequate training as a major barrier.²⁰

Despite the structured appearance of grading systems, substantial subjective judgment remains embedded in the process. Critics have highlighted that GRADE criteria for evidence-based medical decisions are poorly defined and subject to interpretational variability between clinicians, including a potentially circular relationship between rating evidence quality and designating outcomes as critically important.²² Assessments of "directness" (applicability of evidence to real-world settings) are value-laden judgments that may not reflect the perspectives of end-users and stakeholders, yet they are folded into evidence quality ratings in ways that obscure their subjective nature.²² GRADE EtD frameworks have alternatively supported a broader capability of GRADE criteria incorporating multiple layers of assessment criteria, including equity, cost-effectiveness, and perspectives of stakeholders, that can more aptly be applied to public health decisions. However, conversely with board reports, GRADE EtD frameworks are structured, technocratic, rational-choice tools, and that origin is exactly why they map poorly onto the realities of policy making and advocacy. Their core limitations for the political, values-laden, and contested nature of policy and advocacy are well documented.^{23,24} Policy decisions are multidimensional, making the distillation of all the factors to a single grade obscure or mask important trade-offs in a decision.

Grading systems frequently produce conditional/weak recommendations, which create significant difficulties for a board charged with implementation of or recommendations to develop new policy. As the Surviving Sepsis Campaign guidelines note, conditional recommendations "may be less appropriate for policy or performance measure" because they acknowledge that the balance of benefits and harms varies by patient values, clinical context, and resource availability.²⁵ The ACP similarly states that conditional recommendations "are not directly suited to translation into performance measures".²⁶ This leaves policymakers in a difficult position: much of the evidence base yields recommendations that resist the binary yes/no decisions boards often need to make.

Your Board appreciates that the resolution is seeking to instill increased precision and certainty in BOT reports. As discussed above, given the types and range of issues contained in BOT Reports requested by the HOD, your Board does not advise using ratings systems to avoid giving a false sense of certainty or precision. Your Board does not believe that a grading system can accurately

negotiate the fact that public policy decisions are frequently made under conditions of uncertainty, incomplete information, and evolving evidence. Organizations such as the Organization for Economic Co-Operation and Development note that effective policymaking depends on evidence-informed decision-making and that governments often face challenges translating complex evidence into policy choices.²⁷ In such circumstances, a grade (e.g., A, B, or C) may imply greater certainty or consensus than actually exists, potentially obscuring important assumptions, limitations, and areas of disagreement. Additionally, grading systems can mask important trade-offs among decision criteria. A policy option may perform strongly in one domain, such as scientific effectiveness, while creating implementation challenges, budgetary concerns, or equity implications.

Also consider that the GRADE Public Health Group identified five key challenges in applying evidence grading to public health policy decisions. These include: 1. incorporating diverse stakeholder perspectives beyond the traditional patient-clinician relationship; 2. selecting and prioritizing important non-health outcomes, such as economic, social, and environmental impacts; 3. determining decision-making thresholds when evidence does not clearly support one option over another; 4. assessing the certainty of evidence from non-randomized studies, which often form the primary evidence base for policy questions but are initially rated as low certainty within GRADE; 5. and translating conditional recommendations into practical, actionable policy decisions.²⁸ The inherent bias against observational evidence is a particularly significant barrier, where the initial low starting level for non-randomized studies was identified as the major reported barrier to using GRADE in health policymaking.²⁹

Evidence Transparency in Board Reports

For scientific and health policy, evidence is often presented in a multidimensional way in terms of the strength or certainty of evidence, quality of studies, benefit-risk assessments, confidence levels, and scenario analyses rather than simple grades. The GRADE framework, widely used by organizations such as Cochrane, World Health Organization, and the Centers for Disease Control and Prevention advisory committees, specifically evaluates the certainty and quality of evidence and communicates the degree of confidence decision-makers can place in study findings.^{30,31} The U.S. Food and Drug Administration (FDA) employs a structured benefit-risk framework for regulatory decision-making that explicitly considers benefits, risks, risk management options, and the impact of uncertainty on decisions regarding drugs and biologics.³² Additionally, policy and governance bodies increasingly use strategic foresight and scenario analysis to explore alternative futures, test assumptions, and inform decision-making under conditions of uncertainty. These approaches communicate uncertainty, transparency, and scientific rigor more effectively than a single summary grade because they provide decision-makers with information about the quality of the underlying evidence, the confidence that can be placed in conclusions, and the range of possible outcomes. At their core, BOT Reports provide recommendations, and the BOT has confidence that the HOD—as it has done historically—will continue to debate, evaluate, and make its own determinations about the strength and relevance of those recommendations.

CONCLUSION

Physicians use EBM to support confident clinical decision-making by applying grading systems and levels of evidence to clinical recommendations. Policymaking boards, in contrast, generally avoid grading systems because grades can oversimplify complex issues, obscure uncertainty, and weaken the board's responsibility to exercise informed judgment. Your Board works to provide reports to the HOD that emphasize evidence, benefits, risks, weigh different options, and provide recommendations for consideration. BOT reports incorporate the expertise of our professional

1 AMA staff and analysis of the current political, scientific and health care landscape.
2 Recommendations are made weighing the risks and benefits of multiple factors and are supported
3 by clear rationale and with full consideration of existing AMA policy. These complementary—and
4 competing—considerations ultimately resist known grading systems.

5
6 RECOMMENDATION

7
8 The Board of Trustees recommends that Resolution 520, A-25, "Study of Grading Systems in
9 AMA Board Reports" not be adopted and the remainder of the report be filed.

Fiscal Note: Minimal.

APPENDIX

Figure 1. Level of Evidence Pyramid³³

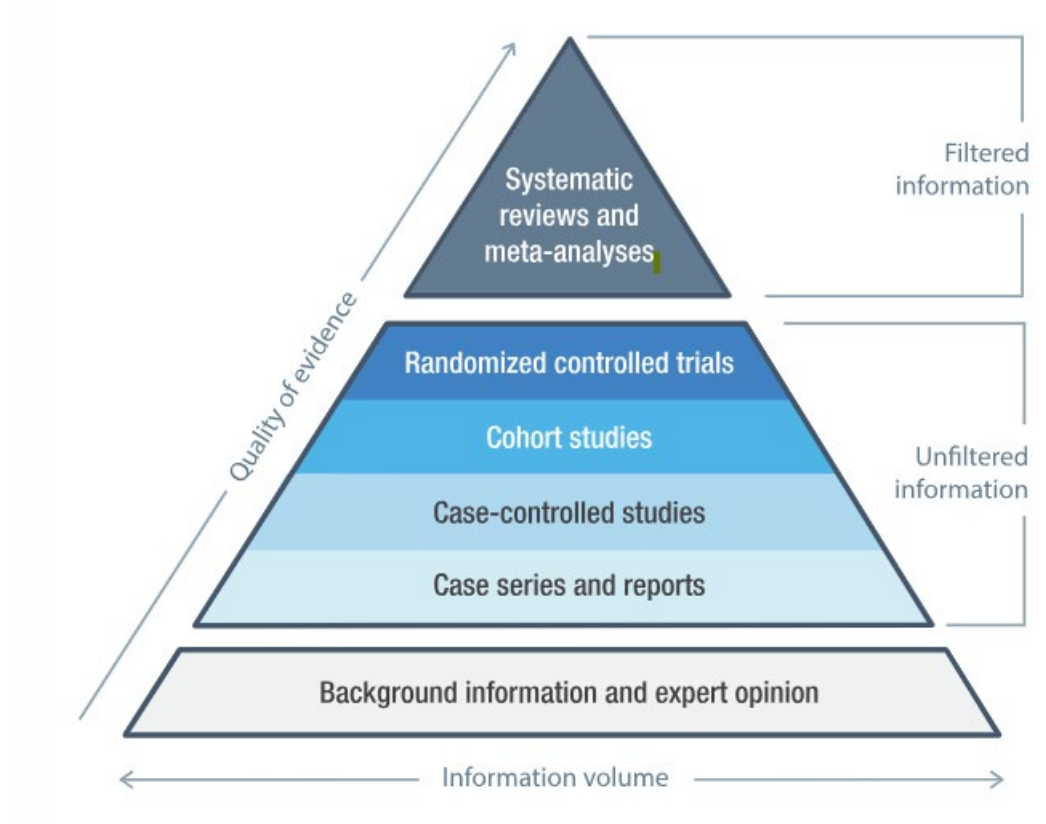


Table 1. Level of Evidence and Grades of Recommendations⁶

Grade of Recommendation	Level of Evidence	Type of Study
A	1a	Systematic review of (homogeneous) randomized controlled trials
A	1b	Individual randomized controlled trials (with narrow confidence intervals)
B	2a	Systematic review of (homogeneous) cohort studies of "exposed" and "unexposed" subjects
B	2b	Individual cohort study / low-quality randomized control studies
B	3a	Systematic review of (homogeneous) case-control studies
B	3b	Individual case-control studies
C	4	Case series, low-quality cohort or case-control studies
D	5	Expert opinions based on non-systematic reviews of results or mechanistic studies

Table 2. Comparison of Evidence-based Grading Systems

Grading System	Evidence Levels	Recommendation Strength	Key Features
GRADE ³⁴	High, Moderate, Low, Very Low	Strong, Weak/Conditional	Most widely adopted; explicit domains (bias, inconsistency, indirectness, imprecision, publication bias); can upgrade observational evidence
USPSTF ³⁵	High, Moderate, Low (certainty)	A, B, C, D, I (insufficient)	Focused on preventive services; grades reflect net benefit magnitude by certainty
ACC/AHA ³⁶	A, B-R, B-NR, C-LD, C-EO	Class I, IIa, IIb, III (benefit/harm)	Distinguishes randomized (B-R) vs nonrandomized (B-NR); expert opinion (C-EO); matrix format
Oxford CEBM ⁹	1 to 5 (by study design)	No formal recommendation grading	Hierarchical by study type; question-specific (therapy, diagnosis, prognosis); levels vary by clinical question
AHRQ ¹⁰	High, Moderate, Low, Insufficient	No formal recommendation grading	Endorses/uses GRADE; rates "strength of evidence" via Evidence-based Practice Centers
NICE ¹¹	High, Moderate, Low, Very Low (adopted GRADE)	Adopted GRADE (strong/conditional)	Transitioned to GRADE in 2007; UK-focused; incorporates cost-effectiveness

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REPORT OF THE BOARD OF TRUSTEES

BOT Report 10-I-26

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates

Presented by: Toluwalasé A. Ajayi, MD, Chair

Referred to: Reference Committee F

At the 2024 Interim Meeting, the House of Delegates adopted Policy D-600.951, “Reimbursement of Necessary Business Meeting Expenses for Delegates and Alternates.” This policy directs the following:

1. Our American Medical Association will issue a report at the 2025 Annual Meeting, and each meeting thereafter, identifying the number of delegates and alternate delegates supported by the grants and the total amount provided under our AMA House of Delegates Emergency Assistance Program (HOD EAP).
2. Our AMA will provide the House of Delegates with reports on a regular cadence detailing ongoing work regarding House of Delegates meetings to mitigate costs, explore solutions, and maintain participation while reducing the financial burden on all parties over the long term.
3. Our AMA will not reduce by one day the 2025 Annual and Interim Meetings and will issue a report for consideration at the 2025 Annual Meeting outlining details for potential changes to the length and format of future House of Delegates meetings.

DISCUSSION

As stated in Board of Trustees Report 16-I-24, the AMA Board of Trustees established the Emergency Assistance Program (EAP) as a temporary program funded at no more than \$1 million annually for two years, beginning with the 2025 Annual Meeting, and specifically provided that it would end after the 2026 Interim Meeting. The program provided financial assistance to eligible Federation organizations while the AMA considered ways to reduce the cost of HOD participation.

Societies were required to apply in each program year. For eligibility purposes, the estimated cost of attending two HOD meetings for nine nights was set at \$5,000 per delegate or alternate delegate. A society qualified when its apportioned delegate and alternate positions multiplied by \$5,000 exceeded 2 percent of the combined revenue reported on the most recent Forms 990 for the society's 501(c)(3) and related 501(c)(6) organizations. Approved societies then submitted a request for each meeting covering delegates, alternates, regional medical student delegates, and sectional resident and fellow delegates. The AMA paid 50 percent in advance and calculated the balance using verified attendance. Funding was capped at \$100,000 per organization across both meetings in a calendar year.

Summary of EAP Participation

The EAP operated in 2025 and 2026. The program funded 764 attendees and paid \$1,066,000 through the 2026 Annual Meeting. Current requests for the 2026 Interim Meeting would bring the two-year total to 1,110 attendees and \$1,446,200. Aggregate results are provided in Appendix A. The EAP did not require participating societies to submit financial remediation plans or report changes in their financial condition.

In 2025, 21 of 186 eligible constituent and national specialty societies applied and 18 qualified. The qualifying societies held 275 of the 1,288 delegate and alternate positions available to those organizations, or 21.4 percent. Two applicants did not meet the 2 percent revenue threshold, and one could not provide the required tax documentation.

In 2026, 24 of 189 eligible constituent and national specialty societies applied and 21 qualified. The qualifying societies held 315 of the 1,400 available delegate and alternate positions, or 22.5 percent. All 18 societies that qualified in 2025 qualified again in 2026, and three additional societies qualified. A further inquiry did not result in an application.

Funding requests for the 2026 Interim Meeting remain in process. Current requests cover 346 attendees and \$380,200. If every eligible delegate, alternate, regional medical student delegate, and sectional resident or fellow delegate were funded, the maximum would be 352 attendees and \$422,400. Final figures will be based on submitted requests and verified attendance.

Cost mitigation efforts

The AMA has continued to seek savings through hotel and travel discounts, negotiated food, beverage, audiovisual, power, internet, and meeting-room terms, virtual viewing options, and complimentary childcare. These measures reduce some expenses but do not eliminate the underlying cost of sending delegations to two national meetings each year. The AMA has also adjusted HOD schedules and processes to explore whether future meetings could be shortened. A shorter meeting could potentially reduce some travel expense and time away from practice.

Actual EAP funding was \$653,500 in 2025. Based on current requests, 2026 funding is projected at \$792,700, an increase of 21.3 percent. Funding could reach \$834,900 if all eligible positions were funded for the 2026 Interim Meeting. Meeting and travel costs have increased by approximately 10 to 20 percent in several categories, and the HOD has continued to grow. A fixed subsidy would cover a declining share of participating societies' expenses. An indexed subsidy would create an increasing AMA obligation. For illustration, annual funding of \$792,700 would exceed \$1 million in the third year at 10 percent annual growth and in the second year at 20 percent annual growth.

CONCLUSION

The EAP provided the temporary assistance for which it was created and will conclude after the 2026 Interim Meeting. It was not designed to establish permanent AMA financing of delegation expenses. Extending the program in its current form would create a recurring obligation whose value would decline if funding remained fixed and whose cost would increase if adjusted for travel costs and HOD growth.

The Board therefore believes the EAP should sunset as planned. It reflects the program's stated duration and the need to use AMA resources in a fiscally responsible manner.

1 RECOMMENDATION

2

3 The Board of Trustees recommends that Policy D-600.951, "Reimbursement of Necessary
4 Business Meeting Expenses for Delegates and Alternates," be rescinded as having been
5 accomplished by this report and the remainder of the report be filed.

Fiscal Note: Minimal

Eligible-universe denominator: 1,288 delegate and alternate positions at each 2025 meeting and 1,400 at each 2026 meeting. Organization-level entries reproduce the V3 appendix; reconciled program totals are shown separately where V3 did not agree with the final aggregate accounting.

Table 1. 2025 Annual Meeting EAP Summary of Support

2025 EAP eligible organizations	2025 apportionmen		A-25 funding request					A-25 actual verified attendance						Total A-25 funding		
	Del.	Alt.	Del. & alt.	MSS	RFS	Requested grant	Initial payment	Del.	Alt.	MSS del.	MSS alt.	RFS del.	RFS alt.	Attendance grant	Less initial	Final installment
Arizona Medical Association	5	5	10	-	-	\$15,000	\$7,500	5	1					\$9,000	\$7,500	\$1,500
Colorado Medical Society	6	6	12	1	3	\$24,000	\$12,000	6	5	1		2	1	\$22,500	\$12,000	\$10,500
Connecticut State Medical Society	4	4	8	3	2	\$19,500	\$9,750	4	3	1	1	1		\$15,000	\$9,750	\$5,250
Florida Medical Association	17	17	34	1	-	\$52,500	\$26,250	17	12	1				\$45,000	\$26,250	\$18,750
Hawaii Medical Association	2	2	2	-	-	\$3,000	\$1,500	2						\$3,000	\$1,500	\$1,500
Illinois State Medical Society	12	12	24	1	2	\$40,500	\$20,250	12	8	1		1	1	\$34,500	\$20,250	\$14,250
Kansas Medical Society	3	3	6	2	-	\$12,000	\$6,000	3	3	1				\$10,500	\$6,000	\$4,500
Kentucky Medical Association	5	5	10	-	-	\$15,000	\$7,500	5	5					\$15,000	\$7,500	\$7,500
Louisiana State Medical Society	7	7	9	1	-	\$15,000	\$7,500	7	-	1				\$12,000	\$7,500	\$4,500
Medical Society of Georgia	7	7	14	1	1	\$24,000	\$12,000	7	6	1		1		\$22,500	\$12,000	\$10,500
Medical Society of the District of Columbia	2	2	4	-	-	\$6,000	\$3,000	2	1					\$4,500	\$3,000	\$1,500
Medical Society of New Jersey	9	9	16	1	-	\$25,500	\$12,750	9	5	1				\$22,500	\$12,750	\$9,750
Medical Society of the State of New York	23	23	41	3	2	\$69,000	\$34,500	23	12	2		2		\$58,500	\$34,500	\$24,000
Michigan State Medical Society	14	14	23	-	2	\$37,500	\$18,750	13	6			1	1	\$31,500	\$18,750	\$12,750
Missouri State Medical Association	6	6	9	1	1	\$16,500	\$8,250	6	4		1	1		\$18,000	\$8,250	\$9,750
Ohio State Medical Association	12	11	19	3	1	\$34,500	\$17,250	12	7	1	2	2		\$36,000	\$17,250	\$18,750
Rhode Island Medical Society	2	2	4	-	1	\$7,500	\$3,750	2	2			1		\$7,500	\$3,750	\$3,750
West Virginia State Medical Association	2	2	2	-	-	\$3,000	\$1,500	2	-					\$3,000	\$1,500	\$1,500
V3 source totals	138	137	247	18	15	\$420,000	\$210,000	137	80	11	4	12	3	\$370,500	\$210,000	\$160,500
Reconciled program total								216 D/A		16 MSS		14 RFS		246 attendees / \$368,400		

The V3 organization rows total 247 attendees and \$370,500; final program accounting reports 246 attendees and \$368,400.

Table 2. 2025 Interim Meeting EAP Summary of Support

2025 EAP eligible organizations	2025 apportionmen		I-25 funding request					I-25 actual verified attendance						Total I-25 funding		
	Del.	Alt.	Del. & alt.	MSS	RFS	Requested grant	Initial payment	DeL.	Alt.	MSS del.	MSS alt.	RFS del.	RFS att.	Attendance grant	Less initial	Final installment
Arizona Medical Association	5	5	10	3		\$15,600	\$6,000	5	3					\$9,600	\$6,000	\$3,600
Colorado Medical Society	6	6	12	1	3	\$19,200	\$9,600	6	6	1		2	1	\$19,200	\$9,600	\$9,600
Connecticut State Medical Society	4	4	8	3	2	\$15,600	\$7,800	4	3	1	2	2		\$14,400	\$7,800	\$6,600
Florida Medical Association	17	17	28	2		\$36,000	\$17,400	17	11	1				\$34,800	\$17,400	\$17,400
Hawaii Medical Association	2	2	3			\$3,600	\$1,800	2	1					\$3,600	\$1,800	\$1,800
Illinois State Medical Society	12	12	24	1	2	\$32,400	\$16,200	12	7	1		1	1	\$26,400	\$16,200	\$10,200
Kansas Medical Society	3	3	6	2	1	\$10,800	\$4,800	3	3	1	1			\$9,600	\$4,800	\$4,800
Kentucky Medical Association	5	5	10			\$12,000	\$6,000	5	5					\$12,000	\$6,000	\$6,000
Louisiana State Medical Society	7	7	14	1		\$18,000	\$9,000	6	-	1				\$8,400	\$9,000	\$(600)
Medical Society of Georgia	7	7	14	2	1	\$20,400	\$10,200	7	6	1		1		\$18,000	\$10,200	\$7,800
Medical Society of the District of Columbia	2	2	4			\$4,800	\$2,400	2	2					\$4,800	\$2,400	\$2,400
Medical Society of New Jersey	9	9	15	1		\$19,200	\$9,600	9	4	1				\$16,800	\$9,600	\$7,200
Medical Society of the State of New York	23	23	44			\$52,800	\$26,400	23	14	2		1	1	\$49,200	\$26,400	\$15,100
Michigan State Medical Society	14	14	24	-	1	\$30,000	\$15,000	13	4			1		\$21,600	\$15,000	\$6,600
Missouri State Medical Association	6	6	9	1	1	\$13,200	\$6,600	6	3		1			\$12,000	\$6,600	\$5,400
Ohio State Medical Association	12	11	18	3	2	\$27,600	\$13,800	11	5	1	2	2		\$25,200	\$13,800	\$11,400
Rhode Island Medical Society	2	2	3			\$3,600	\$1,800	2	1					\$3,600	\$1,800	\$1,800
West Virginia State Medical Association	2	2	3			\$3,600	\$1,800	1		1				\$2,400	\$1,800	\$600
V3 source totals	138	137	249	20	13	\$338,400	\$166,200	134	78	12	6	10	3	\$291,600	\$166,200	\$117,700
Reconciled program total								212 D/A		18 MSS		13 RFS		243 attendees / \$285,100		

The reconciled I-25 grant total reflects final accounting and application of the \$100,000 annual organizational cap.

Table 3. 2026 Annual Meeting EAP Summary of Support

2026 EAP eligible organizations	2026 apportionmen		A-26 funding request					A-26 actual verified attendance						Total A-26 funding		
	Del.	Alt.	Del. & alt.	MSS	RFS	Requested grant	Initial payment	Del.	Alt.	MSS del.	MSS alt.	RFS del.	RFS att.	Attendance grant	Less initial	Final installment
American College of Medical Quality*	1	1	1	-	-	\$1,500	\$750	1						\$1,500	\$750	\$750
Arizona Medical Association	5	5	10	-	-	\$15,000	\$7,500	5	4					\$13,500	\$7,500	\$6,000
Colorado Medical Society	6	6	12	2	1	\$22,500	\$11,250	6	6		1	2		\$22,500	\$11,250	\$11,250
Connecticut State Medical Society	4	4	8	1	2	\$16,500	\$8,250	4	4	1	1			\$15,000	\$8,250	\$6,750
Florida Medical Association	19	19	34	-	2	\$54,000	\$27,000	19	11	1	1			\$48,000	\$27,000	\$21,000
Hawaii Medical Association	2	2	2	-	-	\$3,000	\$1,500	1						\$1,500	\$1,500	\$0
Illinois State Medical Society	13	13	22	2	1	\$37,500	\$18,750	13	8	1		1	1	\$36,000	\$18,750	\$17,250
Iowa Medical Society	4	4	7	-	-	\$10,500	\$5,250	4	3					\$10,500	\$5,250	\$5,250
Kansas Medical Society	4	4	8	1	2	\$16,500	\$8,250	4	3	1	1	1		\$15,000	\$8,250	\$6,750
Kentucky Medical Association	5	5	10	1	-	\$16,500	\$8,250	5	5				1	\$16,500	\$8,250	\$8,250
Louisiana State Medical Society	7	7	10	-	-	\$14,400	\$7,200	5						\$7,500	\$7,200	\$300
Medical Society of Georgia	7	7	14	2	1	\$25,500	\$12,750	7	7	1				\$22,500	\$12,750	\$9,750
Medical Society of the District of Columbia	2	2	4	-	-	\$6,000	\$3,000	2	1					\$4,500	\$3,000	\$1,500
Medical Society of New Jersey	10	10	15	-	2	\$25,500	\$12,750	10	4	1	1			\$24,000	\$12,750	\$11,250
Medical Society of the State of New York	28	28	56	1	2	\$88,500	\$44,250	28	11	1	1	1		\$63,000	\$44,250	\$18,750
Michigan State Medical Society	14	14	22	1	-	\$34,500	\$17,250	14	7			1		\$33,000	\$17,250	\$15,750
Missouri State Medical Association	7	7	10	1	2	\$19,500	\$9,750	7	3	1	1	1		\$19,500	\$9,750	\$9,750
Ohio State Medical Association	12	11	19	1	3	\$34,500	\$17,250	12	7	1	2	1		\$34,500	\$17,250	\$17,250
Oregon Medical Association	4	4	7	-	-	\$10,500	\$5,250	4	3					\$10,500	\$5,250	\$5,250
Rhode Island Medical Society	2	2	4	-	-	\$6,000	\$3,000	2	2					\$6,000	\$3,000	\$3,000
West Virginia State Medical Association	2	2	4	-	1	\$7,500	\$3,750	2	2	1				\$7,500	\$3,750	\$3,750
V3 source totals	158	157	279	13	19	\$465,900	\$232,950	155	91	10	9	8	2	\$412,500	\$232,950	\$179,550
Reconciled program total								246 D/A		19 MSS		10 RFS		275 attendees / \$412,500		

*National specialty society. All other organizations listed are constituent/state medical societies.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-26

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

Presented by: G. Sealy Massingill, MD, Chair

Referred to: Reference Committee F

The American Medical Association (AMA) House of Delegates (HOD) has experienced sustained and accelerating growth over recent decades, causing logistical challenges and rising costs to attendees, the organizations that send delegations as well as to the AMA. HOD growth also raises questions regarding representational fairness and the efficacy of policymaking processes. The Council on Long Range Planning and Development (CLRPD), responding to a charge from the Board of Trustees (BOT), has undertaken a multi-year evaluation to study the size and apportionment practices of the HOD and propose actionable recommendations. Through partnership, education, and collective engagement, CLRPD is confident that consensus can be achieved.

TIMELINES AND PROCESS

CLRPD's efforts have been intentionally collaborative and data driven. Since the beginning of its efforts the Council has worked to ensure that any member of the House who wished to participate in CLRPD's deliberations had a variety of opportunities to do so. The recommendations contained in this report reflect themes most positively received by members.

CLRPD Report 2-I-25 recommended a one-year pause be placed on delegate growth. In that report the Council provided a comprehensive backdrop on the key policy decisions and historical developments that shaped the current structure of the HOD. While this proposal was not adopted by the House, it did underscore how complex and multi-layered the apportionment issue has become.

Recognizing the need for substantial member input, CLRPD convened an in-person listening session, BOT-appointed focus groups, and three virtual town halls with HOD delegates and alternates. These venues allowed members to engage directly with growth data and future projections as well as provide input on potential recommendations, ensuring the Council's deliberations remained grounded in perspectives from across the House. In addition, surveys distributed to HOD members and analysis conducted with assistance from AMA Strategic Insights, as well as regular communications with business units and executive leadership have contributed to a more nuanced understanding of the implications and feasibility of proposed changes. Through these efforts, more than 700 participants have been engaged.

The engagement process highlighted the necessity for education and consensus-building. Structural reform will require changes to AMA Bylaws and support from a two-thirds supermajority of voting delegates. Therefore, CLRPD's work has prioritized transparency, open communication, and the pursuit of solutions that are practical, equitable, and more likely to receive widespread endorsement

by the House. To that end, the Council also offered informational CLRPD report 1-A-26 to enhance transparency in its process and encourage dialogue around the proposals under consideration. The Council encourages members of the House to review both CLRPD Report [2-I-25](#) and [1-A-26](#), which provide both historical context and detailed information on the processes the Council has used for its evaluation.

KEY CONSIDERATIONS

The evaluation of the HOD's current growth trajectory unearthed several critical themes. One of the most significant findings is the sharp acceleration in delegate numbers since the adoption of policy G-600.027 in 2016, which established parity between state and specialty society delegates (See Appendix A, Graphic 1). This policy, combined with no adjustment being made to the HOD's apportionment ratios as well as the House's current rounding practices by which states and specialties are granted an additional delegate for any fraction of 1,000 members, has led to rapid and compounding growth. Additional factors, including individuals being counted across multiple geographic associations and specialty societies for apportionment purposes, increases in group memberships, and the growth of resident sectional and student regional delegations have contributed to a 44 percent increase in the size of the HOD in the last decade.

As a result, the House now approaches 800 voting delegates and an equal number of apportioned alternates. Projections suggest that, should the current membership growth rate persist, without changes to policy, the HOD will surpass 1,000 members in about five years (See Appendix A, Graphic 2). Benchmarking with other medical and professional societies further emphasizes the anomaly of AMA's House size; very few, if any, comparable national interest associations' policymaking bodies approach the size of the HOD (See Page 3 in CLRPD Report [1-A-26](#)).

Stakeholder feedback confirms a sense of urgency, with many delegates and alternates expressing concern about unchecked growth and a willingness to consider changes. A consistent sentiment from survey, focus group and town hall participation is that solutions must remain fair, protect the voices of smaller and underrepresented groups, and not create sudden or destabilizing disruption. There is also an awareness of the common logistical and financial strains imposed by a growing House, particularly regarding structural meeting costs, venue constraints of HOD policy, and overall manageability of policymaking sessions. The issue of increasing meeting costs has impacted a broad cohort of delegations, with some electing not to bring their full delegation to one or both meetings and/or choosing not to fill alternate delegate seats.

While much of the discussion regarding House growth has appropriately focused on the direct financial implications for the AMA, the Council recognizes that a substantial portion of the investment required to sustain the House is borne by constituent state medical associations and national specialty societies. These organizations incur significant expenses associated with delegate and alternate participation, including travel, lodging, registration, staff support, and other governance-related activities. As House representation grows, these investments likewise increase, requiring organizations across the federation to devote additional resources to maintaining full participation in the policymaking process.

These expenditures should also be viewed through the lens of opportunity cost. Representative governance is an essential investment in the Association and should not be evaluated solely as an expense. At the same time, every dollar committed to governance is a dollar that cannot be invested elsewhere in an organization's mission. Resources devoted to supporting larger delegations are resources unavailable for other mission-driven priorities, including:

- 1 • Legislative advocacy and regulatory engagement.
- 2 • Grassroots physician advocacy and public outreach.
- 3 • Leadership development programs for physicians at all career stages.
- 4 • Medical student and resident leadership training, scholarships, mentorship, and advocacy
- 5 experiences.
- 6 • Continuing medical education and other scientific and educational programs for physicians
- 7 and physicians in training.
- 8 • Member recruitment, retention, and engagement initiatives, including state and specialty
- 9 society annual meetings.
- 10 • Investments in innovation, quality improvement, and other strategic organizational
- 11 priorities.

12 Although the financial impact varies considerably among constituent organizations based on
 13 delegation size and travel requirements, the cumulative investment across organized medicine is
 14 substantial. By way of illustration, if the full annual cost of supporting a delegate and alternate for
 15 Annual and Interim meetings is approximately \$5,000, then reducing four delegate and alternate
 16 positions would redirect approximately \$20,000 annually toward these mission-driven priorities.
 17 While modest for any individual organization, these costs are incurred across dozens of constituent
 18 state medical associations and specialty societies, representing a collective investment of several
 19 million dollars each year. Evaluation of both the direct costs of governance and the associated
 20 opportunity costs provides a more complete understanding of the tradeoffs associated with
 21 continued House growth and should be considered alongside the logistical, representational,
 22 operational, and stewardship considerations evaluated by the Council. Recognizing venue
 23 considerations, event size and format, contractual and marketing factors, venue availability, and
 24 potential overall cost analysis, AMA Meeting Services is evaluating the feasibility of alternative
 25 venue options; findings from Meeting Services remain under review.

26
 27 As a result of these financial pressures, the Emergency Assistance Program (EAP) was
 28 implemented at the 2024 Interim Meeting and expired at I-26. According to BOT Report 30-A-26,
 29 for the 2025 Annual and Interim Meetings, \$751,200 was made available for 18 approved societies.
 30 Of this amount, \$653,500 was distributed among 246 delegates and alternate delegates-- this
 31 includes 14 sectional residents and fellows and 16 regional students at A-25, and 243 delegates and
 32 alternates, 13 sectional resident/fellows and 18 regional students at I-25. Additionally, 21
 33 organizations met the criteria for the EAP at A-26, with grants potentially amounting to \$872,200
 34 for 315 delegates and alternates, 22 regional medical students and 15 sectional residents and
 35 fellows for A-26 and I-26. The \$121,000 increase in potential grants between 2025 and 2026
 36 corresponded with an increase of 60 delegates year-over-year. The final amount distributed will be
 37 based on attendance at those two meetings.

38
 39 In an era where organized medicine's value proposition to its members is increasingly measured by
 40 the outcomes it delivers, it is appropriate to evaluate not only the investment required for
 41 representative governance, but also the opportunities forgone when finite organizational resources
 42 are allocated to one mission rather than another. The question is therefore not whether
 43 representative governance is worth the investment, but whether the marginal investment in
 44 additional representation yields greater organizational value than alternative investments that
 45 advance the mission of organized medicine.

46 47 MEMBER INPUT

48
 49 In its review, the Council has presented several possible solutions to HOD members, both through
 50 the BOT-appointed focus group and town hall polling and has used the results of these exercises to

guide its recommendations. One hundred and fifty-eight HOD members attended at least one of the town hall sessions, and the percentages reported in this section of the report reflect the opinions of those attendees. The delegate status and delegation affiliation of those attendees are as follows displaying a representative group of attendees:

Attendees	Percentage
Delegate Status	
Delegates	62.3%
Alternate Delegates	27.8%
Other	9.9%
Affiliation	
State Association	38.9%
Specialty Society	33.3%
AMA Sections	6.2%
Resident Sectional	8.7%
Student Regional	6.8%
Other National Associations	1.2%
Other	4.9%

The Council also acknowledges that there remains a sentiment among some that continued growth should not be viewed negatively, as well as persistent concerns about ensuring access and participation for new and diverse constituencies. While a subject this complex and personal to many is unlikely to garner unanimous approval, the Council has focused on identifying solutions viewed by most as reasonable and equitable while keeping in mind all these considerations.

Recommendations to adjust the apportionment ratio to one delegate per 1,500 members (and proportional changes for student and resident delegates) or one delegate per 1,250 members were considered and discussed in depth. While a recommendation to adjust the current apportionment ratio is not made in this report, the Council believes that the concept warrants further consideration.

Proposals that received the strongest support during town hall polling and focus group sessions, some of which exceeded two-thirds support among attendees, focused on a more gradual approach. The most widely supported options were placing a temporary cap on delegate growth (71.0 percent support) and removing the “or fraction thereof” clause from the apportionment bylaws for additional delegates (70.4 percent support), which would correct artificial inflation in delegate numbers and bring a measure of stability to the apportionment process. It is important to note that while all delegates and alternates were encouraged to attend; town halls were attended by a subset of HOD, not the full governing body (See Appendix C).

Town hall discussions further examined concerns about threats to small specialty societies, possible exclusion of new or underrepresented voices, and the need for alternate ways to participate in AMA advocacy and deliberation beyond participating directly in the House. These perspectives underscore the vital need for ongoing engagement and evaluation.

CONCLUSION

Drawing from extensive stakeholder engagement and policy review, CLRPD has outlined a set of proposals to temporarily stop the growth of the House and make a modest reduction in its size. The Council’s focus remains firmly on developing a structure for the HOD that upholds the principles of effectiveness and fairness, while respecting tradition and ensuring the future sustainability for

1 the body and the future of the AMA, and not simply a response to the current moment. A
2 visualized timeline of proposed implementation of the recommendations and next steps can be
3 found in Graphic 3 of Appendix A.

4
5 The first and second recommendations are to be made in conjunction to cap growth while also
6 immediately implementing bylaws changes. The first recommendation suggests capping the size of
7 the HOD at its current level of 793 delegates for 2027 apportionment, based on year-end 2025
8 membership figures. Constituent society allocation will be capped at 351 and specialty society
9 delegates will likewise be capped at 351 to be apportioned according to Specialty and Service
10 Society (SSS) procedures, with all other delegations maintaining 2026 apportionment levels. This
11 recommendation is being made in accordance with the second recommendation to remove “or
12 fraction thereof” from bylaws dealing with additional delegates via immediate proposed bylaws
13 changes that would take effect for 2027 apportionment.

14
15 The rationale behind this first recommendation is to alleviate the immediate pressure caused by
16 persistent growth while allowing time for implementation of other measures and further
17 consideration by the HOD. Additionally, this temporary cap would allow the second
18 recommendation in this report to be implemented based on already established figures, providing
19 clarity to each delegation on how they are likely to be impacted by the proposal. The Council
20 recognizes that this may mean that certain delegations will not increase in size in 2027 despite
21 membership growth; however, it also believes that reapportioning the HOD at a higher delegate
22 number in 2027 while simultaneously implementing bylaws changes to reduce the size of the
23 House to be circuitous and counterproductive. As noted in the recommendation, this cap will apply
24 only for one year, and in 2028 and moving forward, apportionment will proceed in accordance with
25 new apportionment procedures and based on year-end membership figures from the previous year.

26
27 The Council’s second recommendation is to remove all apportionment language that includes “or
28 fraction thereof” when apportioning additional delegates beyond the first for all delegations. The
29 “or fraction thereof” language facilitated apportionment at a time when the process of obtaining
30 updated accurate membership figures from associations could take months, whereas that
31 information is now available within weeks of the new year. The phrase “or fraction thereof” first
32 appears in AMA archives in a Report of the Committee of Reapportionment in the 1918
33 proceedings of the Annual Session when according to the AMA Constitution, “the total voting
34 membership of the House of Delegates [could] not exceed 150.” Implementation of a standard
35 rounding mechanism (rounding up at 1,500 members and so forth) was also proposed during town
36 hall sessions, but the “fraction thereof” proposal received the most support among attendees.

37
38 The Council wishes to emphasize that this change will not cause the removal of any delegations
39 from the HOD. All associations and societies that gain membership to the House through AMA
40 and SSS policies will be granted at least one delegate; this recommended bylaw change would only
41 apply to the addition of a second and subsequent delegates. This step is projected to bring a
42 measured (93 delegates) reduction in the House’s size. A table projecting how this proposal may
43 impact each delegation within the HOD can be found in Appendix B. The table contains both
44 absolute delegate impact and potential impact to vote share. No delegation would be impacted by
45 more than one delegate, and the impact to delegation vote share ranges from +0.7 percent to -0.1
46 percent. Note that these estimates are based on the apportionment figures provided in January 2026
47 and do not account for delegations added at A-26 and may not incorporate all unique
48 apportionment practices contained in the bylaws and AMA policy, but they should give all
49 delegations an idea of how they are likely to be impacted.

The third and fourth recommendations deal with specialty society membership figures. The third recommends that membership of specialty societies be obtained every three years, as opposed to the current process of obtaining the figures every five years to increase accuracy in apportionment and for the HOD to become more responsive to changes among specialty membership. The fourth recommendation encourages AMA to review its current apportionment processes with a report to the HOD, including the feasibility and costs associated with obtaining membership figures annually, which would align with the membership reporting timeline of constituent associations.

CLRPD offers these recommendations as initial steps toward relieving some of the immediate pressures associated with a rapidly expanding HOD. However, the Council acknowledges that further evaluation and action is still needed and offers its continued collaboration with the Board of Trustees, members of the House, executive leadership, and the broader membership to consider and assess the impacts of the recommendations in this report and potential future recommendations, including further consideration of the delegate apportionment ratios. The Council extends its sincere appreciation to all AMA members who have engaged throughout this process. We remain committed to continuing this dialogue and fostering a culture of ongoing assessment and thoughtful reflection on our AMA's HOD practices, with the shared goal of strengthening a House that is representative, effective and sustainable.

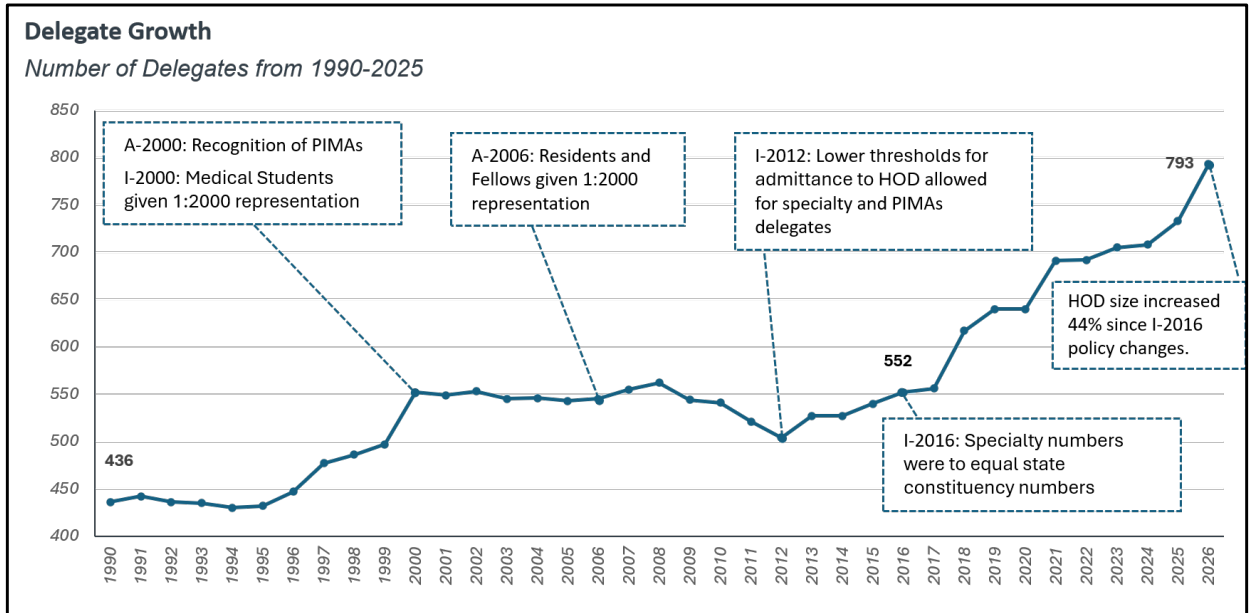
RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed:

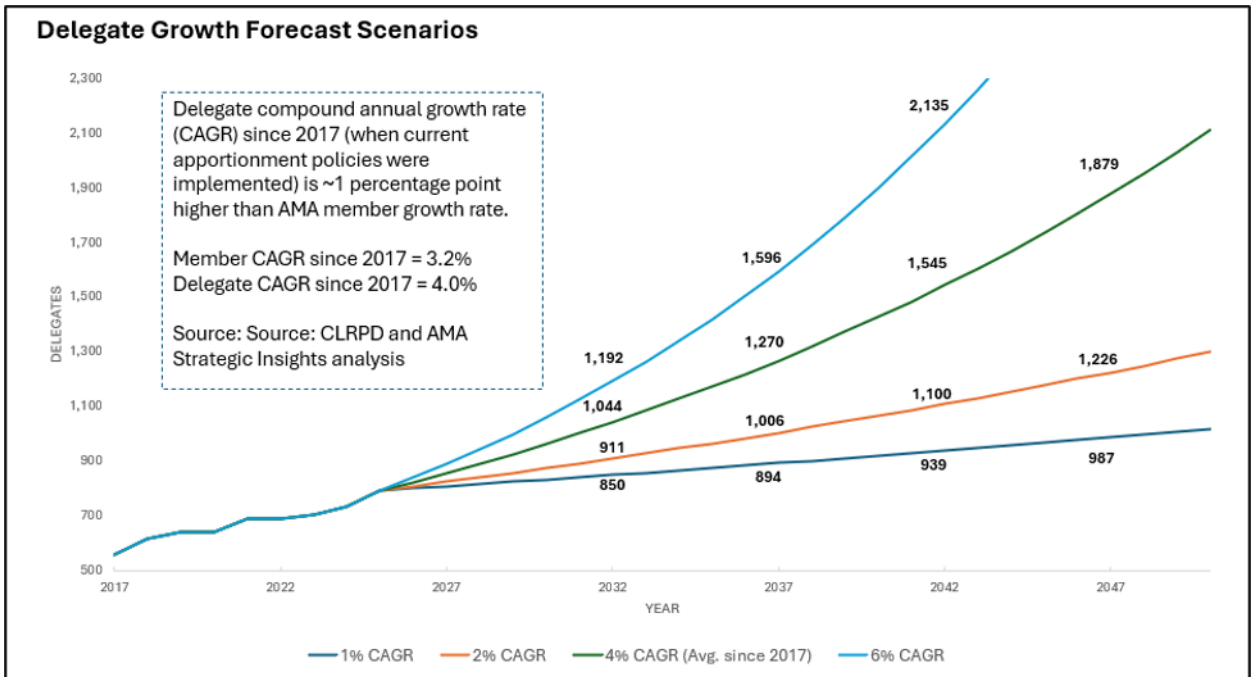
1. That delegate apportionment will be capped at its current level (793 delegates) for 2027 apportionment. Constituent association allocation will remain 351 with a corresponding number of 351 specialty society delegates to be apportioned according to established procedures. All other delegations will continue at their A-26 apportionment. 2028 apportionment will be based on year-end 2027 membership figures and so forth moving forward.
2. That, for 2027 apportionment and onward, the bylaws be amended to delete all apportionment language which includes "or fraction thereof" when apportioning any additional delegates beyond the first, so that additional delegates will not be added for a fraction of the recommended apportionment ratio.
3. That specialty society membership numbers will be obtained every three years as opposed to every five years for increased accuracy.
4. That there is a review of current apportionment rules and procedures with a report back to the HOD at the 2027 Interim Meeting, including assessing the ability to and costs associated with obtaining specialty society membership figures on an annual basis.

Fiscal note: Modest

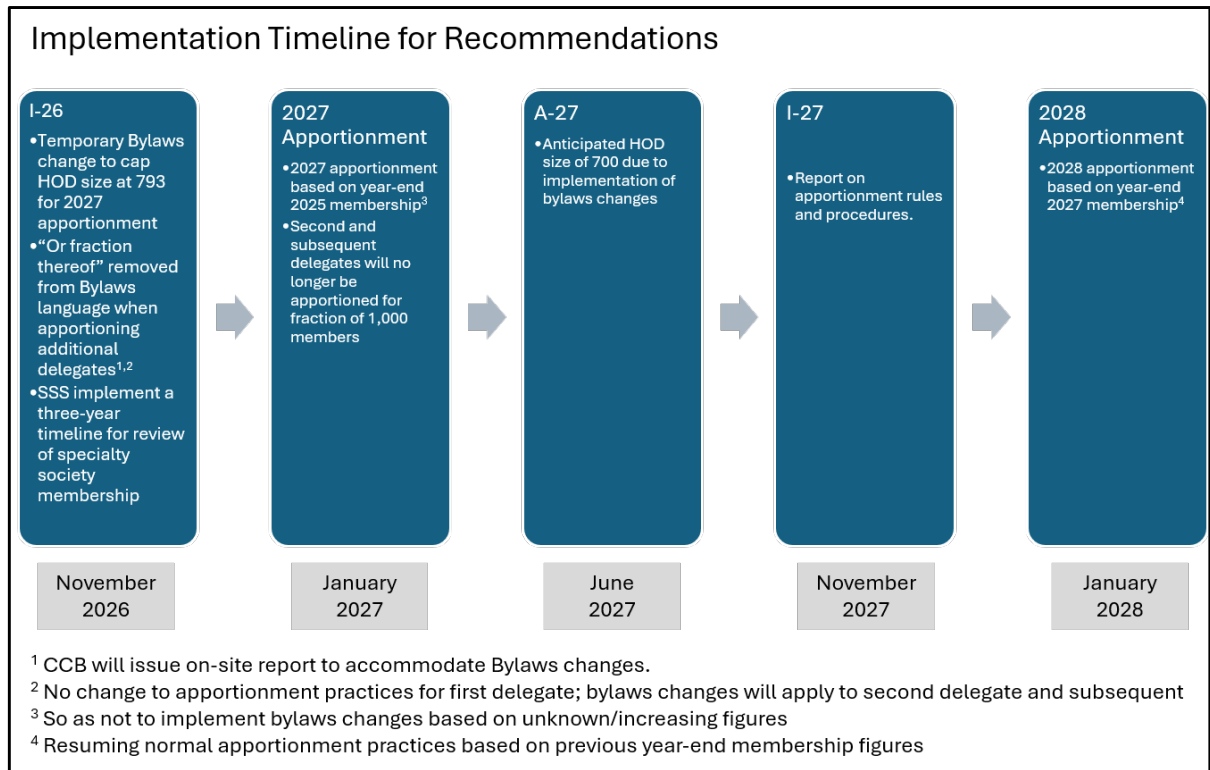
APPENDIX A



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



Graphic 2. Delegate Growth Forecast Scenarios



Graphic 3. Implementation Timeline for Recommendations

APPENDIX B

Projected impacts of recommendations on delegations in the HOD

Association/Society	2026 Delegate Allocation	2027 Delegate Allocation (Proposed)	Difference	2026 Vote Share (Percentage)	2027 Proposed Vote Share (Percentage)	Difference (Percentage)
Academic Physicians Section (APS)	1	1	0	0.126	0.143	0.017
Academy of Consultation-Liaison Psychiatry	1	1	0	0.126	0.143	0.017
Academy of Physicians in Clinical Research	1	1	0	0.126	0.143	0.017
Aerospace Medical Association	1	1	0	0.126	0.143	0.017
Air Force	1	1	0	0.126	0.143	0.017
Alabama	4	3	-1	0.504	0.429	-0.076
Alaska	1	1	0	0.126	0.143	0.017
AMDA-The Society for Post-Acute and Long-Term Care Medicine	2	2	0	0.252	0.286	0.034
American Academy of Addiction Psychiatry	1	1	0	0.126	0.143	0.017
American Academy of Allergy, Asthma and Immunology	1	1	0	0.126	0.143	0.017
American Academy of Child and Adolescent Psychiatry	2	1	-1	0.252	0.143	-0.109
American Academy of Cosmetic Surgery	1	1	0	0.126	0.143	0.017
American Academy of Dermatology Association	5	4	-1	0.631	0.571	-0.059
American Academy of Emergency Medicine	3	2	-1	0.378	0.286	-0.093
American Academy of Facial Plastic and Reconstructive Surgery	1	1	0	0.126	0.143	0.017
American Academy of Family Physicians	26	25	-1	3.279	3.571	0.293
American Academy of Hospice and Palliative Medicine	2	2	0	0.252	0.286	0.034
American Academy of Insurance Medicine	1	1	0	0.126	0.143	0.017
American Academy of Neurology	4	3	-1	0.504	0.429	-0.076
American Academy of Ophthalmology	4	3	-1	0.504	0.429	-0.076
American Academy of Orthopaedic Surgeons	5	4	-1	0.631	0.571	-0.059
American Academy of Otolaryngic Allergy Inc.	1	1	0	0.126	0.143	0.017
American Academy of Otolaryngology-Head and Neck Surgery	4	3	-1	0.504	0.429	-0.076
American Academy of Pain Medicine	1	1	0	0.126	0.143	0.017
American Academy of Pediatrics	5	4	-1	0.631	0.571	-0.059
American Academy of Physical Medicine and Rehabilitation	3	2	-1	0.378	0.286	-0.093
American Academy of Psychiatry and the Law	1	1	0	0.126	0.143	0.017
American Academy of Sleep Medicine	2	1	-1	0.252	0.143	-0.109
American Association for Geriatric Psychiatry	1	1	0	0.126	0.143	0.017
American Association for Hand Surgery	1	1	0	0.126	0.143	0.017
American Association for Thoracic Surgery	1	1	0	0.126	0.143	0.017
American Association of Clinical Endocrinology	2	2	0	0.252	0.286	0.034
American Association of Clinical Urologists, Inc.	2	1	-1	0.252	0.143	-0.109
American Association of Gynecologic Laparoscopists	2	1	-1	0.252	0.143	-0.109
American Association of Hip and Knee Surgeons*	2	2	0	0.252	0.286	0.034
American Association of Neurological Surgeons	2	2	0	0.252	0.286	0.034
American Association of Neuromuscular & Electrodiagnostic Medicine	2	2	0	0.252	0.286	0.034
American Association of Physicians of Indian Origin	1	1	0	0.126	0.143	0.017
American Association of Plastic Surgeons	1	1	0	0.126	0.143	0.017
American Association of Public Health Physicians	1	1	0	0.126	0.143	0.017
American Clinical Neurophysiology Society	1	1	0	0.126	0.143	0.017
American College of Allergy, Asthma and Immunology	2	2	0	0.252	0.286	0.034
American College of Cardiology	9	8	-1	1.135	1.143	0.008
American College of Chest Physicians (CHEST)	3	2	-1	0.378	0.286	-0.093
American College of Emergency Physicians	9	8	-1	1.135	1.143	0.008
American College of Gastroenterology	4	3	-1	0.504	0.429	-0.076
American College of Legal Medicine	1	1	0	0.126	0.143	0.017
American College of Lifestyle Medicine	2	2	0	0.252	0.286	0.034
American College of Medical Genetics and Genomics	1	1	0	0.126	0.143	0.017
American College of Medical Quality	1	1	0	0.126	0.143	0.017
American College of Mohs Surgery	1	1	0	0.126	0.143	0.017
American College of Nuclear Medicine	1	1	0	0.126	0.143	0.017
American College of Obstetricians and Gynecologists	14	13	-1	1.765	1.857	0.092
American College of Occupational and Environmental Medicine	2	2	0	0.252	0.286	0.034
American College of Physicians	26	25	-1	3.279	3.571	0.293
American College of Preventive Medicine	1	1	0	0.126	0.143	0.017

Association/Society	2026 Delegate Allocation	2027 Delegate Allocation (Proposed)	Difference	2026 Vote Share (Percentage)	2027 Proposed Vote Share (Percentage)	Difference (Percentage)
American College of Radiation Oncology	1	1	0	0.126	0.143	0.017
American College of Radiology	8	7	-1	1.009	1.000	-0.009
American College of Rheumatology	2	2	0	0.252	0.286	0.034
American College of Surgeons	14	13	-1	1.765	1.857	0.092
American Contact Dermatitis Society	1	1	0	0.126	0.143	0.017
American Epilepsy Society*	1	1	0	0.126	0.143	0.017
American Gastroenterological Association	3	2	-1	0.378	0.286	-0.093
American Geriatrics Society	2	2	0	0.252	0.286	0.034
American Hernia Society	1	1	0	0.126	0.143	0.017
American Institute of Ultrasound in Medicine	2	2	0	0.252	0.286	0.034
American Medical Group Association	1	1	0	0.126	0.143	0.017
American Medical Women's Association	1	1	0	0.126	0.143	0.017
American Orthopaedic Association	1	1	0	0.126	0.143	0.017
American Orthopaedic Foot and Ankle Society	1	1	0	0.126	0.143	0.017
American Osteopathic Association	1	1	0	0.126	0.143	0.017
American Psychiatric Association	9	8	-1	1.135	1.143	0.008
American Rhinological Society	1	1	0	0.126	0.143	0.017
American Roentgen Ray Society	3	2	-1	0.378	0.286	-0.093
American Society for Aesthetic Plastic Surgery	1	1	0	0.126	0.143	0.017
American Society for Clinical Pathology	3	2	-1	0.378	0.286	-0.093
American Society for Dermatologic Surgery	3	2	-1	0.378	0.286	-0.093
American Society for Gastrointestinal Endoscopy	3	2	-1	0.378	0.286	-0.093
American Society for Laser Medicine and Surgery, Inc	1	1	0	0.126	0.143	0.017
American Society for Metabolic and Bariatric Surgery	1	1	0	0.126	0.143	0.017
American Society for Radiation Oncology	2	2	0	0.252	0.286	0.034
American Society for Reconstructive Microsurgery	1	1	0	0.126	0.143	0.017
American Society for Reproductive Medicine	2	2	0	0.252	0.286	0.034
American Society for Surgery of the Hand	2	2	0	0.252	0.286	0.034
American Society of Addiction Medicine	2	2	0	0.252	0.286	0.034
American Society of Anesthesiologists	8	7	-1	1.009	1.000	-0.009
American Society of Cataract and Refractive Surgery	2	1	-1	0.252	0.143	-0.109
American Society of Colon and Rectal Surgeons	2	2	0	0.252	0.286	0.034
American Society of Cytopathology	1	1	0	0.126	0.143	0.017
American Society of Dermatopathology	1	1	0	0.126	0.143	0.017
American Society of Echocardiography	2	1	-1	0.252	0.143	-0.109
American Society of Hematology	2	1	-1	0.252	0.143	-0.109
American Society of Interventional Pain Physicians	2	2	0	0.252	0.286	0.034
American Society of Maxillofacial Surgeons	1	1	0	0.126	0.143	0.017
American Society of Neuroimaging*	1	1	0	0.126	0.143	0.017
American Society of Neuroradiology	2	1	-1	0.252	0.143	-0.109
American Society of Nuclear Cardiology	2	1	-1	0.252	0.143	-0.109
American Society of Ophthalmic Plastic and Reconstructive Surgery	1	1	0	0.126	0.143	0.017
American Society of Plastic Surgeons	3	2	-1	0.378	0.286	-0.093
American Society of Regional Anesthesia and Pain Medicine	2	2	0	0.252	0.286	0.034
American Society of Retina Specialists	2	2	0	0.252	0.286	0.034
American Society of Transplant Surgeons	1	1	0	0.126	0.143	0.017
American Thoracic Society	2	1	-1	0.252	0.143	-0.109
American Urological Association	2	1	-1	0.252	0.143	-0.109
American Vein & Lymphatic Society	1	1	0	0.126	0.143	0.017
American Venous Forum	1	1	0	0.126	0.143	0.017
AMSUS - The Society of Federal Health Professionals	2	2	0	0.252	0.286	0.034
Arizona	5	4	-1	0.631	0.571	-0.059
Arkansas	3	2	-1	0.378	0.286	-0.093
Army	1	1	0	0.126	0.143	0.017
Association for Clinical Oncology	5	4	-1	0.631	0.571	-0.059
Association of Academic Physiatrists	1	1	0	0.126	0.143	0.017
Association of Academic Radiology	1	1	0	0.126	0.143	0.017
California	45	44	-1	5.675	6.286	0.611
College of American Pathologists	4	3	-1	0.504	0.429	-0.076
Colorado	6	5	-1	0.757	0.714	-0.042
Congress of Neurological Surgeons	2	2	0	0.252	0.286	0.034
Connecticut	4	3	-1	0.504	0.429	-0.076
Delaware	1	1	0	0.126	0.143	0.017
District of Columbia	2	1	-1	0.252	0.143	-0.109
Florida	19	18	-1	2.396	2.571	0.175

Association/Society	2026 Delegate Allocation	2027 Delegate Allocation (Proposed)	Difference	2026 Vote Share (Percentage)	2027 Proposed Vote Share (Percentage)	Difference (Percentage)
Georgia	7	6	-1	0.883	0.857	-0.026
GLMA: Health Professionals Advancing LGBTQ+ Equality	1	1	0	0.126	0.143	0.017
Guam	1	1	0	0.126	0.143	0.017
Hawaii	2	1	-1	0.252	0.143	-0.109
Heart Rhythm Society	3	2	-1	0.378	0.286	-0.093
Idaho	1	1	0	0.126	0.143	0.017
Illinois	13	12	-1	1.639	1.714	0.075
Indiana	6	5	-1	0.757	0.714	-0.042
Infectious Diseases Society of America	2	2	0	0.252	0.286	0.034
Integrated Physician Practice Section (IPPS)	1	1	0	0.126	0.143	0.017
International College of Surgeons - US Section	1	1	0	0.126	0.143	0.017
International Medical Graduates Section (IMGS)	1	1	0	0.126	0.143	0.017
International Pain and Spine Intervention Society	2	2	0	0.252	0.286	0.034
International Society for the Advancement of Spine Surgery	1	1	0	0.126	0.143	0.017
International Society of Hair Restoration Surgery	1	1	0	0.126	0.143	0.017
Iowa	4	3	-1	0.504	0.429	-0.076
Kansas	4	3	-1	0.504	0.429	-0.076
Kentucky	5	4	-1	0.631	0.571	-0.059
LGBTQ+ Section	1	1	0	0.126	0.143	0.017
Louisiana	7	6	-1	0.883	0.857	-0.026
Maine	2	1	-1	0.252	0.143	-0.109
Maryland	6	5	-1	0.757	0.714	-0.042
Massachusetts	14	13	-1	1.765	1.857	0.092
Medical Student Section (MSS)	1	1	0	0.126	0.143	0.017
Michigan	14	13	-1	1.765	1.857	0.092
Minnesota	5	4	-1	0.631	0.571	-0.059
Mississippi	3	2	-1	0.378	0.286	-0.093
Missouri	7	6	-1	0.883	0.857	-0.026
Montana	1	1	0	0.126	0.143	0.017
National Association of Medical Examiners	1	1	0	0.126	0.143	0.017
National Medical Association	1	1	0	0.126	0.143	0.017
Navy	1	1	0	0.126	0.143	0.017
Nebraska	3	2	-1	0.378	0.286	-0.093
Nevada	3	2	-1	0.378	0.286	-0.093
New Hampshire	2	1	-1	0.252	0.143	-0.109
New Jersey	10	9	-1	1.261	1.286	0.025
New Mexico	2	1	-1	0.252	0.143	-0.109
New York	28	27	-1	3.531	3.857	0.326
North American Neuromodulation Society	1	1	0	0.126	0.143	0.017
North American Neuro-Ophthalmology Society	1	1	0	0.126	0.143	0.017
North American Spine Society	2	1	-1	0.252	0.143	-0.109
North Carolina	6	5	-1	0.757	0.714	-0.042
North Dakota	2	1	-1	0.252	0.143	-0.109
Obesity Medicine Association	1	1	0	0.126	0.143	0.017
Ohio	12	11	-1	1.513	1.571	0.058
Oklahoma	4	3	-1	0.504	0.429	-0.076
Oregon	4	3	-1	0.504	0.429	-0.076
Organized Medical Staff Section (OMSS)	1	1	0	0.126	0.143	0.017
Outpatient Endovascular and Interventional Society	1	1	0	0.126	0.143	0.017
Pennsylvania	15	14	-1	1.892	2.000	0.108
Private Practice Physicians Section (PPPS)	1	1	0	0.126	0.143	0.017
Public Health Service	1	1	0	0.126	0.143	0.017
Puerto Rico	2	1	-1	0.252	0.143	-0.109
Radiological Society of North America	3	2	-1	0.378	0.286	-0.093
Renal Physicians Association	2	2	0	0.252	0.286	0.034
Resident and Fellow Section (RFS)	1	1	0	0.126	0.143	0.017
Resident Sectional	42	42	0	5.296	6.000	0.704
Rhode Island	2	1	-1	0.252	0.143	-0.109
Senior Physicians Section (SPS)	1	1	0	0.126	0.143	0.017
Society for Cardiovascular Angiography and Interventions	2	2	0	0.252	0.286	0.034
Society for Cardiovascular Magnetic Resonance	1	1	0	0.126	0.143	0.017
Society for Investigative Dermatology, Inc.	1	1	0	0.126	0.143	0.017
Society for Pediatric Dermatology	1	1	0	0.126	0.143	0.017
Society for Vascular Surgery	2	2	0	0.252	0.286	0.034
Society of American Gastrointestinal Endoscopic Surgeons	2	2	0	0.252	0.286	0.034
Society of Cardiovascular Computed Tomography	2	2	0	0.252	0.286	0.034

Association/Society	2026 Delegate Allocation	2027 Delegate Allocation (Proposed)	Difference	2026 Vote Share (Percentage)	2027 Proposed Vote Share (Percentage)	Difference (Percentage)
Society of Critical Care Medicine	2	1	-1	0.252	0.143	-0.109
Society of Hospital Medicine	3	2	-1	0.378	0.286	-0.093
Society of Interventional Radiology	2	2	0	0.252	0.286	0.034
Society of Nuclear Medicine and Molecular Imaging	1	1	0	0.126	0.143	0.017
Society of Thoracic Surgeons	2	1	-1	0.252	0.143	-0.109
South Carolina	4	3	-1	0.504	0.429	-0.076
South Dakota	2	1	-1	0.252	0.143	-0.109
Student Regional	26	26	0	3.279	3.714	0.436
Tennessee	6	5	-1	0.757	0.714	-0.042
Texas	25	24	-1	3.153	3.429	0.276
The American Society of Breast Surgeons	2	1	-1	0.252	0.143	-0.109
The Endocrine Society	2	1	-1	0.252	0.143	-0.109
The Society of Laparoscopic and Robotic Surgeons	2	1	-1	0.252	0.143	-0.109
The Triological Society	1	1	0	0.126	0.143	0.017
Underrepresented in Medicine Advocacy Section (UMAS)	1	1	0	0.126	0.143	0.017
Undersea and Hyperbaric Medical Society	1	1	0	0.126	0.143	0.017
Utah	3	2	-1	0.378	0.286	-0.093
Veterans Affairs (VA)	1	1	0	0.126	0.143	0.017
Vermont	1	1	0	0.126	0.143	0.017
Virgin Islands	1	1	0	0.126	0.143	0.017
Virginia	7	6	-1	0.883	0.857	-0.026
Washington	7	6	-1	0.883	0.857	-0.026
West Virginia	2	1	-1	0.252	0.143	-0.109
Wisconsin	5	4	-1	0.631	0.571	-0.059
Women Physicians Section (WPS)	1	1	0	0.126	0.143	0.017
Wyoming	1	1	0	0.126	0.143	0.017
Young Physicians Section (YPS)	1	1	0	0.126	0.143	0.017
Total	793	700	-93	100	100	0

Table 1. Impact of Proposed Bylaws Changes on HOD

Delegation Size	2026 Percentage of Delegations	2027 Projected Percentage of Delegations with Bylaw Change Implementation
1 ¹	41.6%	54.2%
2	26.6%	22.0%
3	7.9%	5.6%
4	5.6%	3.7%
5	3.7%	2.3%
6	2.3%	2.3%
7	2.3%	0.9%
8	0.9%	1.4%
9	1.4%	0.5%
10+	7.5%	7.0%

Table 2. Current and Projected Delegation Size Distribution 2026-2027

¹ Delegations comprised of one delegate and alternate delegate will not be impacted by proposed bylaw changes.

Appendix C

CLRPD Town Hall Polling

The Council convened three town hall sessions for HOD members to work toward further developing a shared understanding of the scope of growth of the HOD and the trajectory of future growth, the drivers of that growth, and the proposals under consideration. Across the three town halls, 301 AMA delegates and alternate delegates registered for participation, 184 of whom attended at least one of the sessions. While the poll results were obtained anonymously, it should be noted that 28 participants attended multiple sessions, so it is likely that some attendees responded to the poll more than once. While these sessions were comprised of a representative sample of HOD members, these results reflect only the opinions of those attendees and do not necessarily reflect the will of the House at large.

Attendees were polled on a Likert scale on their likeliness to support each of the proposals. In each poll, they were asked whether they were very likely, somewhat likely, unsure, somewhat unlikely, or very unlikely to support a given proposal. The council used a software platform called Slido to obtain anonymous poll results, which allowed results to be shared with participants in real time. Participation in polling was optional, and the results below reflect the opinions of those participants who chose to respond.

Proposal 1

This proposal suggested removing the language “and fraction thereof” from bylaws and policy related to apportionment of additional delegates after the first for all state and specialty delegations. Under current policy, a second delegate is apportioned to a delegation once they reach 1,001 delegates. Were this proposal to be adopted, a second delegate would be apportioned at 2,000 members, and so on. The size of the HOD would be reduced by 93 delegates across state and specialty delegations using 2026 apportionment figures.

Results

Total Responses: 142

Likely: 100 (70.4%)

Unsure: 16 (11.3%)

Unlikely: 26 (18.3%)

Proposal 2

This proposal was to pause delegate growth while other changes are phased in. This reflects the belief that some immediate stabilization may be necessary to prevent continued expansion while the House considers longer-term reform. This proposal would temporarily cap the total number of delegates at 793.

Results

Total Responses: 145

Likely: 103 (71.0%)

Unsure: 20 (13.8%)

Unlikely: 22 (15.2%)

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-I-26

Subject: Underrepresented in Medicine Advocacy Section Five-Year Review

Presented by: G. Sealy Massingill, MD, Chair

Referred to: Reference Committee F

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

The Council assessed information from the letter of application submitted by the Underrepresented in Medicine Advocacy Section (UMAS), formerly the Minority Affairs Section, for renewal of delineated section status.

APPLICATION OF CRITERIA

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

The UMAS serves as the AMA’s central body for efforts to expand equitable opportunities and diversity in medicine; policy and advocacy initiatives for underrepresented physicians and patients; communication and partnerships with external underrepresented in medicine (URiM) national organizations; convening, education and mentorship for underrepresented members; and advocating to eliminate health disparities.

During the last five years the following priority issues have been the focus of the UMAS:

- Increase equitable opportunities for, and diversity of, medical students, trainees, and physicians: To amplify equitable opportunities and demonstrate representation in historically underrepresented student populations, UMAS co-founded the United Leaders in Advocacy (ULA), which convenes leaders from URiM student medical associations, such as the Student National Medical Association (SNMA), Latino Medical Student Association (LMSA), Association of Native American Medical Students (ANAMS), in addition to leaders from allied sections within our AMA. The bi-annual ULA sessions during each HOD meeting have resulted in increased communication and collaboration between student leaders within organized medicine and fostered opportunities for leadership development for underrepresented medical students.

- 1 • Champion key policy initiatives and advocacy efforts on behalf of underrepresented
2 physicians and patients: Since UMAS became a voting member of our HOD in 2011, the
3 Section has served as the leading voice within the HOD on policy matters that impact
4 underrepresented physicians, trainees, and students, and historically marginalized patient
5 populations. This representation in the HOD was a vital step taken by our AMA to address
6 and remedy historical harms and codified discrimination. The UMAS, alongside the
7 International Medical Graduates Section (IMGS), co-founded a caucus within the Sections
8 to convene on matters of health equity. The caucus expanded in recent years and is now
9 also co-led by the LGBTQ+ Section and the Women Physicians Section (WPS).
10
- 11 • Strengthen communication and partnerships with URiM external organizations: For nearly
12 thirty years, UMAS has served as a conduit between our AMA and URiM national
13 organizations including the National Medical Association (NMA), SNMA, National
14 Hispanic Medical Association (NHMA), LMSA, Association of American Indian
15 Physicians (AAIP), ANAMS, and National Minority Quality Forum (NMQF). UMAS’
16 strategic partnerships with these institutions and their underrepresented physician and
17 medical student members continues to produce valuable relationships and coalitions on
18 policy and educational programming, leadership opportunities on the UMAS Governing
19 Council (GC), liaison between our AMA Board of Trustees leadership and the respective
20 board leaders of these URiM organizations, and UMAS staff and membership presence at
21 these organizations’ annual conventions.
22
- 23 • Create space for underrepresented physicians to convene, learn, and mentor within our
24 AMA: The Section has organized various mentorship sessions, such as the joint Medical
25 Student Section (MSS)-UMAS bi-annual speed mentoring event; leadership development
26 opportunities; educational programs with health equity as a foundational element; policy
27 work groups like the American Indian and Alaska Native (AI/AN) work group; receptions
28 and mixers. These efforts encourage professional development, continued, high-quality
29 medical education, and personal well-being for underrepresented members of our AMA.
30
- 31 • Advocate to eradicate health disparities: In the past five years, UMAS has spearheaded
32 initiatives alongside partners such as NMA, SNMA, NHMA, AAIP, the AMA Advocacy
33 Center, and the AMA Center for Optimal Health Outcomes (COHO). UMAS has hosted
34 and/or supported educational programs and webinars on the high rates of maternal
35 morbidity and mortality among Black patients; amplified the Release the Pressure (RTP)
36 campaign whose mission is to “reduce hypertension in women, especially where disparities
37 hit hardest, through education, community and culturally responsive care”; and spotlighted
38 the health disparities of historically marginalized patient populations in rural areas across
39 the United States.
40

41 Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the
42 AMA. Activities make good use of available resources and are not duplicative.
43

44 UMAS contributes to the AMA’s strategic direction through efforts to embed inclusion in
45 medicine, build alliances, empower members to address upstream drivers of health, and create
46 pathways for the next generation of underrepresented physicians. The Section is in alignment with
47 our AMA’s strategic objectives set forth in its 2024-2025 Organizational Strategic Plan to Advance
48 Health Equity.

49 In August 2025, the UMAS GC developed its 2025-2026 strategic plan with the issues of concern
50 above addressed in the plan’s objectives, goals, and tactics. The section developed SMART

(Specific, Measurable, Achievable, Relevant, Timebound) goals that included increasing the engagement of UMAS members in policymaking activities to include at least ten non-GC members by A-26, resulting in at least five UMAS-sponsored resolutions to the HOD at A-26; collaborating with at least three URiM medical societies to advance UMAS policymaking and advocacy initiatives and completing at least two activities to influence and/or inform AMA policy on the state of public health infrastructure in the United States by A-26; facilitating and/or co-hosting at least four mentorship opportunities annually; and strengthening relationships with medical societies serving underrepresented physicians and/or medical trainees and collaborating on an annual joint program and/or initiative.

Tactics to increase member engagement in policymaking include further defining the UMAS policymaking process and developing a policymaking workshop and a standing committee on policymaking activities. UMAS also works to ensure that resolutions are informed or co-sponsored by other URiM organizations, convenes leaders and staff from URiM organizations to align policy priorities, and integrates ongoing initiatives led by COHO and URiM organizations with the efforts of the Section. The UMAS partners with AMA business units and external organizations to host events during HOD meetings that allow underrepresented physicians to convene, network, and mentor. Additionally, UMAS determined that it would connect with at least one URiM medical society on topics/policy issues of mutual interest and ensure bidirectional reporting, as well as support GC member attendance at URiM medical society conferences.

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

Eligible voters with full rights and privileges are referred to as UMAS members. Membership in UMAS is initiated upon the request of the individual physician or medical student, open to any AMA member physician or medical student who expresses an interest in racial and ethnic underrepresented physicians or health matters affecting historically marginalized communities.

The UMAS GC meets remotely each month and at least four times per year in person. Officer positions on the GC are elected annually in closed session at the Annual Meeting of our HOD. Three URiM physician organizations (NMA, NHMA, and AAIP) nominate representatives to be elected to designated positions on the UMAS GC. Each of the three AMA Sections (MSS, RFS, and YPS) endorse their respective representatives, who are elected by the UMAS membership via electronic ballot. Only current AMA-UMAS members with an active AMA membership are eligible to be nominated to the designated positions on the GC. All UMAS affiliated pages on the AMA website are up to date with a current roster of UMAS leaders and how to best contact their Section leadership and staff through the operational support of UMAS staff.

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.

Over 27,000 underrepresented physicians and medical students are members of our AMA, with over 141,000 underrepresented physicians and medical students are in medicine nationally. According to the Association of American Medical Colleges' (AAMC's) 2023 Physician Workforce Data report (the most recent data available at the time of application), underrepresented physicians make up approximately 12% of the physician workforce. UMAS is able to accurately identify the number of underrepresented medical student and physician members and hosts events

1 during HOD meetings to encourage attendance from underrepresented members and allies creating
2 inclusive spaces and community for all AMA members.

3
4 Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can
5 demonstrate an ongoing and viable group of physicians, who will be represented by this section.
6 Both the segment and the AMA will benefit from an increased voice within the policymaking
7 body.

8
9 On average, UMAS expects between 100-150 attendees across in-person meetings held during
10 annual and interim meetings. In recent years, the Section has seen a consistent increase in the
11 number of attendees during assembly meetings, during which UMAS receives informational and
12 organizational updates from business units such as COHO, MedEd, the Advocacy Resource Center,
13 and the AMA Foundation.

14
15 The Section employs two primary modes of communication with its members. The first is through
16 a monthly newsletter emailed to approximately 1,600 subscribers that includes Section-specific
17 updates, enterprise-wide updates, and timely news articles and press releases related to health
18 equity and underrepresented physicians. The second is through group chat platforms such as
19 GroupMe for more timely updates, opportunities, and communications from UMAS leadership
20 directly to members. The opportunities provide communication for accessible membership
21 experience, resulting in an increase in UMAS membership over the past five years.

22
23 UMAS receives consistent and competitive interest when leadership opportunities arise.
24 Throughout the year, the UMAS GC promotes leadership development opportunities that provide
25 membership with the tools and education to be leaders within the section or otherwise.

26
27 Criterion 6: Accessibility - Provides opportunity for members of the constituency who are
28 otherwise underrepresented to introduce issues of concern and to be able to participate in the
29 policymaking process within the AMA HOD.

30
31 Work of constituencies like UMAS within our AMA allows for the fostering of opportunities to
32 reconcile and transform policies and practices that perpetuate health inequities and racial injustices
33 in the medical profession through institutional and structural means.

34
35 UMAS' representation in the HOD has allowed for the perspectives and policy positions of the
36 Section to be conveyed through resolutions, testimony, and alliances formed with other Sections
37 and delegations on matters of inclusion and health equity. UMAS supports AMA policy that aligns
38 with the Section's mission and values throughout the HOD policymaking process, from acting as a
39 leader among allied Sections, as a resource in resolution drafting, offering mentorship opportunities
40 on the HOD policymaking process, showing support for resolutions that address health disparities
41 and racial justice during the online and in-person reference committee processes, and during HOD
42 policymaking sessions.

43
44 UMAS members have numerous opportunities throughout the year to engage in dialogue with
45 Section leaders, contribute to the Section's work, and build consensus. UMAS utilizes online open
46 forums prior to HOD handbook deadlines, assembly meetings during bi-annual HOD meetings, the
47 convening of the Health Equity Caucus, ad-hoc or town-hall meetings, standing committees, two
48 annual opportunities to submit resolution proposals for GC consideration, and other opportunities
49 to provide comment or testimony virtually or in-person.

1 DISCUSSION

2
3 The UMAS serves a pivotal role within the AMA on matters that impact underrepresented
4 physicians, residents and fellows, medical students, and the historically marginalized patient
5 populations they serve. As a formalized body to facilitate and encourage the participation of
6 underrepresented physicians in the deliberations of the HOD and other AMA activities, the Section
7 fills a demonstrable need. The efforts of UMAS directly impact on AMA membership, particularly
8 as it relates to the recruitment and retention of underrepresented medical students and physicians.
9

10 The efforts of the Section support the AMA's strategic direction through UMAS' own initiatives
11 and in collaboration with internal and external partners. The UMAS acts as a crucial link between
12 the AMA and other organizations representing the interests of underrepresented physicians and
13 medical students, strengthening relationships between these organizations and creating and
14 amplifying educational, networking and mentorship opportunities.
15

16 Since becoming a voting member of our HOD in 2011, the Section has served as the leading voice
17 within the HOD on the policy matters that impact underrepresented physicians and students and on
18 matters related to health care and historically marginalized communities. The Section remains a
19 significant voice within AMA policymaking, and since the 2020 Interim Meeting, has authored or
20 significantly contributed to more than 30 resolutions that align with the Section's mission and
21 values, enhancing the AMA's policymaking process and the breadth of the HOD's knowledge and
22 deliberations.
23

24 The Council appreciates the thorough work of UMAS leadership and staff in completing this letter
25 of application and follow-up communications, as well as the thoughtfulness of the Section as it
26 looks to build upon its already laudable work in the future.
27

28 CONCLUSION

29
30 The CLRPD has determined that the UMAS meets all required criteria; therefore, it is appropriate
31 to renew the delineated section status of the UMAS.
32

33 RECOMMENDATION

34
35 The Council on Long Range Planning and Development recommends that our American Medical
36 Association renew delineated section status for the Underrepresented in Medicine Advocacy
37 Section through 2031 with the next review no later than the 2031 Interim Meeting and that the
38 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 3-I-26

Subject: Integrated Physician Practice Section Five-Year Review

Presented by: G. Sealy Massingill, MD, Chair

Referred to: Reference Committee F

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

The Council accessed information from a letter of application submitted by the Integrated Physician Practice Section (IPPS) for renewal of delineated section status.

APPLICATION OF CRITERIA

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

The IPPS seeks to advance the interests of physicians who practice in multispecialty, physician-led, integrated health care delivery systems, and groups actively working toward such systems of coordinated care.

During the last five years the following priority issues have been the focus of the IPPS:

- Develop and activate impactful policy on issues relevant to section constituencies: The IPPS Governing Council (GC) and Policy Development Committee developed work groups and policy around issues of significance to the Section, including social determinants of health (SDOH) and the hospital at home model of care. The Section also achieved the adoption of resolutions on ethical guidelines for private equity, SDOH and health information technology (IT), and the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as an Essential Health Benefit under the Patient Protection and Affordable Care Act.
- Cultivate physician leadership and section diversity: The IPPS has engaged in proactive outreach efforts to recruit executive level and diverse candidates for GC positions and other leadership positions at the AMA. As a result, most new GC members over the past five years have held senior leadership positions in their health systems and diversity in the GC has increased. Additionally, IPPS has worked successfully to encourage its members to

pursue leadership roles outside of the Section.

- Retain and grow Section membership: The IPPS has combined collaborative outreach with the AMA Health System Member Program with personalized outreach from GC members, contributing to a 75 percent increase in IPPS membership from 2021 through 2025. The Section has also set a measurable target to increase membership by ten percent annually, with a particular focus on recruiting executive and influential physicians from their respective health systems, as well as revisiting membership criteria to attract new applicants and reduce barriers to participation.
- Advance physician-led integrated care and awareness: The Section has worked to expand awareness on its priority issues through showcasing members in a variety of formats and forums including webinars, podcasts, presentations, updates to health system partners, publications and collaborative events. The IPPS has also developed an inventory of opportunities for member participation in AMA advisory roles and committees, such as the Value-Based Care Workgroup. The Section also aims to position itself as a resource and support entity to AMA business units like Professional Satisfaction and Practice Sustainability (PS2) and the Health System Member Program.
- Strengthen Section engagement and collaboration within the AMA: The IPPS has worked to encourage involvement in Section activities between meetings, such as through participation in the Policy Development Committee and other workgroups, and promoted collaboration, policy development, and joint sessions with other sections like the Organized Medical Staff Section (OMSS) and the Private Practice Physicians Section (PPPS). Most recently, the IPPS, OMSS, and PPPS co-sponsored a panel session at I-25 titled *The Trillion-Dollar Cut: Impact of Medicaid Cuts on Health Care*. The panel focused on how providers can adapt clinical operations and financial models to respond to reduced payment and highlighted opportunities for physicians and health system leaders to advocate for policy solutions that protect patients, physicians and other health care providers. Over 110 AMA members attended the panel.

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.

Every year, the IPPS GC and staff collaborate to develop a comprehensive strategic plan for the Section. Strategic priorities include Section governance, policymaking, efforts to expand core membership and strengthen partnerships with other sections. The strategic plan is reviewed and updated regularly to ensure alignment and ongoing progress.

The IPPS has played a significant role in advancing the AMA's membership strategy, which increasingly emphasizes engagement with large health systems through the Health System Member Program. This focus has helped our AMA consistently meet and exceed its annual membership targets. The IPPS has aided in the recruitment and retention of health system members by helping systems discover that they have an active voice in shaping AMA policy and opportunities to participate meaningfully in organizational governance through IPPS engagement. Physician executives are also introduced to a network of peers and opportunities for collaboration and shared learning through events such as the Insight Network Summit, an invitation-only event held in conjunction with the IPPS Annual Meeting where participants engage in organized peer-to-peer presentations and discussions about their system's successes and challenges.

1 The Section also partners with staff from the PS2 business unit, which leads initiatives in health
2 care quality. Collaborative efforts have included the co-development of educational programs and
3 featuring PS2 leaders in IPPS roundtable discussions. These interactions create a mutually
4 beneficial environment through which PS2 gains frontline perspectives from integrated practice
5 leaders, while IPPS can influence and align with the latest developments in AMA quality
6 improvement work. Additionally, IPPS has partnered with the Joy in Medicine program to
7 celebrate and recognize IPPS members. These efforts demonstrate how the subject matter expertise
8 provided by IPPS members can enhance both individual AMA initiatives and the strategic goals of
9 the Association.

10
11 Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and
12 activities.

13
14 The IPPS is structured to allow for open participation by any member on nearly all functions of the
15 Section. While the GC is tasked with managing the operational functions of the Section, which is
16 largely conducted through regular meetings, directional planning for the Section is presented to the
17 general membership for discussion, debate, and approval.

18
19 Membership of the Section consists of associate members, defined in the Section's Internal
20 Operating Procedures (IOP) as members of the AMA who are in physician-led, integrated health
21 care organizations that coordinate patient care across specialties and among physicians who share
22 common records and clinical care processes, and affiliate members, who are members of the AMA
23 who practice in organizations moving toward physician-led integrated health care that do not yet
24 satisfy the characteristics of organizations eligible to qualify their physicians as associate members.
25 All members of the GC members must be associate members of the IPPS.

26
27 Physicians interested in IPPS membership must complete an application, which is reviewed by the
28 Credentials Committee. IPPS membership ranges from the largest health systems to clinically
29 integrated networks of smaller independent practices. There are slotted seats on the GC for larger
30 groups (351+ members) and smaller groups (350 members and under).

31
32 Criterion 4: Representation Threshold - Members of the formal group would be based on
33 identifiable segments of the physician population and AMA membership. The formal group would
34 be a clearly identifiable segment of AMA membership and the general physician population. A
35 substantial number of members would be represented by this formal group. At minimum, this
36 group would be able to represent 1,000 AMA members.

37
38 In 2025 the IPPS represented a projected (at the time of application) 56 member organizations
39 representing approximately 79,700 physicians. While it is difficult to determine the total number of
40 physicians in the United States that could be represented by the IPPS, given recent trends of
41 consolidation of health care systems, as well as the recent increases in IPPS membership and
42 engagement with the Section, it can be safely inferred that well over 1,000 AMA members can be
43 represented by the IPPS.

44
45 Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can
46 demonstrate an ongoing and viable group of physicians, who will be represented by this section.
47 Both the segment and the AMA will benefit from an increased voice within the policymaking
48 body.

49
50 Since the 2021 Annual Meeting, IPPS meetings have averaged 52 attendees registered through the
51 CVENT registration system, though the Section notes that actual attendance typically exceeds

1 registration. Recent additions of the Joy in Medicine Recognition Program and the Insight Network
2 Summit have led to increased attendance at IPPS meetings. As noted previously, IPPS membership
3 increased by 75 percent from 2021-2025.

4
5 The Section communicates with members primarily through its monthly newsletter that keeps
6 members updated on all Section activities. That communication is sent to approximately 2,500
7 IPPS subscribers and has an average monthly open rate of 47 percent.

8
9 Members demonstrate consistent interest in serving in leadership roles within the IPPS, and
10 positions have been filled without difficulty. The section has established a clear pathway to the GC
11 by encouraging members to attend Assembly meetings, speak at events, participate in the Policy
12 Development Committee, and attend the Insight Network Summit. Members who demonstrate
13 active engagement in these activities often run for open Governing Council seats as they become
14 available.

15
16 Criterion 6: Accessibility - Provides opportunity for members of the constituency who are
17 otherwise underrepresented to introduce issues of concern and to be able to participate in the
18 policymaking process within the AMA HOD.

19
20 Despite the growing prevalence of integrated physician practices like multispecialty groups and
21 large health systems, members of the IPPS remain underrepresented in many aspects of AMA
22 policymaking. Historically, the AMA's attention and advocacy efforts have focused more heavily
23 on the perspectives of physicians in independent and smaller practice settings. As a result, the
24 unique challenges faced by physicians practicing in integrated models, such as navigating complex
25 group governance, implementing coordinated care across specialties, and adapting to system-wide
26 technological changes, are often less recognized and insufficiently addressed in broader policy
27 initiatives. With the rapid shift in the health care landscape toward integration and consolidation,
28 physicians working within these practice settings will increasingly need a voice. Through its
29 representation in the House of Delegates, IPPS has championed issues that are particularly relevant
30 to integrated practice environments including advocating for streamlined regulatory requirements,
31 fostering adoption of health IT and interoperability, and supporting team-based models of care.

32
33 Policy is openly debated through both an online forum open to all AMA members and through
34 virtual and face-to-face meetings. Any IPPS member may submit a resolution for consideration at
35 annual or interim meetings, and the IPPS Policy Development Committee reviews issues and draft
36 resolutions. All resolutions are accepted provided they pass a review from the AMA Office of the
37 General Counsel. The IPPS GC reviews resolutions and makes recommendations, which are shared
38 with the IPPS Assembly. During IPPS Assembly meetings, policy discussions occur allowing all
39 members to share input and during which final decisions are made on amendments and whether a
40 resolution should be adopted on behalf of the Section. These sessions are typically led by IPPS
41 Delegate/Alternate Delegate, helping familiarize others with the policymaking process. Before
42 each Assembly, IPPS members also receive an HOD Handbook review report that identifies items
43 relevant to IPPS from the HOD Handbook.

44 45 DISCUSSION

46
47 The IPPS is the only AMA component group that focuses on issues concerning integrated
48 physician practices and physician-led coordinated health care, and IPPS provides a direct and
49 ongoing relationship between the AMA and this cohort of physicians. Given recent evolutions in
50 the health care environment toward consolidation, multispecialty groups and large systems, there
51 has likely never been a greater need among organized medicine for representation for physicians

1 working in integrated practice settings. The Section's rapid growth in membership since its last
2 review demonstrates its strong and growing necessity within the AMA.

3
4 In addition, as the AMA's growth and strategy are increasingly influenced by group recruitment
5 and the Health System Member Program, and the IPPS serves as a crucial entry point for new
6 members by helping large health systems discover a tangible home within the AMA; the IPPS has
7 been instrumental in the recruitment and retention of health system members. The IPPS also
8 collaborates closely with the Health System Member Partner team to identify shared goals and
9 areas of mutual interest for physicians practicing within integrated health systems.

10
11 In policymaking, the IPPS acts as the central body to bring forward the needs of integrated practice
12 physicians for deliberation. Maintaining section status for IPPS is essential to enhance
13 representation and ensure that policies reflect the experiences of these physicians. With a distinct
14 presence in AMA governance, the profession amplifies the contributions and challenges of
15 integrated medical practices, making IPPS's continued advocacy and involvement highly relevant
16 to AMA's mission.

17
18 The Council appreciates the thorough work of IPPS leadership and staff in completing this letter of
19 application and follow-up communications, as well as the thoughtfulness of the Section as it looks
20 to build upon its work in the future.

21 22 CONCLUSION

23
24 The CLRPD has determined that the IPPS meets all required criteria; therefore, it is appropriate to
25 renew the delineated section status of the IPPS.

26 27 RECOMMENDATION

28
29 The Council on Long Range Planning and Development recommends that our American Medical
30 Association renew delineated section status for the Integrated Physician Practice Section through
31 2031 with the next review no later than the 2031 Interim Meeting and that the remainder of this
32 report be filed. (Directive to Take Action)

Fiscal Note: Minimal

REPORT OF THE SPEAKERS

Speakers' Report 1-I-26

Subject: Election Rule Updates

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

Referred to: Reference Committee F

1 Your Speakers, in consultation with the Election Committee (EC), review the American Medical
2 Association's (AMA) policy G-610.090, "AMA Election Rules and Guiding Principles," following
3 each election cycle. This report offers recommended clarifications to the election rules based on
4 this review.

5 6 DISCUSSION

7
8 During the A-26 election cycle, candidates reported that some interviewing groups required
9 candidates to complete questionnaires in addition to their interview. Requiring completion of a
10 questionnaire unfairly expands the interview for these interviewing groups as candidates are asked
11 to answer questions asynchronously in addition to their allotted in-person or virtual time.
12 Additionally, the election rules state, "printed or digital campaign materials may not be distributed
13 to members of the House other than by the HOD office candidate email and on the AMA
14 Candidates' Page." There was some concern expressed by candidates that sending campaign
15 materials to these groups could be interpreted as a violation of this election rule.

16
17 Current election interview rules make an exception for questionnaires. Several candidates reported
18 that some groups were utilizing questionnaires to facilitate the group's internal assessment to
19 "support" the candidate. However, groups who used this process did not submit information as an
20 interviewing group. Candidates reported that some groups on the interview list asked candidates to
21 fill out questionnaires in addition to their interview while other groups, not on the list, asked
22 candidates to fill out questionnaires to gain the group's support. Candidates were concerned that
23 completing either or both types of questionnaires could be a campaign violation. Not only does this
24 contribute to the candidate confusion discussed in the preceding paragraph, but it also makes
25 administering the interview process difficult for the HOD Office. Therefore, your Speakers
26 recommend that questionnaires be treated as an interview and groups wishing to use them in lieu of
27 a virtual or in-person interview be required to submit information to the Official Group Interview
28 List.

29
30 Policy passed at the 2026 Annual Meeting regarding the endorsement process will have significant
31 impact beginning with the A-28 election cycle (elections held at the 2028 Annual Meeting).
32 Changes to policy include moving the deadline for groups to submit information about their
33 endorsement process to be "no later than 30 days prior to the start of the Interim Meeting preceding
34 the Annual Meeting at which the election is to take place." In addition, the endorsement window
35 cannot open until the commencement of that Interim Meeting. Under current rules, formal
36 questioning of an announced candidate is an interview, and therefore, any 2028 candidate who
37 announces their candidacy at the 2027 Annual Meeting would not be able to participate in the

1 endorsement window at the 2027 Interim Meeting. Therefore, your Speakers recommend a change
2 in policy be made to allow candidates the ability to participate in the endorsement process during
3 the identified endorsement window, even if they have previously announced their candidacy.
4

5 As communicated previously to members of the House, the terms “sponsored by” or “endorsed by”
6 should be used when describing organizations on a candidates’ announcement card or campaign
7 materials. The terms “nominated by” or “supported by” should not be used. Sponsoring group and
8 endorsing group are explicitly defined in the election rules glossary, however the term “support” is
9 still occasionally used by groups. Your Speakers are recommending that a definition of “support”
10 be added to the glossary of the election rules. Organizations may only use the term “support” when
11 discussing within their closed group about an internal decision to recommend a given candidate to
12 that group’s members. This support may not lead to a public endorsement, nor may the candidate
13 be apprised of having received a group’s support. It is important for groups to specify to their
14 members when providing such information that delegates should ultimately vote individually, with
15 no implied or inferred repercussions should they choose not to vote for a “supported” candidate.
16

17 CONCLUSION

18
19 After a thorough review and debrief of the A-26 election cycle in consultation with the EC,
20 recommendations for clarification to the election rules are being proposed to promote fairness
21 across campaigns.
22

23 RECOMMENDATIONS

24
25 Your Speakers recommend that the following updates be made to the AMA election rules and that
26 the remainder of the report be filed:
27

- 28 1. That any written or oral questioning of an announced candidate is considered an interview and
29 subject to the interview rules. Groups may utilize either a written questionnaire or an oral
30 interview process, but not both, in any given contest. No additional candidate or campaign
31 information, other than pertinent contact information, may be requested from candidates or
32 shared with the group by candidates.
- 33 2. That all candidates may participate in the endorsement interview process during the identified
34 endorsement window for the election cycle in which they are running for office even if they
35 have previously announced their candidacy.
- 36 3. That the term “support” be defined as an internal decision, made in a closed meeting (e.g. only
37 members of the group are present) to recommend a specific candidate for a given contest. This
38 support should not be shared with the candidate or otherwise announced or made public by the
39 group and should not imply a requirement for group members to vote for the supported
40 candidate.

Fiscal note: Minimal

Relevant AMA Policy

The Speaker and Vice Speaker of the House of Delegates are responsible for overall administration of our AMA elections, although balloting is conducted under the supervision of the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker will advise candidates on allowable activities and when appropriate will ensure that clarification of these rules is provided to

all known candidates. The Speaker, in consultation with the Vice Speaker and the Election Committee, is responsible for declaring a violation of the rules.

Glossary of Election Terms

Active campaign window – Period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.

Active campaigning – Outreach by candidates or their surrogate(s), including but not limited to members of their campaign team, to members of the House of Delegates with the goal of being elected by the AMA House of Delegates.

Announced candidate – Person who has indicated their intention to run for elected position; announcement can be made only by sending an electronic announcement card to the Speakers via the HOD office by email to hod@ama-assn.org.

Campaign manager(s) – Person(s) identified by the candidate to the HOD Office as the person(s) responsible for running the campaign.

Campaign presentation – A written or verbal presentation about a campaign or a solicitation of votes for an AMA election to a non-sponsoring group. A candidate may attend and participate in the business of a non-campaign-related meeting or event of a non-sponsoring group or non-endorsing group, but the candidate shall not engage in campaigning of any kind.

Campaign team – Campaign manager(s) and/or staff identified by the candidate to the HOD Office.

Campaign-related – Any content that includes reference to an announced candidate in the context of their candidacy for an elected position within the AMA.

Digital – Relating to, using, or storing data or information in the form of digital signals; involving or relating to the use of computer technology; this includes, but is not limited to, social media and communication platforms.

Elected position(s) – Council or Officer position within the AMA elected by the House of Delegates of the AMA.

Endorsing group - Any group that wishes to endorse candidates other than the candidates they are eligible to sponsor. See definition of "Sponsoring Group."

Endorse - Any public acknowledgement by a candidate or members of a group of the group's support of a candidate. Internal discussions of support in a closed session of the group are not considered public for the purpose of this definition.

Featured – Identification of a candidate at an event by the host or organizer of the event, including but not limited to, written or verbal announcement of the candidate or their candidacy.

Sponsoring group

- Sponsoring group is an endorsing group that may offer endorsements to the delegate(s) and/or alternate delegate(s) representing that sponsoring group without the need to provide their endorsement process to the HOD Office.
- The association, society, AMA section, or other entity for which a prospective candidate serves as an AMA HOD delegate or alternate delegate as certified with the HOD office.
- The Section delegate and alternate delegate are the only individuals who may be sponsored by their respective AMA Section.
- Current trustees or Council members seeking re-election or election to president-elect may be sponsored by the delegation for which they served as an AMA HOD delegate or alternate delegate immediately prior to their election.
- Individuals may self-sponsor (self-nomination).

I. Guiding Principles

The following principles provide guidance on how House elections should be conducted and how the selection of AMA leaders should occur:

1. Our American Medical Association delegates should:
 - a. avail themselves of all available background information about candidates for elected positions in our AMA.
 - b. determine which candidates are best qualified to help the AMA achieve its mission.
 - c. make independent decisions when voting for candidates.
2. Any electioneering practices that distort the democratic processes of House elections, such as vote trading for the purpose of supporting candidates, are unacceptable. This principle applies between as well as within caucuses and delegations.
3. Candidates for elected positions should comply with the requirements and the spirit of House of Delegates policy on campaigning and campaign spending.
4. Candidates and their sponsoring organizations should exercise restraint in campaign spending. Federation organizations should establish clear and detailed guidelines on the appropriate level of resources that should be allocated to the political campaigns of their members for our AMA leadership positions.
5. Incumbency should not assure the re-election of an individual to an AMA leadership position.
6. Service in any AMA leadership position should not assure ascendancy to another leadership position.
7. Delegations and caucuses when evaluating candidates may provide information to their members encouraging open discussion regarding the candidates.
8. Delegations and caucuses should be a source of encouragement and assistance to qualified candidates. Nomination and endorsement should be based upon selecting the most qualified individuals to lead our AMA regardless of the number of positions up for election in a given race. Delegations and caucuses are reminded that all potential candidates may choose to run for office, with or without their endorsement and support.
9. Every state and specialty society delegation is encouraged to participate in a caucus, for the purposes of candidate review activities.

II. Guidelines for Candidacy for AMA Offices

1. Every effort should be made to have two or more candidates for each vacancy.
2. The Federation (in sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) should consider the need to enhance and promote diversity.

III. Candidate Announcement, Nominations and Open Positions

1. Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, the office sought, the sponsoring group, if any, and a list of endorsing groups, if any. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed to members of the House by any method.
2. Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website. Following each meeting, an "Official Candidate Notification" will be sent electronically to

the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out with regular Speaker communications to the HOD and with the Speaker's notice of the opening of active campaigning which generally follows the April Board meeting.

3. Candidates may notify the HOD Office of their intention to run for potential newly opened positions, as well as any scheduled open positions on the elected councils or the Board of Trustees, at any time by submitting an announcement card to the House Office. They will then be included in all subsequent projections of announcements before the House, "Official Candidate Notifications," and in any campaign activity that had not yet been finalized. All previously announced candidates will continue to be included on each Official Candidate Notification. Any candidate may independently announce their candidacy after active campaigning is allowed, but no formal announcement from the HOD office will take place other than on Official Candidate Notifications.
4. The Federation and members of the House of Delegates will be notified of unscheduled potential newly opened positions that may become available as a result of the election of announced candidates. Candidates will be allowed to announce their intention to run for these positions.
5. If a potential newly opened position on the Board or a specified council does not open but there are other open positions for the same council or the Board, an election will proceed for the existing open seats. Candidates will be offered the opportunity to withdraw their nomination prior to the vote. If there are no scheduled open seats on the Board or specified council for which a potential newly opened position is announced and if the potential newly opened position does not open (ie., the individual with the unexpired term is not elected to the office they sought), no election for the position will be held. In the event that a prior election results in a newly opened position without a nominated candidate or more positions are open than nominated candidates, the unfilled positions would remain unfilled until the next annual meeting.
6. Our AMA believes that:
 - a. specialty society candidates for our AMA House of Delegates elected offices should be listed in the pre-election materials available to the House as the representative of that society and not by the state in which the candidate resides.
 - b. elected specialty society members should be identified in that capacity while serving their term of office.
 - c. nothing in the above recommendations should preclude endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose.
7. Our AMA requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election. Conflict of interest forms must be submitted after an individual has announced their candidacy and before the active campaign window begins or, if not previously announced, within 24 hours of the conclusion of the HOD Opening Session. The HOD Office will post such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents.
8. Candidates will be provided with a copy of the current election rules and will be required to attest to abiding by them. Candidates are responsible for any and all actions or inaction undertaken on their behalf that is campaign related.

IV. Communications, Campaign Memorabilia and Literature

1. Active campaigning for an elected AMA position may not begin until the active campaign window opens as announced by the Speaker following the Spring Board of Trustees

meeting immediately preceding the meeting at which the election is scheduled to take place.

2. An announced candidate may discuss their candidacy on an individual basis in private conversations after the announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy except in private conversations with the announced candidate on an individual basis. This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team or from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.
3. An Election Manual containing information on all candidates for election shall continue to be developed annually, with distribution limited to publication on our AMA website, typically on the Web pages associated with the meeting at which elections will occur. The Election Manual will provide a link to the AMA Candidates' Page, but links to personal, professional or campaign related websites will not be allowed. The Election Manual provides an equal opportunity for each candidate to present the material they consider important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings. The Election Manual serves as a mechanism to reduce the number of telephone calls, mailings and other messages members of the House of Delegates receive from or on behalf of candidates.
4. Our AMA Office of House of Delegates Affairs will provide an opportunity for all announced candidates to submit material to the HOD office which will then be sent electronically by the HOD Office in a single communication to all delegates and alternates. Parameters regarding content and deadlines for submission will be established by the Speaker and communicated to all announced candidates.
5. An AMA Candidates' Page will be created on our AMA website or other appropriate website to allow each candidate the opportunity to post campaign materials. Parameters for the site will be established by the Speaker and communicated to candidates.
6. Campaign expenditures and activities should be limited to reasonable levels necessary for adequate candidate exposure to the delegates. Campaign memorabilia and giveaways that include a candidate's name or likeness may not be distributed at any time.
7. Active campaigning via mass outreach to delegates by candidates or on behalf of the candidate by any method is prohibited. A reduction in the volume of telephone calls and personal electronic communication from candidates and on behalf of candidates is encouraged. No part of this rule shall be interpreted to limit developing or communicating within a campaign team. Electronic messages must include a simple mechanism to allow recipients to opt out of receiving future messages.
8. Printed and digital campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the AMA Candidates' Page.
9. Displays of campaign posters, signs, and literature in public areas of the venue at which Annual Meetings are held are prohibited because they detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at a single campaign reception at which the candidate is featured. No campaign literature shall be distributed in the House of Delegates and no mass outreach electronic messages shall be transmitted after the opening session of the House of Delegates.
10. Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group. General distribution of any pin, button or sticker is disallowed.

11. Candidates and campaigns may not produce a personal campaign-related website or other digital campaign-related content. Candidates may not direct to personal or professional websites as a method of campaigning other than to the AMA Candidates' Page.

V. Group Dinners and Meetings

1. Candidates for our AMA office should not attend meetings of state medical societies unless officially invited and could accept reimbursement of travel expenses by the state society in accordance with the policies of the society.
2. At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, other formal campaign activities and the distribution of campaign literature and gifts are prohibited. It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.
3. Each participant in group dinners, if attended by an announced candidate in a currently contested election, must pay their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. Gatherings of 4 or fewer delegates or alternates are exempt from this rule.

VI. Interview Rules

Candidates and interviewers must comply with the following rules:

1. Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information to both groups. Groups must indicate whether they wish to interview in-person or virtually and for which contest by the deadlines designated by the speaker.
2. Any formal questioning of an announced candidate, excluding a written questionnaire, is an interview and subject to the rules for interviews.
3. Interviews may be arranged between the parties once active campaigning is allowed.
4. Groups conducting interviews with announced candidates for a given office must offer an interview to all announced candidates at the time the group's interview schedule is finalized.
 - a. A sponsoring group may meet with an announced candidate who is a member of their group during the active campaign window without meeting with other candidates for the same office.
 - b. Interviewing groups may, but are not required to, interview persons who become announced candidates during the active campaign window. Should an interview be offered to such a candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.
 - c. Any campaign-related presentation to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in their current formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.
5. Groups may elect to conduct interviews virtually or in-person.
6. In-person interviews may be conducted between Friday and Monday of the meeting at which elections will take place.

7. Virtual interviews are subject to the following constraints:
 - a. Interviews may be conducted only during a 9-14 day window (preferably across two separate weekends) as designated by the Speaker beginning at least two weeks but not more than six (6) weeks prior to the scheduled Opening Session of the House of Delegates meeting at which elections will take place.
 - b. Interviews conducted on weeknights must be scheduled between 5 pm and 10 pm or on weekends between 8am and 10 pm based on the candidate's local time, unless another mutually acceptable time outside these hours is arranged.
 - c. Caucuses and delegations scheduling interviews for candidates within the parameters above must offer alternatives to those candidates who have conflicts with the scheduled time.
8. Recording of interviews is allowed only with the knowledge and consent of the candidate.
9. Interviews are recommended to be recorded with consent of all participating individuals and disseminated to the interviewing group members when all are not able to be present for the interview.
10. Recordings of interviews may be shared only among members of the group conducting the interview.
11. A candidate is free to decline any interview request.
12. In consultation with the Election Committee, the Speaker, or where the Speaker is in a contested election, the Vice Speaker, may issue special rules for interviews to address unexpected situations.
13. The Speakers are encouraged to continue recorded virtual interviews of announced candidates in contested races, to be posted on the AMA website.

VII. Campaign Receptions

1. Our AMA will sponsor the AMA Candidate Reception which will be open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA Candidate Reception. There will not be a receiving line at the AMA Candidate Reception. The rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception will apply to the AMA Candidate Reception.
2. A state, specialty society, caucus, coalition, etc. may contribute to more than one party. However, a candidate may be featured at only one party, which includes: (a) being present in a receiving line, or (b) appearing by name or in a picture on a poster or notice in or outside of the party venue. At these events, alcohol may be served only on a cash or no-host bar basis.

VIII. Election Process

1. At the Opening Session of the Annual Meeting, officer candidates in a contested election will give a two-minute self-nominating speech, with the order of speeches determined by lot. No speeches for unopposed candidates will be given, except for president-elect. When there is no contest for president-elect, the candidate will ask a delegate to place their name in nomination, and the election will then be by acclamation. When there are two or more candidates for the office of president-elect, a two-minute nomination speech will be given by a delegate. In addition, the Speaker of the House of Delegates will schedule a debate in front of the AMA-HOD to be conducted by rules established by the Speaker or, in the event of a conflict, the Vice Speaker.
2. Nominating speeches for unopposed candidates for office, except for President-elect, will not be heard.
3. AMA elections will be held on Tuesday at each Annual Meeting.
4. Voting for all elected positions including runoffs will be conducted electronically during an Election Session to be arranged by the Speaker.

5. All delegates eligible to vote must be seated within the House at the time appointed to cast their electronic votes.
6. The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House.
7. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced, including collecting written personal points from candidates to be shared electronically with the House after the meeting or imposing time limits on such comments.

IX. Election Committee

1. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 9 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. The Speaker and Vice Speaker shall be full members of the Election Committee.

X. Campaign Complaint Reporting, Validation and Resolution Process

1. Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:
 - a. The name of the person(s) thought to have violated the rules
 - b. The date of the alleged violation and the location if relevant
 - c. The specific violation being alleged (i.e., the way the rules were violated)
 - d. The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.
2. 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.
3. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.
 - a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
 - b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
 - c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
 - d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
 - e. Deliberations of the Election Committee shall be confidential.
 - f. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House, following each meeting at which an election

was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.

4. A record of all complaints and the results of the validation and the resolution processes, including penalties, shall be maintained by our AMA Office of General Counsel and kept confidential.
5. The Election Committee will review the Campaign Complaint Reporting, Validation and Resolution Process as implemented and make further recommendations to the House as necessary.

XI. Endorsements

1. Our American Medical Association requires all groups that endorse candidates turn in information about their endorsement process, the deadline, and a staff contact for applications in a timely and streamlined manner, no later than 30 days prior to the start of the Interim Meeting preceding the Annual Meeting at which the election is to take place.
2. Our AMA will then post this information on the election website in a timely manner, with the information being easily digestible and accessible.
3. Our AMA will not allow any group that fails to provide this information in a timely manner to offer an endorsement during that election cycle.
4. Our AMA will create a specific period (similar to virtual elections) during which endorsements may be sought, with the endorsement window opening at the commencement of the Interim Meeting immediately preceding the Annual Meeting at which the election is to take place.

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

Compensation Committee Report, I-2026

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

Presented by: Hilary Fairbrother, MD, MPH, FACEP, Chair

Referred to: Reference Committee F

1 This report by the committee at the November 2026 Interim Meeting documents the compensation
2 paid to Officers for the period July 1, 2025, through June 30, 2026, including 2025 calendar year
3 IRS reported taxable value of benefits, perquisites, and services for all Officers. The report also
4 provides an updated analysis of Board leadership, Speaker and Vice Speaker compensation and
5 recommends changes to the compensation of these positions based on these findings.

6
7 BACKGROUND

8
9 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
10 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
11 “Committee”). The Officers are defined in the American Medical Association’s (AMA)
12 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
13 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among
14 whom are President, President-Elect, Immediate Past President, Secretary, Speaker and Vice
15 Speaker of the HOD, collectively referred to in this report as Officers.) The composition,
16 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
17 under the AMA Bylaws. Bylaws 2.13.4.5 provides:

18
19 The Committee shall present an annual report to the House of Delegates recommending the
20 level of total compensation for the Officers for the following year. The recommendations of the
21 report may be adopted, not adopted, or referred back to the Committee, and may be amended
22 for clarification only with the concurrence of the Committee.

23
24 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s
25 definition of total compensation which was added to the Glossary of the AMA Constitution and
26 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
27 individual for work performance, including: (a) all forms of money or cash compensation; (b)
28 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

29
30 Since the inception of this Committee, its reports document the process the Committee follows to
31 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective
32 compensation practices derived from research and use of independent external consultants, expert
33 in Board compensation. Reports beginning in December 2002 documented the principles the
34 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, 2025, to June 30, 2026.

AMA Officers	Position	Total Compensation	Total Days
David H Aizuss, MD	Chair	\$285,886	92
Toluwalase A. Ajayi, MD	Chair-Elect	\$211,630	69
John H. Armstrong, MD	Vice Speaker, House of Delegates	\$129,700	62.5
Geralyn R. Breig	Officer	\$68,500	39
Alex Ding, MD, MS, MBA	Secretary	\$77,800	51.5
Lisa Bohman Egbert, MD	Speaker, House of Delegates	\$127,100	91.5
Scott Ferguson, MD	Officer	\$70,825	42.5
Sandra Adamson Fryhofer, MD	Officer	\$95,475	60.5
Melissa J. Garretson, MD	Officer	\$89,425	62
Marilyn Heine, MD	Officer	\$73,150	53
Pauline P. Huynh, MD	Officer	\$68,500	40.5
Lynn Jeffers, MD, MBA	Officer	\$75,475	56
Ilse R. Levin, DO, MPH & TM	Officer	\$84,000	52
Justin W. Magrath, PhD	Officer	\$89,425	58
Bobby Mukkamala, MD	President	\$298,865	192
Sheila Rege, MD	Officer	\$76,250	55
Bruce A. Scott, MD	Immediate Past President	\$290,659	84.5
Michael Suk, MD, JD, MPH, MBA	Immediate Past Chair	\$149,100	120
Willie Underwood, III, MD, MSc, MPH	President-Elect	\$290,659	177.5
Marta J. Van Beek, MD	Officer	\$69,275	47.5
David Welsh, MD, MBA	Officer	\$85,550	61

President, President-Elect, Immediate Past President, and Chair

In 2025-2026, each of these positions received an annual Governance Honorarium which was paid in monthly increments. These four positions spent a total of 546 days on approved Assignment and Travel, or on average 136.5 days each.

1 Chair-Elect

2 This position received a Governance Honorarium of approximately 74% of the Governance
3 Honorarium provided to the Chair.

4
5 All Other Officers

6 All other Officers received cash compensation, which included a Governance Honorarium of
7 \$68,500 paid in monthly installments and per diems for approved assignment days.

8
9 Assignment and Travel Days

10 As defined, these are Assignment and Travel Days that are approved by the Board Chair to
11 externally represent the AMA. These days were compensated at a per diem rate of \$1,550. The
12 total Assignment and Travel Days for all Officers (excluding the President, President-Elect,
13 Immediate Past President, and Chair) were 1,021.5.

14
15 EXPENSES

16
17 Total expenses paid for period, July 1, 2025 – June 30, 2026, was \$1,119,773.84.

18
19 BENEFITS, PERQUISITES AND SERVICES

20
21 Officers are able to request benefits, perquisites and services, as defined in the “AMA Board of
22 Trustees Standing Rules on Travel Expenses.” These non-taxable business expenses are provided
23 to assist the Officers in performing their duties.

- 24
25
 - AMA Standard laptop computer or iPad
 - 26 • American Express card (for AMA business use)
 - 27 • Combination fax/printer/scanner (reimbursable up to \$250)
 - 28 • An annual membership to the airline club of choice offered each year during the Board
 - 29 member’s tenure
 - 30 • Personalized AMA stationery, business cards, and biographical data for official use
 - 31 • Airline upgrade allowances of up to \$5,000 per term for Presidents and \$2,500 per term for
 - 32 all other Officers.

33
34 Additionally, all Officers are eligible for \$305,000 term life insurance and are covered under the
35 AMA’s \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out
36 of any accident while traveling on official business for the AMA. Life insurance premiums paid by
37 the AMA are reported as taxable income. Also, travel assistance is available to all Officers when
38 traveling more than 100 miles from home or internationally.

39
40 Secretarial support, other than that provided by the AMA’s Board office, is available up to defined
41 annual limits as follows: President, during the Presidential year, \$15,000, and \$5,000 each for the
42 President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses
43 incurred by other Officers in conjunction with their official duties are paid up to \$1,125 per year
44 per Officer. This is reported as taxable income to the recipient. Calendar year taxable life insurance
45 and taxable secretarial fees included in the 2025 compensation reported to the IRS for the above
46 individuals totaled \$20,826 and \$45,313 respectively. An additional \$10,125 was paid to third
47 parties for secretarial services during 2025.

48
49 Officers are also eligible to participate in a service provided to AMA employees by Care@Work
50 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 November 2024, the Committee commissioned Ms. Becky Glantz Huddleston, a consultant expert in board compensation with Willis Towers Watson (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 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 from \$67,000 to \$68,500, the Per Diem for Representation increased \$1,400 to \$1,550 and the Telephonic Per Diem increased from \$700 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.

In June 2026, the Committee commissioned Ms. Becky Glantz Huddleston to review the secretarial maximums and travel upgrade allowances for both leadership and non-leadership roles based on feedback from Board leadership. As a result of this analysis, the Committee recommended increasing the secretarial maximums for Speakers and non-leadership Officers and increasing the travel upgrade allowances for leadership and all other officers. These recommendations moved the Speakers to the same secretarial maximum as the President-Elect, Chair, Chair-elect and Immediate Past President but did not change the President's secretarial allowance of \$15,000. The following recommendations were approved by the HOD effective July 1, 2026: Secretarial maximums were increased from \$1,125 to \$5,000 for the Speaker and Vice Speaker and from \$1,125 to \$1,200 for non-leadership positions; the travel upgrade allowance for Presidents was increased from \$5,000 to \$6,000 and the Chair was moved to same allowance as Presidents; the travel upgrade allowance for non-leadership roles was increased from \$2,500 to \$3,000.

In September 2026, the Committee commissioned Ms. Becky Glantz Huddleston to update the 2023 research on compensation of Board leadership and the 2025 research on compensation of the Speaker and Vice Speaker roles. The purpose of the review was to ensure leadership roles are compensated appropriately for their work performed on behalf of the AMA. The Speaker and Vice Speaker roles were included in this analysis given these roles transitioned to a Governance Honorarium in July 2025 that, like Board Leadership, is not eligible for Per Diem compensation.

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.

The compensation analysis conducted by WTW for the Chair position considered a not-for-profit peer group of organizations that compensate their directors. Due to the limited number of not-for-profit organizations that compensate directors, the search was broadened to extend beyond AMA's industry and focused on organizations with similar revenue size. The resulting peer group included 15 of the 17 organizations in the 2023 peer group.

Given the leadership structure at the AMA (with the exception of the Chair role) is unique to medical associations, WTW gathered data from a secondary/supplemental group of other not-for-profit associations, irrespective of size, to review against the AMA's other (non-Chair) leadership positions. However, given the small size of some of these associations, WTW recommended considering internal equity when evaluating the non-Chair leadership positions.

AMA's Board leadership has a significant level of responsibility in their roles, resulting in a time commitment well above that required by other not-for-profit boards. Accordingly, it is appropriate to assess the AMA compensation levels on an hourly rate basis, not simply total pay, when compared to the not-for-profit comparable markets.

2025/2026 hourly rates for AMA's positions range from the 41st to 62nd percentiles for leadership and the 25th to 31st percentiles for the Speaker/Vice Speaker compared against the peer group.

- Chair data reported by the not-for profit peer group grew at an annual rate of 5% since the prior study in 2023.
- President, President-Elect, and Immediate Past President data reported by the Association peer group grew, on average, at an annual rate of 12% since the prior study in 2023.
- Speaker and Vice Speaker were not included in the 2023 analysis; due to unavailability of Speaker and Vice Speaker market data, the positions were compared to the median officer pay from the primary not-for-profit peer group.

WTW indicated the overall market movement of salaries for 2027 was expected to be approximately 3.5%. Given Board Leadership positions were determined to be generally aligned to market median, and considering the anticipated market movement, WTW recommended increasing the Governance Honorariums for Board Leadership as well as the Speaker and Vice Speaker by 2 to 6 percent.

In addition to the Governance Honorariums, the Committee also considered the current travel upgrade allowance based on additional feedback from Board Leadership. WTW included the travel upgrade allowance in their assessment as follows:

- 2025-2026 travel allowance usage was reviewed against 2025-2026 and 2026-2027 maximum allowances.
- Seven Officers utilized the full 2025-2026 allowance; it's unclear whether these Officers would have reached the higher travel upgrade allowance maximums established for 2026-2027.

The Committee discussed the option of permitting travel upgrades on all flights greater than four hours in lieu of a travel upgrade allowance and agreed that allowing each Officer to choose between the existing policy and this new option would be administratively burdensome. The Committee further agreed that given the increase to travel allowances in July 2026, it was prudent for the Committee to review travel upgrade usage under the new policy before considering further changes.

The Committee also considered a new benefit for Board Leadership that would provide additional cyber security protection, recognizing the additional risk associated with public facing roles. The AMA Board of Trustees recently approved an advanced cyber security benefit for AMA senior executives effective January 1, 2027, that includes advanced security monitoring for the executive and family members and restoration services reimbursement of up to \$3M. The estimated cost of this benefit is \$2,000 per executive per year. The Committee agreed that providing this benefit to the Board President, President Elect, Immediate Past President and Board Chair was appropriate.

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

RECOMMENDATION

Based on the Committee's review of Board leadership, Speaker and Vice Speaker compensation and recent changes to Officer compensation approved effective July 1, 2025, and July 1, 2026, the Committee on Compensation of the Officers recommends the following changes to Officer compensation be adopted effective July 1, 2027:

1. That the Governance Honorariums for the President, President-Elect, Immediate Past President, Board Chair, Board Chair-Elect, Speaker and Vice Speaker be increased by 3.5% effective July 1, 2027.
2. That the Governance Honorariums under Rule I. Compensation and Travel Expense Reimbursement in the Standing Rules, section A, be changed as follows:

July 2026 – June 2027 July 2027 - June 2028 Governance Honorarium

\$298,865	\$309,325	President
\$290,659	\$300,832	President-Elect and Immediate Past President
\$285,886	\$295,892	Board Chair
\$211,630	\$219,037	Board Chair-Elect
\$125,000	\$129,375	Speaker of the House of Delegates
\$115,000	\$119,025	Vice Speaker of the House of Delegates
\$68,500		All other officers

3. That a new cyber security benefit be provided to the Board President, President Elect, Immediate Past President and Board Chair effective January 1, 2027, that is consistent with the program provided to AMA senior executives.
4. That the remainder of the report be filed.

Fiscal Note: \$64,619 additional expense on an annual basis.

1 APPENDIX

2

3 Board Leadership Honoraria during the Period of July 1, 2025, to June 30, 2026

4

POSITION	GOVERNANCE HONORARIUM
President	\$298,865
Immediate Past President	\$290,659
President-Elect	\$290,659
Chair	\$285,886
Chair-Elect	\$211,630
Speaker	\$125,000
Vice Speaker	\$115,000

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-26)

Introduced by: American Society of Plastic Surgeons; American Society for Maxillofacial Surgeons; Michigan State Medical Society; American Association for Hand Surgery; American Society of Aesthetic Plastic Surgeons; Missouri State Medical Association; American Society for Reconstructive Microsurgery

Subject: Strengthening Board Oversight and Engagement in Major AMA Federal Advocacy

Referred to: Reference Committee F

1 Whereas, the American Medical Association House of Delegates serves as the legislative and
2 policymaking body of the AMA, and the AMA Board of Trustees is responsible for conducting
3 the affairs of the Association consistent with policies and directives adopted by the House of
4 Delegates; and

5
6 Whereas, the AMA Board of Trustees exercises broad oversight and guidance of the AMA
7 through its oversight of the Executive Vice President, while AMA management is responsible for
8 the day-to-day activities of the Association, including advocacy activities; and

9
10 Whereas, state and federal health policy decisions can have substantial and long-lasting effects
11 on patients, physicians, physician practices, and the health care system; and

12
13 Whereas, major state and federal advocacy initiatives and negotiations may develop rapidly and
14 require timely AMA engagement, making effective communication and coordination among AMA
15 management, the Board of Trustees, and other appropriate AMA leadership particularly
16 important; and

17
18 Whereas, enhanced Board awareness and engagement regarding significant state and federal
19 advocacy matters can help ensure that AMA advocacy remains aligned with House of
20 Delegates policy and appropriately reflects the interests of patients and physicians; therefore be
21 it

22
23 RESOLVED, that our American Medical Association develop and maintain an appropriate
24 process to ensure that the Board of Trustees receives timely information regarding significant
25 state and federal advocacy initiatives, negotiations, and policy developments that could
26 substantially affect patients, physicians, physician practices, or the health care system (Directive
27 to Take Action); and be it further

28
29 RESOLVED, that our AMA ensure that, except when immediate action is reasonably necessary,
30 the Board of Trustees is informed and provided an appropriate opportunity for consultation
31 before AMA management endorses, formally supports, or commits the AMA to a significant
32 state or federal legislative or regulatory proposal that could substantially affect physician
33 payment, patient access to care, administrative burden, or other significant aspects of the
34 practice of medicine (New HOD Policy); and be it further

35 RESOLVED, that when immediate action is reasonably necessary and prior consultation is not
 36 practicable, our AMA inform the Board of Trustees of the action taken as soon as practicable
 37 thereafter (New HOD Policy); and be it further
 38

39 RESOLVED, that our AMA report to the House of Delegates on the process developed pursuant
 40 to this resolution at the next meeting of the House. (Directive to Take Action)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

RELEVANT AMA POLICY

G-600.071 Actions and Decisions by the AMA House and Policy Implementation

1. AMA policy on House actions and decisions includes the following:

a. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.

b. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.

c. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.

2. AMA policy on implementation of policy includes the following:

a. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.

b. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.

c. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.

3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject

matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.

4. In urgent situations, the Board of Trustees will exercise its authority to take appropriate action. The Board shall make decisions that it deems to best represent the interests of patients, physicians, and to advocate for science and public health. The Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

HOD C- Article IV

The House of Delegates is the legislative and policymaking body of the Association. It is composed of elected representatives and others as provided in the Bylaws. The House of Delegates transacts all business of the Association not otherwise specifically provided for in this Constitution and Bylaws and elects the officers except as otherwise provided in the Bylaws.

[Last modified 2017]

B-5.3 Duties and Privileges

In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.

5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.

5.3.1.2 Board of Trustee actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter.

5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President.

5.3.6.1 The Executive Vice President is the chief executive officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees.

5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(I-26)

Introduced by: Resident and Fellow Section

Subject: Enhancing Equity in House of Delegates Resolution Processes by Removal
of the Resolutions Committee and Broadening of the Interim Meeting's Focus

Referred to: Reference Committee F

1 Whereas, one of the central tenets of parliamentary procedure, including the parliamentary
2 authority of the AMA, The American Institute of Parliamentarians Standard Code of
3 Parliamentary Procedure (B-11.1, G-600.054), is to protect the rights of minority viewpoints¹;
4 and

5
6 Whereas, at the Annual 2002 House of Delegates, Board of Trustees Report 23 was adopted,
7 which included a recommendation establishing a Resolution Committee “to ensure that the
8 emphasis of the Interim Meeting is placed on advocacy and legislation”²; and

9
10 Whereas, at the Annual 2003 House of Delegates, Council on Constitution and Bylaws Report 2
11 was adopted, which codified the establishment of the Resolution Committee in the AMA Bylaws
12 “to formally reflect the defined scope of the Interim Meeting”³, as currently reflected in B-2.13.3;
13 and

14
15 Whereas, the Resolution Committee was repurposed during the COVID-19 pandemic to help
16 the AMA House of Delegates transition to a virtual format and ensure smooth processing of
17 business under extenuating operational challenges;⁴ and

18
19 Whereas, the Resolution Committee fulfilled a critical role at that time, providing structure and
20 predictability when the House of Delegates was adapting to new virtual technology, compressed
21 timelines, and rapidly evolving public health demands;⁴ and

22
23 Whereas, although the Committee has continued its work during subsequent Interim Meetings,
24 its charge (e.g. reviewing and determining whether submitted resolutions meet criteria such as
25 advocacy, legislation, and ethics) has, in practice, generated prolonged procedural debate
26 within the House; and

27
28 Whereas, these deliberations, while well-intentioned, often shift focus away from the substance
29 of proposed policies, thereby consuming time that could otherwise be dedicated to meaningful
30 discussion, refinement, and evaluation of resolutions within the traditional Reference Committee
31 process; and

32
33 Whereas, delegates may spend more time debating whether a resolution should be discussed
34 than it would take to simply refer it to the appropriate Reference Committee, where expertise,
35 testimony, and amendment processes are already well-established and designed to manage
36 prioritization; and

Whereas, the pre-screening function may now inadvertently disadvantage smaller delegations and sections that rely heavily on the opportunity to have their unique perspectives heard through the standard Reference Committee process; and

Whereas, the introduction of preliminary Reference Committee reports and the streamlined deliberative structure at the 2025 Interim Meeting enabled the HOD to conclude its business a full day ahead of schedule, demonstrating that the current meeting format has adequate capacity to consider all submitted resolutions without the need for an additional pre-screening body; therefore be it

RESOLVED, that our American Medical Association rescind the Resolution Committee as defined in Bylaw 2.13.3 (Directive to Take Action); and be it further

RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings, which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1. (Directive to Take Action)

Fiscal Note: Minimal – less than \$5,000

Received: 9/16/26

References:

1. American Institute of Parliamentarians. *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*. New York, New York: McGraw-Hill; 2012.
2. Board of Trustees Report 23, American Medical Association Annual 2002 House of Delegates. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed September 16, 2026.
3. Council on Constitution and Bylaws Report 2, American Medical Association Annual 2003 House of Delegates. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed September 16, 2026.
4. Report of the Resolutions Committee, American Medical Association November 2020 Special Meeting of the House of Delegates. <https://www.ama-assn.org/system/files/2021-01/nov-s20-call-to-order.pdf>. Accessed September 16, 2026

RELEVANT AMA POLICY

Resolution Committee. B-2.13.3

The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.

2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.

2.13.3.2 Size. The committee shall consist of a maximum of 31 members.

2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.

2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.

2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.

2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.

2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.

Parliamentary Procedure. B-11.1

In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the

then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

Procedures of the House of Delegates G-600.054

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
 - A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
 - B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.
3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly.

Report of the Speakers: Rep. 02, A-16; Modified: CCB Rep. 01, A-17

Introducing Business to the AMA House G-600.060

AMA policy on introducing business to our AMA House includes the following:

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database

identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.

9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.

Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08; Modified: CCB/CLRPD Rep. 1, A-12

Meetings of the House of Delegates. B-2.12

2.12.1 Regular Meetings of the House of Delegates. The House of Delegates shall meet twice annually, at an Annual Meeting and an Interim Meeting.

2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.

2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one-third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.

2.12.3 Locations. The House of Delegates shall meet in cities selected by the Board of Trustees.

2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

2.12.4 Meetings.

2.12.4.1 Open. The House of Delegates may meet in an open meeting to which any person may be admitted. By majority vote of delegates present and voting, an open meeting may be moved into either a closed or an executive meeting.

2.12.4.2 Closed. A closed meeting shall be restricted to members of the AMA, and to employees of the AMA and of organizations represented in the House of Delegates.

2.12.4.3 Executive. An executive meeting shall be limited to the members of the House of Delegates and to such employees of the AMA necessary for its functioning.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(I-26)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Ensuring Relevance and Mission Alignment in House of Delegates Business

Referred to: Reference Committee F

1 Whereas, the American Medical Association is the largest and only national association of
2 physicians in the United States of America; and
3

4 Whereas, the House of Delegates (HOD) is the principal policy-making body of our American
5 Medical Association (AMA), responsible for policies that improve patient care, the health of the
6 public, and the practice of medicine; and
7

8 Whereas, the effectiveness and credibility of our AMA with lawmakers, government
9 administration, and the public depends on maintaining focus on issues within its expertise and
10 sphere of influence; and
11

12 Whereas, the introduction of resolutions addressing matters outside our AMA's mission, such as
13 issues without a clear and direct connection to health or medical practice in the United States,
14 may detract from the HOD's ability to address issues of primary importance to physicians and
15 their patients in the United States; and
16

17 Whereas, the breadth of our AMA's mission encompasses the practice of medicine, the
18 professional interests of physicians, and public health issues for which medical expertise,
19 evidence, or physician advocacy can meaningfully contribute to the prevention of disease,
20 physical injury, disability, or death; and
21

22 Whereas, House of Delegates policy is most effective when it clearly identifies the medical,
23 health policy, or public health objective to be achieved and affords our AMA appropriate
24 discretion to advance that objective in collaboration with policymakers and organizations
25 possessing relevant subject-matter expertise; and
26

27 Whereas, policy outside our AMA's mission detracts from the ability of our staff in Washington to
28 present a focused plan for improving health and the practice of medicine in America; and
29

30 Whereas, asking our AMA's Washington staff to lobby on a multitude of issues often results in
31 legislators lacking understanding of what is truly important to physicians; and
32

33 Whereas, our AMA has finite time and resources during HOD meetings, necessitating
34 prioritization of issues where the Association can have a direct and meaningful impact; and
35

36 Whereas, resolutions put forth to amend broad policies in the context of current events, or to
37 reaffirm current policy, may be utilized to request action where the previous policy could have
38 been applied with an internal organizational request, thus taking time away from HOD
39 discussions on new topics; therefore be it

1 RESOLVED, that our American Medical Association require that all submitted resolutions
2 include a brief statement describing the direct relevance within the United States to the mission
3 of our AMA “to promote the art and science of medicine and the betterment of public health” and
4 explaining how the subject matter and action requested of our AMA fall within its medical, health
5 policy, or public health expertise (New HOD Policy); and be it further
6

7 RESOLVED, that our AMA direct reference committees, in collaboration with the Speakers, to
8 consider relevance to the AMA’s mission and jurisdiction and whether the action requested of
9 our AMA by the resolution falls within its medical, health policy, or public health expertise when
10 making recommendations on resolutions at meetings of the HOD (Directive to Take Action); and
11 be it further
12

13 RESOLVED, that our AMA encourage and publicize the use of alternative mechanisms for
14 consideration of issues that do not meet criteria for policy actions or in lieu of resolutions asking
15 for reaffirmation or minor changes which would not substantially alter the AMA’s ability to take
16 action based upon existing policy (Directive to Take Action); and be it further
17

18 RESOLVED, that our AMA report back at the 2028 Annual Meeting of the House of Delegates
19 on the implementation and impact of these guidelines on the volume and scope of resolutions
20 considered by the House of Delegates. (Directive to Take Action)

Fiscal Note: Minimal – less than \$5,000

Received: 9/20/26

RELEVANT AMA POLICY

G-640.050 Preserving the AMA's Grassroots Legislative and Political Mission

Our American Medical Association will ensure that all Washington activities, including lobbying, political education, grassroots communications and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner. ☐ Res. 619, A-00Reaffirmed: BOT Rep. 6, A-10CCB/CLRPD Rep. 3, A-12Reaffirmed: CCB/CLRPD Rep. 1, A-22

G-625.010 AMA Mission and Vision

Mission: To promote the art and science of medicine and the betterment of public health.

Core Values:

1. Leadership
2. Excellence
3. Integrity and Ethical Behavior.

Vision: To be an essential part of the professional life of every physician. BOT Rep. 1, A-01Consolidated: CLRPD Rep. 3, I-01Modified: BOT Rep. 2, A-02Reaffirmed, BOT Rep. 1, A-03Modified: BOT Rep. 14, I-03Modified: BOT Rep. 22, I-06Reaffirmed: BOT Rep. 5, A-11Reaffirmation A-11Reaffirmed: BOT Rep. 4, I-11Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

G-600.060 Introducing Business to the AMA House

AMA policy on introducing business to our American Medical Association House includes the following:

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and

include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.

3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which they consider significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House. Sub. Res. 120, A-84BOT Rep. D and CLRPD Rep. C, I-91CLRPD Rep. 3 - I-94CLRPD Rep. 5, I-95Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99Res. 604, I-00Consolidated: CLRPD Rep. 3, I-01Modified: CLRPD Rep. 2, A-03Reaffirmed: BOT Rep. 19, A-04CC&B Rep. 3, I-08Modified: CCB/CLRPD Rep. 1, A-12Reaffirmed: CCB/CLRPD Rep. 1, A-22Modified: Speakers Rep. 01, A-24Modified: Speakers Rep. 02, I-24

G-600.061 Guidelines for Drafting a Resolution or Report

Resolutions or reports with recommendations to our American Medical Association House of Delegates shall meet the following guidelines:

1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:
 - a. The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession.
 - b. The proposed policy should be clearly identified at the end of the resolution or report.
 - c. Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline.
 - d. A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution or report is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers

- (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.
2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.
 3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.
 4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.
 5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.
 6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.
 7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.
 8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
 - a. New HOD Policy
 - b. Modify Current HOD Policy
 - c. Consolidate Existing HOD Policy
 - d. Modify Bylaws
 - e. Rescind HOD Policy
 - f. Reaffirm HOD Policy
 - g. Directive to Take Action
 9. Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy. ☐ CLRPD Rep. 4, A-99 Modified by BOT Rep. 15, A-00 Consolidated: CLRPD Rep. 3, I-01 Modified: CLRPD Rep. 2, A-02 Modified: CLRPD Rep. 6, A-03 Reaffirmed: BOT Rep. 19, A-04 Appended: Res. 606, A-05 Appended: Res. 611, A-07 Modified: CCB/CLRPD Rep. 1, A-12 Modified: Speakers Rep., A-18 Reaffirmed: CCB/CLRPD Rep. 1, A-22

G-600.111 Consolidation and Reconciliation of AMA Policy

Our American Medical Association House of Delegates endorses the concept of consolidating its policies in order to make information on existing AMA policy more accessible and to increase the readability of our AMA Policy Database and our AMA PolicyFinder Program.

1. The policy consolidation process allows for:
 - a. rescinding outmoded and duplicative policies.
 - b. combining policies that relate to the same topic.
2. Our AMA House requests that each AMA council, AMA section, and Board of Trustees advisory committee accept ongoing responsibility for developing recommendations on how to consolidate the policies in specific sections of our AMA Policy Database. In developing policy consolidation recommendations, our AMA councils should seek input from all relevant AMA bodies and units. Other groups represented in the House of Delegates also are encouraged to submit consolidation recommendations to the Speakers.
3. The House encourages each AMA council to develop two or more policy consolidation reports each year, recommending changes that will result in significant improvements in the readability of our AMA Policy Database.

4. The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning.
5. Policy Reconciliation. The AMA's policy database should not include duplicative, conflicting or inconsistent AMA policies.
 - a. If a new or modified policy supersedes or renders obsolete one or more existing AMA policies, those existing policies should be identified and presented to the AMA House of Delegates with a recommendation for rescission. The AMA Councils, with the input of appropriate AMA sections and Board advisory committees, have a role to play in reconciling existing policies by presenting reports with recommendations for policy reconciliation. Any organization that has representation in the AMA House of Delegates is encouraged to identify to the Speakers inconsistent or obsolete policies. The Speakers should then decide whether a policy reconciliation report is in order and which council or other entity should most appropriately be asked to develop the consolidation report.
 - b. At each meeting, the Speaker will present one or more reconciliation reports for action by the House of Delegates relating to newly passed policies from recent meetings that caused one or more existing policies to be redundant and/or obsolete. Where a report is needed to reconcile disparate policies, the Speakers will identify the appropriate council or group responsible for the reconciliation report on a specific topic.

CLRPD Rep. 1-A-94Modified by CLRPD Rep. 4, I-95Consolidated: CLRPD Rep. 3, I-01Reaffirmed: CC&B Rep. 2, A-11Modified: CCB/CLRPD Rep. 1, A-12Appended: CCB/CLRPD Rep. 2, A-12Reaffirmed: CCB/CLRPD Rep. 1, A-22

G-600.071 Actions and Decisions by the AMA House and Policy Implementation

1. AMA policy on House actions and decisions includes the following:
 - a. Other than CEJA reports and some CSAPH reports, the procedures of our AMA House allow for: (i) correcting factual errors in AMA reports, (ii) rewording portions of a report that are objectionable, and (iii) rewriting portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible.
 - b. A negative vote by the House of Delegates on resolutions which restate AMA policy does not change the existing policy. AMA policy can only be amended by means of a positive action of the House specifically intended to change that policy.
 - c. Minor editorial changes to existing policies are allowed for accuracy, so long as such changes are reported to the House of Delegates so as to be transparent. Editorially amended policies, however, do not reset the sunset clock.
2. AMA policy on implementation of policy includes the following:
 - a. Our AMA House of Delegates shall be apprised of the status of adopted or referred resolutions and report recommendations and specific actions that have been taken on them over a one-year period. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted.
 - b. Our AMA shall inform and afford an opportunity for each delegation to send a representative for any resolution introduced that is referred to a council or other body to the meeting at which that resolution will be considered. Our AMA shall incur no expense as a result of inviting the sponsors of resolutions to discuss their resolutions.
 - c. Any resolution which is adopted by our AMA House remains the policy of the Association until amended, rescinded or sunset by the House.
3. Except as noted herein and consistent with the AMA Bylaws, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.
4. In urgent situations, the Board of Trustees will exercise its authority to take appropriate action. The Board shall make decisions that it deems to best represent the interests of patients,

physicians, and to advocate for science and public health. The Board will take into consideration existing AMA policy, recommendations from AMA policy staff, and input solicited or obtained from the House of Delegates or its Councils and Sections to inform its position on the interests of patients, physicians, and the AMA. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a 2/3 vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

5. Our AMA considers transformational occurrences, including public health phenomena, sudden changes to national health policies, and sudden disruptions of health and science funding, to be urgent situations worthy of AMA Board of Trustees advocacy and action.
6. Our AMA considers sudden federal funding cuts to foundational institutions of science research and public health to be urgent situations and requests the Board of Trustees take immediate action to respond responsibly, clearly, and expediently as an advocate for science, health care, and public health.
7. Our AMA will provide an online list of AMA Council and Board reports under development, including a staff contact for providing stakeholder input.

Res. 45, I-89Res. 609, I-95Res. 605, I-98Reaffirmed: Sunset Report and Modified: BOT Rep. 15, A-00Consolidated: CLRPD Rep. 3, I-01Appended: BOT Rep. 19, A-04Modified: CCB/CLRPD Rep. 1, A-12Appended: Res. 618, A-19Modified: Res. 602, A-25

G-600.100 AMA Programs for Delegates and Alternate Delegates

Our American Medical Association policy on programs for Delegates and Alternate Delegates includes the following:

1. The Speaker of the House of Delegates shall solicit proposals from various AMA departments to hold programs for AMA Delegates.
2. These programs should be held at our AMA Meetings at times that minimize scheduling conflicts with House of Delegates or Reference Committee meetings.
3. Materials from such programs shall be made available to those who are unable to attend.

Res. 609, I-97Consolidated: CLRPD Rep. 3, I-01CC&B Rep. 3, I-08Reaffirmed: CCB/CLRPD Rep. 3, A-12Reaffirmed: CCB/CLRPD Rep. 1, A-22

G-625.020 AMA Strategic Planning

1. Our AMA annual strategic planning cycle shall include the following dimensions:
 - a. Information: Our AMA strategic planning process shall be based on information about the environment in which medicine and our AMA must function. Drawing from a variety of sources including public and physician survey data, other types of research findings and data, and the work of our AMA councils, sections, and special groups, the Council on Long Range Planning and Development (CLRPD) shall provide strategic support to our AMA Board by identifying, analyzing, and interpreting environmental trends. The Board of Trustees and the CLRPD shall work collaboratively to distribute information on the environment and our AMA's vision, objectives, and strategies to all the participants in the strategic planning process.
 - b. Participation: Our AMA strategic planning process should provide for broad participation by the House of Delegates, Councils, Sections, Special Groups, staff, and other appropriate internal and external sources. The Board of Trustees shall provide opportunities for these entities to provide input into the development of our AMA's strategic plan.
2. Our AMA strategic planning process should generate:
 - a. a multi-year plan that identifies the most critical strategic issues for the organization.
 - b. the critical success factors for each issue.
 - c. annual work plans with measurable performance objectives, tasks and timelines, assignments for implementation, and expected outcomes.
3. The Board must ensure that adequate resources - staff, funding, and material - are available for developing our AMA strategic plan.

4. The goals of our AMA strategic plan should become an overarching part of all Board and Council meetings. All ongoing initiatives and new undertakings must be regularly measured against the plan, and emerging issues that impact the plan should be identified.
 5. Our AMA strategic plan will be presented to the HOD in a more visible, proactive, and interactive way.
 6. Our AMA Board of Trustees will continue to:
 - a. consider input from the House, CLRPD, and broad physician community when developing the Strategic Plan and making resource allocation decisions.
 - b. exercise its fiduciary responsibilities with respect to allocating resources appropriately and consistent with the AMA's vision, goals and priorities.
 - c. monitor the activity and results related to commitments established in the planning process.
 7. Our AMA will continue to communicate activities, achievements, and opportunity for physician involvement through the Federation, Physician Grassroots Network, AMA publications (paper, email, and web-based), and other channels as appropriate.
- Sub. Res 613, A-97CLRPD Rep. 2, A-99Consolidated: CLRPD Rep. 3, I-01Modified: CLRPD Rep. 1, A-03Rep. of the Speakers Special Advisory Committee on the House of Delegates, A-09Appended: BOT Rep. 5, I-11Appended: Res. 609, A-13Modified: Speakers Rep. 2, I-14Modified: CCB/CLRPD Rep. 01, A-23

G-600.045 Online Reference Committee Hearings in the House of Delegates

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 days.

Prior to House of Delegates meetings, reference committees will convene after the close of the Online Reference Committee Hearings to develop a Preliminary Reference Committee Report. These reports shall include preliminary recommendations and will serve as the agenda for the in-person reference committee hearing.

BOT Rep. 8, A-13Modified: CCB Rep. 1, I-13Modified: Speakers Rep. 2, I-14Reaffirmed: CCB/CLRPD Rep. 01, A-23Appended: Res. 604, A-23Modified: Speakers Rep. 0

G-615.071 Activities of the Council on Legislation

1. Our American Medical Association Council on Legislation (COL) will continue to convene forums at AMA meetings to provide members of the Federation an opportunity to hear about and discuss major and emerging legislative and regulatory issues important to physicians and patients.
2. The COL will be represented at AMA-convened meetings focused on advocacy, such as the State Advocacy Summit and National Advocacy Conference.
3. COL members will actively represent, at the discretion of the Chair of the Board of Trustees, our AMA before state and federal government committees and agencies.

BOT Rep. 12, A-07Reaffirmed: BOT Rep. 4, I-10Modified: CCB/CLRPD Rep. 3, A-12Modified: CCB/CLRPD Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-26)

Introduced by: Texas

Subject: Increasing Time Between Handbook Release and Opening of Online
Reference Committees

Referred to: Reference Committee F

1 Whereas, the HOD policy making process was updated by creation of online reference
2 committees (G600.045) with an opening date to be ten days following the resolution submission
3 deadline; and
4

5 Whereas, the current dates for the 2026 Interim meeting have the ORC opening one day after
6 the handbook release; and
7

8 Whereas, there was much discussion at the 2026 Annual Speakers Forum regarding testimony
9 in ORC coming late in the open period making commentary difficult; and that the time allowed to
10 read, evaluate the handbook and to formulate testimony is too short therefore be it; and
11

12 RESOLVED, that our American Medical Association ensure that the House of Delegates
13 handbook is released at least five business days before the opening of the Online Reference
14 Committees to allow adequate time to read and evaluate handbook materials and formulate
15 testimony, while also maintaining the current 21-day window of ORC comment period. (Directive
16 to Take Action)

Fiscal Note: Minimal – less than \$5,000

Received: 9/22/26

REFERENCES

1. AMA Policy G-600.045, Online Reference Committees.

RELEVANT AMA POLICY

AMA Policy G-600.045, Online Reference Committees