REPORTS OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

The following reports, 1–2, were presented by H. Hugh Vincent, MD, Chair:

1. PROPOSAL FOR A WOMEN PHYSICIANS SECTION

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED
Also see Council on Constitution and Bylaws Report 3

In September 2012, the Council on Long Range Planning and Development (CLRPD) received a letter of application from the Women Physicians Congress (WPC) requesting a change in status from an advisory committee to the American Medical Association (AMA) Board of Trustees (BOT) to a section, the Women Physicians Section. The AMA Bylaws on Sections (§7.00) define an AMA section and identify the process by which any new section will be formed and/or change its status and identify each section as fixed or delineated. This report outlines the CLRPD's evaluation of the proposal for a change in status for the WPC, using the criteria in Policy G-615.001. The appendix provides relevant AMA policies.

APPLICATION OF CRITERIA

Following initial review and discussion of the WPC proposal for section status, the CLRPD posed additional questions to the WPC for clarification of some of the information presented in its letter of application. This part of the report presents each criterion followed by material excerpted from the WPC letter of application and its response to CLRPD's request for additional information. An assessment of how this information aligns with the six criteria is included.

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.

Established in 1997 as an advisory committee to the BOT, the WPC serves to provide a dedicated forum within the AMA to create awareness of women physician issues and strengthen the AMA's ability to represent this physician constituency. Over the past fifteen years, the WPC has evolved to identify and address issues of significance and to provide educational opportunities to women physicians attending AMA meetings. These issues include discrimination and income disparity, lack of women physicians in leadership positions in organized and academic medicine, and health issues that disproportionately or uniquely affect women patients.

Despite a steady increase in the number of female medical school deans, women are still under-represented in this position. For example, women represented only 15 percent of new deans appointed in 2000 through 2006. In addition, female deans take longer to advance through the ranks, serve at less research-intensive institutions, and have shorter tenures—only three years as opposed to 5.4 years for men. Creation of the Women Physicians Section could be an avenue to affirm the AMA's commitment to promote diversity and address the concerns of an under-represented group in organized medicine.

Studies have revealed gender differences in physicians' pay that are unexplained by specialization, practice setting, work hours, productivity or other factors; whereby, female physician salaries may be substantially less than their male cohorts' salaries. Efforts to investigate the mechanisms by which these gender differences develop and ways to mitigate their effects merit continued attention, as these differences have not been eliminated through the passage of time alone, and are difficult to justify.

CLRPD Assessment: The proposed Women Physicians Section (WPS) would be the only group in the AMA that would be dedicated to advocacy on women physician policy issues, providing leadership development and educational opportunities for women, and monitoring trends and issues that affect women in medicine and women's health. There are two groups, which have some overlap with the WPC, the American Congress of Obstetricians and

Gynecologists (ACOG) and American Medical Women's Association (AMWA). However, the objectives and activities of ACOG, which are specialty-focused, relate to women's health issues and not professional issues faced by women physicians. The WPC does share some common goals with the AMWA and being a partner with this organization has been beneficial to both groups, though AMWA ultimately has its own distinct advocacy agenda and does not act as an agent of the AMA.

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

The goals of the WPC include, but are not limited to, the following:

- Providing a forum for networking, mentoring, advocacy, and leadership development for women physicians and medical students.
- Contributing to AMA efforts to increase the membership, participation, and leadership of women in the AMA.
- Monitoring trends, identifying and addressing emerging professional issues affecting women in the profession.
- Expanding AMA advocacy on women's health and women in medicine policy issues.
- Enhancing AMA cooperation and collaboration with organizations with mutual concerns, including the AMWA or specialties that deal with health issues of women.

The activities of the WPC include:

a. Physician Mentor Recognition Program: Through its Physician Mentor Recognition Program, the WPC provides an opportunity for physicians to express appreciation to the special men and women who have offered their time, wisdom and support throughout their professional journeys.
b. Giambalvo Memorial Scholarship Fund: The AMA Foundation in association with the WPC has established the Joan F. Giambalvo Memorial Scholarship Fund with the goal of advancing the progress of women in the medical profession and strengthening the ability of the AMA to identify and address the needs of women physicians and medical students.
c. Educational Sessions: Over the past three years, the WPC has organized the following educational sessions:
    - Women in Combat –New Challenges for Medicine and Society;
    - Physician Re-entry to Clinical Practice: What You Need to Know;
    - Strategies to Eliminate Physician Pay Disparities; and
    - Negotiation and the Gender Divide: The Power to Get What You Really Want.

Overall, two key objectives of the WPC relate to the AMA strategic direction: physician workforce issues impacting women physicians (Transforming Medical Education) and health issues that disproportionately affect women patients (Improving Health Outcomes).

CLRPD Assessment: The WPC supports projects of interest to women physicians, including advocacy on women physician policy issues, providing leadership development and educational opportunities for women, and monitoring trends and issues that affect women in medicine and women's health. Within the AMA, there are no other groups devoted to advocacy and education related to issues that affect women in medicine and women's health.

Despite the close relationship with AMWA, the association is still a separate entity. Accordingly, AMWA focuses on its own objectives, which may not always match those of the WPC. Therefore, the AMWA delegate chooses to use their political capital to support AMWA, not the WPC. Through its liaison relations, the WPC can influence, but not dictate the activities of the AMWA delegate.

As a note, this overlap relationship is not unique. For example, the AMA-Integrated Physician Practice Section and the American Medical Group Association have similar objectives, and both groups have a seat in the HOD. In addition, the AMA-Minority Affairs Section and the National Medical Association have overlapping interests, and both have seats in the HOD. Consequently, the activities of the WPC are consistent with its objectives, yet distinct from those of other groups in the AMA.

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

The WPC Governing Council is composed of eight (8) AMA members, including one designated position each from the Medical Student, Resident and Fellow, and Young Physician Sections, and the AMWA.

The proposed structure of the Women Physicians Section (WPS) would be comparable to the structure of the Minority Affairs Section (MAS). The MAS is guided by a nine-member Governing Council that includes three at-large members and one representative each from the AMA Medical Student, Resident and Fellow, and Young Physicians Sections. Similarly, the WPS would have an eight member Governing Council that includes four at-large members and one representative each from these sections and the AMWA. The only significant change to the structure of the WPS will be a change in two of its four at-large positions to that of a delegate and alternate delegate to the AMA's House of Delegates.

CLRPD Assessment: The structure of the WPC is conducive to sharing key concerns and identifying meaningful opportunities for women physicians, which supports the objectives of this group. In accordance with the AMA Bylaws, sections are required to have an elected governing council from the voting members of that section and establish a business meeting that would be open to its members. The WPC presently has an established online balloting process, which creates an avenue for a voting body to elect WPC Governing Council members. Currently the WPC conducts a caucus at the AMA Annual and Interim Meetings. As a Women Physicians Section, the caucus will be re-structured to mirror the Assemblies used by the current delineated sections of the House.

4. Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. 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. It is important to note this threshold will not be used to determine representation, as each new section will be allocated only one delegate and one alternate delegate in the AMA HOD.

The WPC represents more than 67,000 current AMA members. All female physicians and medical student members of the AMA are automatically enrolled in the WPC; however, membership in the WPC is not restricted by gender. The WPC provides an "opt-out" mechanism for female AMA members who express that they do not wish to be included in the WPC, as well as an "opt-in" mechanism for male AMA members to join the WPC.

CLRPD Assessment: According to the Board of Trustees Report 6-A-12, "Demographic Report of the House of Delegates and AMA Membership," 31.38 % of all physicians and medical students in 2011 were female. This same report notes that in 2011, 30.64% of AMA members were female.

Members of this segment can be easily identified because representation for this group is determined primarily by gender. With more than 67,000 AMA members, the threshold criterion representing 1,000 AMA members has been met. Further, the WPC can demonstrate an ongoing and viable group of physicians will be represented by a section. As the percentage of physicians in this demographic group increases, it may be beneficial for the AMA to enhance its partnership with this growing segment of the medical profession.

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

The WPC was established 15 years ago; however, the history of the group dates back to the establishment of the Ad Hoc Committee on Women Physicians in Organized Medicine, initiated in 1979 by mandate of the BOT. The initial goals of the Ad Hoc Committee and its later incarnation, the Advisory Panel on Women in Medicine, were to identify and address issues important to women physicians, and to increase AMA membership and participation of women physicians and medical students at all levels of the Association. Throughout the 1980s and 1990s, the groups conducted surveys, organized conferences and workshops, produced publications, and encouraged AMA membership though numerous advertising efforts.

The Women Physicians Congress carries on the initial mission of its predecessor groups, by striving to increase representation of women physicians in leadership positions throughout organized medicine. In addition, the goals of

the Congress include enhancing AMA advocacy on policy issues, providing leadership development and educational opportunities, and monitoring trends and issues that affect women in the medical profession.

CLRPD Assessment: The WPC has a history of more than 15 years with the AMA. Since its inception as an AMA special group, the WPC has taken steps to align its structure with the policymaking activities of the AMA. The WPC Governing Council has worked to build a solid foundation for the group, which, at this stage, would benefit from a delegate's voice to address issues of concern in the HOD.

6. Accessibility - Provides opportunity for members of the constituency, who are otherwise under-represented, to introduce issues of concern and to be able to participate in the policymaking process within the HOD. During the last thirty years, there has been a dramatic shift in the gender make up of medicine. From 1980 to 2010, the number of female physicians in the United States increased by 447%. Additionally, nearly half of medical students in 2011-2012 were women, compared to 31 percent in 1982-1983. Despite these demographic changes, women physicians remain under-represented in leadership positions, both within the workplace and within organized medicine.

According to the 2011 Demographic Characteristics of the House of Delegates and AMA Leadership (CLRPD 1-A-09), female physicians are relatively under-represented among delegates and alternate delegates and more proportionately represented among the AMA Board and AMA councils, sections and special groups. The report also states, "Both women and international medical graduate physicians are under-represented on state delegations. Women physicians make up over twenty-nine percent (29.5%) of AMA members across the states; however, only twenty-one percent (21.0%) of the delegates and alternates are women."

Unfortunately, the trend for representation of women in the HOD continues to decline. According to the Board of Trustees Report 6-A-12, "Demographic Report of the House of Delegates and AMA Membership," in 2011 the percentage of women in the HOD dropped to 19.87%. Only 192 delegates or alternates in 2011 were women as compared to 202 in 2010. This same report notes that in 2011, 30.64% of AMA members were female. This is encouraging considering that in 2010 only 29.5% of AMA members were female. Overall, 31.38 % of all physicians and medical students in 2011 were female, while 30.9% of all physicians and medical students were female in 2010.

CLRPD Assessment: Accessibility relates to a group having an opportunity to engage in the policymaking process of the HOD with respect to their specific issues of concern. A group with a large number of individuals is not necessarily guaranteed access to this process. Consequently, the perspectives of a group may not be truly represented, as is the case with the WPC.

Often issues of specific concern to women physicians are not brought forward for discussion in the house of medicine. A review of AMA PolicyFinder revealed that less than a dozen policies, adopted or reaffirmed in the past decade, specifically relate to professional issues for women physicians. Even with the number of women physicians in the HOD, many members of this group have an obligation to represent the priorities of their respective state or specialty delegations. Given the limited opportunity to present issues of concern specific to this demographic group, the CLRPD believes it would be appropriate to afford women physicians with an opportunity for a focused voice on their issues of concern.

DISCUSSION

Following initial review and discussion of the WPC proposal for section status, the CLRPD posed additional questions to the WPC for clarification of some of the information presented in its letter of application. The CLRPD engaged in several extended deliberations regarding the WPC's request for a change to section status and on two occasions met with members of the WPC Governing Council for discussion of the proposal.

While women physicians comprise over 30 percent of all US physicians and medical students, women in medicine are not generally advancing to the highest level of the profession and are continuing to encounter subtle and overt forms of discrimination during their training and careers, including exclusion from leadership positions and discrepancy in income. The creation of the Women Physicians Section could be an avenue to affirm the AMA's commitment to promote diversity and address the concerns of this under-represented group in organized medicine.

The issue of unique concerns was considered as part of the rationale for establishing sections within the AMA. Women physicians often have a distinct set of experiences related to medical practice and patient care. Similar to

other AMA sections, the WPC holds governing council meetings in conjunction with HOD meetings, engages in advocacy and coalition building, and provides opportunities for education and involvement. Based on the assessment of the proposal for a Women Physicians Section using the adopted criteria, the CLRPD has determined that the proposed section meets the criteria.

Granting the WPC section status will allow the WPC an opportunity to have focused representation. The CLRPD believes it is appropriate to provide the WPC with an opportunity to have their issues heard in the HOD by granting them with delineated section status. Furthermore, delineated sections are subject to a five-year review after which time the role of this section can be evaluated.

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 our American Medical Association transition the Women Physicians Congress to the Women Physicians Section as a delineated section.

2. That our AMA develop bylaw language to recognize the Women Physicians Section.

APPENDIX – Relevant AMA Policy

B-7.01 Mission of the Sections
7.01 Mission of the Sections. A Section is a formal group of physicians or medical students directly involved in policymaking through a Section delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Sections shall be established by the House of Delegates for the following purposes:

7.011 Involvement. To provide a direct means for membership segments represented in the Sections to participate in the activities, including policy-making, of the AMA. 7.012 Outreach. To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections. 7.013 Communication. To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section. 7.014 Membership. To promote AMA membership growth. 7.015 Representation. To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates. 7.016 Education. To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.

G-615.001 Establishment and Function of Sections
1. Our AMA adopts the following criteria in consideration of requests for establishing or changing the status of member component groups:

A. 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.

B. 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.

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

D. 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. It is important to note this threshold will not be used to determine representation as each new group will be allocated only one delegate and one alternate delegate.

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

F. Accessibility - Provides opportunity for members of the constituency who are otherwise under represented to introduce issues of concern and to be able to participate in the policymaking process within the HOD.

2. Our AMA will consider requests for a change in status for existing groups or formation of new groups by letter of application to the CLRPD, which will make recommendations to the BOT and HOD for further action. (CLRPD Rep. 1, I-10)

G-615.002 AMA Member Component Groups
A "Section" is a formal group of physicians or medical students directly involved in policymaking through a delegate and representing unique interests related to professional lifecycle, practice setting, or demographics. Each Section will continue to have representation in the House of Delegates. There will be two types of Sections, fixed and delineated.

"Fixed Sections" will represent the natural cycles related to a physician's career span. Since members of these groups would have limited opportunities for representation through their state/specialties societies, the need for focused representation will be enduring.

"Delineated Sections" will allow a voice in the house of medicine for large groups of physicians, who are connected through a unique perspective, but may be underrepresented. These Sections will often be based on demographics or mode of practice. Delineated Sections will have a single delegate and alternate delegate in the HOD, and will operate under Internal Operating Procedures approved by the Board of Trustees. Delineated Sections will be reviewed every 5 years by the Council on Long Range Planning, which will make recommendations through the Board of Trustees to the House of Delegates, for renewal of the Section, based on criteria adopted by the House. The review provision allows for fluidity in the Association's structure as the activities and impact of the member groups are routinely evaluated.

An "advisory committee" is an entity whose activities relate to education and advocacy. An advisory committee will have a governing council and a direct reporting relationship to the BOT. Advisory committees, however, will not have representation in the HOD. Advisory committees will operate under a charter that will be subject to review and renewal by the BOT at least every four years.

An "ad hoc committee" is a special committee, workgroup, or taskforce appointed by the BOT, the Speaker of the House, or the House of Delegates. These committees will operate for a specific purpose and for a prescribed period of time.

A "caucus" is an informal group of physicians (from specialty and/or geographic medical groups or focused interest areas) who meet at the Annual and/or Interim meetings to discuss issues, pending resolutions and reports, candidates, and possible actions of the HOD. With the exception of AMA Section caucuses, these groups will not have a reporting relationship or resources allocated by the AMA. (CC&B Rep. 5, A-11)

AMA Policies Related to Women Physicians

D-525.996 Prevention of Harassment and Discrimination of Women in Medicine
(1) The AMA Women Physicians Congress will continue to monitor and disseminate information on harassment and discrimination of women in medicine. (2) Our AMA will: (a) encourage the collection of grievance policies and procedures by the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education; (b) encourage institutions belonging to the Association of American Medical Colleges Council of Teaching Hospitals to continue to distribute, at resident orientation, a copy of their institution's sexual harassment policy; (c) forward this report to the American Hospital Association; and (d) support existing programs that address harassment, discrimination, and sexism. (3) Our AMA will approve the Guidelines for Preventing and Addressing Harassment in the Medical Profession for posting on the AMA web site, and other distribution where appropriate. (CME Rep. 3, A-03; Modified: BOT Rep. 25, I-04)

D-295.962 Prevention of Harassment and Discrimination of Women in Medicine
The AMA Model Harassment and Discrimination Grievance Policy and Procedure will be widely distributed throughout the medical education community and placed on the AMA Web site. (CME Rpt. 3, A-03)

H-525.981 Discrimination of Women Physicians in Hospital Locker Facilities
The AMA, in an effort to promote professional equality as guaranteed by the law, requests that appropriate organizations require: that male and female physicians have equitable locker facilities including equal equipment, similar luxuries and equal access to uniforms. (Res. 810, A-93; Modified and Reaffirmed: CCB Rep. 6, A-03)

B-1.40 Discrimination.
Membership in the AMA or in any constituent association, national medical specialty society or professional interest medical association represented in the House of Delegates, shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

H-310.976 Gender-Based Questioning in Residency Interviews
The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias. (Res. 125, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08)

H-295.969 Nondiscrimination Toward Medical School and Residency Applicants
Our AMA urges (1) the Liaison Committee on Medical Education to amend the Standards for Accreditation of Medical Education Programs Leading to the MD Degree, Part 2, Medical Students, Admissions to read: "In addition, there must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation"; and (2) the Accreditation Council for Graduate Medical Education to amend the "General Essentials of Accredited Residencies, Eligibility and Selection of Residents" to read: "There must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity or sexual orientation." (Res. 12, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-07)

H-525.998 Women in Organized Medicine
Our AMA: (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession; (2) supports the concept of increased tax benefits for working parents; (3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings; (4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs; and (5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress, and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site. (BOT Rep. T, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation A-00; Modified: CME Rep. 3, A-03)

E-9.035 Gender Discrimination in the Medical Profession
Physician leaders in medical schools and other medical institutions should take immediate steps to increase the number of women in leadership positions as such positions become open. There is already a large enough pool of female physicians to provide strong candidates for such positions. Also, adjustments should be made to ensure that all physicians are equitably compensated for their work. Women and men in the same specialty with the same experience and doing the same work should be paid the same compensation. Physicians in the workplace should actively develop the following: (1) retraining or other programs which facilitate the re-entry of physicians who take time away from their careers to have a family; (2) on-site child care services for dependent children; and (3) policies providing job security for physicians who are temporarily not in practice due to pregnancy or family obligations. Physicians in the academic medical setting should strive to promote the following: (1) extension of tenure decisions through "stop the clock" programs, relaxation of the seven year rule, or part-time appointments that would give faculty members longer to achieve standards for promotion and tenure; (2) more reasonable guidelines regarding the appropriate quantity and timing of published material needed for promotion or tenure that would emphasize quality over quantity and that would encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research; and (3) fair distribution of teaching, clinical, research, administrative responsibilities, and access to tenure tracks between men and women. Also, physicians in academic institutions should consider formally structuring the mentoring process, possibly matching students or faculty with advisors through a fair and visible system. Where such policies do not exist or have not been followed, all medical workplaces and institutions should create strict policies to deal with sexual harassment. Grievance committees should have broad representation of both sexes and other groups. Such committees should have the power to enforce harassment policies and be accessible to those persons they are meant to serve. Grantors of research funds and editors of scientific or medical journals should consider blind peer review of grant proposals and articles for publication to help prevent bias. However, grantors and editors will be able to consider the author's identity and give it appropriate weight. (II, VII) Issued June 1994 based on the report "Gender Discrimination in the Medical Profession," adopted June 1993 (Women's Health Issues. 1994; 4: 1-11)

E-9.122 Gender Disparities in Health Care
A patient's gender plays an appropriate role in medical decision making when biological differences between the sexes are considered. However, some data suggest that gender bias may be playing a role in medical decision making. Social attitudes, including stereotypes, prejudices, and other evaluations based on gender role expectations, may play themselves out in a variety of subtle ways. Physicians must ensure that gender is not used inappropriately as a consideration in clinical decision making. Physicians should examine their practices and attitudes for influence of social or cultural biases which could be inadvertently affecting the delivery of medical care. Research on health problems that affect both genders should include male and female subjects, and results of medical research done solely on males should not be generalized to females without evidence that results apply to both sexes. Medicine and society in general should ensure that resources for medical research should be distributed in a manner which promotes the health of both sexes to the greatest extent possible. (I, IV) Issued March 1992 based on the report "Gender Disparities in Clinical Decision Making," adopted December 1990 (JAMA. 1991; 266: 559-62); Updated June 1994.

H-65.987 Gender Exploitation in the Workplace
Our AMA declares it is opposed to any exploitation and discrimination in the workplace based on gender. (Res. 195, A-90; Reaffirmation A-00; Reaffirmation A-05)

H-525.992 Women in Medicine
Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine. (BOT Rep. G, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10)

D-65.998 Elimination of Discrimination of Women
Our Board of Trustees believes that existing AMA policy addresses the need for equitable treatment of men and women, and recommends an examination of AMA policy to the extent that gaps exist in this area. (BOT Rep. 21, I-01; Reaffirmation A-05)

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

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

This informational report, "Demographic Characteristics of the House of Delegates and AMA Leadership," is prepared biennially in odd numbered years by the Council on Long Range Planning and Development pursuant to American Medical Association (AMA) Policy G-610.040, "Promoting Diversity." This policy states:

Our AMA encourages: (1) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year starting in 2003; and (2) the Federation (in nominating or sponsoring candidates for leadership positions), the House of Delegates (in electing Council and Board members), and the Board, the Speakers, and the President (in appointing or nominating physicians for service on AMA Councils or in other leadership positions) to consider the need to enhance and promote diversity.

In even numbered years, the AMA Board of Trustees creates an abbreviated version of this document in line with Policy G-600.035, "The Demographics of the House of the Delegates":

A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. (2) As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and our AMA physician membership every other year.

Similar to previous reports, this document compares AMA leadership with the entire AMA membership and with the overall US physician population. Medical students are included in all references to the total physician population, which is consistent with past practice. Resident/fellow physicians endorsed by their states to serve as sectional delegates and alternate delegates are included in the appropriate comparisons for the state and specialty societies. For the purposes of this report, AMA leadership includes the following groups:

- Delegates
- Alternate Delegates
- The AMA Board of Trustees
- AMA councils and the sections and special groups (hereinafter referred to as CSSG; see detailed listing in Appendix A).

Some comparisons are made separately for state and specialty society delegations, in which case delegates and alternate delegates are combined for the states or specialties.

DATA SOURCES

Lists of delegates and alternate delegates are maintained by the Office of House of Delegates Affairs and based on official rosters provided by the relevant societies. The lists used in this report reflect delegation rosters as of year-end 2012. AMA council rosters as well as listings for the governing bodies of each of the sections and special groups were provided by the relevant AMA staff.

Data on demographic characteristics of individuals are taken from the AMA Physician Masterfile, which provides comprehensive demographic, medical education, and other information on all US and international medical graduates who have undertaken residency training in the US. These data reflect material contained in the Masterfile at the end of 2012. Data on AMA members and the total physician population are taken from the year-end 2012 Masterfile, after it is considered final.

Some key considerations must be kept in mind regarding the information in this report. First, members of the Board of Trustees, AMPAC and the Council on Legislation who are not physicians or medical students are not included in any tables. Second, vacancies in delegation rosters mean the total number of delegates is fewer than the 504 allotted at the 2012 Interim Meeting. The number of alternate delegates is nearly always less than the full allotment. Third, race and ethnicity information, which is provided directly by physicians, is missing for slightly under one-sixth of AMA members and just over one-fifth of the total US physician population, limiting the ability to draw firm conclusions. Board of Trustees Report 24-I-06 described efforts to improve AMA data on race and ethnicity, and improvements have been made resulting in a decline in reporting race/ethnicity as unknown in some of the leadership groups and overall AMA membership.

Lastly, readers are reminded that most AMA leadership groups considered herein include slotted seats for students and resident/fellow physicians. This affects some characteristics, particularly age, as well as the makeup of groups that are age-related, namely the student, resident and young physician sections.

CHARACTERISTICS OF AMA LEADERSHIP

Table 1 presents basic characteristics of AMA leadership along with corresponding information for the total AMA membership and the entire US physician population. On the whole, numbers are not significantly different from two years ago (see CLRPD Report 3-A-11). The average age of delegates increased by only 0.4 years and alternate delegates shifted up by 0.3 years. Delegates, alternate delegates, and the Board are all somewhat older than the average member or physician (including medical students). The average age for the CSSG is 2.5 years older than the average member and 0.6 years older that the average physician.

Other characteristics shown in Table 1 indicate female physicians are relatively underrepresented among delegates and alternate delegates. The proportion of male physicians in each category increased slightly since 2010.

Female physicians are more proportionately represented among the AMA Board and CSSG. The proportion of women on the AMA Board grew from 25% in 2010 to 40% in 2012, and the numbers for the CSSG went from 28.6% in 2010 to 33.7% in 2012. This corresponded with a growing number of female physicians and AMA members. In 2010, 30.9% of all physicians and medical students were female. This grew to 32.0% in 2012. AMA membership went from 29.5% female in 2010 to 31.3% female in 2012.

Comparisons across race and ethnicity categories are complicated by the large proportion of physicians for whom data are missing. Except for the Board and CSSG, for whom it is comparatively easy to solicit information, data are missing for approximately eleven to twenty-one percent (11%–21%) of the groups arrayed in Table 1. Nonetheless, for all four leadership groups, at least two-thirds are White, non-Hispanic. The percentage of AMA delegates who identified as White, non-Hispanic held fairly steady going from 76.5% in 2010 to 76.8% in 2012, but there was a decline of three to five percentage points for alternate delegates and members of the AMA Board who were identified as White, non-Hispanic. The proportion of Asian/Asian American delegates held at 5.3% for both 2010 and 2012, although the number of Asian/Asian American alternate delegates went up 3.6 percentage points. AMA Board membership among Asian/Asian Americans increased by five percentage points, which is consistent with the trend identified in the 2011 report.

Additionally, Table 1 includes data on medical education, which shows that more than eighty-nine percent (89.5%) of each of the leadership groups are graduates of LCME-accredited schools in the US or Canada. This compares to eighty-four percent (84.0%) of AMA membership and more than seventy-seven percent (77.2%) of the US physician population, including medical students.

Data on physicians' and students' current activities appear in Table 2. The "life stage" classifications correspond with the membership criteria for specific AMA groups such as: young (under age 40 or in first eight years of practice), mature (age 40-64), and senior (age 65 or more).

The figures for the student and resident/fellow physician categories are quite comparable to the 2011 report. Over twenty-two percent (22.2%) of AMA members are students, compared to nearly eight percent (7.9%) of the US physician population. One in 20 delegates and one in 13 alternate delegates are medical students. Regional student delegates and alternate delegates number 23 and 22, respectively. Seventeen percent (17.0%) of AMA members are resident/fellow physicians, compared to nearly ten percent (9.8%) of the US physician population. One in 24 delegates and one in 16 alternate delegates are resident/fellow physicians. The data include the 15 resident sectional delegates and 15 resident sectional alternate delegates.

One in 55 delegates and one in 12 alternate delegates are young physicians. Overall, more than half of the delegates and alternate delegates are mature physicians, defined as 40-64 years of age. More than one-third of delegates and one-fifth of alternate delegates are senior physicians, which is defined as over the age of 65.

Table 2 also includes data on present employment patterns for the leadership groups as well as AMA members and the total US physician population. Pursuant to Policy G-600.035, "Resident/Fellow," has been included under "Present Employment." As students are reported separately in the Present Employment section, reporting resident/fellow physicians in this manner allows for consistency in differentiating physicians in practice from physicians in training.

Most changes from 2010 among the leadership groups are relatively small, and comparisons to the AMA membership or to the total physician population show only subtle differences. Compared to 2010, the proportion of physicians in private practice settings is relatively static, with the greatest growth in group practice. The percentage of physicians in group practice increased from 30.8% in 2010 to 42.6% in 2012. The proportion of AMA members in group practice grew from 23.5% in 2010 to 27.7% in 2012.

The percentage of retired physicians among all US physicians remained relatively stable at 9.4% in 2010 and 9.5% in 2012, while the proportion of AMA members within this designation fell from 19.3% in 2010 to 10.0% in 2012.

The self-designated specialties of AMA leadership appear in the lower panel of Table 2. Except for a slight overrepresentation of surgical and internal medicine specialists among delegates and alternate delegates, the distribution of specialties is consistent with AMA membership and reasonably similar to the entire physician population.

Specialty Delegations to the AMA House of Delegates

While the preceding comparisons examined AMA leadership across four groups, the stated goal of the demographic report is to offer data that encourages state and specialty delegations to increase diversity. The Council acknowledges most delegations are too small to exhibit true diversity within their ranks, but hopes diversity will be apparent within the composition of the House of Delegates.

In this regard, Table 3 presents data on specialty society delegations. Because individual delegations are too small to analyze separately, the data are presented by specialty discipline rather than delegation. The specialty disciplines and specific specialty designations contained within each are found in Appendix B. The totals for the delegates and alternate delegates are combined.

At the end of 2012, there were 377 delegates and alternate delegates representing specialty societies in the House of Delegates. The mean age of AMA specialty society delegates and alternate delegates is 57.3 years and the median age is 59.0 years, significantly higher than the mean age for AMA members of 49.0 and the median age of 45.0 years.

Resident/fellow physicians and international medical graduates are uniformly underrepresented across the specialty disciplines. At the same time, because most specialty disciplines have relatively few slots, a change of only one more or one less resident/fellow physician or international medical graduate would dramatically change the proportions. These data must be interpreted cautiously.

Female physicians make up slightly less than one-third (31.3%) of AMA members, but only have at least that level of representation in obstetrics and gynecology. On a cautionary note, these comparisons do not take into account the proportion of women within these specialties.

State Delegations to the AMA House of Delegates

Table 4 presents data on the mean and median age of AMA members by state as well as the mean and median age of each state delegation. The mean age of AMA members across states is 49.0 years, and the median age is 45.0 years, representing very little change from 2010. That year the mean age of AMA members was 49.6, and the median age was 47.0 years. Most state delegations are, on average, older than the average for the state's AMA members. The mean age for state delegations is 9.9 years greater than the mean age of AMA members per state. This is 3.8 years higher than the difference of 6.1 years documented for 2010.

Table 5 provides state-by-state information on the numbers of female and international medical graduate physicians per state and per state delegation. Similar information for resident/fellow physicians and students is presented in Table 6.

Key findings include:

- Both women and international medical graduate physicians are underrepresented on state delegations.
  - Women physicians make up over thirty-one percent (31.3%) of AMA members across the states; however, only around nineteen percent (19.5%) of delegates and alternates are female.
  - International medical graduate physicians comprise sixteen percent (16.0%) of AMA members across the states, while making up approximately ten percent (10.6 %) of the delegates and alternate delegates.

- Students and resident/fellow physicians have fewer slots on delegations than would be expected given their overall numbers among AMA membership.
  - Students comprise more than twenty-two percent (22.2%) of AMA members but hold nearly twelve percent (11.6%) of positions in state delegations.
  - Resident/fellow physicians hold slightly more than six percent (6.2%) of the slots in state society delegations even though they constitute seventeen percent (17.0%) of AMA members across the states.

CHARACTERISTICS OVER TIME SINCE 2000

Figures 1 through 3 present data related to age of the groups of interest. The average age of all physicians and medical students changed significantly in comparison to 2000, while the age of AMA members, delegates and alternate delegates held fairly steady. The AMA Board got slightly younger and the average age of CSSG went up.

In 2000, the average age of physicians and medical students was 48.0 years old, but in 2012 that number had inched up to 50.9. The average AMA member age increased slightly from 48.7 years in 2000 to 49.0 in 2012. The average age of delegates went from 58.6 years in 2000 to 58.3 in 2012, and alternate delegates went from 52.5 in 2000 to 53.3. The average age of AMA Board members went from 58.6 in 2000 to 56.9 in 2012. CSSG went from an average age of 50.0 years in 2000 to 51.5 in 2012.

Present employment is detailed in Table 2 and Figure 4. Significant changes that occurred since the 2011 report include:

- Small Practice and Group Practice Employment Settings:
  - The proportion of AMA members who are self-employed in solo practice grew from 8.3% in 2010 to 10.9% in 2012. This practice style declined slightly among all physicians and medical students from 10.9% in 2010 to 10.5% in 2012. Representation for this group of physicians is considerably higher among delegates and alternate delegates.

- Group practice physicians grew from 30.8% of all physicians and medical students in 2010 to 42.6% in 2012. The proportion of group practice physicians among AMA members increased from 23.5% in 2010 to 27.7% in 2012. Group practice physicians among delegates, alternate delegates, the AMA Board and CSSG held steady in comparison to 2010.

- Retired/Inactive Physicians:
  - The proportion of retired/inactive physicians went up among AMA delegates and alternate delegates but went down among AMA members. A total of 9.5% of all physicians were retired or inactive in 2012, which is not significantly higher than the 9.4% reported for 2010. About 3.8% of delegates and 2.0% of alternate delegates were retired or inactive in 2010, and these numbers went up to 5.1% and 4.6% respectively in 2012. In 2010, 19.3% of AMA members reported that they were retired or inactive, and this number declined to 10.0% in 2012.

Figure 5 illustrates the gender composition for AMA leadership, AMA membership and the US physician population. Figure 6 shows representation of women physicians over time. The representation of women physicians has generally improved since 2000. The proportion of delegates who are female increased from 15.0% in 2000 to 20.2% in 2012. Among alternate delegates, the numbers went up from 15.9% in 2000 to 21.5% in 2012. The AMA Board was 15.0% female in 2000 but 40.0% female in 2012. CSSG was 25.3% female in 2000, but this number grew to 33.7% in 2012.

Race and ethnicity of AMA leadership groups, AMA membership, and the US physician population are illustrated in Figure 7. Compared to the US physician population, White, non-Hispanic physicians continue to be generally overrepresented in AMA leadership and membership, despite efforts to attract other minority physicians.

Figure 8 depicts similar information on international medical graduate physicians. The proportion of physicians and medical students who are international medical graduates grew from 20.8% in 2000 to 22.8% in 2012. The percentage of AMA members who are international medical graduates grew from 14.8% to 16.0%. Trends among AMA leadership groups show only slight changes, with a small decline among the CSSG and insignificant growth among delegates and alternate delegates.

Table 1. Basic Demographic Characteristics of AMA Leadership, December 2012

	AMA Delegates (n=495) [1, 2]	AMA Alternate Delegates (n=438) [2]	AMA Board (n=20) [3]	AMA Councils & Leadership of Sections & Special Groups (n=175) [4]	AMA Members (n=224,503)	All Physicians & Medical Students (n=1,189,096)
Mean age (years)[5]	58.3	53.3	56.9	51.5	49.0	50.9
Age distribution (percent)						
Under age 40	10.7%	21.0%↑	10.0%	28.6%	43.7%↑	29.8%
40-49 years	11.7%	12.3%↓	5.0%	10.9%	11.3%	19.9%
50-59 years	24.2%	27.2%↓	40.0%↑	20.6%↓	13.8%	20.2%
60-69 years	35.4%	29.5%↑	35.0%↓	29.1%↑	11.1%	15.3%
70 or more	18.0%	10.0%↑	10.0%	10.9%↑	20.2%	14.9%
Gender (percent)						
Male	79.8%	78.5%	60.0%↓	66.3%↓	68.7%	68.0%
Female	20.2%	21.5%	40.0%↑	33.7%↑	31.3%	32.0%
Race/ethnicity (percent)						
White non-Hispanic	76.8%	71.2%↓	80.0%	69.1%	61.9%	53.9%
Black non-Hispanic	3.4%	3.7%	5.0%↑	6.9%	4.2%	4.0%
Hispanic	2.0%	3.0%	0.0%	2.9%	4.0%	4.9%
Asian/Asian American	5.3%	10.0%↑	15.0%↑	12.0%	13.7%	14.5%
Native American	0.2%	0.2%	0.0%	1.7%	0.3%	0.2%
Other[6]	1.0%	0.5%	0.0%	0.0%	1.0%	1.3%
Unknown	11.3%	11.4%	0.0%↓	7.4%	14.7%	21.2%
Education (percent)						
US or Canada	92.7%	89.5%	100.0%	91.4%	84.0%	77.2%
IMG	7.3%	10.5%	0.0%	8.6%	16.0%	22.8%

[1] There were nine vacancies as of the 2012 Interim Meeting.
[2] Numbers include medical students and resident/fellow physicians endorsed by their states for delegate and alternate delegate positions.
[3]Numbers do not include the public member of the Board of Trustees, who is not a physician.
[4]Numbers do not include non-physicians on the Council on Legislation and the American Medical Political Action Committee. Appendix A contains a listing of the AMA Councils, Sections, and Special Groups.
[5] Age as of December 31. Mean age is the arithmetic average.
[6] Includes other self-reported racial and ethnic groups.
↑ Indicates an increase of at least two percentage points compared with 2010; see text.
↓ Indicates a decrease of at least two percentage points compared with 2010; see text.

Table 2. Life Stage, Present Employment and Self-Designated Specialty[1] of AMA Leadership, December 2012

	AMA Delegates (n=495)	AMA Alternate Delegates (n=438)	AMA Board (n=20)	AMA Councils & Leadership of Sections & Special Groups (n=175)	AMA Members (n=224,503)	All Physicians & Medical Students (n=1,189,096)
Life Stage (percent)						
Student[2]	5.1%	7.8%	5.0%	10.9%	22.2%	7.9%
Resident/Fellow[2]	4.2%	6.2%	5.0%	12.0%	17.0%↑	9.8%
Young (Under age 40 or first eight years of practice)[3]	1.8%	8.2%	0.0%↓	8.0%	8.2%	17.0%
Mature (Age 40-64)[3]	53.9%↓	56.4%↓	60.0%↑	46.3%	27.8%	44.0%
Senior (Age 65 or more)[3]	34.9%	21.5%↑	30.0%↓	22.9%	24.9%	21.3%
Present Employment						
Self-employed solo practice	17.0%	16.9%	20.0%↑	14.9%	10.9%↑	10.5%
Two-physician practice	3.0%	2.3%	0.0%	2.3%	2.1%	2.0%
Group practice	45.1%	38.4%↓	45.0%↑	34.3%	27.7%↑	42.6%↑
Non-government hospital	5.7%	4.1%	10.0%	2.9%	2.6%	3.4%
State or local government hospital	4.6%	6.8%↑	10.0%↑	5.1%	3.2%	4.6%
HMO	0.4%	0.5%	0.0%	1.1%	0.1%	0.2%
Medical School	6.1%	6.6%	5.0%↓	9.1%	1.8%	2.0%
US Government	3.0%	4.8%	0.0%↓	1.7%	1.3%	2.3%
Locum Tenens	0.4%	0.0%	0.0%	1.1%	0.2%	0.2%
Retired/Inactive	5.1%	4.6%↑	0.0%	4.6%	10.0%↓	9.5%
Resident/Fellow	4.2%	6.2%	5.0%	12.0%	17.0%↑	9.8%
Student	5.1%	7.8%	5.0%	10.9%	22.2%	7.9%
Other/Unknown	0.4%↓	1.1%↓	0.0%↓	0.0%↓	0.8%↓	4.8%↓
Self-designated specialty						
Family Medicine	11.5%	11.9%	15.0%	11.4%	9.6%	12.2%
Internal Medicine	19.6%	20.1%	20.0%↓	20.6%	18.7%	22.8%
Surgery	26.7%	21.7%	15.0%	20.6%	15.0%	13.8%
Pediatrics	3.6%	3.2%	5.0%	5.1%	4.9%	8.6%
OB/GYN	6.1%	4.6%	5.0%	3.4%↓	5.9%	4.9%
Radiology	4.4%	5.0%	5.0%↑	6.3%	4.1%	4.6%
Psychiatry	4.2%	4.1%	5.0%	3.4%↓	3.9%	4.8%
Anesthesiology	4.2%	4.1%	5.0%↓	3.4%↓	3.9%	4.8%
Pathology	1.8%	2.3%	0.0%	0.0%	1.9%	2.3%
Other specialty	12.7%	14.2%↑	15.0%↑	10.9%	9.9%	12.5%
Student	5.1%	7.8%	5.0%	10.9%	22.2%	7.9%

[1] See Appendix B for a listing of specialty classifications.
[2] Students and resident/fellow physicians are so categorized without regard to age.
[3] Age delineation reflects section/group definition of its membership.
↑ Indicates an increase of at least two percentage points compared with 2010; see text.
↓ Indicates a decrease of at least two percentage points compared with 2010; see text.

Table 3. Characteristics of Specialty Society Delegations, December 2012

	Mean Age*	Median Age*	% Female	% IMG	% Resident/Fellow
AMA Members (n =224,503)	49.0	45	31.3%	16.0%	17.0%
Specialty Society Delegates and Alternates (n =377)	57.3	59	20.4%	6.6%	1.9%
Family Medicine Delegates (n =31)	59.2	61	16.1%	3.2%	3.2%
Internal Medicine Delegates (n =61)	60.9	63	21.3%	9.8%	1.6%
Surgery Delegates (n =92)	57.1	58	9.8%	5.4%	0.0%
Pediatrics Delegates (n =13)	61.0	63	23.1%	0.0%	0.0%
OB/GYN Delegates (n =20)	58.9	60	50.0%	5.0%	0.0%
Radiology Delegates (n =31)	60.3	63	12.9%	12.9%	3.2%
Psychiatry Delegates (n =20)	59.1	58	15.0%	5.0%	0.0%
Anesthesiology Delegates (n =19)	53.0	56	26.3%	5.3%	0.0%
Pathology Delegates (n =14)	58.5	58	28.6%	7.1%	0.0%
Other specialty Delegates (n =76)	52.2	55	27.6%	5.3%	3.9%

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

Table 4. Mean and Median Age of AMA Members and Delegations by State, December 2012*

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
Alabama	2,822	50.4	51	5	58.6	59
Alaska	310	55.8	55	2	†	†
Arizona	3,514	50.4	47	7	56.4	53
Arkansas	1,952	46.8	43	4	63.0	63
California	19,286	53.4	51	35	58.9	63
Colorado	3,607	45.5	38	8	57.0	59
Connecticut	3,511	48.2	45	8	68.3	70
Delaware	707	58.1	56	2	†	†
District of Columbia	1,568	40.8	29	4	62.0	59
Florida	12,344	52.2	51	21	57.9	61
Georgia	4,810	48.8	46	10	61.1	59
Guam	22	52.8	50	1	†	†
Hawaii	1,046	54.3	54	2	†	†
Idaho	573	56.2	54	2	†	†
Illinois	11,138	50.6	49	23	60.6	64
Indiana	4,610	47.5	42	10	63.0	61
Iowa	2,630	49.6	48	6	57.7	59
Kansas	2,041	53.4	52	5	69.2	67
Kentucky	3,459	46.7	41	8	59.9	60
Louisiana	3,538	42.2	32	8	57.8	63
Maine	1,142	45.0	37	4	58.0	57
Maryland	4,200	49.4	46	10	61.4	62
Massachusetts	5,839	47.1	41	12	59.5	62
Michigan	9,867	48.0	44	22	54.0	57
Minnesota	4,687	47.2	41	11	52.2	58

Table 4. Mean and Median Age of AMA Members and Delegations by State, December 2012*

State	Total AMA Members in State	Mean Age of AMA Members	Median Age of AMA Members	Total Number of Delegates and Alternate Delegates	Mean Age of AMA Delegates and Alternate Delegates	Median Age of Delegates and Alternate Delegates
Mississippi	2,182	51.1	51	6	52.0	51
Missouri	5,326	42.7	34	12	57.8	63
Montana	556	52.8	52	2	†	†
Nebraska	1,663	44.5	37	4	63.0	63
Nevada	1,113	50.0	49	4	62.3	64
New Hampshire	825	50.3	49	2	†	†
New Jersey	5,778	52.0	52	11	64.9	63
New Mexico	1,308	49.1	45	4	58.0	61
New York	17,593	47.7	41	33	57.3	58
North Carolina	5,428	49.6	47	10	58.9	58
North Dakota	728	44.2	35	2	†	†
Ohio	10,238	45.9	37	20	53.3	54
Oklahoma	3,339	49.6	48	9	61.4	63
Oregon	1,938	55.2	55	4	59.5	59
Pennsylvania	11,922	50.5	48	26	60.1	60
Puerto Rico	1,254	46.3	37	3	†	†
Rhode Island	1,027	45.3	37	2	†	†
South Carolina	3,266	43.5	35	8	62.5	64
South Dakota	895	46.5	43	2	†	†
Tennessee	4,729	48.2	45	10	64.5	64
Texas	15,538	46.7	42	33	56.6	59
Utah	1,546	50.6	48	4	51.3	49
Vermont	400	52.2	49	2	†	†
Virgin Islands	45	60.3	59	-	N/A	N/A
Virginia	6,272	46.3	41	14	63.5	62
Washington	3,628	55.6	54	8	57.9	59
West Virginia	1,604	46.3	40	4	67.3	67
Wisconsin	4,226	48.2	43	10	56.1	61
Wyoming	219	57.8	56	2	†	†
APO/FPO/Foreign	694	77.1	81	-	N/A	N/A
TOTAL	224,503	49.0	45	481	58.9	60

* The mean age is the arithmetic average age. The median age is the age at which 50% of the group is older and 50% is younger.
† To protect the privacy of these individuals, data for three or fewer persons are not presented in the table, although the data are included in the overall totals.
β This table does not include regional student delegates or alternate delegates. It also does not include resident sectional delegates or alternate delegates.

Table 5. Women and International Medical Graduates on State Association Delegations, December 2012

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Alabama	2,822	5	723	1	283	-
Alaska	310	2	111	-	32	-
Arizona	3,514	7	1,006	2	495	-
Arkansas	1,952	4	561	-	178	1
California	19,286	35	5,799	6	2,931	2
Colorado	3,607	8	1,287	4	145	-
Connecticut	3,511	8	1,163	-	708	2
Delaware	707	2	187	2	155	-
District of Columbia	1,568	4	682	2	125	1
Florida	12,344	21	3,290	2	3,067	5
Georgia	4,810	10	1,526	3	709	1
Guam	22	1	7	-	11	-

Table 5. Women and International Medical Graduates on State Association Delegations, December 2012

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Women AMA Members in State	Number of Women Delegates and Alternate Delegates	Total IMG Members in State	Number of IMG Delegates and Alternate Delegates
Hawaii	1,046	2	301	-	120	-
Idaho	573	2	111	2	29	1
Illinois	11,138	23	3,581	4	2,331	4
Indiana	4,610	10	1,341	-	653	1
Iowa	2,630	6	757	2	338	-
Kansas	2,041	5	569	1	259	-
Kentucky	3,459	8	1,029	1	492	-
Louisiana	3,538	8	1,256	1	387	-
Maine	1,142	4	421	2	108	-
Maryland	4,200	10	1,413	1	771	2
Massachusetts	5,839	12	2,073	3	861	1
Michigan	9,867	22	3,068	4	2,209	7
Minnesota	4,687	11	1,509	3	616	-
Mississippi	2,182	6	541	-	160	-
Missouri	5,326	12	1,832	-	599	3
Montana	556	2	147	1	23	-
Nebraska	1,663	4	519	-	134	-
Nevada	1,113	4	302	1	188	1
New Hampshire	825	2	243	-	123	-
New Jersey	5,778	11	1,734	1	1,603	5
New Mexico	1,308	4	457	1	148	-
New York	17,593	33	5,964	6	4,591	3
North Carolina	5,428	10	1,568	3	573	-
North Dakota	728	2	244	-	100	-
Ohio	10,238	20	3,389	8	1,514	-
Oklahoma	3,339	9	898	3	429	1
Oregon	1,938	4	556	1	127	-
Pennsylvania	11,922	26	3,666	5	1,538	1
Puerto Rico	1,254	3	456	-	332	1
Rhode Island	1,027	2	395	-	143	-
South Carolina	3,266	8	1,094	-	226	-
South Dakota	895	2	251	1	82	-
Tennessee	4,729	10	1,425	-	477	1
Texas	15,538	33	5,188	6	2,153	4
Utah	1,546	4	375	1	97	-
Vermont	400	2	132	-	23	-
Virgin Islands	45	-	13	-	17	-
Virginia	6,272	14	2,107	3	818	1
Washington	3,628	8	998	3	411	1
West Virginia	1,604	4	504	-	285	1
Wisconsin	4,226	10	1,292	4	618	-
Wyoming	219	2	45	-	26	-
APO/FPO/Foreign	694	-	89	-	408	-
TOTAL	224,503	481	70,195	94	35,979	51

This table does not include the 13 regional student delegates or alternate delegates who are female. It also does not count the 10 resident sectional delegates or alternate delegates who are women and the seven who are international medical graduates.

Table 6. Medical Students and Resident Physicians on State Association Delegations, December 2012

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Medical Student AMA Members in State[1]	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[2]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates
Alabama	2,822	5	470	-	-	402	-
Alaska	310	2	3	-	-	19	-
Arizona	3,514	7	805	1	1	486	-
Arkansas	1,952	4	558	1	1	231	-
California	19,286	35	2,829	6	4	3,958	4
Colorado	3,607	8	1,396	1	1	331	-
Connecticut	3,511	8	821	-	-	594	-
Delaware	707	2	4	-	-	77	-
District of Columbia	1,568	4	754	-	-	275	-
Florida	12,344	21	1,857	2	2	2,107	2
Georgia	4,810	10	1,069	2	2	744	-
Guam	22	1	-	-	-	3	-
Hawaii	1,046	2	167	-	-	128	-
Idaho	573	2	3	-	-	35	-
Illinois	11,138	23	2,549	2	1	1,437	1
Indiana	4,610	10	780	3	3	1,159	-
Iowa	2,630	6	551	1	1	248	-
Kansas	2,041	5	288	1	1	265	-
Kentucky	3,459	8	682	-	-	782	-
Louisiana	3,538	8	1,112	-	-	1,018	2
Maine	1,142	4	434	-	-	150	-
Maryland	4,200	10	897	1	-	674	2
Massachusetts	5,839	12	1,207	3	2	1,258	2
Michigan	9,867	22	2,022	3	2	1,711	1
Minnesota	4,687	11	651	-	-	1,298	2
Mississippi	2,182	6	447	2	2	191	-
Missouri	5,326	12	1,733	3	2	1,157	1
Montana	556	2	162	-	-	14	-
Nebraska	1,663	4	584	1	1	196	1
Nevada	1,113	4	254	-	-	74	-
New Hampshire	825	2	133	-	-	95	-
New Jersey	5,778	11	1,012	2	2	768	-
New Mexico	1,308	4	387	-	-	149	-
New York	17,593	33	4,185	4	3	4,054	1
North Carolina	5,428	10	1,048	-	-	791	1
North Dakota	728	2	297	-	-	74	1
Ohio	10,238	20	2,932	3	2	2,000	2
Oklahoma	3,339	9	642	2	2	627	-
Oregon	1,938	4	227	-	-	197	-
Pennsylvania	11,922	26	3,029	3	2	1,578	2
Puerto Rico	1,254	3	452	-	-	164	-
Rhode Island	1,027	2	319	-	-	175	1
South Carolina	3,266	8	1,183	-	-	436	-
South Dakota	895	2	280	-	-	40	-
Tennessee	4,729	10	1,225	2	2	688	1
Texas	15,538	33	3,922	3	2	2,388	1
Utah	1,546	4	183	-	-	251	-
Vermont	400	2	85	-	-	63	-
Virgin Islands	45	-	1	-	-	2	-
Virginia	6,272	14	1,875	2	2	866	1
Washington	3,628	8	157	-	-	416	1
West Virginia	1,604	4	506	1	1	195	-
Wisconsin	4,226	10	641	1	1	1,011	-

Table 6. Medical Students and Resident Physicians on State Association Delegations, December 2012

State	Total AMA Members in State	Total Number of Delegates and Alternate Delegates	Total Medical Student AMA Members in State[1]	Number of Medical Student Delegates and Alternate Delegates	Number of Regional Medical Student Delegates and Alternate Delegates[2]	Total Resident Physician AMA Members in State	Number of Resident Delegates and Alternate Delegates
Wyoming	219	2	1	-	-	12	-
APO/FPO/Foreign	694	-	-	-	-	26	-
TOTAL	224,503	481	49,811	56	45	38,088	30

[1] Alaska, Delaware, Guam, Idaho, Montana, Virgin Islands, and Wyoming do not have a medical school.
[2] The Medical Student Section elects AMA delegates and alternate delegates from Medical Student Regions. There are seven Medical Student Regions defined for the purposes of electing AMA Delegates from Medical Student Regions. Each Region is entitled to delegate and alternate delegate representation based on the number of seats allocated to it by apportionment. A delegate is seated with the state delegation in which his or her medical school resides.

Figure 1. Age Makeup of AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.

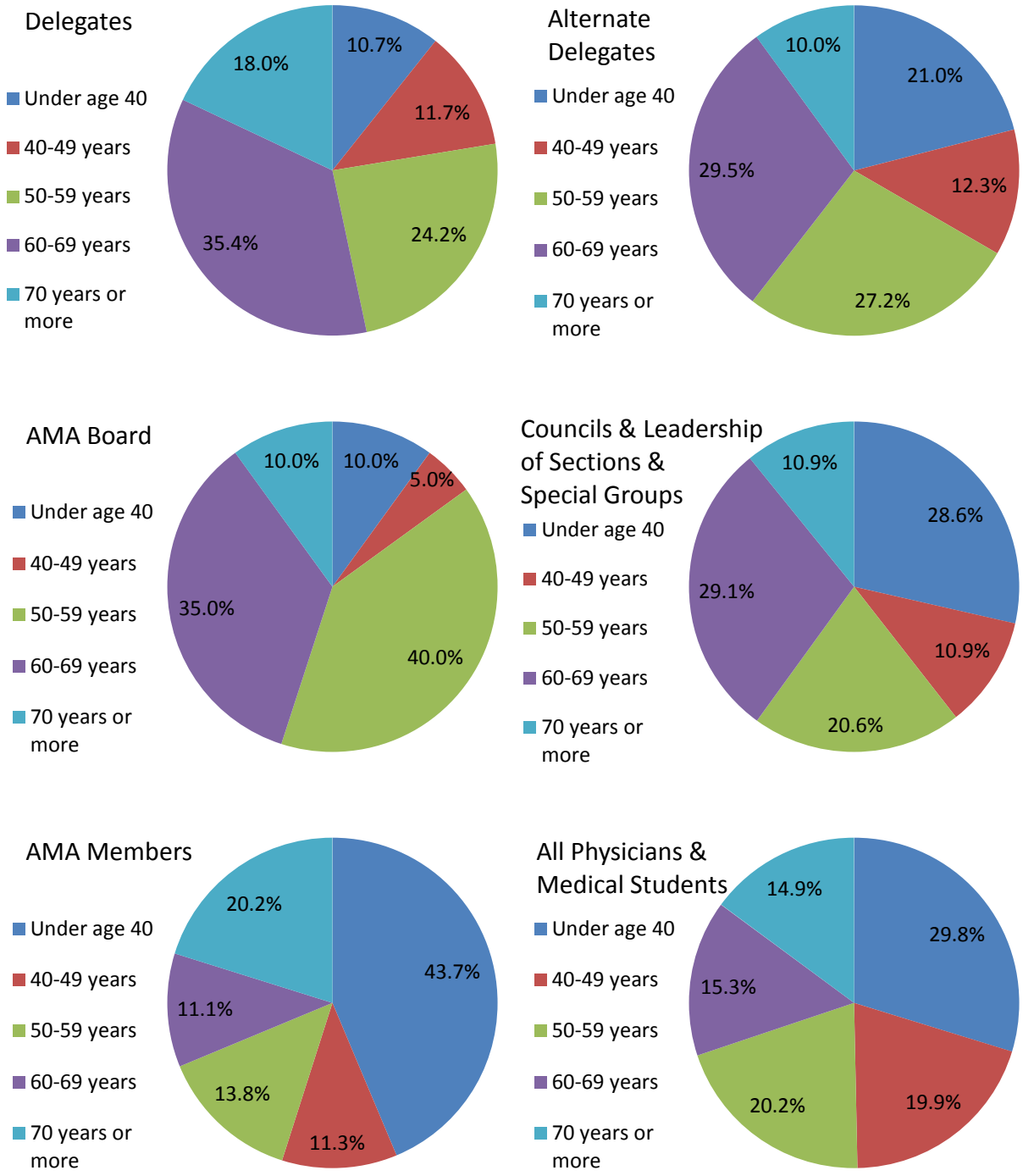


Figure 2. Average Age of AMA Leadership Groups, AMA Members, and US Physician Population, including Medical Students.

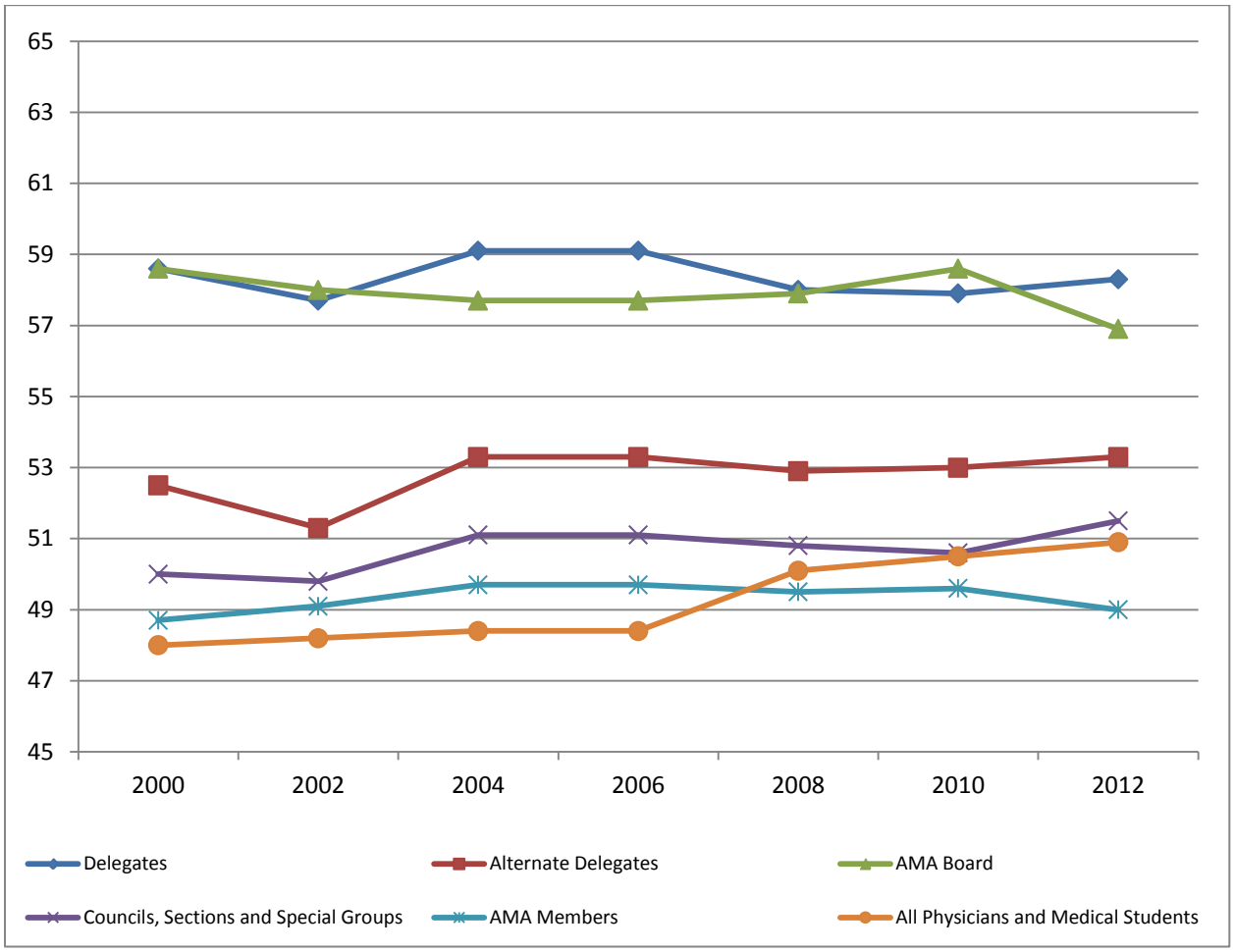


Figure 3. Life Cycle Data for AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.

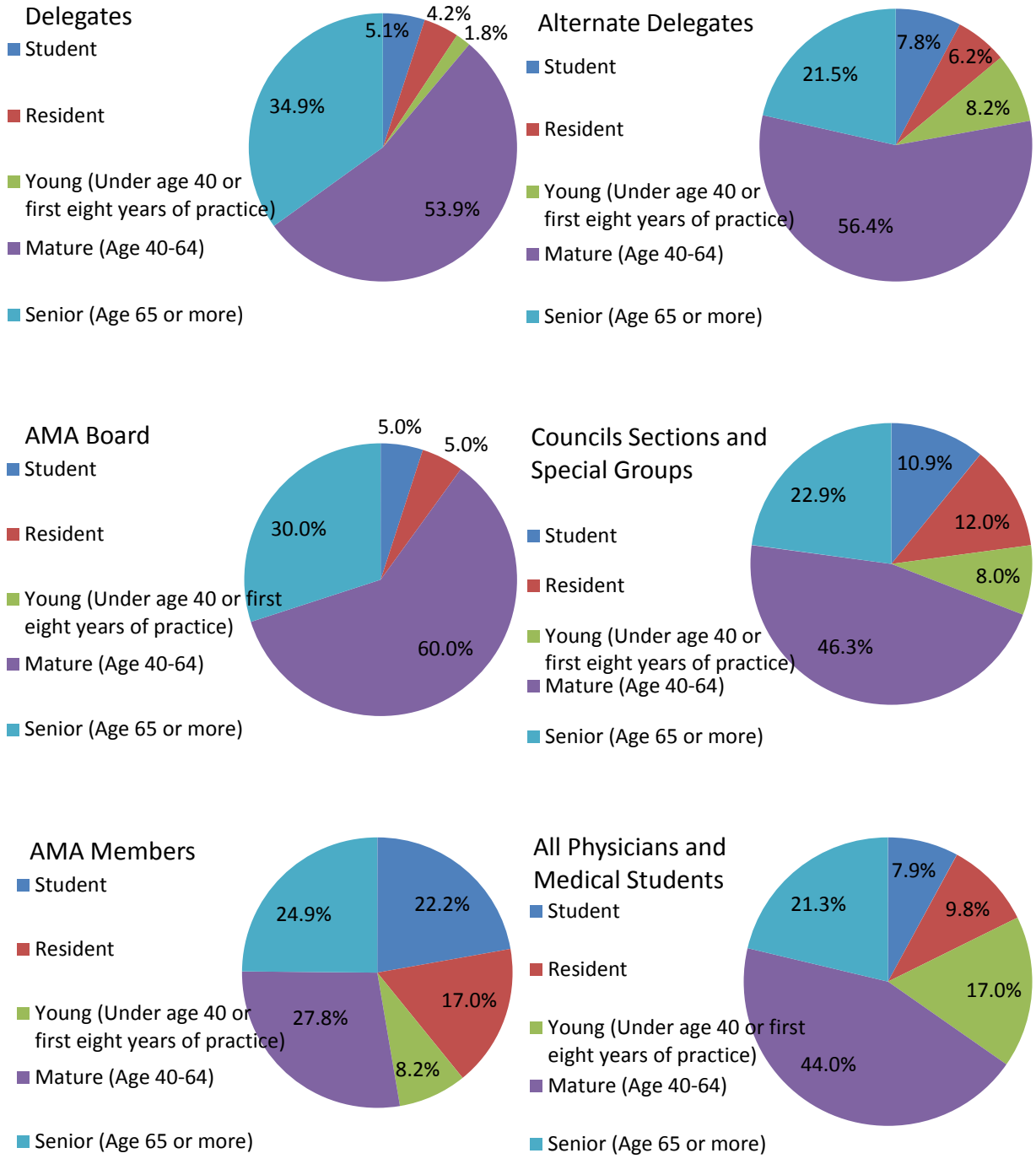


Figure 4. Select Categories of Present Employment of AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.

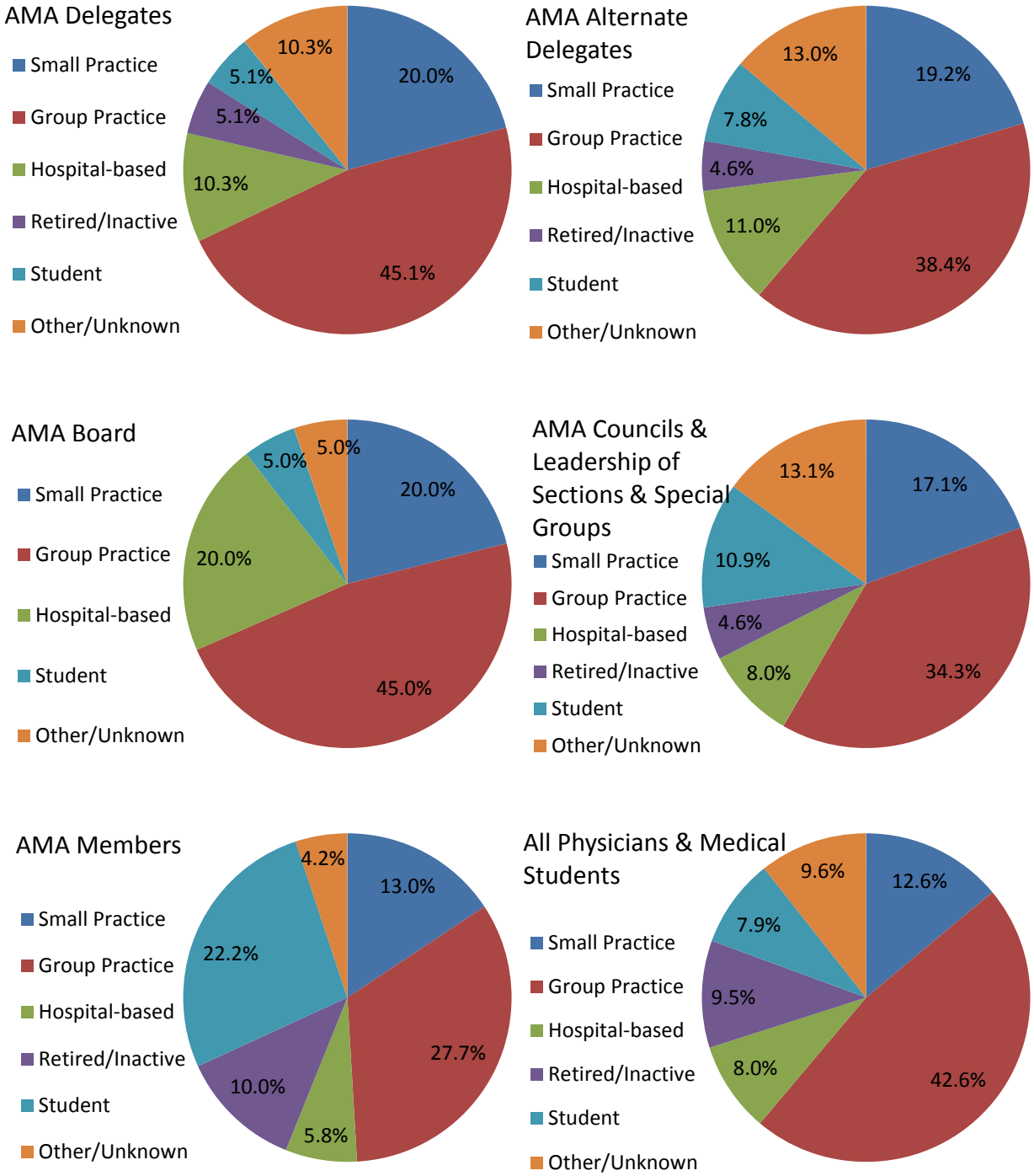


Figure 5. Gender Makeup of AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.

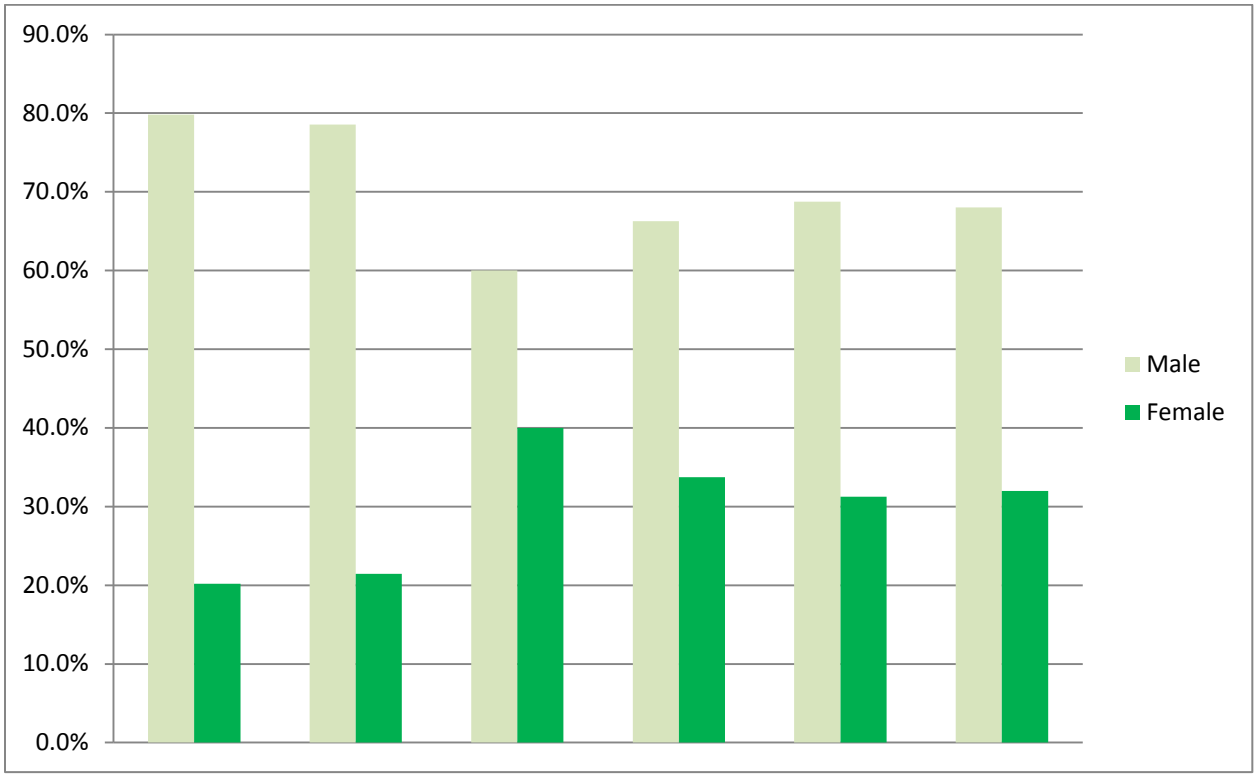


Figure 6. Proportion Female Among AMA Leadership Groups, AMA Members, and US Physician Population, including Medical Students.

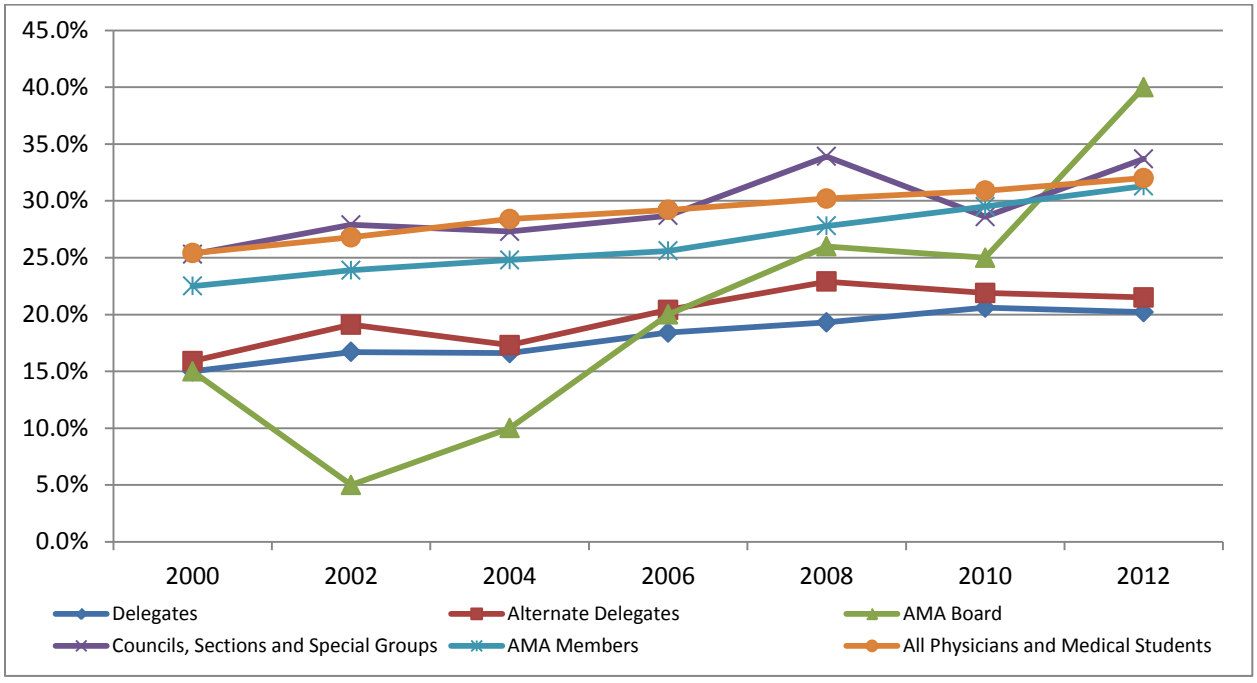


Figure 7. Race and Ethnicity of AMA Leadership Groups, AMA Membership, and US Physician Population, including Medical Students.

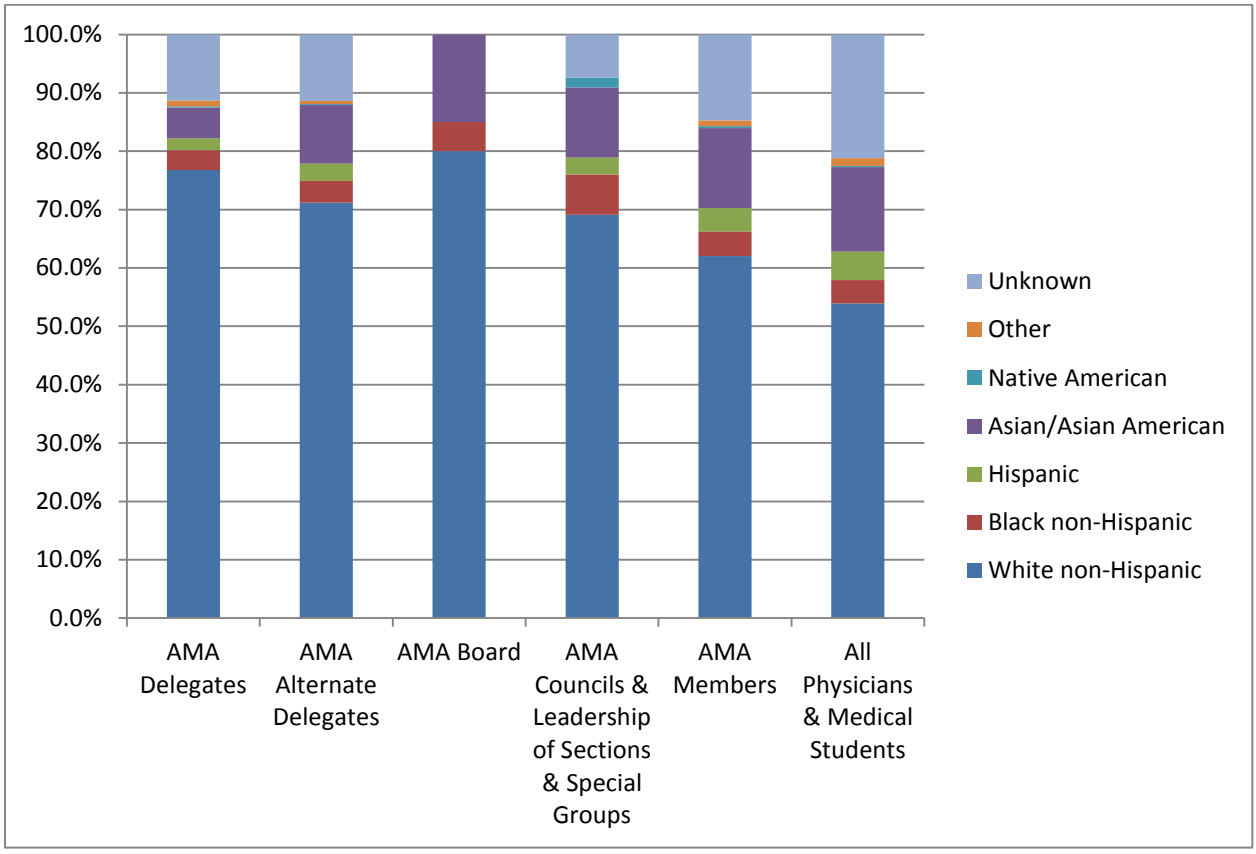
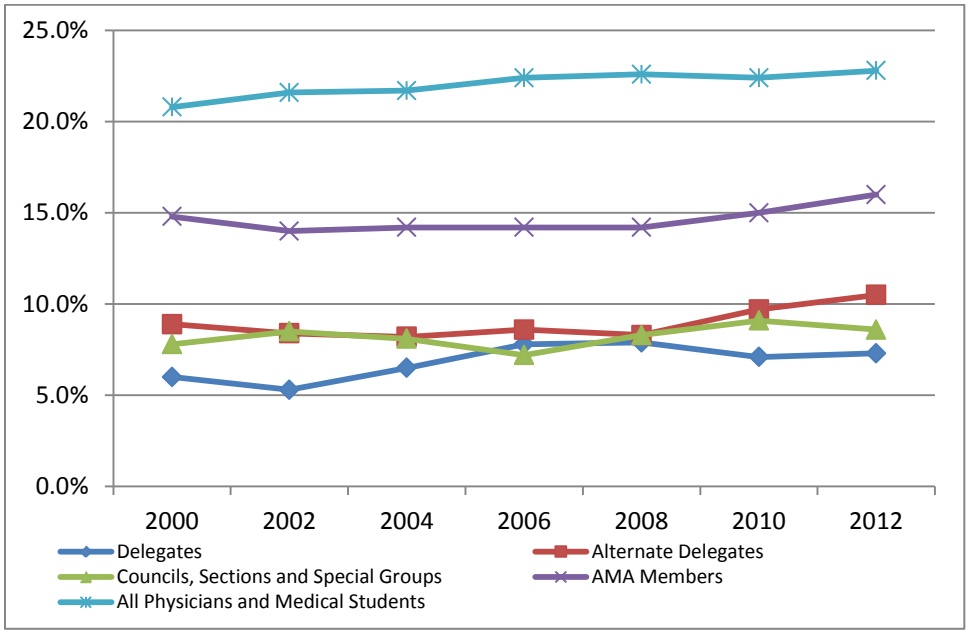


Figure 8. Proportion of IMGs in AMA Leadership Groups, AMA Members, and US Physician Population, including Medical Students.



APPENDIX A – American Medical Association Councils, Sections, and Special Groups.

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

Sections
- Integrated Physician Practice Section[1]
- International Medical Graduates Section
- Medical Student Section
- Minority Affairs Section
- Organized Medical Staff Section
- Resident and Fellow Section
- Section on Medical Schools
- Senior Physicians Section[2]
- Young Physician Section

Special Groups
- Advisory Committee on Gay, Lesbian, Bisexual and Transgender Issues
- Women Physicians Congress

[1] Pursuant to AMA Policy B-7.80 "Integrated Physician Practice Section," this listing reflects a change in status for the Integrated Physician Practice Section (formerly the Advisory Committee on Group Practice Physicians)
[2] Pursuant to AMA Policy B-7.90 "Creation of an AMA Senior Physicians Section" this listing reflects a change in status for the Senior Physicians Section (formerly the Senior Physicians Group)

APPENDIX B – Specialty classification using physician's self-designated specialties.

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