## REPORTS OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

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

### 1. PRIVATE PRACTICE PHYSICIANS SECTION FIVE-YEAR REVIEW

*Reference committee hearing: see report of Reference Committee F.*

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

The Council on Long Range Planning and Development (CLRPD) analyzed information from a letter of application submitted before November 2024 from the Private Practice Physicians Section (PPPS) for renewal of delineated section status and representation in the American Medical Association (AMA) House of Delegates (HOD). The letter focuses on activities beginning in November 2020 special meeting of the HOD, when the Private Practice Physicians Caucus became the PPPS.

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

APPLICATION OF CRITERIA

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

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

*Leveling the Economic Playing Field*

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

*Pharmacy Benefit Manager Control of Treating Disease States*

In response to growing concern over pharmacy benefits managers (PBMs) diverting patients to designated care teams, PPPS led development of AMA policy opposing this practice and called for immediate legal and policy measures to prevent it. Outcomes included AMA advocacy for network adequacy standards that prevent steerage of patients to certain physicians or other providers, the development of "any willing provider" state model legislation and recognizing the need for federal oversight of relationships between PBMs and insurers. This issue remains a cross-sectional priority shared with the Organized Medical Staff Section (OMSS) and the Integrated Physician Practice Section (IPPS).

*Prior Authorization and Patient Autonomy*

PPPS successfully introduced a resolution directing the AMA to advocate for electronic prior authorization systems with transparent monitoring capabilities. The measure was incorporated into the AMA policy compendium, supporting broader advocacy to streamline prior authorization and reduce administrative burdens on physicians and patients.
*Proper Use of Virtual Overseas Assistants in Medical Practice*

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

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

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

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

The PPPS has engaged in numerous efforts that support the AMA's strategic arcs. The Section has worked to address key issues impeding physicians' ability to deliver care including advocating for preserving private practice options in corporate health care environments, promoting continuity of care across diverse medical challenges, supporting physician reimbursement for interpreter services, and addressing financial conflicts in corporate medicine. By leading educational programming, the Section has addressed emerging issues such as physician burnout, workplace violence, and cybersecurity. Other sessions have focused on empowering physicians through practice growth strategies, navigating employment contracts, and fostering success in private practice. These initiatives underscore the Section's commitment to reimagining medical education and lifelong learning to meet modern health care demands.

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

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

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

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

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

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

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

Since obtaining section status, much of the PPPS leadership has been comprised of legacy leadership from its time as a caucus, with the first two Chairs and the first and current Delegate comprised of longtime Private Practice Physician Caucus leadership. Members of the next generation of leaders have been identified through personal connections with existing GC members or risen through involvement with Section committees or other organizing events. The Section has carefully employed mechanisms like voluntary committee service as a potential recruitment pipeline for developing future PPPS leadership and plans to continue to generate similar opportunities to open multiple pathways to future leadership.

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

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

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

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

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

This membership represents physicians from solo practices and multi-physician practices. Among physicians in multi-physician practices, only the physician that applied to PPPS is credentialed by the Section and counts toward Section

membership. An analysis of the PPPS membership roster revealed 40 members with double digit physician representation. Adding the number of private practice physicians in each of those 40 practices yielded a total of 1,062 physicians. In addition to those physicians in solo practice, a conservative estimate is that 1,409 private practice physicians are directly represented in the PPPS through their Section membership.

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

The PPPS is one of three AMA sections that advocate through the lens of practice setting rather than demographics or career stage. While the OMSS and the IPPS represent employed physicians or those whose income is largely tied to corporate or contractual arrangements, PPPS is unique in its representation of independent physicians who own or co-own small practices and retain operational and financial control. Without PPPS, there would be no formalized structure within the AMA to identify issues unique to private practice physicians, develop policy solutions tailored to small-scale, independent practice realities and ensure these issues reach the HOD for consideration.

PPPS offers multiple avenues for members to introduce issues and engage in policymaking including the opportunity to develop resolutions for all members in good standing. Open forums and virtual town halls give members opportunities to discuss practice-specific challenges and shape resolutions collaboratively and allow members to work with elected Section leadership to refine policy language and prepare for HOD advocacy. All proposed resolutions are accepted as items of business following legal review from the AMA Office of the General Counsel. Resolutions are reviewed by a reference committee composed of PPPS members, or, in the event of late or emergency resolutions, by the PPPS Chair and Chair-Elect. The Section maintains a Resolution Writing Committee that serves as a peer resource for members who request assistance in drafting their resolutions. These processes ensure that solo and small-group physicians have a direct pipeline to influence AMA policy at the national level.

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

DISCUSSION

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

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

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

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

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

The Council appreciates the thorough work of PPPS leadership and staff in completing this letter of application and follow-up communications, as well as the deliberation of the Section as it looks to build on its first five successful years of delineated section status.

CONCLUSION

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

RECOMMENDATION

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

Fiscal Note: Minimal

## 2. EVALUATION OF THE STRUCTURE OF THE AMA HOUSE OF DELEGATES

*Reference committee hearing: see report of Reference Committee F.*

**HOUSE ACTION: RECOMMENDATIONS NOT ADOPTED**

As noted in Board of Trustees (BOT) Report 27-A-25, "AMA Reimbursement of Necessary HOD Business Expenses for Delegates and Alternates," the Council on Long Range Planning and Development (CLRPD) has been asked to comprehensively study and report back on potential changes to the length, format and structure of future AMA House of Delegates (HOD or House) meetings. The charge to CLRPD has been further defined to studying possible solutions to address the issue of the rapid growth of the HOD, while preserving its representative nature and improving efficiency and effectiveness.

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

HOD APPORTIONMENT

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

With the adoption of Council on Long Range Planning and Development Report A-I-77, "Specialty Society Representation," pathways for direct specialty society representation were created. From 1978 to 1996, each specialty society, 50 at the outset, was apportioned one delegate regardless of the number of AMA members in that specialty. The recognition of the increasing number of smaller and more narrowly focused specialty organizations wishing to participate in the HOD led to the adoption of CLRPD Report D-I-90, "Representation of Specialty Organizations in the House of Delegates," which created alternative pathways with reduced membership thresholds for organizations wishing to join the HOD. In 1996, the House adopted recommendation 8 of BOT Report 2-A-96, "Transmission of the Report of the Study of the Federation," by which specialty societies would be apportioned one delegate for every 2,000 AMA members. Three years later, the representation ratio was reduced to one delegate for every 1,000 AMA members. At the 2016 Interim Meeting BOT Report 6-I-16, "Designation of Specialty Societies for Representation in the House of Delegates," modified the specialty society delegate allocation system so that the total number of national specialty society delegates would be equal to the total number of delegates apportioned to constituent societies, leading to an immediate and significant increase in the number of HOD delegates.

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

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

Student and resident/fellow representation were added in 1969 and 1971, respectively, to the HOD, with one delegate for each section. The adoption of BOT Report 19-I-00, "Medical Student Representation in the AMA House of Delegates," and BOT Report 20-A-06, "Resident and Fellow Representation in the AMA House of Delegates" led to the apportionment of one medical student delegate for every 2,000 medical student members in each of the seven regions defined in the Medical Student Section (MSS) Regional Section Structure, and one Resident and Fellow Section (RFS) delegate and for every 2,000 resident members, respectively.
Current allocation numbers as of January 1, 2025, consist of the following: constituent delegates 322; specialty delegates 322; section delegates 12; PIMA and other national society delegates 6; armed services 5; medical student delegates 25; and resident and fellow sectional delegates 41.

CHALLENGES ASSOCIATED WITH HOD GROWTH

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

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

apportionment established in 2016, has similarly increased the number of specialty delegates. The recent growth in the number of delegates has created pain points associated with logistics, cost and the deliberations of the HOD.

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

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

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

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

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

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

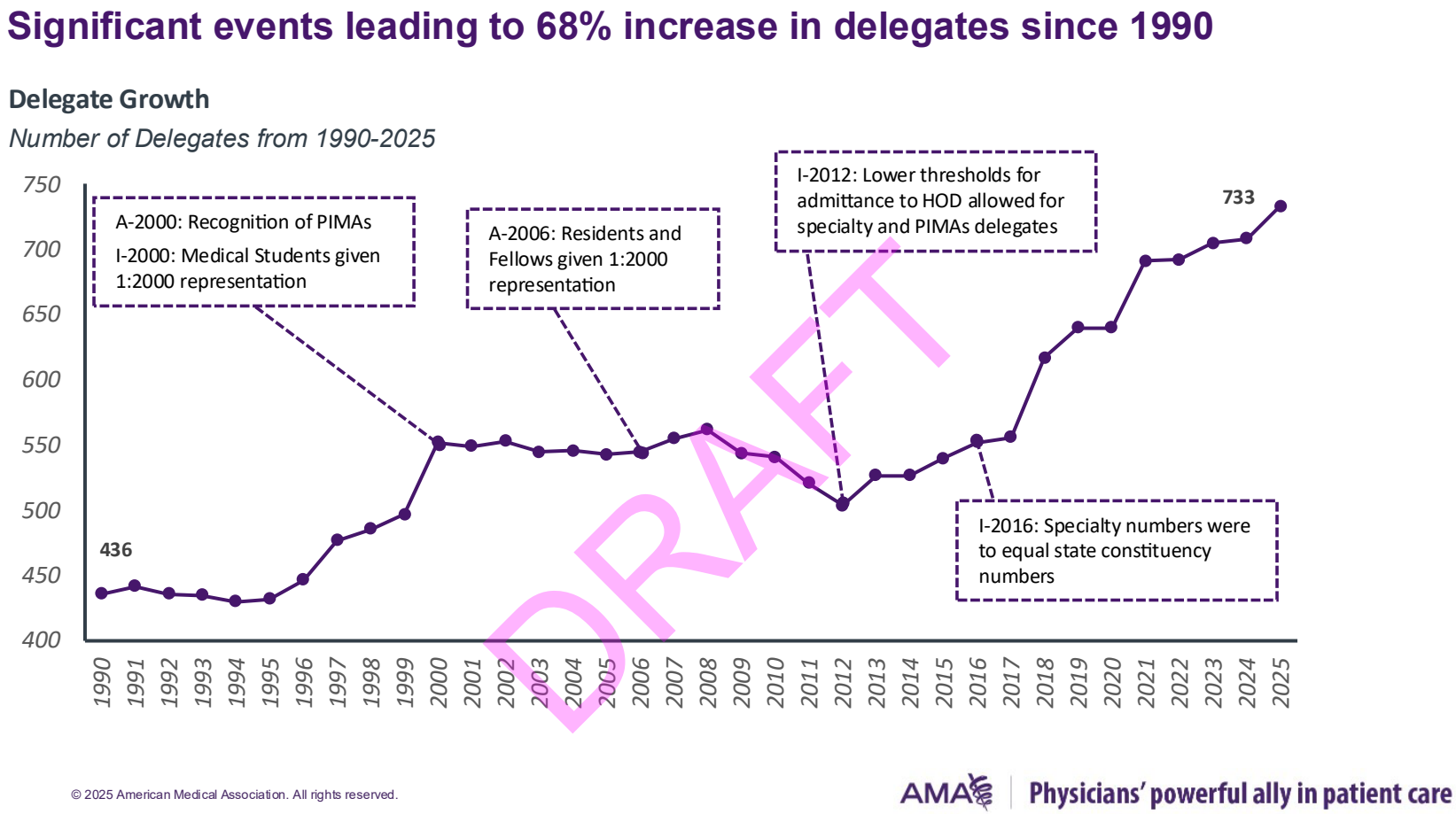
While this work takes place, the Council believes that instituting a temporary pause on increases to delegate allocation will allow the House to avoid further logistical disruption that would likely accompany the addition of 50-plus additional delegates to next year's apportionment.

RECOMMENDATION

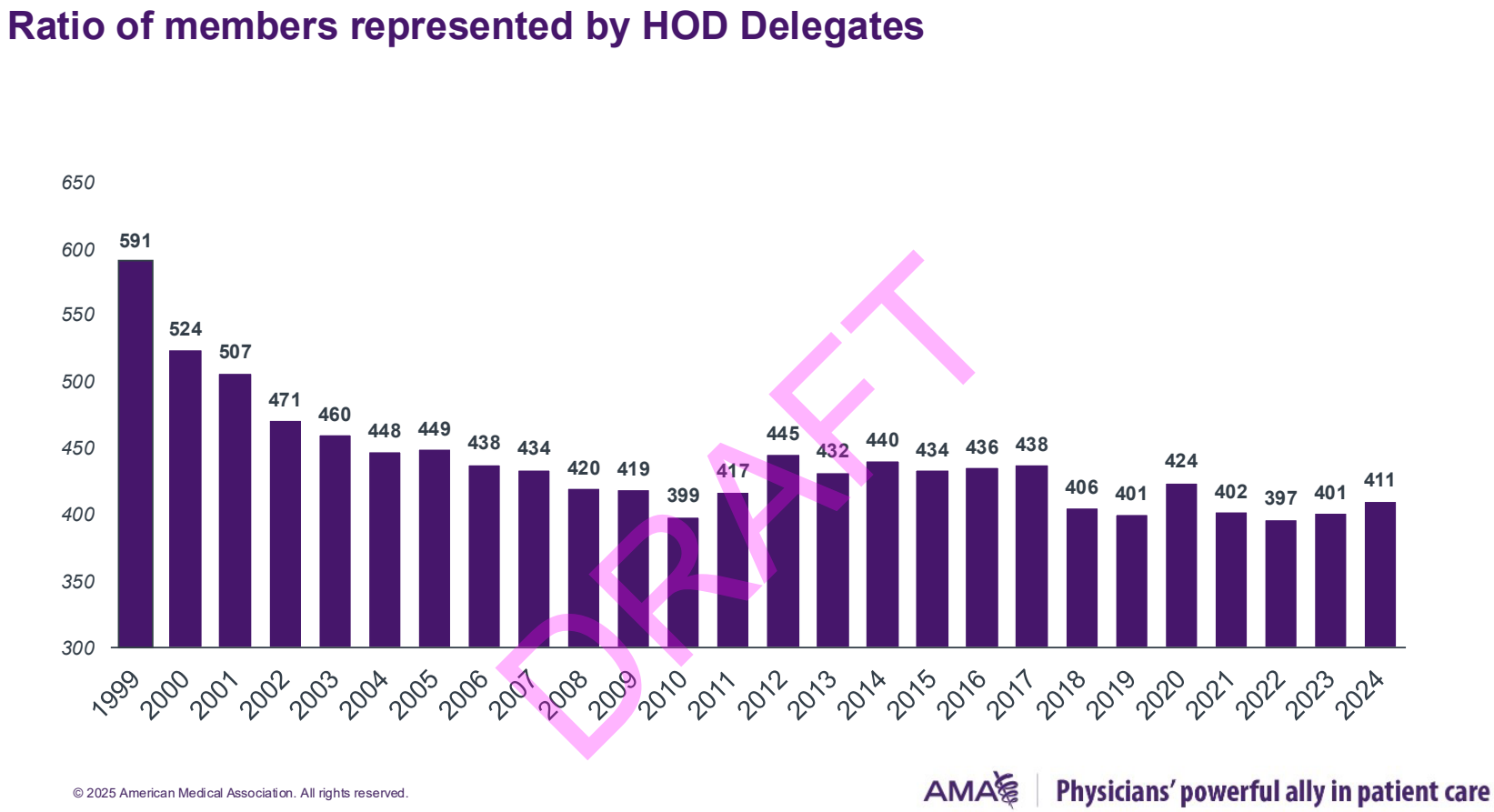
The Council on Long Range Planning and Development recommends that the delegate apportionment for the AMA House of Delegates be paused at 2025 levels through year-end 2026 and that this report be filed.

Fiscal Note: Minimal

Appendix A




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




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

APPENDIX B: RELATED AMA POLICIES

Statement of Collaborative Intent G-620.030

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

Delegate Apportionment and Pending Members G-600.959

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

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

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

Composition and Representation. B-2.0.1

Constituent Associations. B-2.1

Meetings of the House of Delegates. B-2.12

Committee on Rules and Credentials. B-2.13.2

National Medical Specialty Organizations. B-2.2

Medical Student Regional Delegates. B-2.3

Delegates from the Resident and Fellow Section. B-2.4

Speaker and Vice Speaker Additional Delegate. B-2.5

Other Delegates. B-2.6

Alternate Delegates. B-2.8

Delegate and Alternate Delegate. B-7.0.5

Representation in the House of Delegates. B-8.1

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

Specialty and Service Society. B-8.3

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

Periodic Review Process. B-8.5