OGC 223

American Medical Association

Physicians dedicated to the health of America

James S. Todd, MD
Executive Vice President

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

February 23, 1994

Office of the General Counsel
Federal Election Commission
999 E Street, N.W.
Washington, D.C. 20463

Re: Advisory Opinion Request

Ladies and Gentlemen:

I am writing on behalf of the American Medical Association ("AMA") and the American Medical Association Political Action Committee ("AMPAC") to request an advisory opinion regarding the application of 11 C.F.R. §§100.8(b)(4)(iv)(B)&(C) and 114.1(e)(2)&(3) (the"regulations") to the AMA and AMPAC. I am specifically requesting that you issue an advisory opinion holding (a) that the House of Delegates of the AMA is the "highest governing body" of the AMA within the meaning of 11 C.F.R. §§100.8(b)(4)(iv)(B) and 114.1(e)(2), and (b) that "direct members" of the AMA have sufficient organizational and financial attachments to the AMA to qualify as members under 11 C.F.R. §§100.8(b)(4)(iv)(C) and 114.1(e)(3).

I. Highest Governing Body

The AMA is a membership organization which was established in 1847 and incorporated under Illinois law in 1897. As an Illinois corporation, the AMA is governed by the Illinois not-for-profit Corporation Act. It is exempt from federal income tax pursuant to §501(c)(6) of the Internal Revenue Code. Its membership consists of approximately 290,000 physicians and medical students. The AMA is the connected organization of AMPAC, a separate segregated fund which is registered as a multi-candidate committee pursuant to the Federal Election Campaign Act ("FECA").

In order to explain why we believe the House of Delegates, rather than the Board of Trustees, is the highest governing body of the AMA it is necessary to briefly describe the AMA's organizational structure. The structure is described in more detail in the AMA Constitution and Bylaws[1].

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[1] The December, 1993 edition of the Constitution and Bylaws, which contains Bylaw amendments adopted during 1993 is currently at the printer. We expect to receive the printed copies by the end of February, and will send you a copy for your information as soon as it is available.

The AMA is a federation of 50 state medical societies and the medical societies of the District of Columbia, Guam, Puerto Rico and the United States Virgin Islands. These constituent medical associations are organized separately from the AMA and are not bound by AMA policy decisions.

The AMA Constitution states that the House of Delegates is " the legislative and policy-making body" of the AMA. Each constituent medical association is entitled to select one delegate for each 1,000 or fraction thereof AMA members within its jurisdiction. A constituent association is entitled to one additional delegate if 75% or more of its members are members of the AMA, and a second additional delegate if 100% of its members are members of the AMA.

The AMA Bylaws do not specify how the delegates representing the constituent medical associations are to be chosen. In most states, the delegates are elected by the state medical association House of Delegates. In California and Oregon they are elected by a secret ballot of state medical society members who are also members of the AMA. If the Board of Trustees is deemed to be the AMA's highest governing body, only a small number of individuals would qualify as members of the AMA under the Regulations in most states. If the House of Delegates is the highest governing body, a substantially larger number would qualify.

The House of Delegates also includes representatives of various national medical specialty societies. These societies are not considered to be constituents of the AMA, but are allowed representation so that their viewpoints may be considered in AMA policy formation. Each specialty society has one delegate regardless of the number of members. The House of Delegates also includes one delegate each from the United States Army, Navy, Air Force and Public Health Service, who are appointed by Surgeons General of each service; a delegate from the Veterans Administration, appointed by its Chief Medical Director and one delegate each from the AMA's Resident Physicians Section, Medical Student Section, Hospital Medical Staff Section, Medical Schools Section and Young Physicians Section.

The House of Delegates currently consists of 435 members: 343 representing constituent medical associations, 82 representing medical specialty societies, five representing the armed services, Public Health Service and Veterans Administration, and five representing the five special sections of the AMA.

The Board of Trustees of the AMA, which constitutes its Board of Directors under Illinois law, consists of 17 members. Twelve are elected, four each year, for three year terms by the House of Delegates. A resident physician trustee is elected by the House of Delegates for a two year term. The President, President-elect and Immediate Past President, who are also elected by the House of Delegates, serve as ex-officio members.

The seventeenth member of the Board of Trustees is a medical student representing the Medical Student Section. The medical student trustee is elected annually by the Medical Student Section Assembly and is allowed to vote on policy-making issues, but not on Board elections and appointments.

The House of Delegates also annually elects a Speaker and Vice-Speaker. These officers meet with, but are not members of, the Board of Trustees.

The AMA Constitution and Bylaws are silent as to whether the House of Delegates has the authority to remove officers or members of the Board of Trustees. The House of Delegates does, however, have the

power to remove both officers and Trustees under the Illinois Not For Profit Corporation Act, 805 ILCS 105/108.35 & 108.55.

The Illinois Not For Profit Corporation Act provides that, "except as provided in the articles of incorporation[2] or the bylaws, the affairs of the corporation shall be managed by or under the direction of the board of directors." The law does not require that the board of directors be a corporation's highest governing body. Whether the House of Delegates or the Board of Trustees is the AMA's highest governing body must, under Illinois law, be determined from the powers granted to each under the AMA Constitution and Bylaws.

The AMA Constitution provides that the Board of Trustees "shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws." Section 5.40 of the Bylaws spells out the powers and responsibilities of the Board in more detail. These include managing the property and general affairs of the AMA, determining AMA publication policies, appointing the Secretary-Treasurer and Executive Vice President of the AMA, and overseeing the AMA's finances. Section 5.401 gives the Trustees authority to reject recommendations and resolutions of the House of Delegates pertaining to the expenditure of funds if it deems an expenditure to be inadvisable.

Thus the AMA Constitution and Bylaws envision a structure in which the House of Delegates determines the overall policy of the AMA, while the Board of Trustees is in charge of day-to-day operations. But the description in the Constitution and Bylaws does not even begin to describe the scope of the House of Delegates' legislative and policy-making functions. At its June, 1993 Annual Meeting, for example, the House of Delegates considered 223 substantive items of business, in addition to the election of AMA officers and Trustees, involving 118 reports from the Board of Trustees and AMA Councils and 218 resolutions submitted by members of the House of Delegates. These covered a wide range of subjects, including organization of the AMA, medical ethics, professional liability, legislation affecting health care, medical insurance, scientific issues relating to health care, legal issues affecting physicians and medical care, medical education and public health. The House of Delegates is thus a deliberative body which debates and sets AMA policy on a wide range of important and complex issues.

This does not, of course, mean that the Board of Trustees is not involved in policy formation. The House of Delegates is a large body which is better suited to setting general policies than working out specific details. In addition, the House of Delegates meets only two times a year--for four and one-half days in June and three and one-half days in December. The Board of Trustees currently meets at least five times a year, and is able to confer by conference telephone between meetings if necessary. The Board is thus often required to make policy decisions between House of Delegates meetings. But these are generally decisions regarding details of general policy positions adopted by the House.

The House of Delegates has recognized that the Board of Trustees has an important, but subordinate, role in policy formation. In 1979, it adopted a policy statement, which was reaffirmed in 1989, stating that:

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[2] The provisions of the AMA Constitution are identical to the governing provisions in the articles of incorporation filed under Illinois law.

> The Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates....In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considered to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.

In December, 1992, the House of Delegates adopted a Report of the Board of Trustees which authorized the Board "to act on behalf of the Association to promote proactively and negotiate for those elements of health system reform which they feel will best represent the interests of patients and the profession." This authority was granted because the House believed it was necessary for the AMA to be able to react quickly to developments regarding health system reform. The Report explicitly recognized that in its exercise of this authority the Board would be "accountable to the House for its actions."[3]

The fact that the Board of Trustees is subordinate to the House of Delegates was clearly illustrated by events at the December, 1993, Interim Meeting of the House of Delegates. In 1989, the House of Delegates adopted a report which recommended providing health insurance coverage for the working uninsured "through methods such as a phased-in requirement that all employers provide health insurance coverage to all full-time employees." This policy has continued to be supported by the Board of Trustees, but has been opposed by substantial numbers of Delegates. Resolutions were introduced at the December, 1993 meeting calling for the House to rescind its support of the employer mandate. Members of the Board of Trustees argued that adoption of such a resolution would deprive the Board of the flexibility necessary to effectively represent the medical profession in the debate over health care reform. Eventually a compromise was adopted stating that the AMA supports financing health care reform by some form of individual mandate, an employer mandate, or a combination of the two. The House of Delegates thus significantly softened the AMA's support for a policy strongly supported by the Board of Trustees.

An even more dramatic demonstration of the House of Delegates primacy in policy formation occurred at the Interim Meeting in December, 1978. The AMA had had a comprehensive health insurance proposal introduced in every session of Congress since 1970. These proposals, which were based on 17 general principles previously adopted by the House of Delegates, were intended to provide an alternative to comprehensive national health insurance proposals sponsored by Senator Kennedy and others. The Board of Trustees submitted a report to the House of Delegates recommending that the 17 principles be reaffirmed and an AMA bill be introduced in the next Congress. This report was rejected by the House of Delegates, and a resolution adopted calling for development of programs to provide coverage to uninsured individuals at the state level and by the private insurance industry. The Board of Trustees was authorized to draft a bill for consideration by the House of Delegates only "if necessary."

Numerous other examples could be cited where the House of Delegates have rejected recommendations of the Board of Trustees or referred issues back to the Board for further study. Such incidents clearly

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[3] The Board also relies heavily on the advice of a Technical Advisory Committee consisting of representatives of the House of Delegates and various AMA Councils and Sections. This Committee was appointed by the Board pursuant to a resolution adopted by the House at its June, 1992 meeting.

illustrate that the primary role in policy formation given to the House of Delegates by the AMA Constitution and Bylaws is an accurate description of how the AMA actually operates.

Both the AMA Constitution and Bylaws and actual practice clearly indicate that the House of Delegates is the AMA's highest governing body. I therefore respectfully request that you issue an advisory opinion so holding.

II. Direct Members

The membership structure of the AMA and the rights of various classes of members are strongly influenced by the fact that the AMA is a federation of state and other constituent medical associations.

Prior to 1982, physicians and medical students were generally allowed to become members of the AMA only through a constituent medical association. Each constituent medical association would submit invoices for both constituent and AMA dues to physicians within its jurisdiction. Some constituent societies were "unified" with the AMA and required their members to also join the AMA. Most constituent societies, however, allowed physicians to join without also joining the AMA. Individuals were allowed to become direct members of the AMA only if they were ineligible for membership in a constituent association. For example, if a state medical society did not allow physicians on active duty in the armed forces to join, military physicians stationed in that state could join the AMA directly.

The adoption of a broader direct membership option beginning in 1982 was the result of trends in AMA membership during the 1970s. AMA membership had decreased from 48% of all physicians in 1975 to 45% in 1980. More significantly, the number of full dues paying members had declined from 51% of the non-resident physicians to 38%. Such trends were believed to be due, at least in part, to the increasing cost of being involved in organized medicine. A 1981 Report of the AMA Council on Long Range Planning and Development reported that average dues for the AMA and a typical state, county and medical specialty society were approximately $900, and that 25% of AMA members would have total dues over $1,000 if they joined all applicable medical societies. The Council concluded that many physicians chose not to join some or all medical societies for which they were eligible as a means of reducing the cost. It also concluded that many of the 178,000 physicians who belonged to neither the AMA nor a constituent medical association would join the AMA if a direct membership option were available.

Under the current AMA Bylaws, any physician or medical student may join the AMA directly unless he or she lives in a state where the constituent medical association requires all its members to be members of the AMA. Physicians in such unified states (there are currently five) may become direct AMA members only if serving full time in the armed forces , the United States Public Health Service or the Veterans Administration.

Over the years the number of direct members has increased substantially, to a total of approximately 82,000 in 1992 and 89,000 in 1993.

Like other members, the direct members of the AMA pay substantial dues, ranging from $20 per year for medical students to $420 per year for regular members. But because most members of the House of Delegates are elected through the constituent medical societies, many of the direct members do not have any right to vote, either directly or indirectly, for members of either the House of Delegates or the Board

of Trustees.[4] These direct members thus do not qualify as members of the AMA under 11 C.F.R. §100.8(b)(4)(iv)(B) or 114.1(e)(2). I believe, however, that the direct members have other organizational attachments which are sufficient for them to be considered members under 11 C.F.R. §§ 100.8(b)(4)(iv)(C) and 114.1(e)(3). (It is significant that neither the National Right to Work Committee ("NRWC") case nor the Regulations state that only voting rights can constitute an organizational attachment.) The most significant of these organizational attachments are the following:

1. Obligations to the AMA. All members of the AMA, including direct members, are required to comply with the provisions of the AMA Constitution and Bylaws and the Principles of Medical Ethics of the AMA (Bylaw 1.20). The Principles of Medical Ethics have been promulgated by the AMA House of Delegates and are interpreted in opinions of the AMA Council on Ethical and Judicial Affairs. The Council has the authority to censure, suspend or expel any member who it determines, after notice and a hearing, to have violated the Principles or otherwise engaged in unethical or illegal conduct.Since June, 1991, 57 members have been expelled for unethical conduct. (This does not include members who resigned or did not renew their membership after being informed that the Council was instituting proceedings against them.) Of these 15, or approximately 26%, were direct members.

2. The Right to Participate in AMA Policy Formation. Prior to each meeting of the House of Delegates, the Speaker and Vice Speaker of the House appoint nine "reference committees", each consisting of five members of the House plus two alternates. These committees hold hearings on all reports, resolutions and other new business before the House and submit reports recommending what action the House should take. All AMA members, including the direct members, have the right to attend the reference committee hearings and testify on any item of business. Members also have the right to attend all meetings of the House of Delegates, other than executive sessions.

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[4] Although direct members do not have voting rights as such, some also belong to other membership categories which have voting rights. Approximately 24% of 1993 direct members were also members of a constituent society and thus had the same voting rights as other constituent society members. Most of these probably joined the AMA after joining the constituent society to spread out payment of dues. Approximately 17% were medical students. All medical student members have the right to vote for representatives to the Medical Student Section Business Meeting, which elects the medical student Trustee and a delegate and alternate delegate to the House of Delegates. Direct members who are members of a hospital medical staff have the right to vote for a hospital representative to the Hospital Medical Staff Section Business Meeting, which elects a delegate and alternate delegate to the House of Delegates. The AMA does not have information as to the number of direct members who are also hospital medical staff members. However, it appears that a majority of the direct members do not belong to any of these categories and have no voting rights.

It should also be noted that direct members can join their constituent medical society and obtain the same voting rights as other constituent members. Direct members who choose to join only the AMA and not a constituent medical society are in most cases probably more interested in the national issues dealt with by the AMA than the local and state issues dealt with by state and county medical societies. In this sense, they would be more strongly attached to the AMA than many constituent members.

I am enclosing a copy of the 1994 Guide to Member Benefits which contains a more detailed description of these benefits for your information.

3. Right to Receive Member Benefits. All members of the AMA, including direct members, receive significant member benefits. They receive free subscriptions to the Journal of the American Medical Association, one of the world's most prestigious scientific journals, and American Medical News. They also receive the right to purchase many other AMA publications, products and services at a discount. These include life, health, disability, and office overhead insurance, and a unique HIV infection insurance policy, sponsored by AMA Insurance Agency, a subsidiary of the AMA. Other member benefits include discounts on car rentals and a home mortgage program that provides low rates and an expedited application and approval process.

4. The Right to Participate in AMA Political Activities. The AMA and AMPAC conduct a number of programs designed to assist its members in getting more involved in the political process in addition to sponsoring AMPAC and sending partisan communications to its members. The most significant of these are the following:

a. Participation Programs. These programs are designed to encourage and assist members of the AMA and constituent medical societies and their families to become involved in the campaigns of candidates of their choice. The first such program was Participation '88 in 1988, which focused on analyzing the delegate selection process and encouraging members of the medical community to try to become delegates to the presidential nominating conventions of both parties. Subsequent programs have expanded to encourage participation in presidential, congressional, state and local campaigns. No AMA endorsement of specific candidates is involved since the purpose is encourage each individual to work for the candidate of his or her choice. These programs are aimed at all AMA members, including the direct members.

b. Campaign Management Schools. AMPAC sponsors a one-week Campaign Management School and a four-day Advanced Campaign Strategy School which is open to graduates of the Campaign Management School. Many graduates of these schools have run for political office or worked in political campaigns. These schools are free for AMA members, including direct members.

c. AMPAC Candidates Workshop. This program was designed to educate individuals who are interested in becoming candidates as to what is involved in running for office. The program includes discussion of the time and financial commitments necessary to be a successful candidate as well as an introduction to campaign management. This program is being replaced by a new, expanded program called Medicine's Candidate--A Prescription for Success, which will also be free for AMA members.

d. AMA P.O.W.E.R. This is a new program designed to get more AMA members and their spouses, especially those who are members of the AMA Alliance (formerly the AMA Auxiliary) involved in grassroots political activities. Information regarding the program will be sent to all AMA members. Those who respond will be provided information and assistance. I am enclosing a brochure which describes this program in more detail.

The AMA's AMPAC and partisan communications activities are thus part of a larger group of activities designed to further the AMA's overall legislative and political objectives. Physicians who become involved in such programs demonstrate a strong interest in working with the AMA in achieving such goals, regardless of whether they are direct or constitutent members. This would include a strong interest in supporting AMPAC and knowing what candidates are supported by the AMA.

It is important to realize that many physicians join the AMA because they want the AMA to represent them in the political and legislative arenas,[5] and they pay significant dues to secure that representation. Regulations that would prevent the AMA from soliciting AMPAC contributions from, or making partisan communications to, such physicians would constitute a serious restriction on their, and the AMA's, constitutional rights.

It is well established that the limits on political contributions and communication impact fundamental rights of free speech and freedom of association. Buckley v. Valeo, 424 U.S. 1, 14(1976). A statutory provision, or regulation, which directly and substantially burdens such rights is "presumptively unconstitutional." Harris v. McRae 448 U.S. 297, 312(1980). In order to avoid such constitutional questions, courts interpret statutes and regulations so as to not infringe on fundamental rights whenever possible.

Given the significance of the constitutional rights involved, the Commission should determine that the direct members are members of the AMA unless it believes that there is no basis for such a conclusion under the criteria presented by the Supreme Court in the NRWC case. Any doubts should be resolved in favor of holding that the direct members are members of the AMA. I believe that the facts set forth above indicate that the direct members do have sufficient financial and organizational attachments to qualify as members under the Regulations and respectfully request that you issue an advisory opinion to that effect.

Please direct any questions concerning this request, or any requests for additional information to Mr. Leslie J. Miller, (312)464-4608.

Very truly yours,

James S. Todd M.D.

James S. Todd, M.D.

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[5] A 1987 survey by the AMA found that about 75% of AMA members feel that the most important function of the AMA is representation of the interests of physicians, either on a broad range of issues or on specific issues such as professional liability. About twenty-five percent felt the AMA's main role should be in the area of medical information and education.

American Medical Association
Physicians dedicated to the health of America

Peter B. Lauer, CAE
Vice President
Membership Group

515 North State Street
Chicago, Illinois 60610

312 464-4760
312 464-5838 Fax

Memo to: All Employees

From: Peter B. Lauer, CAE

Date: January 27, 1994

Subject: *1994 Guide to Member Benefits*

Attached, please find your *1994 Guide to Member Benefits.* This guide is sent to all members soon after joining the American Medical Association (AMA).

All of the tangible and intangible benefits of AMA membership are listed in this concise source book. In addition, information on AMA sections, special services and programs is included.

Use this guide to explain our services to members and also to help recruit potential members who call the AMA with questions. For additional copies, call Karen Armaganian at ext. 4592.

American Medical Association

Physicians dedicated to the health of America

Guide to Member Benefits

1994

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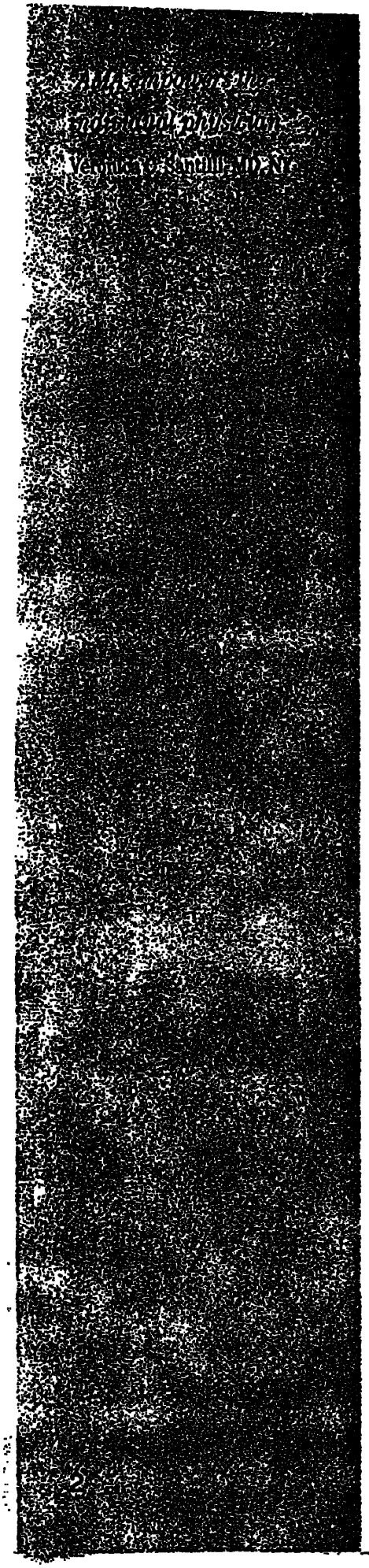
* Offered by AMA Financing & Practice Services, Inc.

Questions? Call us directly at your Member Service Center: 800 AMA-3211, 8:30am-4:45pm CST, Monday-Friday.



Your Link to Benefits

For the 147th consecutive year, the American Medical Association (AMA) is once again pleased to say: welcome members! With 300,000 member physicians and medical students, your association is actively working to ensure that patients' needs are met and to preserve physicians' autonomy.

By choosing AMA membership, you have expressed your commitment to medicine, to your profession, and to your patients. You and your member colleagues represent what the AMA is all about: *Physicians dedicated to the health of America.*

Just as your membership helps the AMA make a difference in society, so too can the AMA help make a difference in your life. To help you become acquainted with AMA benefits, services and products, please refer to your *Guide to Member Benefits.* Two other resources will also help you: your AMA Member Service Center and the AMA *Catalog of Publications, Products and Services.*

Member Service Center: 800 AMA-3211
Members-only fax: 800 262-3221

The AMA's Member Service Center is your single-source clearinghouse for information on all your member benefits. You can get help now, with one convenient toll-free phone call.

Knowledgeable Member Service staff are waiting to provide you with the courteous priority response you deserve as an AMA member. They will answer your questions, fill your requests or connect you with the person who can help.

You will also find helpful phone extensions listed throughout this *Guide to Member Benefits.*

In addition, we now have the capability to access a translator for members through our AT&T translating services, which offers up to 150 languages.

AMA Catalog of Publications, Products and Services

The 1994 AMA *Catalog of Publications, Products and Services* features an array of products and services to help you better manage your practice, keep current on scientific advances, and stay on top of the legal, ethical, economic and social developments in medicine.

To order your free AMA *Catalog of Publications, Products and Services* now, call your AMA Member Service Center at 800 AMA-3211.

Your Association

The AMA, Democracy in Action

The mission of the American Medical Association is to promote the science and art of medicine and the betterment of public health.

Your AMA achieves this goal in many ways. Through representation before lawmakers. Defending you and your patients before the courts. Furnishing information to you and to the public. Continuing as one of America's largest publishers of scientific information. Providing you with career and financial services. And, by assuring that the benefits of our nation's health care system are available to all.

House of Delegates

For information, call: 800 AMA-3211 ext. 4344

The House of Delegates meets twice yearly. As the AMA's policymaking body, it is the forum for influencing AMA policy. Four hundred and thirty-five members of the House of Delegates represent you and your colleagues through state and specialty medical societies, hospital medical staffs, medical students, residents, young physicians, uniformed services physicians, Veterans Administration physicians, and US Public Health Service physicians.

AMA Leadership and Headquarters

Board of Trustees and Officers

For information, call: 800 AMA-3211 ext. 5035
Fax: 312 464-5543

Officers

*Joseph T. Painter, MD, President
*Robert E. McAfee, MD, President-Elect
John L. Clowe, MD, Immediate Past President
*Nancy W. Dickey, MD, Secretary-Treasurer
Daniel H. Johnson, Jr., MD, Speaker
House of Delegates
Richard F. Corlin, MD, Vice Speaker
House of Delegates

David S. Cockrum, Student Trustee
*Nancy W. Dickey, MD, Secretary-Treasurer
Palma E. Formica, MD, Trustee
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Jerald R. Schenken, MD, Trustee
*P. John Seward, MD, Trustee
Randolph D. Smoak, Jr., MD, Trustee
*Frank B. Walker, MD, Trustee
Percy Wootton, MD, Trustee
*Member of Executive Committee

James S. Todd, MD, Executive Vice President

AMA Addresses

AMA Chicago Headquarters
515 North State Street
Chicago, Illinois 60610
800 AMA-3211
312 464-4184 (fax)

AMA Financing & Practice Services, Inc.
200 North LaSalle Street, Suite 500
Chicago, Illinois 60601
800 366-6968
312 419-5042

AMA Insurance Agency, Inc.
200 North LaSalle Street, Suite 400
Chicago, Illinois 60601
800 458-5736
312 419-9010

AMA Investment Advisers, Inc.
200 North LaSalle Street, Suite 500
Chicago, Illinois 60601
800 262-3863
312 332-4700

AMA Washington, DC Office
1101 Vermont Avenue, NW
Washington, DC 20005
202 789-7400

AMA Calendar of Events

1994 Board of Trustees Meetings
February 7-11, San Francisco, CA
April 11-14, Chicago, IL
June 7-11, Chicago, IL
October 17-20, Chicago, IL
November 30 - December 3, Honolulu, HI

Annual Meetings
1994: June 12-16, Chicago Hilton & Towers
June 10-11, AMA Section Assembly Meetings
1995: June 11-15, Chicago Hilton & Towers
June 9-10, AMA Section Assembly Meetings
1996: June 23-27, Chicago Hyatt Regency
1997: June 22-26, Chicago Hyatt Regency

Interim Meetings
1994: December 4-7, Honolulu, HI
Hilton Hawaiian Village
December 1-3, AMA Section Assembly Meetings
1995: December 3-6, Washington, DC
Sheraton Washington
December 1-2, AMA Section Assembly Meetings
1996: December 8-11, Atlanta, GA
Marriott Marquis
1997: December 7-10, Dallas, TX
Loews Anatole

*National Leadership Conference**
1994: February 11-13, San Francisco, CA
Hilton and Towers
*NLC will be held with Interim Meetings beginning in 1995.

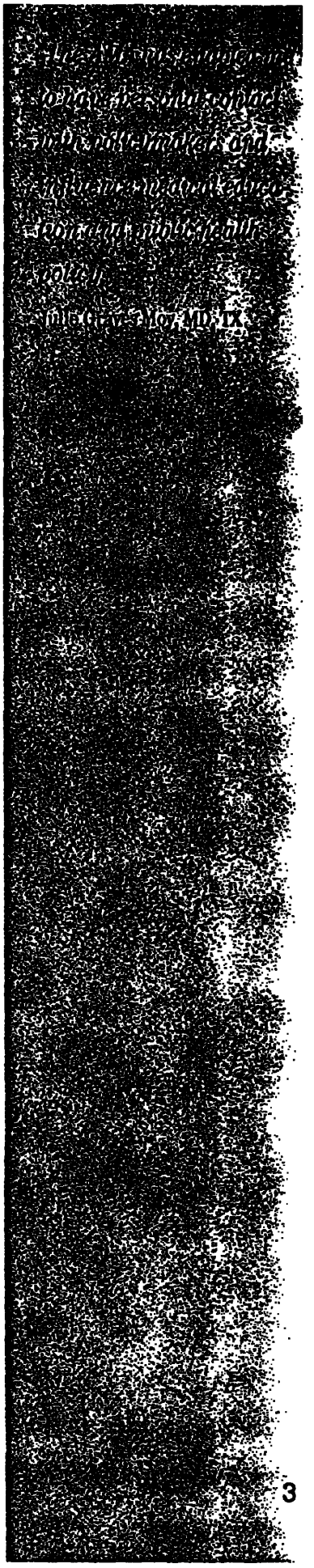
Your AMA Membership

Membership Information

For information, call: 800 AMA-3211

As a valued member of the AMA, you are eligible for an outstanding selection of quality benefits. These benefits take many forms and include representation at the county, state and national levels, complimentary subscriptions to *JAMA*, *AM News* and *Member Matters* newsletter, and discounts on practice management workshops, continuing medical education, insurance plans and more. Please refer to this *Guide to Member Benefits* for more complete, detailed explanations of the products and services your AMA membership entitles you to receive.

Continued on pg. 4



Physicians

Regular membership Includes full benefits	$420
Second year in medical practice Includes full benefits	$315
First year in medical practice Includes full benefits	$210
Military Physicians Includes full benefits	$280
65 or older, working 20 hours a week or less Includes full benefits	$210
65 or older, working more than 20 hours a week Includes full benefits	$420
Fully retired, under 65 Includes full benefits, choice of *JAMA* or *AM News*; the other is available at half-price	$84
Fully retired, 65 or older Includes full benefits, except *JAMA* and *AM News* subscriptions (available at half-price)	Free

Resident Physicians/Interns

Three-year membership, available to first year residents only Includes full benefits and free *Drug Evaluations* (*DE*)	$120
Regular one-year membership Includes full benefits	$45

Medical Students

Four-year membership Includes full benefits and free *Drug Evaluations* (*DE*)	$68
Three-year membership Includes full benefits and free *Drug Evaluations* (*DE*)	$54
Two-year membership Includes full benefits	$38
Regular one-year membership Includes full benefits	$20

Honorary — Reserved for physicians of foreign countries who have achieved preeminence in the profession and who have attended an AMA convention. Bestowed by House of Delegates upon nomination by Board of Trustees — includes full benefits, except *JAMA* and *AM News* (available at half-price).

Affiliate — Reserved for exemplary non-physician contributors to the medical profession (such as pharmacists, teachers) and physicians practicing in a missionary or philanthropic environment. Bestowed by House of Delegates upon nomination of the Council on Ethical and Judicial Affairs — includes full benefits, except *JAMA* and *AM News* (available at half-price).

Answers to Frequently Asked Questions About AMA Membership

Q. I'm changing my address. Does the AMA need my new address?

A. Yes. Whenever you move or your professional status changes, be sure to inform your AMA Member Service Center at 800 AMA-3211 — even if you've notified your county, state or specialty medical society. That way, you'll keep receiving all your complimentary subscriptions, important announcements and special offers.

Q. I'm a first year medical student. What are the advantages of a three- or four-year membership?

A. First, you'll save money. Second, you'll receive *Drug Evaluations* (*DE*) — a $95 value and essential reference for second year students — free. And finally, it's more convenient. You join once, so there's less hassle and paperwork, ensuring continuity of benefits even if you move frequently.

Q. I'm a medical student with a multi-year membership. When can I expect to get my free *DE*?

A. If you joined for '94 prior to January 1, you will receive your book after January 1. However, if you join after January 1, you'll receive the book in time for your pharmacology course.

Q. What happens if I pay my AMA dues through a county, state or specialty society?

A. Your county, state or specialty society will process your dues and forward your AMA portion to the AMA.

Q. How will retirement affect my membership?

A. That depends on whether you plan to practice part-time or not. Members who are 65 or older and fully retired pay no dues. Members who are 65 or older and continue to practice 20 hours or less a week qualify for a reduced rate of $210. Members who are 65 and continue to practice 20 hours or more a week pay the regular rate of $420. Members who are under age 65 and fully retired pay $84.

Q. I live in a "unified" territory. How does this affect my membership?

A. Members who reside in unified territories and belong to their county and state medical societies, and the AMA, receive a 10% discount on their AMA dues. That's as much as $42 a year savings on a regular membership.

Q. How can I get more involved in the AMA?

A. The best way is to attend AMA Annual and Interim meetings. The dates are listed in this *Guide*. You may also want to become more involved in your county and state medical societies.

Q. I have a colleague who is interested in joining the AMA. Who should he contact?

A. We're always looking for new members, especially when they're recommended by a member. Your colleague can call the Member Service Center at 800 AMA-3211 for an application. As an aside, you can earn attractive rewards for helping recruit new members. For more information about our On Call: Member-Get-A-Member Program, call 800 AMA-3211 ext. 5956.

Your Practice

Your AMA provides many specific publications and career programs to help you more effectively manage your practice and stay up-to-date with the rapidly changing business of health care.

AMA's National Physician Credentials Verification Service (AMA/NCVS®)

For information, call: 800 677-NCVS

Save time and eliminate the "hassles" you encounter when applying for licenses and hospital privileges. The AMA/NCVS sets up your permanent portfolio of core primary-source verified credentials and professional information so that it is quickly and conveniently available when you need it. Only you decide who receives your portfolio. With updates, your AMA/NCVS portfolio will be useful throughout your career. Call for your AMA/NCVS Sign-up Kit or for more information. *AMA members receive a 50% discount.*

AMA Physician Guidelines

For information, call: 800 AMA-3211

In the interest of improved public health, your AMA develops and disseminates state-of-the-art medical and scientific information to members and other health professionals. These guidelines cover a wide range of vital subjects. Some of these are HIV Blood Test Counseling, HIV Early Intervention, Child Sexual Abuse, Child Physical Abuse and Neglect, Domestic Violence, and Elder Abuse and Neglect. Other guidelines now under development include Smoking Cessation, Women and HIV, and Alcoholism in the Elderly.

AMA-sponsored Equipment Leasing Program

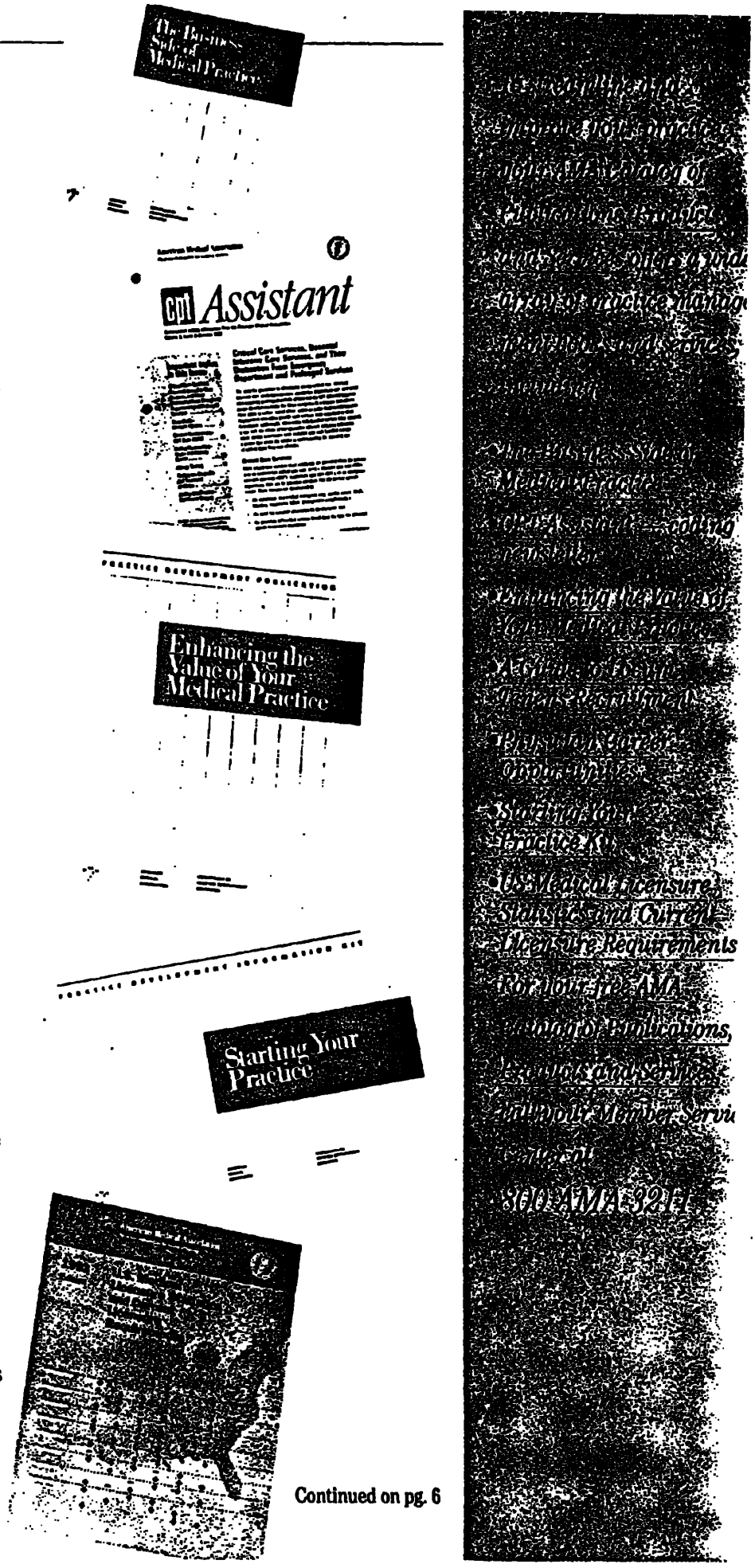
For information, call: 800 262-4262

Offered by AMA Financing & Practice Services, Inc. (a subsidiary of AMA) and Eato Financial Corporation (a subsidiary of AT&T Capital) for physicians, this leasing program addresses your needs for more value and flexibility in a payment system for new equipment. Your customized lease card can qualify you for a pre-approved lease line of credit, favorable lease rates, and a dedicated toll-free number for transactions.

Current Procedural Terminology (CPT)

For information, call: 800 621-8335 ext. 4737

Your AMA is the source for coding information and assistance. We are responsible for maintaining and updating the Physicians' CPT each year, and offer one of the largest selections of coding materials available. Your AMA also answers questions concerning the appropriate interpretation of



Continued on pg. 6

"AMA membership has offered me a great opportunity to network with other physicians locally, statewide and nationally, with benefits not limited to patient referrals, important general knowledge, up-to-date managed care information, liability reform and numerous other areas."

Anthony W. Middleton, Jr., M.D., Ut.

number listed for assistance. For those seeking coding assistance on a regular basis, the AMA publishes *CPT Assistant*, a quarterly newsletter on coding.

Group Practice Database

For information, call: 800 AMA-3211 ext. 5318

As the most comprehensive database of over 16,500 medical groups throughout the US, this resource offers you customized data on group practices and physicians practicing in groups.

Leaving the Bedside: The Search for a Nonclinical Medical Career

For information, call: 800 955-3565

This guide helps physicians determine if a career change would lead to greater professional fulfillment. You'll work through the tough psychological issues of career change, explore opportunities in and outside of medicine, and gain savvy strategies on preparing your curriculum vitae, interviewing and job hunting. *Discounted for AMA members.*

Medicine in Transition™

Now your AMA offers you three new, unique ways to learn the ins and outs of managed care from the physician's perspective:

AMA Doctors Advisory Network

For information, call: 800 AMA-1066

The AMA Doctors Advisory Network is a select group of physicians, lawyers and business consultants who are experts in managed care. AMA members can access the Doctors Advisory Network through a toll-free number. You'll talk with a member of our legal department who will assess your needs and refer you to qualified individuals from our database of managed care experts — physicians, attorneys, and business consultants. *This assessment and referral service is provided free to AMA members only.*

Doctors Resource Service™ (DRS)

For information or to order, call: 800 AMA-1066

Everything you need to know about managed care is at your fingertips in this unique new multimedia information service. Created just for physicians, DRS draws from the extensive resources of the AMA to give you timely advice on specific legal and financial practice concerns every six weeks. The first nine issues are devoted exclusively to managed care and health system reform.

Strategies for Change Workshops

For information, call: 800 AMA-1066

Strategies for Change Workshops are four-hour, interactive practice workshops for physician groups of 25 to 100. Workshops are hosted by local medical societies, hospitals or other groups and your AMA. Instructors are attuned to your concerns and skilled options you need to consider to deal with the changes managed care may have on your practices. Physician and attorney presenters chosen by the host organization, assure that local as well as national perspectives are reviewed.

Physician Marketplace Statistics

For information, call: 800 AMA-3211 ext. 5022

The source for authoritative data on US physicians' incomes, expenses, and other practice data. Invaluable for comparing national and individual practice trends. Includes data for 18 specialty categories and 18 geographic areas. Contains over 100 tables plus a new section on physician involvement with managed care plans. Available in hard copy and diskette. *AMA members save almost 50%.*

Physician Negotiation Advisory Office

For information, call: 800 AMA-3211 ext. 5490

Improve your ability to negotiate with payers and employers, whether you are a salaried or independent physician.

The Office of the General Counsel (OGC) can answer your questions about antitrust laws, constitutionality of fee controls, legal aspects of utilization-review, and physician negotiating groups.

Practice Management

For information, call: 800 366-6968

Too often, the business of medicine gets in the way of the practice of medicine. AMA Financing & Practice Services, Inc. (a subsidiary of the AMA) provides hands-on practice management workshops, for groups of 20 or more to guide physicians and staff through the complexities of building and running a successful practice.

Practice Parameters

For information, call: 800 AMA-3211 ext. 5518

To keep you apprised of the most up-to-date patient management strategies developed to assist in clinical decision making, the AMA offers the *Directory of Practice Parameters: Titles, Sources, and Updates* and *Practice Parameters on CD-ROM.* The Directory lists sources for all available parameters and the CD contains a selection of full text parameters. Both products are updated quarterly.

Project USA

For information, call: 800 AMA-3211

This worthwhile program recruits physicians for short-term service in underserved rural areas throughout the US. Physicians participating in Project USA receive a stipend and round-trip coach airfare. Many physicians return year after year.

Record of Physicians' Professional Activities (PPA)

For information, call: 800 AMA-3211 ext. 5184

This is the primary source of information regarding type of practice, employment, primary, second-

hospital and group affiliation. Information on the number of hours worked, routinely updated, is used as the primary basis for classifying physicians.

Socioeconomic Characteristics of Medical Practice, 1993 Edition

For information, call: 800 AMA-3211 ext. 5022

The AMA Center for Health Policy Research provides reliable data on the socioeconomic aspects of current medical practice. This book offers data and analyses of physician fees, hours, patient visits, income, expenses, and weeks worked. Also includes six new analytical studies on the socioeconomic environment of medicine. Available in hard copy and diskette. *Substantial discount for AMA members.*

Current Licensure Requirements

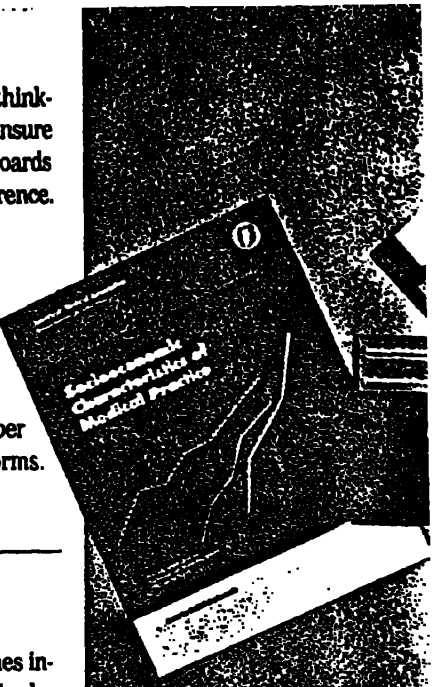
For information, call: 800 621-8335

If you're seeking initial licensure or are thinking about relocating, you'll find the latest licensure requirements and policies of state medical boards across the country in this comprehensive reference. *Discounted for AMA members.*

Unique Physician Identification Number (UPIN)

For information, call: 800 AMA-3211

As a benefit for our members, you can easily obtain your own or a referring physician's Unique Physician Identification Number (UPIN) required for your Medicare claim forms.



Your Medical Education

Your AMA is a leader in the formulation and implementation of policies and standards in medical and allied health education. We also maintain the largest repository of medical and allied health education information in the nation. For information, call the numbers listed in this section.

AMA Department of Library Services

For information, call: 800 AMA-3211 ext. 4855

For document delivery, call: 800 AMA-3211 ext. 5124

For archives, call: 800 AMA-3211 ext. 4083

The AMA Department of Library Services maintains a large collection of current and historical medical and socioeconomic journals, as well as a reference book collection. The archives contains materials on the history of the AMA. The library offers document delivery services at member and non-member rates.

Accreditation and Licensure

Call the numbers listed for direct contact with AMA or Accreditation Council for Graduate Medical Education (ACGME) staff who specialize in accreditation and licensure in the following areas.

Allied Health Education:
800 AMA-3211 ext. 4623

Compiles information on AMA activities related to allied health education and accreditation and staffs the AMA Committee on Allied Health Education and Accreditation (CAHEA).

Continuing Medical Education:
800 AMA-3211 ext. 4671

To facilitate continuing medical education and policy activities, your AMA conducts national conferences on continuing medical education and coordinates AMA participation on the Accreditation Council for Continuing Medical Education (ACCME).

Graduate Medical Education:
800 AMA-3211 ext. 4804

Your AMA collects, analyzes, and publishes information on graduate medical education. We also coordinate the activities of the Graduate Medical Education Advisory Committee and participate in the Accreditation Council for Graduate Medical Education (ACGME), which accredits nearly 7,000 training programs for resident physicians across the US.

Undergraduate Medical Education:
800 AMA-3211 ext. 4657

Your AMA provides information and assistance to current and potential medical students, education and career counselors, medical schools, and policy makers. Accreditation of medical education programs leading to the MD degree is performed by the Liaison Committee on Medical Education (LCME) of which the AMA Council on Medical Education is a sponsor.

American Medical Television (AMT®)

CME Credit: 800 398-CNBC

General Information: 800 AMA-3211 ext. 5525

American Medical Television airs every Saturday and Sunday from 10 am to 1 pm (EST) on CNBC. For the CNBC channel in your area, call 800 Smart-TV. Earn continuing medical education credits by using the study guides and evaluations for weekly programs. AMT study and program guides are available to you by calling 800 398-CNBC.

Continuing Medical Education

For information, call: 800 AMA-3211

Through television and videotape programs, your AMA makes it easy, convenient and inexpensive to study independently and keep pace with the constant advances of medical science.

The AMA Physician's Recognition Award program (PRA), which is celebrating its 25th anniver-

Continued on pg. 8

For details on upcoming conferences and workshops, and the PRA program, call these numbers:

CME Course List from Accredited Institutions: 800 AMA-3211 ext. 4952
Conference Information and Registration: 800 621-8335
General Information and CME Accreditation: 800 AMA-3211 ext. 4670
Physician's Recognition Award: 800 AMA-3211 ext. 4665

Fellowship and Residency Electronic Interactive Database Access System (FREIDA®)

For information, call: 800 AMA-3211 ext. 5331

This computerized, expanded companion to the *Graduate Medical Education Directory* is now available in DOS and Macintosh versions, giving you rapid access to information on graduate training programs in 76 specialties and subspecialties. Information includes the number of budgeted positions, program length, start dates, program directors, where to apply and more.

For information, call: 800 AMA-3211 ext. 4956

Medical education data that are collected and analyzed are used primarily for the development and implementation of AMA policy. These data are also available to outside organizations and individuals.

Allied Health Education Directory 800 AMA-3211 ext. 4956
Continuing Medical Education Directory 800 AMA-3211 ext. 4952
Fellowship and Residency Electronic Interactive Database System (FREIDA®) 800 AMA-3211 ext. 5331
Graduate Medical Education Directory 800 AMA-3211 ext. 4695
Medical Education Data Directory 800 AMA-3211 ext. 4695
Medical Education Data Service 800 AMA-3211 ext. 4695

AMA Publications

The AMA is one of the world's largest scientific publishers. *JAMA*, the *Archives* journals, and *American Medical News* keep you abreast of changes in the science, art and business of medicine, and serve as your connection to the national and global medical community.

Many publications are complimentary to you as an AMA member. For information on articles or submissions, call the numbers listed in this section.

AMA Healthcare Resource and Reference Guide

For information, call: 800 AMA-3211 ext. 4839

This new publication is designed as a convenient resource for group practices and solo practitioners. The guide provides timely, relevant information on a wide array of medical subjects and topics in an easy-to-use desktop format.

Dues-paying members: $34.95
Nonmember price: $49.95

AMA Policy Compendium

For information, call: 800 AMA 3211 ext. 4888

This volume identifies AMA policy on a wide range of topics. Used by the AMA House of Delegates and the AMA Board of Trustees in establishing new policy positions, this reference work provides comprehensive and clear descriptions of more than 3,000 current AMA policies. *AMA members receive a 50% discount on this valuable resource.*

American Medical News (AM News)

Information: 800 AMA-3211 ext. 4429
Subscriptions: 800 AMA-2350
Advertising: 800 AMA-3211 ext. 2476

Stay current with our weekly report on socioeconomic and legal issues, local, national and international affairs, people and the Washington scene.

Dues-paying members: *Complimentary*
Nonmember subscription: $100.00
Dues-exempt and fully retired members: $ 50.00

AM News Classified Advertising
For more information or to place an ad, call: 800 237-9851

Looking to sell a set of golf clubs? Rent a condo? Trade artwork? Market a hobby? Whatever the product or service, you'll get results in *AM News*. *AM News* reaches 360,000 of your peers. It's the physicians' trade paper. *And as an AMA member, you'll save 50% off our regular rates when you advertise with us!*

Journal of the American Medical Association (JAMA®)

Information: 800 AMA-3211 ext. 2400
Subscriptions: 800 AMA-2350
Advertising: 800 AMA-3211 ext. 2475

...ch and every week, the most widely ...
...al journal in the world brings you articles on the cutting edge of clinical developments and research advances in medicine.

Dues-paying members: *Complimentary*
Nonmember subscription: $115.00
Dues-exempt and fully retired members: $ 57.50

Member Matters® Newsletter

For information, call: 800 AMA-3211 ext. 4591

Member Matters is changing. Look for it in the middle of *AM News*. Published 12 times a year, the newsletter will reach you easier and faster. Our improved format will bring you expanded coverage of AMA actions and news and more in-depth reporting. You'll find easy-to-read, easy-to-understand news briefs. Regular features like "What Every Doctor Needs to Know." Ongoing news on specific member populations. And a special members-only benefit section. *Complimentary to members.*

Archives Specialty Journals

Information: 800 AMA-3211 ext. 2430
Subscriptions: 800 AMA-2350
Advertising: 800 AMA-3211 ext. 2470

Members receive a 50% discount off the annual published subscription rate for these peer-reviewed, primary source journals that give you access to the best new clinical information in each specialty. Their new, reader friendly design helps you digest key findings.

	Nonmember Price	Member Price
Archives of Pediatrics and Adolescent Medicine (formerly AJDC)	$100.00	$50.00
Archives of Dermatology	$125.00	$62.50
Archives of Family Medicine	$ 95.00	$47.50
Archives of General Psychiatry	$ 90.00	$45.00
Archives of Internal Medicine (Published twice a month)	$115.00	$57.50
Archives of Neurology	$135.00	$67.50
Archives of Ophthalmology	$105.00	$52.50
Archives of Otolaryngology –Head & Neck Surgery	$120.00	$60.00
Archives of Pathology & Laboratory Medicine	$135.00	$67.50
Archives of Surgery	$ 95.00	$47.50

AMA Books

For information, call: 800 AMA-3211

AMA membership entitles you to discounts on many helpful AMA-published books and other publications. Call the toll-free number above for a complete current listing of titles, or to place your order.

Book Source

For information or to order, call: 800 451-2262

Have medical books shipped to you within 24 hours by simply calling the AMA's Book Source toll-free.

The Book Source has more than 25,000 titles in stock and has access to most titles available in print. Even if you are uncertain of an exact title, the Book Source will help you find any medical book in print you need, even if it is not published by the AMA.

There's one low postage and handling fee no matter how many books you order at one time. All major credit cards are accepted.

All books come with a 30-day money-back guarantee.

Diagnostic and Therapeutic Technology Assessment (DATTA)

For information, call: 800 AMA-3211 ext. 4531

The AMA's *DATTA* program provides accurate, balanced and timely evaluations for physicians on the appropriate application of medical technologies. *DATTA* evaluations are particularly significant because they incorporate the clinical judgments of practicing physicians. Your subscription includes 8 publications per year, the *Technology News* newsletter and free attendance to the *DATTA* Forum.

Drug Evaluations (DE)

For information, call: 800 621-8335

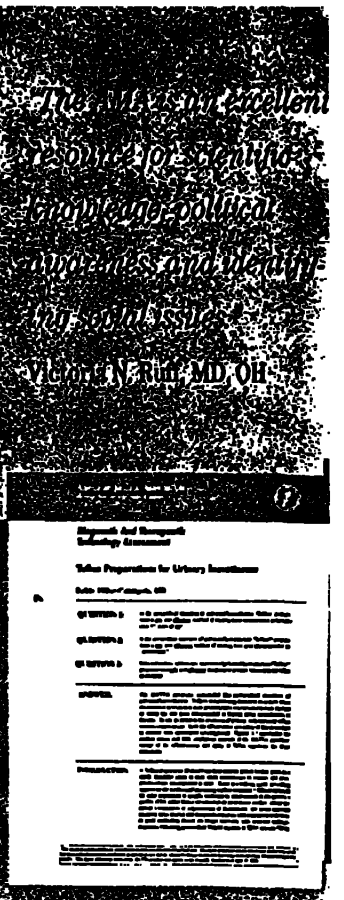
The *only* drug reference written specifically for the way you practice medicine, *Drug Evaluations* (*DE*) is organized by therapeutic application to help make prescribing decisions. Available in three formats: an annual textbook, a quarterly updated subscription with newsletter, and CD-ROM. *As an AMA member, you receive a substantial discount. Plus, DE is free to students who join for three to four years and to first-year residents who join for three years.*

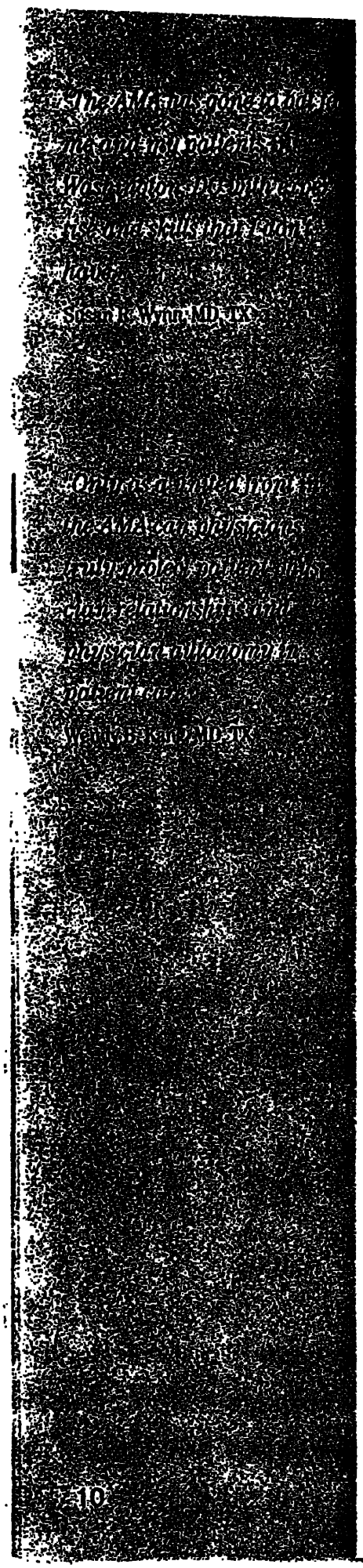
Guides to the Evaluation of Permanent Impairment, 4th Edition

For information, call: 800 621-8335

Determine and report impairments easily and consistently with this authoritative reference work. Charts, illustrations, and easy-to-follow procedures for each system of the human body help you achieve more consistent evaluations with greater ease. Includes a new chapter on assessing pain. Mandated or recommended by 75% of the United States Workers Compensation Boards and Canadian provinces.

For a complete list — and ordering information — of all books published by your AMA, call 800 621-8335.





You and Your Patients

The AMA remains the nation's leader in organized medicine and patients' and physicians' leading advocate in the defense and promotion of public health.

Our members demand that we tackle medically demanding and sensitive issues, from HIV/AIDS, smoking, substance abuse, to family violence. Our work extends to protecting the environment and defending the vital role and work of medical researchers.

Health System Reform: *Health Access America*

For information, call: 800 AMA-3211 ext. 4701

As the 21st century approaches, America faces one of the most daunting and critical challenges in its history — how to reform the nation's health system. The AMA believes that meaningful health system reform must place patients' needs first and must address physicians' concerns. In 1990, we published our comprehensive plan for health system reform, *Health Access America (HAA)*. The plan provides a workable agenda for change, preserving established strengths while addressing key issues such as:

- bringing health insurance to all Americans
- preserving the quality of care
- ensuring liability reform
- easing paperwork burdens
- improving public health
- cutting costs
- making managed care work fairly
- supporting medical education
- upholding medical ethics

Since *HAA* was published, the AMA has been busy on many fronts focusing our country's attention on health system reform. Initiating intense lobbying efforts. Implementing targeted media and public relations activities. Meeting regularly with legislators. Consulting with Administration officials. Speaking to the public. As the debate intensifies and the Clinton and other plans work their way through Congress, your AMA will continue to represent the best interests of patients and the profession.

To learn more about *HAA* and what the AMA is doing, call the number above.

Consumer Books Program

For information, call: 800 AMA-3211

The AMA Consumer Books Program, started 15 years ago, has sold more than 15 million books about health care to the American public. The books are medically accurate and up-to-date, highly readable, and easy to understand. They stress preventive health measures and seek to demystify medical terminology and technology for the consumer.

Among the titles available through your local bookstore that you'll want to refer your patients to are:

- *AMA Encyclopedia of Medicine*
- *AMA Family Medical Guide*
- *AMA Guide to Prescription and Over-the-Counter Drugs*
- *AMA Handbook of First Aid and Emergency Care*
- *AMA Kids Books*
- *AMA Pocket Guides*

Consumer Health Programs

For information, call: 800 AMA-3211 ext. 4444

The AMA's Consumer Health Programs use a variety of media to educate both consumers and physicians on important health topics including immunization, dietary fat and cholesterol, women's health, smoking cessation, childhood safety, and mental health. Through the "Profiles in Health" programs, private and public sponsorships are used to develop important health messages that reach their audience through television, videotape, brochures, radio, special events, and educational inserts in national publications. Several of these products are available to you for distribution to your patients.

Domestic Violence Guidelines

For information, call: 800 AMA-3211 ext. 5066

The AMA, as part of its National Coalition of Physicians Against Family Violence, has begun releasing expert-drafted guidelines designed to help our member physicians better handle situations many physicians now avoid — identifying and intervening in family violence. *For your complimentary guidelines, call the number above.*

Patient Education Brochures

For information, call: 800 621-8335

No time to educate your patients on treatment options? There is a smart solution! Order AMA and specialty society informational brochures to tell your patients about health developments, issues and options so they can make better choices. You can order copies of:

- *Choosing Your Physician*
- *Communication. It's Good for Your Health.*
- *First Aid Chart*
- *First Aid Guide*
- *Let's Talk About AIDS*
- *Medicare: What It Will and Will Not Pay For*

(For information, call: 800 227-USPC)

- *Why I Belong* (to the AMA)

And remember, as an AMA member, you're entitled to significant discounts!

To assist members in improving patient safety and reducing liability risk, your AMA provides publications, information services and educational programming.

Your Advocate in Congress and the Courts

We make Washington listen! The AMA is your advocate in the House and Senate in Washington, DC. The AMA informs, explains and details the scientific and policy arguments to enhance physicians' ability to provide quality care for their patients. Each month of every year, the AMA testifies before Congress and sends Washington hundreds of legislative critiques and commentaries on proposed legislation and regulations that could affect your practice.

The AMA is your personal representative. For specifics on current issues, contact the departments listed here.

AMA Washington Office

1101 Vermont Avenue, NW
Washington, DC 20005
For information, call: 202 789-7400

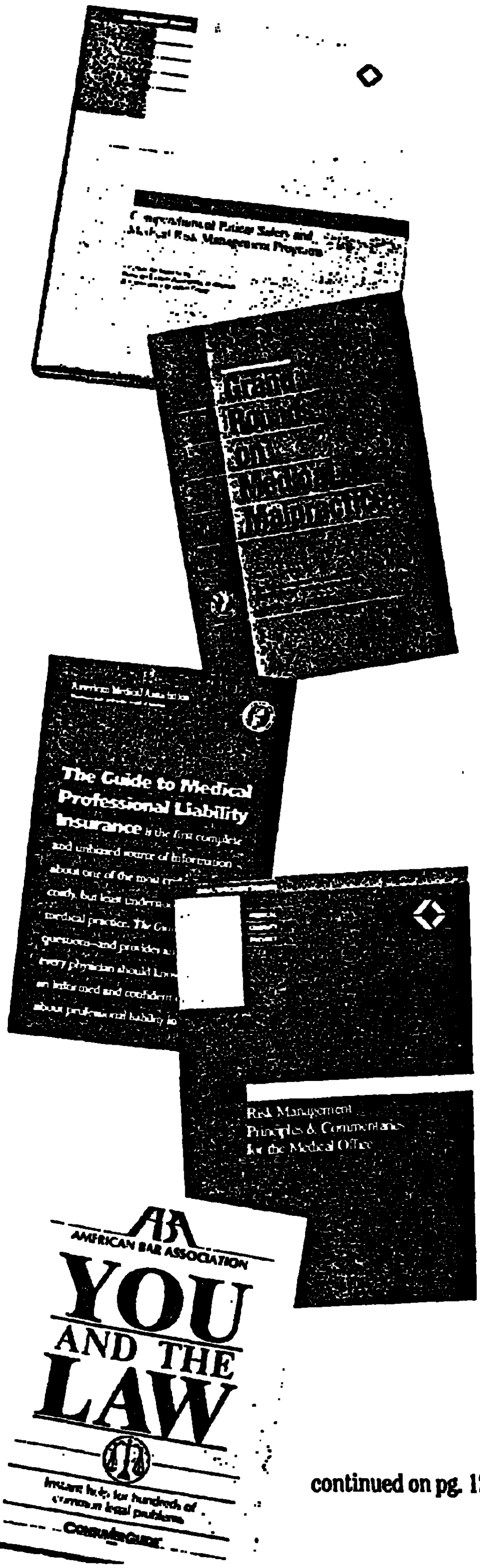
AMA's Washington, DC office lobbies with Congress, and works with state and specialty societies and group practices on legislation affecting your practice and your patients. It also represents you before the executive branch of the federal government and various regulatory agencies. The Washington office, with state and specialty societies, mobilizes grassroots support for legislative initiatives significant to the medical profession.

American Medical Political Action Committee (AMPAC)

1101 Vermont Avenue, NW
Washington, DC 20005
For information, call: 202 789-7466
Political Education Training: 202 789-7472

The American Medical Political Action Committee (AMPAC) supports candidates for the US House and Senate, while your state PAC uses your contributions to support state legislative candidates. The key voice of organized medicine in the political arena, AMPAC influences legislation and government policy.

AMPAC conducts political education programs for you and your spouse and maintains extensive contacts in the political community throughout the nation.



Who wants to see the inside of a courtroom? For current information on professional liability, look in your AMA Catalog of Publications, Products and Services:

- *Compendium on Patient Safety and Medical Risk Management Programs*
- *Grand Rounds on Medical Malpractice*
- *The Guide to Medical Professional Liability Insurance*
- *Risk Management Principles and Commentaries for the Medical Office*
- *You and the Law*

Order your free AMA Catalog of Publications, Products and Services now by calling your AMA Member Service Center at 800 AMA-3211

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Office of the General Counsel

For information, call: 800 AMA-3211 ext. 5448

Think of us as your law firm. The AMA is the leading advocate — often the only advocate — for our medical profession in the courts. Our actions prevent many medically inappropriate proposals from becoming law. For information about your legal rights or about matters of medical ethics, call the Office of the General Counsel.

Alliance for Medical Liability Reform (AMLR)

For information, call: 800 AMA-3211 ext. 4078

The AMA has taken the lead in addressing the growing liability problem and is building an alliance for change, the Alliance for Medical Liability Reform (AMLR). This grassroots coalition of physicians is dedicated to building a fair and efficient liability litigation system to make health care accessible and affordable for everyone. *To receive a complimentary Medical Liability Information Packet, call the number listed above.*

Current Legislative Issues

Federal Legislation: 800 AMA-3211 ext. 4764
State Legislation: 800 AMA-3211 ext. 4765

AMA staff is actively involved with a wide variety of legislation on issues affecting physicians and the public.

Call the numbers listed for general legislative information or updates on the following issues:

AIDS
Alcohol
Allied Health
Americans with Disabilities Act
Animal Welfare
Automobile and Highway Safety
Clinical Laboratories
CLIA
Drugs and Devices
Environmental Health
Health Care Financing
Health System Reform
Indigent Health Care
Licensure
Long-term Care
Medicaid
Medical Education Financing
Medicare
OSHA Information
Professional Liability
Professional Review Organizations
Quality Assurance
Reimbursement (RBRVS)
Self-Referral
Substance Abuse
Tobacco

Professionalism

Council on Ethical and Judicial Affairs

For information, call: 800 AMA-3211

The AMA's Council on Ethical and Judicial Affairs establishes ethical policy for the medical profession. This policy is set forth in the *Current Opinions* of the AMA's Council on Ethical and Judicial Affairs, which are used by grievance and disciplinary committees of state, county and specialty societies in enforcement proceedings.

Your Unique Concerns

A growing, vigorous and increasingly diverse organization, your AMA has formed special sections to target the unique concerns and needs of specific groups of physicians. These groups are a more effective framework for involvement in the medical community at large and play an ever-expanding role in your Association and our profession.

Direct involvement in a special section amplifies your opportunities to directly influence AMA policy — and make a difference.

AMA Education and Research Foundation

For information, call: 800 AMA-3211 ext. 4543

Your involvement, support and contributions to this foundation demonstrate organized medicine's commitment to the future of our profession in a tangible way. Founded in 1951 as an initiative to help medical schools meet expenses, the AMA Education and Research Foundation (AMA-ERF) has grown to become a major philanthropy of organized medicine. The foundation makes grants to medical schools to support excellence in medical education and to help medical students. Funding for biomedical research and experimental health care projects is also available. Since its inception, the AMA-ERF has provided more than $55 million directly to medical schools.

Sections

Smaller democracies within the AMA, these sections help to form AMA policy through their Governing Councils, biannual assembly meetings, and by electing delegates to the AMA House of

sent to the full AMA House of Delegates for action. For details about your preferred sections, call the numbers listed.

Hospital Medical Staff Section

For information, call: 800 AMA-3211 ext. 4754

The Hospital Medical Staff Section is dedicated to addressing the needs and concerns of practicing physicians who participate as members of a hospital medical staff. Each hospital medical staff is entitled to a representative in this important national forum.

Medical Schools Section

For information, call: 800 AMA-3211 ext. 4655

Established as a forum for discussing and disseminating information, this section provides participating medical schools with voting representation in the formulation of policy by the House of Delegates.

Medical Student Section (MSS)

For information, call: 800 AMA-3211 ext. 4746

This section introduces medical students to organized medicine and voices their distinct concerns on such issues as student loan repayment, sexual harassment policies and the quality of their education. In addition, MSS has developed a variety of specialized services and products targeting students' current and long-range needs. For example, you can *save up to 70% on air travel for residency interviews*.

Resident Physician Section (RPS)

For information, call: 800 AMA-3211 ext. 4751

Residency is possibly the most demanding period of a physician's career. This section understands the concerns of residents and addresses issues specific to their needs. For example, RPS was instrumental in formulating the often-praised residents' work-hour reform policy and works tirelessly to support student loan deferrals, a six-week maternity leave and other initiatives.

Young Physicians Section (YPS)

For information, call: 800 AMA-3211 ext. 4978

This section, representing nearly a third of all physicians, focuses on the concerns of those under age 40 or in their first five years of practice, emphasizing twin goals of leadership development and mainstreaming young physicians into the larger body of organized medicine. An example of this is the major role AMA-YPS played in winning equal pay for young physicians under Medicare. In addition, skill development sessions in media relations, political activism, legislative skills, and parliamentary procedure are offered twice yearly. Among its publications are *YPS Facts* (statistical information); *Primer on Organized Medicine*; and *Directory of Young Physician Leaders*. Projects include medical/legal clinics on caring for the science ambassadors program, and CPR training.

Special Services

Special interest areas of the AMA have evolved and grown from specific needs of members. These areas publish materials, sponsor conferences and provide information on issues of special concern to each group. For details about these services, call the numbers listed.

Group Practice Liaison

For information, call: 800 AMA-3211 ext. 5473

The Group Practice Liaison Office works to address the concerns and issues of group practice physicians and serves as the liaison between group practices and the AMA. The Advisory Committee on Group Practice Physicians reports to the Board of Trustees and helps formulate and articulate policy relevant to group practice needs.

International Medical Graduate Services

For information, call: 800 AMA-3211 ext. 5624

The International Medical Graduate Advisory Committee is an increasingly vocal participant in the affairs of the AMA. It is concerned with state licensure, residency selection and general discrimination against IMGs. Learn the experiences and insights of this group of physicians who received their medical education outside the USA, Canada, and Puerto Rico.

Minority Physician Services

For information, call: 800 AMA-3211 ext. 5624

The newly created Advisory Committee on Minority Physicians has three principle missions: to analyze pertinent data, trends, policy and ongoing activities concerning the health status of minorities; to increase membership and representation of minority physicians and medical students in the AMA; and to increase the number of minority physicians, students and faculty in US medical schools. The AMA Board of Trustees has defined minorities as African Americans, Hispanic Americans and Native Americans for the purpose of this Committee.

Senior Physician Services

For information, call: 800 AMA-3211 ext. 2460

Inquire about unique membership opportunities and benefits including retirement planning seminars for AMA member physicians over 55 years of age. Issues addressed by this group include closing or selling a practice, investments and voluntary opportunities.

Women in Medicine

For information, call: 800 AMA-3211 ext. 4392

Although women participate in all areas of the AMA, your AMA's office of Women in Medicine concentrates on subjects of particular interest to the rapidly increasing ranks of women physicians, such

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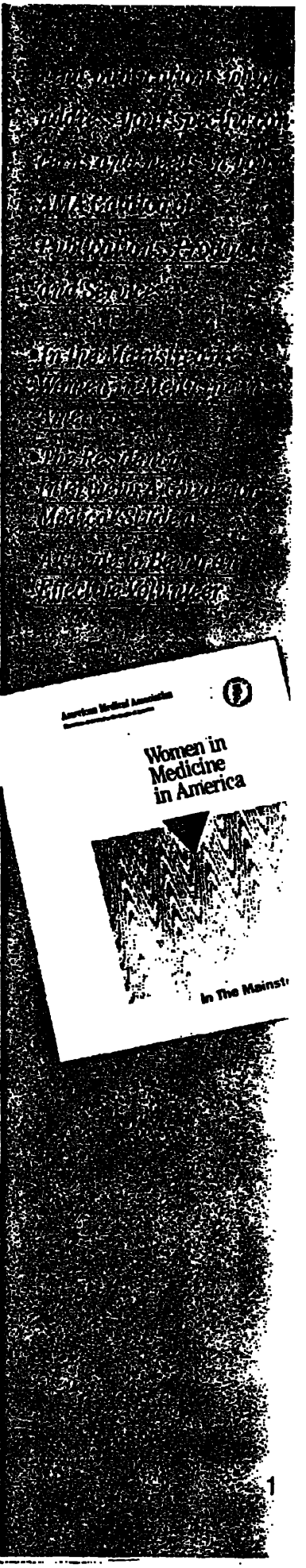

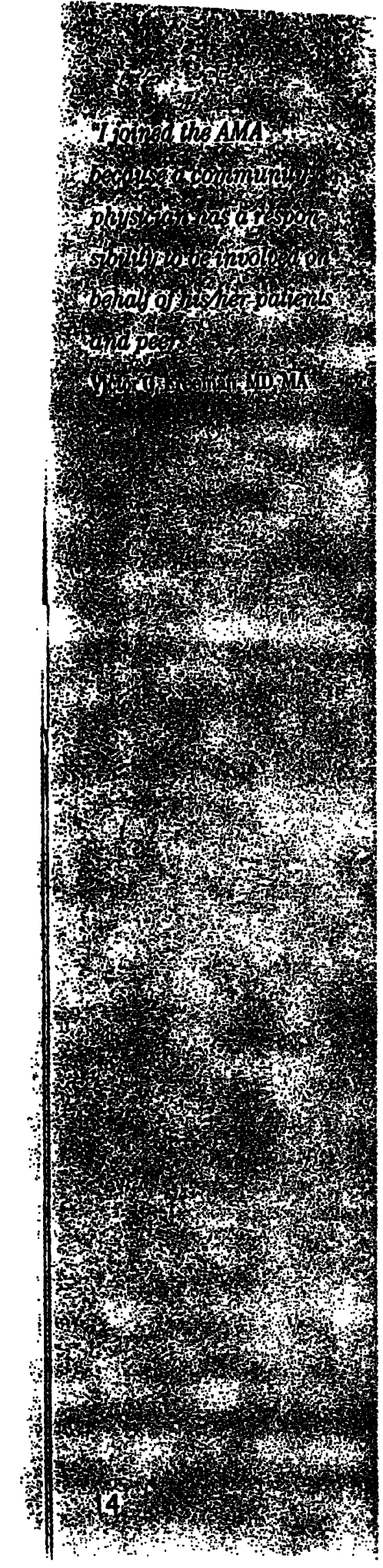

as maternity/paternity leave, group practices, sexual harassment and gender disparity. Working through the AMA Board of Trustees, the Women in Medicine Advisory Panel helps form and mold AMA policy.

State and County Medical Society Relations

For information, call: 800 AMA-3211 ext. 4491

Your AMA maintains direct liaison with state and county medical societies [illegible] general concerns of our members, the medical profession and our patients.

Specialty Medical Society Relations

For information, call: 800 AMA-3211 ext. 4412

Your AMA works to build and maintain relationships with national medical specialty society membership, leadership and staff, as represented in the AMA House of Delegates.

You and Your Family

Income-enhancing investments. Exclusive home mortgage program. Cost-effective insurance. Custom credit cards. Discounts on rental cars. Greater savings on long-distance calls. Volunteer opportunities for your spouse. These benefits offered by AMA subsidiaries are designed to benefit you and your entire family.

The benefits package from AMA subsidiaries can maximize your earnings while helping you save money. Consider your choices:

AMA Alliance (formerly AMA Auxiliary)

For information, call: 800 AMA-3211 ext. 4470

The AMA Alliance, a voluntary nationwide network of physicians' spouses, supports the goals of organized medicine. Activities include assisting with the AMA's National Coalition of Physicians Against Family Violence; raising more than $2 million each year for the AMA Education and Research Foundation; and activating phone banks to encourage medical community support for state and federal legislation. The AMA Alliance publishes materials for distribution to the public, including *Be a Winner*, a health coloring book for children; and maintains a health promotion clearinghouse that can be accessed by any member. The Alliance also publishes a series of booklets called *What Every Physician's Spouse Should Know*, which covers such medical family concerns as professional liability, physician well-being, retirement and estate planning, working in a spouse's office, and marriage. Periodic publications include *Facets*, a bimonthly magazine for members; and *Newsline*, a bimonthly tabloid for Medical Alliance leaders.

AMA Financing & Practice Services, Inc.

200 North LaSalle Street, Suite 500
Chicago, Illinois 60601
For information, call: 800 366-6968

AMA Financing and Practice Services, Inc. strives to provide services that reflect the financing and practice needs of physicians, their families and their employees. These business and personal products feature attractive benefits, convenience, personalized service and competitive rates.

Financing Products

AMA-sponsored Gold VISA Card

For information, call: 800 366-6968

AMA Member Gold VISA offers qualifying AMA members advantages such as no annual fee for the first year, a high initial credit line, 24-hour customer service, emergency travel assistance, and purchase security and extended protection. The card is issued by The Chase Manhattan Bank (USA).

AMA-sponsored Home Equity Line of Credit

For information, call: 800 262-6250

Here's the smart, simple and cost-effective way to harness the valuable equity in your home. Available through the Prudential Bank, this program offers AMA members lines of credit at rates as low as prime, with preliminary approval usually within five business days and closing often within 3-4 weeks after approval.

AMA-sponsored Home Mortgage Program

For information, call: 800 262-4778

This program, available through Prudential Home Mortgage, makes it easy for you or your family members to purchase or refinance a home. The program offers 15- and 30-year fixed rate and one-year adjustable rate mortgages. Loan approvals are usually granted within 12 days, and AMA members receive a 1/4% origination fee discount and reimbursement of their appraisal fee after their loan closes.

Practice Products

AMA-sponsored Rental Car Program

For information, call: 800 654-2200
Hertz AMA member CDP#11635

With more cars and locations worldwide, special year-round discounts up to 15%, innovative services like Hertz #1 Club Gold®, coupon specials, and over 75 years of leadership and experience as the #1 car rental company in the world, Hertz is committed to providing high quality service and valuable savings for AMA members.

Telephone Program

For information, call: 800 367-3604

As an AMA member, you can enjoy substantial savings on most AT&T direct-dialed long-distance calls from your office with this exclusive program. And, there's no service order charge or monthly service charge.

AMA Insurance Agency, Inc.

200 North LaSalle Street, Suite 400
Chicago, Illinois 60601
For general information, call: 800 458-5736

The AMA Insurance Agency, Inc. provides a full range of top-quality AMA-sponsored insurance products for physicians and their families. Some programs are intended to meet professional needs, while others are designed for physicians' personal security needs and those of their families. All of the programs are offered at very competitive group rates.

Insurance Programs for Personal Needs

Accidental Death and Dismemberment Plan

This plan offers you benefits up to $500,000, 24-hour, year-round, worldwide coverage, and a special loss-of-use benefit for physicians.

Excess Major Medical Plan

This plan gives you and your family comprehensive protection by providing up to $2,000,000 for medical catastrophes. Coverage is available for physician's spouse and children with a choice of deductible amounts from $20,000 to $1,000,000.

HIV Indemnity Insurance Plan

This plan provides a lump-sum benefit payment up to $500,000 and is guaranteed renewable for five years. Rates and benefits are not based on age, gender, specialty or geography.

Hospital Indemnity Plan

To help physicians and their families cover ever-rising hospital costs, your AMA sponsors this exclusive plan. You can opt for daily benefits up to $250. The benefits are payable for up to 500 days and paid directly to you. Also includes maternity benefits.

Long-Term Care Plan

The costs for extended nursing home and home health care are staggering. This plan offers superior coverage that will help protect you and your assets from the devastating effects of long-term nursing home and health care costs. Benefits are paid for up to six years and coverage is guaranteed renewable and includes benefits for Alzheimer's Disease. The plan provides coverage for all levels of nursing home care and offers a choice of daily benefit amounts up to $200.

As you know, most costs associated with hospitalization exceed the benefits allowed by Medicare. This plan helps cover out-of-pocket expenses. We offer three options, Plans A, E and J. Acceptance into any of the Medicare Supplement Plans is guaranteed for eligible physicians and their spouses.

Term Life Insurance

We offer a choice of two plans, each designed to provide high-quality coverage. You and your spouse can choose benefits up to $2,000,000 with additional benefits for accidental death and special savings for non-tobacco users.

$10,000 Deductible Comprehensive Medical Expense Plan

This new plan is designed for physicians who want to save money over traditional major medical insurance plans. With this plan, you're eligible for up to $2,000,000 in lifetime benefits and you have up to two years to satisfy the $10,000 deductible.

Insurance Programs for Professional Needs

Disability Income Plan

You can choose benefits up to $20,000 a month, as well as a choice of three elimination periods. The plan covers your own specialty, and premiums are automatically waived during periods of disability.

Office Overhead Expense Plan

What would happen to your practice if you became disabled due to an accident or illness? This plan will provide you with monthly benefits up to $15,000 for rent, employee salaries, utilities, leasing, and other charges needed for continuing your practice after a disabling accident or illness.

AMA Investment Advisers, Inc.

200 North LaSalle Street, Suite 500
Chicago, Illinois 60601
For information, call: 800 262-3863

Prudent investment planning today for a secure future is important. Backed by more than 25 years of investment management experience, we offer individualized service and expertise from seasoned financial counselors. Our professional investment specialists can introduce you to a wide array of products and help you create a personalized investment strategy to fulfill your short- and long-term financial goals.

Cash Management Brokerage Services

This progressive all-in-one account is the choice of many busy physicians and can simplify your financial life, too. It combines a no minimum personal checking account with complete brokerage services and up to $10,000,000 in account protection, and monthly and annual statements that track and categorize all your checking and brokerage account activity.

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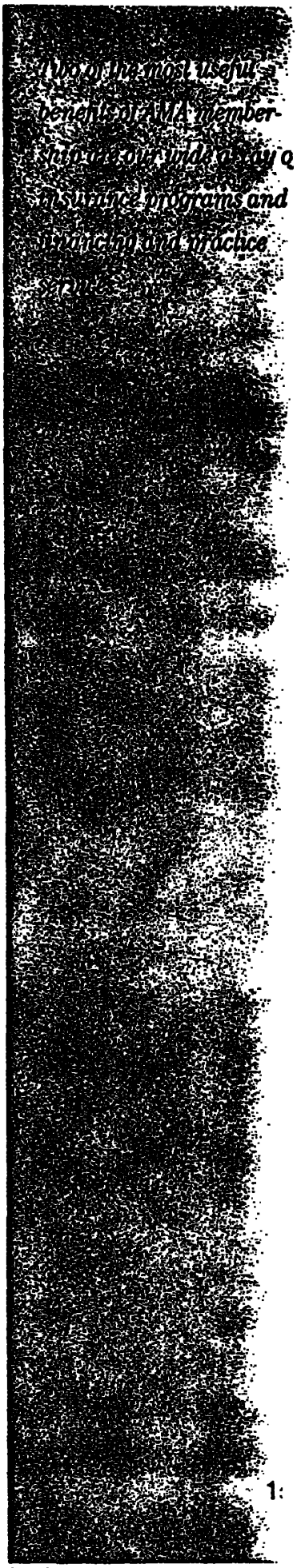


Financial Independence Service

If you are looking to develop a truly personalized investment plan which implements strategies for approaching your goals over various time frames, this service may be the solution. Working from a thorough understanding of the concerns of physicians, your investment counselor will structure a customized portfolio to achieve your personal investment goals. This is a fee-based program, so you pay no commissions.

Financial Planning Services

To help you better manage your money in changing economic climates and adjust your personal finances to meet your own changing goals, we also offer regional financial planning seminars, personalized goal setting, tax planning and analysis, educational needs analysis, and written financial plans.

Institutional Advisory Service

Our comprehensive institutional investment consulting service will review current investment programs, refine investment strategies, develop alternative portfolio structures, evaluate current investment managers and help select new ones, produce written investment policy statements, and monitor and support investment programs.

Investment Products

Through AMA Investment Advisers, you have access to many other high-quality investment vehicles such as mutual funds, money market funds, tax-free funds, tax-free unit investment trusts, insured and traditional trusts, tax-deferred annuities, stocks, bonds, CDs and more.

Retirement and Financial Planning Seminars

AMA Investment Advisers has developed workshops to teach you the basics of successful personal money management, as well. Full day, half day and one hour briefing sessions are available. Contact us for more information.

Retirement Planning Services

When it comes to your retirement planning, you'll benefit from our expert guidance and service in these key areas: retirement planning seminars, IRAs and SEP IRAs, qualified retirement plans, and retirement plan distribution and accumulation analysis and counseling.

AMA Financing & Practice Services, Inc., AMA Insurance Agency, Inc., and AMA Investment Advisers, Inc. are wholly owned subsidiaries of the AMA.

What is AMA P.O.W.E.R.?

Physicians Organized to Work for Effective Reform

P.O.W.E.R. is the American Medical Association's legislative and political grassroots network. It is designed to provide AMA members and their families the tools necessary to communicate with their Senators and Representatives on the many issues surrounding the debate on health system reform.

Physicians are the most important link in the AMA legislative and political grassroots chain and Members of Congress will be reaching out to their physician constituents for advice. Physicians must be ready to give that advice.

Organized efforts are the key to any campaign. The legislative and political grassroots programs outlined in this article will provide ample opportunity for physician constituents to develop long-term relationships with their Representatives.

The Work necessary to develop these relationships must be shared by many, as every physician has a stake in health system reform.

Effective Reform will put patients first; it will protect the physician-patient relationship; it will allow physicians and patients to make the clinical decisions in the best interests of the patient, not the plan; it will free physicians to practice medicine rather than accounting; and it will lift the cloud of frivolous lawsuits that hangs over the physician-patient relationship.

For physicians and their families, legislative and political grassroots action has never been so important. With the introduction of the President's plan for health system reform, along with numerous other bills all aimed at a major overhaul of the nation's health care delivery system, the U.S. Congress will be making fundamental changes in the lives of physicians, their families and their patients.

Members of the AMA P.O.W.E.R. Network will receive the latest inside information on health system reform, on other legislative issues important to organized medicine and timely political updates as well.

But most important, members of the AMA P.O.W.E.R. Network will be called upon to build the relationships and ultimately seek support for the views of organized medicine.

Join the AMA P.O.W.E.R. Network today. Your participation will make a difference for you, for your family, for your patients and for the future of health care in this country.

How Does AMA P.O.W.E.R. Work?

The AMA Congressional One-on-One Program - It is esse that the AMA and physicians across the nation have access to Members of Congress who will be deciding the ultimate direction the ultimate fate of health system reform. But access is based u relationships -- and relationships are not built overnight. Rather, strongest relationships are built on trust over time. The AMA Cong sional One-on-One Program creates an environment in which s relationships will grow.

- You will be notified of the date, time and location for the Congr sional One-on-One meeting in your area. As the meeting approach materials will be provided to update you on the latest health syst reform developments in Washington.

- Prior to the meeting, you will be briefed by the One-on-One Distr Chair in your area on the goals for the meeting and subjects t discussion.

- The results of the meeting will be shared with the state medical socie and the AMA lobbying team in Washington, D.C.

AMA Calls to Action - As the need arises, you will be asked to wri or call your Senators and Representative on timely issues important organized medicine. As a member of the AMA P.O.W.E.R. Networ you will be called upon to speak with Members of Congress seekin their support for the AMA and organized medicine.

Your State Medical Society - Members of the AMA P.O.W.E.R Network may be called to lobby not only their federal representative but state legislators as well. Meeting with state legislators, working o political campaigns, writing or phoning your local legislator, an participating in "mini-internships" are just a few of the many ways yo may be called to act.

Join the AMA P.O.W.E.R. Network today!

Join the AMA P.O.W.E.R. Network - *Please complete the questionnaire below and return it to the AMA Division of Political Action*

Name_____ Home Address _____ Office Address _____

Office Telephone _____ Home Telephone _____ Fax Number _____

AMA Member?_____ AMA Alliance Member? _____ Other?_____

My current U.S. Representative is:_____ Please describe, if applicable, any relationship you may have with your U.S. Senators or U.S. Representative: _____ Have you ever worked, either as a volunteer or otherwise, in a political campaign? If yes, please describe: _____

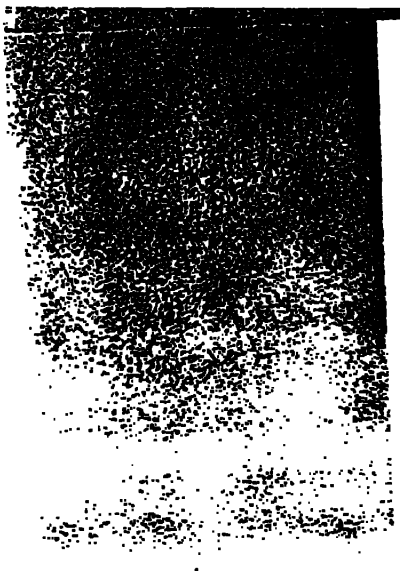
Please indicate the legislative and political grassroots activities in which you would be interested in participating:

_____ Receive alerts of upcoming grassroots activities _____ Congressional One-on-One Meetings

_____ Write Letters to Senators and Representatives _____ Send telegrams/mailgrams to Senators and Representative

_____ Sponsor/participate in a mini-internship _____ Volunteer for a political campaign _____ Attend a fundraiser for a political candidate

Please return to: AMA Division of Political Action, 1101 Vermont Avenue, N.W., Washington, DC 20005, Attention: Anne Marie Crane



Remember,
to take advantage of your AMA membership benefits, call your Member Service Center at:
800 AMA-3211.

American Medical Association
Physicians dedicated to the health of America

James S. Todd, MD
Executive Vice President

515 North State Street
Chicago, Illinois 60610

312 464-5000
312 464-4184 Fax

April 21, 1994

Office of the General Counsel
Federal Election Commission
999 E Street, N.W.
Washington, D.C. 20463

ATTN: **Lawrence M. Noble**
General Counsel

AOR 1994-12

RE: Advisory Opinion Request

Dear Mr. Noble:

I am writing in response to your letter of March 4, 1994, requesting additional information in connection with the February 23, 1994, Advisory Opinion Request on behalf of the American Medical Association (AMA). For your convenience, I have numbered the responses to correspond to the numbers of the requests for information in your letter.

1. The AMA Constitution and Bylaws contain no provisions governing the removal of Trustees or officers by the House of Delegates. A Trustee may be removed by a two-thirds vote of the AMA House of Delegates pursuant to §35 of the Illinois General Not For Profit Corporation Act (the "Act") 805 ILCS 108.35 (Exhibit A). Since the Board of Trustees is divided into classes, with overlapping three year terms, a Trustee could be removed only for cause. The Speaker, Vice Speaker, President, President-Elect, and Immediate Past President could be removed by the House of Delegates pursuant to §55 of the Act, 805 ILCS 108.55 (Exhibit B). The Executive Vice President, the Chair of the Board, Vice-Chair and Secretary-Treasurer, who are chosen by the Board of Trustees, can be removed by the Board.

The Board of Trustees has no power to remove, discipline or otherwise affect the tenure of members of the House of Delegates.

2. The 1979 policy statement which (a) requires the Board of Trustees to conduct AMA affairs in accordance with policies adopted by the House of Delegates and (b) allows the Board to establish temporary policy on issues where there is no established policy is attached as Exhibit C. This policy statement was amended in December, 1993 to give the Board additional authority to act in urgent situations which arise between meetings of the House of Delegates (Exhibit D).

3. There are no policy statements currently (or to my knowledge ever) in effect which refer to the Board of Trustees as the leading policy maker or governing body of the AMA.

I am enclosing for your information a copy of the most recent AMA Policy Compendium (Exhibit E). This is the official reference for all AMA policies currently in effect. The parenthetical notation at the end of each listing states the resolution or report which contains the policy and the meeting of the House of Delegates at which it was adopted. (The letters A and I refer, respectively, to the annual meetings in June and the interim meetings in December of each year. A reference to A-92, for example, would indicate a policy adopted by the House of Delegates at the 1992 annual meeting.) As a review of the Compendium indicates, many policies are based on reports of the Board of Trustees or one of the AMA Councils. But such reports are only recommendations, and do not become policy, unless they are adopted by the House of Delegates.

4. The Board of Trustees has power to refuse to act on resolutions in certain situations. The most important source of this authority is section 5.401 of the Bylaws, which provides that

> All resolutions and recommendations of the House of Delegates pertaining to the expenditure of funds shall be referred to the Board of Trustees which shall determine whether the expenditure is advisable. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House of Delegates the reason for its decision.

Since a statement of policy would normally not involve expenditure of funds, this power does not give the Trustees any significant control over AMA policy. But it does give the Trustees significant control over the means by which policy is implemented.

The Trustees may also refuse to implement House of Delegates resolutions which raise serious legal concerns. In 1966, the Trustees refused to implement a resolution passed at the annual meeting due to the threat of antitrust litigation. This resolution was rescinded by the House at its December, 1966 meeting (Exhibit F). So far as I am aware, this is the only time the Trustees have refused to implement a resolution for legal reasons.[1]

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[1] It should be noted that both the applicable law and AMA policy have changed since 1966. Section 163a 16 of the Illinois General Not for Profit Corporation Act, as in effect in 1966, stated that, "The affairs of a corporation shall be managed by a board of directors." The

5. The following is a description of the division of power among the House of Delegates, the Board of Trustees and other parts of the AMA in various areas.

a. Public Policy Positions. As is discussed in detail above and in the February 23 Advisory Opinion Request, the House of Delegates is clearly in charge of AMA policy formation. Article VI of the AMA Constitution provides that the House of Delegates is "[t]he legislative and policy-making body of the Association." All AMA policy, except for limited exceptions described below, is created by actions of the House of Delegates.

The Board of Trustees' primary role in policy formation is providing advice and recommendations. The House of Delegates often establishes AMA policy by adopting (or rejecting) recommendations contained in reports of the Board of Trustees or the various AMA Councils. But these reports are only recommendations, not AMA policy, until they are adopted by the House.

The Board of Trustees does have authority to create policy in limited circumstances. As was discussed above, the Board has the authority to make policy decisions on questions where there is no existing policy or in urgent situations which arise between meetings of the House of Delegates (Exhibit D). Such policy determinations may be rescinded by the House at any time. And any Board action which differs from existing policy must be presented to the House for action at the next meeting.

The House of Delegates has also given the Board of Trustees authority "to act on behalf of the Association to promote proactively and negotiate for those elements of health system reform which they feel will best represent the interests of patients and the profession" (Exhibit H). This power is to be exercised primarily in accordance with policy positions adopted by the House, but may involve Board determinations of policy on some issues. In its report to the House containing this recommendation, the Board stated that it would place particular consideration on the advice of the Technical Advisory

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comparable provision of the current law states that "except as provided in the articles of incorporation or the bylaws, the affairs of a corporation shall be managed by or under the direction of the board of directors." In addition, the 1955 policy statement cited on the 1966 letter to Delegates is no longer in effect. I believe that section 5.401 of the Bylaws and the current policy on litigation (Exhibit G) would authorize the Board of Trustees to take comparable action if a similar situation were to develop.

committee which it established at the direction of the House (Exhibit I) and which includes representatives of the House and various AMA councils.

The AMA's rules of parliamentary procedure also allow the House to delegate decisions to the Board. When considering a resolution or report, the House of Delegates can take a number of actions, including adoption or rejection of a resolution or the recommendations in a report, referring the matter to the Board with instructions to report back at the next meeting of the House, or referring the item of business to the Board "for decision." Referring an item to the Board "for decision" allows the Board to take whatever action it deems appropriate without further action by the House. This procedure is not normally used for items of business involving major policy decisions, but can allow the Board to take some actions which establish AMA policy.

The Board of Trustees thus has limited, but not insignificant, policy-making responsibilities. But its powers to set policy are delegated to it by the House of Delegates and could be revoked by the House at any time. The House can also rescind any policy adopted by the Board. The House of Delegates therefore clearly has ultimate responsibility for formation of AMA policies.

You ask in your letter for "an estimate of percentages" if power in any area is divided. In one sense, the House of Delegates could be said to have 100% of the AMA policy-making power, since it has the ability to withdraw all power to set policy from the Board. As a practical matter, however, the House is unable to conduct the analysis and information gathering necessary to set policy, and must rely on the Board and AMA Councils for background and advice. And the House is unlikely to withdraw all authority from the Board to make policy decisions between House meetings. I would estimate about 90% percent of the power to set AMA policy is currently retained by the House of Delegates, with about ten percent residing in the Board of Trustees.

b. Ethics. Authority regarding the promulgation and enforcement of professional ethics within the AMA is divided between the House of Delegates and the Council on Ethical and Judicial Affairs ("CEJA").

The primary sources of AMA rules regarding medical ethics are the Principles of Medical ethics and the opinions of CEJA.

The Principles of Medical Ethics are adopted, and can be amended by, the House of Delegates.

CEJA issues two types of opinions: interpretations of the Principles of Medical Ethics and opinions on other "matters pertaining to the relations of physicians to one another or to the public." The House of Delegates has the authority to debate and ask CEJA to reconsider, but not the power to reject, interpretations of the Principles of Medical Ethics. Neither the House of Delegates or the Board of Trustees has any authority over other CEJA opinions. These rules are set forth in more detail in a report adopted by the House in 1991 (Exhibit J).

CEJA also has authority to investigate accusations of unethical conduct against members of the AMA, and can expel members who are found to have engaged in unethical conduct. It also fulfills a number of other judicial functions, including interpretating the AMA Constitution and Bylaws, and hearing appeals of cases, including disciplinary cases against members, from state medical associations.

Members of CEJA are appointed by the President of AMA and confirmed by the House of Delegates. So far as I am aware, no person appointed by the President has ever been rejected by the House.

In the area of professional ethics, I would estimate that authority resides approximately 60 percent in CEJA, 30 percent in the House of Delegates and less than ten percent in the President.

c. Operation of the AMA. The operation of the corporate structure of the AMA is primarily under the control of the Board of Trustees. The Trustees select the Executive Vice President, who is the chief executive officer of the AMA. The Trustees are responsible for the AMA's budget, and have control over fiscal policy. The Trustees have been authorized by the House of Delegates to make decisions regarding litigation involving the AMA (Exhibit G).

The House of Delegates has some influence over the operation of the AMA. A major source of revenue is membership dues. Dues levels are set by the House of Delegates. Some of the Board's authority, such as the authority to control litigation, is at least partially delegated by the House. The Board's choices regarding AMA operation are also constrained somewhat by the necessity to provide the organizational and financial resources needed to implement policies adopted by the House. And the House can eliminate any of the Board's powers by amending the Constitution or Bylaws. A reasonable estimate is that internal operations are about 90 percent under the control of the Board of Trustees, 10 percent under the control of the House of Delegates.

d. Publications. Section 5.402 of the AMA Bylaws gives the Board of Trustees authority to, "[w]ithin the policies adopted by the House of Delegates, provide for the publication of the Journal of the American Medical Association ["JAMA"] and such specialty journals, periodicals and other publications as it may deem to be desirable...."

The House of Delegates has adopted few policies regarding publications. The most important guarantees editorial independence to the editors of JAMA and the other scientific journals (Exhibit K). Other policies include a requirement that American Medical News provide editorial space to the Chair of the Board of Trustees and include a disclaimer that views expressed are not necessarily endorsed by the AMA (Policy 530.983, Policy Compendium page 453), and policies requiring use of gender neutral language and recycled paper (Policies 530.976 and 530.982, Policy Compendium page 452).

AMA publications are thus primarily under the control of the Board of Trustees. The Trustees have ultimate responsibility for determining which books and periodicals will be published, setting budgets for publications and hiring editorial staff. A reasonable estimate is that publications are about 90 percent under the control of the Board of Trustees, 10 percent under the control of the House of Delegates.

e. Scientific and Medical Information. There are three primary sources of medical and scientific information from the AMA. The first is AMA publications. These include JAMA, several medical specialty journals, and various books intended to provide information to medical professionals or the general public. Most of these are published by the AMA, although some of the consumer books are published by commercial publishers under license from the AMA. As was discussed above, these publications are primarily under the control of the Board of Trustees.

A second source is reports of AMA Councils, particularly the Council on Scientific Affairs. The Council may choose to issue a report on a particular subject or be directed to study a particular subject by the House of Delegates. Reports of the Council of Scientific Affairs generally provide in depth analysis and are often important sources of information concerning the state of knowledge on the subject under consideration.

AMA Councils are elected by the House of Delegates, and recommendations in council reports which affect AMA policy are subject to House approval. (See Policy 540.994, Policy Compendium page 456). The Board of Trustees has some influence due to its ability to nominate members of councils. But this area is almost 100 percent under the control of the House of Delegates.

There is also some medical information generated by the internal operations of the AMA. The AMA Center for Health Policy Research conducts studies of economic and sociological characteristics of physicians and medical practice. The Division of Survey and Data Resources maintains a data base containing information about all physicians in the United States. These internal operations are, as discussed above, primarily under the control of the Board of Trustees.

f. Accreditation of medical education. The AMA does not directly accredit medical education programs. It is, however, a member of three organizations which accredit educational programs -- the Liaison Committee on Medical Education ("LCME"), which accredits medical schools; the Accreditation Council for Graduate Medical Education ("ACGME"), which accredits medical residency programs; and the Accreditation Council for Continuing Medical Education ("ACCME"), which accredits sponsors of continuing medical education programs. The AMA also sponsors the Committee on Allied Health Education and Accreditation ("CAHEA"), which oversees accreditation of allied health education programs. CAHEA will cease operations on June 30, 1994, and be replaced by a new accreditating agency. The AMA will provide some funding and staff support for the new organization, but will not be involved in the accreditation process. I am enclosing a copy of a portion of a report by the Council on Medical Education which describes these programs in more details (Exhibit L).

Control over the AMA educational accreditation activities is vested primarily in the House of Delegates and the Council on Medical Education. The House of Delegates elects members of the Council and establishes AMA policies regarding medical education. The Council appoints members of CAHEA and nominates AMA representatives to ACGME, ACCME and ACGME residency review committees for appointment by the Board of Trustees. AMA representatives to LCME, ACGME and ACCME are almost always members of the Council at the time of their appointment. A reasonable estimate is that authority in this area resides approximately 50 percent in the Council on Medical Education, 40 percent in the House of Delegates and less than 10 percent in the Board of Trustees.

g. Accreditation of Health Care Providers. The AMA is a member of the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), which accredits hospitals, long term care facilities, health maintenance organizations, ambulatory care facilities and home health care providers.

The AMA commissioners on the JCAHO are appointed by the Board of Trustees and currently are all members of the Board. The House of Delegates has adopted a substantial body of policies regarding accreditation which govern the AMA

Commissioners. (See Policy Compendium pages 184-191). A reasonable estimate is that authority in this area resides approximately 75 percent in the House of Delegates and 25 percent in the Board of Trustees.

As the above discussion illustrates, the House of Delegates clearly has primary responsibility for establishing AMA policy. It also elects, and has the power to remove, the members of the Board of Trustees and AMA officers, other than the Chair and Vice Chair of the Board, the Secretary-Treasurer and the Executive Vice President, who are chosen by the Board. (The House could, of course, effectively remove the Chair, Vice Chair or Secretary-Treasurer by removing him or her from the Board.) The House of Delegates also has exclusive authority to amend the AMA Constitution and Bylaws.

The Board of Trustees has primary authority primarily for the finances and internal operations of the AMA. This authority is important, but is secondary to the policy-making authority of the House of Delegates since the organizational structure exists for the purpose of promoting the AMA's basic purposes and policies. Furthermore, the House of Delegates has the power, either by resolutions or amending the Constitution and Bylaws, to eliminate any powers currently vested in the Trustees.

I believe that these facts clearly indicate that the House of Delegates is the AMA's highest governing body, and again request that you issue an Advisory opinion so holding.

Copies of the AMA Constitution and Bylaws and Articles of Incorporation have been already mailed to you. If you have not received them, or if you have any additional questions, please contact Mr. Leslie J. Miller in the AMA Chicago office (312) 4644608/Fax (312) 464-4073.

Very truly yours,

James S. Todd M.D

James S. Todd, M.D.

EXHIBIT A

Historical and Statutory Notes

Prior Laws:
Laws 1943, vol. 1, p. 481, § 22.
Ill.Rev.Stat.1985, ch. 32, ¶ 163a21.

Library References

Corporations ⇐298(3).
WESTLAW Topic No. 101.
C.J.S. Corporations § 464.

105/108.30. Vacancies

§ 108.30. Vacancies. Any vacancy occurring in the board of directors and any directorship to be filled by reason of an increase in the number of directors may be filled by the board of directors unless the articles of incorporation or the bylaws provide that a vacancy or directorship so created shall be filled in some other manner, in which case such provision shall control. A director elected or appointed, as the case may be, to fill a vacancy shall be elected or appointed for the unexpired term of his or her predecessor in office.

P.A. 84–1423, Art. 8, § 108.30, eff. Jan. 1, 1987.
Formerly Ill.Rev.Stat.1991, ch. 32, ¶ 108.30.

Historical and Statutory Notes

Prior Laws:
Laws 1943, vol. 1, p. 481, § 19.
Ill.Rev.Stat.1985, ch. 32, ¶ 163a18.

Library References

Corporations ⇐295.
WESTLAW Topic No. 101.
C.J.S. Corporations § 435.

105/108.35. Removal of directors

§ 108.35. Removal of directors. (a) One or more of the directors may be removed, with or without cause. In the case of a corporation having a board of directors which is classified in accordance with subsection 108.10(e) of this Act, no director may be removed except for cause if the articles of incorporation or the bylaws so provide.

(b) In the case of a corporation with no members or with no members entitled to vote on directors, a director may be removed by the affirmative vote of a majority of the directors then in office present and voting at a meeting of the board of directors at which a quorum is present.

(c) In the case of a corporation with members entitled to vote for directors, no director may be removed, except as follows:

(1) A director may be removed by the affirmative vote of two-thirds of the votes present and voted, either in person or by proxy.

(2) No director shall be removed at a meeting of members entitled to vote unless the written notice of such meeting is delivered to all members entitled to vote on removal of directors. Such notice shall state that a purpose of the

meeting is to vote upon the removal of one or more directors named in the notice. Only the named director or directors may be removed at such meeting.

(3) In the case of a corporation having cumulative voting, if less than the entire board is to be removed, no director may be removed, with or without cause, if the votes cast against his or her removal would be sufficient to elect him or her if then cumulatively voted at an election of the entire board of directors.

(4) If a director is elected by a class of voting members entitled to vote, directors or other electors, that director may be removed only by the same class of members entitled to vote, directors or electors which elected the director.

(d) The provisions of subsections (a), (b) and (c) shall not preclude the Circuit Court from removing a director of the corporation from office in a proceeding commenced either by the corporation or by members entitled to vote holding at least 10 percent of the outstanding votes of any class if the court finds (1) the director is engaged in fraudulent or dishonest conduct or has grossly abused his or her position to the detriment of the corporation, and (2) removal is in the best interest of the corporation. If the court removes a director, it may bar the director from reelection for a period prescribed by the court. If such a proceeding is commenced by a member entitled to vote, such member shall make the corporation a party defendant.

P.A. 84–1423, Art. 8, § 108.35, eff. Jan. 1, 1987.
Formerly Ill.Rev.Stat.1991, ch. 32, ¶ 108.35.

Library References

Corporations ⇐294.
WESTLAW Topic No. 101.
C.J.S. Corporations §§ 454 to 457.

105/108.40. Committees

§ 108.40. Committees. (a) If the articles of incorporation or bylaws so provide, a majority of the directors may create one or more committees and appoint directors or such other persons as the board designates, to serve on the committee or committees. Each committee shall have two or more directors, a majority of its membership shall be directors, and all committee members shall serve at the pleasure of the board.

(b) Unless the appointment by the board of directors requires a greater number, a majority of any committee shall constitute a quorum, and a majority of committee members present and voting at a meeting at which a quorum is present is necessary for committee action. A committee may act by unanimous consent in writing without a meeting and, subject to the provisions of the bylaws or action by the board of directors, the committee by majority vote of its members shall determine the time and place of meetings and the notice required therefor.

(c) To the extent specified by the board of directors or in the articles of incorporation or bylaws, each committee may exercise the authority of the

where evidence was insufficient to support finding that secretary commingled funds or, even if she did, that such commingling harmed creditor. Macaluso v. Jenkins, 1981, 50 Ill. Dec. 934, 95 Ill.App.3d 461, 420 N.E.2d 251.

Secretary for nonprofit corporation was not personally liable to creditor, who entered into contract with corporation, on ground of fraud or misrepresentation where creditor failed to introduce any evidence of misrepresentation or fraudulent concealment made by secretary which induced creditor's decision to enter into or perform contract. Macaluso v. Jenkins, 1981, 50 Ill.Dec. 934, 95 Ill.App.3d 461, 420 N.E.2d 251.

5. Actions

Defense of want of authority on part of an officer of a corporation organized under this chapter, to execute notes in name of corporation could be made under the verified plea of non est factum. St. Vincent College v. Hallett, 1913, 201 F. 471, 119 C.C.A. 647.

105/108.55. Removal of officers

§ 108.55. Removal of Officers. Any officer or agent may be removed by the board of directors or other persons authorized to elect or appoint such officer or agent but such removal shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment of an officer or agent shall not of itself create any contract rights.

P.A. 84-1423, Art. 8, § 108.55, eff. Jan. 1, 1987.
Formerly Ill.Rev.Stat.1991, ch. 32, ¶ 108.55.

Historical and Statutory Notes

Prior Laws:
Laws 1943, vol. 1, p. 481, § 24.
Ill.Rev.Stat.1985, ch. 32, ¶ 163a23.

Library References

Corporations ⇐294.
WESTLAW Topic No. 101.
C.J.S. Corporations §§ 454 to 457.

Notes of Decisions

Power to remove officer 1

1. Power to remove officer

The majority of the members of a corporation have the right to remove its presiding officer and choose another in his place. American Aberdeen Breeder's Ass'n v. Fullerton, 1927, 325 Ill. 323, 156 N.E. 314. See, also, People ex rel. Stevenson v. Higgins, 1853, 15 Ill. 110.

105/108.60. Director conflict of interest

§ 108.60. Director conflict of interest. (a) If a transaction is fair to a corporation at the time it is authorized, approved, or ratified, the fact that a director of the corporation is directly or indirectly a party to the transaction is not grounds for invalidating the transaction.

(b) In a proceeding contesting the validity of a transaction described in subsection (a), the person asserting validity has the burden of proving fairness unless:

(1) The material facts of the transaction and the director's interest or relationship were disclosed or known to the board of directors or a committee consisting entirely of directors and the board or committee authorized, approved or ratified the transaction by the affirmative votes of a majority of disinterested directors, even though the disinterested directors be less than a quorum; or

health care services and to unreasonably restrain duly licensed chiropractors from competing in the delivery of health care services. The plaintiffs also allege a conspiracy to isolate and eliminate chiropractic by the adoption and enforcement of statements labeling chiropractic as an unscientific cult and the practice of chiropractic as a hazard to the health of the public. The suit seeks a permanent injunction, triple damages, attorney's fees, costs and one million dollars for each of the next ten years to establish and operate an interprofessional research institute.

There has been extensive discovery in the litigation with more than 100 depositions completed and more than 100,000 pages of documents cataloged in the repository maintained by AMA legal counsel. On May 23, 1979, the court granted the AMA's request for an order striking the plaintiff's demand for a payment of ten million dollars to fund a research institute. The court also ruled that the Illinois State Medical Society could seek information concerning the role played in the lawsuit by the National Chiropractic Antitrust Committee, a fund-raising committee used to finance the litigation. In response to motions of the American Academy of Orthopaedic Surgeons, the court proposed a method to lead to information in the patient records of the five plaintiffs.

No date for trial of the case has been set. Discovery and preparation for trial are being aggressively pursued by all parties.

Harvey Barry Jacobs v. AMA, et al.:

On May 21, 1979, the AMA was served with a complaint drafted and filed by Harvey Barry Jacobs, M. D., alleging a conspiracy in violation of the antitrust laws by numerous insurance companies, hospitals and medical societies to deprive plaintiff of access to malpractice insurance coverage, hospital privileges and the right to advertise his services. The complaint seeks $17.5 million dollars in actual damages and $20 million in punitive damages as well as injunctive relief and triple damages. Doctor Jacobs is a medical director of Malpractice Research, Inc., and author of a book on malpractice.

FF. AMA POLICY ACTIONS

(Reference Committee on Amendments to Constitution and Bylaws, page 301)

HOUSE ACTION: ADOPTED AS FOLLOWS:

Customarily, the American Medical Association considers the most recent actions of the House of Delegates as the current policy of the Association. At times, however, a current policy appears to be contradictory to past actions of the House of Delegates.

In an effort to resolve the problem, the Board recommends that the following statement be adopted by the House of Delegates:

> The Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considered to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates.

2. That guideline G be eliminated.

3. That, henceforth, new specialty organization applications be considered only at Annual Meetings of the House of Delegates.

4. That this report be adopted in lieu of Resolutions 49 and 62 (A-89).

B. REVIEW OF ASSOCIATION POLICIES: 1979

HOUSE ACTION: POLICY NUMBERS 34 (Opposition to Federal Drug Administration Proposal Requiring Drug Labeling and Patient Package Inserts, Resolution 66, I-79) AND 73 (Final Report of Ad Hoc Committee on Foreign Medical Graduate Affairs, Report G of Board of Trustees, I-79) REFERRED TO BOARD OF TRUSTEES

REMAINDER OF REPORT ADOPTED AND AMA COUNCILS COMMENDED FOR THEIR OUTSTANDING CONTRIBUTION TO THE POLICY SUNSET PROCESS

At the 1984 Interim Meeting, the House of Delegates adopted Report PP of the Board of Trustees which provided for implementation of a sunset mechanism for AMA policy. Under the sunset mechanism, policies adopted by the House of Delegates will remain viable and active only for a period of ten years, unless reaffirmed by the House. In its Report PP, the Board cited several reasons for establishing a sunset mechanism:

- to promote efficiency in House of Delegates deliberations;
- to identify and rescind outmoded, duplicative or inconsistent policies; and
- to facilitate development of an AMA policy information base.

In its Report PP (I-84), the Board provided that a review of historical AMA policies should be conducted before a sunset mechanism is implemented in order to ensure that older, viable policies are not eliminated inadvertently. Over the past several years, the Council on Long Range Planning and Development, in cooperation with the Board and the other AMA councils, conducted a detailed and systematic review of policies adopted by the House of Delegates between 1847 and 1978. The Council has submitted, and the House has adopted, a series of reports with recommendations for retention and rescission of specific policies from this period. The last report in this series, covering over 1,400 policies from 1969 to 1978, was adopted by the House at the 1989 Annual Meeting. (One policy from this period, Report Y of the Board of Trustees, I-77, was referred to the Board for further study.) The House is now in a position to fully implement the sunset mechanism, with a review at this meeting of policies adopted in 1979, and a review at each subsequent Interim Meeting of policies adopted by the House ten years previously.

Also adopted at the 1989 Annual Meeting was Report A of the Council on Long Range Planning and Development which sets out a process for the implementation and ongoing operation of the policy sunset mechanism. The process outlined by the Council includes the following steps: initial review of the policies by the Council on Long Range Planning and Development; subsequent review and input by the other AMA councils, with a particular focus on policies within their specific areas of expertise; development of a report compiling the councils' recommendations for transmittal to the Board and the House; assignment of the

report to a single reference committee; and use of a consent calendar format by the House in considering the policies encompassed within the report.

Over the past several months, the Council on Long Range Planning and Development has coordinated a review of policies adopted by the House of Delegates in 1979. Each council was requested to review and provide recommendations on specified policies within its areas of expertise. In addition, the councils were given the opportunity to provide input on any other policies adopted during 1979.

To assist the councils, the Board of Trustees and the House of Delegates with review of policies adopted in 1979, the Council on Long Range Planning and Development compiled the "Digest of Policy Actions: 1979." It contains summaries of House of Delegates policy actions from the "Digest of Official Actions" arranged within broad subject matter classifications. It does not contain nonpolicy actions of the House of Delegates, nor does it contain policies that are inherently temporary in nature, neither of which are within the scope of the AMA's sunset mechanism.

Set out in the appendix is a listing of the policies from 1979 recommended for retention or retention-in-part. All other policies from 1979 are being recommended for rescission. Also recommended for rescission is Report Y of the Board of Trustees (I-77) which was referred to the Board for further study at the 1989 Annual Meeting. The Council on Scientific Affairs has reexamined this policy, at the request of the Board, and recommends that it be rescinded because the AMA may want to reconsider the regulatory activities of the Nuclear Regulatory Commission, especially as they pertain to the responsibilities of physicians and other health professionals.

With respect to the 176 policies adopted by the House of Delegates in 1979, if one or more councils have recommended a policy for retention, it has been recommended for retention in this report, unless the policy was determined to present legal risks or unless clearly superseding policy was subsequently identified. All other policies have been recommended for rescission; they will, of course, be retained in the historical records of the Association. Since the process has worked so effectively and efficiently in the past, the Council again urges the House to utilize a consent calendar format in reviewing the policies adopted in 1979.

Also, the Council strongly urges the House not to recommend modifications in the policy statements under review. Attempting to modify policies is inconsistent with the policy sunset mechanism, is likely to slow the review process and may create considerable confusion in the House of Delegates. It is suggested that, where new or modified policy may be desirable, the traditional process for House of Delegates policy development should be followed.

The Council on Long Range Planning and Development expresses its appreciation to each of the other AMA councils for their continued cooperation in this activity. The contributions and collective expertise of the councils have ensured the continued success of this project.

POLICY RECOMMENDATIONS

1. That the policies specified in the appendix be retained as official, active policies of the AMA.

2. That all other policies adopted by the House of Delegates in 1979 be rescinded.

3. That Report Y of the Board of Trustees (I-77) be rescinded.

APPENDIX

AMA POLICIES RECOMMENDED FOR RETENTION: 1979

Policy numbers correspond to "Digest of Policy Actions: 1979"
*Policy recommended for retention-in-part

Policy Number	Topic
1	Information on Alternative Health Care Benefits, Report A of Council on Medical Service (A-79)
2	*AMA Involvement in Alcoholism Activities (retain Recommendations 1, 2, 3 and 6), Report E of Council on Scientific Affairs (A-79)
4	Dual Disease Classification of Alcoholism, Resolution 22 (I-79)
7	*AMA Organizational Structure (retain Recommendation 1), Report B of Council on Long Range Planning and Development (A-79)
9	Graduate Medical Education in the Military, Substitute Resolution 1 (A-79)
13	*Dual Approach to Blood Collection (retain point No. 1), Resolution 150 (A-79)
14	AMA Policy Actions, Report FF of Board of Trustees (A-79)
15	Refusal of Third Party Payors to Pay for Reconstructive Surgery of the Breast to Correct Deformities, Substitute Resolution 174 (A-79)
16	Out-of-Hospital Birth Risks, Resolution 22 (A-79)
17	Ipecac as Household Poison Emetic, Substitute Resolution 94 (A-79)
19	Child Care Facilities in Medical Centers, Resolution 90 (I-79)
24	Computer-Based Hospital and Order System, Report F of Council on Medical Service (I-79)
28	Council on Scientific Affairs Reports – Procedure Change, Report of Convention Committee on Rules and Order of Business (I-79)
30	Uniform Brain Death Act, Report P of Board of Trustees (I-79)
35	Due Process, Report D of Council on Medical Education (A-79)
41	Relationship of Hospital Costs and Hospital Charges, Report H of Council on Medical Service (I-79)
47	State Medical Society Support of Legislation Affecting Medical Students, Substitute Resolution 163 (A-79)
53	Continuing Medical Education, Substitute Resolution 13 (A-79)
54	"Medical Education" Travel, Substitute Resolution 84 (A-79)
55	Reaffirmation of Support for Continuing Medical Education, Substitute Resolution 122 (A-79)

The House of Delegates amended the Recommendation in Report 2 of the Council on Long Range Planning and Development which modified policy 535.995 to read as follows:

> Except as noted herein, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians and the AMA. In representing AMA policy in critical situations, the Board will take into consideration existing policy. The Board will immediately inform the Speaker of the House of Delegates and direct the Speaker to promptly inform the members of the House of Delegates when the Board has taken actions which differ from existing policy. Any action taken by the Board which is not consistent with existing policy requires a two-thirds vote of the Board. When the Board takes action which differs from existing policy, such action must be placed before the House of Delegates at its next meeting for deliberation.

RECOMMENDATION IN REPORT 2 OF COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT ADOPTED AS AMENDED IN LIEU OF RESOLUTION 613 AND REMAINDER OF REPORT FILED

8. RESOLUTION 608 — AMA ANNUAL AND INTERIM MEETINGS/CAUCUSES

Resolution 608 requested that the AMA House of Delegates schedule one day during each Annual and Interim Meeting of the House where there are no caucuses, committee meetings or other official or unofficial activities prior to 10:00 a.m.

RESOLUTION 608 NOT ADOPTED

9. RESOLUTION 603 — USE OF RECYCLABLE PAPER FOR MEDICAL PUBLICATIONS

Resolution 603 asked that the American Medical Association encourage the publishers of all medical publications to use recyclable paper.

RESOLUTION 603 REFERRED TO BOARD OF TRUSTEES FOR DECISION

10. RESOLUTION 606 — AMA PRESIDENT'S PRIZE FOR TOBACCO-RELATED DISEASE WRITING

Resolution 606 called upon the AMA to award a prize of $5,000 annually, until the year 2000, entitled "The President's Prize for Outstanding Achievement in Tobacco-Related Disease Writing," which would reward publication of accuracy in tobacco disease reporting in magazines which carry tobacco advertisements.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report I-93-2

Subject: Authority of the AMA Board of Trustees

Presented by: C. Burns Roehrig, MD, Chair

Referred to: Reference Committee F
(Jere E. Freidheim, MD, Chair)

In today's rapidly changing legislative and socioeconomic environment, the American Medical Association (AMA) must be able to respond in a prompt and flexible manner to developments if it is to continue to advocate effectively for physicians and their patients. The House of Delegates has recognized this situation with regard to the critical issue of health system reform. At the 1992 Interim Meeting, the House established AMA Policy 165.945, AMA Policy Compendium, which states, in part, that:

> At a time of the potential for imminent health system reform the House of Delegates empowers the Board of Trustees to act on behalf of the Association to promote proactively and negotiate for those elements of health system reform that they feel will best represent the interests of patients and the profession.

The Council on Long Range Planning and Development is very supportive of Policy 165.945. Indeed, the Council believes that the authority given to the Board by Policy 165.945 should be extended to all issues. The Council also believes that the role of the House of Delegates should be more clearly delineated in those situations where the Board exercises such authority.

CURRENT BOARD AUTHORITY ON AMA POLICY POSITIONS

The authority of the AMA Board of Trustees is established through the AMA Constitution and Bylaws, AMA policy, and Illinois law. Article VIII of the AMA Constitution defines and describes "the AMA Board of Trustees," and states specifically, in part, that "It [the Board of Trustees] shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws." Yet, nothing in the AMA Bylaws explicitly authorizes the Board to employ a flexible interpretation of AMA policy in situations where such an approach would be appropriate.

As mentioned previously, Policy 165.945 gives the Board authority to act, on behalf of the AMA, to promote and negotiate for elements of health system reform that will represent the best interests of patients and the profession. AMA Policy 535.995 gives the Board the authority, in the absence of specifically applicable current statements of policy, to determine what it considers to be the position of the House of Delegates, based upon the tenor of past and current actions that may be related in subject manner. Further, AMA Policy 535.996 grants the Board the authority to initiate, defend, settle, or in any way terminate litigation in accordance with its best and prudent judgment. This authority includes litigation related to AMA policy.

Under Illinois corporate law, the AMA Board of Trustees has a fiduciary responsibility to take action to protect the AMA's corporate and financial interests. This authority also extends to AMA policy issues.

ANALYSIS OF THE AUTHORITY OF THE BOARD ON AMA POLICY POSITIONS

Today's legislative and regulatory environment has become so fast-paced that the current AMA policy process may not always allow for timely action by the AMA. New legislation and regulations may be proposed and enacted before the House of Delegates has an opportunity to meet and consider the issues involved. Although the AMA Bylaws provide for special meetings of the AMA House of Delegates, the Council does not believe that special meetings of the House are a viable way to accelerate the AMA policy process because of the difficulties in scheduling such meetings and the costs associated with them.

The Council believes that current AMA policy gives the Board an appropriate scope of authority in representing AMA policy positions in three specific areas: (a) the issue of health system reform, (b) situations where relevant House policy does not exist, and (c) litigation. Given these precedents and the fast-paced policy environment, the Council believes that the AMA would be best served by giving the Board flexibility in representing any policy position in urgent situations when, in the judgment of the Board, the issue cannot wait until the next meeting of the House of Delegates.

The Council is aware that the Board routinely provides the House with many detailed reports about the Board's activities. Consistent with this approach, the Council believes AMA policy should require the Board to report to the House when the Board takes action contrary to existing policy. The House could affirm, reverse, or take no action with regard to the Board's report.

The Council on Long Range Planning and Development is not proposing that the Board should be the policy-making body for the AMA. The AMA Constitution, Bylaws, and the AMA's history all clearly vest that authority with the House of Delegates. The Council is proposing that the Board should be granted explicit authority by the House to exercise judgment in representing any policy position, as long as the House clearly retains the ultimate authority with regard to AMA policy positions.

RECOMMENDATIONS

The Council on Long Range Planning and Development recommends that AMA Policy 535.995 be modified by addition to read:

> Except as noted herein, the Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. Further, the Board of Trustees has the authority in urgent situations to take those policy actions that the Board deems best represent the interests of patients, physicians, and the AMA. In representing AMA policy in critical situations, the Board will take into consideration

existing policy without necessarily being bound by any specific element of that policy. The Board will inform the House of Delegates when the Board has taken actions which differ from existing policy.

Fiscal Note: No significant fiscal impact

Report T is an extensive and comprehensive study of the problems inherent in selection of physicians for military service in the light of the total physician needs of this country, including the needs for the private medical care of the American public, and the needs in non-military governmental medical services.

The report was studied in toto and several areas were the subjects of considerable discussion and special attention. The committee believes that the report as a whole is excellent and that changes in the text are not indicated. The committee wishes to emphasize that the members appointed to the recommended National Commission on Health Resources and Medical Manpower include strong representation of those most familiar with civilian medical needs, the physicians in the active private practice of medicine. Many of these physicians are knowledgeable of military needs inasmuch as they constitute the pool of medical manpower from which the physicians are and have been drawn for national emergencies.

The committee believes that needs reflected in resolution no. 4, and those reflected in resolution no. 37, will receive due attention and appropriate answers within the terms of the recommendations of Report T.

I move the *adoption of Report T of the Board of Trustees and the acceptance of resolutions nos. 4 and 37 for information.*

U. Resolution No. 104 – 1966 Annual Convention

On August 5, 1966, the attached self-explanatory letter was sent to Delegates and Alternate Delegates of the American Medical Association. The Board of Trustees requests the House of Delegates to ratify and approve the action taken by the Board, as stated in this letter, and to rescind resolution no. 104 adopted at the 1966 Annual Convention. This report is submitted to complete the record.

Delegates and Alternate Delegates
to the House of Delegates of the
American Medical Association

Dear Doctor:

On June 29, 1966, the attached resolution no. 104 was adopted by the House of Delegates of the American Medical Association at the Annual Convention in Chicago. Subsequently, and after due deliberation, the Board of Trustees voted unanimously (1) that this resolution should not be implemented by the AMA, and (2) that constituent and component medical societies be advised, likewise, to refrain from implementing resolution no. 104.

This letter is intended to inform you of the sequence of events and the reasons for the unusual action taken by the Board of Trustees.

The action of the Board of Trustees was taken pursuant to Article VIII of the AMA *Constitution*, Section 163a16 of the Illinois General Not For Profit Corporation Act, and the following statement of policy adopted by the House of Delegates in June 1955, at Atlantic City:

> "It is the understanding of the Board of Trustees that prior to any action on the implementation of resolutions passed by the House the legal implications are to be fully investigated. If there are any indications of legal implications, the Board will delay action and report back to the House."

In adopting resolution no. 104 on June 29, 1966, the House of Delegates rejected the recommendation of the reference committee that this resolution be referred to the Board of Trustees for study because of possible legal implications. The following day, the then Speaker, Dr. Milford O. Rouse, read the following statement prepared by the AMA Law Department to the House:

> "The implementation of resolution no. 104 would expose the American Medical Association to litigation under anti-trust and monopoly laws with respect to persons and institutions that may allege injuries or damages as a result of such action. When matters of this nature are litigated, the costs are substantial and the results are unpredictable . . . .
>
> "Obviously, we cannot anticipate the extent of the impact of resolution no. 104, but it does state a policy in terms of ethics which involves significant exposure to possible legal involvement."

Thereupon, a member of the Oregon delegation, which had introduced the resolution originally, made a motion to reconsider its adoption. The motion was defeated.

Resolution no. 104 and the relevant discussion in the House of Delegates were reported extensively in the press. Some accounts included interpretations by the press of the resolution.

Under date of July 6, 1966, the AMA received an inquiry from the Anti-Trust Division of the Department of Justice (responsible for enforcing the Sherman Anti-Trust Act) requesting information concerning a resolution it believed had been adopted by the House in June of this year. (Various governmental agencies, including the Department of Justice, routinely seek factual information concerning matters in their area of interest which come to their attention.)

Our outside legal counsel conferred with representatives of the Department of Justice. Pursuant to the Department's request, a copy of resolution no. 104, the report of the reference committee, and a verbatim transcript of the pertinent portions of the proceedings of the House of Delegates were submitted.

In the meantime, the Board of Trustees reviewed resolution no. 104. The Board concluded that a statement by the Board concerning this resolution would be advisable for the guidance of the profession. Such a statement was believed desirable even had there been no inquiry from the Department of Justice.

Resolution no. 104 relates to the financial arrangement between a physician and a hospital by which a "hospital-based" physician obtains remuneration for services. The wording of the resolution in regard to "separate" billing may be subject to varying interpretations because of the differential financial arrangements that exist between "hospital-based" physicians and hospitals. The effect of the application of resolution no. 104 in specific instances would depend both on the interpretation given to it and the facts of the particular case.

Nevertheless, to interpret resolution no. 104 as prohibiting any "hospital-based" physician from accepting a position and performing services in a hospital by displacing another physician under the circumstances indicated in the resolution involves serious risks of litigation (including damage claims by persons asserting economic injury). We have been informed by our outside legal counsel that the possible economic effects of this resolution are of concern to the Department of Justice.

Physicians cannot avoid legal consequences of certain actions merely by categorizing them as "ethical" or "unethical." The medical profession properly can establish and apply ethical standards to improve the quality of professional services, enhance public health, and promote comparable goals in the public interest. However, to describe an ethical principle or rule of conduct for physicians does not preclude a court or jury from determining from the facts in a particular situation that its purpose or effect is the unreasonable restraint of trade, or is otherwise unlawful.

The Board of Trustees believes that the implementation of resolution no. 104 by the AMA or state or county medical societies would involve significant legal risks. Even the successful defense of litigation of this nature is extremely costly and time-consuming, and the results are frequently unpredictable.

The Board of Trustees wishes to emphasize that it unanimously supports the position of the House of Delegates that (1) direct billing to patients for services of all physicians instead of assignment is to be preferred and encouraged, as a matter of policy, as being in the best interests of the public and profession, although physicians are entitled to choose either method of billing; and (2) physicians' services, such as those of pathologists or radiologists who practice in hospitals, should be billed and collected by physicians as medical services, and not billed as hospital services, since they constitute the practice of medicine. Nothing in this letter is intended as a departure from these principles of policy adopted by the House.

The message of this letter is that certain means – eg, resolution no. 104, June 1966, which expose the AMA to severe legal risks, cannot be employed if we are to exercise prudent stewardship over the affairs of the Association.

In view of these considerations and after careful deliberation, the Board of Trustees has directed that the AMA not implement resolution no. 104, and it recommends to the constituent and component medical societies that the resolution not be implemented by them.

Sincerely,

Wesley W. Hall, MD
Chairman, Board of Trustees

PS – A copy of this letter is being sent to state presidents and presidents-elect, state medical society headquarters, and secretaries of county medical societies.

Resolution no. 104. Separate Billing for Professional Services

by Hospital-Based Physicians

Introduced by the Oregon Delegation

WHEREAS, The *Principles of Medical Ethics* declare that a physician shall not dispose of his services to a third party or "lay" organization; and

WHEREAS, Title XVIII of Public Law 89-97 recognizes the principle of the separation of professional and hospital costs for services rendered by hospital-based physicians; and

WHEREAS, This principle has been advocated by the AMA, the American College of Radiology, the American College of Pathologists, and many regional organizations; and

WHEREAS, A great number of hospital-based physicians throughout the nation have declared their intention to bill separately for their professional services in keeping with this principle; therefore be it

Resolved, That, since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing when said displacement is primarily designed to circumvent separate billing.

Report of Reference Committee
on Amendments to Constitution and Bylaws

The Reference Committee recommended that resolution no. 104 be referred to the Board of Trustees for study. The House did not agree with this recommendation and voted that resolution no. 104 be adopted. At the Thursday session, at the request of the AMA Law Department, the Speaker asked for a motion to reconsider this action; the House voted not to reconsider.

REPORT OF REFERENCE COMMITTEE D: On the recommendation of the Reference Committee, the House adopted Report U of the Board of Trustees and rescinded resolution no. 104.

The following report was presented by Dr. W. Benson Harer, *Chairman*:

Your reference committee, in considering Report U, examined very closely the reasons for the actions of the Board of Trustees in relation to resolution no. 104 (A-66).

Your reference committee wishes to cite particularly the following excerpts from Report U:

1. We have been informed by our outside legal counsel that the possible economic effects of this resolution are of concern to the Department of Justice.

2. The Board of Trustees believes that the implementation of resolution no. 104 by the AMA or state or county medical societies would involve significant legal risks.

3. Resolution no. 104, June 1966, which expose(s) the AMA to severe legal risks, cannot be employed if we are to exercise prudent stewardship over the affairs of the Association.

V was considered together with

Report F by Reference Committee F

(See page 96)

Doctor Nesbitt's call received wide support from government policy makers as well as from business leaders. Of the state medical societies whose houses of delegates have met since the end of June, at least twelve have passed resolutions supporting Doctor Nesbitt's plan. In addition, a number of county medical societies have also expressed support for the plan.

The continuing moderation in physicians' fees during 1978, despite the recent large increases in the all items index, may be viewed, in a sense, as achieving Doctor Nesbitt's goal ahead of schedule. During 1978, physicians' fees have in fact increased at a lower annual rate than has the all items index.

PRESIDENT CARTER'S VOLUNTARY PROGRAM

On October 24, 1978, President Carter announced his voluntary program to restrain wages and prices. The program calls for an average maximum increase in wages of 7 percent and a deceleration in prices. However, the Carter program singles out the health sector for special treatment. For the health care industry, the price guideline is a 2 percentage point deceleration as compared with a half a percentage point for the rest of the economy. In addition, President Carter urged the passage of a bill giving the government the power to control hospital costs.

Although AMA applauded President Carter's call for voluntary restraint of wages and prices, the Association expressed regret that the President chose to single out the health care industry, and stated that voluntary cost containment programs already in place in the health care sector should be allowed to work. These existing voluntary programs include Doctor Nesbitt's call for fee restraint as well as the AMA-sponsored Voluntary Effort.

SUMMARY

The AMA has long expressed concern with rising health care costs as well as with the economy-wide inflation problem. The willingness of the Association to act on the problem is evidenced by its sponsorship of the NCCMC and participation in the VE. In its activities related to the health care costs issue, the AMA has consistently expressed the view that the voluntary approach to the problem is vastly superior to one based on mandatory governmental controls.

The Board recommends that the AMA's House of Delegates endorse an AMA voluntary program to restrain the rate of increase in physicians' fees, as initially suggested by Tom E. Nesbitt, M. D., AMA President. By publicly supporting this plan, the membership of the Association will reaffirm its conviction that health care costs can be restrained most effectively through a voluntary program. Supporting Doctor Nesbitt's call will again demonstrate the AMA's willingness to assume a leadership role on the health care cost issue.

JJ. AUTHORITY TO SETTLE LITIGATION
(Reference Committee F, page 237)

HOUSE ACTION: ADOPTED

The duties, responsibility and authority of the Board of Trustees are derived from the Constitution and Bylaws of the AMA and the laws of the state of its incorporation.

Article VIII of the Constitution and Bylaws provides that the Board of Trustees "shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws. Chapter XVII, Section 4 provides that the Board shall "Perform all acts and transact all business for or on behalf of the Association and manage the property and conduct the affairs, work and activities of the Association, except as may be otherwise provided in the Constitution or these Bylaws."

Section 163a16 of the Illinois General Not for Profit Corporation Act states that "The affairs of a corporation shall be managed by a board of directors." (As used in the law, directors and trustees are synonomous terms.)

The Board of Trustees is mindful of its legal and fiduciary duties and responsibility to conduct and manage the affairs of the AMA in the best interests of the membership and the public, in keeping with policy established by the House of Delegates, in conformity with the laws of the land. Since no exception is provided either in the AMA Constitution and Bylaws or the laws of Illinois, the Board of Trustees believes that it has the duty and responsibility to initiate, defend, settle or in any way terminate litigation in accordance with its best and prudent judgment. In this connection, the Board believes that it must be guided by its responsibility to conduct the affairs of the Association in observance with law and its fiduciary responsibility to act prudently on behalf of the membership in the conservation of funds and protection of the Association's assets.

The conduct of litigation in the best interests of the Association, its members and the public frequently requires prompt decisions. Aside from other considerations, it would not be practicable for this Association to leave the initiation, conduct or termination of litigation for action by the House of Delegates.

Inasmuch as the question of the Board's authority and duties with respect to litigation has been raised by certain delegates, the Board requests that the House of Delegates express its approval of this report.

KK. WORLD MEDICAL ASSOCIATION
(Reference Committee H, page 248)

HOUSE ACTION: FILED

For the information of the House of Delegates, the AMA will rejoin the World Medical Association on January 1, 1979. This action follows the adoption of new WMA Articles and Bylaws at the 32nd World Medical Assembly in Manila in November.

A founding member of the WMA in 1947, the AMA resigned from the organization in 1974. Renewed AMA membership was made conditional upon WMA's adoption of revisions based on these principles:

1. That there be an equitable dues formula that would apply to all member associations;
2. That there be equitable representation on a per capita membership basis in the World Assembly of the WMA;
3. That representation on the Council of the WMA be on a national organizational basis rather than by individuals;
4. That there be complete freedom of access to meetings of the World Assembly and of the Council by representatives of member associations in good standing.

The acceptance of these principles will lead to a more effective WMA, the Board of Trustees believes. There was never any doubt about the value of WMA's objectives – To serve humanity by endeavoring to achieve the highest international standards in medical education, medical science, medical art, medical ethics, and health care. These objectives reflect the AMA's goals in international health.

The WMA's adoption of a system of proportional representation will enable the AMA to be a more effective member, commensurate with the strength of its membership. The AMA and its members will benefit from the knowledge and expertise in medicine and health care systems that have been developed in other countries.

5. The AMA make support for any "managed competition" proposal contingent, in part, on:

   -- relief from existing antitrust laws with respect to the right of physicians and physician organizations to engage in group negotiation, and

   -- modifications to ERISA to ensure that any rules and negotiation requirements apply equally to self-insured and insured health benefit plans.

6. The AMA study appropriate means of risk indexing and adjusting premiums used under any "managed competition" proposals.

OO. HEALTH ACCESS AMERICA -- ORGANIZED MEDICINE'S ROLE IN HEALTH CARE POLICY DEVELOPMENT AND IMPLEMENTATION

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 103 AND REMAINDER OF REPORT FILED:

At the 1992 Annual Meeting, the House of Delegates adopted Substitute Resolution 206, Policy 165.954. The House also requested a report back from the Board of Trustees at the 1992 Interim Meeting about the activities and progress made pursuant to the policy. The following summary of the policy has guided the activities of the Board and its Ad Hoc Technical Advisory Committee on Health System Reform (TAC), which was established by direction of the House:

> Without intending to limit additional aspects of Substitute Resolution 206 (A-92), it is considered that the main directive is that the AMA take leadership, through legislative, regulatory and judicial action, to obtain formal physician organization involvement in all areas of health care policy development and implementation.
>
> While the AMA should be involved in all areas of policy discussions and should seek the best possible implementation roles for organized medicine, there are certain areas where the AMA should clearly not be advocating or endorsing: price fixing in any form, budget predictability achieved by expenditure targets, budget caps or global budget limits.

The policy requires the TAC to help explore and define the options and activities necessary to achieve the policy's goals. The TAC is designed to have broad representation from the policy making units of the AMA that have previously deliberated the issues addressed by the policy. It is chaired by P. John Seward, M. D., of the Board. Its other members include Thomas Reardon, M. D., and Nancy Dickey, M. D., of the Board; Perry A. Lambird, M. D., and T. Reginald Harris, M. D., of the Council on Medical Service; Donald T. Lewers, M. D., and Merle W. Delmer, M. D., of the Council on Legislation; C. Burns Roehrig, M. D., and Kim Bateman, M.D., of the Council on Long Range Planning and Development; Lee McCormick, M. D., of the Hospital Medical Staff Section; Joy Maxey, M. D., of the Young Physicians Section; and William Gamel, M. D., as an at-large representative from the House of Delegates.

Pursuant to its mandate, the full TAC has met four times since the 1992 Annual Meeting, including meetings before and after the presidential election on November 3, 1992. In addition, there have been meetings of two TAC

subcommittees on Negotiations and on Managed Care/Managed Competition. The TAC and its committees have reviewed substantial materials and considered the issues involved in depth. The TAC has made full reports to the Board on three occasions. The materials set forth below reflect the conclusions and recommendations of the TAC and the Board and also reflect the actions taken by the AMA on these issues since the 1992 Annual Meeting.

BACKGROUND — THE RATIONALE FOR RECOGNITION OF THE PHYSICIANS' RIGHT TO NEGOTIATE

To better focus their activities pursuant to Policy 165.954, the Board and the TAC have articulated the reasons why it is critical for patients and the profession that the AMA and other physician organizations be formally involved in health policy development by governments and the private sector.

The Board and the TAC believe that now is a critical time for patients and for the profession. There is a high degree of concern among patients, physicians, business and government about access to medical care and health care costs. These concerns are legitimate and need to be resolved. Paradoxically, these problems arise out of the phenomenal success of modern American medicine. The advances and high level of quality achieved have caused most Americans to regard health care as a necessity for the maintenance and enjoyment of life. As a result, there is tremendous demand for high quality medical care, and the demand keeps growing.

As the profession and the public search for solutions to the cost and access problems, two items should be kept in mind about the role of physicians and organized medicine. First, the high level of quality that has created such enormous demand for physician services is in large part attributable to the self-regulatory structure that organized medicine has built over the last century and a half. The profession created and continues to operate most of the entities that assure the quality of physician education and future professionalism from the beginning of a physician's medical education until retirement. For example, the AMA and other physician organizations accredit medical schools, residency programs, and continuing medical education. Physician operated boards certify the education, clinical training, and knowledge of a physician to practice a medical specialty. Medical staffs engage in regular peer review of all members of the medical staff.

Second, this self-regulatory structure was created because physicians have traditionally taken the lead role in solving important problems that have arisen in the evolution of medicine. For example, the structure for accreditation of undergraduate medical education was created because of problems with quality caused by the emergence of numerous substandard medical schools. State governments and the federal government have adopted or rely on the processes or decisions of the self-regulatory structure of medicine, but they did not create them and do not operate them.

Today, the profession faces another momentous challenge that will define the nature of medical practice well into the next century. The challenge is to work with all interested parties to resolve the problems of access and cost while maintaining the high level of quality upon which patients have come to rely. While the profession has stepped forward to meet this challenge with its own proposal, Health Access America, it is not alone in attempting to resolve these problems. In particular, government policy makers at the federal and state level are actively seeking to control health care costs with dramatic restructuring of the health care system and intensive government regulation. There is strong political support for these initiatives, and one of them may well be enacted by Congress in the near future. Indeed, similar proposals have already been enacted in at least five states, including three states during 1992 (Vermont, Minnesota and Florida).

Current congressional proposals can be divided into two groups. One group would control costs with central government control and administration. These proposals would rely upon global budgets, expenditure targets, fee controls, and the regulation of medical decision making to control the amount of care provided and prices. The other

group would rely on the transformation of the health care system into managed care, regulated by the government, for cost control. At the present time, efforts are being made to forge a compromise between proponents of each group by developing a proposal that will contain a combination of the cost control methods advocated by the two sets of proposals. The AMA has worked with both presidential campaigns to encourage a market-based rather than a government-controlled health care system.

The profession is familiar with both methods of cost control because they are already used on a limited scale. The features of central control and administration are currently used by the Medicare program. Many private sector payers now use some managed care techniques. What is new is the effort to move toward large concentrations of market power in fewer payors.

The profession has many serious concerns with the comprehensive use of these cost control methods. Among them is the difficulty in maintaining quality with the erosion of patient and physician autonomy that inevitably results from the methods that would be used. Sustained application of these methods inevitably causes increasingly difficult judgments to be made about what kind of medical services to provide patients given arbitrary limits on the resources available to provide care. The ability of physicians to continue to deliver quality care to patients is of primary concern to the AMA.

Another concern of the profession is the lack of physician participation in these methods of regulating the provision of health care. It would seem beyond question that physicians' professional and standard setting organizations must be formally involved in establishing any regulatory schemes and in making the difficult decisions about health care. However, that has generally not been the case in recent years. While physicians are expected to cooperate with these regulatory schemes and make them work as effectively as possible, their role in developing them is minimal. Neither centralized government control as applied in the Medicare program nor managed care as currently operated by private payors satisfactorily incorporates the expertise of practicing physicians. Indeed, the current relationship among physicians and the public and private payors is largely one of confrontation and alienation. The payors unilaterally develop regulatory schemes that are imposed on patients and the profession, and physicians become resentful, especially when they see the interests of patients put at risk.

However, political conditions are such that these cost-control methods could be implemented on a national scale regardless of concerns about them. There are increasing demands that limits be set and sacrifices made. Some of these methods are already being implemented in the states where health reform legislation has been passed. Therefore, it may become necessary for the profession to work within these constraints and make them function for patients as well as possible.

Patients want, and are entitled to have, the profession involved. Only through active, formal inclusion of the profession will an appropriate balance of cost and quality concerns be maintained. Some health policy planners and some reform proposals expressly recognize the need for enhanced physician involvement, but do not adequately describe what the physician role would be. None are specific, and most speak only of "negotiations" on "provider fees" or the need for "collaboration" or a "seat" for physicians on a commission or board.

These generalized references are not sufficient. More importantly, physician participation in the development of standards of medical care must be incorporated into the private market and public regulatory processes of the future. Only physicians have the clinical expertise and experience in providing medical care to patients, the knowledge of what does and does not work as a matter of practical application, and the self regulatory institutions which give this knowledge form and credibility. Of course, such participation also must include negotiation on other key issues, such as payment for services. The AMA must have a fair and clear participatory role — a role commonly provided in foreign health care systems — in the public and private regulatory structure of the present and in the future.

Now is the time for the AMA to establish a process that assures that this unique professional contribution can be made. In order to obtain the role that it is requesting, the AMA should demonstrate that it has the capability and will to carry out the responsibility in a fashion that is effective and in the best interests of patients. To make this demonstration, the AMA should open and improve its self-regulatory structure for the benefit of government, private payors and patients. The profession must confirm and enhance its support for the excellent institutions of self regulation that the AMA and other physician organizations have built, and the AMA should rededicate itself to the development of new initiatives, such as the Practice Parameters Partnership and Forum to develop and implement practice parameters.

The balance of this report describes the areas in which the AMA must strive to obtain a formal role, and the activities being carried out to obtain those roles.

AREAS OF REGULATION FOR PHYSICIAN PARTICIPATION

The Board and the TAC have developed the following list of broad areas of health policy regulation in which the AMA and other physician organizations must participate.

1. Mandates or Regulations Designed to Assure Universal Access. The AMA is committed to universal access. It must be an integral part of any health reform package. The profession must be involved in the development and administration of regulations designed to assure universal access.

2. Benefit Packages. The AMA must be involved in the development of minimum and other health benefit packages that are part of universal access. These regulations will determine what health care services will be made available under universal access schemes.

3. Developing Criteria for Medical Decision-Making. Both the central control and the managed care methods of controlling costs rely heavily on the development and enforcement of criteria for medical decision-making. The purpose is to control the volume of services provided to patients by limiting care to that considered to be appropriate or necessary. It is essential that the profession be involved in the development of these criteria. The development of criteria for medical decision-making includes the following activities:

    a. The development of the clinical decision criteria used by payors.

    b. Development of practice parameters that are used as the basis for medical review criteria.

    c. Activities designed to create data bases or other objective information for the purpose of creating practice parameters, including:

        - Technology dispersion and assessment;

        - Outcomes studies;

        - Literature reviews.

4. Applying Criteria for Medical Decision-Making. Once medical decision-making criteria are developed, they have to be applied. The AMA and other physician organizations must be involved in the development of these techniques and the procedures used in their application. Commonly used techniques are as follows:

   a. Utilization review;

   b. Physician profiling;

   c. Physician credentialing; and

   d. Mandated use of such criteria as the standard of care in professional liability decisions.

5. Limitations on Funding for Health Care. Because it has such an impact on the actual delivery of care to patients, the AMA and other physician organizations must be involved if there are to be any procedures designed to set limits for the funding of health care, such as expenditure targets and controls on payment to physicians and other providers or reimbursement to patients. This activity must take place with reference to the benefits package and practice parameters that will be used, so that the limitations set are appropriate in light of the services that are mandated to be provided.

6. Rules for the Competitive Marketplace. To the extent that reform includes competition among health plans and providers as an essential component, there should be fair and equitable rules for competition. The AMA and other physician organizations should be involved in setting the rules, particularly regarding strengthening peer review and applying sanctions. Certain amendments of the antitrust laws are essential. There are separate reports from the Board and the TAC on managed competition and managed care before the House of Delegates at this meeting.

7. Rules for Self-Regulation. The AMA contemplates a strong self-regulatory role for physicians and organized medicine. At present, the profession's self-regulatory efforts are burdened with litigation or the fear of litigation. The AMA and physician organizations should be involved in the development of a new legal structure.

8. Administrative Simplification. There are numerous proposals to simplify the claims submission and review process. The AMA should be involved since the office operations of physicians will be affected.

TYPES OF NEGOTIATING ROLES

In addition to reviewing the areas of regulation in which the AMA must have formal involvement, the Board and the TAC considered the types of negotiating roles that the AMA should have. Optimally, the AMA would be able to engage in "true negotiations" with government entities or other institutions over many of the issues described above. The Board and the TAC understand true negotiations to mean a process which provides the AMA with a meaningful power of approval over the result. The Board and the TAC are pursuing roles that, within the limits of legal and political constraints, approach the status of true negotiations as closely as possible. These include application of principles similar, but not identical to, the Negotiated Rulemaking Act of 1990, 5 USC 581 et seq., if true negotiating roles are unattainable.

With respect to the regulation of medical decision-making, the AMA will commit to the establishment of mechanisms to fulfill essential standards setting roles necessary to assure the quality and cost effectiveness of medical services provided through public and private health plans. These mechanisms will be dedicated to achieving the same high level of rigorous objectivity and service to the public as has been attained by such universally accepted organizations as the Liaison Committee on Medical Education, and the Accreditation Council for Graduate Medical Education. The AMA will ask for protection from antitrust and other tort liability necessary for these mechanisms to function. Such legislation was submitted to the last Congress in HR 5309 and HR 6171, and the AMA will endeavor to have similar legislation submitted in the next Congress.

The AMA expects that governments and private payors will rely upon these standard setting mechanisms as opposed to developing standards through processes that do not have the same degree of broad based physician involvement and expertise. Where appropriate, the AMA will invite other organizations, such as national medical specialty societies, other provider trade associations, associations of private payors, government agencies or public interest groups to participate in these mechanisms. Such participation will provide the broad based input that may be necessary to assure the broad application and general acceptance of the standards developed. Participation of other organizations may also be necessary to attract the resources that may be needed to carry out some of these standard setting functions.

With respect to the private sector, the AMA is pressing for reasonable modifications of the antitrust laws to facilitate negotiations between payors and groups of physicians. The AMA is not seeking modifications that would allow physicians to engage in anticompetitive conspiracies to fix prices or otherwise stifle competition. That would be counter to the AMA's market based approach to health system reform. However, the AMA is seeking to have the legitimate needs of independent physicians to approach large, financially powerful payors with group proposals. Recently the AMA participated as an amicus curiae in a federal appellate court decision U.S. v. Alston that recognized the need for independent physicians to be able to present positions to private payors in groups. In this respect the decision says:

> But health care providers who must deal with consumers indirectly through plans such as the one in this case face an unusual situation that may legitimize certain collective actions. Medical plans serve, effectively, as the bargaining agents for large groups of consumers: they use the clout of their consumer base to drive down health care service fees. Uniform fee schedules — anathema in a normal, competitive market — are standard operating procedure when medical plans are involved. In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or a group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules.

The AMA has followed up on this case by filing a petition with the Federal Trade Commission that urges that enforcement agency to change its posture against allowing independent physicians to present joint proposals to private payors.

NATIONAL BOARDS, COMMISSIONS AND TASK FORCES

Most health reform proposals, including almost all of the proposals that are being given serious consideration by government policy makers, contemplate that a national advisory health commission or task force will be created. For that reason, the Board and the TAC have considered whether the AMA could accept the creation of such an entity as part of health reform legislation. Since the AMA is adamantly opposed to the use of global budgets, expenditure targets, and payment controls to control health care costs, the Board and the TAC concluded that the

AMA should vigorously oppose the creation of a new federal entity that would develop global budgets and the controls necessary for budget enforcement.

However, the Board and the TAC recognize that some kind of government entity will administer any new government regulations or programs that are passed by Congress as part of a health reform program, even if the reforms are designed to enhance the functioning of a free market for health plans and health care services to control costs as opposed to the use of global budgets and payment controls. The duties of any national health advisory commission or task force will depend on the ideology and nature of the underlying reforms of which it is a part. The real concern is that the reforms be consistent with AMA policy.

The Board and the TAC also believe that no national health advisory body or task force will be effective in administering reforms, including market-based reforms, unless it adequately incorporates the skills, knowledge, values, opinions, and resources of the profession. Mere inclusion of a physician as a member of a national health advisory body or task force, even if that physician is from the AMA, would not be sufficient to provide the physician perspective. Instead, a true partnership with the profession would be necessary in which new and existing standards setting mechanisms of the AMA and other physician organizations were relied upon as an integral part of the reformed system.

The AMA supports the creation, and will assist in the development, of a national health advisory body that truly forms a public/private partnership with the AMA to formulate policy and implement activities in areas of health policy, such as technology use and dispersion, benefit packages, parameters and quality/utilization review, medical education, and the other areas listed in the previous pages of this report under the section entitled Areas of Regulation for Physician Participation, except for global budgets, expenditure targets, and payment determinations. The AMA contributes at least three essential ingredients to such a partnership:

a. use of the broad network of the profession's existing and new standard-setting organizations and the clinical expertise they draw upon;

b. credibility for the body and its recommendations with practicing physicians and the public; and

c. use by the body of the direct and pervasive AMA communication vehicles to the profession — *JAMA*, *AMNews*, *American Medical Television* and other vehicles as they develop.

Moreover, regulatory functions regarding standard setting, which the government itself exercises today, should be delegated to private standard setting mechanisms established by the AMA and other physician organizations. At the very least, any federal agency that establishes medical standards should formally consult with the AMA and the other essential standard setting mechanisms of the federation when setting medical professional standards or the developing guidelines or other standards that pertain to the practice of medicine. Legislation with that kind of requirement was submitted to the last Congress in HR 5309 and HR 6171, and will be submitted in the next Congress as well.

ENDORSEMENT OF PHYSICIAN NEGOTIATION RIGHTS

The House of Delegates has repeatedly endorsed the principle of physician negotiating rights. (Substitute Resolution 206 (A-92), Policies 165.954, 385.971, 385.973 and 385.976.) As the AMA moves forward to gain the necessary legal and legislative recognition for physician negotiation rights, the TAC and Board believe it is critical

to emphasize several key points about the negotiation process itself, so that everyone is fully aware of such matters ahead of time. Any negotiating process requires:

-- A small team to do negotiating;

-- Empowerment of negotiating team to negotiate within policy parameters, without prior public disclosure of specific positions;

-- The small "rapid response team" must exert both proactive, aggressive leadership and quick responses;

-- Compromise; and

-- The ability to make "best" decisions quickly; some of which may be unpopular.

LEADERSHIP/RAPID RESPONSE TEAM

The AMA Board of Trustees, in the exercise of its fiduciary and legal responsibilities and the constitutional authority conferred upon it by the House of Delegates, is the appropriate body to act as the leadership/rapid response team on the negotiations issue. Of course, the Board will:

-- act pursuant to the policy set by the House of Delegates;

-- seek timely advice and recommendations from not only AMA councils but also state, specialty and other physician organizations. In particular, the Board will seek to create the same kind of successful coalitions with national medical specialty societies as the AMA/Specialty Society Medical Liability Project, the Practice Parameters Partnership and Forum, and the Relative Value Update Committee. With respect to health reform legislation, particular consideration will be placed upon the ongoing advice/recommendations of the TAC. The TAC was formed pursuant to direction of the House for this very purpose and represents a broad-base of council, section, and House input. Cutting across these various organizational entities, the TAC has developed in-depth knowledge on health system reform issues, enabling it to provide rapid, judicious advice and recommendations to the Board; and

-- make every effort to provide as broad and early information to the House and the federation as possible, recognizing the point stressed earlier that, in certain situations, the negotiations process requires quick action which may preclude optimal broad-based discussion.

The Board, which is, of course, accountable to the House for its actions, believes that this House wants the Board to aggressively exercise its responsibility in regard to negotiating on behalf of the best interests of patients and physicians. Ultimately, the true test of success of negotiated positions will be the degree of acceptance and support from the House, medical profession, and the public.

CONTINUING ADVOCACY

Physicians have a right to be at the negotiating table. It is in the best interest of quality patient care that they be there. Physicians must place the interests of patients as primary. Physician interests will be best served when

patients' interests are best served. Physicians must convince those who will decide upon legal and legislative recognition of physician negotiating rights that such recognition really is in the best interests of patients — that such recognition will provide the best basis for strengthening that special bond between a patient and a physician, a bond that is being eroded because of government and other third party interference. Reestablishing the physician's clinical prerogatives to serve his or her patients with their best professional judgment will be a key aspect of negotiations. Strengthening the patient-physician bond really is a quality of care issue.

The AMA will need to enlist broad-scale physician and patient support in pursuit of legal and legislative recognition of physician negotiating rights. Early and widespread information to and request for support from the profession and the public will be needed.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted:

1. That the AMA continue its aggressive leadership campaign for antitrust relief and legal and legislative recognition of physicians' right to negotiate.

2. That the AMA continue to position the Association to provide rapid, judicious and effective actions and responses regarding negotiating roles that allow physicians to protect the interests of patients and legitimate interests of their own.

3. That the AMA commit itself to the establishment of mechanisms to fulfill essential standards setting roles necessary to assure the quality and cost effectiveness of medical services provided through public and private health plans and, where appropriate, invite other organizations (such as national medical specialty societies or provider trade associations, associations of private payors, government agencies or public interest groups) to participate in these mechanisms.

4. That the AMA support the creation of a national health advisory body or task force that will form a public/private partnership with the AMA to formulate policy and implement activities in areas of health policy, such as technology use and dispersion, benefit packages, parameters/quality assurance and other areas except for global budgets, expenditure targets or payment determination.

5. At a time of the potential for imminent health system reform the House of Delegates empower the Board of Trustees to act on behalf of the Association to promote pro-actively and negotiate for those elements of health system reform which they feel will best represent the interests of patients and the profession.

No. 202 AIR BAGS IN AUTOMOBILES
Introduced by New York Delegation

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES

RESOLVED, That the American Medical Association seek enactment of legislation which would mandate that all new vehicles have air bags for the driver and for the front seat passenger.

No. 203 REQUIRED AIR BAGS FOR THE FRONT SEAT IN ALL NEW CARS
Introduced by Medical Student Section

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES

RESOLVED, That the American Medical Association encourage the requirement that all new cars be equipped with both driver's side and passenger's side air bags in addition to a three-point restraint (Type II).

No. 204 QUALIFICATIONS FOR STATE HEALTH DIRECTORS
Introduced by North Carolina Delegation

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION 204 ADOPTED:

RESOLVED, That the American Medical Association recommend to state medical societies that they advocate with their respective legislatures the adoption of statutory requirements that the qualifications for state health director include a doctoral degree in medicine or osteopathy, public health training or experience, and preparation, both academic and experiential, adequate for the management of a large and complex health agency.

No. 205 LEGISLATIVE SUPPORT FOR PAY PARITY FOR NEW PHYSICIANS
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont Delegations

Resolution 205 was considered with Resolution 269 and Report R of the Board of Trustees
see page 59

No. 206 ORGANIZED MEDICINE'S ROLE IN HEALTH CARE POLICY DEVELOPMENT AND IMPLEMENTATION
Introduced by Kansas Delegation

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION 206 ADOPTED IN LIEU OF RESOLUTIONS 206, 212, 213, 215, 216, 229, 231, 254, 259 AND 275:

RESOLVED, That, in order to maintain the role of physicians as patient advocates, the American Medical Association support appropriate legislative, regulatory and judicial action providing for formal physician organization involvement in all areas of public and private sector health care policy development and implementation, which should include but not be limited to review of quality and appropriateness of care, appropriateness of payments and

fees, negotiation of reimbursement, and predictability of health care costs, and should not exclude any other areas of legislative or regulatory activities affecting physicians; and be it further

RESOLVED, That the AMA continue to seek, as the highest of priorities, the necessary changes in the antitrust laws to permit involvement of organized medicine in the negotiating process which is inherent in the development and implementation of all areas of health policy; and be it further

RESOLVED, That, to reaffirm present policy of the House of Delgeates, the AMA shall not endorse or advocate price fixing in any form, or budget predictability achieved by expenditure targets, budget caps or global budget limits; and be it further

RESOLVED, That the AMA Board of Trustees establish an Ad Hoc Technical Advisory Committee to help explore and define the options and activities necessary to achieve the policies set forth by the establishment of formal physician organization involvement in the development and implementation of health care policy and to include options outlining alternative approaches and innovative concepts (such as mandatory membership in state or national medical societies) that may be necessary to allow the voice of medicine to speak with maximum authority; and be it further

RESOLVED, That the AMA Board of Trustees report back to the House at the 1992 Interim Meeting on the activities and progress made relating to the provisions of this resolution.

No. 207 OBRA REGULATION
Introduced by Nebraska Delegation

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES FOR DECISION

RESOLVED, That the American Medical Association express to Congress and to the appropriate regulating entities our concern that many of the Omnibus Budget Reconciliation Act (OBRA) regulations are harming our nursing home patients and the nursing home industry.

No. 208 HOSPITAL ACCESS
Introduced by Nebraska Delegation

HOUSE ACTION: NOT ADOPTED

RESOLVED, That the American Medical Association work toward legislation which would require the use of the same criteria for access to all federally funded and federally reimbursed hospitals.

No. 209 CONSTITUTIONALITY OF LIMITING CHARGES
Introduced by Missouri Delegation

HOUSE ACTION: REFERRED TO BOARD OF TRUSTEES

RESOLVED, That the American Medical Association challenge the constitutionality of the law that places limits on the amounts physicians may charge Medicare patients; and be it further

RESOLVED, That the AMA develop a plan of action to have these limits removed.

JOINT REPORT OF COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS AND COUNCIL ON CONSTITUTION AND BYLAWS

The following report was presented by Oscar W. Clarke, M. D., Chairman, Council on Ethical and Judicial Affairs, and Eugene F. Worthen, M. D., Chairman, Council on Constitution and Bylaws:

CLARIFICATION OF HOUSE PROCEDURES WITH RESPECT TO THE OPINIONS AND REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTIONS 3 AND 11, AND REMAINDER OF REPORT FILED

At the request of the Speakers, the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws have met to develop rules of procedure for handling opinions and reports of the Council on Ethical and Judicial Affairs. This joint report of the Councils, which is based upon the Councils' interpretation of the Constitution and Bylaws of the Association, will propose those rules for consideration by the House of Delegates.

BACKGROUND

At recent meetings of the House of Delegates, questions have arisen regarding the procedures by which the House should consider opinions and reports of the Council on Ethical and Judicial Affairs. The "Procedures of the House of Delegates" include provisions that, at times, appear to be inconsistent. According to the Procedures, "Opinions" of the Council that are reported to the House and designated as informational "may be filed or referred." The Procedures also provides, however, that the Council has authority to publish its "interpretations" of the Principles of Medical Ethics "without submitting them to the House for comment," and that "when the Council chooses to present its interpretations of the Principles of Medical Ethics to the House for information, filing is the proper form of action since the House cannot modify the interpretations of the Principles of Medical Ethics."

Uncertainty about House procedures has occurred because "opinions" may also be "interpretations" of the Principles of Medical Ethics. As stated in the preface to "Current Opinions," the Council derives its authority to issue opinions from two sources. Section 6.4021 of the Constitution and Bylaws grants the Council authority to interpret the Principles of Medical Ethics. It functions in this regard as the Association's Supreme Court and its decisions are "final." Section 6.4023 also grants the Council authority to investigate general ethical conditions and make recommendations to the House of Delegates. When an opinion is issued pursuant to section 6.4021, the Council is issuing an interpretation of the Principles of Medical Ethics, and the House must therefore file the opinion. When an opinion is issued pursuant to section 6.4023, the Council is making recommendations to the House, which can be either filed or referred.

The characterization of "opinions" as "interpretations" of the Principles of Medical Ethics arose when the House of Delegates modified the Principles of Medical Ethics in 1957 from a code of conduct consisting of 47 sections to a succinct list of 10 general principles. In its report to the House that accompanied the new version of the Principles, the Council on Constitution and Bylaws explained that the Principles were written so that "interpretations can and will be made by the Judicial Council to adapt them to particular factual situations." The report further observed that the Judicial Council would be elaborating the meaning and intent of the new Principles through "interpretive opinions."

The procedures for Council "reports" have also been confusing. According to the Procedures of the House, reports that request House action or reports in response to a request from the House must be

adopted, not adopted or referred. At times, however, the Council has issued reports that are essentially opinions with a discussion of the reasons for the opinion. Sometimes the rationale has included observations and considerations which were broader than the opinion itself, and some members of the House have been concerned that the Council was making House policy in those situations. Those statements, however, are not Association policy even after the opinion is filed. Any proposals to clarify the procedures for Council opinions and reports must reflect two fundamental principles of the Constitution and Bylaws. First, the Council should be given a substantial degree of independence from the political processes of the House as long as it is genuinely interpreting the Principles of Medical Ethics. Second, the House should be given mechanisms with which to check and balance the independence of the Council.

Council independence from the political process has always been an essential element of the American Medical Association's structure. In many respects, the Council is modeled on the United States Supreme Court and its relationship to other branches of the federal government. Like the Supreme Court, the Council has nine members. According to section 6.405 of the Constitution and Bylaws, members elected to the Council "shall resign all other positions held by them in the Association." Council members may not serve as a delegate or alternate delegate to the House, as a General Officer of the Association, as a member of another council or committee, or as Representative to or Governing Council Member of a Special Section of the Association. The independence of the Council from the political process is analogous to the independence of members of the federal judiciary from Congress. As with federal judges, members of the Council do not run for election, but are appointed by the executive and confirmed by the legislative branch.

In isolating the Council from the political process, the Association has recognized that ethics, like scientific matters, cannot be decided purely on the basis of a popular vote. Just as this country's constitutional interpretations are decided by an independent tribunal rather than the legislative process, this Association's ethical interpretations should be determined by an independent Council rather than the House's policymaking process. Such independence is essential to ensuring that patients, ethicists, policymakers and physicians view the Association's ethical pronouncements as being grounded in the Principles of Medical Ethics rather than in the political temperament of the times. The perception that the Association's ethics are determined by majority vote could undermine the legitimacy of the Council and prevent its code of ethics from being viewed as an authoritative code for the entire profession.

Most importantly, the Council's opinions have impact far beyond the members of the Association. They have come to be viewed by the courts, policymakers in government and the general public as the profession's code, binding all physicians and establishing rights and responsibilities in all patients as well.

There are times when Council opinions may reach conclusions that are not clearly derived from the Principles of Medical Ethics. The Council must carefully endeavor to limit its opinions and interpretations to matters within the Principles of Medical Ethics established by the House. But it would be difficult to draft a set of cogent and concise principles that specifically discuss all ethical situations. The same issue has arisen with respect to interpretations of the Constitution by the Supreme Court. Fundamental rights that are not explicitly mentioned in the Constitution have been recognized by the Supreme Court. For example, the right to travel, a right long denied by Communist governments to its citizens, is not mentioned in the U. S. Constitution, but is nonetheless fundamental to our society. When issuing each of its opinions, the Council has indicated which of the Principles of Medical Ethics serve as the source of the opinion. In "Current Opinions," each opinion is followed by the number(s) of the Principle(s) from which the opinion is derived.

House Checks and Balances

Like the federal Constitution, the Association's Constitution and Bylaws have recognized the need for checks and balances among the different branches of the government. There are several provisions that ensure appropriate oversight of the Council's activities. First, the House can influence the Council's deliberative process through its authority to confirm all appointments of members to the Council. Second,

if the House believes that the Council is not interpreting the Principles of Medical Ethics appropriately, the House can amend the Principles to clarify their meaning. Third, if the Council has issued an opinion with which the House disagrees, the House can pass a resolution requesting the Council to reconsider or withdraw its opinion. When that happens, the Council will be responsive to the concerns of the House. At the 1990 Annual Meeting, the House passed two resolutions asking the Council to reconsider its position on physician ownership of medical facilities. Since then, the Council has been restudying the issue, and it is presenting a new report on the issue to the House at this meeting. Fourth, on matters that do not involve interpretations of the Principles of Medical Ethics, the Council makes recommendations to the House which the House can either adopt, not adopt or refer.

An important question that has arisen is the apparent conflict between Council independence and the authority of the House of Delegates as the policymaking body of the Association. When the Council issues an opinion, members of the public may not appreciate the distinction between opinions of the Council and policies of the House of Delegates.

By delegating to the Council the "final" authority to interpret the Principles of Medical Ethics, the Association has given over to the Council authority, as a practical matter, to make ethics policy for the Association. But even then, the interpretations have their source in the Principles established by the House as the Association's broad policymaking body. At times, the House may adopt a policy that is in conflict with an opinion of the Council. This is an inevitable feature of tripartite governments, whether in the American Medical Association or the United States of America. In practice, there has not been an "opinion" which conflicts with House policy; as the House and Council are shaping their positions, they are aware of each other's views. On rare occasions, a Council report has conflicted with House policy, but such conflicts have not caused significant problems.

The Council recognizes that House input is an important part of its deliberative process and welcomes the perspectives of the House. In order to enhance the ability of the House to contribute to the development of the Association's ethics, the Council will endeavor to inform the House of the issues which it will be considering at the outset of its consideration. Members of the House will then have an opportunity to submit statements of their perspectives to the Council for its consideration. Just as legal briefs assist courts in deciding legal questions, submissions to the Council will assist it in deciding ethical questions.

It is important to preserve the Council's ability to issue opinions without prior submission to the House of Delegates. Important ethical questions typically arise between meetings of the House. At times, a rapid response by the Council is essential if the Council is to maintain a leading role in the development of the ethics of the profession. While the need for a rapid response will occur infrequently, authority should exist for the Council to meet that need when it arises.

RECOMMENDATIONS

The Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws recommend that:

1. The Council on Ethical and Judicial Affairs will inform the House of Delegates of an ethical opinion adopted by the Council by presenting the Opinion to the House. The Council:

    a. Will identify the Opinion as informational.

    b. May provide a description or discussion of the underlying facts and circumstances leading to the adoption of the ethical Opinion, and also an explanation of the Opinion and the reasons for its adoption by the Council. This explanatory material is neither the opinion of the Council nor policy of the Association.

c. Will identify one or more Principles of Medical Ethics that form the basis for issuing the ethical Opinion.

d. Will provide the text of the ethical Opinion.

2. Opinions of the Council on Ethical and Judicial Affairs will be placed on the consent calendar for informational reports, but may be withdrawn from the consent calendar on motion of any member of the House of Delegates and referred to a reference committee.

   a. The members of the House may discuss an ethical Opinion fully in reference committee and on the floor of the House.

   b. After concluding its discussion, the House shall file the Opinion.

   c. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion. The Council on Ethical and Judicial Affairs shall respond to such a request in due course, after reconsidering the issues presented. The Opinion of the Council on Ethical and Judicial Affairs that responds to such a request will be considered as informational, and therefore shall be filed.

3. Reports of the Council on Ethical and Judicial Affairs which respond to requests from the House or which make recommendations to the House may be adopted, not adopted or referred, as may be appropriate. A report may not be amended, except for amendments that clarify the meaning of the report and only with the concurrence of the Council.

4. At each meeting of the House, the Council on Ethical and Judicial Affairs will endeavor to inform the House of the issues that it plans to consider in the subsequent months. Members of the House will be able to submit statements of their perspectives to the Council for its consideration.

JOINT REPORT OF COUNCIL ON MEDICAL EDUCATION AND COUNCIL ON SCIENTIFIC AFFAIRS

The following report was presented by Sam A. Nixon, M. D., Chairman, Council on Medical Education, and E. Harvey Estes, Jr., M. D., Chairman, Council on Scientific Affairs:

FEDERAL RESEARCH GRANT INDIRECT COST POLICY (RESOLUTION 233, A-91)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

RESOLUTION 233 (A-91) ADOPTED

Resolution 233 (A-91), which was referred to the Board of Trustees, asks the American Medical Association to review the issues related to reimbursement of grant-related indirect costs and familiarize the membership with federal indirect cost principles and policies.

The AMA Health Policy Agenda for the American People recognized the impact of biomedical research on the improvement of the nation's health. Federal funding of basic and applied medical research through the National Institutes of Health (NIH), the Department of Veterans Affairs, and the Alcohol, Drug Abuse

On October 26, 1992 U. S. District Judge Nicholas Politan dismissed the case on the grounds that it was not "fit for judicial decision." Judge Politan's opinion stated, in part:

> The plaintiffs in their briefs and at oral argument claim to be challenging an articulated policy of the Secretary [of HHS] "which specifically prohibits Medicare patient-beneficiaries from paying for such services entirely out of their own funds and requesting their physician not to submit a claim for Medicare Part B benefits to the Secretary on their behalf." As evidence of this articulated policy the plaintiffs proffered the two bulletins attached to their complaint and the advisory letters issued by the HCFA in response to questions concerning private contracting.
>
> The plain reading of the bulletins and the two advisory letters from HCFA clearly demonstrate that plaintiffs have failed to establish the existence of an articulated policy from the Secretary on the issue of private contracting. The various documents themselves are not in accord and none of them explicitly recounts the policy as alleged by plaintiffs.
>
> . . . I understand the plaintiffs' constitutional attack to be predicated on a finding by this court that the statutory provision being challenged authorizes the alleged policy. Inasmuch as I have concluded that the plaintiffs' challenge to the alleged policy of the Secretary is not ripe for determination because plaintiffs have failed to establish the existence of such a policy, I find that it is unnecessary to address plaintiffs' constitutional attack on the statute.

UPDATE

Since the ruling by the District Court, there have been many interpretations of the court's opinion. The plaintiffs claimed victory in this case and stated the ruling means physicians are free to contract privately with their patients. AMA legal counsel advises a more measured response. The District Court merely held that the plaintiffs had not proven that a government policy prohibiting private contracting existed. It did not decide whether such a policy, if it exists, was lawful. Therefore, the Board urges physicians to proceed cautiously in this area and to seek competent legal counsel prior to treating Medicare patients on a private contract basis. Physicians should not use the Stewart case as a justification for exceeding the limiting charges for Medicare billing. Meanwhile, the AMA has sought a clear statement from HCFA as to the government's position on opting out by Part B beneficiaries.

RECOMMENDATION

The Board of Trustees recommends that, in lieu of Resolutions 209 and 237 (A-92), the AMA continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances.

PP. JAMA EDITORIAL FREEDOM (RESOLUTION 904, I-92)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED:

At the 1992 Interim Meeting, Resolution 604 was referred to the Board of Trustees for study and report at the 1993 Annual Meeting. The resolution asks that The Journal of the American Medical Association (JAMA) strengthen its peer review process while refraining from entering the public policy debate, devote equal space to proponents of all sides of an issue addressed in its pages and, as a matter of policy, letters to the editor from state medical association presidents be printed in JAMA.

BACKGROUND

The Journal of the American Medical Association was founded in 1883, functions as a peer review journal, and has become the most widely circulated and read medical journal in the world. It is distributed as one United States and 19 international editions in 13 languages with a total readership in excess of 700,000. The trust that physicians, scientists, policy makers, media, and the public place in JAMA is one of its most valuable qualities. This trust is engendered by the principle of editorial freedom in which the owners of JAMA, the American Medical Association, delegate to the editor complete authority to determine what will appear in the journal. The editor has more than 8,000 voluntary peer reviewers, of whom nearly 3,000 were used in 1992 to guide the editor and his staff to wise editorial decisions.

This traditional principle of editorial freedom for JAMA and the AMA's ten peer-reviewed specialty journals was most recently supported by a unanimous vote of the House of Delegates in response to a 1990 resolution seeking to limit that freedom.

DISCUSSION

The Board of Trustees requested study of the background of the principle of editorial freedom for JAMA and had discussion with the Editor-in-Chief, AMA Scientific Publications, as well as the Senior Vice President for Communications and Publishing and the Executive Vice President.

The AMA was a founding member of the International Committee of Medical Journal Editors which develops policy for peer review medical journals for the world. This committee requires that editorial freedom and integrity of its member journals be assured. The Board of Trustees reaffirms its support for the principle of editorial freedom for JAMA and the AMA's ten specialty journals so as to continue to assure the integrity of this major segment of the scientific peer review medical literature.

The Journal of the American Medical Association has functioned under a set of goals which was originally approved in 1982 and was updated in 1987. As part of the current review, the Editor-in-Chief used a multiple step iterative Delphi process to validate and update these previously approved goals and objectives. Utilizing his strong in-house editorial staff and 25-member prestigious Editorial Board, the Editor-in-Chief developed the following revised Key and Critical Objectives for 1993.

Key Objective:

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

Critical Objectives:

1. To publish original, important, well-documented, peer-reviewed clinical and laboratory articles on a diverse range of medical topics.

2. To provide physicians with continuing education in basic and clinical science to support informed clinical decisions.

3. To enable physicians to remain informed in multiple areas of medicine, including developments in fields other than their own.

4. To improve public health internationally by elevating the quality of medical care, disease prevention and research provided by an informed readership.

5. To foster responsible and balanced debate on controversial issues that affect medicine and health care.

6. To forecast important issues and trends in medicine and health care.

7. To inform readers about nonclinical aspects of medicine and public health, including the political, philosophic, ethical, legal, environmental, economic, historical and cultural.

8. To recognize that, in addition to these specific objectives, The Journal has a social responsibility to improve the total human condition and to promote the integrity of science.

9. To inform readers of American Medical Association policy, as appropriate, while maintaining editorial independence, objectivity and responsibility.

10. To achieve the highest level of ethical medical journalism and to produce a publication that is timely, credible and enjoyable to read.

RECOMMENDATIONS

The Board of Trustees recommends:

1. That the AMA reaffirm existing policy on the editorial independence of the editors of AMA scientific journals in lieu of Resolution 604 (I-92).

2. That JAMA and other AMA scientific journals display a disclaimer in prominent print that editorial views are not necessarily AMA policy.

QQ. VACCINE LIABILITY: UPDATE ON THE NATIONAL CHILDHOOD VACCINE INJURY ACT OF 1986

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED:

The essential elements of the National Childhood Vaccine Injury Act of 1986 were presented in Report DDD of the Board of Trustees (A-91), Final Report: National Childhood Vaccine Injury Act of 1986 (Policy 60.978). This report reviews the act in greater detail and presents an update on the current status of the act. In addition, Resolution 421 (I-92), CDC Vaccine Information Pamphlets: What You Need to Know, adopted by the House of Delegates, recommends that the Association work with other professional and lay organizations to urge the federal government to abandon the use of the current CDC Vaccine Information Pamphlet forms for childhood vaccines in favor of a one-page Important Information form as used in the past. As the Vaccine Information Pamphlets are specified in the act, the current status of attempts to simplify these forms also is included in this report.

After two decades of controversy over whether and how adverse reactions to vaccines should be compensated, in 1985 there was a liability crisis facing the U. S. vaccine manufacturers -- lawsuits had resulted in claims that reached a high of $3.1 billion. The tort system, under which cases were tried, could not predict who would prevail and awards of several million dollars were made in individual cases. This resulted in escalating costs of vaccines, the unwillingness of some manufacturers to continue making certain vaccines (e. g., pertussis), and the overemphasis of the adverse effects of vaccines. Given the relatively low profit margins on vaccines, the possibility of losing just one costly lawsuit made manufacturers very wary. As the number of domestic vaccine producers had been declining since the 1960s, public health officials were very concerned that if manufacturers abandoned the vaccine market, the United States might be left without an adequate vaccine supply. Because certain vaccines were mandated, there was no real opportunity to give informed consent and it was nearly impossible to predict who might suffer an adverse vaccine reaction in the absence of a known allergy, immunodeficiency, or previous neurologic deficit. Parents of children with severe vaccine-related injuries found that health insurance rarely covered their long-term health care

REPORTS OF COUNCIL ON MEDICAL EDUCATION

The following reports, A-T, were presented by Sam A. Nixon, MD, Chair:

A. ANNUAL REPORT ON MEDICAL EDUCATION: 1992-1993

HOUSE ACTION: FILED

I. BACKGROUND OF THE COUNCIL ON MEDICAL EDUCATION

The American Medical Association was founded in 1847 with the primary purpose of improving medical education in order to provide better medical care to the public. After 50 years of appointing committees and attempting to raise the standards of medical education, the results were so discouraging that the AMA was considering discontinuing its efforts in medical education. That situation changed with the reorganization of the AMA at the turn of the century, when a committee was appointed to examine the entire issue of medical education. As a result of its examination, the committee recommended creation of a permanent council to improve and advance standards of medical education. In response to that recommendation, the Council on Medical Education (Council) was created in 1904.

The Council was charged broadly with (1) making an annual report to the House of Delegates on conditions in medical education in the United States; (2) suggesting ways by which the AMA might best favorably influence medical education; and (3) acting as the agent of the AMA, under instructions from the House of Delegates, in its efforts to elevate medical education. Today, the Council is responsible for studying and evaluating all aspects of medical and allied health education, reviewing and recommending policies, assisting in the development of programs, and continuing to lead and direct the AMA's role as a major force in medical education. To fulfill these responsibilities, the Council meets four times a year. In addition, the chair and vice-chair meet twice a year with the Board of Trustees and once a year with officers of other AMA councils and with sections concerned with medical education to exchange information and to explore cooperation and collaboration on projects and reports.

The strong, viable cooperative groups -- including, among others, the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Accreditation Council for Continuing Medical Education, the Committee on Allied Health Education and Accreditation, the American Board of Medical Specialties, the National Board of Medical Examiners, the National Resident Matching Program, and the Educational Commission for Foreign Medical Graduates -- attest to the historical leadership of the AMA in the constellation of organizations that guide medical education and practice in this country.

The Council continues to collaborate with various units within the AMA. In 1992, in cooperation with the Council on Legislation, the Section on Medical Schools, the Resident Physicians Section and the Medical Student Section, the Council submitted an extensive report to the House of Delegates on financing graduate medical education. The Council has also invited representatives of the AMA Hospital Medical Staff Section and the American Hospital Association to work with the Council on a task force that will consider issues related to physician professional credentialing and privileging.

The Council is involved in the 26 Residency Review Committees (RRC) by nominating physicians to be appointed as members by the AMA Board of Trustees. The Council's Executive Committee conducts annually an orientation session for newly-appointed RRC representatives. The Council reviews all changes to the standards for graduate medical education accreditation.

The Council's work is augmented by the Graduate Medical Education Advisory Committee (GMEAC) and the Continuing Medical Education Advisory Committee (CMEAC). The former reviews and recommends the

acceptance, rejection or modification of proposed changes in the standards for accrediting residency programs. The latter reviews and evaluates present activities, procedures, policy recommendations and decisions in continuing medical education. In addition, the CMEAC provides program advice and liaison with other organizations, such as specialty societies. Both advisory committees identify, study and document problems and formulate recommendations toward their solutions.

This annual informational report of the Council to the House of Delegates on conditions in medical education is intended (1) to inform the House and the profession and (2) to solicit feedback. A list of reports and resolutions with major Council responsibilities, including the 21 new Council reports being considered at this meeting, appears in Section VII.

II. CURRENT ISSUES OF CONCERN IN MEDICAL EDUCATION

Since June of 1992, the Council has been involved in analyzing several important issues that impact significantly on medical education at all levels. These include the impact of health system reform on medical education, physician workforce planning, financing graduate medical education, credentialing and privileges, primary care, and activities of the Council on Graduate Medical Education (COGME).

The Impact of Health System Reform on Medical Education

The principal issue, which the Council is attempting to highlight and establish as a high priority for attention by the AMA, involves the impact of health system reform on medical education. Because it has been substantially overlooked by government officials and other policy makers involved in the current health system reform debate, the Council has been addressing this issue through special task forces, including a task force of the Section on Medical Schools.

Recommendations of the first Council report on this subject, Report D, The Effects of National Healthcare Reform on Medical Education, were adopted by the House of Delegates during the 1992 Interim Meeting. Four experts in the area of health policy worked with the Council and staff to develop an updated report, which was presented to a newly-created Council Task Force for final development. The Council's Report S, Health System Reform and Medical Education, will be considered during this meeting.

With regard to undergraduate education, the report concludes that while medical schools will be able to adapt to changes in the size and specialty mix of their faculties in order to maintain their primary educational mission, reform will result in a decrease in the discretionary funds provided by teaching hospitals and faculty practice plans. Health systems reform and evolving workforce policy initiatives are likely to have a more dramatic impact on the nation's graduate medical education system. The widely perceived need to increase the supply of primary care physicians will be fueled by the evolution of a competitive managed care environment and provide policymakers with a compelling reason for effecting fundamental change in the organization and financing of GME. The report concludes that GME will therefore become more community-based, with a larger proportion of primary care residency positions and a greater emphasis on education in the ambulatory setting across all specialties.

Physician Workforce Planning

The Council Task Force on Physician Workforce Planning, which held its first meeting on March 7, 1993, and which will include input from other AMA councils, has representatives from the Medical Student Section, the Resident Physicians Section and the Section on Medical Schools. The Task Force will evaluate existing AMA policy on physician workforce planning, consider updating that policy, and develop AMA positions on creating and participating in a national physician workforce planning effort. A preliminary report, issued as a joint report between the Council on Medical Education and the Council on Long Range Planning and Development, will be considered during this meeting.

Financing Medical Education

The financing of medical education has been particularly focused on financing graduate medical education. The recommendations of Council Report G, Financing Graduate Medical Education, adopted during the 1992 Interim Meeting, will provide guidelines for AMA action as the issue of residency funding becomes a priority item in the current budgetary debate.

Credentialing and Privileges

The Council task force created to address the important issue of credentialing and privileges for physicians has held its first meeting and will be issuing a report for the 1993 Interim Meeting.

Primary Care

The Council was represented on the Section on Medical Schools task force charged with examining the issue of how to increase interest in primary care. The task force's Report on Primary Care, with its 16 recommendations, was published in the September 2, 1992, medical education issue of JAMA. The Council's Report N, Increasing the Availability of Primary Care Physicians, a comprehensive summary of strategies designed to increase interest in primary care for consideration during this meeting, calls for the AMA to adopt as policy the recommendations of the Task Force on Primary Care. The Council's Report L, Medical School Clerkships in Family Practice, also for consideration at this meeting, presents data on schools that have instituted required clerkships. The report also notes the newly approved LCME standard, which requires a core curriculum in primary care and now lists family practice among the traditional clinical clerkships.

III. UNDERGRADUATE MEDICAL EDUCATION AND ACCREDITATION: 1992-1993

The Liaison Committee on Medical Education (LCME)

The LCME approves educational programs leading to the MD degree in the United States and Canada, the latter in cooperation with the Committee on Accreditation of Canadian Medical Schools (CACMS). The LCME also serves as the deliberative body through which standards and procedures for accrediting these programs are established. The LCME, established by the AMA and the AAMC in 1942, held its 50th anniversary educational conference in June 1992 in Chicago, around the theme of "Innovation and Quality in Medical Education: The LCME as Facilitator?"

Structure/Meetings

The AMA, through the Council, is one of two parent sponsors of the LCME; the other parent sponsor is the Association of American Medical Colleges (AAMC) in Washington, D.C. Six members are appointed by the AMA, six by the AAMC, and one member by the CACMS; in addition, there are two public members and two non-voting student members (representing the respective student organizations of the AMA and AAMC). The LCME generally conducts four meetings in each academic year, alternating between Chicago and Washington, D.C.

Scope

The LCME accredits educational programs leading to the MD degree at 125 United States and 16 Canadian medical schools. In addition, one US medical school with a 2-year program is accredited. Accreditation is awarded for a standard term of 7 years.

Authority

Students and graduates of LCME-accredited schools are eligible to take the United States Medical Licensing Examination (USMLE) and have unrestricted eligibility to enter

residency programs approved by the Accreditation Council for Graduate Medical Education. Graduation from an LCME-accredited US medical school and passing a national certifying examination are accepted as prerequisites for medical licensure in most states. The LCME is recognized by the U. S. Department of Education and the Council on Postsecondary Accreditation as the body responsible for accrediting educational programs leading to the MD degree in the United States and Canada. LCME accreditation is required for schools to receive federal grants for medical education and to participate in federal loan programs.

Accreditation Actions

The LCME conducted full accreditation surveys of 18 medical schools and limited accreditation surveys of seven medical schools during the 1992-1993 academic year. In addition, the LCME Secretariat conducted four consultation visits to medical schools.

Standards Review

The LCME also continued the process of reviewing its accreditation standards, making proposals for changes in the Functions and Structure of a Medical School. Within the past 12 months, public hearings have been held on nine proposed standard changes and those nine changes have been approved by the parent sponsors. The LCME Rules of Procedure have also been revised during the current academic year.

Orientation

Orientation sessions for new LCME members, for new LCME survey team members, and for faculty and deans of schools undergoing an LCME accreditation visit were held during the 1992-1993 academic year.

Concerns/Landmark Activities

Medical students/admissions: Three other Council reports will be considered during this meeting: Report F, Reduction in the Cost of Medical School Education; Report H, Recruiting Students of Medicine at the Elementary and High School Levels; and Report O, Repayment of Medical School Loans.

Undergraduate medical curriculum: The recommendations of Council Report A, Preserving the Vital Role of the Autopsy in Medical Education, were adopted at the 1992 Interim Meeting, and the Council's Report B, Initiatives in Clinical Assessment, was filed.

Challenge to voluntary accreditation: During the past year the Council and the LCME have been concerned by the challenge to the traditional voluntary accreditation. Prompted mainly by the high default rate in student loans in a number of schools (which has not been a significant problem in medical schools), a number of proposals were offered during the process of reauthorizing the Higher Education Act (signed into law in July 1992) that would have dramatically altered the voluntary accreditation process. The AMA and the AAMC were actively involved in attempts to preserve the many good features of the existing structure of the LCME and its accreditation activities. But final regulations have not been issued and the outcome is yet to be determined.

IV. GRADUATE MEDICAL EDUCATION AND ACCREDITATION: 1992-1993

The Accreditation Council for Graduate Medical Education (ACGME)

The ACGME, a private national body, accredits graduate medical education programs of clinical education, usually called residency training programs. The ACGME serves as the deliberative body through which standards for residency programs and procedures for accreditation are established.

Structure/Meetings

The five member organizations of the ACGME are the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and Council of Medical Specialty Societies. The ACGME, which oversees committees of volunteer physicians in each of the 26 specialty areas that make accreditation decisions in their areas of expertise, meets three times each year.

Scope

The ACGME accredits over 6,900 residency programs in 26 major specialty areas and 56 other specialized training areas. Accreditation is awarded for a variable term of up to 5 years. These programs are sponsored by almost 1000 institutions across the nation, and more than 600 additional institutions participating in the educational process. Accredited programs enroll approximately 86,000 residents each year.

Authority

ACGME accreditation is required for hospitals to receive reimbursement for medical services provided to patients by residents. Graduation from an ACGME-accredited program is regarded as a prerequisite to sit for most certifying examinations offered by member boards of the American Board of Medical Specialties.

Accreditation Actions

In 1992, the ACGME conducted 1,818 on-site surveys and 113 institutional reviews. Of the 3,038 agenda items, 2,070 involved first-time status decisions, 169 adverse decisions (8 percent), 141 deferrals, and 658 actions that did not involve a status decision. Resident complement decisions made separately from status decisions included 105 approvals for increases and 111 denials or deferrals.

Standards Review

In 1992, the ACGME reviewed 24 sets of special requirements.

Concerns/Landmark Activities

Perhaps the main concern in 1993 is related to the interrelationship between accreditation and medical workforce planning. Recommendations from different national organizations have proposed to use the accreditation system to influence the number and type of residency positions. But current AMA policy clearly states that "accreditation must be based on the determination of quality and not used for the purpose of regulating physician supply" (Policy 200.987 and Policy 200-990, I-92). In practice, the AMA has adhered to the fundamental principle that accreditation decisions must be based solely on valid educational standards. While the Council believes in the need for a national effort and incentives designed to ensure an appropriate physician mix, the Council opposes using the accreditation system to determine residency positions.

A somewhat similar concern revolves around the relationship between the certifying and accrediting processes. At its June 9, 1992, meeting, at the request of the Council, the ACGME approved a 1-year moratorium on considering any "Special Requirements" for new specialties or subspecialties that were not already approved by a related residency review committee, freezing the recognition of any new specialties or subspecialties until June 1993. An ad hoc committee was charged with defining the parameters to be used for approving new "Special Requirements," including the respective roles of the ACGME and the American Board of Medical Specialties. On May 19, 1993, the ACGME held a retreat to discuss a proposed draft of ACGME Policies and Procedures for the Recognition of Subspecialty Areas for Accreditation.

Section VII of this report contains descriptions of reports and resolutions for which the Council has primary responsibility; they are related to many of the major issues impacting on graduate medical education, of which the following are of particular importance:

- -- Medical specialty and subspecialty mix
- -- Adequacy of primary care practitioners to meet population needs
- -- Role of graduate medical education in preparing primary care practitioners
- -- Impact of health system reform on graduate medical education
- -- Financing graduate medical education

V. CONTINUING MEDICAL EDUCATION AND ACCREDITATION: 1992-1993

The Accreditation Council for Continuing Medical Education (ACCME)

The ACCME, founded in January 1981, directly accredits national sponsors of continuing medical education (CME) and recognizes state medical societies as local accrediting agencies. The ACCME/state medical society system for accrediting CME is of critical importance in maintaining and improving quality CME programming.

Structure/Meetings

The AMA is one of seven national organizations that sponsor the 20-member ACCME: the American Medical Association, American Board of Medical Specialties, American Hospital Association, Association of American Medical Colleges, Council of Medical Specialty Societies, Federation of State Medical Boards, and Association for Hospital Medical Education. Two members of the Council and the chair of the Council's CME Advisory Committee (CMEAC) are appointed to the ACCME to represent the AMA. The Council and the CMEAC therefore have a direct voice in ACCME discussions on accreditation policies and procedures, as well as in evaluation of administrative activities. The ACCME meets three times a year.

Scope

The ACCME directly accredits almost 500 "national" sponsors and recognizes the accreditation of almost 1800 "intrastate" sponsors of CME by state and territorial medical societies. Accreditation is awarded for a standard term of 4 years, with 6 years for exceptional programs.

Authority

Educational activities sponsored by accredited institutions and organizations qualify practitioners for the AMA Physician's Recognition Award, licensure renewal in 24 states, hospital staff privileges, and membership in many specialty and state medical societies.

Accreditation Actions

During 1992, the ACCME reviewed 218 accredited sponsors of CME (about 45 percent of the total number) for continued or initial accreditation. Fourteen sponsors were placed on probation and 14 applicants were denied accreditation. The reviewed sponsors reported 9,962 separate CME activities (conducted directly or through joint sponsorship), which involved 442,376 physicians.

Concerns/Landmark Activities

Needs of state medical societies: The Council has been attentive to the needs of state medical societies in their accreditation of intrastate sponsors of CME. The Council continues to monitor the activities of the ACCME Committee for Review and Recognition (CRR), opposing undue imposition of uniform administrative and procedural requirements on all state medical societies, regardless of their individual circumstances and needs. In addition, the Council has questioned a proposal by the ACCME to modify the Protocol for the Recognition of State Medical Society Accreditation Programs.

PRA revision: The Council supported revisions to the AMA Physician's Recognition Award, including offering physicians the option of choosing the standard PRA certificate, in which category 2 credit hours are encouraged, or a certificate with Special Commendation for Self-Directed Learning, in which category 2 credit hours are required. These revisions were accepted by the AMA Board of Trustees.

Conflict of interest: The Council adopted policies and procedures that require full disclosure of potential conflict of interest in CME programming sponsored by the AMA.

CME learning assessment form: The AMA House of Delegates approved the use of the revised CME Learning Assessment Form (CLAF) developed by the Council and the American Hospital Association. The form addresses the need for more specific information on CME intended to support a physician's request for new or expanded hospital privileges relating to newly developed procedures.

Unifying CME credits: The Council's efforts to encourage discussions on unification and simplification of various credit systems in CME include ongoing meetings with relevant specialty and state medical societies.

The Council has identified the following issues and concerns in CME:

- the impact of health systems reform on CME
- likelihood of decreased commercial support of CME
- application of the principles of continuing quality improvement to CME
- unifying and simplifying CME credit systems
- greater emphasis on accountability
- role of CME in credentialing
- the application of ethical principles to CME
- application of advances in communications technology in CME

VI. ALLIED HEALTH EDUCATION AND ACCREDITATION: 1992-1993

The Committee on Allied Health Education and Accreditation (CAHEA)

CAHEA accredits programs that prepare individuals for entry into 28 allied health professions, using standards that are developed and adopted jointly with 51 medical and allied health organizations that collaborate in the accreditation review process.

Structure/Meetings

The 14-member CAHEA, sponsored and staffed by the AMA, works with 20 review committees that evaluate educational programs and forward accreditation recommendations to CAHEA.These 20 committees are sponsored by 51 medical and allied health organizations. CAHEA meets three times a year in Chicago.

Scope

CAHEA accredits over 3000 allied health educational programs, sponsored by over 1500 institutions including hospitals, clinics, blood banks, community colleges, vocational-technical schools, senior colleges, universities, medical schools, consortia, proprietary schools, and U. S. government institutions. Maximum intervals between on-site evaluations range from 5 to 8 years. Annually CAHEA-accredited programs enroll more than 73,000 students and produce more than 33,000 graduates.

Authority

In cooperation with the review committees, CAHEA is recognized by the Council on Postsecondary Accreditation and the U. S. Department of Education to be in compliance with their standards for national accrediting agencies. CAHEA accreditation is required by many programs to receive federal grants for allied health education and to participate in federal loan programs for health professions students.

Accreditation Actions

Between March 1992 and March 1993, CAHEA took 687 accreditation actions based on recommendations submitted by the review committees with which it collaborates. Accreditation was awarded to 128 new programs, continuing accreditation was awarded to 503 programs, and accreditation was withheld or withdrawn from 56 programs.

Concerns/Landmark Activities

Orthotics and prosthetics recognized: Following an open hearing on August 29, 1992, the Council, acting on behalf of the AMA, recognized the professions of orthotics and prosthetics and established a collaborative relationship with its two sponsors, the American Orthotic and Prosthetic Association and the American Academy of Orthotists and Prosthetists.

The evolution of an independent accrediting agency: In October 1992, the AMA made known its intent to support the establishment of a new free-standing accrediting agency to assume the responsibilities of CAHEA. An AMA Task Force on Restructuring CAHEA was appointed and developed a proposal for a Council on Accreditation of Allied Health Education Programs (CAAHEP). On May 13-14, 1993, suggestions on the proposal were solicited at an open forum CAHEA conducted with the Assembly of Review Committee Chairpersons, the Panel of Consultants and Special Advisors, the Assembly of Institutional Administrators, and other interested parties. The comments were taken into consideration in the final Task Force proposal prepared for circulation in mid-June. Review committees and the allied health and medical specialty organizations that sponsor them will be asked to review the final proposal and to notify CAHEA by October 1, 1993, of the likelihood of their participation in CAAHEP. Immediately following the last meeting of CAHEA in October 1993, a provisional Board of Directors of CAAHEP will be named to carry out the directives of the proposal. An informational report from the Council on the establishment of a new allied health accrediting agency will be considered during this meeting.

VII. REPORTS AND RESOLUTIONS WITH MAJOR COUNCIL RESPONSIBILITIES

Council Reports Presented During the 1993 Annual Meeting

Annual Report on Medical Education: 1992-1993 (Report A)

Speech Tests for International Medical Graduates (Resolution 301/A-92; Report B)

Recertification Alternatives (Resolution 317/I-92; Report C)

Broad-Based General Medical Training in the First Year of Postdoctoral Medical Education (Resolution 306/A-92; Report D)

Council on Graduate Medical Education (COGME) (Resolution 307/A-92; Report E)

Reduction in the Cost of Medical School Education (Resolution 308/A-92; Report F)

EXHIBIT E

American Medical Association

Physicians dedicated to the health of America

Policy Compendium

Supplement to the 1993 Edition

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American Medical Association

Physicians dedicated to the health of America

Policy Compendium

Supplement

Containing Policies Adopted by the House of Delegates at the 1993 Annual Meeting.

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Council on Long Range Planning and Development
in cooperation with the Group on Health Policy Management

Foreword

This supplement to the main volume of the American Medical Association (AMA) *Policy Compendium* (1993 Edition) contains policies adopted by the AMA House of Delegates at the 1993 Annual Meeting. Because the 1993 Edition of the *Policy Compendium* (the main volume) and this supplement contain a comprehensive compilation of AMA House of Delegates policy, previous editions of the *Policy Compendium* and prior supplements should be discarded.

As with the main volume of the *Compendium*, this supplement contains only permanent policies adopted by the AMA House of Delegates. It does not contain: items that were referred to the Board of Trustees, filed, or not adopted; policy authorizing a change in the AMA *Constitution and Bylaws*; temporary policy or directives (e.g., that a specific, immediate action be taken or that a study be conducted); reports that merely summarize policy implementation activities; legislative and regulatory statements or testimony; and appointments, awards, or commendations. Readers are encouraged to consult, as appropriate, the AMA *Constitution and Bylaws*; the *Current Opinions* of the AMA Council on Ethical and Judicial Affairs; and the AMA *House of Delegates Proceedings*.

For the convenience of the user, as a new feature in the supplement there are three appendices which outline, respectively: (1) AMA policy which was reaffirmed at the 1993 Annual Meeting; (2) existing AMA policy that was amended; and (3) existing AMA policy which was rescinded.

Please note that, although care has been taken to ensure that this supplement reflects accurately the policies as adopted by the House of Delegates at the 1993 Annual Meeting, the descriptions of policies contained herein are unofficial until the House votes to approve the transcript of that meeting (as contained in the AMA House of Delegates *Proceedings*) at the 1993 Interim Meeting.

A number of individuals contributed to the development of this edition of the *Compendium*. Although they cannot all be recognized here, the following people deserve special thanks and appreciation for their contributions: the members of the AMA Council on Long Range Planning and Development (CLRPD); John A. Krichbaum, JD, Vice President of the AMA Group on Health Policy Management; John C. Gaffney, PhD, Director of the AMA Division of Strategic Policy Planning; John E. Kasper, CAE, Director of the AMA Department of Long Range Policy Analysis; Carol-Lynn Zurek, Staff Assistant, AMA Department of Long Range Policy Analysis; and Thomas M. Gorey, JD, President of Policy Planning Associates.

C. Burns Roehrig, MD
Chair, CLRPD

Kim A. Bateman, MD
Vice Chair, CLRPD

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implement educational programs on violence prevention and substance abuse. (Amended BOT Rep. K, A-93)

515.978 **Misuse of Hypnosis and Other Techniques of "Memory Enhancement/Creation":** The AMA considers the technique of "memory enhancement" in the area of childhood sexual abuse to be fraught with problems of potential misapplication. (Sub. Res. 504, A-93)

520.000 War

520.990 **End the War in Bosnia/Herzegovina:** The AMA: (1) will communicate to our government, the United Nations and to other appropriate organizations and governments its deepest concern for the loss of human life, the gravity of human suffering and inhumanity to people, the destruction of man's creativity, the collapse of social values and the devastation to the environment brought about by the strife in Bosnia/Herzegovina; (2) deplores and condemns "ethnic cleansing"; (3) urges physicians to participate in voluntary organizations providing health assistance and funding for the purchase of medical supplies to Bosnia/Herzegovina; (4) will make available to interested physicians the names and addresses of voluntary relief and service organizations who need physician volunteers for emergency and trauma care and other health and medical services in Bosnia/Herzegovina and many other areas around the globe where conflicts have disrupted medical practice and the delivery of medical care; and (5) urges Congress to make physicians and volunteers aware of the dangers in Bosnia/Herzegovina. (Amended Sub. Res. 611, A-93)

525.000 Women

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; and that, if physical changes must be made to the hospital's locker facilities to comply with these requirements, they must be budgeted and implemented within a period of five years of the adoption of these requirements. (Res. 810, A-93)

530.000 AMA: Administration and Organization

530.969 **AMA Is Us:** It is the policy of the AMA that in all written material and all spoken communication, our AMA leaders and members use the possessive adjective "our" or "my" to describe AMA actions, policies and positions, whenever possible. (Amended Res. 616, A-93)

530.970 **Policy Promotion Grants for Resident Physicians:** The AMA will establish a program of modest policy program grants to resident physician groups to support regionally diverse projects and activities designed specifically to further AMA policy. This policy promotion grant program will be operated with maximum flexibility to encourage the development, funding and promulgation of state medical society endorsed resident physician projects to promote AMA policy. Individual policy promotion grants will not exceed $500 per project, with total annual grant amounts not to exceed $35,000. (Amended Res. 604, A-93)

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530.971 JAMA Editorial Freedom: JAMA and other AMA scientific journals should display a disclaimer in prominent print that the editorial views are not necessarily AMA policy. (Amended BOT Rep. PP, A-93)

530.972 Study of Organizational Structure: The AMA endorses the concept of convening a broadly based ad hoc consortium to be charged with studying the organizational structure of AMA and the Federation and developing recommendations on how all of medicine could better speak with one voice to issues affecting patients and physicians and how organized medicine could function more efficiently and effectively. (CLRPD Rep. A, A-93)

545.000 AMA: House of Delegates

545.966 Specialty Society Admission to the House of Delegates: It is the policy of the AMA that: (1) the maximum number of state and specialty society delegates in the AMA House of Delegates be limited to a total of 500, with a maximum of 400 delegate positions for state associations and a maximum of 100 for specialty societies.

(2) the system of awarding delegates, described in Section 2.12 of the AMA Bylaws, to special sections, the U.S. military services, the U.S. Public Health Service, and the Veterans Administration continue and that the number of such delegates be in addition to the limit of 500 delegates for state and specialty societies.

(3) the system, described in Section 2.112 of the AMA Bylaws, of awarding extra delegates to state associations for meeting AMA membership levels continue and the number of such delegates be in addition to the limit of 500 delegates for state and specialty societies.

(4) upon election of the Speaker or Vice Speaker, the state or specialty society of which that officer is a delegate shall be given an additional delegate for the term of that office. The two additional delegate positions created by this change shall be in addition to the limit of 500 delegates for state and specialty societies.

(5) the system of awarding delegates to state associations, as described in Section 2.11 of the AMA Bylaws, continue until a total of 400 state association delegates is reached. When the number of state association delegates reaches 400, the pool of 400 state delegate positions be apportioned on an annual basis to state medical associations such that the percentage of the pool that is awarded to a state association is approximately equal to the percentage of total AMA members within the jurisdiction of that state association, with each state medical association being ensured of at least one delegate position by virtue of being a constituent society.

(6) all specialty societies that wish to apply for representation in the AMA House of Delegates must first apply for membership in the Specialty and Service Society (SSS) and must participate in the SSS for a three-year period before applying for representation in the AMA House. In deciding whether or not to accept a specialty society that applies for membership in SSS, the Specialty and Service Society be guided by the following criteria: (a) the organization must not be in conflict with the Constitution and Bylaws of the AMA by discriminating in membership on the basis of race, religion, national origin, sex, or handicap; (b) the organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges and are eligible to hold office; (c) the organization must be active within its field of medicine and hold at least one meeting of its members per year; (d) the organization must be national in scope; it must not restrict its members geographically and must have members from a majority of the states; (e) the organization must submit a resolution or other official statement to

show that the request is approved by the governing body of the organization; and (f) if international, the organization must have a U.S. branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

(7) after a specialty society has participated in SSS for a three-year period, the society may apply for representation in the AMA House of Delegates by requesting the SSS to report to the House of Delegates, through the AMA Board of Trustees, on the eligibility of the society for representation in the AMA House of Delegates. In making its report, SSS will state explicitly whether or not the society in question meets the criteria established in AMA Policy 545.984 and will recommend whether or not the specialty society should be represented in the House.

(8) the SSS, in conjunction with the AMA Council on Long Range Planning and Development, will submit a plan for the sharing of delegate seats by the specialty societies represented in the House of Delegates. If the plan is approved by the House, the system through which specialty societies share delegate seats shall be described in the AMA Bylaws.

(9) Section 8.40 of the AMA Bylaws be changed in the following manner. Each specialty organization represented in the House of Delegates must continue to reconfirm its qualifications for representation every five years, but the entity that conducts the review be the SSS. If a specialty society does not meet the criteria after the one-year grace period established by Section 8.44 of the Bylaws, that society be removed from representation in the AMA House but continue as a member of SSS. A specialty society which has been removed from the House for noncompliance with the criteria found in AMA Policy 545.984 but believes that it has subsequently come into compliance with those criteria, may apply to SSS for reinstatement in the AMA House without having to participate in the SSS for an additional three-year period. In its report to the House, SSS will state whether or not the society in question complies with all of the criteria established in Policy 545.984 and will recommend to the AMA House whether or not to reinstate the society in the AMA House.

(10) the Specialty and Service Society develop a membership, organizational, and operational plan as quickly as possible and, when that plan has been approved by the AMA Board, the SSS and its new responsibilities be recognized in the AMA Bylaws.

(11) the AMA Bylaws be changed such that any specialty society that is a member of the AMA House of Delegates but is unrepresented at three consecutive meetings of the House or unrepresented at three of any five consecutive meetings of the House be removed from the House but continue as a member of the Specialty and Service Society. After three additional years of participation in SSS, such an organization may request that SSS evaluate its qualifications for representation in the AMA House of Delegates and report its findings and recommendation to the House.

(12) the AMA Bylaws be changed to be consistent with the recommendations made in this report. (Amended CLRPD Rep. B, A-93)

545.967 **Ancillary Meetings and Conference at the Time of Meetings of the House of Delegates:** It is the policy of the AMA that the Speakers be notified prior to any planning for ancillary meetings and conferences to be scheduled in conjunction with the Annual or Interim Meetings of the House of Delegates in sufficient time to assess the impact of the timing and purpose on the deliberations of the House of Delegates. Prior approval of the Speaker and Vice Speaker is required before any meeting other than regular meetings of AMA Councils, Committees, Sections, and other groups that are part of the formal structure of the AMA can be scheduled in conjunction with Meetings of the House of Delegates. (Rep. on Rules and Credentials, A-93)

550.000 AMA: House of Delegates - Sections

550.991 Hospital Medical Staff Section: The AMA encourages all U.S. hospitals to support representation of their medical staffs in the AMA Hospital Medical Staff Section meetings. (Res. 831, A-93)

555.000 AMA: Membership and Dues

555.971 Physician Outreach Program Improvement: The AMA will provide to members of the House of Delegates, when registering for the Physician Outreach Program, the option on the sign-up form of receiving non-member information on a disk compatible with their word processing software. (Res. 601, A-93)

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EXHIBIT E

American Medical Association

Physicians dedicated to the health of America

Policy Compendium

1993 Edition

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American Medical Association

Physicians dedicated to the health of America

Policy Compendium

Current policies of the American Medical Association (AMA)
House of Delegates through the 1992 Interim Meeting

AMA Council on Long Range Planning and Development
in cooperation with the Group on Health Policy Management

Foreword

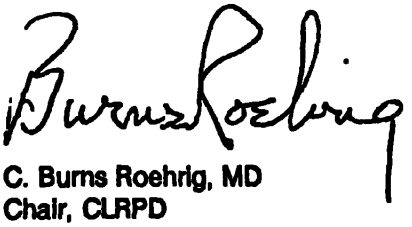
This edition of the *AMA Policy Compendium* presents the policy positions of the American Medical Association (AMA) as of the close of business at the 1992 Interim Meeting of the House of Delegates. Please note that the descriptions of policies adopted at the 1992 Interim Meeting are unofficial until the House votes to approve the transcript of that meeting, as contained in the *AMA House of Delegates Proceedings*, at the 1993 Annual Meeting.

As with previous editions, this volume is arranged by major subject headings. Under each subject heading, the most recent policies have lower policy numbers and are, therefore, listed first. This approach is used so readers can quickly identify the most current statement of AMA policy on a given topic. At the end of each policy statement is a citation to the original report or resolution that established the policy position. In those rare instances in which there appear to be inconsistencies between two or more policies on the same topic, the most recent statement of policy should be deemed to supersede the contradictory earlier policy.

In using the *Compendium*, please keep in mind that it contains only permanent policies adopted by the AMA House of Delegates. It does not contain items that were referred, filed or not adopted; policy calling for a change in the *AMA Constitution and Bylaws*; temporary policy or directives (e.g., that a specific, immediate action be taken or that a study be undertaken); reports that merely summarize policy implementation activities; legislative and regulatory statements or testimony; and appointments, awards, or commendations. Readers are encouraged to consult, as appropriate, the *AMA Constitution and Bylaws*; the *Current Opinions of the AMA Council on Ethical and Judicial Affairs*; and the *AMA House of Delegates Proceedings*.

None of the policies contained in the *Compendium* is intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all of the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. The policies on scientific issues reflect the views of the scientific literature as of the date of the adoption of the report by the House of Delegates.

A number of individuals contributed to the development of this edition of the *Compendium*. Although they cannot all be recognized here, the following people deserve special thanks and appreciation for their contributions: the members of the AMA Council on Long Range Planning (CLRPD); John A. Krichbaum, JD, Vice President of the AMA Group on Health Policy Management; John C. Gaffney, PhD, Director of the AMA Division of Strategic Policy Planning; John E. Kasper, CAE, Director of the AMA Department of Long Range Policy Analysis; Carol-Lynn Zurek, Council Coordinator, AMA Department of Long Range Policy Analysis; George Kruto, Indexer, AMA Department of Scientific and Socioeconomic Indexing; and Thomas M. Gorey, JD, President of Policy Planning Associates.



C. Burns Roehrig, MD
Chair, CLRPD

Kim A. Bateman, MD
Vice Chair, CLRPD

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after experiencing the possible subjective benefits. (CSA Rep. G, I-81; Reaffirmed CLRPD Rep. F, I-91)

525.998 Women in Organized Medicine: (1) The AMA reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession. (2) The AMA supports the concept of increased tax benefits for working parents. (3) The AMA (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) The AMA reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs. (BOT Rep. T, A-81; Reaffirmed CLRPD Rep. F, I-91)

525.999 Women Physicians in Organized Medicine: The AMA supports the following actions to increase the participation by women physicians in organized medicine: (1) The AMA supports undertaking a membership effort aimed at encouraging women physicians to join organized medicine at all levels. This campaign should promote AMA membership benefits and AMA activities that respond to the particular needs of women physicians. (2) The AMA supports working with the American Medical Women's Association in a coordinated effort to encourage membership and participation in both organizations. (3) The AMA supports utilizing its publications to attempt to dispel the stereotypes and misconceptions about women physicians, and to publicize women physicians' contributions to medicine across a wide variety of professional activities, in order to establish a more realistic "role model" for women physicians. (4) The AMA encourages state, county and specialty societies to make special efforts to recruit women physicians to membership in organized medicine. (5) The AMA encourages state, county and specialty societies to appoint and nominate women physicians to committees, officerships, delegate seats, etc., and does this with the attitude of recognizing and tapping their professional capabilities rather than simply of having a "proportionate" number of women physician participants. (CLRPD Rep. A, A-79; Reaffirmed CLRPD Rep. B, I-89)

530.000 AMA: Administration and Organization (See also: AMA: Board of Trustees; AMA: Councils and Committees; AMA: House of Delegates; AMA: House of Delegates — Sections; AMA: Membership and Dues; AMA: Officers — Nomination, Election and Tenure; AMA: Political Action)

530.973 AMA Proactive Newsletter for Patients: The AMA will integrate the communication of positive achievements of American medicine into its consumer magazine and newsletter projects. (BOT Rep. VV, I-92)

530.974 Enhancing Leadership Opportunities in the AMA: (1) For those first appointed or first elected to AMA Councils after the 1992 Annual Meeting, their term of office will be three years, with members being allowed to serve for no more than two terms with two exceptions: the Council on Ethical and Judicial Affairs with one seven-year term and the Council on Legislation with annual appointments with a maximum of six terms. (Current exceptions in the Bylaws for filling unexpired terms would remain in force.) (2) No change will be made in the current processes for election and appointment of Councils. (3) The current provisions for terms of service and tenure for members of the Board of Trustees will remain unchanged. (4) House of Delegates reference committees and convention committees will be expanded to seven members and alternate delegates will be eligible for service on these committees. (A two-year sunset mechanism shall apply to this provision.) (5) The AMA will actively encourage state medical associations and national medical specialty societies to review the composition of their AMA delegations. As one means of encouraging greater awareness and responsiveness to the need to enhance diversity, the AMA will prepare and distribute annually a state-by-state demographic analysis of the House of Delegates, with

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comparisons to the physician population and to the AMA physician membership. (6) The AMA will prepare and distribute on an annual basis a demographic analysis of the Councils and the Board of Trustees, with comparisons to the physician population overall and to the AMA physician membership, and will encourage 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. (7) As a means of broadening opportunities for service on House of Delegates' reference committees and convention committees, the Speakers are encouraged to avoid, whenever possible, the appointment of physicians who are currently serving on one of the AMA Councils. (8) The AMA will take the following as well as other appropriate steps to more actively encourage physician leadership development: (a) to continue efforts to provide enhanced leadership development programming at AMA National Leadership Conferences; (b) to utilize more ad hoc committees and task forces to address specific issues; and (c) to continue to encourage the growth of the current Special Sections, as a means of identifying and supporting the development of future leaders. (Amended CLRPD Rep. A, A-92; See also AMA Constitution and Bylaws)

530.975 Support for the AMA Auxiliary: The AMA (1) encourages medical associations and societies to support the membership efforts of the auxiliaries, particularly if dual membership billing is utilized; and (2) with the state and county associations, supports and acknowledges the efforts of the AMA Auxiliary and state and county medical auxiliaries, whenever it is deemed possible and appropriate. (Res. 608, A-92)

530.976 Gender-Neutral Language: The AMA recognizes and encourages the continuing contributions of women in medicine and is committed to eliminating all gender-related barriers. Therefore: (1) The AMA adopts a policy of gender-neutral language, to be incorporated into its bylaws, policies, procedures, and publications, during the normal process of printing and updating/reprinting documents. (2) The term "chairman" no longer is to be used to designate the head of a committee; the term "chair" or "chairperson" is to be used instead. (3) The AMA encourages state, county, and national medical specialty societies to review their bylaws and policies and eliminate gender-biased language where it exists. (BOT Rep. K, A-92)

530.977 Integrating the *Policy Compendium* into the AMA Policymaking Process: The implementation of the new AMA policymaking process (described in Policy 545.973) will be in two phases, the first phase requiring all AMA Board of Trustees and Council reports to comply with the new requirements at the 1992 Interim Meeting, and the second phase requiring compliance for resolutions submitted for the 1993 Annual Meeting. (CLRPD Rep. B, A-92)

530.978 Unified Voice for Physicians: The AMA (1) reaffirms its goal to be the unified voice of the medical profession speaking for all physicians and (2) will act as a catalyst to encourage and assist specialty societies to meet and discuss differences and to resolve problems, where possible, in a specialty society forum. (Res. 606, A-92)

530.979 Promotion of Conservation Practices Within the AMA: The AMA directs its offices to implement conservation-minded practices whenever feasible. (Res. 16, A-91)

530.980 Relocation of the National Leadership Conference: The AMA will continue to hold the National Leadership Conference in Sunbelt locations. (BOT Rep. F, A-91)

530.981 AMA Corporate Visits: It is the policy of the AMA to notify the corporate medical director whenever preparing to visit a corporation. (Amended Res. 27, A-91)

530.982 AMA Use of Recycled Paper: It is the policy of the AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including *American Medical News, The Journal of the American Medical Association* and materials used by the House of Delegates, and

that AMA printed material using recycled paper should be labeled as such. (Amended Res. 111, A-91)

530.983 American Medical News Disclaimer: The AMA adopts the following statement: "*American Medical News* will make editorial space available to the Chairman of the AMA Board or his/her designee. *American Medical News* will publish the following disclaimer in each issue: *American Medical News* is published weekly by the AMA and is intended to serve as an impartial forum for information affecting physicians and their practices. Treatment of articles, views and opinions expressed in *American Medical News* are not necessarily endorsed by the AMA." (BOT Rep. G, A-91)

530.984 Waste Reduction And Fiscal Responsibility: It is the policy of the AMA that the AMA, its Board of Trustees, councils and committees reduce wastage whenever possible through reduction or elimination of the distribution of expendable supplies, such as notebook binders and stationery, to members of the Board, councils and committees. (Res. 24, I-90)

530.985 Exclusion From Exclusionary Institutions: It is the policy of the AMA not to hold meetings or pay member, officer or employee dues in any club, restaurant or other institution that has exclusionary policies based on sex, race, color, religion, national origin, or sexual orientation. (Res. 101, I-90)

530.986 Discounted Registration Fees For AMA And Federation Seminars: It is the policy of the AMA to (1) adjust all of its registration fees to encourage and permit participation by resident physician and medical student members; and (2) urge all federation associations to discount their registration fees for seminars to accommodate their resident physician and medical student membership. (Res. 3, A-90)

530.987 Age Discrimination In Distributing Complimentary Copies Of Specialty Journals To Members: The AMA continues its policy of providing specialty journals for those who are in active practice and are otherwise eligible. (Sub. Res. 177, A-90)

530.988 Delineation Of Responsibilities: It is the policy of the AMA to (1) evaluate the roles of its elected officers and the Executive Vice President with regard to delineation of duties, functions, obligations and responsibilities; and (2) make available to the House of Delegates, on a yearly basis, the total compensation of its individual elected officers and the Executive Vice President; and (3) report back to the House of Delegates on these issues annually. (Sub. Res. 83, A-90)

530.989 AMA Communications With Scientific Content: The AMA House of Delegates directs the Board of Trustees to require that AMA communications and public promotional activities with scientific content be reviewed and approved for scientific accuracy and for consistency with AMA policy by appropriate AMA officers, councils and/or committees, staff, or designees who have appropriate scientific knowledge and experience. (Res. 294, A-90)

530.990 Funding for the AMA Physicians' Assistance Program: The AMA supports continuing to adequately fund and maintain an impaired physicians program (Physicians' Assistance Program) whose charge will include, but not be limited to, promoting state medical society impaired physician programs and medical student impairment programs, providing technical assistance to these programs, conducting scientific and socioeconomic research and hosting an annual conference to share research and exchange ideas on the field of physician impairment. (Res. 102, I-89)

530.991 Policy Promotion Grants for Students: (1) The AMA supports establishment of a program of modest grants to medical student groups to support projects and activities designed specifically to further AMA policy. (2) Such program should be operated with maximum flexibility to encourage the development, funding, and execution of state medical society endorsed student projects to promote AMA policy. (3) Grant amounts should not exceed $250 per project and each school should be limited to one grant project at a time, with total annual grant amounts not to exceed $250 multiplied by the number of schools at which attendance qualifies a student for membership in the AMA. (Res. 120, I-88)

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530.992 AMA Division of Health Education: The AMA opposes combining all of the Association's public health, health education, and health promotion activities into a single AMA Division of Health Education. (BOT Rep. S, A-88)

530.993 Hotels Used by Medical Associations: The AMA (1) supports choosing hotels for its meetings, conferences and conventions based on size, service, location, cost, and similar factors; (2) supports considering a hotel's smoking policy (or lack thereof) as a criterion for selecting hotels for meetings, conferences and conventions; and (3) encourages national medical specialty societies, state and county medical societies, and other health organizations to adopt a similar policy. (Res. 2, I-87)

530.994 AMA Physician Masterfile Coding: The AMA supports (1) continued inclusion of information on self-designated practice specialties (SDPS), as well as board certification and residency training history, in the AMA Physician Masterfile; (2) continued use of the complete term "self-designated practice specialties" when referring to Masterfile codes; and (3) continuation of an awareness campaign regarding the intended use of Masterfile SDPS codes. (BOT Rep. U, I-86)

530.995 AMA Drug Evaluations: The AMA supports processing applications for complimentary copies of AMA *Drug Evaluations* for medical students during the early spring of the freshman medical school year. (Res. 84, I-83)

530.996 AMA Public Relations: The AMA supports continued analysis of its public relations program in a way that will foster expanded coordination with state and county medical societies. (Res. 28, I-80; Reaffirmed, CLRPD Rep. B, I-90)

530.997 AMA Organizational Structure: The AMA endorses the concept that the Association should strive to become the umbrella organization for physicians' associations. (CLRPD Rep. B, A-79; Reaffirmed CLRPD Rep. B, I-89)

530.998 AMA Organizational Structure: The AMA shall function with as few standing councils as possible and use committees with specific goals and limited time horizons to address specific issues whenever possible. (CLRPD Rep B, Rec. 14, I-75; Reaffirmed CLRPD Rep. C, A-89)

530.999 Office of Executive Vice President: The office of the Executive Vice President shall be filled, if possible, by a Doctor of Medicine who is an active member of the AMA at the time of his appointment and who possesses the necessary managerial qualifications. (Res. 40, I-68; Reaffirmed CLRPD Rep. C, A-88)

535.000 AMA: Board of Trustees (See also: AMA: Administration and Organization; AMA: Councils and Committees; AMA: House of Delegates; AMA: House of Delegates — Sections; AMA: Membership and Dues; AMA: Officers — Nomination, Election and Tenure; AMA: Political Action)

535.994 House Of Delegates' Policy: Whenever the Board of Trustees does not implement policy as instructed by the House, the AMA House of Delegates directs that the Board indicate in the Resolution Status Report the reasons why House policy was not followed. (Res. 125, A-90)

535.995 AMA Policy Actions: The Board of Trustees shall conduct the affairs of the Association in keeping with current policy actions adopted by the House of Delegates. The most recent policy actions shall be deemed to supersede contradictory past actions. In the absence of specifically applicable current statements of policy, the Board of Trustees shall determine what it considers to be the position of the House of Delegates based upon the tenor of past and current actions that may be related in subject matter. Such determinations shall be considered to be AMA policy until modified or rescinded at the next regular or special meeting of the House of Delegates. (BOT Rep. FF, A-79; Reaffirmed CLRPD Rep. B, I-89)

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535.996 Authority to Settle Litigation: The Board of Trustees has the duty and responsibility to initiate, defend, settle or in any way terminate litigation in accordance with its best and prudent judgment. (BOT Rep. JJ, I-78; Reaffirmed CLRPD Rep. C, A-89)

535.997 Rules Governing the Conduct of Meetings of the Board of Trustees: The Board of Trustees will distribute to each delegate, alternate delegate and constituent state association, as soon as practical after each meeting of the Board, an appropriate summary report of the actions taken at that meeting to include Board members in attendance. (Sub. Res. 52, A-74; Reaffirmed CLRPD Rep. C, A-89)

535.998 Communication: The AMA reaffirms its policy that meetings of the Board be open to members of the AMA by prior arrangement, under reasonable circumstances and minutes of the Board be available for inspection. (Sub. Res. 35, I-72; Reaffirmed CLRPD Rep. C, A-89)

535.999 Congressional Testimony: The AMA House of Delegates hereby specifically authorizes the Board of Trustees and the persons designated by it to appear as witnesses before committees of Congress or to appear before other groups where the policy of the AMA is to be stated, and to do so with full authority to speak for and state the policy of the AMA. (1950 Clinical Session; Reaffirmed CLRPD Rep. B, A-87)

540.000 AMA: Councils and Committees (See also: AMA: Administration and Organization; AMA: Board of Trustees; AMA: House of Delegates; AMA: House of Delegates — Sections; AMA: Membership and Dues; AMA: Officers — Nomination, Election and Tenure; AMA: Political Action)

540.989 Advisory Committee on Minorities: The AMA will establish an Advisory Committee on Minorities, patterned after the AMA's current advisory committees and panels, to assist with AMA efforts regarding minorities. (Res. 604, A-92)

540.990 Clarification of House Procedures with Respect to the Opinions and Reports of CEJA: (1) CEJA will inform the House of Delegates of an ethical Opinion adopted by the Council by presenting the Opinion to the House. The Council: (a) will identify the Opinion as informational; (b) may provide a description or discussion of the underlying facts and circumstances leading to the adoption of the ethical Opinion, and also an explanation of the Opinion and the reasons for its adoption by the Council. This explanatory material is neither the opinion of the Council nor policy of the Association; (c) will identify one or more Principles of Medical Ethics that form the basis for issuing the ethical Opinion; and (d) will provide the text of the ethical Opinion.

(2) Opinions of CEJA will be placed on the consent calendar for informational reports, but may be withdrawn from the consent calendar on motion of any member of the House of Delegates and referred to a Reference Committee. (a) The members of the House may discuss an ethical Opinion fully in Reference Committee and on the floor of the House. (b) After concluding its discussion, the House shall file the Opinion. (c) The House may adopt a resolution requesting CEJA to reconsider or withdraw the Opinion. CEJA shall respond to such a request in due course, after reconsidering the issues presented. The Opinion of CEJA that responds to such a request will be considered as informational, and therefore shall be filed.

(3) Reports of CEJA which respond to requests from the House or which make recommendations to the House may be adopted, not adopted, or referred, as may be appropriate. A Report may not be amended, except for amendments that clarify the meaning of the Report and only with the concurrence of the Council.

(4) At each meeting of the House, CEJA will endeavor to inform the House of the issues that it plans to consider in the subsequent months. Members of the House will be able to submit statements of their perspectives to the Council for its consideration. (C&B/CEJA Joint Rep., I-91)

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540.991 Nominees for Council Positions: It is the policy of the AMA to continue to make every effort to nominate two or more eligible members for each Council vacancy as required by Sections 6.1021, 6.2021, 6.3021, and 6.8021 of the AMA Bylaws. (CCB Rep. B, I-91)

540.992 Resident Physician Representation On Advisory Committee For International Medical Graduates: It is the policy of the AMA that a representative of the AMA Resident Physician Section attend all meetings of the AMA Advisory Committee on International Medical Graduates and that this representative participate in all discussions and deliberations of the Committee. (Sub. Res. 18, I-90)

540.993 House Actions on Judicial Council Reports: On recommendation of the Convention Committee on Rules and Order of Business, the AMA adopted the following rule pertaining to House action on Judicial Council Reports: For opinions of the Judicial Council reported to the House and designated as information, the House may file or refer the report. A motion to adopt the report is out of order. (A-85)

540.994 Reports of the AMA CSA: (1) CSA reports that do not have policy implications should be distributed to the membership as soon as is practical after approval by the Council. (2) CSA reports that call for policy decisions should continue to move through the House by the usual process. (3) CSA should utilize representatives of appropriate specialty societies in developing reports of a scientific nature. (Res. 65, I-84)

540.995 Council and Committee Costs: The AMA supports the Board of Trustees' provision of information on the costs related to each council and committee as part of its routine annual financial reporting to the House, so as to permit a continuing cost/benefit appraisal of their role in the organization. (Res. 57, A-81; Reaffirmed CLRPD Rep. F, I-91)

540.996 Medical School Accreditation: The AMA delegates to the CME the authority to approve, on behalf of the AMA, policies of the LCME, including the approval of Essentials for the accreditation of medical schools. (CME Rep. I, I-77; Reaffirmed CLRPD Rep. C, A-89)

540.997 Joint Council for Accreditation: (1) The name of the CME's Advisory Committee on Allied Health Education is changed to the Committee on Allied Health Education and Accreditation. (2) Two public representatives and two members of the CME shall be added to the Committee. (3) The responsibility to accredit allied health educational programs is delegated to the Committee, and accreditation shall continue to be by the AMA in collaboration with the various medical specialty and allied health organizations now involved in the process. (4) The AMA's responsibility to adopt Essentials for educational programs in allied health fields is delegated to the CME with the understanding that before adopting any Essentials the Council shall secure the comments and advice of appropriate Section Councils, medical specialty societies and collaborating allied health organizations. (CME Rep. B, I-76; Reaffirmed CLRPD Rep. C, A-89)

540.998 Improved Communications with Medical Students: The Association supports intensified efforts of the CME and other bodies within the AMA to initiate meetings and encourage continuing dialogue with medical students, interns and residents in their respective states. (Sub. Res. 22, I-69; Reaffirmed CLRPD Rep. C, A-89)

540.999 COL Activities: (1) All medical legislative issues should be cleared through the COL before action is taken by any other AMA council or committee, and the Board shall take whatever action is appropriate to attempt to achieve this objective; (2) The Council shall continue to refer issues to other committees and councils for advise and recommendation, when said issues properly fall within their sphere of knowledge and activities; (3) The Board shall be advised of the Council's desire to maintain constant surveillance of legislative matters; (4) The Council shall have authority to recommend to the Board the initiation of specific legislation or legislative policy to meet current problems confronting physicians or the AMA; and (5) The Board shall be advised of the Council's willingness and ability to testify before congressional committees or to accompany the principal witnesses who may testify on behalf of the Association. (COL/BOT Rec., I-63; Reaffirmed CLRPD Rep. C, A-88)

545.000 AMA: House of Delegates (See also: AMA: Administration and Organization; AMA: Board of Trustees; AMA: Councils and Committees; AMA: House of Delegates — Sections; AMA: Membership and Dues; AMA: Officers — Nomination, Election and Tenure; AMA: Political Action)

545.968 Unified Meeting: The concept of a Unified Meeting, which combines the Interim Meeting and the National Leadership Conference, is approved with the current scheduling of the Section meetings and the House of Delegates left intact. The schedule for the unified meeting will be structured with input from the Sections, Councils, Board of Trustees and Speakers, with the first unified meeting to be held in December 1994 and in late November or early December thereafter. (BOT Rep. LL, I-92)

545.969 Report of the Convention Committee on Rules and Order of Business: (1) House Security — Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly badged will be permitted to attend. (2) Credentials — The registration record of the Convention Committee on Credentials shall constitute the official roll call at each meeting of the House. (3) Order of Business — The order of business as published in the Handbook shall be the official order of business for all sessions of the House of Delegates. This may be varied by the Speaker if, in his judgment, it will expedite the business of the House, subject to any objections sustained by the House. (4) Privilege of the Floor — The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chairman of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House. (5) Limitation on Debate — There shall be a three minute limitation on debate per presentation subject to the discretion of the Speaker, who may waive the rule for just cause. (Con. Comm. on Rules and Order of Business, I-91)

545.970 AMA Representation: It is the policy of the AMA that, when appropriate, AMA public statements note that AMA policy is formulated by the House of Delegates whose members represent approximately 90 percent of American physicians, even though only 42 percent of eligible physicians are currently dues-paying members. (Sub. Res. 605, I-91)

545.971 Fiscal Note Requirements: It is the policy of the AMA that all Board of Trustees and Council reports to the House of Delegates with recommendation for action include a fiscal note and a designation whether or not this is within the current budget. (Amended Res. 601, I-91)

545.972 Reconsideration of Referred Reports: The practice of submitting status reports for House action on referred resolutions is discontinued; this information will be included in the chart entitled "Implementation of Resolutions." (BOT Rep. D, I-91)

545.973 Integration of the Policy Compendium into the AMA Policymaking Process: (1) Effective at the 1992 Annual Meeting, all references to existing AMA policy in resolutions, Board reports, council reports, and reference committee reports must cite the *Policy Compendium* in lieu of, or in addition to, the report or resolution title. (2) The AMA endorses the development of a revised House of Delegates' policymaking process consisting of the following features: (a) Proponents of new or modified policy (i.e., the sponsors of resolutions and the authors of reports) be required to cite pertinent, existing policy as set out in the *Compendium* and to indicate whether the policy proposed in their resolution or report would result in a modification of existing policy or in an addition of new policy to the AMA policy base. (b) If a modification of existing policy is being proposed, the sponsor be required to set out the pertinent text of the existing policy and clearly identify the proposed modification; for example, by underlining proposed new text and lining through any text proposed for deletion. (c) If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the *Policy Compendium* should be identified and recommended for rescission. (3) The proposed new House of Delegates' policymaking procedure described above be implemented no later than the 1992 Interim Meeting. (CLRPD Rep. E, I-91)

545.974 Reaffirmation Consent Calendar: (1) Resolutions will be placed on the Reaffirmation Consent Calendar only if they are identical or substantially identical to existing AMA policy. (2) For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the *Policy Compendium* identification number. (3) For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing AMA policy will be reaffirmed in lieu of the submitted resolution. (4) The ten-year sunset "clock" for such reaffirmed policies will continue to run from the original date of their adoption. (CLRPD Rep. C, I-91)

545.975 Identification Badges: It is the policy of the AMA to (1) develop mechanisms to facilitate the display of state and candidate emblems on identification badges and maintain the identification function of the badges; and (2) to reinstitute specialty designation on identification badges. (Sub. Res. 57, I-90)

545.976 House Of Delegates Procedures: The following recommendations of the Convention Committee on Rules and Order of Business have been adopted by the House of Delegates: (1) that the House of Delegates establish the rule that reports of the Board of Trustees and Councils be written with the recommendations, conclusions and policy statements at the end of the report for debate and action as policy and that the supporting text of reports be filed effective at the 1991 Annual Meeting; and (2) that the House of Delegates establish the rule that reports to be considered as items of business exceeding seven pages be preceded with a one page or less Executive Summary. (I-90)

545.977 Interim Meeting Location: The AMA supports scheduling more meetings in Washington, D.C., specifically including Interim Meetings of the House on a rotating schedule as frequently as practicable. The AMA believes, however, that it would not be financially prudent to hold all Interim Meetings in Washington, D.C., nor would such a decision be equitable for other regions of the country. (BOT Rep. I, I-90)

545.978 Action on AMA Policy: A negative vote by the House of Delegates on resolutions which restate AMA policy should not change the existing policy. AMA policy can only be changed by means of a positive action of the House specifically intended to change that policy. (Res. 45, I-89)

545.979 Expediting the Business of the House of Delegates: The Speaker of the AMA House of Delegates shall investigate, and implement as appropriate, means to expedite the business of the House, including consideration of a "Reaffirmation Consent Calendar" which would allow the Speaker to identify resolutions felt to be reaffirmations of current AMA policy and to allow the House to deal with these resolutions in a consent calendar manner. (Sub. Res. 52, I-89)

545.980 Unification Delegate Census: The AMA believes that any state which unifies membership with the AMA and suffers the loss of membership should have no decrease in its allocation of delegates for two years from its pre-unification number because of said loss of membership, and the unification incentive of two additional delegates should also apply. (Res. 52, A-89)

545.981 Implementing the AMA Policy Sunset Mechanism: In the implementation and ongoing operation of the AMA policy sunset mechanism, the following procedures shall be followed: (1) initial review of the policies by the CLRPD; (2) subsequent review and input by the other AMA councils, with a particular focus on policies within their specific areas of expertise; (3) development of a report compiling the councils' recommendations, for transmittal to the Board and House; (4) assignment of the report to a single reference committee for consideration; and (5) use of a consent calendar format by the House in considering the policies encompassed within the report. (CLRPD Rep. A, A-89)

545.982 AMA Policymaking Process: (1) Proposed statements of AMA policy in reports and resolutions should be clearly identified as policy recommendations at the end of reports and resolutions.

(2) Where a resolution or report, including a reference committee report, contains a recommendation that present AMA policy be reaffirmed, there should be a clear restatement of the existing policy.

(3) Where the House intends to supersede an earlier policy with a new policy, there should be a statement to that effect and a reference to the superseded policy.

(4) Where the recommendation in a report or resolution is in the nature of a directive, there should be a clear statement of the existing or proposed policy underlying the directive.

(5) Policy statements in reports and resolutions should be written as broad guiding principles that set forth the general philosophy of the Association on specific issues of concern to the medical profession.

(6) The House of Delegates, in acting on reports and resolutions, should state clearly when it intends to adopt a statement of policy, through "adoption" of the policy statement. (CLRPD Rep. B, A-88)

545.983 Characteristics of AMA Delegates: The AMA (1) encourages medical societies to develop methods for selecting AMA delegates that provide an exclusive role for AMA members; and (2) encourages AMA delegates and alternates who may be entitled to a dues exemption, because of age and retirement status, to demonstrate their full commitment to the AMA through payment of dues. (CLRPD Rep. C, A-87)

545.984 Representation of Specialty Organizations in the House of Delegates: The following guidelines shall be utilized in evaluating specialty society applications for representation in the AMA House of Delegates (new specialty organization applications will be considered only at Annual Meetings of the House of Delegates): (1) The organization must not be in conflict with the Constitution and Bylaws of the AMA by discriminating in membership on the basis of race, religion, national origin, sex or handicap. (2) An organization that is not represented in the House of Delegates but which is seeking representation must demonstrate (a) that it represents a field of medicine which has recognized scientific validity or that it serves physicians in some capacity related to their professional activities and (b) that it has a unique expertise, perspective, or capability that is not already represented in the House of Delegates. (3) The organization must meet one of the following criteria: (a) a specialty organization with a total of 500 or more physician members must demonstrate either that a majority of its physician members who are eligible for AMA membership are members of the AMA or that it has 1,000 or more AMA members; (b) a specialty organization with a total of fewer than 500 physician members must demonstrate either that it has a minimum of 250 AMA members or that it was represented in the House of Delegates at the 1990 Annual Meeting and that a majority of its physician members who are eligible for AMA membership are members of the AMA. (4) The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application. (5) Physicians should comprise the majority of the voting membership of the organization. (6) The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges and are eligible to hold office. (7) The organization must be active within its field of medicine and hold at least one meeting of its members per year. (8) The organization must be national in scope. It must not restrict its members geographically and must have members from a majority of the states. (9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization. (10) If international, the organization must have a U.S. branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines. (CLRPD Rep. A, A-87; Amended CLRPD Rep. D, I-90; Amended CLRPD Rep. B, I-91)

545.985 Implementation of House Actions: The AMA House of Delegates shall be apprised of the status of resolutions and what actions have been taken. When situations preclude successful implementation of specific resolutions, the House and authors should be advised of such situations so that further or alternative actions can be taken if warranted. (Res. 52, I-86)

545.986 Support for the Forum for Medical Affairs: The AMA affirms its wholehearted support of the Forum for Medical Affairs and urges that the various delegates within the House persuade their parent organizations to participate in the support of the Forum for Medical Affairs. (Res. 25, I-86)

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545.987 **Sunset Mechanism for AMA Policy:** The AMA established a sunset mechanism with a ten-year time horizon for AMA policy. A policy will remain viable for ten years unless action is taken by the House of Delegates to reestablish it. (BOT Rep. PP, I-84)

545.988 **Last Minute Resolutions:** The AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House, to include fiscal notes when appropriate, and to research existing AMA policy prior to submitting resolutions. (Sub. Res. 120, A-84)

545.989 **Recognition of Members Departing the House:** (1) Member states or sections announcing departure of their delegates or alternates should notify the AMA in sufficient time to have their names collated alphabetically by state and published for the House of Delegates Meeting. (2) Such recognition should be made during the opening session. (Res. 42, A-84)

545.990 **Honors and Recognition:** The AMA supports the following procedures: (1) that the Speaker of the House of Delegates establish a Registry of Recognition for delegates; (2) that the various delegations to the AMA present names and qualifying information for inclusion in the Registry; (3) that when the time of recognition occurs during a session of the House, the Speaker refer to the Registry; and (4) that at the time of recognition, the Speaker read only the name of each physician, and the individual delegates can review at their leisure the qualifications for the recognition. (Res. 132, A-84)

545.991 **AMA House of Delegates Procedures:** The AMA supports efforts to ensure that accurate, comprehensive, current information on the contents of legislative proposals is available to the House of Delegates. (Sub. Res. 44, I-83)

545.992 **Availability of AMA Counsel Opinion During Sessions of the AMA House of Delegates:** The AMA believes that legal counsel opinion should be immediately available to all reference committee deliberations by appropriate mechanisms. (Sub. Res. 18, A-83)

545.993 **Representation in the AMA House of Delegates:** (1) The AMA believes that it is necessary to strengthen the Association's position as the universal organization seeking to represent all of medicine, with policies developed in a forum that provides for the broadest representation of views. (2) The AMA urges all states that gain additional seats in the House on the basis of increased student and/or resident members in their societies to select students and/or residents to assume some of those seats. (BOT Rep. R, I-82; Reaffirmed: CLRPD Rep. A, I-92)

545.994 **Annual and Interim Meetings - Modification of Format and Procedure of the House of Delegates:** (1) The Speaker and Vice Speaker of the House of Delegates are encouraged to refer items of business among the Reference Committees as evenly as possible. (2) The House should formally examine its format and procedures every five years. (3) The House reaffirms its position as the primary policymaking body for the American medical profession and urges its members to recognize a responsibility to represent the AMA throughout the year. (Spec. Advis. Comm. Rep., I-82; Reaffirmed: CLRPD Rep. A, I-92)

545.995 **Listing of Specialty Society Candidates and Office Holders:** The AMA believes that: (1) specialty society candidates for AMA House of Delegates elected offices should be listed in the pre-election materials sent to the House and on the ballot as the representative of that society and not by the state in which the candidate resides; (2) elected specialty society members should be identified in that capacity while serving their term of office; and (3) nothing in the above recommendations should preclude formal co-endorsement by any state delegation of the national specialty society candidate, if that state delegation should so choose. (Res. 22, I-81; A-82; Reaffirmed CLRPD Rep. F, I-91)

545.996 **Impact of Legal Advice on AMA Policymaking Decisions:** The following procedure for providing legal advice on issues before the House shall be followed: (1) All resolutions received at AMA Headquarters will be reviewed by the Office of the General Counsel and the Office of the Executive Vice President. When a resolution poses serious legal problems, the Office of the Executive Vice President will communicate with the sponsor or medical association. (2) If the text of the proposed

resolution that poses serious legal problems is not changed or if the resolution is not withdrawn, the Chairman or another member of the Board will be available to speak to the legal objections in open or executive sessions of the reference committee or before the House of Delegates. (3) In the case of late resolutions that pose serious legal problems, the Chairman or another member of the Board will inform the House of Delegates of the legal objections prior to a vote to accept or reject the resolution. (4) In accordance with the current procedures, any reference committee may request the Executive Vice President to provide additional legal advice and other information during the committee's executive session. (5) Delegates may also seek legal advice on an individual basis from the Office of the General Counsel. (BOT Rep. Q, A-80; Reaffirmed Rep. B, I-90)

545.997 AMA Vote Count Reporting: The final vote count of all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the House. (Sub. Res. 3, I-74; Reaffirmed CLRPD Rep. C, A-89)

545.998 Attachment of Fiscal Note to Resolutions: The AMA recommends that (1) all reports to the House from the Board, Councils and Committees, and all resolutions introduced in the House include a fiscal note; (2) such fiscal note set forth the estimated cost of such policy, program or action proposed; and (3) no report or resolution requiring finances be considered without attachment of such fiscal note. (Sub. Res. 37, I-72; Reaffirmed CLRPD Rep. C, A-89)

545.999 Implementation of Adopted and Referred Resolutions: The AMA calls for (1) an account to be made to the House of Delegates of the results of every resolution which is adopted or referred not less than two months prior to the next Annual Convention; (2) the delegation which introduced a resolution which is referred to a council or other body to be informed and afforded an opportunity to send a representative to the meeting at which that resolution will be considered; (3) notification to the author of a resolution which is adopted or referred for action if the intent of the resolution cannot be achieved prior to the next Annual Convention; (4) a determination that a resolution which is adopted remains the standing policy of the Association until modified or rescinded by the House; and (5) no expense to the AMA be incurred by the sponsors invited to discuss a resolution. (Res. 111, A-72, CLRPD Rep, I-72; Reaffirmed CLRPD Rep. C, A-89)

550.000 AMA: House of Delegates — Sections (See also: AMA: Administration and Organization; AMA: Board of Trustees; AMA: Councils and Committees; AMA: House of Delegates; AMA: Membership and Dues; AMA: Officers — Nomination, Election and Tenure; AMA: Political Action)

550.992 Election Campaigns: It is the policy of the AMA that: (1) <u>There should be no formal campaign activities during the Interim Meeting.</u> This would not preclude distribution of a declaration of candidacy on the last day of the Annual Meeting or one announcement of candidacy by a mailing prior to the Interim Meeting. This rule would prohibit the campaign parties at the Interim Meeting and the distribution of campaign literature and gifts at the Interim Meeting.

(2) <u>There will be only one big party at the Annual Meeting financed by a coalition or a state or specialty delegation irrespective of the number of candidates from the society or coalition.</u> This would limit a candidate to only one big party at the Annual Meeting whether financed by a coalition or a state or specialty delegation. This would also limit a state or specialty society or coalition to one big party irrespective of the number of candidates from that society or coalition.

(3) <u>Displays of campaign posters, signs, and literature in public areas of the hotel in which Annual Meetings are held are prohibited.</u> Displays of campaign posters, signs, and literature in public areas of hotels in which Annual Meetings are held detract from the dignity of the position being sought and are unsightly. Campaign posters may be displayed at the campaign parties and campaign literature may be distributed in the non-official business folder for members of the House of Delegates.

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(4) A reduction in the volume of telephone calls from candidates, literature and letters by or on behalf of candidates should be encouraged. The Election Manual was initiated as a mechanism to reduce the number of telephone calls and mailings members of the House of Delegates receive from or on behalf of candidates. The Election Manual provides an equal opportunity for each candidate to present the material he or she considers important to bring before the members of the House of Delegates and should relieve the need for the additional expenditures incurred in making non-scheduled telephone calls and duplicative mailings.

(5) Campaign gifts can be distributed only at the Annual Meeting in the non-official business folder and at one campaign party. Campaign gifts should only be distributed during the Annual Meeting and not mailed to Delegates and Alternate Delegates in advance of the meeting. (CCRC Special Report, I-92)

550.993 **Re-Election Of Officers Of AMA Hospital Medical Staff Section:** The AMA has established a limit of two consecutive terms in the same position on the Governing Council of the Hospital Medical Staff Section, excluding the delegate and alternate delegate to the AMA House of Delegates. (Res. 14, I-90)

550.994 **Young Physicians in Organized Medicine and Special Section for Young Physicians:** (1) The AMA strongly encourages and will assist each state society in establishing a state-level Young Physicians Section as a means of strengthening the direct and meaningful participation of young physicians throughout the Federation. (2) The AMA supports taking the lead through its appointment process and, while doing so, strongly encourages state, county and medical specialty societies to actively seek out and appoint qualified young physicians to appropriate council and committee leadership positions. (BOT Rep. FF, A-86)

550.995 **Quorum for Business Meeting of Hospital Medical Staff Section:** Fifty percent of the credentialed registered representatives at any business meeting of the Hospital Medical Staff Section shall constitute a quorum for the conduct of business at that meeting. (BOT Rep. X, A-85)

550.996 **Establishment of State Hospital Medical Staff Sections:** The AMA encourages every state medical association to establish a statewide hospital medical staff section. (Res. 149, A-83)

550.997 **Hospital Medical Staffs:** The AMA supports working with county medical societies and state medical associations to provide the counsel and services necessary to strengthen local hospital medical staffs. (BOT Rep. E, A-82; Reaffirmed: CLRPD Rep. A, I-92)

550.998 **Student and Resident Representation in the House of Delegates:** The AMA encourages medical societies to provide mechanisms for more direct involvement of students at the state and local levels. (CLRPD Rep. C, I-80; Reaffirmed CLRPD Rep. B, I-90)

550.999 **Definition of a Resident:** The term "resident" or "residents serving in programs approved by the Association," as applied to qualifications for membership in the Resident Physicians Section, shall include only: (1) members serving in residencies approved by the LCGME [now ACGME]; (2) members serving in fellowships approved as residencies by the LCGME [now ACGME]; (3) members serving fellowships in subspecialty training when such program is affiliated with and under the supervision of an approved residency training program; and (4) members serving fellowships in structured clinical training programs for periods of at least one year, to broaden competency in a specialized field, whether or not the program is affiliated with an approved residency training program. (C&B Rep. B, A-79; Reaffirmed CLRPD Rep. B, I-89)

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555.000 AMA: Membership and Dues (See also: AMA: Administration and Organization; AMA: Board of Trustees; AMA: Councils and Committees; AMA: House of Delegates; AMA: House of Delegates — Sections; AMA: Officers — Nomination, Election and Tenure; AMA: Political Action)

555.972 Member/Non-Member Price Differential for AMA Products and Services: The AMA will (1) increase the member/non-member price differential for its products and services wherever possible; and (2) standardize the member/non-member price differential wherever possible. (Res. 612, I-92)

555.973 Qualifications for Membership: It is the policy of the AMA not to discriminate with regard to membership on the basis of age, sex, color, creed, race, religion, disability, ethnic origin, national origin, or any other criterion unrelated to the delivery of quality patient care, professional ability and judgment. (Sub. Res. 13, I-92)

555.974 MD (Member Driven) 2000 — Status Report: The AMA encourages leaders from county, state, and specialty societies to become involved in membership recruitment and retention activities in their county, state, national, and specialty societies. (BOT Rep. TT, A-92)

555.975 Dues Reduction: (1) It is the constitutional duty of the AMA House of Delegates to set the membership dues structure. (2) Any reduction of the level of dues within each category of membership can only be done with the approval of the House of Delegates. (3) The AMA Board of Trustees will obtain the cooperation and documented consent of the state and component medical societies before and during any negotiations on reductions in the level of dues for groups. (Amended Res. 603, A-92)

555.976 Increasing Participation in Organized Medicine: (1) The reduced-dues category pilot study called for at the 1991 Annual Meeting will be continued through 1992. (2) The AMA will explore the possibility of initiating a voluntary physician membership contribution program, the objective of which would be to develop innovative membership programs targeted to physicians who are experiencing financial difficulties, including the evaluation of its potential costs and benefits and its impact on current AMA membership. (3) The AMA will explore the possibility of initiating one or more trial projects on combined dues billing for AMA, county, state, and/or specialty societies, including evaluating the impact of such an approach on membership in all components of the Federation, and the cost effects and potential cost savings of such a billing process. (4) The AMA, in conjunction with state, county, and specialty medical societies, will study the duplicative membership benefits offered by all organizational Federation members, with the objective of identifying services and activities with a potential for consolidation. (Amended CLRPD Rep. C, A-92)

555.977 Resident Physician Membership in the AMA: The AMA encourages all sponsors of resident training programs to seek means to fund membership in the AMA and state and county medical societies for resident physicians and fellows. (Sub. Res. 601, A-92)

555.978 Multiple Year Membership Option for Residents: The AMA will undertake a multi-year resident membership pilot project during the 1993 and 1994 dues years. In cooperation with the states, all first-year residents will be offered a three-year membership option at the discounted rate of $120. As an incentive to join for the three-year period, participants will be given a Drug Evaluations Annual as a benefit of membership. (BOT Rep. AA, I-91)

555.979 Model Membership Bylaws for Component Medical Societies: The AMA urges state and component medical associations to review the membership bylaw provisions of component medical societies and recommends that the Model Membership Bylaws for Component Medical Societies set forth below be utilized in the study and review of the component medical society's bylaws.

Section 1. Categories of Membership (a) Regular Membership. Regular members shall hold the degree of MD or DO or the equivalent and shall be licensed to practice medicine in this state. (b) Young Physician Membership. Regular members who are under 40 years of age or are within the

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first five years of professional practice after residency and fellowship training programs shall be Young Physician members. (c) Resident Physicians Membership. Physicians licensed in this state who are serving full time in a program of Graduate Medical Education shall be Resident Physician members. (d) Medical Student Membership. Full time students enrolled in a medical or osteopathic school in this state shall be Medical Student members. (e) Other Members:

Section 2. Qualifications for Membership Members must reside or practice within the jurisdiction of this society. Resident Physician members and Medical Student members must be participating in a Residency program or enrolled in a medical or osteopathic school within the jurisdiction of this society. All members must be of good moral and professional standing and must support the Principles of Medical Ethics of the American Medical Association.

Section 3. Application for Membership Applicants must request membership in writing on a form prepared by the Membership Committee. (a) The Membership Committee shall review all application forms and verify the information provided. If additional information is needed, the Committee will request that it be provided. (b) The Executive Committee shall grant or deny all applications for membership. In the event of a denial of membership, the applicant shall be advised in writing of the basis for denial and shall be entitled to a prompt hearing before an objective ad hoc committee of Regular Members.

Section 4. Transfer of Membership (a) A physician transferring from another component society to this society shall be granted membership in this society, without payment of dues for the current year, upon providing evidence of membership in another component society immediately prior to moving into the jurisdiction of this society. (b) A member moving out of the jurisdiction of this society will, upon request, be provided with evidence of membership in this society and such other documents as may be necessary to transfer to another component society. (C&B Rep. C, I-91)

555.980 Membership Provisions of Constituent and Component Medical Association Bylaws: The AMA (1) urges states medical associations to review and study the membership provisions of their bylaws for the purpose of facilitating the recruitment and retention of members. (2) recommends that state medical associations encourage their component medical societies to review and study the membership provisions of their respective bylaws for the purpose of facilitating the recruitment and retention of members; (3) recommends that the said studies of state medical association bylaws and component medical society bylaws be coordinated for the purpose of amending and updating the membership provisions of the bylaws, where appropriate, by: (a) removing unnecessary obstructions to membership recruitment and retention; (b) facilitating membership for students, residents, and young physicians; (c) developing efficient mechanisms to evaluate the qualifications of applicants for membership; and (d) providing simplified transfer of membership provisions. (C&B Rep. A, A-91)

555.981 Dues Incentives for AMA Recruiters: The AMA has some doubts about the merits of offering financial rewards as a recruitment incentive. Additionally, programming and administrative costs necessary to implement a dues rebate system would be excessive. The AMA believes that recognition and nonfinancial awards are more suitable motivation techniques. (BOT Rep. J, I-89)

555.982 Participation of Minorities in Organized Medicine: The AMA (1) supports actively recruitment of minority physicians into membership through all reasonable means and encourages their participation in leadership positions within the AMA; and (2) encourages the efforts of the federation to continue to involve minority physicians in both membership and leadership positions at all levels. (Res. 259, A-89)

555.983 AMA Membership in Large Group Practices: The AMA supports activities to improve membership among physicians in large medical group practices, including operation of a liaison program for large medical groups and for national organizations that represent these groups. (CLRPD Rep. A, A-88)

555.984 Membership Requirement for Position on the Editorial Boards of AMA Published Journals: The AMA encourages all physicians serving on the editorial boards of AMA published journals to become members of the AMA. (Sub. Res. 95, I-86)

555.985 Lifetime Dues Option and First-Time Member Dues: The AMA does not support (1) a reduced membership rate for physicians who join the AMA for the first time; or (2) a lifetime membership option for physicians who have been long-term members and who are nearing retirement. (BOT Rep. X, A-86)

555.986 Unified Membership: The AMA urges state medical associations to require membership in the AMA as a condition of state society membership, in order to unify and solidify all levels of organized medicine. (Res. 112, A-86)

555.987 Enhancing Membership Benefits Through Non-Dues Income: The Association (1) encourages state and local medical societies; and AMA, to explore new programs, activities and services which can provide meaningful benefits to members, produce additional non-dues income for medical societies, make it possible to hold the line on dues, and provide potentials for increasing physician membership; and (2) commends those medical societies which are endeavoring to hold the line on dues as a responsive action to the needs of their members. (Sub. Res. 91, I-85)

555.988 Dues Increase Exemption: No AMA dues increase will apply to any state association for one year following unification. (Sub. Res. 156, A-85)

555.989 AMA Membership: The AMA supports the development an implementation of additional incentives to encourage unified membership among the members of the Federation. (Res. 42, A-85)

555.990 Membership Dues Stabilization: By consideration of the delicate balance of dues and memberships, and by maintaining dues reasonableness within the context of budgetary reviews and long-range planning, the AMA is committed to preserving medicine's strength by membership involvement and participation. (Res. 40, A-85)

555.991 Benefits of Unified Membership: The AMA supports (1) establishment of an AMA ombudsman to work with members of unified societies; (2) a 10 percent reduction in AMA dues for members from unified state medical societies; (3) providing unified societies with reimbursement for collection of AMA dues at a rate of 3 percent of dues received by January 15, 2.5 percent of dues received by February 15, and 2.0 percent of dues received by March 15 of each year; (4) providing AMA staff services to unified societies on special projects which are mutually agreeable to the unified society and the AMA, and which are within the limits of staff and resource availability; (5) establishment of a Unified Societies Advisory Committee consisting of representatives from all unified societies; (6) a special annual briefing for officers of unified societies; and (7) dissemination to the federation and to all members of unified societies of a summary of benefits accruing to unified medical societies. (BOT Rep. DD, I-84)

555.992 Membership and Organizational Structure: (1) Application and billing procedures and the general format and content of application forms should be standardized throughout the Federation and designed to make membership application as easy and convenient as possible. This should include procedures for membership transfers between states, and transition from student member to resident member to regular member. (2) State and county societies should review their bylaws and remove unnecessary restrictive language that impedes recruitment and limits membership potential. (3) A formal and organized membership promotion program that coordinates membership promotion efforts at the county, state and national levels in terms of both promotional strategy and tactics should be implemented. (4) Membership incentives that will make membership attractive at all levels of the Federation should be further developed and improved. (5) Incentives at all levels of the Federation to promote cooperation with Federation-wide membership marketing programs should be further developed and improved. (6) Every county and state society should have a formal membership recruitment activity. (7) A standardized dues billing process throughout the Federation should be adopted. (CLRPD Rep. D, I-80; Reaffirmed CLRPD Rep. B, I-90)

555.993 Membership to the State Medical Societies: The AMA continues to encourage student membership and participation in organized medicine. The early involvement of medical students in organized medicine is not only important to the students but also to the future of organized medicine. The AMA urges all county and state societies to review their dues structure for medical students so that the total dues for county, state and AMA membership can be held to a realistic figure. The

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AMA also urges all county and state medical associations to review their application procedures in an effort to remove unnecessary requirements and facilitate the process by which a medical student may join organized medicine. (BOT Rep. BB, A-80; Reaffirmed CLRPD Rep. B, I-90)

555.994 AMA Institutional Members: In order to achieve the desired results of affiliating medical staff organizations and other groupings of physicians into organized medicine (including, at the discretion of the individual medical society, recognized HMOs and large group practices), the AMA: (1) supports advising local medical societies of the desirability of including representation of hospital medical staffs in their organizations; (2) supports working with and providing assistance to local societies in developing liaison with hospital medical staffs and in developing appropriate representational mechanisms at the local level; (3) supports efforts to make available to local societies specifics of new models of hospital medical staff representational mechanisms as they are developed; and (4) encourages and assists local medical societies in recruiting individuals of affiliated institutions as full local, state, and AMA dues-paying members. (CLRPD Rep. C, I-79; Reaffirmed CLRPD Rep. B, I-89)

555.995 Transition from Resident to Regular AMA Membership: The AMA encourages those state and county medical societies which have time restrictions on attaining new regular membership to effect changes in their rules so that active resident AMA or state society members may transfer to regular membership status without delay. (Res. 43, A-79; Reaffirmed CLRPD Rep. B, I-89)

555.996 Distribution of the Principles of Medical Ethics: The AMA is in favor of distributing a copy of the AMA Principles of Medical Ethics to every new AMA member. (Res. 158, A-78; Reaffirmed CLRPD Rep. C, A-89)

555.997 Unified Membership: The AMA will provide all feasible and reasonable services to state associations that seek to maintain or accomplish unified membership. (Sub. Res. 82, A-76; Reaffirmed CLRPD Rep. C, A-89)

555.998 Model Membership Bylaws for State Medical Societies:

ACTIVE MEMBERS I: Members of component societies who hold the degree of Doctor of Medicine, Bachelor of Medicine or the equivalent; and who hold an unrestricted license to practice medicine and surgery in any state of the United States of America, or who are eligible for licensure in the State of _____ upon endorsement or examination; are eligible for active membership in this society. Upon admission to membership, such members shall have the right to vote and hold office in this society.

II: Interns and Residents serving in training programs approved by the American Medical Association are eligible for active membership in this society. Upon admission to membership, such members shall have the right to vote and hold office in this society.

III: Medical Students enrolled in a medical school approved by the American Medical Association are eligible for active membership in this society. Upon admission to membership, such members shall have the right to vote and hold office in this society.

If the Bylaws of the component societies contain active membership provisions which effectively offer membership to all physicians within the society's jurisdiction, the following provisions for Direct Membership and Associate Membership will be unnecessary.

DIRECT MEMBERS Any person within the State of _____ who meets the qualifications for active membership in this society, except that such person cannot qualify for membership in a component society, shall be eligible for Direct Membership in this society. Upon admission to membership, such members shall have the right to vote and hold office in this society.

ASSOCIATE MEMBERS Physicians, Interns, and Residents serving in training programs approved by the American Medical Association, and Medical Students enrolled in medical schools approved by the American Medical Association may apply for Associate Membership in this society.

Associate members shall not have the right to vote or hold office in this society.(C & B Rep G, A-75; Reaffirmed CLRPD Rep. C A-89)

555.999 Uniform Membership Requirements: The AMA urges state and local societies to review and simplify their membership requirements to be consistent with AMA's Constitution and Bylaws, thus facilitating membership programs by AMA. (C&B Rep. J, A-73; Reaffirmed CLRPD Rep. C, A-89)

560.000 AMA: Officers — Nomination, Election and Tenure (See also: AMA: Administration and Organization; AMA: Board of Trustees; AMA: Councils and Committees; AMA: House of Delegates; AMA: House of Delegates — Sections; AMA: Membership and Dues; AMA: Political Action)

560.994 AMA Campaign Activities: (1) All candidate support activity at AMA meetings should be limited to hospitality suites or public meeting rooms no larger than the largest suite within the headquarters hotel. (2) No state or coalition should have more than two nights of hospitality. (3) Large events with bands, entertainment, and decorations should be eliminated. (4) The state where the AMA meets should feel no obligation to sponsor a "host-state party." (Res. 61, I-87)

560.995 Commercial Use of Officer Titles: The AMA encourages physicians who have served as an elected officer of the Association to guard against commercial exploitation of any officer position served in any manner that implies, directly or indirectly, endorsement of a commercial product or service by the AMA. (Sub. Res. 147, A-86)

560.996 AMA Election Process: The AMA recommends (1) that a prototype campaign manual containing information on all candidates for election be developed; (2) that the announcement of the Council nominations and the official ballot list candidates in alphabetical order by name only; and (3) that fiscal restraint be exercised in planning campaign activities. (Special Committee Report, A-86)

560.997 AMA Election Process: AMA elections will continue to be held on Wednesday mornings, with nominations on Tuesday afternoons, during the Annual Meetings. (BOT Rep. W, A-85)

560.998 AMA Election Process — Campaign Expenses: The AMA urges restraint in planning campaign activities for AMA offices, but believes it would be nearly impossible to set reasonable limits on campaign expenditures that would be equitable and enforceable. Furthermore, the AMA does not believe that it should be given the responsibility for approving campaign plans and expenditures of state medical associations and national medical specialty societies. (BOT Rep. HH, A-84)

560.999 AMA Election Process: (1) Campaign expenditures and activities should be limited to prudent and reasonable levels necessary for adequate candidate exposure to the delegates. (2) Campaign related expenditures and activities at the Interim Meeting should be discouraged and there should be no large campaign receptions or campaign luncheons at the Interim Meeting. (3) The Speaker of the House should meet with all announced candidates and campaign managers at each meeting of the House of Delegates to agree on general campaign procedures. (4) The elections of AMA Officers and Councils should be held on Wednesday morning at the Annual Meeting. (5) All state and specialty society delegations should be urged to participate in a regional caucus, for the purposes of candidate review activities. (CLRPD Rep. E, I-80; Reaffirmed CLRPD Rep. B, I-90)

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565.000 AMA: Political Action (See also: AMA: Administration and Organization; AMA: Board of Trustees; AMA: Councils and Committees; AMA: House of Delegates; AMA: House of Delegates — Sections; AMA: Membership and Dues; AMA: Officers — Nomination, Election, and Tenure)

565.991 Physician and Spouse Voter Identification Project: The AMA, in conjunction with state and local medical associations, will assist and encourage physician and spouse voter identification projects as part of efforts to build stronger and more effective key contact programs. (Sub. Res. 216, I-92)

565.992 Increase State Participation in Washington Lobbying: It is the policy of the AMA (1) to develop a plan to expand its grassroots participation of physicians and auxilians in congressional advocacy both locally and through visitations to Washington, D.C.; and (2) that this grassroots advocacy plan consider that all Washington, D.C., visitation be coordinated through the AMA Washington Office. (Sub. Res. 86, I-90)

565.993 Doctor's Day in Congress: Rather than developing a program to coordinate on a nationwide level a Doctor's Day in Congress, whereby representatives of each state would send delegations to Washington to meet with their Congressional delegations, the AMA believes that it would be more cost-effective to use the existing National Political Education Conference in Washington as the vehicle for this type of meeting. Under a new format, the program's content will be dedicated to activities which will enhance communication between the medical profession and members of Congress. In addition, the AMA believes that all AMA-sponsored meetings held in Washington should provide participants with the opportunity for AMA staff briefings and Capitol Hill visits. (BOT Rep. CC, I-90)

565.994 Candidates For Governmental And Third Party Payer Offices: It is the policy of the AMA to (1) continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; (2) continue to actively solicit and promote qualified physicians as candidates for public office; and (3) encourage qualified physicians to actively seek positions with third party payers. (Sub. Res. 147, A-90)

565.995 Reduced Political Action Committee (PAC) Dues for Resident Physicians: The AMA encourages its members who are involved in state PACs to establish a discounted dues membership category for resident physicians and medical students. (Res. 175, A-88)

565.996 Assistance to Physician Candidates for State and National Office: The AMA (1) commends AMPAC for its educational and political programs to help physicians and other members of the medical community to become involved in political campaigns and become candidates for public office; and (2) recommends that AMPAC and state medical association political action committees continue to give priority to the support of qualified physician candidates in making contributions to candidates for public office. (Sub. Res. 8, A-86)

565.997 Participation in the Political Process Through Support of AMPAC: The AMA: (1) strongly supports physician/family leadership in the campaign process; (2) encourages AMA members to participate personally in the campaign of their choice; (3) urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; and (4) believes that better informed and more active citizens will result in better legislators, better government and better health care. (BOT Rep. II, I-83)

565.998 "Key Physician": The AMA urges state and county medical societies to develop "key physician" contacts to aid the AMA staff in its Washington program. (Res. 72, A-83)

565.999 Limitations on Political Action Committee (PAC) Contributions: The AMA opposes legislative initiatives that improperly limit individual and collective participation in the democratic process. (Res. 119, A-83)

FEDERAL ELECTION COMMISSION
WASHINGTON DC 20463

March 4, 1994

James S. Todd, M.D.
Executive Vice President
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Todd:

This refers to your letter dated February 23, 1994, on behalf of the American Medical Association ("AMA") concerning the issue of whether certain persons qualify as "members" of the AMA according to the Federal Election Campaign Act of 1971, as amended ("the Act"), and Commission regulations.

You request that the Commission issue an advisory opinion holding that the House of Delegates is the AMA's "highest governing body" within the meaning of 11 CFR 100.8(b)(4)(iv)(B) and 114.1(e)(2) and that "direct members" of the AMA have sufficient organizational and financial attachments to the organization to qualify as members under 11 CFR 100.8(b)(4)(iv)(C). Your letter includes arguments in support of both proposed holdings.

The Act authorizes the Commission to issue an advisory opinion in response to a "complete written request" from any person with respect to a specific transaction or activity by the requesting person. 2 U.S.C. §437f(a). Commission regulations explain that such a request "shall include a complete description of all facts relevant to the specific transaction or activity with respect to which the request is made." 11 CFR 112.1(c).

In view of the cited requirements, you will need to provide responses to the following questions and requests for documents.

(1) Please describe in detail the power of the AMA House of Delegates to remove, discipline, or otherwise affect the tenure of members of the Board of Trustees and other officers or officials. Describe in detail the power of the Board of Trustees to remove, discipline, or otherwise affect the tenure of members of the AMA House of Delegates and other officers or officials. Please enclose appropriate sections of AMA governing documents or rules, as well as appropriate sections of the Illinois Not For Profit Corporation Act pertaining to your responses.

(2) Please enclose a copy of the policy statement written in 1979 and re-affirmed in 1989 discussing the relationship of the Board to the House of Delegates. Please highlight all references to the above relationship. In addition, submit any amendments to the policy on the relationship between the Board and the House of Delegates.

(3) Please enclose any policy statements still in effect affirming the Board's role as the leading policy maker or governing body.

(4) Describe in detail the Board's power to act contrary to, to veto, or to refuse to act on recommendations of the House of Delegates.

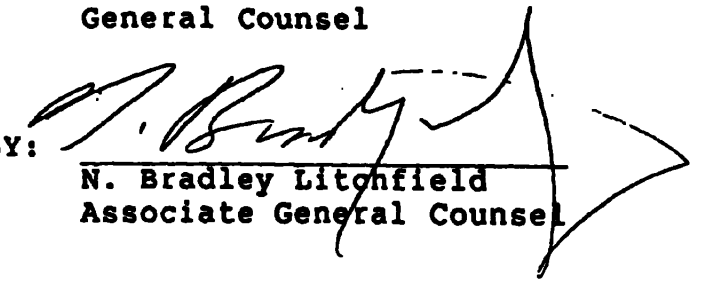
(5) Please provide a detailed description of the division between the Board and the House of Delegates of areas of decision-making and power, e.g., matters of internal governance, publications, standards of professional conduct, educational and accreditation requirements, medical information and education, and public policy positions. Include an estimate as to percentages if power in any areas is divided. Provide the documents presently in effect that refer to or discuss such divisions of decision-making or power.

In addition to asking for responses to the above questions, this office notes that you will send us a copy of the AMA By-Laws and Constitution. Please also send a copy of the Articles of Incorporation as well.

For your information and guidance, we enclose a copy of Advisory Opinion 1993-24. If you have any questions about the advisory opinion process, the enclosed opinion, or this letter, please contact the undersigned.

Sincerely,

Lawrence M. Noble
General Counsel

BY: 
N. Bradley Litchfield
Associate General Counsel

Enclosure

American Medical Association
Physicians dedicated to the health of America

Leslie J. Miller, JD
Senior Attorney
Corporate Law Division

515 North State Street
Chicago, Illinois 60610

312 464-4608
312 464-5846 Fax

March 4, 1994

Mr. N. Bradley Litchfield
Office of the General Counsel
Federal Election Commission
999 E Street, N.W.
Washington, D.C. 20463

Dear Mr. Litchfield:

Enclosed is a copy of the current American Medical Association Constitution and Bylaws. This is being submitted in connection with our recent Advisory Opinion Request, but was still being printed when the request was submitted.

Very truly yours,

Leslie J. Miller

Leslie J. Miller

LJM/mam
Enclosure

American Medical Association

Physicians dedicated to the health of America

Constitution and Bylaws

of the American Medical Association

December 1993 Revision

Constitution and Bylaws

of the American Medical Association with Principles of Medical Ethics

Amnerican Medical Association
515 North State Street
Chicago, Illinois 60610

Contents

Constitution

By-Laws

Constitution

Article I—Title and Definition

The name of this organization is the American Medical Association. It is a federacy of its state associations.

Article II—Objects

The objects of the Association are to promote the science and art of medicine and the betterment of public health.

Article III—State Associations

Constituent or state associations are those recognized medical associations of states, commonwealths, territories or insular possessions which are, or which may hereafter be, federated to form the American Medical Association.

Article IV—Component Societies

Component societies are those county or district medical societies contained within the territory of and chartered by the respective state associations.

Article V—Members

The American Medical Association is composed of individual members of state associations and others as shall be provided in the Bylaws.

Article VI—House of Delegates

The legislative and policy-making body of the Association is the House of Delegates composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in this Constitution and Bylaws and shall elect the general officers except as otherwise provided in the Bylaws.

Article VII—General Officers

The general officers of the Association shall be a President, President-Elect, immediate Past President, Secretary-Treasurer, Speaker of the House of Delegates, Vice Speaker of the House of Delegates and fourteen Trustees, including a Resident Physician member and a medical student member. Their qualifications and terms of office shall be provided in the Bylaws.

The Board of Trustees is composed of seventeen members, thirteen Trustees elected by the House of Delegates, including a Resident Physician member, a medical student trustee elected by the Medical Student Section Assembly, and the President, President-Elect and Immediate Past President of the Association. It shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the Bylaws.

Article IX—Scientific Assembly

The Scientific Assembly of the American Medical Association is the convocation of its members for the Presentation and discussion of subjects pertaining to the science and art of medicine.

Article X—Conventions

The House of Delegates shall meet annually and at such other times as deemed necessary or as provided in the Bylaws, in cities or places selected by the Board of Trustees. The Scientific Assembly shall meet at such times as the Board of Trustees deems necessary, or as provided in the Bylaws, in cities or places selected by the Board of Trustees.

Article XI—Funds, Dues and Assessments

Funds may be raised by annual dues or by assessment on the Active Members on recommendation by the Board of Trustees and after approval by the House of Delegates, or in any other manner approved by the Board of Trustees as provided in the Bylaws.

Article XII—Amendments

The House of Delegates may amend this constitution at any convention provided the proposed amendment shall have been introduced at the preceding convention and provided two-thirds of the voting members of the House of Delegates registered at the convention at which action is taken, vote in favor of such amendment.

OGC note: The above AMA Constitution is the same as the AMA articles of incorporation which are in our file but not circulated with ADR. 4-22-94

Bylaws of the American Medical Association

1.00 Membership

1.10 Categories. Categories of membership are: 1. Active Constituent; 2. Active Direct; 3. Affiliate; 4. Honorary.

1.11 Active Constituent. Active Constituent members are members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who fulfill at least one of the following requirements.

A. Possess the degree of Doctor of Medicine or its equivalent.
B. Possess an unrestricted license to practice medicine and surgery.
C. Are Residents serving in training programs approved by the Association, or serving in osteopathic training programs approved by an appropriate accrediting agency.
D. Are Medical Students enrolled in a medical school, approved by the Association, or in an osteopathic medical school, approved by an appropriate accrediting agency.

1.111 Admission. A person eligible for Active Constituent membership in the American Medical Association becomes a member of the Association upon certification by the secretary of the constituent association to the Executive Vice President of the American Medical Association, provided there is no disapproval by the Council on Ethical and Judicial Affairs. Said Council may consider information pertaining to the character, ethics, professional status and professional activities of the applicant. The Council shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

1.12 Active Direct. Active Direct members are those who apply for membership in the American Medical Association directly rather than through a constituent association. Applicants residing in states where the constituent medical association requires all of its members to be members of AMA are not eligible for this category of membership unless the applicant is serving full time in the United States Army, the United States Navy, the United

Administration. Active Direct members must fulfill at least one of the following requirements.

A. Possess the degree of Doctor of Medicine or its equivalent.
B. Possess an unrestricted license to practice medicine and surgery.
C. Are Residents serving in training programs approved by the Association, or serving in osteopathic training programs approved by an appropriate accrediting agency.
D. Are Medical Students enrolled in a medical school approved by the Association, or in an osteopathic medical school approved by an appropriate accrediting agency.

1.121 **Admission.** Active Direct members are admitted to membership upon application to the Executive Vice President of the American Medical Association, provided that there is no disapproval by the Council on Ethical and Judicial Affairs. Said Council may consider information pertaining to the character, ethics, professional status and professional activities of the applicant. The Council shall provide by rule for an appropriate hearing procedure to be provided to the applicant.

1.1211 **Notice.** AMA shall immediately notify each constituent association of the name and address of those applicants for Active Direct membership residing within its jurisdiction.

1.1212 **Objections.** Objections to applicants for Active Direct membership must be received by the Executive Vice President of AMA within 45 days of receipt by the constituent association of the notice of the application for such membership. All objections will immediately be referred to the Council on Ethical and Judicial Affairs for prompt disposition pursuant to the rules of the Council on Ethical and Judicial Affairs.

1.126 **Rights and Privileges.** Active Constituent and Active Direct members are entitled to receive the Journal of the American Medical Association, American Medical News and such other publications as the Board of Trustees may authorize.

1.127 **Dues and Assessments.** Active Constituent and Active Direct members are liable for such dues and assessments as are determined and fixed by the House of Delegates.

1.1271 **Active Constituent Members.** Active Constituent members shall pay their annual dues to the constituent associations for transmit-

Trustees.

1.1272 **Active Direct Members.** Active Direct members shall pay their annual dues directly to the Executive Vice President of the Association.

1.1273 **Exemptions.** Upon request, Active Constituent and Active Direct members may be exempt from the payment of dues on January 1 following their sixty-fifth birthday, provided that they are fully retired from the practice of medicine. Additionally, the Board of Trustees may excuse members from payment of dues to alleviate financial hardship or because of forced retirement from medical practice due to physical disability. The Board of Trustees shall establish appropriate standards and procedures for granting all dues exemptions. Members who were exempt from payment of dues based on age and retirement under bylaw provisions applicable in prior years shall be entitled to maintain their dues-exempt status in all subsequent years. Dues exemptions for financial hardship or disability shall be reviewed annually.

1.1274 **Delinquency.** Members are delinquent if their dues and assessments are not received by the American Medical Association by April 30 of the year for which they are prescribed, or by such other date as the House of Delegates may specifically prescribe, and shall forfeit their membership in the American Medical Association if such delinquent dues and assessments are not received by the Association within thirty days after notice of delinquency has been mailed to the member's last known address by the Executive Vice President of the American Medical Association.

1.14 **Affiliate Members.** Persons who belong to one of the following classes may become affiliate members.

A. Physicians in foreign countries who have attained distinction in medicine and who are members of their National Medical Society or such other medical organization as will verify their professional credentials.
B. American physicians located in foreign countries or in possessions of the United States who are engaged in medical missionary, educational or philanthropic endeavors.
C. Dentists who hold the degree of D.M.D. or D.D.S. who are members of the American Dental Association and their state and local dental societies.
D. Pharmacists who are Active members of the American Pharmaceutical

of the United States and are ineligible for Active membership.

F. Individuals engaged in scientific endeavors allied to medicine and others who have attained distinction in their fields of endeavor but who are not eligible for other categories of membership.

1.141 **Admission.** By majority vote of the House of Delegates following nomination by the Council on Ethical and Judicial Affairs. Nominations for D, E, and F must also be approved by the appropriate component and constituent medical society. The election of Affiliate members shall take place at a time recommended by the Convention Committee on Rules and Credentials and approved by the House.

1.142 **Rights and Privileges.** Affiliate Members may attend AMA meetings but may not vote, hold office or receive publications of the Association except by subscription.

1.143 **Dues and Assessments.** Affiliate members are not subject to dues or assessments.

1.15 **Honorary Members.** Physicians of foreign countries who have achieved pre-eminence in the profession of medicine and who attend a convention of the American Medical Association.

1.151 **Admission.** Elected at that convention by the House of Delegates upon nomination by the Board of Trustees. The election of Honorary members shall take place at a time recommended by the Convention Committee on Rules and Credentials and approved by the House. No more than three Honorary members shall be elected at any convention except on special recommendation of the Board of Trustees and the unanimous vote of House.

1.152 **Rights and Privileges.** Honorary Members may attend AMA meetings but may not vote, hold office or receive publications of the Association except by subscription.

1.153 **Dues and Assessments.** Honorary members are not subject to dues or assessments.

1.20 **Maintenance of Membership.** A member may hold only one type of membership in the American Medical Association at any one time. Membership may be retained only as long as the member complies with the provisions of the Constitution and Bylaws and Principles of Medical Ethics of the American Medical Association.

1.30 **Transfer of Membership.** Members of the American Medical Association, ex

United States Air Force, the United States Public Health Service or the Veterans Administration, who move to a jurisdiction in which the constituent medical association requires that all members of the constituent association be members of the American Medical Association must apply for membership in the constituent association within one year after moving into the jurisdiction in order to continue membership in the American Medical Association. Unless membership in the constituent association has been granted within two years after application, membership in the American Medical Association shall cease.

1.40 Termination of Membership. Upon official notification to the American Medical Association that an Active Constituent member is not in good standing in a constituent association, such member shall cease to be a member of the AMA, subject to the member's right of appeal as provided in 1.613.

1.50 Discrimination. Membership in any category of the American Medical Association or in any of its constituent associations shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation or age, or for any other reason unrelated to character or competence.

Nor shall membership in any category of the American Medical Association or in any of its constituent associations be denied to any person who meets the requirements for membership as set forth in these bylaws and in the bylaws of the applicant's respective constituent association. In considering applicants for membership, information as to the character, ethics, professional status and professional activities of the individual may be considered.

1.60 Discipline

1.61 Active Constituent Members

1.611 The Council on Ethical and Judicial Affairs, after due notice and hearing may censure, suspend or expel such member from AMA membership for an infraction of the Constitution or these Bylaws for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct.

1.612 In addition to the disciplinary action referred to in 1.611, Active Constituent members may be subject to the following disciplinary actions.

1.6121 Actions under the constitution and bylaws of the component society and constituent association to which the member belongs.

1.6122 A request from the constituent association to which a member belongs for the AMA to take disciplinary action.

1.6123 A request by the AMA to the constituent association ... member belongs to consent to disciplinary proceedings by the AMA.

1.613 Appeals

1.6131 All disciplinary actions by a component society or a constituent association against a member may be appealed to the Council on Ethical and Judicial Affairs of the American Medical Association on questions of law and procedure only but not on questions of fact.

1.6132 Notice of appeal shall be filed with the Council on Ethical and Judicial Affairs within thirty (30) days of the date of the decision of the constituent association, and the appeal shall be perfected within sixty (60) days thereof.

1.6133 The Council on Ethical and Judicial Affairs, for what it deems good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

1.62 All Other Members

1.621 The Council on Ethical and Judicial Affairs, after due notice and hearing, may censure, suspend or expel any Active Direct, Affiliate or Honorary Member of the Association for an infraction of the Constitution or these Bylaws, for a violation of the Principles of Medical Ethics, or for unethical or illegal conduct:

2.10 Composition. The House of Delegates is composed of Delegates selected by constituent associations and other delegates as defined in 2.12 and 2.13.

2.101 Qualification of Members of House of Delegates. Members of the House of Delegates must be active members of the American Medical Association.

2.11 Constituent Associations. Each constituent association is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seats as may be provided under 2.112.

2.111 Apportionment. The apportionment of delegates from each constituent association is one delegate for each thousand (1,000) or fraction thereof Active Constituent and Active Direct members of the American Medical Association within the jurisdiction of each constituent association, as recorded in the office of the Executive Vice President of the American Medical Association on December 31 of each year.

2.1111 Effective Date. Such apportionment shall take effect the ensuing January 1 and shall remain effective for one year thereafter. In January of each year the Executive Vice President of the American Medical Association shall notify each constituent association of the number of seats in the House of Delegates to which it is entitled during the current year.

2.11111 Retention of Delegate. If the membership information as recorded in the Office of the Executive Vice President of the American Medical Association on December 31 warrants a decrease in the number of delegates representing a constituent association, said association shall be permitted to retain the same number of delegates, without decrease, for one additional year, but only if it promptly files with the Office of the Executive Vice President of the American Medical Association a written plan of intensified AMA membership development activities among its members.

2.1112 Unified Membership. A constituent association that adopts bylaw provisions requiring all members of the constituent association to be members of the AMA shall not suffer a reduction in the number of delegates allocated to it by apportionment hereunder during the first two years in which the said unified membership bylaw provisions are implemented.

an additional delegate and alternate in the House of Delegates [illegible] or more of its members are also members of the American Medical Association. A constituent association shall be entitled to two additional delegates and alternates in the House of Delegates if all of its members are also members of the American Medical Association. No constituent association shall be entitled to more than two additional delegates and alternates under this section.

2.1121 **Effective Date.** The additional delegates provided for under 2.112 shall be based upon membership information recorded in the Office of the Executive Vice President of the American Medical Association on December 31 of each year.

2.1122 **One Additional Delegate.** In order to be entitled to one additional delegate, the membership information must confirm that 75% or more of the constituent association's members are also members of the American Medical Association.

2.1123 **Retention of Additional Delegate.** A constituent association that has achieved 75% or more AMA membership shall retain the additional delegate only if the membership information recorded in the Office of the Executive Vice President of the American Medical Association on each subsequent December 31 confirms that 75% or more of the Constituent association's members are members of the AMA, as provided in these bylaws. If the membership information for a constituent association having an additional delegate pursuant to this section of the bylaws, as recorded in the Office of the Executive Vice President of the American Medical Association on December 31, indicates that less than 75% of the constituent association's members are members of the AMA, the constituent association shall be permitted to retain the additional delegate for one additional year, but only if it promptly files with the Office of the Executive Vice President of the American Medical Association a written plan of intensified AMA membership development activities among its members. On the following December 31, if the membership information for such constituent association, as recorded in the Office of the Executive Vice President of the American Medical Association, indicates that for the second successive year less than 75% of the constituent association's members are members of the AMA, the constituent association shall not be entitled to retain the additional delegate.

ship information confirms that during [illegible]
constituent association has adopted bylaw provisions requiring unified membership, and such unified membership is to be fully implemented within the following calendar year, the constituent association shall be entitled to 2 additional delegates. The constituent association shall retain the 2 additional delegates only if the membership information recorded in the Office of the Executive Vice President of the American Medical Association on each subsequent December 31 confirms that all of the Constituent association's members are members of the American Medical Association, as provided in these bylaws.

2.1125 Notification. In January of each year the Executive Vice President of the American Medical Association shall notify each constituent association of the number of additional delegates to which each constituent association is entitled.

2.113 Selection. Each constituent association shall select and adjust the number of delegates and alternates to conform with the number of seats authorized under 2.111 and 2.112.

2.114 Certification. Presidents or Secretaries of constituent associations shall certify, to the Executive Vice President of the AMA, the delegates and alternate delegates from their respective associations.

2.115 Autonomy of Constituent Medical Associations. The participation of a constituent medical association in the House of Delegates is voluntary. Policy actions of the association do not in themselves bind a constituent medical association or subject it to any obligation that it does not voluntarily assume.

2.12 Other Delegates. Each of the following is eligible to select one delegate and one alternate delegate: Specialty organizations, as provided in 8.00; Special Sections as provided in 7.00; the Surgeons General of the United States Army, United States Navy, United States Air Force and United States Public Health Service and the Chief Medical Director of the Veterans Administration.

2.121 Certification. The President or Secretary of each specialty organization as provided in 8.00 and each Special Section as provided in 7.00; the Surgeons General of the United States Army, United States Navy, United States Air Force and United States Public Health Service and the Chief Medical Director of the Veterans Administra-

respective delegate and alternate delegate.

2.13 Ex-officio Members. The current General Officers (except Speaker and Vice Speaker), the Past Presidents, Past Vice Presidents, Past Trustees of the Association and the Chairs of Councils of the AMA shall be ex-officio members of the House of Delegates.

2.131 Rights and Privileges. Ex-officio members have the right to speak and debate on the floor of the House, but do not have the right to introduce business, introduce an amendment, make a motion or vote.

2.14 Alternate Delegates. Each Constituent Association, the Specialty Organizations as provided in 8.00; the Special Sections as provided in 7.00; the Surgeons General of the United States Army, United States Navy, United States Air Force and United States Public Health Service; and the Chief Medical Director of the Veterans Administration may select an Alternate Delegate for each delegate entitled to be seated in the AMA House of Delegates.

2.141 Qualifications. Alternate Delegates must be active members of the American Medical Association.

2.142 Certification. Alternate Delegates shall be certified to the Executive Vice President of the AMA in the same manner as Delegates.

2.143 Term. Alternate Delegates shall be selected for a two-year term, and shall assume office on January 1 of the year succeeding their selection, unless otherwise provided in these bylaws.

2.144 Vacancies. Alternate Delegates selected to fill a vacancy shall assume office immediately after selection and shall serve for the remainder of that calendar year.

2.145 Rights and Privileges. An Alternate Delegate may substitute for a Delegate, on the floor of the House of Delegates, at the request of the Delegate by complying with the procedures established by the Convention Committee on Rules and Credentials. While substituting for a Delegate, the Alternate may speak and debate on the floor of the House, may offer an amendment to a pending matter, make motions and vote, except when the vote is by ballot.

2.146 Other. The Alternate Delegate is not a "member of the House of Delegates" as that term is used in these Bylaws. Accordingly, an Alternate Delegate may not introduce resolutions into the House of Delegates, may not vote in any election conducted by the House of Delegates, nor vote when any matter is to be decided by written ballot.

An Alternate Delegate is not eligible for nomination ...
Speaker or Vice Speaker of the House of Delegates. The Alternate Delegate must immediately relinquish his position on the floor of the House of Delegates upon the request of the Delegate for whom the Alternate is substituting.

2.20 Terms of Delegates

2.21 Delegates from Constituent Associations

2.211 Delegates and alternate delegates from constituent associations shall be selected for 2 year terms and assume office on January 1 of the year succeeding their selection, provided that such seats are authorized as defined in 2.1111.

2.212 When the number of delegate seats of constituent associations is increased in accordance with 2.111, the delegates and alternates selected to fill vacancies shall assume office immediately after selection and serve during that calendar year.

2.213 Constituent associations entitled to more than one delegate shall select them so that half the number, as near as may be, are selected each year. If necessary to accomplish this proportion, one year terms may be provided but only to the extent and for such time as is necessary to accomplish it.

2.214 Resident and Medical Student Delegates: A constituent association may designate one or more of its delegate and alternate delegate seats to be filled by a Resident member or a Medical Student member who is an active member of the American Medical Association.

2.2141 Term: Such Resident or Medical Student delegate or alternate delegate shall serve for a term beginning as of the date of certification of the said delegate or alternate delegate by the constituent association to the Executive Vice President of the AMA, as required by Section 2.114, and concluding on the following December 31.

2.2142 Nothing in section 2.214 and the subsections thereunder shall authorize the early termination of a delegate's or alternate delegate's term in order to create a seat for a Resident or Medical Student member.

2.2143 Nothing in section 2.214 and the subsections thereunder shall preclude a Resident or Medical Student member from being selected to fill a full 2 year term as a delegate or alternate delegate from a constituent association as provided in section 2.211.

2.221 Delegates and alternate delegates from Specialty Organizations, the United States Army, the United States Navy, the United States Air Force, the United States Public Health Service and Veterans Administration shall be selected for 2 year terms, and shall assume office on January 1 of the year succeeding their selection.

2.222 The delegate and the alternate delegate from each of the Special Sections as provided in 7.00 shall be elected as provided in that section for the term specified therein.

2.30 **Vacancies.** When vacancies occur, the delegate and alternate selected to fill such vacancy shall assume office immediately after selection and serve for the remainder of that calendar year.

2.40 **Registration and Seating of Delegates**

2.41 **Credentials.** Before being seated at any convention, each delegate or alternate delegate shall deposit with the Convention Committee on Rules and Credentials a certificate signed by the president or secretary of the constituent association, or of the specialty organization as provided in 8.00, or the special section as provided in 7.00, or the Surgeon General of the respective government service, or the Chief Medical Director of the Veterans Administration stating that the delegate or alternate delegate has been properly selected to serve in the House of Delegates.

2.42 **Lack of Credentials.** A delegate or alternate may be seated without the certificate defined in 2.41 provided proper identification as the delegate o alternate selected by the respective constituent association, specialty organization, service, or section is established, and so certified to the Executive Vice President of the American Medical Association.

2.43 **Substitute.** When a delegate and/or an alternate is unable to attend a convention, the appropriate authorities of the constituent association, specialty organization, service or section concerned, may appoint a substitute delegate and/or alternate delegate, who on presenting proper credentials shall be eligible to serve as such delegate and/or alternate delegate in the House of Delegates at that convention.

2.431 **Temporary Substitute Delegate.** A delegate whose credentials hav been accepted by the Convention Committee on Rules and Credentials and whose name has been placed on the roll of the Hou of Delegates shall remain a delegate until final adjournment of that convention. However, if the delegate is not able to remain in attendance, that delegate's place may be taken during the period of

absence by an alternate delegate, selected in accordance with 2.43 if an alternate delegate is not available. The person who takes the place of the Delegate must comply with the formal recredentialing procedures established by the Convention Committee on Rules and Credentials for such purpose, and shall be known as a Temporary Substitute Delegate. Such Temporary Substitute Delegate shall have all of the rights and privileges of a Delegate while serving as such Temporary Substitute Delegate, including the right to vote by ballot and to vote in any election conducted by the House of Delegates. The Temporary Substitute Delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates.

2.44 Constituent Association President. The current president of a constituent medical association may also be certified as an additional alternate delegate at the discretion of each constituent medical association.

2.45 Representation. No delegate or alternate may be registered or seated at any meeting to represent more than one organization in the House Delegates.

2.50 Procedure

2.51 Order of Business. The following shall be the general order of business at all conventions of the House of Delegates:

1. Call to order by the Speaker
2. Invocation
3. Report of the Convention Committee on Rules and Credentials
4. Presentation, correction and adoption of the Minutes
5. Reports of officers
6. Reports of committees
7. Unfinished business
8. New business

At any meeting, the house, by majority vote, may change the order of business.

2.52 Privilege of the Floor. The House of Delegates by a two-thirds vote of those present and voting may extend to any person an invitation to address the House.

2.53 Introduction of Business

2.531 Resolutions. To be considered as regular business, each resolution must be introduced by a voting delegate and must have been submitted to the Headquarters Office of the Association not later

than 30 days prior to the commencement of the session at which it is to be considered, with the following exceptions.

2.5311 A constituent society whose House of Delegates or comparable policy making body adjourns during or one week preceding 30 days prior to commencement of a meeting of the AMA House of Delegates is allowed 7 days after close of the constituent society meeting in which to submit resolutions to the headquarters office. In no event, however, may such resolutions be received later than noon of the day before the opening meeting of the AMA House of Delegates. The presiding officer of the constituent society meeting shall certify that the resolution was adopted at the meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.5312 A specialty organization whose policy making body adjourns during or one week preceding 30 days prior to commencement of a meeting of the AMA House of Delegates is allowed 7 days after close of the specialty organization meeting in which to submit resolutions to the headquarters office. In no event, however, may such resolutions be received later than noon of the day before the opening meeting of the House of Delegates. The presiding officer of the specialty organization meeting shall certify that the resolution was adopted at the meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.5313 Resolutions presented from the Business Meetings of the Special Sections as provided in 7.00 may be presented for consideration by the House of Delegates at any time before the close of business on the day preceding the final day of the convention.

2.5314 Resolutions not properly qualified and accepted pursuant to 2.531 or 2.5311 or 2.5312 may be presented by a voting delegate any time prior to the final day of a convention but will be accepted for consideration by the House of Delegates only upon $^{2}/_{3}$ vote of delegates present and voting.

2.5315 Resolutions submitted pursuant to 2.531, 2.5311, 2.5312, 2.5313 and 2 .5314 shall be accepted as business of the Association upon presentation by the Speaker of the House, unless there is formal objection to consideration, sustained by the House.

2.5316 On the final day of a convention, voting delegates may present resolutions of an emergency nature which shall be accepted pursuant to 2.552.

resolutions or other new business, may be presented to the Board of Trustees at any time during a convention.

2.533 **Reports of Councils.** Reports or recommendations from a Council of the AMA or a Special Committee of the House of Delegates may be presented at any time before the close of business on the day preceding the final day of a convention.

2.54 **Referral to Reference Committee.** Reports, recommendations, resolutions or other new business presented before the close of business on the day preceding the final day of a session shall be referred to an appropriate reference committee for hearings and report.

2.55 **New Business on Final Day of Convention**

2.551 Reports, recommendations, resolutions or other new business presented by the Board of Trustees on the final day of a convention shall not be referred to a reference committee but favorable action shall require an affirmative vote of $^3/_4$ of all delegates present and voting.

2.552 **Emergency Resolutions.** Resolutions of an emergency nature presented by voting delegates on the final day of a convention shall be referred by the Speaker to an appropriate reference committee, which shall then report to the House as to whether the matter involved is or is not of an emergency nature.

2.5521 If the reference committee reports that the matter is of an emergency nature, it shall be presented to the House without further consideration by a reference committee. Favorable action shall require the affirmative vote of $^3/_4$ of all delegates present and voting.

2.5522 If the reference committee reports that the matter is not of an emergency nature, the Speaker shall defer its introduction until the next convention of the House of Delegates.

2.56 **Quorum.** One hundred voting members of the House of Delegates shall constitute a quorum.

2.60 **Conventions**

2.61 **Regular Conventions.** The House of Delegates shall meet annually. The House of Delegates shall also hold one interim convention each year. Business that may properly come before an annual convention may be considered at any interim convention subject to the provisions of the Bylaws.

acting for, or in the name of, not less than one-third of the constituent associations, or on request of a majority of the Board of Trustees. When a special convention is thus called, the Executive Vice President shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special convention is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the convention is called.

2.63 Locations. The House of Delegates shall meet annually and at such other times as deemed necessary or as provided in these Bylaws in cities selected by the Board of Trustees.

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

2.64 Meetings

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

2.642 Closed. A closed meeting shall be restricted to members of this Association, and to members of the staff of this Association, constituent associations and component medical societies.

2.643 Executive. An executive meeting shall be limited to the members of the House of Delegates as defined in 2.10 and to such employees of the Association necessary for its functioning.

2.70 Committees of the House of Delegates. The following classes of committees are hereby provided:

Reference Committees
Convention Committees
Special Committees

2.701 Qualification of Members

2.7011 Membership on Reference committees and Convention committees is restricted to delegates and alternate delegates.

eligible to serve on a special committee. Members of committees who are not members of the House may present their reports in person to the House and may participate in debate thereon but are not entitled to vote.

2.702 Relation to the Board of Trustees. Committees that function during the interval between conventions of the House shall be under the direction of the Board of Trustees.

2.71 Reference Committees of the House of Delegates

2.711 Enumeration. The following Reference Committees are hereby provided:

2.7111 Amendments to the Constitution and Bylaws. To which shall be referred all proposed amendments to the Constitution or Bylaws and matters pertaining to the Principles of Medical Ethics of the American Medical Association.

2.7112 Additional Reference Committee. Such additional reference committees as may be required to consider the items of business before the House of Delegates. They shall be designated Reference Committee A, Reference Committee B, Reference Committee C, etc. Business relating to a particular subject shall, as nearly as possible, be referred to the same Reference Committee.

2.712 Appointment. The Speaker shall appoint from the delegates and alternate delegates, the Chair and other members of committees enumerated in 2.7111 and 2.7112 and such other reference committees as the House may approve.

2.713 Size. Each reference committee shall consist of seven members, unless otherwise provided.

2.714 Term. These committees shall serve only during the convention at which they are appointed, unless otherwise directed by the House.

2.715 Organization

2.7151 Consideration of Business. Each Reference Committee shall convene whenever necessary. It shall consider business referred to it and report to the House of Delegates.

2.7152 Quorum. A majority of the members of each committee shall constitute a quorum.

2.7153 **Request Witnesses.** Reference Committees may request whomever they wish to appear before them to help formulate their conclusions and recommendations.

2.716 **Procedure and Reports**

2.7161 **Method.** Resolutions, reports and proposals presented to the House of Delegates shall be referred to appropriate Reference Committees. The reports of Reference Committees shall be presented to the House before final action may be taken on such resolutions, reports and proposals, unless otherwise provided in these Bylaws, or unless otherwise unanimously ordered by the House of Delegates.

2.7162 **Minority Reports.** A member of a Reference Committee who intends to make a minority report shall not sign the majority report and shall make this intention known to the other members of the Reference Committee while it is in executive session and prior to the presentation of the majority report to the House of Delegates.

2.7163 **Withdrawal of Resolutions.** A resolution may be withdrawn by its sponsor at any time prior to its referral to a Reference Committee. After such referral has been made, the resolution is the property of the House of Delegates. If, in the judgment of the sponsor and of the Reference Committee, it appears that withdrawal of the resolution is preferable to presentation for action, the Reference Committee may recommend withdrawal to the House in its report. If the House supports this recommendation by a majority vote, the resolution is withdrawn and is recorded in the minutes of the convention as having been withdrawn without action.

2.72 **Convention Committees**

2.721 **Committee on Rules and Credentials.** The Committee on Rules and Credentials is responsible for consideration of all matters relating to the registration and certification of delegates, and is also responsible for proposing rules of conduct and procedure for the orderly transaction of the business of the House of Delegates.

2.723 **Other Committees.** The Speaker may appoint such other Convention Committees as may be desirable for the efficient transaction of business of the House of Delegates.

2.7231 **Appointment.** The Speaker shall appoint the chair and other members of Convention Committees from the delegates and alternate delegates.

2.7232 **Size.** Each convention committee shall consist of seven members, unless otherwise provided.

2.7233 **Term.** These committees shall serve only during the convention at which they are appointed, unless otherwise directed by the House.

2.7234 **Quorum.** A majority of the members of each Committee shall constitute a quorum.

2.7235 **Reports.** The reports of the Convention committees shall be presented to the House of Delegates at the call of the Speaker.

2.73 **Special Committees of the House of Delegates.** The House may create special committees for specified terms of one to three years. The number of members, the manner of their appointment and the functions of these Committees shall be in accordance with terms of the motions authorizing their appointment.

2.74 **Sunset Provision.** The provisions of these bylaws increasing the size of Reference Committees and Convention Committees from five members to seven members and enabling alternate delegates to serve on said committees shall expire at the conclusion of the 1994 Interim Meeting of the House of Delegates, unless by action of the House of Delegates this paragraph is deleted from the bylaws and the aforesaid provisions are expressly retained.

3.00 General Officers

3.10 **Designations.** The general officers of the Association shall be those specified in Article VII of the Constitution.

3.20 **Qualifications.** A general officer must have been an Active member of the Association for at least two years immediately prior to election. The Speaker and Vice Speaker of the House shall be elected from among the members of the House.

3.30 **Nominations.** Nominations for officers except for Secretary-Treasurer, shall be made from the floor by a member of the House of Delegates. A nominating speech shall not exceed two minutes.

3.40 **Elections**

3.41 Time of Election. Officers of the Association, except the [illegible] Treasurer and the Medical Student Member of the Board of Trustees shall be elected by the House at the annual convention, except as provided in 3.60 and 3.70. On recommendation of the Convention Committee on Rules and Credentials, the House shall set the day and hour of such election by adopting an appropriate motion.

3.42 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

3.421 Trustees, Other Than the Resident Physician Members, to be Elected for full Three Year Term.

3.4211 First Ballot. All nominees for the office of Trustee for a full term of three years shall be listed alphabetically on a single ballot. Each elector shall have four votes and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more than four votes, or if the ballot contains more than one vote for any nominee. A nominee that has received a vote on a majority of the legal ballots cast and is one of the four nominees receiving the largest number of votes shall be elected.

3.4212 Run-Off Ballot. A run-off election shall be held to fill any vacancy which cannot be filled because of a tie vote.

3.4213 Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot and three or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating those nominees who received the fewest number of votes on the preceding ballot, except where there is a tie . When two or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees for a full term yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until four Trustees have been elected.

3.422 Trustees, Other than the Resident Physician Member, to be Elected to Fill Unexpired Terms. The nomination and election of Trustees to fill unexpired terms shall be held after election of Trustees for full three year terms and shall follow the same

automatically be nominated for subsequent elections until all Trustees have been elected. In addition, nominations from the floor shall be accepted. Election of Trustees to fill unexpired terms of two years shall be completed before the nomination and election of Trustees to fill an unexpired term of one year.

3.4221 If two or more unexpired terms of the same length are to be filled, the election procedure shall be the same as that provided in Section 3.421 and the subsections thereof, for the election of multiple Trustees for a full term.

3.4222 If only one unexpired term is to be filled, the election procedure shall be the same as provided in Section 3.423 for the separate election of officers.

3.423 Resident Physician Member of the Board of Trustees and all Other Officers. The Resident Physician Member of the Board of Trustees and all other officers shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee receiving the lowest number of votes shall be eliminated from consideration, except where there is a tie for the lowest number of votes, and a new ballot is taken. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

3.50 Terms

3.501 President-Elect. The President-Elect shall be elected annually and shall serve as President-Elect until the next inauguration and shall become President upon installation at the inaugural ceremony, serving thereafter as President until the installation of a successor. The inauguration of the President may be held at any time during the convention.

3.502 Speaker and Vice Speaker. The Speaker and Vice Speaker of the House of Delegates shall be elected annually, each to serve for one year or until their successors are elected and installed.

3.503 Secretary-Treasurer. A Secretary-Treasurer shall be selected by the Board of Trustees from one of its members and shall serve for a term of one year.

3.504 Trustees other than the Resident Physician Member and the Medical Student Member. Four Trustees, other than the Resident Physician member and the medical student member, shall be elected annually, each to serve for a term of three years. A Trustee shall not

serve for more than three ...

unexpired term shall not be regarded as having served a term unless two or more years have been served.

3.5041 **Prior Service as Resident Member of the Board of Trustees.** A member elected as provided in 3.504 who has previously served as Resident Member of the Board of Trustees shall be limited to a maximum tenure of eleven years combined service on the Board as Resident Member and Active Member elected under 3.504 above.

3.505 **Resident Physician Member of the Board of Trustees.** The Resident Physician member of the Board of Trustees shall serve a term of two years and shall not serve for more than three terms. If the Resident Physician member of the Board of Trustees is unable, for any reason, to complete the term for which he or she was elected, the remainder of the term shall be deemed to have expired. The successor, elected by the House of Delegates pursuant to Section 3.60 of these bylaws, shall be elected to a term to expire at the conclusion of the second Annual Meeting of the House of Delegates following the meeting at which said Resident was elected.

3.5051 The term of the Resident Physician member of the Board of Trustees shall terminate and the position shall be declared vacant if the said member should cease to be in an approved training program that qualifies the said member for Resident Physician membership in the AMA. Notwithstanding the foregoing, if the said member shall complete an approved training program within 90 days prior to an annual convention, he or she shall be permitted to continue to serve on the Board of Trustees until the completion of the annual convention.

3.506 **Medical Student Member of Board of Trustees.** A medical student member of AMA shall be elected annually by the Medical Student Section Assembly to serve as a member of the Board of Trustees. The medical student member of the Board of Trustees shall have all of the rights of any other member of the Board to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, except that the medical student member of the Board of Trustees shall not have the right to vote on intra-Board elections or other elections, selections, appointments or nominations conducted by the Board of Trustees.

3.5061 The Medical Student Trustee shall be elected at the Business Meeting of the Medical Student Section prior to the Interim

close of the next Annual Meeting of the Association and continuing at the close of the second Annual Meeting of the Association following the meeting at which the member was elected.

3.5062 The medical student member elected to serve as a member of the Board of Trustees shall be eligible for re-election as long as the member remains eligible for Medical Student membership in AMA.

3.5063 The term of the medical student member of the Board of Trustees shall terminate and the position shall be declared vacant if the said medical student member should cease to be eligible for Medical Student membership in AMA by virtue of the termination of the member's enrollment in an approved medical school. Notwithstanding the foregoing, if the medical student member shall graduate from an approved medical school within 90 days prior to an annual convention, the said medical student shall be permitted to continue to serve as a member of the Board of Trustees until completion of the annual convention.

3.60 Vacancies

3.601 Appointment. The Board of Trustees may by appointment, fill any vacancy in the office of Speaker, Vice Speaker or Trustee to serve until the next meeting of the House of Delegates. A vacancy in the office of medical student member of the Board of Trustees shall be filled by appointment by the Board of Trustees from two or more nominations provided by the AMA Medical Student Section Governing Council. The Board of Trustees may request additional nominations from the AMA Medical Student Section Governing Council before making the appointment.

3.602 Election to fill Vacancy. Any vacancy in the office of President-Elect, Trustee, Speaker or Vice Speaker shall be filled by election by the House of Delegates at the earliest convenient time recommended by the Convention Committee on Rules and Credentials and approved by the House of Delegates.

3.603 Absences. If a general officer misses six (6) consecutive regular meetings of the Board, this matter shall be reported to the House of Delegates by the Board of Trustees and the office shall be considered vacant. The vacancy shall be filled as provided in 3.602.

3.70 Successor to the President. If the Office of President becomes vacant, the President-Elect shall immediately become President and serve the remainder of the unexpired term and then assume office in accordance with 3.501. If the Office of President becomes vacant during a period when the office of

President for the remainder of the unexpired term.

3.80 Installation of General Officers. The general officers of the Association, except the President, shall assume their duties at the close of the last meeting of the House of Delegates at the annual convention at which they are elected. The Medical Student Trustee shall assume office at the close of the last meeting of the House of Delegates at the annual convention following the Interim Meeting at which the said Medical Student Trustee was elected.

3.81 Installation of the President. The President-Elect shall be installed as President, and shall assume the duties of that office, at the inaugural meeting.

3.811 Inaugural. The inaugural meeting shall be held during the annual convention and shall be presided over by the President. If the President is absent, or so requests, the Speaker shall preside until the induction of the incoming President. The program for this meeting shall be arranged by the Executive Vice President of the Association, subject to approval by the Board of Trustees.

4.00 Duties and Privileges of Officers

4.10 President. The President shall:

4.101 Deliver an inaugural address,

4.102 Address the opening meeting of the annual convention of the House of Delegates,

4.103 Participate, ex-officio and without the right to vote in sessions of the House of Delegates

4.104 Nominate, subject to confirmation by the Board of Trustees, committee requested by the councils and committees for emergencies and purpos not otherwise provided for in the Constitution and in these Bylaws.

4.105 Nominate, for election by the House of Delegates, members of the Cou on Ethical and Judicial Affairs.

4.106 Serve, ex-officio, as a member of the Board of Trustees.

4.20 President-Elect. The President-Elect shall:

4.201 Participate, ex-officio and without the right to vote, in the sessions of House of Delegates.

4.202 Serve, ex-officio, as a member of the Board of Trustees.

officio, as a member of the Board of Trustees.

4.40 Speaker. The Speaker:

4.401 Shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require,

4.402 May address the House of Delegates at the opening meeting of all conventions. Such address shall be limited to matters of conduct and procedure in the House. The Speaker is entitled to vote when the vote is by ballot. Otherwise, the Speaker has the right to vote only in case of a tie,

4.403 Shall attend all meetings of the Board of Trustees (including executive sessions) with right of discussion but without the right to vote.

4.50 Vice Speaker. The Vice Speaker shall:

4.501 Officiate for the Speaker in the latter's absence or at the request of the speaker.

4.502 In the event of vacancy in the office of Speaker, the Vice Speaker shall officiate during the unexpired term.

4.503 The Vice Speaker shall be entitled to vote when the vote is by ballot. Otherwise, when officiating for the Speaker or when filling a vacancy in the office of Speaker, the Vice Speaker shall have the right to vote only in case of a tie.

4.504 Attend all meetings of the Board of Trustees (including executive sessions) with right of discussion but without the right to vote.

4.60 Secretary-Treasurer. In addition to the duties ordinarily incumbent on the secretary of a corporation by law and custom, and those granted or imposed in other provisions of the Constitution and these Bylaws, the Secretary-Treasurer shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

5.00 Board of Trustees

5.10 Composition. The Board of Trustees shall consist of seventeen members, as follows:

A. Twelve members elected as provided in 3.504
B. The Resident Physician member elected as provided in 3.423 for the term provided in 3.505

C. A medical student member elected by the Medical Student Section Assembly as provided in 3.506

D. The President, President-Elect and Immediate Past President

5.101 Members of the Board of Trustees elected under 3.504, the Resident Physician member and the medical student member of the Board of Trustees, shall resign all other positions held by them in the Association upon their election to the Board of Trustees. No person, while serving as a member of the Board of Trustees shall be a delegate or an alternate delegate to the House of Delegates.

5.102 Members of the Board of Trustees may serve on Councils or Committees when specifically provided for in the Bylaws.

5.11 Speakers. The Speaker and Vice Speaker of the House of Delegates shall attend all meetings of the Board (including executive sessions) with right of discussion but without the right to vote.

5.20 Organization

5.201 Officers and Committees. Immediately following the conclusion of the annual convention, the Board shall organize by electing a chairman, a vice-chairman, a secretary and committees necessary for its functions.

5.202 Executive Committee. The Board of Trustees at its organization meeting, by resolution adopted by a majority of the Trustees in office, may designate three or more Trustees to constitute an executive committee. Members of the committee shall serve until the next organization meeting of the Board and until their successors are elected and qualified. The executive committee shall have such powers and duties as may be defined from time to time by the Board of Trustees.

5.30 Meetings

5.301 Regular Meetings. There shall be at least four regular meetings of the Board of Trustees each calendar year, held at such time and place as the Board shall determine. Notice of each regular meeting shall be given at least ten days before each such meeting.

5.302 Special Meetings. Special meetings may be called at any time by the chairman or at the request of seven members of the Board. Notice shall be given at least two days before each such meeting.

5.303 Quorum. A majority of the voting members of the Board of Trustees shall constitute a quorum.

phone, mail, telegram or any other means of electronic communication approved by the Board of Trustees. Notice shall be deemed to be received upon delivery to the Trustee's address then appearing on the records of the Association.

5.305 Waiver of Notice. Notice of any meeting need not be given if waived in writing before, during or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting except where such attendance is for the express purpose of objecting to the transacting of any business because of a question as to the legality of the calling or convening of the meeting.

5.306 Telephone Conference. Trustees may participate in and act at any meeting through the use of a conference telephone or other communications equipment by means of which all persons participating in the meeting can communicate with each other. Such participation shall constitute attendance and presence at the meeting.

5.40 Duties and Privileges. In addition to the rights and duties conferred or imposed upon the Board of Trustees elsewhere in the Constitution and Bylaws, it shall:

5.401 Perform all acts and transact all business for or in behalf of the Association and manage the property and conduct the affairs, work and activities of the Association, except as may be otherwise provided in the Constitution or these Bylaws. All resolutions and recommendations of the House of Delegates pertaining to the expenditure of funds shall be referred to the Board of Trustees which shall determine if the expenditure is advisable. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House of Delegates the reasons for its decision;

5.402 Within the policies adopted by the House of Delegates, provide for the publication of *The Journal of the American Medical Association* and such specialty journals, periodicals and other publications as it may deem to be desirable in the best interests of the public and medical profession;

5.403 Select annually from one of its members a Secretary-Treasurer who shall assume the duties of a general officer as provided in 4.60 of the Bylaws;

5.404 Appoint an Executive Vice President to manage and direct the activities of the Association and to perform the duties commonly

5.405 Have the accounts of the Association audited at least annually;

5.406 Make proper financial reports concerning Association affairs to the House at its annual convention;

5.407 Appoint such committees as necessary to carry out the purposes of the Association and other committees as the House of Delegates may direct;

5.408 Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws.

6.00 Councils of the American Medical Association

6.01 Commencement of Term. Members of Councils of the AMA who are elected by the House of Delegates pursuant to the provisions of these Bylaws shall assume office immediately upon their election.

Members of Councils of the AMA who are appointed shall assume office as provided in the Bylaws.

6.011 Term of Resident or Medical Student Member. A Resident or medical student member of a Council of the AMA who graduates from medical school or completes an approved residency program within 9(days prior to an annual convention shall be permitted to serve on said Council until the completion of said Annual Convention.

6.02 Rules and Regulations. Each Council shall select a Chairman and Vice Chairman and it may adopt such rules and regulations as it deems necessary and appropriate for the conduct of its affairs subject to approval by the Boar of Trustees.

6.03 Committees of Councils of the AMA

6.031 Proposal of Committees. A Council of the AMA may propose the creation of a committee of the Council by submitting to the Board of Trustees a proposed charter that includes:

6.0311 A specific purpose for the committee.

6.0312 A specific program for the committee.

6.0313 A specific expected result of the Committee's activities.

6.0314 A specific time limitation, not to exceed 2 years, for the committee's existence. At the expiration of the specified time, t

6.0315 The size of the committee.

6.0316 A specific cost estimate.

6.032 **Board Approval.** The Board of Trustees shall review the proposed charter of the committee and shall have the right to approve, disapprove or recommend changes in the charter.

6.033 **Appointment.** The Board of Trustees, in conjunction with the Speaker of the House of Delegates, shall appoint the members of any committee of a Council of the AMA. The parent Council of the AMA may submit recommendations for membership on the committee to the Board of Trustees.

6.05 Reports and Referrals

6.051 **Information and Recommendations.** All Councils of the AMA have a continuing duty to provide information and to submit recommendations to the House of Delegates, through the Board of Trustees, on matters relating to the areas of responsibility assigned to them under the provisions of these Bylaws.

6.052 **Method of Reporting.** Councils of the AMA, with the exception of the Council on Ethical and Judicial Affairs, shall report to the House of Delegates through the Board of Trustees. The Board of Trustees may make such recommendations regarding the reports to the Councils as it deems appropriate, prior to transmitting the reports to the House of Delegates. The Board may also submit recommendations regarding the reports to the House of Delegates.

6.053 **Method of Referral.** Referrals from the House of Delegates to a Council or Councils of the AMA shall be made through the Board of Trustees. The Board may, in addition, refer the matter to such other councils as it deems appropriate.

6.10 Council on Constitution and Bylaws

6.101 **Functions.** The functions of the Council on Constitution and Bylaws are to serve as a fact-finding and advisory committee on matters pertaining to the Constitution and Bylaws. The Council will recommend such changes in the Constitution and Bylaws as it deems appropriate for action by the House of Delegates.

6.102 **Membership.** The Council on Constitution and Bylaws shall consist of the following:

House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House.

6.1022 In addition, the Speaker and Vice Speaker of the House of Delegates shall be ex-officio members of the Council without the right to vote.

6.1023 A medical student member of the AMA appointed by the Governing Council of the AMA Medical Student Section with the concurrence of the Board of Trustees shall also serve on the Council. The Council shall determine annually the voting privileges of the medical student member.

6.103 Term

6.1031 Voting Members other than the Resident Member. Voting members of the Council on Constitution and Bylaws other than the Resident Member shall be elected by the House of Delegates for terms of three years, so arranged that at each Annual Convention the term of two members expire.

6.1032 Resident Member. The Resident Member of the Council on Constitution and Bylaws shall be elected by the House of Delegates for a term of three years provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which elected, the service of such Resident member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.104 Tenure. Members of the Council on Constitution and Bylaws shall serve for no more than three terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless the time served was two or more years.

6.1041 Begining at the 1993 Annual Meeting, those members who are elected to the Council for the first time, for a full term (including an unexpired term of two years or more) shall serve for no more than two terms.

6.105 Vacancies

6.1051 Voting Members other than the Resident Member. Any vacancy among the voting members of the Council other than the Resident member shall be filled at the next meeting of the House of

Delegates for the remainder of the unexpired term.

6.1052 **Resident Member.** If the Resident Physician member of the Council is unable, for any reason, to complete the term for which he or she was elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at its next meeting for a term to expire at the conclusion of the third Annual Meeting of the House of Delegates following the meeting at which said Resident was elected.

6.20 Council on Medical Education

6.201 **Functions.** The functions of the Council on Medical Education are:

6.2011 To study and evaluate all aspects of medical education, including the development of programs approved by the House of Delegates for the provision of an adequate continuing supply of well-qualified physicians to meet the medical needs of the public;

6.2012 To study and evaluate education needs in the allied health professions and services, including the development of programs approved by the House of Delegates, to insure the provision of an adequate continuing supply of well-qualified allied health personnel;

6.2013 To review and recommend policies for medical and allied health education, whereby the AMA may provide the highest education service to both the public and the profession;

6.2014 To consider and recommend means by which the AMA may, on behalf of the public and the medical profession at-large, continue to provide information, leadership and direction to the existing inter-organizational bodies dealing with medical and allied health education;

6.2015 To consider and recommend the means and methods whereby physicians and allied health personnel may be assisted in maintaining their professional competence and the development of means and criteria for recognition of such achievement.

6.202 **Membership.** The Council on Medical Education shall consist of the following:

6.2021 Eleven Active members of the AMA, at least one of whom shall be a private practitioner of medicine who is not a salaried faculty member of a medical school, and one of whom shall be a Resident.

Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House.

6.2022 In addition, a medical student member of the AMA appointed by the Governing Council of the AMA Medical Student Section with the concurrence of the Board of Trustees shall also serve on the Council. The Council shall determine annually the voting privileges of the medical student member.

6.203 Term of Office

6.2031 Voting Members other than the Resident Member. Voting members of the Council on Medical Education, other than the Resident Member, shall be elected by the House of Delegates for terms of three years, so arranged that at two annual conventions the terms of four members shall expire and at one annual convention the terms of two members shall expire.

6.2032 Resident Member. The Resident member of the Council on Medical Education shall be elected by the House of Delegates for a term of three years provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which he or she was elected, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant.

6.204 Tenure. Members of the Council on Medical Education shall serve for no more than three terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served two or more years.

6.2041 Begining at the 1993 Annual Meeting, those members who are elected to the Council for the first time, for a full term (including an unexpired term of two years or more) shall serve for no more than two terms.

6.205 Vacancies

6.2051 Voting Members other than the Resident Member. Any vacancy among the voting members of the Council other than the Resident member shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates for the remainder of the unexpired term.

6.2052 Resident Member. If the Resident Physician member of the

to have expired. The successor shall be elected by the House of Delegates at its next meeting for a term to expire at the conclusion of the third Annual Meeting of the House of Delegates following the meeting at which said Resident was elected.

6.30 Council on Medical Service

6.301 Functions. The functions of the Council on Medical Service are:

6.3011 To study and evaluate the social and economic aspects of medical care; and, on behalf of the public and the profession, to suggest means for the timely development of services in a changing socio-economic environment;

6.3012 To investigate social and economic factors influencing the practice of medicine;

6.3013 To confer with state associations, component societies and National Medical Specialty Societies regarding changing conditions and anticipated proposals that would affect medical care;

6.3014 To assist medical service committees established by state associations, component societies of the American Medical Association, and the National Medical Specialty Societies.

6.302 Membership. The Council on Medical Service shall consist of the following:

6.3021 Eleven Active members of the AMA, one of whom shall be a Resident. These members of the Council shall be elected by the House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House.

6.3022 In addition, a medical student member of the AMA appointed by the Governing Council of the AMA Medical Student Section with the concurrence of the Board of Trustees shall also serve on the Council. The Council shall determine annually the voting privileges of the medical student member.

6.303 Term

6.3031 Voting Members other than the Resident Member. Voting members of the Council on Medical Service, other than the Resident member, shall be elected by the House of Delegates for terms of three years, so arranged that at two annual conventions

convention the terms of two members shall expire.

6.3032 **Resident Member.** The Resident member of the Council on Medical Service shall be elected by the House of Delegates for a term of three years provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which he or she was elected, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant.

6.304 **Tenure.** Members of the Council on Medical Service shall serve for no more than three terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served two or more years.

6.3041 Begining at the 1993 Annual Meeting, those members who are elected to the Council for the first time, for a full term (including an unexpired term of two years or more) shall serve for no more than two terms.

6.305 **Vacancies**

6.3051 **Voting Members other than the Resident Member.** Any vacancy among the voting members of the Council other than the Resident member shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates for the remainder of the unexpired term.

6.3052 **Resident Member.** If the Resident Physician member of the Council is unable, for any reason, to complete the term for which he or she was elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at its next meeting for a term to expire at the conclusion of the third Annual Meeting of the House of Delegates following the meeting at which said Resident was elected.

6.40 **Council on Ethical and Judicial Affairs**

6.401 **Authority.** The Council on Ethical and Judicial Affairs is the judicial authority of the American Medical Association and its decision shall be final.

6.402 **Functions.** The functions of the Council on Ethical and Judicial Affairs are:

6.4021 To interpret the Principles of Medical Ethics of the American Medical Association.

6.4023 To investigate general ethical ... to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates or the constituent associations.

6.4024 To receive appeals filed by applicants who allege that they, because of color, creed, race, religion, ethnic origin, national origin, or sex, have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or in the event of repeated violations, recommend to the House of Delegates that the constituent association involved be declared to be no longer a constituent member of the American Medical Association.

6.4025 To request the President to appoint investigating juries to which it may refer complaints or evidences of unethical conduct which in its judgment are of greater than local concern. Such investigative juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Council on Ethical and Judicial Affairs in the name and on behalf of the American Medical Association. The Council may acquit, admonish, suspend or expel the accused.

6.4026 To approve applications and nominate candidates for affiliate membership as otherwise provided for in 1 .141 of these Bylaws.

6.403 **Original Jurisdiction.** The Council on Ethical and Judicial Affairs shall have original jurisdiction in:

6.4031 All questions involving membership.

6.4032 All controversies arising under this Constitution and Bylaws and under the Principles of Medical Ethics to which the American Medical Association is a party.

6.4033 Controversies between two or more state associations or their members and between a constituent association and a component society or societies of another state association or associations or their members.

6.404 **Appellate Jurisdiction.** The Council on Ethical and Judicial Affairs shall have appellate jurisdiction in questions of law and procedure but not of

A. Between a constituent association and one or more of its component societies.
B. Between component societies of the same constituent association.
C. Between a member or members and the component society to which said member or members belong following an appeal to the member's constituent association.
D. Between members of different component societies of the same constituent association following a decision by the constituent association.

6.4041 Appeal Mechanisms. Notice of appeal shall be filed with the Council on Ethical and Judicial Affairs within thirty (30) days of the date of the decision by the state association and the appeal shall be perfected within sixty (60) days thereof; provided, however, that the Council on Ethical and Judicial Affairs, for what it considers good and sufficient cause, may grant an additional thirty (30) days for perfecting the appeal.

6.405 Membership. The Council on Ethical and Judicial Affairs shall consist of nine Active members of the American Medical Association, including one Resident Physician member and one Medical Student member. Members elected to the Council on Ethical and Judicial Affairs shall resign all other positions held by them in the Association upon their election to the Counci No member, while serving on the Council on Ethical and Judicial Affairs, shall be a delegate or an alternate delegate to the House of Delegates, or a General Officer of the Association, or serve on any other council, committe or as Representative to or Governing Council Member of a Special Section of the American Medical Association.

6.4051 Limit on Medical Student Participation. The Medical Student membe of the Council shall have the right to participate fully in the work of the Council, except that in disciplinary matters and in matters relating to membership the Medical Student member shall participate only if a medical student is the subject of the disciplinary matter or is the applicant for membership.

6.406 Nomination and Election. The members of the Council shall be elected the House of Delegates on nomination by the President. State Medical Associations, National Medical Specialty Societies, Special Sections of th AMA, and other organizations represented in the AMA House of Delegates, and members of the Board of Trustees may submit the names and qualifications of candidates for consideration by the President.

terms of office:

6.4071 The Medical Student member of the Council shall be elected for a term of two years, provided that if the Medical Student member ceases to be enrolled in an approved medical school or in an osteopathic medical school approved by an appropriate accrediting agency at any time prior to the expiration of the term for which the Medical Student member was elected, the service of such Medical Student member on the Council shall thereupon terminate, and the position shall be declared vacant. The Council shall determine the voting privileges of the Medical Student member for each term of service.

6.4072 The Resident Physician Member of the Council shall be elected for a term of three years provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which the Resident Physician member was elected, the service of such Resident member on the Council shall thereupon terminate, and the position shall be declared vacant. The Resident Physician member shall have the right to vote in all matters in which said member participates under the rules of the Council.

6.4073 All other members of the Council shall be elected by the House of Delegates for a term of seven years, so arranged that at each Annual Convention the term of one member shall expire.

6.408 Tenure. Members of the Council on Ethical and Judicial Affairs shall serve only one term, except that the Resident Physician member and the Medical Student member shall be eligible to serve for two terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of said term.

6.409 Vacancies

6.4091 Members other than the Resident Member. Any vacancy among the members of the Council on Ethical and Judicial Affairs other than the Resident member shall be filled at the next meeting of the House of Delegates. The new member shall be elected by the House of Delegates, on nomination by the President, for the remainder of the unexpired term.

Council is unable, for any reason, to complete the ... which he or she was elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at its next meeting, on nomination by the President, for a term to expire at the conclusion of the third Annual Meeting of the House of Delegates following the meeting at which said Resident was elected.

6.50 Council on Long Range Planning and Development

6.501 Charge. The functions of the Council on Long Range Planning and Development are:

6.5011 To study and make recommendations concerning the long-range objectives of the Association.

6.5012 To study and make recommendations concerning the projected resources, programs and organizational structure by which the Association attempts to reach its long-range objectives in 6.5011 above.

6.5013 To serve as a focal point for the planning activities of the Association and to stimulate and evaluate planning activities throughout the organization.

6.5014 To study, or cause to be studied, anticipated changes in the environment in which medicine and the Association must function, collect relevant data and transmit interpretations of these studies and data to the Board of Trustees for distribution to decision making centers throughout the Association, and submit reports to the House of Delegates at appropriate times.

6.502 Membership. The Council on Long Range Planning and Development shall consist of ten Active members. Five members of the Council shall be appointed by the Speaker of the House of Delegates as follows: two members shall be appointed from the membership of the House of Delegates, two members shall be appointed from the membership of the House of Delegates or from the AMA membership at large and one member appointed shall be a Resident. Four members of the Council shall be appointed by the Board of Trustees from the membership of the House of Delegates or from the AMA membership at large. One member appointed shall be a medical student member of AMA appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

1 and so arranged that in each of two years the terms of three members shall expire and in the third year the terms of four members shall expire, provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term for which he or she was appointed, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant; and provided further that if the medical student member ceases to be enrolled in an approved medical school at any time prior to the expiration of the term for which he or she was appointed, the service of such medical student member on the Council shall thereupon terminate and the position shall be declared vacant.

6.504 Tenure. Members of the Council on Long Range Planning and Development shall serve for no more than three terms, but a member appointed to serve an unexpired term shall not be regarded as having served a term unless such member has served two or more years.

6.5041 For terms begining July 1, 1993 and thereafter, those members who are appointed to the Council for the first time, for a full term (including an unexpired term of two years or more) shall serve for no more than two terms.

6.505 Vacancies. Any vacancy occurring on the Council on Long Range Planning and Development shall be filled by appointment by either the Speaker of the House of Delegates or by the Board of Trustees as provided in 6.502. The new member shall be appointed for the remainder of the unexpired term.

6.60 Council on Legislation

6.601 Functions. The functions of the Council on Legislation are:

6.6011 To review proposed federal legislation and recommend appropriate action in accordance with AMA policy;

6.6012 To recommend changes in existing AMA policy when necessary to accomplish effective legislative goals;

6.6013 To serve as a reference council through which all legislative issues of the Association are channeled prior to final consideration by the Board of Trustees.

6.6014 To maintain constant surveillance over the legislation scene and to anticipate future legislative needs.

6.6016 To monitor the development and issuance of federal regulations and to make recommendations to the Board of Trustees concerning action on such regulations.

6.6017 To develop and recommend to the Board of Trustees models for state legislation.

6.602 **Membership.** The Council on Legislation shall consist of the following:

6.6021 Eleven Active members of the AMA, one of whom shall be a Resident. These members of the Council shall be appointed by the Board of Trustees.

6.6022 In addition, the Board of Trustees may appoint a member of the American Dental Association as a voting member of the Council on Legislation upon nomination by the American Dental Association. The appointment of a member of the American Dental Association to the Council on Legislation is subject to a reciprocal right to have an American Medical Association member, nominated by the AMA Board of Trustees, appointed as a voting member of the Council on Legislation of the American Dental Association.

6.6023 The Board of Trustees shall also appoint a medical student member of the AMA as a member of the Council on Legislation from nominations submitted by the AMA Medical Student Section. The Council shall determine annually the voting privileges of the medical student member.

6.603 **Term.** Members of the Council on Legislation shall be appointed by the Board of Trustees for terms of one year, beginning on July 1 of each year, provided that if the Resident or medical student member ceases to be enrolled in an approved program, their service on the Council shall thereupon terminate and the position shall be declared vacant.

6.604 **Tenure.** Members of the Council on Legislation shall serve no more than nine terms.

6.6041 For terms begining July 1, 1993 and thereafter, those members who are appointed to the Council for the first time shall serve for no more than six terms.

6.605 **Vacancies.** Any vacancy occurring on the Council shall be filled for the remainder of the unexpired term at the next meeting of the Board of Trustees.

6.8011 To advise on substantial and promising developments in the scientific aspects of medicine and biomedical research that warrant public attention.

6.8012 To advise on professional and public information activities that might be undertaken by the AMA in the field of scientific medicine.

6.8013 To assist in the preparation of policy positions on scientific issues raised by the public media.

6.8014 To advise on policy positions on aspects of government support, involvement in or control of biomedical research.

6.8015 To advise on opportunities to coordinate or cooperate with the scientific activities of national medical specialty societies, voluntary health agencies, other professional organizations and governmental agencies.

6.8016 To consider and evaluate the benefits that might be derived from joint development of domestic and international programs on scientific affairs.

6.8017 To propose and evaluate activities that might be undertaken by the AMA as major scientific projects, either individually or jointly with state and local medical societies.

6.802 Membership. The Council on Scientific Affairs shall consist of the following:

6.8021 Eleven Active members of the AMA, one of whom shall be a Resident. These members of the Council shall be elected by the House of Delegates. The Board of Trustees shall nominate two or more eligible members for each vacancy on the Council, and further nominations may be made from the floor of the House.

6.8022 In addition, a medical student member of the AMA appointed by the Governing Council of the AMA Medical Student Section with the concurrence of the Board of Trustees shall also serve on the Council. The Council shall determine annually the voting privileges of the medical student member.

6.803 Term

6.8031 Voting Members other than the Resident Member. Members of the Council on Scientific Affairs, other than the Resident member, shall

shall expire and at one annual convention the terms of two members shall expire.

6.8032 Resident Member. The Resident member of the Council on Scientific Affairs shall be elected by the House of Delegates for a term of three years provided that if the Resident member ceases to be in an approved training program at any time prior to the expiration of the term, the service of such Resident member on the Council shall thereupon terminate and the position shall be declared vacant.

6.804 Tenure. Members of the Council on Scientific Affairs shall serve for no more than three terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served two or more years.

6.8041 Begining at the 1993 Annual Meeting, those members who are elected to the Council for the first time, for a full term (including an unexpired term of two years or more) shall serve for no more than two terms.

6.805 Vacancies

6.8051 Voting Members other than the Resident Member. Any vacancy among the voting members of the Council other than the Resident member shall be filled at the next meeting of the House of Delegates. Such member shall be elected for the remainder of the unexpired term.

6.8052 Resident Member. If the Resident Physician member of the Council is unable, for any reason, to complete the term for which he or she was elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at its next meeting for a term to expire at the conclusion of the third Annual Meeting of the House of Delegates following the meeting at which said Resident was elected.

6.90 Method of Election

6.901 Members of the Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service and Council on Scientific Affairs shall be elected by the following method:

6.9011 Separate Election. The Resident member of said Councils, as well a: the private practitioner of medicine who is not a salaried faculty member of a medical school on the Council on Medical Education

shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee receiving the lowest number of votes shall be eliminated from consideration, except where there is a tie for the lowest number of votes, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

6.9012 Other Council Members to be Elected for a full Term. With reference to each such Council, all nominees for membership for a full term shall be listed alphabetically on a single ballot. Each elector shall have as many votes as there are members to be elected and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer votes or more votes than the number of members to be elected, or if the ballot contains more than one vote for any nominee. A nominee shall be elected if he or she has received a vote on a majority of the legal ballots cast and is one of the nominees receiving the largest number of votes within the number of members to be elected.

6.9013 Run-off Ballot. A run-off election shall be held to fill any vacancy which cannot be filled because of a tie vote.

6.9014 Subsequent Ballots. If all vacancies are not filled on the first ballot and three or more Members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating those nominees who received the fewest number of votes on the preceding ballot, except where there is a tie. When two or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council for a full term yet to be elected, and must cast each vote for a different nominee. This procedure shall be repeated until all members of the Council for a full term have been elected.

6.9015 Council Members to be Elected to fill Unexpired Terms. With reference to each such Council, the nomination and election of Members of the Council to fill unexpired terms shall be held after election of Members of the Council for full terms, and shall follow the

of the Council for a full term shall automatically be nominated for subsequent elections until all Members of the Council have been elected. In addition, nominations from the floor shall be accepted. Election of Members of the Council to fill unexpired terms of two years shall be completed before the nomination and election of Members of the Council to fill an unexpired term of one year.

6.90151 If two or more unexpired terms of the same length and for the same Council are to be filled, the election procedure shall be the same as provided in Sections 6.9012-6.9014 for the election of multiple Council members.

6.90152 If only one unexpired term for the same Council is to be filled, the election procedure shall be the same as provided in Section 6.9011 for the separate election of Council members.

7.00 Special Sections

7.10 **Resident Physicians Section.** The Resident Physicians Section is composed Resident Members of the Association who are serving in approved training programs.

7.11 **Governing Council.** There shall be a Governing Council for the Resident Physicians Section. The Governing Council shall consist of the officers of the Resident Physicians Section and two members at-large of the Counc All members of the Governing Council must be Resident Physician members of the American Medical Association elected by the representatives to the Business Meeting of the Resident Physicians Section.

7.111 **Duties.** The Governing Council shall direct the programs and the activities of the Resident Physicians Section, subject to the appr of such programs and activities by the Board of Trustees or the House of Delegates of the American Medical Association.

7.112 **Termination.** The service of a Governing Council member shall terminate and the position shall be declared vacant if the said member ceases to be in an approved training program that qual the said member for Resident Physician membership in the AM Notwithstanding the foregoing, if the said member shall comple approved training program within 90 days prior to an annual convention, the said member shall be permitted to continue to s on the Governing Council until the completion of the annual convention.

Section. The new members shall be elected for the remainder of the unexpired term by the Representatives to the Business Meeting.

7.12 Officers and Their Duties. The representatives to the Business Meeting of the Resident Physicians Section shall elect the following officers:

7.121 Chair. The Chair shall preside at all meetings of the Governing Council and the Business Meetings of the Resident Physicians Section.

7.122 Chair-Elect. The Chair-Elect shall assist the officers in the discharge of their duties.

7.123 Vice Chair. The Vice Chair shall preside at meetings of the Governing Council or the Business Meetings of the Resident Physicians Section, in the absence of the Chair or at the request of the Chair.

7.124 Secretary. The secretary shall maintain such records as are required or advisable for the conduct of the activities of the Resident Physicians Section.

7.125 Delegate and Alternate. The Delegate and Alternate Delegate shall represent the Section in the AMA House of Delegates.

7.13 Business Meeting. There shall be a Business Meeting of members of the Resident Physicians Section. The Business Meeting shall be held on a day prior to each Annual and Interim Meeting of the House of Delegates, at a time and place designated by the Executive Vice President.

7.131 Representatives to the Business Meeting

7.1311 Constituent Members. Resident Members of the AMA in those constituent associations that provide full membership for them shall select one representative for each one hundred (100) or fraction thereof Regular Members of the AMA who are Resident Physicians serving in approved training programs and are members of the constituent association. The Executive Vice President of the American Medical Association shall notify each constituent association of the number of representatives to which it is entitled. Each representative to the Business Meeting of the Resident Physicians Section must be serving in an approved training program and shall be certified by the President or Secretary of the constituent association to be a member in good standing.

training programs who are Direct Members of AMA may be selected as Representatives to the Business Meeting of the Resident Physicians Section upon application to the Governing Council for the Resident Physicians Section. The Governing Council shall select representatives from those states that do nc provide full membership for Resident Physicians on the basis of one representative for each one hundred (100) or fraction thereof Direct Members of AMA from that state who are Resident Physicians serving in approved training programs. The Governing Council shall select such representatives pursuant tc such uniform rules and criteria as they may adopt from time to time for such purpose.

7.1313 Members Serving in the Military or in Federal Agencies. Resident physicians serving in training programs approved by the Association who are Direct Members of the AMA and servin in the United States Army, the United States Navy, the United States Air Force, the United States Public Health Service, the Veterans Administration or other Federal agencies may be selected as Representatives to the Business Meeting of the Resident Physicians Section upon application to the Governing Council for the Resident Physicians Section. The Governing Council shall select representatives from the said services and government agencies on the basis of one representative for eac one hundred (100) or fraction thereof Direct Members of AMA from each of the said services and government agencies who ai Resident Physicians serving in training programs approved by the Association. The Governing Council shall select such representatives pursuant to such uniform rules and criteria as they may adopt from time to time for such purpose.

7.1314 National Medical Specialty Organizations. Those National Medical Specialty Organizations that have been granted representation in the AMA House of Delegates and have established a Resident Physician membership component ma; be represented at the Business Meeting of the Resident Physicians Section by a Representative selected by the Reside Member of the Specialty Organization. The Governing Council shall adopt uniform rules and criteria to determine if a Natior Medical Specialty Organization has established a Resident Physician membership component so as to qualify for represe tation at the Business Meeting of the Section. The procedure

Organization is selected must meet the requirements established by the Governing Council.

7.132 Rules of Order. Only duly selected Representatives to the Business Meeting of the Resident Physicians Section shall have the right to vote, but the meeting shall be open to any member of the American Medical Association. The meeting shall be conducted pursuant to established rules of procedure adopted by the Governing Council, subject to approval by the Board of Trustees.

7.133 Purposes of the Meeting. The purposes of the meeting shall be:

7.1331 To hear such reports as may be appropriate.

7.1332 To elect, at the meeting immediately prior to the Interim Meeting, a Chair-Elect who shall serve as Chair-Elect until the conclusion of the next Annual Meeting, whereupon the Chair-Elect shall become Chair and serve until the conclusion of the following Annual Meeting.

7.1333 To elect, at the meeting immediately prior to the Annual Convention, the other officers of the Resident Physicians Section, and two members at-large of the Governing Council. Those elected shall assume office at the conclusion of the Annual Convention at which they are elected and shall serve until the conclusion of the next Annual Convention.

7.1334 To consider and vote upon such matters as may properly come before the meeting.

7.134 Quorum. Twenty per cent of the authorized Representatives representing at least fifteen states shall constitute a quorum for the Business Meeting of the Resident Physician's Section.

7.20 Medical Schools Section

7.21 Purpose. The purpose of the Medical Schools Section is to provide a direct means for approved Medical Schools to participate in American Medical Association activities.

7.22 Membership. All members of the Section must be active members of the American Medical Association. The membership of the Section shall consist of the following:

7.221 The Chief Administrative Officer (ie: Dean) of each approved Medical School, or a member of the staff of the Chief Administrative Officer designated by the Chief Administrative Officer.

Dean) or the faculty of each approved Medical School, selected by the Chief Administrative Officer of the Medical School.

7.223 A member of the faculty of each approved Medical School, selecte by the physician members of the faculty.

7.23 Governing Council. There shall be a Governing Council of the Section or Medical Schools that shall have the responsibility of directing the programs and activities of the Section, subject to the approval of the Boa of Trustees. The members of the Governing Council shall be the followin

7.231 Chair-Elect, Chair, Immediate Past Chair.

7.2311 Duties. The Chair shall preside at all Business Meetings of th Section and the Governing Council. The Chair-Elect shall assi the Chair and preside at meetings in the absence of the Chai or at the Chair's request. The Immediate Past Chair shall attend all meetings of the Governing Council.

7.2312 Term. A Chair-Elect shall be elected annually at the Busines Meeting of the Section held immediately prior to the Annual Convention of the Association. The member elected shall assume office at the conclusion of the Annual Convention at which the election was held and shall serve until the conclus of the next Annual Convention; whereupon the Chair-Elect shall succeed to the office of Chair and shall serve in that off for one year until the conclusion of the next Annual Convention; whereupon the Chair shall become Immediate Past Chair and shall serve in that office for one year until th conclusion of the next Annual Convention.

7.2313 Vacancy. In the event the office of Chair shall become vaca for any reason, the office shall remain vacant until the conclusion of the next Annual Convention of the Associatio which time the Chair-Elect shall succeed to the office of Ch During any vacancy in the office of Chair, the duties and responsibilities of the office shall be assumed by the Chair-Elect. In the event the office of Chair shall become vacant for any reason while the office of Chair-Elect is vacant, bot offices shall be filled by election at the next Business Meet the Section. The office of Chair shall be filled before an ele is held to fill the office of Chair-Elect. Those elected shall s the unexpired term remaining for each office.

7.2321 Duties. The Delegate and Alternate Delegate shall represent the members of the Section in the House of Delegates.

7.2322 Term. The Delegate and Alternate Delegate shall be elected in even numbered years at the Business Meeting of the Section held immediately prior to the Annual Convention of the Association. Those elected shall assume office at the conclusion of the Annual Convention at which the election was held and shall serve until the conclusion of the second Annual Convention after they assume office.

7.2323 Vacancy. If the office of Delegate becomes vacant for any reason, the Alternate Delegate shall assume the office of Delegate and serve for the remainder of the unexpired term. If the office of Alternate Delegate becomes vacant for any reason, at the next Business Meeting of the Section a successor shall be elected to serve the remainder of the unexpired term.

7.233 Three members of the Section who will serve on the Governing Council.

7.2331 Duties. The members shall attend all meetings of the Governing Council.

7.2332 Term. The members shall be elected annually at the Business Meeting of the Section held immediately prior to the Annual Convention of the Association. Those elected shall take office at the conclusion of the Annual Convention at which they are elected and shall serve until the conclusion of the next Annual Convention. No member shall serve for more than two terms.

7.2333 Vacancy. In the event of a vacancy, at the next Business Meeting of the Section, a successor shall be elected to serve the remainder of the unexpired term.

7.25 Business Meeting. The Section on Medical Schools shall hold a business meeting on a day prior to each Annual and Interim Meeting of the House of Delegates, at a time and place fixed by the Executive Vice President. The purposes of the meeting shall be:

7.251 To discuss such matters as may be appropriate.

7.252 To elect, at the meeting immediately prior to the Annual Convention, the Chairman-Elect, and three members of the Governing Council; and to elect, at the meeting immediately prior to

Alternate Delegate.

7.253 To consider and vote upon such matters as may properly come before the meeting.

7.30 Medical Student Section. There shall be a Special Section for Medical Student Members of the American Medical Association.

7.31 Purpose. The purpose of the Medical Student Section is to provide a direct means for medical students to participate in the activities of the Association.

7.32 Governing Council. There shall be a Governing Council of the Medical Student Section.

7.321 Members. The Governing Council shall consist of the officers of the Medical Student Section and one member at large of the Governing Council, all of whom shall be elected at the Business Meeting of the Medical Student Section held prior to the Annual Meeting of the Association. All members of the Govering Council must be Medical Student members of the American Medical Association. No more than one voting member of the Governing Council may be elected from any one state. The Immediate Past Presiding officer shall be, ex-officio, a non-voting member of the Governing Council.

7.322 Term and Tenure. Governing Council members shall serve one year terms, beginning at the conclusion of the Annual Meeting at which they were selected and ending at the conclusion of the next Annual Meeting of the Association. Voting members of the Governing Council shall serve for no more than two terms.

7.323 Duties. The Governing Council shall direct the programs and activities of the Medical Student Section, subject to the approval of such programs and activities by the Board of Trustees or the House of Delegates of the American Medical Association.

7.324 Vacancies. Any vacancy occurring on the Governing Council shall b filled at the next business meeting of the Medical Student Section. The new member shall be selected for the remainder of the unexpired term in the same manner as the original selection was made, as outlined in 7.321.

7.3241 Temporary Appointment. If a vacancy on the Governing Council occurs more than 30 days prior to the next Assembly meeting, the Governing Council may appoint a Medical Stude Member of AMA to fill the vacancy until the next business

be held pursuant to rules adopted by the Medical Student Section.

7.325 Officers. The officers of the Medical Student Section and their duties shall be as follows:

7.3251 Chair. The Chair shall preside at all meetings of the Governing Council of the Medical Student Section and shall otherwise represent the Section when appropriate.

7.3252 Vice Chair. The Vice Chair shall preside at meetings of the Governing Council in the absence of the Chair or at the request of the Chair. The Vice Chair shall assist the Chair in the discharge of his or her duties.

7.3253 Delegates and Alternate Delegate. The Delegate and Alternate Delegate shall represent the Medical Student Section in the AMA House of Delegates.

7.3254 At Large Member of Governing Council. The At Large Member of the Governing Council shall assist the officers in the dis charge of their duties.

7.326 Election of Officers. The Officers of the Medical Student Section shall be elected in the following manner.

7.3261 Election Procedure for Chair. The election of the Chair shall precede the election of all other officers and shall be conducted as follows:

7.32611 Nomination. Nomination for the office of Chair shall be received in advance of the Annual Meeting pursuant to the rules of the Medical Student Section. Further nominations may be made from the floor of the Business Meeting at a time determined by the Governing Council.

7.32612 Election. Each voting Representative to the Business Meeting who is present at the meeting may cast a written ballot for the election of the Chair from among those nominated for that office. Said balloting shall be conducted pursuant to the Rules of the Medical Student Section. Election to the office of the Chair requires a majority of the legal votes cast. If no candidate receives a majority of the legal votes cast, a run-off election will be held between the two candidates with the highest number of votes.

7.32613 Unsuccessful Candidates for Chair. Nominees for the office of Chair who are not elected to that office may be nominated from the floor of the Business Meeting for election to any other office.

7.3262 Procedure for election of all other offices. The election of all offices other than the Chair shall follow the election of the Chair and shall be conducted as follows:

7.32621 Nomination. Nominations for the office of Vice Chair, Delegate and At Large Member, shall be received in advance of the Annual Meeting pursuant to the rules of the Medical Student Section. Futher nominations may be made from the floor of the Business Meeting at a time determined by the Governing Council. Additionally, unsuccessful candidates for the office of Chair may be nominated from the floor of the Business Meeting immediately following the election of the Chair.

7.32622 Election. Each voting representative to the Business Meeting who is present at the meeting may cast a written ballot containing three votes, one vote each for the election of a Vice Chair, Delegate and At Large Member, from among those nominated for those respective offices. Said balloting shall be conducted pursuant to the Rules of the Medical Student Section. Election to each such office requires a majority of the legal votes cast. If no candidate receives a majority of the legal votes cast for any office, a run-off election will be held for said office between the two candidates with the highest number of votes..

7.32623 Election of Alternate Delegate. After the election of the Delegate, all unsuccessful candidates who were nominated for the office of Delegate will be placed on a ballot for the election of the Alternate Delegate. Each voting Representative to the Business Meeting who is present at the meeting may cast a written ballot for the election of the Alternate Delegate from among those so nominated. Said balloting sha be conducted pursuant to the Rules of the Medical Student section. Election to the office of Alternate Delegate requires majority of the leagl votes cast. If no candidate receives a majority of the legal votes cast, a run-off election will be hel between the two candidates with the highest number of vot

procedures for the election of officers, Section 7.326 and the subsections thereunder, shall expire at the conclusion of the 1995 Interim Meeting of the House of Delegates, unless by action of the House of Delegates this paragraph is deleted from the bylaws and the aforesaid provisions are expressly retained.

7.33 Business Meeting. There shall be a Business Meeting of Medical Student members of the American Medical Association. The Business Meeting shall be held on a day prior to each meeting of the AMA House of Delegates at a time and place designated by the Executive Vice President.

7.331 Representatives to the Business Meeting

7.3311 The AMA Medical Student Members of each medical school approved by the Association and each osteopathic medical school approved by an appropriate accrediting agency may select one voting member and one alternate member who must be Medical Student Members of the American Medical Association. The members so selected shall be properly certified to the Governing Council of the Medical Student Section in accordance with rules established by the Governing Council.

7.3312 The AMA Medical Student Members of a medical school as defined in 7.3311 that has more than one campus may select a voting member and an alternate from each campus. The members selected must be Medical Student members of the AMA and shall be properly certified to the Governing Council of the Medical Student Section. For purposes of this section a separate campus is defined as a separate facility in a city other than where the main campus is located, and where part of the medical school student body is assigned for some portion of their instruction over a period of time not less than an academic year.

7.33121 Request to seat a voting representative from a campus other than the main campus of the medical school must be submitted to the Medical Student Section at least 90 days in advance of the first meeting at which the representative will be seated. The Governing Council of the Medical Student Section shall establish appropriate rules for credentialling all representatives.

7.3313 Those national medical specialty organizations that have been

have established a Medical Student component may be represented at the Business Meeting of the Medical Student Section by one voting member and one alternate selected by the medical student members of the specialty organization, both of whom must be Medical Student Members of AMA and must be properly certified to the Governing Council of the Medical Student Section. The Governing Council shall adopt uniform rules and criteria to determine if a National Medical Specialty Organization has established a medical student membership component so as to qualify for representation at the Business Meeting of the Section. The procedure by which the medical student representative from the specialty organization is selected must meet the requirements established by the Governing Council.

7.3314 National Medical Student Organizations that have been granted representation in the Medical Student Section Business Meeting pursuant to the provisions of these bylaws may select one voting member and one alternate member, both of whom must be Medical Student Members of the American Medical Association. The members so selected shall be properly certified to the Governing Council of the Medical Student Section in accordance with rules established by the Governing Council.

7.33141 Criteria for Eligibility. National Medical Student Organizations that meet the following criteria may be considered for representation in the AMA Medical Student Section Business Meeting.

a. The organization must be national in scope.
b. The organization must be composed solely of medical students enrolled in accredited medical or osteopathic schools.
c. Membership in the organization must be available to all medical students, without discrimination.
d. The purposes and objectives of the organization must be consistent with AMA's purposes and objectives.
e. The organization's Code of Medical Ethics must be consistent with AMA's Principles of Medical Ethics.

7.33142 Procedure. The organization must submit a written application containing sufficient information to establish that the organization meets the criteria described in

following:

a. The organization's charter, constitution, bylaws and Code of Medical Ethics.
b. A list of the sources of the organization's financial support, other than the dues of its medical student members.
c. A list or description of all of the organization's affiliations.
d. Such additional information as may be requested.

The Governing Council shall review the application. If it recommends that the organization be granted representation in the Medical Student Section Business Meeting, the recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the organization may be represented in the Medical Student Section Business Meeting.

7.33143 **Biennial Review Process.** Each National Medical Student Organization represented in the Medical Student Section Business Meeting must reconfirm biennially that it continues to meet the criteria for eligibility by submitting such information and documentation as may be required by the Governing Council.

7.33144 **Rights and Responsibilities.** National Medical Student Organizations granted representation in the Medical Student Section Business meeting shall have the following rights and responsibilities.

a. Full voting rights in the Business Meeting, but shall not have the right to vote in any elections.
b. Shall not be eligible for election to any office in the AMA Medical Student Section.
c. To present its policies and opinions in the Business Meeting.
d. It shall require its representatives to report on the actions of the AMA Medical Student Section.
e. It shall cooperate in enhancing AMA Medical Student Section Membership.

7.33145 **Discontinuance of Representation.** The Governing Council may recommend discontinuance of the representation by a National Medical Student Organization on the basis that the organization fails to meet the criteria in 7.33141, has failed

attend the Business Meeting of the AMA Medical Student Section. The recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the representation of the National Medical Student Organization in the AMA Medical Student Section Business Meeting shall be discontinued.

7.3315 The AMA Medical Student members of the Charles R. Drew University of Medicine and Science campus of the University of California at Los Angeles Medical School may select one voting member and one alternate member to represent the campus at the Business Meeting of Medical Student Members. Both the voting member and the alternate member must be Medical Student Members of AMA and must be properly certified to the Governing Council of the Medical Student Section in accordance with rules established by the Governing Council.

7.332 Quorum. Twenty Five Voting Members shall constitute a quorum, provided that there is representation from three of the four demographic regions defined by the Medical Student Section rules.

7.333 Participation. Only duly selected Voting Members to the Business Meeting of the Medical Student Section shall have the right to vote, but the Meeting shall be open to all Medical Students. The meeting shall be conducted pursuant to established rules of procedure adopted by the Governing Council.

7.334 Speaker and Vice Speaker. A Speaker and a Vice Speaker shall be elected by the Representatives to the Business Meeting of The Medical Student Section. Any medical student member of the American Medica Association shall be eligible for the position of Speaker and Vice Speak

7.3341 Term and Tenure. The Speaker and Vice Speaker shall serve one y terms, beginning at the conclusion of the Annual Meeting at which they were elected and ending at the conclusion of the next Annual Meeting. No Representative shall serve for more than two terms in each position.

7.3342 Duties of Speaker. The Speaker shall preside at the Business Meeting of the Medical Student Section and perform such duties a are customarily required by parliamentary procedure.

7.3343 Duties of Vice Speaker. The Vice Speaker shall officiate for the Speaker in the Speaker's absence or at the request of the speake

the unexpired term. If the position of Speaker becomes vacant while the position of Vice Speaker is also vacant, the Representatives to the Business Meeting shall elect a successor to fill the unexpired term at the next Business Meeting. Until a successor is elected the Chairman of the Governing Council shall preside at the Business Meeting.

7.3345 Voting Rights. If the presiding officer is a Representative to the Business Meeting of the Medical Student Section, he or she shall be entitled to vote only when the vote is by ballot or to break a tie. If the presiding officer is not a Representative to the Business Meeting of the Medical Student Section, he or she shall be entitled to vote only to break a tie.

7.3346 Governing Council. The Speaker and Vice Speaker may attend Governing Council meetings without the right to vote.

7.335 Purposes of the Meeting. The purposes of the meeting shall be:

7.3351 To hear such reports as may be appropriate.

7.3352 To elect, at the Business Meeting prior to the Annual Meeting of the Association, the voting members of the Governing Council of the Medical Student Section, the officers pursuant to 7.325 and a Speaker and Vice Speaker.

7.3353 To elect, at the Business Meeting prior to the Interim Meeting of the Association, a medical student member of AMA to serve as a member of the AMA Board of Trustees for a term of one year begining at the close of the next Annual Meeting of the Association and concluding at the close of the second Annual meeting of the Association following the meeting at which the member was elected.

7.3354 To adopt resolutions for submission by the Medical Student Section to the House of Delegates of the American Medical Association.

7.3355 To conduct such other business as may properly come before the meeting.

7.40 Hospital Medical Staff Section. There shall be a special section for hospital medical staff physicians.

7.41 Purpose. The purpose of this section is to provide a direct means to address the relationship between members of the AMA and hospital staffs.

7.42 Membership. Membership in the section shall be limited to AMA members selected by physician members of the medical staffs of hospitals.

7.43 Governing ...
Medical Staff Section to direct the programs and activities ... subject to the approval of the AMA Board of Trustees.

7.431 Members. There shall be seven voting members of the Governing Council, consisting of the Officers, Delegate, Alternate Delegate and tw Governing Council members elected at the business meeting of the section as provided in 7.443(d) of these bylaws. In addition, the Immedicate Past Chair of the Governing Council shall serve, ex-officio, as a voting member of the Governing Council for one year only, to provi continuity in the leadership of the section.

7.432 Officers. The officers of the section shall have the following duties and responsibilities.

7.4321 Chair. The Chair shall preside at the business meetings of the sectic and at meetings of the Governing Council.

7.4322 Vice Chair. The Vice Chair shall assist the Chair and preside in the absence of the Chair or at the request of the Chair.

7.4323 Secretary. The secretary shall maintain such records as may be necessary or advisable for the conduct of the activities of the secti

7.4324 Delegate and Alternate Delegate. The Delegate and Alternate Delegate shall represent the members of the section in the AMA House of Delegates.

7.433 Term. Governing Council members, including the Delegate and Alternate Delegate, shall serve a term of two years, beginning at the conclusion of the Annual Meeting at which they were elected and er at the conclusion of the second Annual Meeting after their election. provisions of this section shall not be applicable to the Immediate F Chair, whose term is specified in section 7.431 of these bylaws.

7.434 Tenure. Governing Council members, excluding the Delegate and Alternate Delegate to the AMA House of Delegates, shall serve for r more than two consecutive terms in the same position on the Gove Council, but a member elected to serve an unexpired term shall nc regarded as having served a term. The provisions of this section sh be applicable to the Immediate Past Chair, whose total tenure is l to one year under Section 7.431 of these bylaws.

7.435 Vacancies. Any vacancy occurring on the Governing Council shal filled at the next business meeting of the section.

7.44 Business Meeting. There shall be a business meeting of members o

7.441 Representatives to the Business Meeting. The physician members of the medical staff of each hospital may select a representative to the business meeting of the Hospital Medical Staff Section. The representative must be an AMA member who is an active voting member of the medical staff with clinical privileges at the hospital.

7.4411 Representatives to the business meeting shall be elected by and from the active voting members of the medical staff of each hospital. Elected representatives to the Business Meeting shall be properly certified by the President or Secretary of the medical staff.

7.4412 The Chairs of State Medical Association Hospital Medical Staff Sections may be seated as ex-officio representatives to the Business Meeting, provided they are AMA members and are properly certified by the President or Secretary of the State Medical Association. Ex-officio representatives have the right to speak and debate in the meeting but do not have the right to introduce business introduce an amendment, make a motion or vote .

7.442 Rules of Order. Only duly selected representatives to the Hospital Medical Staff Section shall have the right to vote at the business meeting of the section, but the meeting shall be open to any member of the American Medical Association. The meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council of the section and approved by the AMA Board of Trustees.

7.443 Purposes of the Business Meeting. The purposes of the business meeting shall be:

A. to hear such reports as may be appropriate.
B. to consider and vote upon such matters as may properly come before the meeting.
C. to adopt resolutions for submission by the section to the House of Delegates of the American Medical Association.
D. to elect, at the business meeting prior to the annual meeting of the AMA House of Delegates in even numbered years, a Chair, Vice Chair, Secretary and one member of the Governing Council of the section; and to elect, at the business meeting prior to the annual meeting of the AMA House of Delegates in odd numbered years, a Delegate, Alternate Delegate and one member of the Governing Council of the section.

meeting.

7.444 Quorum. A quorum for the business meeting at the Hospital Medical Staff Section shall be recommended by the Board of Trustees and approved by the House of Delegates.

7.50 Young Physicians Section. There shall be a special section for young physician members of the American Medical Association which shall be known as the Young Physicians Section.

7.51 Purpose. The purpose of the Young Physicians Section is to provide a direct means for young physician members of the AMA to participate in the activities of the Association.

7.52 Membership. All active physician members of the American Medical Association who are not Residents serving in an approved training program, but who are under 40 years of age or are within the first five (5) years of professional practice after residency and fellowship training programs, shall be members of the Young Physicians Section.

7.53 Governing Council. There shall be a Governing Council of the Young Physicians Section that shall have the responsibility of directing the activities of the Section, subject to the approval of the Board of Trustees.

7.54 Officers and Members of Governing Council. The Young Physicians Section shall have the following officers, who shall be the members of the Governing Council. Any member of the Young Physicians Section, as defined in 7.52 above, shall be eligible for election to the Governing Council. If any such officer ceases to be a member of the Young Physicians Section for any reason at any time prior to the expiration of the term for which the member was elected, the term of such member shall thereupon terminate and the position shall be declared vacant. Notwithstanding the immediately preceeding provision of this section, the Immediate Past Chair shall be permitted to complete his or her term of office even if the said Immediate Past Chair is unable to continue to meet all of the membership requirements of Section 7.52 of these bylaws, as long as the individual remains an active physician member of the American Medical Association.

7.541 Chair-Elect, Chair, Immediate Past Chair.

7.5411 Duties. The Chair shall preside at all business meetings of the Young Physicians Section and the Governing Council. The Chair-Elect shall assist the Chair and preside at meetings in the absence of the Chair or at the Chair's request. The Immediate Past Chair shall attend all meetings of the Section and the Governing Council and shall assist and advise the Chair.

meeting of the Section held immediately prior to the [illegible] Convention of the Association. The member elected shall assume office at the conclusion of the Annual Convention at which the election was held and shall serve until the conclusion of the next Annual Convention; whereupon, the Chair-Elect shall succeed to the office of Chair and shall serve in that office for one year until the conclusion of the next Annual Convention; whereupon, the Chair shall become Immediate Past Chair and shall serve in that office for one year until the conclusion of the next Annual Convention.

7.5413 Vacancy. In the event the office of Chair shall become vacant for any reason, the office shall remain vacant until the conclusion of the next Annual Convention of the Association, at which time the Chair-Elect shall succeed to the office of Chair. During any vacancy in the office of Chair, the duties and responsibilities of the office shall be assumed by the Chair-Elect. In the event the office of Chair shall become vacant while the office of Chair-Elect is vacant, both offices shall be filled by election at the next business meeting of the Section. The office of Chair shall be filled before an election is held to fill the office of Chair-Elect. Those elected shall serve the unexpired term remaining for each office.

7.542 Delegate and Alternate Delegate.

7.5421 Duties. The Delegate and Alternate Delegate shall represent the Young Physicians Section in the AMA House of Delegates.

7.5422 Term. The Delegate and Alternate Delegate shall be elected in even numbered years at the business meeting of the Section held immediately prior to the Annual Convention of the Association. Those elected shall assume office at the conclusion of the Annual Convention at which the election was held and shall serve until the conclusion of the second Annual Convention after they assume office.

7.5423 Tenure. The Delegate and Alternate Delegate shall serve in each respective office for no more than two terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served one full year or more.

7.5424 Vacancy. If the office of Delegate becomes vacant for any reason, the Alternate Delegate shall assume the office of Delegate and serve for the remainder of the unexpired term. If the office of

business meeting of the Section a successor shall be elected to serve the remainder of the unexpired term.

7.543 Two Governing Council Members at Large.

7.5431 Duties. The Governing Council Members at Large shall participate in all deliberations of the Governing Council.

7.5432 Term. The Governing Council Members at Large shall be elected in odd numbered years at the business meeting of the Section held immediately prior to the Annual Convention of the Association. Those elected shall assume office at the conclusion of the Annual Convention at which the election was held and shall serve until the conclusion of the second Annual Convention after they assume office.

7.5433 Tenure. The Governing Council Members at Large shall serve no more than two terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served one full year or more.

7.5434 Vacancy. In the event of a vacancy in the office of Governing Council Member at Large, a successor shall be elected at the next business meeting of the Section to serve the remainder of the unexpired term.

7.55 Business Meeting. There shall be a business meeting of members of the Young Physicians Section held on a day prior to each Annual and Interim Meeting of the AMA House of Delegates, at a time and place designated by the Executive Vice President.

7.551 Delegates and Alternate Delegates to the Business meeting.

7.5511 Constituent Associations. Each constituent medical associati shall be entitled to delegate representation based on the number of seats allocated to it by apportionment.

7.55111 Apportionment. The apportionment of delegates and alternat delegates from each constituent association is one delegate an one alternate delegate for each thousand (1,000) or fraction thereof members of the AMA Young Physicians Section who a members of the constituent association, as recorded in the off of the Executive Vice President of the AMA on December 31 o each year.

7.55112 Effective Date. Such apportionment shall take effect the ensuing January 1 and shall remain effective for one year

of the AMA shall notify each constituent association of the number of seats in the AMA Young Physicians Section Business Meeting to which it is entitled during the current year.

7.55113 Gradual Phase-in of Apportionment. Notwithstanding the provisions of sections 7.55111 and 7.55112 above, constituent associations may increase their representation at the AMA Young Physicians Section Business Meeting consistent with the apportionment procedure described above but limited to an increase of two delegates and alternate delegates per year beginning with the AMA Young Physicians Section Business Meeting to be held immediately prior to the 1991 Annual Meeting of the AMA House of Delegates.

7.55114 Selection of Delegates. Young Physician members in each constituent association shall select the delegates and alternate delegates to the Business Meeting of the AMA Young Physicians Section. The procedure by which the delegates to the Business Meeting of the AMA Young Physicians Section are selected must be consistent with the rules and criteria established by the AMA Young Physicians Section Governing Council for that purpose.

7.55115 Refusal to Seat Delegates. The Young Physicians Section Governing Council shall review the procedures used by constituent associations to select delegates to the AMA Young Physicians Section Business Meeting. On the recommendation of the Governing Council, the delegates to the AMA Young Physicians Section Business Meeting may vote to refuse to seat delegates that have not been selected in a manner consistent with the rules and criteria established by the Governing Council.

7.5512 Federal Services. The Surgeons General of the United States Army, United States Navy, United States Air Force and United States Public Health Service shall each be entitled to select one voting delegate and one alternate delegate to serve in the Business Meeting of the Young Physicians Section.

7.5513 National Medical Specialty Organization. Those National Medical Specialty Organizations that have been granted representation in the AMA House of Delegates, and have established a Young Physicians membership component, may each be represented at the Business Meeting of the Young Physicians Section by one voting delegate and one alternate delegate. The Governing Council shall adopt uniform rules and criteria to determine if a national medical

Meeting of the Section. The procedure by which the Young Physician delegate and alternate delegate from the specialty organization is selected must meet the requirements established by the Governing Council.

7.5514 **Qualifications.** Each delegate to the Business Meeting of the Young Physicians Section must be a member of the AMA who meets the requirements for membership in the Young Physicians Section as set forth in 7.52. If a delegate is elected to the Governing Council of the Young Physicians Section, that delegate shall be required to resign as a delegate to the Business Meeting. The delegate's Constituent Association, Service or Specialty Organization may thereupon fill the vacancy so created.

7.5515 **Quorum.** Thirty voting delegates shall constitute a quorum for the business meeting of the Young Physicians Section.

7.552 **Rules of Order.** The business meeting of the Young Physicians Section shall be conducted pursuant to established rules of procedure adopted by the Governing Council, subject to the approval of the Board of Trustees. Only delegates to the business meeting shall have the right to vote in said meeting, and the chair shall have the right to vote only in case of a tie, but any member of the Young Physicians Section shall have the right to participate in discussions during the business meeting pursuant to the rules of procedure adopted for the meeting. The meeting of the Young Physicians Section shall be open to any member of the American Medical Association.

7.553 **Purposes.** The purposes of the business meeting shall be:

7.5531 To hear such reports as may be appropriate

7.5532 To consider and adopt resolutions for submission by the Young Physicians Section to the AMA House of Delegates

7.5533 To consider and vote upon such matters as may properly come before the meeting

7.5534 To elect at the business meeting prior to the annual meeting of the AMA House of Delegates the Officers and Members of the Governing Council of the Section as provided in 7.54.

7.5535 To conduct such other business as may properly come before the meeting.

8.10 Representation in the House of Delegates. National Medical Specialty Organizations qualifying under the provisions of this chapter shall be eligible for representation in the House of Delegates.

8.20 Purposes. The purposes of this chapter are:

8.201 to provide a mechanism for National Medical Specialty Organizations to participate in the deliberations of the House of Delegates;

8.202 to establish a system for effective and efficient mutual communications between AMA and the National Medical Specialty Organizations, and

8.203 to provide for input and participation in AMA activities by the National Medical Specialty Organizations.

8.30 Procedure. A National Medical Specialty Organization may apply for representation in the House of Delegates by submitting an application for such representation to the Board of Trustees. The applicant shall provide information to establish the organization's qualifications for representation under the current guidelines adopted by the House of Delegates and such additional information as the Board may request for its review. Upon completion of its study of the request for representation, the Board of Trustees shall make a recommendation to the House of Delegates. The House of Delegates shall take such action as it deems advisable on the request for representation.

8.40 Periodic Review Process. Each Specialty Organization represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating periodically, i.e., approximately every five years, that it continues to meet the current guidelines required for granting such representation, and that it has complied with the responsibilities imposed under Section 8.60 of these Bylaws. Each Specialty Organization represented in the House of Delegates must submit the information and data required by the Board of Trustees to conduct the review process provided for hereunder. Said information and data shall include a description of how the Specialty Organization has discharged the responsibilities required under Section 8.60 of these Bylaws.

8.41 Specialty Organizations granted representation in the House of Delegates will be notified by the Board of Trustees of the time of their review.

8.42 The Board of Trustees will provide the Specialty Organization with the

ting its report thereon to the House of Delegates, provided that the Specialty Organization has promptly furnished the information and data requested by the Board of Trustees for the review. Any delay in providing the requested information and data will result in a corresponding decrease in the amount of advance notice to the Specialty Organization before the Board of Trustees report is presented to the House of Delegates.

8.43 If a Specialty Organization fails or refuses to provide the information and data requested by the Board of Trustees for the review process described hereunder, so that the Board of Trustees is unable to conduct the review process, the Board of Trustees shall so report to the House of Delegates. In response to the Board of Trustees report, the House of Delegates may terminate the representation of the Specialty Organization in the House of Delegates by majority vote, or may take such other action as it deems appropriate.

8.44 If the Board of Trustees report of the review process finds the Specialty Organization to be in noncompliance with the current Guidelines for Representation in the House of Delegates or the responsibilities under Section 8.60 of these Bylaws, the Specialty Organization will have a grace period of one year to bring itself into compliance.

8.45 Another review of the Specialty Organization's compliance with the current Guidelines for Representation in the House of Delegates and the responsibilities under Section 8.60 of these Bylaws will then be conducted and the Board of Trustees will submit a report thereon to the House of Delegates at the end of the one year grace period.

8.451 If the Specialty Organization is then found to be in compliance with the current Guidelines for Representation in the House of Delegates and the responsibilities under Section 8.60 of these Bylaws, the Specialty Organization will continue to be represented in the House of Delegates and the current review process is completed.

8.452 If the Specialty Organization is then found to be in noncompliance with the current Guidelines for Representation in the House of Delegates, or the responsibilities under Section 8 .60 of these Bylaws, the House may take one of the following actions:

8.4521 It may continue the representation of the Specialty Organization in the House of Delegates, in which case the result will be the same as in 8.451 above.

Organization in the House of Delegates, in which case the Specialty Organization can reapply for representation under the provisions of 8.30 of these Bylaws.

8.4523 It may place the Specialty Organization on probationary status for a period of one year.

8.45231 Probationary status is defined as suspension from active representation in the House. The Specialty Organization on probationary status would not have a voting delegate in the House and would not have the privilege of the floor, but would be entitled to continue to have representation in the Specialty Section Council.

8.45232 Another review of the Specialty Organization's compliance with the current Guidelines for Representation in the House of Delegates and the responsibilities under Section 8.60 of these Bylaws will be conducted during the probation period and the Board of Trustees shall report thereon to the House of Delegates at the end of the probationary period. If the Specialty Organization has failed to bring itself into compliance with the Guidelines, it will automatically be terminated from representation in the House of Delegates. The Specialty Organization can then reapply for representation under the provisions of 8.30 of these Bylaws.

8.50 **Qualifications and Terms of Delegates.** The delegate and alternate delegate selected by a National Medical Specialty Organization to serve in the House of Delegates shall have the qualifications provided in 2.101 of these Bylaws and shall be selected for the terms provided in 2.221 of these Bylaws.

8.60 **Responsibilities of National Medical Specialty Organizations.** Each National Medical Specialty Organization represented in the House of Delegates shall have the following responsibilities:

8.61 To cooperate with the AMA in increasing its AMA membership.

8.62 To keep its delegate to the House of Delegates fully informed on the policy positions of the organization so that the delegate can properly represent the organization in the House of Delegates.

8.63 To require its delegate to report to the organization on the actions taken by the House of Delegates at each meeting.

8.64 To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.

8.65 To provide information and data to the AMA when requested.

8.70 **Discontinuance of Representation.** Any request to discontinue the representation of a National Medical Specialty Organization in the House of Delegates shall be referred to the Board of Trustees for study and report to the House of Delegates, whereupon the House may take such action as it deems advisable.

8.701 The Board of Trustees may initiate action to discontinue the representation of a National Medical Specialty Organization in the House of Delegates by recommending such action to the House of Delegates, whereupon the House may take such action as it deems advisable.

8.80 **Report by Board of Trustees.** The Board of Trustees shall report to the House of Delegates on matters relating to Specialty Organization representation in the House of Delegates and the status of the relationship of National Medical Specialty Organization to any approved examining board whenever the Board of Trustees has information which it believes should be transmitted to the House of Delegates or upon the specific request of the House of Delegates.

9.00 Specialty Section Councils

9.10 **Titles.** Specialty Section Councils shall be established for the following specialties:

(A) Allergy
(B) Anesthesiology
(C) Cardiovascular Disease
(D) Clinical Pharmacology and Therapeutics
(E) Colon and Rectal Surgery
(F) Dermatology
(G) Diseases of the Chest
(H) Emergency Medicine
(I) Family and General Practice
(J) Federal and Military Medicine
(K) Gastroenterology
(L) General Surgery
(M) Internal Medicine

(O) Neurology
(P) Nuclear Medicine
(Q) Obstetrics and Gynecology
(R) Opthalmology
(S) Orthopedic Surgery
(T) Otorhinolaryngology
(U) Pathology
(V) Pediatrics
(W) Physical Medicine and Rehabilitation
(X) Plastic, Reconstructive and Maxillofacial Surgery
(Y) Preventive Medicine
(Z) Psychiatry
(AA) Radiology
(BB) Urology

9.20 Purpose

9.21 Specialty Section Councils shall provide for deliberation and study of scientific educational and other appropriate interests and concerns of the specialty disciplines and the specialty organizations representing these disciplines within the AMA.

9.22 The Section Council shall on request submit to the Board of Trustees nominations for AMA representatives to serve on approved Specialty Certifying Boards.

9.30 Composition

9.31 National Medical Specialty Organizations represented in the AMA House of Delegates may appoint representatives to the Specialty Section Council for the medical specialty in which the specialty organization participates. Such representatives must be members of the AMA.

9.32 Upon recommendation of the Specialty Section Council and approval of the AMA Board of Trustees, National Medical Specialty Organizations which are not represented in the AMA House of Delegates may appoint representatives to the Specialty Section Council for the medical specialty in which the specialty organization participates.

9.33 The AMA Board of Trustees shall determine the number of representatives from each National Medical Specialty Organization to the Specialty Section Council in which such organization will participate on the basis of the number of AMA members belonging to each such specialty organization.

9.40 Specialty Organization Delegate. The AMA Delegate and Alternate Delegate from each National Medical Specialty Organization represented in the House of Delegates shall also serve in the Specialty Section Council of their respective specialty.

9.50 Chair and Vice Chair. Each Specialty Section Council shall elect a Chair and Vice Chair from within its membership.

9.60 Rules and Regulations. Each Specialty Section Council shall adopt such rules and regulations as the Specialty Section Council deems appropriate for the conduct of its affairs, subject, however, to the approval of the AMA Board of Trustees.

10.00 Scientific Assembly

10.10 Definition. The Scientific Assembly of the American Medical Association is defined in Article IX of the Constitution.

10.101 Rules and Regulations. All activities of the Scientific Assembly shall be conducted in accordance with rules and regulations promulgated from time to time by the Board of Trustees.

10.102 Meetings. The Scientific Assembly shall meet at such times and places as determined by the Board of Trustees.

11.00 Awards and Honors

11.10 Distinguished Service Award

11.11 Award. This award shall consist of a suitable medal and a citation selected and approved by the Board of Trustees.

11.12 Eligibility. This award may be made to a member of the Association for meritorious services in the science and art of medicine.

11.13 Nominations and Selection. Names of prospective nominees, together with a brief statement of their qualification for the award, shall be submitted to the Board of Trustees at least two months prior to the interim meeting of the House of Delegates. The Board shall select the recipient from among the nominees submitted.

11.14 Endorsement. The name of the nominee selected by the Board of Trustees to receive the Distinguished Service Award shall be presented to the House of Delegates for its endorsement.

11.15 Presentation. The award shall be presented to the recipient selected by the Board of Trustees at the next annual convention, or at a time and place designated by the Board of Trustees.

11.20 Citation of a Layman for Distinguished Service

11.21 Award. This award shall consist of a suitable certificate of citation selected and approved by the Board of Trustees.

11.22 Eligibility. This award shall be made to a person not of the medical profession who has contributed to the achievement of the ideals of American medicine by aid and cooperation in the advancement of medical science, medical education, or medical care.

11.23 Nominations and Selection. Names of prospective nominees, together with a brief statement of their qualification for the citation, shall be submitted to the Board of Trustees at least two month prior to the interim meeting of the House of Delegates. The Board of Trustees shall select the recipient from among the nominees submitted.

11.24 Endorsement. The name of the nominee selected by the Board of Trustees to receive the Citation of a Layman for Distinguished Service shall be presented to the House of Delegates for its endorsement.

11.25 Presentation. The citation shall be presented to the recipient selected by the Board of Trustees at the next annual convention, or at a time and place designated by the Board of Trustees.

11.30 Other Awards and Honors. Any other awards conferred by the AMA shall be as authorized and approved by the Board of Trustees.

12.00 Miscellaneous

12.10 Parliamentary Procedure. In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the Association and all meetings of the House of Delegates, of the Board of Trustees, of sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of *Davis' Rules of Order*.

12.20 Official Statements. Memorials, resolutions, or opinions of any character whatever which conflict with the policies of the House of Delegates shall not be issued in the name of the American Medical Association.

12.30 Papers and Reports. All papers and reports presented at any scientific or education meeting of the American Medical Association or of any of its

councils, committees or departments, shall become the exclusive property of the Association. However, the Board of Trustees may permit the publishing of a paper elsewhere than in a publication of the American Medical Association.

13.00 Amendments

13.10 Bylaws. These Bylaws may be amended by the approval of two-thirds of the members of the House of Delegates present and voting, provided an amendment shall not be acted on sooner than the day following that on which it was introduced, except that the Board of Trustees by unanimous vote may make such changes, and only such changes, as may be required to adapt them to the rules and regulations of the United States Post Office Department.

13.20 Principles of Medical Ethics. The Principles of Medical Ethics of the American Medical Association may be amended at any convention on the approval of two-thirds of the members of the House of Delegates present and voting, provided that the proposed amendment shall have been introduced at the preceding convention.

13.30 Articles of Incorporation. The Articles of Incorporation of the American Medical Association may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved said amendment and submitted it in writing to each member of the House of Delegates at least five days, but not more than forty days, prior to the meeting of the House at which the amendment is to be considered.

Index to Constitution and Bylaws of the American Medical Association
December, 1993 Revision

References to Articles of the Constitution are given in roman numerals. References to sections of the Bylaws of the American Medical Association are given in arabic numerals and decimal points, for example "other awards and honors, 11.30"

Principles of Medical Ethics

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV.A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.