



Constitution and Bylaws

Internal Affairs

Preamble, Purposes  
and Principles

2008–2009

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# **CONSTITUTION AND BYLAWS**

## **OF THE**

### **AMERICAN MEDICAL STUDENT ASSOCIATION**

#### **ARTICLE I. NAME**

The name of this Association shall be the American Medical Student Association.

#### **ARTICLE II. OBJECTIVES**

The objectives of the Association shall be as follows:

To be committed to the improvement of health care and health care-delivery to all people; to promote the active improvement of medical education; to involve its members in the social, moral and ethical obligations of the profession of medicine; to assist in the improvement and understanding of world health problems; to contribute to the welfare of all members, including premedical students, medical students, interns, residents and post-M.D./D.O. trainees; to advance the profession of medicine; to work to ensure that medicine reflects the diversity of society, with diversity including but not limited to differences in age, culture, race/ethnicity, sexual orientation and gender identity, gender and disability.

#### **ARTICLE III. MEMBERSHIP**

Membership in the Association shall be classified as follows:

- A. Full Membership
  - 1. Medical student membership (2003)
  - 2. Resident membership (2003)
- B. Affiliate Membership
  - 1. Supporting affiliate membership
  - 2. Corporate sustaining membership
  - 3. Premedical sustaining membership
  - 4. International sustaining membership
- C. Alumni Membership

##### **Section 1—Full Membership**

##### **A. Medical Student Membership**

Medical Student membership in the Association shall be available to medical students who have demonstrated a serious interest in the profession of medicine and the objectives of the organization and who have paid the required dues of the Association.

Medical Student membership shall be that period from the time of receipt of dues at the AMSA national office until termination of undergraduate medical education. At such a point, medical student members who pursue graduate medical education shall become resident members.

A “medical student” is defined as any individual enrolled in or on leave of absence from any LCME- or AOA-accredited or provisionally accredited North American allopathic or osteopathic training program or any international medical school listed in the International Medical Education Directory (IMED) of the Educational Commission for Foreign Medical Graduates (ECFMG). “Medicine” is defined as a profession of an individual from an allopathic or osteopathic educational background. (2007)

Full medical student members of the Association shall have the right to become medical student members of the various committees of the Board of Trustees, as specified in Article IV, Section I of the Constitution and Bylaws, and shall be entitled to the full privileges of the Association. (2003)

B. Resident Membership

Resident Membership in the Association shall be available to any person engaged in graduate education in the United States who has demonstrated a serious interest in the profession of medicine and the objectives of the organization and who have paid the required dues of the Association.

Resident membership shall be from the time of receipt of dues at the AMSA national office (in the case where dues are owed) or the initiation of graduate medical education (in the case where dues are not owed) until the completion or termination of graduate medical education.

Resident membership shall be conferred automatically to medical student members upon the completion of undergraduate medical education, provided that they fulfill the resident membership requirements above. International affiliate members who have completed medical school and fulfill the resident membership requirements may become resident members by contacting the AMSA national office.

Resident members shall have all benefits of the Association that are determined to be legally and fiscally feasible by the Board of Trustees. (2003)

**Section 2—Affiliate Membership**

A. Supporting Affiliate Membership

Supporting affiliate membership shall be available to any person not eligible for full membership, on payment of dues prescribed by the Board of Trustees. Supporting affiliate dues shall be uniform for all persons, except those in foreign countries, for whom a higher rate may be necessary.

Supporting affiliate members shall carry partial privileges in the Association, which shall not include election to national or regional office, voting privileges in the House of Delegates and regional meetings, or such benefits as shall be deemed legally or fiscally infeasible by the Board of Trustees. Supporting affiliate membership may be subject to annual renewal of membership upon recommendation of the Board of Trustees.

B. Corporate Sustaining Membership

Corporate sustaining membership may be granted upon the approval of the Board of Trustees of the Association and the payment of dues prescribed by the Board of Trustees to corporations, agencies, professional societies, or other organizations that have demonstrated a serious interest in the objectives of the Association. Such membership shall be nonvoting and non-office holding, but shall include receipt of such of the Association's publications as the Board of Trustees may deem appropriate.

C. Premedical Sustaining Membership

Premedical sustaining membership in the Association shall be available to any student attending or having graduated from an accredited university in the United States who has demonstrated a serious interest in the profession of medicine and the objectives of the Association, and who has paid the required National premedical sustaining dues of the Association. (2004)

1. Premedical sustaining membership shall carry partial privileges of the Association, which shall not include election to national or regional office, except for Premedical Trustee and Premedical Regional Director, as specified in Article IV, Section 11 of the Constitution and Bylaws, and Action Committee Coordinator and Project Coordinator as specified in Section III, Part B of the Internal Affairs. No more than two premedical students may serve as committee coordinators in each of the Action Committees. (2007)

2. Premedical sustaining members shall not have voting privileges in the House of Delegates and regional meetings, or such benefits as shall be deemed legally or fiscally infeasible by the Board of Trustees.
3. There shall be a Premedical Caucus, which shall be composed of all premedical sustaining members of the Association. The Premedical Caucus will convene during each annual meeting under the direction of the Premedical Trustee and the National President. The Premedical Caucus shall elect a Premedical Trustee and the Premedical Regional Director as specified in Article VIII, Section 4 of the Association's Constitution and Bylaws. (1991)
4. The Premedical Trustee will represent the views of the premedical caucus to the Board of Trustees. (2001)

**D. International Sustaining Membership**

International sustaining membership in the Association shall be available to all American and foreign students ineligible for full membership, who are in training at foreign medical institutions who have demonstrated a serious interest in the profession of medicine and the objectives of the organization, and who have paid the required yearly dues of the Association. (2007)

1. International sustaining members shall carry full privileges of the Association, except for election to offices other than International Trustee or International Programming Coordinator, Action Committee Coordinator and Interest Group Coordinator, voting privileges in the House of Delegates and regional meetings (2003) and such benefits as shall be deemed legally or fiscally infeasible by the Board of Trustees. The Board of Trustees may annually renew international membership subject to recommendation. (1991)
2. There shall be an International Caucus, which shall be composed of all international full and international sustaining members of the Association. The International Caucus will convene during each annual meeting under the direction of the International Trustee and the National President. The International Caucus shall elect an International Trustee and the International Programming Coordinator as specified in Article VII, Section 13 of the Association's Constitution and Bylaws. (2007)
3. The International Trustee will represent the views of the International Caucus to the Board of Trustees. During Board of Trustees meetings, the Board will hold comments and/or suggestions made from the International Trustee as equal to those of a voting member of the Board of Trustees. (2003)

**Section 3—Alumni Membership**

Lifetime alumni membership is conferred upon all members of the Board of Trustees, Board of Regional Directors, Regional Programming Coordinators, Student Office Fellows, Action Committee Chairs and Coordinators, Chapter Presidents (or equivalent chapter officer), Interest Groups and any full AMSA member or International affiliate who demonstrates interest in becoming an alumni member by contacting the AMSA National Office. (2007)

**Section 4—Resignation**

Any member may resign upon written notification to the Board of Trustees and to the local chapter, if there is one. Resignation shall entail forfeiture of all dues paid to the Association.

**ARTICLE IV. CHAPTERS**

**Section 1—Petitioning for a New Chapter**

**A. Medical Chapters**

Any group of at least five (5) medical students in any one medical school in the United States or Canada may petition for a chapter within the Association. The petitioners shall sign the petition and date their signatures, and shall supply any additional information requested by the Board of Trustees. There shall not be more than one (1) such chapter at any medical school campus. Eligibility for multiple chapters at single medical schools or joint chapters between multiple medical schools will be at the discretion of the Board of Trustees after reviewing the individual school's structure, finances and geographical limitations. (2008)

Branch campuses providing less than two years of medical education and/or which do not have a Dean of Medical Studies shall be considered part of the accredited degree granting institution rather than an independent chapter. Such branch campuses may receive all chapter mailings and shall retain all program affiliations; however, the number of delegates to the House of Delegates for a degree granting institution shall be determined by the total number of student members at the main campus, plus those at all branch campuses which do not have separate chapter status.

B. Premedical Chapters

Similarly, any group of at least five premedical students studying at an accredited university in the United States who have demonstrated a serious interest in the profession of medicine and the objectives of the organization, may petition for affiliate chapter status within the Association. There shall be not more than one (1) such chapter at any undergraduate campus or program. (1991)

1. Each affiliate Premedical Chapter shall be entitled to (1) vote in the Premedical Caucus, as specified in Article VIII, Section 4 of the Constitution and Bylaws. (1991)
2. Chapter Officers representing Premedical Chapters may attend the yearly Chapter Officers Conference. Premedical chapters may plan meetings for the purpose of education and leadership development, in association with the Premedical Trustee.
3. Any potential premedical chapters must submit a constitution to be considered for a charter. (1995)
4. Premedical chapters of AMSA shall strive to create a system of support through the presentation of information and resources to its members while also seeking to expose them directly to the medical community, provide forums of interaction with their peers, medical students and physicians.
5. Premedical chapter officers shall not charge local membership dues without collecting national AMSA dues nor will they retain members who do not pay national AMSA membership. Whether events are open to the AMSA members-only or not is left to the discretion of the local leaders. (2008)

C. International Chapters

Similarly, any group of at least five medical students studying at an international medical school may petition for chapter status within the Association. There shall be not more than one (1) such chapter at any campus. That chapter may receive information about AMSA's activities and programs through chapter mailings, if that group meets expenses. Such services will be provided at cost, to be determined by the BOT on an annual basis. (1991)

1. Each International Chapter shall be entitled to (1) vote in the International Caucus (2003)
2. Chapter Officers representing International Chapters may attend the yearly Chapter Officers Conference. International chapters may plan meetings for the purpose of education and leadership development, in association with the International Trustee. (2003)
3. International chapters of AMSA shall strive to create a system of support through the presentation of information and resources to its members while also seeking to expose them directly to the medical community, provide forums of interaction with their peers, medical students and physicians. (2003)

D. Requirements Pertaining to All Chapters

1. All petitions, including medical school, premedical and international charters, and all supporting materials must be postmarked no later than sixty (60) days prior to the opening session of the House of Delegates at the annual meeting at which they are to be considered. If this date falls on a Sunday or a legal holiday in any given year, then the deadline is extended to the next regular business day. The Board of Trustees shall reserve the right to extend this deadline only under extenuating and extraordinary circumstances with a 2/3 vote. Furthermore, the school petitioning for charter must have a minimum of 5 registered active, medical, premedical or international members no later than sixty (60) days prior to the opening session of the House of Delegates in order for the petition to be considered.
2. All constitutions and changes to them must be submitted to the National Office.
3. All newly elected officers must be updated to the National Office within two months after elections. (1995)

4. Chapters shall not impede any interested party from becoming a member for any reason. Chapters may, however, maintain records of membership participation and allot funding for travel, projects, etc. to those most active members, as the leadership of the chapters deems appropriate.
5. Chapter Officers must be members of national AMSA. (2004)

### **Section 2—Ratification of Charter**

A charter shall be granted to the petitioning chapter upon approval of the Board of Trustees and subject to ratification by a simple majority vote at the House of Delegates at its next Annual Meeting.

### **Section 3—Suspension and Expulsion of Chapter Members**

The chapters shall be vested with the power to suspend or expel their members, so long as such suspension or expulsion is not inconsistent with the Constitution and Bylaws of the Association.

## **ARTICLE V. SUSPENSION OR REVOCATION OF A CHAPTER**

### **Section 1—Revocation of a Charter by the National Office**

The national office reserves the right to review and demand correction of any gross violation of either AMSA policy or basic democratic philosophy. In worst case scenarios the national office reserves the right to revoke the charter of any chapter that either refuses to rectify any heinous situation after being notified by the national office or one that has done such damage through the misuse of authority and/or of AMSA's name that the national office deems it prudent to discontinue association with the chapter. The charter of any chapter may be suspended or revoked by the House of Delegates upon a vote to that effect by at least three-fourths (3/4) of those voting.

### **Section 2—Revocation of a Charter by an Individual**

1. Any individual may file written charges against any chapter that the accuser feels to have acted in conflict with the letter or intent of the Constitution and Bylaws of the Association, or to have failed to comply with all requirements of the Constitution and Bylaws of the Association, or with any lawful requirement of the House of Delegates. Such charges shall be signed, dated, and filed with the Executive Director of the Association, who shall submit a copy of said charges to the accused chapter and request of the chapter a written reply. He/she shall so present said charges and the reply to the Board of Trustees at its next meeting.
2. If the Board of Trustees fails to dismiss said charges, it shall fix a time and place for the hearing of the charges, which time shall be not less than fifteen (15) days, nor more than ninety (90) days, after the serving of such charges. If, following the hearing, the Board of Trustees fails to dismiss the charges, it shall advise the accused chapter of its recommendations, and shall make known its decision in a written resolution signed by the President of the Association at least thirty (30) days prior to the next Annual Meeting of the Association.
3. At the next Annual Meeting of the Association, the resolution shall be presented to and acted upon by the House of Delegates. Before the voting shall commence, the chapter shall be allowed forty-five (45) minutes to answer charges. Upon suspension or revocation of the charter by a three-fourths vote of the House of Delegates, the delegation of that chapter shall leave the floor of the House of Delegates.

### **Section 3—Petitioning for a New Charter After Revocation**

A chapter whose charter is thus revoked may petition for a new charter as specified in Article IV Section I of the Constitution and Bylaws. Chapters that had their charters revoked may not apply for a new charter for one year after such revocation has occurred.

### **Section 4—Procedure for Revocation of Chapters with Fewer than Five Members**

To remain a chartered chapter of AMSA, a medical, premedical affiliate, or international affiliate chapter must maintain at least five national members in good standing. If a chapter has five or fewer members on January 1st of a calendar year, then the Chapter President and appropriate school administrator of said chapter shall receive a warning from the National Office stating that the chapter charter will be revoked on December 31st. Chapters that do not have at least five members by October

15th shall receive a second notice of probation. If a chapter still does not have at least five members in good standing by December 31st, then the charter of said chapter shall be automatically revoked. (2004)

The Regional Director, Regional Programming Coordinator, International Trustee, and International Programming Coordinator, and/or Premedical Trustee and Premedical Regional Directors shall work with chapters with fewer than five members to expand chapter membership to at least five individuals. (2004)

## **ARTICLE VI. WITHDRAWAL OF A CHAPTER**

### **Section 1—Withdrawal by a Medical Chapter From the National Association**

1. If a medical chapter wishes to withdraw from the Association, it shall present a petition to the Board of Trustees. This petition shall carry the signature of at least two-thirds (2/3) of the medical student members of the chapter as found on the national membership rolls. The signatures on the petition shall be dated.
2. When the Board of Trustees has established the authenticity of the petition for withdrawal, the chapter shall be considered to have withdrawn from the Association. The President of the Association shall immediately notify the chapter that its petition for withdrawal has been accepted and its charter revoked.
3. The withdrawal of a chapter shall immediately cause the loss of membership privileges of all members of that chapter signing the petition for withdrawal.

### **Section 2—Withdrawal by a Premedical Chapter From the National Association** (2005)

1. If a premedical chapter wishes to withdraw from the Association, it shall present a petition to the Board of Trustees. This petition shall carry the signatures of at least two-thirds (2/3) of the premedical student members of the chapter as found on the national membership rolls. The signatures on the petition shall be dated. (2005)
2. In the event that the premedical chapter does not obtain two-thirds (2/3) of the total premedical members of the chapter as found on the national membership rolls and has reason to believe that some members may have graduated, they shall submit a letter to the national office containing the names of the members that the chapter believes are no longer affiliated with the school. The national office shall attempt to contact every member on that list within one month of receiving the petition in order to verify their enrollment. If after two successive attempts the members are unable to be reached, these members will no longer count toward the total number of premedical members of the given premedical chapter. (2005)
3. When the Board of Trustees has established the authenticity of the petition for withdrawal, the premedical chapter shall be considered to have withdrawn from the Association. The President of the Association shall immediately notify the chapter that its petition for withdrawal has been accepted and its charter revoked. (2005)
4. The withdrawal of a chapter shall immediately cause the loss of membership privileges of all members of that chapter signing the petition for withdrawal. Members not signing the petition shall retain their membership privileges. (2005)

### **Section 3—Petitioning for a New Charter After Withdrawal**

A chapter that has withdrawn from the Association may petition for a new charter in the manner outlined in Article IV, Section I of the Constitution and Bylaws.

## **ARTICLE VII. LEADERSHIP AND STRUCTURE**

### **Section 1—Qualifications of the Officers and Trustees**

All Officers and Trustees of the Association shall be medical student members of the Association, except for the Alumni and Resident Trustee, Premedical Trustee and Premedical Regional Directors, International Trustee and International Programming Coordinator, at the time of their election and during their term of office. In addition, each Regional Director and Regional Programming Coordinator shall be an active member of a chapter located in the established geographical region from which he/she is elected. The Trustees shall represent all of the regions and shall not be elected on a regional basis. The Vice President for Programming shall be an active member of the Association and shall represent all of the regions and therefore be elected by the House of Delegates. (2008)

## **Section 2—Term of Office**

The term of office for all Officers, Regional Directors, Regional Programming Coordinators, Premedical Trustee, Premedical Regional Directors, International Trustee, International Programming Coordinator and Vice President for Programming, shall be for one (1) year, or until their successors are duly elected and qualified. The Secretary and Vice President for Internal Affairs shall serve two (2) year terms such that one Secretary shall be elected a year. None of the above Officers or Trustees serves more than two (2) consecutive terms in the same position. (2008)

The above Officers and Trustees shall serve for a total of fourteen months, the final two months as Outgoing Officers and Trustees, except for the President-Elect, who shall have a two-week in-person transition period following his/her election. The President-Elect will assume responsibilities as President approximately 30 days prior to the spring meeting of the Board of Trustees following his/her election. (2008)

## **Section 3—Training of the Officers**

The American Medical Student Association will devote a day to training its elected officers in the skills they will need to successfully execute their offices. The exact content of the leadership training will be left to the discretion of the ED, the National President and the Secretary and Vice President for Internal Affairs. (2008)

## **Section 4—Dismissal of the Officers**

The Board of Trustees (BOT) shall be empowered to dismiss from his/her position any Officer, Trustee, Regional Director, Regional Programming Coordinator, Premedical Trustee, Premedical Regional Director, Alumni and Resident Trustee, International Trustee, International Programming Coordinator, Immediate Past President (2006), or ED of the Association, who has failed to perform the duties of his/her position, providing that the person in question shall have the opportunity to answer the charges against him/her in writing or in person before the BOT votes on the question of dismissal. (2005) A vote of at least two-thirds (2/3) of the voting members of the BOT shall be necessary for such dismissal. (2008)

With regard to the Regional Directors, the local AMSA chapters in the region involved shall be empowered to dismiss a Regional Director who has failed to perform his/her position, providing that the person in question be given the opportunity to answer the charges against him/her in writing or in person before a meeting of regional AMSA Chapter Presidents. A vote of at least two-thirds (2/3) of the AMSA Chapter Presidents shall be necessary for dismissal.

With regard to the Vice President for Programming, the Executive Board of the Action Committees shall be empowered to dismiss the Trustee if he/she has failed to perform his/her duty, providing the person in question be given one warning and then, upon further complaint, the opportunity to answer the charges against him/her in writing or in person before a meeting of the Executive Board of the Action Committees. A vote of at least two-thirds (2/3) of the Executive Board of the Action Committees shall be necessary for dismissal. (2008)

The Executive Board of the Action Committees shall be empowered to dismiss from his/her position any Action Committee Chair or Committee Coordinator who has failed to perform the duties of his/her position. The Officer in question must be given one written warning and then, upon further complaint, the opportunity to answer the charges against them in writing or in person before a meeting of the Executive Board. A vote of at least two-thirds (2/3) of the Executive Board shall be necessary for dismissal. The Executive Board shall fill vacant positions through appointment. (2004)

## **Section 5—Rules of Succession**

In the event of the inability of any Officer or Trustee to fulfill the duties of his/her position for any reason, the vacancy thus created shall be filled in the following manner: in the case of the vacancy in the position of President, the Vice President for Membership shall serve in that position for the remainder of the term; and in the case of a vacancy in the position of Vice President for Membership, Vice President for Finance, or Secretary or Vice President for Internal Affairs, the BOT shall designate an individual to serve in that position for the remainder of the term; and in the case of a vacancy in any of the positions of Regional Director, the Board of Regional Directors, with the approval of a majority of the Chapter Presidents in said Region, shall designate individuals who meet the qualifications for holding said positions to serve in those positions for the remainder of the terms. In the event of a vacancy of a Regional Programming Coordinator, Premedical Trustee, Premedical Regional Director, Alumni and Resident Trustee, International Trustee or International Programming Coordinator (2003), the Board of Trustees shall designate an individual to serve in that position for the remainder of the term. (2008)

In the case of a vacancy of the Vice President for Programming, the remaining members of the Executive Board of the Action Committees shall arrange to elect a person to serve in that position for the remainder of the term. In the event of a vacancy of an Action Committee Chair, the remaining members of the Executive Board of the Action Committees (2004) shall designate an individual to serve in that position for the remainder of the term.



## **Section 6—Duties of the Officers**

The Officers of the Association shall be a President, President-Elect, and Vice President for Membership, Vice President for Finance, and Vice President for Programming, and Vice President for Internal Affairs and Secretary. (2008) The duties of the Officers shall be as follows:

**THE PRESIDENT**—The President shall be the Senior Elected Officer of the Association, an ex-officio member of all committees (except the Nominations Committee), and the official representative and spokesperson for the Association. The President shall be responsible for presiding over all meetings of the Board of Trustees. The President shall be responsible for training the President-Elect in the duties and responsibilities as the senior elected officer of the Association. The President shall take a one-year leave-of-absence from his/her medical training to serve in a full-time capacity with the Association. Remuneration in the form of a salary is paid to the President, commensurate with 85% of the sum received by a first-year postgraduate resident of the Washington, D.C. area. (2003) (2007)

The President shall not be eligible to apply for a fulltime salaried staff position with the AMSA Association or Foundation, including a Student Office Fellow position or National President, for a period of three (3) full years after they complete their duties. (2006)

**THE PRESIDENT-ELECT**—The President-Elect shall be in training for the duties and responsibilities of the senior elected officers of the Association, a nonvoting member of the Board of Trustees and ex-officio (nonvoting) member of the Executive Committee. The President-Elect will have a two-week in-person transition period during the early weeks of May following his/her election. (2003)

**THE VICE PRESIDENT FOR MEMBERSHIP**—The Vice President for Membership shall carry out those duties and responsibilities assigned to him/her by the Board of Trustees (BOT) or the House of Delegates and shall be responsible for the conduct of the meetings of the BOT in the absence of the President.

The function and role of the Vice President for Membership encompasses the following areas:

1. Plan and oversee the annual Chapters Officers Conference and to have an active role in planning additional leadership training activities throughout the year; (2000)
2. Plan membership recruitment activities in conjunction with the President; (2000)
3. Provide direct leadership to a strategic priority of the association as determined by the BOT; (2000)
4. Act as a resource for the Regional Conference Coordinators in collaboration with the respective Regional Directors and Regional Programming Coordinator; (2000)
5. In collaboration with the BOT, presiding over all meetings of the Board of Regional Directors. (2008)
6. Representing the Board of Regional Directors on the BOT. (2008)

**THE VICE PRESIDENT FOR FINANCE**—The Vice President for Finance (2008) shall have final responsibility for writing the budget of the Association, and, under the direction of the BOT, shall oversee the expenditures of the Association; serve as the primary liaison among the BOT, regions and the chapters and the Controller of the Association with regard to financial affairs; and prepare a financial report for consideration by the House of Delegates at the Annual Meeting. (2003)

**THE IMMEDIATE PAST PRESIDENT**—The role of the Immediate Past President is to ensure continuity of the organization and its projects. The Immediate Past President shall serve in an advisory capacity to the BOT and ED at the discretion of the President and respect the autonomy of the newly elected officers and BOT. (2006)

The Immediate Past President shall have the following responsibilities:

1. To provide guidance to the organization at the request of the President, ED, and the BOT; (2006)
2. To serve in an advisory capacity to the BOT at the discretion of the President; (2006)
3. To serve in an advisory capacity to the ED at the discretion of the President, ED, and BOT; (2006)
4. To attend only the Fall BOT meeting unless otherwise requested by the President, ED, or the BOT; (2006)

**SECRETARY**—The Secretary is the first year of a two year consecutive Secretary-Vice President for Internal Affairs role. The first year, the Secretary shall serve to represent the entire membership of the Association to the Board of Trustees (BOT) and shall carry out the policy of the House of Delegates (HOD) as a member of the BOT. Following their year as Secretary, they shall be promoted to the role of Vice President for Internal Affairs as specified below in Article VII of the Constitution and Bylaws. The Secretary shall be elected as specified in Article VIII of the Constitution and Bylaws. (2008)

Each Secretary and Vice President for Internal Affairs serves on the BOT for a period of two total years, with one Secretary elected each year at the Annual Meeting. (2008)

The roles and responsibilities of the Secretary shall include the following:

1. Representation of all AMSA members and affiliate members to the BOT.
2. The Secretary shall serve as Vice-Chairperson of the HOD. The Vice-Chairperson shall assume the duties of the Chairperson in the event of his/her absence or unwillingness to perform his/her duty.
3. Collaborating with the Vice President for Internal Affairs to ensure that AMSA's core documents are current and relevant through a coordinated process of review and submission of resolutions to the HOD.
4. Collaborating with the Vice President for Internal Affairs to maintain these core documents through appropriate integration of newly passed resolutions and corresponding updating/correcting of affected sections. Such changes may be done with Board approval, so long as they are consistent with the intent of the HOD.
5. Collaborating with the Vice President for Internal Affairs to appoint, with the approval of the President, members of the Reference Committees, Nominations Committee and Credentials Committee of the HOD.
6. He/she will be responsible for communicating the most recent BOT's plans, actions and deliberations as specified in Article VII, Section 14, Subsection E.

**VICE PRESIDENT FOR INTERNAL AFFAIRS**—The Vice President for Internal Affairs is the second year of a two year consecutive Secretary-Vice President for Internal Affairs role. The Vice President for Internal Affairs shall serve to represent the entire membership of the Association to the BOT and shall carry out the policy of the HOD as a member of the BOT. (2008)

The roles and responsibilities of the Vice President for Internal Affairs shall include the following: (2001)

1. Representation of all AMSA members and affiliate members to the BOT.
2. The Vice President for Internal Affairs shall serve as Chairperson of the HOD and shall be responsible for the conduct of all sessions of the HOD.
3. Collaborating with the Secretary to ensure that AMSA's core documents are current and relevant through a coordinated process of review and submission of resolutions to the HOD.
4. Collaborating with the Secretary to maintain these core documents through appropriate integration of newly passed resolutions and corresponding updating/correcting of affected sections. Such changes may be done with Board approval, so long as they are consistent with the intent of the HOD.
5. Collaborating with the Secretary to appoint, with the approval of the President, members of the Reference Committees, Nominations Committee and Credentials Committee of the HOD.

## **Section 7—The Regional Directors**

Regional Directors shall represent the interests of their regional constituency and shall be elected from each of the geographical regions established by the House of Delegates. The Regional Directors shall carry out the policy of the House of Delegates as members of the Board of Regional Directors. (2008)

The functions of the Regional Director encompass the following general areas:

1. communication with local chapter officers on areas of concern to medical students and on activities of the Association;
2. coordination of regional meetings and regional conferences;
3. coordination of the annual membership drive on the regional level with the chapter officers and assist chapters with fewer than five members in good standing at risk of charter revocation; (2004)

4. formulation, development and administration of the programs for the region determined by the members within the region;
5. representation of regional concerns to the deliberations of the Board of Regional Directors; (2008)
6. coordination of Delegates from the region in policy deliberations of the House of Delegates at the Annual Meeting; and,
7. service as a resource to regional members for information about, or contact with, all levels of the organization.
8. for two months after the election of the new Regional Directors, National Officers, Alumni and Resident Trustees, Premedical Trustee, International Trustee and Vice President for Programming, the outgoing Board members will assist and orient the new Directors to their responsibilities. (2008)
9. coordination of regional events and communication with the Regional Programming Coordinator(s). The Regional Director shall be in charge of keeping in monthly communication with the Regional Programming Coordinator. They shall approve the regional project plan of the Regional Programming Coordinator, and assist him/her with implementation of the project to local chapters. (2005)

### **Section 8—Regional Programming Coordinator**

For as long as the BOT shall authorize, through funding in the budget, the association shall have Regional Programming Coordinators (RPC). (2007) One (1) RPC shall be elected from each of the geographical regions established by the House of Delegates. The roles and responsibilities of the RPC shall include the following: (2006)

1. Organize at least one regional project that shall attempt to include all the chapters in that region and will increase awareness of, or engagement in, one of the strategic priorities of the Association. The RPC shall be required to submit for approval a final proposal of their regional project to be reviewed by the AC Executive Committee Meeting at COC. (2006)
2. Serve on the Steering Committee of their respective regional conference. The RPCs shall work in collaboration with the Regional Conference Coordinator, and shall have as their primary responsibility the task of providing programming options for the Steering Committee. The RPC is also responsible for presenting one session at the conference, which may include aspects of their regional project. (2006)
3. Assist the Regional Directors in the development and maintenance of local project databases on the national AMSA Web site. The RPC shall assist chapter officers and the Regional Directors in entering new project information and updating the database as necessary. (2005)
4. Perform any regional duty mutually agreed upon with the Regional Director. The RPC shall assist the Regional Director with relevant duties throughout the year, and shall also assist with the end-of-the-year report. (2005)
5. Attend the June National Leadership meeting (but not the Board of Trustees meeting) through funding from National AMSA. The meeting shall include training and project planning to assist RPCs with their annual tasks. The RPC also will attend COC. (2006)
6. The Board of Trustees shall review the RPC position and evaluate its role in the organization in terms of effectiveness to achieve assigned responsibilities, fulfillment of members, support within the organizations infrastructure, and cost/benefit to the goals of the organization on an annual basis and allocate funds appropriately. (2006)

### **Section 9—The Alumni and Resident Trustee**

An Alumni and Resident Trustee shall be elected to serve on the Board of Trustees and shall be both a resident and alum of the Association. The Trustee shall represent all alumni and residents of the Association in all matters relating to participation in Association programs and membership. The Alumni and Resident Trustee shall be elected as specified in Article VIII of the Constitution and Bylaws. (2008)

The Alumni and Resident Trustee shall be responsible for coordinating, with the National Office, the activities of the Association's Resident membership, and shall act as a liaison between the Board of Trustees and the Resident Network (2003). The Alumni and Resident Trustee will organize, with approval of the Board of Trustees, the Resident Caucus. The Alumni and Resident Trustee shall be responsible for ensuring continuity of communication and programming involving resident and physician members of AMSA, AMSA Alumni and the medical community at large. (2008)

## **Section 10—The Premedical Trustee and Premedical Regional Directors**

Representatives of the premedical membership shall be elected to coordinate activities of the premedical membership along with the National President. The Premedical Trustee will organize, with approval of the Board of Trustees, the Premedical Caucus. The Premedical Trustee and the Premedical Regional Directors, of which there shall be a number equal to the number of regions with the exception of Region X, which shall have two (2) Premedical Regional Directors (2007), shall be elected as specified in Article VIII Section 4 of the Constitution and Bylaws. The Premedical Trustee shall serve as a voting member (2007) of the Board of Trustees (BOT), and a Premedical Regional Director shall serve as an ex-officio member in the absence of the Premedical Trustee. (2006)

The Premedical Trustee shall have the following functions:

1. Assistance of chapters petitioning to be chartered at the National Convention; (2006)
2. Regular communication with the President, Vice President for Membership, Vice President for Finance, Vice President for Internal Affairs, Secretary, and the Premedical Regional Directors by attending the BOT meetings, facilitating monthly conference calls with the Premedical Regional Directors a week in advance, and returning emails within one week of receipt, (2006)
3. Representation of the concerns of premedical student membership and leadership to the BOT; (2006)
4. Collaboration with the Premedical Regional Directors to: provide leadership training at the Chapter Officers Conference and with media uses such as the chapter officers list serve and Premed AMSA Web site; develop and maintain premedical chapters through consistent presence via emails and telephone calls; promote and nurture multiple local chapter collaborations including medical chapters; encourage chapter visit requests; distribute needed funds to chapters and chapter members; and provide premedical programming at Regional Conferences. (2006)
5. Guidance and support of member projects including, but not limited to premedical conferences; AMSA-based research and posters; and institutes and internships; (2006)
6. Development of premedical programming at the National Convention in conjunction with the convention theme and current concerns of premedical members. (2006)

The Premedical Regional Directors shall have the following functions:

1. Development and maintenance of the premedical chapters and assistance of chapters with fewer than five members in good standing at risk of charter revocation; (2006)
2. Regular communication with the Premedical Trustee by attending the monthly conference call; providing an informal report of regional activities and chapter statistics monthly via email prior to each conference call; and submitting a formal report of their region on October 15 and on January 15; (2006)
3. Representation of the concerns of premedical student membership and leadership to the Premedical Caucus; (2006)
4. Collaboration with the Premedical Trustee to: provide leadership training at the Chapter Officers Conference and with media uses such as the chapter officers listserve and Premed AMSA Web site; develop and maintain premedical chapters through consistent presence via emails and telephone calls; promote and nurture multiple local chapter collaborations including medical chapters; encourage chapter visit requests; distribute needed funds to chapters and chapter members; and provide premedical programming at Regional Conferences. (2006)
5. Development of premedical programming at their regional conference in conjunction with the conference theme and current concerns of premedical members. (2006)
6. Dissemination of information pertaining to Premed AMSA and premedical students and promoting discussion via the premed list serve with two Premedical Regional Directors assigned to the listserve a month at a time. (2006)

## **Section 11—The Premedical Representative** (2004)

The Premedical Representative shall represent the premedical membership on each Action Committee and Interest Group. This position shall be limited to one (1) premed member per Action Committee or Interest Group that shall be elected at the annual Convention and will serve a one-year term. The functions of the Premedical Representative include, but are not limited to:

1. informing the premedical membership of Action Committee or Interest Group events and/or projects via posting to the AMSA premed listserve at least quarterly; (2004)
2. representing the concerns of the premedical membership to the Action Committee Chair or Interest Group Coordinator and working with the Chair/Coordinator to deal with premedical member needs; (2004)
3. completing a resource-based project to be developed in conjunction with the Action Committee Chair or Interest Group Coordinator; (2005)
4. in conjunction with the Action Committee Chair or Interest Group Coordinator, submit a section of an annual report to the House of Delegates for consideration on a “For Information Only” basis detailing the Representative’s projects and activities. (2005)
5. The Premedical Representative shall, upon successful presentation of their resource-based project (as assessed by the DSP and the AC Chair/Coordinator) and receipt of their year-end report, receive a waiver of their registration fee for the AMSA National Convention, but they are not required to attend. (2008)
6. The Premedical Representative shall be fully funded to attend the November meeting of the Action Committees with the AC Coordinators. (2008)

## **Section 12—The International Trustee and International Programming Coordinator**

The International Trustee and the International Programming Coordinator shall be elected in a manner set forth in the Bylaws. The International Trustee shall serve as a member of the Board of Trustees.

1. The International Trustee shall be responsible for coordinating, with the other members of the national leadership, the activities of the Association’s international membership. (2004)
2. The International Programming Coordinator shall be responsible for maintaining accurate membership records for international chapters, assisting chapters with fewer than five members in good standing at risk of charter revocation, and disseminating information from the Action Committees and Interest Groups to the international chapters. (2004)

## **Section 13—The Board of Trustees**

- A. The Board of Trustees (BOT) of the Association shall be composed of the President, Vice President for Membership, Vice President of Finance, Vice President of Internal Affairs, Vice President of Programming, Secretary, Premedical Trustee, International Trustee, Alumni and Resident Trustee, and *The New Physician* Magazine Student Editor, all of whom are voting members of the BOT. In addition, the Immediate Past President, the ED, and other individuals designated as such by the BOT shall serve as ex-officio, nonvoting members. The BOT shall be responsible for carrying out such duties and responsibilities as may be designated in this Constitution and Bylaws of the Association.
- B. The BOT will meet a minimum of four times per annum. The first, for information and training shortly after the Annual Meeting; the second, shortly thereafter to plan activities and projects for the coming year; a minimum of once in the mid-year to check on progress; and once at year’s end. Emergency meetings of the BOT may be called by a majority of the members of the Board.
- C. The BOT shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law for trustees of corporations and as may be prescribed by this Constitution and Bylaws. It will be the responsibility of the BOT to see that the policy determined by the HOD is carried out and interpreted correctly, and that the Association is responsive to local chapters.
- D. The BOT shall bear the responsibility of assuring the HOD and the Membership-at-Large that it is functioning responsibly; that it is carrying out and interpreting the Association’s policy in light of the sentiment of the Membership-at-Large and the HOD. This function will be accomplished by the preparation of a report by the Secretary within two weeks following each meeting or substantive action of the BOT outlining the BOT’s plans, actions and deliberations. This report shall be titled “Board of Trustees Action Report” and shall be disseminated to the membership at-large through electronic mail, on the AMSA Web site, and/or through an official Association publication. (2008)

- E. The Board of Trustees shall not amend or change AMSA's Constitution and Bylaws section by creating interim policy of the Association. The Board of Trustees shall be authorized by a 2/3 vote to create new policies in the Internal Affairs and Principles section of the PPP if timely issues arise between meetings of the House of Delegates. Creation of and implementation of interim policy in Principles shall occur in consultation with the appropriate national leadership and Student Office Fellow. The passing of any interim policy of the Association shall be voted on at the next House of Delegates meeting for official adoption in the PPP. (2007)
- F. The functions of the Board of Trustees also include the following areas:
1. serve as members of any other committees and/or task forces as appropriate; (2008)
  2. supervision of all fiscal affairs of the Association; (2008)
  3. approval and justification of all income solicited for the Association; (2008)
  4. supervision of all expenditures; (2008)
  5. preparation of budgetary priorities; (2008)
  6. compilation of reimbursement guidelines for expenses incurred in activities related to the Association (2008)
  7. resolution of disputes which may arise in reimbursements of staff and students; and, (2008)
  8. preparation of an annual financial report, which shall include income and expenditures for the current and previous fiscal years. The report shall be in an easily understandable form with special itemization of National Officer, Regional Directors, Regional Conference and Action Committee budgets. This financial statement shall be published in one of the official publications of the Association, which circulates to the Membership-at-Large, between thirty and sixty days prior to the Annual Meeting. This statement shall also be included in the Delegates Handbook at the Annual Meeting. (2008)

#### **Section 14—The Board of Regional Directors (2008)**

- A. The Board of Regional Directors is charged with supporting the chapters of the Association. This includes:
- a. The recruitment and engagement of the membership through the coordination and dissemination of materials and communications from the national office and professional staff.
  - b. Empowering chapter officers through application of the resources available throughout the national leadership
  - c. Collaborating with the Director of Student Programming and Vice President for Membership to support the Regional Conferences
  - d. Developing and executing the Chapter Officers Conference programming as directed by the Vice President for Membership
  - e. Developing and executing regional programming in collaboration with the Regional Programming Coordinators, Action Committees, Interests Groups, Task Forces, and other programming leaders as needed.
  - f. Recommending, through the Vice President for Membership, which Board of Trustee actions would enhance the effectiveness of the Board of Regional Directors.
  - g. Advise the Board of Trustees on matters which pertain to AMSA resource allocation and planning to best support chapters, recruitment and regional programming.
- B. The Vice President for Membership shall chair the Board of Regional Directors. The Vice President for Membership shall serve as a non-voting member of the Board of Regional Directors except in cases of a tie. The Vice President for Membership shall represent the Board of Regional Directors on the Board of Trustees.
- C. One (1) Director from Regions I, IV, V, VI, VII and IX, and two (2) Co-Directors from Regions II, III, VIII and X shall be invited to each of the Board of Regional Directors meetings. Each Regional Director or Co-Director will be financed by the national budget, and each Regional Director or Co-Director will have a single vote on the Board of Regional Directors.

## **Section 15—Action Committees**

Action Committees represent the long-term, ongoing and overall priorities of the Association. The programming work of AMSA's Action Committees will be separated into issue based Committees and functional Teams. There shall be six Committees of the Association: Community and Environmental Health; Culture of Medicine; Gender and Sexuality; Global Health; Race, Ethnicity and Culture in Health; and Student Life. In addition, coordinators from the above committees will serve on four functional Teams: Education, Grassroots Leadership, Humanism in Medicine and Policy. The Education, Humanism in Medicine and Policy Teams will be led by Action Committee Chairs, while the Grassroots Leadership Team will be led by the Director of Student Programming. Restructuring of the Action Committees shall occur no more frequently than reevaluation of our external Strategic Priorities. (2008)

The members of each Committee with the aid and advice of the Committee Chairs and the Board of Trustees shall set the agenda of such committees. Their purpose shall be to implement the policy of the House of Delegates and the Association in each area. They shall carry out projects, distribute information, and aid in policy development for each area. They shall operate under the leadership of Action Committee Chairs, who shall report to the Board of Trustees at each meeting and to the House of Delegates at the Annual Meeting. (1997) (1999) (2001) Chairpeople for Action Committees and Committee Coordinators shall be chosen as set forth in Article VIII, Section 10 of the Constitution and Bylaws. (2005)

## **Section 16—Vice President for Programming**

One representative shall be elected to the Board of Trustees from the Action Committees and Issue Response Groups. The Vice President for Programming shall act as a liaison between the Board of Trustees and the Action Committees. The Vice President for Programming shall also represent the interests of the Action Committees as well as those of the general membership involved in the Action Committees and other initiatives. (2008)

This Trustee shall serve as a member of the Board of Directors of the AMSA Foundation.

The Vice President for Programming shall:

1. Plan and coordinate all meetings of the Executive Board of the Action Committees, through conference calls or in person. (2001)
2. Communicate regularly with the Action Committee Chairs, Director of Student Programming (DSP), the President, Secretary, and Regional Programming Coordinator. (2008)
3. Assist all Committees in staying within their budgets as well as preparing budgets for the Vice President for Finance to consider in the following year. (2008)
4. Facilitate and encourage communications of the Action Committees with the membership through innovative uses of media such as listserves, the AMSA Web site, AMSA Focus, etc. (2001)
5. Coordinate Action Committee chair participation in the Chapter Officers Conference and the Regional Conferences. (2001)
6. Offer input for meeting agendas to the DSP and the President, who respectively are responsible for constructing the agendas for the meetings of the Board of Trustees and the Action Committees.
7. Co-facilitate meetings of the Action Committees whenever possible and appropriate, while the DSP will lead the two national office meetings, since the Vice President for Programming must spend much time with the BOT. (2008)
8. Facilitate meetings of the Action Committee leadership throughout the year, including the elections of new Chairs and Committee Coordinators at the Annual Meeting. (2001)
9. Communicate as necessary with other national leaders, but especially with the Premedical Trustee and Alumni and Resident Trustee in order to stimulate Action Committee work with these two groups of members. (2008)
10. Communicate as necessary with the Legislative Affairs Director in order to stimulate an activist/health policy component within each Action Committee. (2001)
11. Review the PPP yearly and facilitate the writing of resolutions to correct and update AMSA policies. (2001)
12. Provide a report within two weeks following each meeting or substantive action of the Executive Board of the Action Committees to the membership-at-large. (2003)
13. Work with the Secretary and Vice President for Internal Affairs and Action Committee Chairs to disseminate information about Action Committees and Interest Groups to the Regional Programming Coordinator. (2008)

## **Section 17—Executive Board of the Action Committees**

The Action Committee Chairs, Vice President for Programming and Director of Student Programming shall form an Executive Board for the purpose of administration of Action Committees. It shall oversee the performance of all Action Committees, Issue Response Groups and Interest Groups; budget appropriate funds for the completion of projects, and undertake strategic planning for future issues as necessary for the Action Committees, Issue Response Groups and Interest Groups.

## **Section 18—The Executive Director**

The Executive Director (ED) shall be appointed by a joint commission of the Board of Trustees and the Board of Directors of the AMSA Foundation, and shall serve as the chief administrative officer of the Association. He/she shall have supervision of its administrative, membership and business personnel and direct the operations of the offices of the Association.

The ED shall prepare an annual budget for review by the Board of Trustees. The ED shall undergo an annual performance review that will be conducted by representatives of the Board of Trustees. The ED shall attend the annual convention and the meetings of the Board of Trustees and the Board of Trustees and shall ensure that minutes of these meetings shall be prepared and distributed to the members of the Board of Trustees and shall perform such other duties as may be designated in this Constitution or in the Bylaws or by the Board of Trustees of the Association.

## **Section 19—Student Office Fellows**

For each year that the Board of Trustees (BOT) authorizes, as indicated by allocated funding through the annual budget, the Association shall have Student Office Fellow (SOF) positions outlined below. (2007) SOF shall be medical student members of AMSA in good standing that work in the National Office full-time for a period of one year. The positions described below, and any other SOF position created by the BOT, shall be filled by an application process. Applications for each of the positions will be solicited in the fall and winter of the prior year. Candidates for the SOF positions must be medical students in good standing. The position will be selected by a committee composed of the ED, the National President, the SOF currently holding the position, a member(s) of the AC Executive Board appointed by the AC Executive Board, and a full-time AMSA or AMSA Foundation staff member designated by the ED. The selection shall occur prior to the deadline for submitting a rank-list to the National Residency Matching Program. To accept the SOF position, the candidate must be a member of the Association. (2006) If a SOF position will likely not be funded for the upcoming fiscal year, the BOT will make every effort to inform potential applicants early, prior to the application deadline. (2007)

In the event that a suitable medical student applicant is not located, the Board of Trustees shall establish eligibility guidelines and requirements for additional applications. (2006)

The ED shall be empowered to dismiss any SOF member in cases of gross misconduct, abusive behavior toward other office staff, and other serious violations of AMSA workplace rules. The same codes of conduct for acceptable workplace conduct shall be used for the SOF as shall be used for all other staff members of the AMSA Association/Foundation. The ED shall report failures of the SOF to perform their duties to the Board of Trustees, who are required to act on the notice. (2006)

The Board of Trustees shall also be empowered to recommend to the ED that any SOF member be dismissed in cases of gross misconduct and/or failure to perform the duties of the position. In the case of failure to perform duties, the SOF in question shall be given the opportunity to address the concerns in writing or in person to the Board of Trustees. A vote of at least two-thirds (2/3) of the voting members of the Board of Trustees shall be necessary for such a motion to dismiss a member of the SOF. (2006)

In case of resignation, dismissal or otherwise permanent incapacitation of a SOF member, the ED and the President are empowered to select a new SOF member from the medical student membership of the organization through an application process. (2006)

The roles and responsibilities of the Student Office Fellow members are described below:

### **1. The Legislative Affairs Director**

The Legislative Affairs Director (LAD) shall be responsible for representing the public policy concerns of the Association to the legislative branches of the government of the United States of America and facilitating membership involvement in public policy issues.



The LAD will educate the membership on health policy and legislative issues, represent the Association to federal and local legislative bodies, advocate for the Association's positions in other policy arenas, and train the membership in the legislative process. General functions of the LAD include, but are not limited to:

1. serve as the primary Association contact for all health policy and legislative issues; (2003)
2. educate and train the membership in health policy issues and the legislative process through lobby days to coincide with the Annual Meeting in the Washington, D.C., area, through periodic legislative conferences at the Association, and through regular informational bulletins distributed to the officers, trustees, and members of the Association; and, (2003)
3. maintain, through the Legislative Affairs Office, a health policy internship program available to Association members for the purpose of directly training medical students in the federal legislative process. (2003)

The LAD shall take a one-year leave of absence from his/her medical training to serve in a full-time capacity with the Association. Remuneration in the form of a salary is paid to the LAD, commensurate with 85% of the sum received by a first-year postgraduate resident in the Washington, D.C., area. In addition, the Legislative Affairs Director (LAD) is responsible for: (2007)

1. developing, with the input and cooperation of the National President, the ED and the outgoing LAD, a Legislative Agenda to present to the Board of Trustees at the Spring Board meeting; and, (2003)
2. reporting to the Board of Trustees at each Board meeting by presenting a detailed report on the state of the Legislative Agenda. (2003)

The LAD's performance will be evaluated by the ED and Board of Trustees at the Fall Board meeting. (2003)

The American Medical Student Association will develop and sponsor at least one Political Leadership Institute (PLI), administered and executed by the LAD. Each PLI will consist of medical students who apply through a competitive application process. They will be trained in political leadership, the exact content of which will be determined by the LAD. Funding for the PLI will consist of funding for materials, communications and a few speakers. Travel will be funded by each participant's school and housing will be provided at the AMSA properties. (2006)

The LAD shall not be eligible to apply for a fulltime *appointed* salaried staff position with the AMSA Association or Foundation, including a Student Office Fellow position, for a period of three (3) full years after they complete their duties. (2006)

## **2. Director of Student Programming**

One member shall be chosen to coordinate the Action Committees and initiatives of the membership.

The duties of the Director of Student Programming (DSP) shall include, but are not limited to, the following:

1. To act as chair of all Issue Response Groups and oversee their administration, budgets and operations. (2001)
2. To oversee the Interest Groups and to help coordinate access to the Internet, newsletters, or other resources deemed necessary for the dissemination of information. (2001)
3. To act along with the Secretary to represent the Interest Groups to the Board of Trustees. (2001)
4. To coordinate programming at the Annual Meeting with the Action Committees, Interest Groups and on other topics as deemed necessary. (2001)
5. To act as the national resource for the Action Committees, Interest Groups, and for projects and initiatives on the local level including soliciting and obtaining resources for projects, coordinating fundraising, advertising and other programming areas in order to help these groups achieve their programming goals. (2001)
6. To coordinate the training of and communication with local chapter members to help organize independent projects on the local level. (2001)
7. To work with the Regional Directors and Action Committee leadership to create a database of active projects that occur at each local chapter. (2001)

8. To aid in the distribution of information through newsletters, listserves and *The New Physician* about Action Committee and Interest Group projects as well as other opportunities and deadlines of which the membership should be aware. (2001)
9. To represent the interests of the Action Committees and Interest Groups to the membership as a whole. (2001)
10. To report to the Board of Trustees both orally and in writing on the status of Issue Response Groups, Interest Groups and initiatives (Strategic Priorities) that are being coordinated by the DSP. (2001)
11. To work with AMSA Regional Conference Coordinators to facilitate their training in planning, organizing, and executing their Regional Conference and to act as a resource through this process. (2001)
12. To plan and facilitate, along with the Vice President for Programming, the June and November Action Committee Planning Meetings. (2001)
13. To coordinate the application for, and administration of the AMSA liaisons with input from the relevant Action Committee Leadership. (2001)

The DSP's performance will be evaluated by the ED and Board of Trustees at the Fall Board meeting. (2003)

The DSP shall take a one-year leave of absence from his/her medical training to serve in a full-time capacity with the Association. Remuneration in the form of a salary is paid to the Director of Student Programming commensurate with 85% of the sum received by a first-year postgraduate residency in the Washington, D.C. area. (2003) (2007)

The DSP shall not be eligible to apply for a fulltime *appointed* salaried staff position with the AMSA Association or Foundation, including a Student Office Fellow position, for a period of three (3) full years after they complete their duties. (2006)

### **3. Jack Rutledge Fellow**

One member shall be chosen to lead initiatives directly related to AMSA's Strategic Priorities and shall serve as AMSA's expert on grass roots organizing and coalition building

The Jack Rutledge Fellow (JRF) shall take a one-year leave of absence from his/her medical training to serve in a full-time capacity with the Association. Remuneration in the form of a salary is paid to the Jack Rutledge Fellow, commensurate with 85% of the sum received by a first-year postgraduate resident in the Washington, DC area. (2007)

The JRF's performance will be evaluated by the ED and the Board of Trustees at the Fall Board Meeting. The general function and work of the JRF shall include but not be limited to the following:

The JRF will focus on AMSA's Strategic Priorities, primarily on Universal Health Care (UHC). Work on this priority should continue until a more pressing topic is proposed and voted upon by the Board of Trustees and the Executive Board of the Action Committees. To complement the skills of the other Student Office Fellow members, the JRF will serve as AMSA's expert on grassroots organizing and will make strategic coalitions with other organizations working on similar issues, especially UHC. In addition, the JRF will train AMSA's leadership and membership about effective organizing, and will serve as a resource for those AMSA members/leaders who want to plan rallies, vigils, or similar events.

The JRF will work closely with the President to offer leadership on grassroots organizing for the Association's priority areas.

To develop the skills needed to be an effective organizer, the JRF will attend a community organizing training session early in her/his tenure. As a means for practicing these acquired skills, s/he will have limited but important administrative roles. The JRF will hold one "grass roots organizing" institute as modeled after AMSA's ongoing Political Leadership Institutes (PLI). In addition, the JRF should develop a "constituency" of leaders/members with whom s/he will coordinate regional and local activities as related to AMSA's strategic priority areas, especially Universal Health Care. To allow for an inherent flexibility in this position's responsibilities, the administrative portion should take less than 10% of the Fellow's time. The remainder of the year should be spent pursuing research projects, curriculum initiatives, or other activities as deemed necessary.

As part of the work on Universal Health Care initiative, two specific outcomes should be addressed by the JRF:

1. An overarching strategic plan for the Universal Health Care strategic must be developed. This can be used to benchmark AMSA's progress on this issue. It should include ways that specific parts of the leadership will be involved, i.e. Action Committee coordinators.
2. Proposals that seek to find outside funding for AMSA's work on this strategic priority must be developed, i.e. grants, research monies, and government contracts. (2003)

The Jack Rutledge Fellow will chair a committee to review AMSA's progress on eliminating health disparities. The members of the committee will include, but not be limited to, Action Committee coordinators and chairs whose work directly addresses the issue of domestic health disparities. The JRF will present AMSA's progress on eliminating health disparities to be reported to the Board of Trustees at the June and November national leadership meetings. (2006)

The JRF shall not be eligible to apply for a fulltime *appointed* salaried staff position with the AMSA Association or Foundation, including a Student Office Fellow position, for a period of three (3) full years after they complete their duties. (2006)

#### 4. **Global AIDS Fellow (GAF)**

One member shall be chosen to lead initiatives directly related to AMSA's Strategic Priorities and shall serve as AMSA's expert on global health, activism and policy. (2007) The term 'global' should be understood to reflect the issue both domestically and beyond U.S. borders. (2006)

The GAF shall take a one-year leave of absence to serve in a full-time capacity with the Association. Remuneration in the form of a salary is paid to the GAF, commensurate with 85% of the sum received by a first-year postgraduate resident in the Washington, DC area. (2007) If sustainable and adequate funding for the GAF position and related expenses is not secured by March 1, 2008, the funding for the GAF will be temporarily suspended for fiscal year 2009. (2007)

The GAF will work very closely with the AIDS Advocacy Network (AAN) Steering Committee. The AAN Steering Committee helps bring in a diverse group of opinions and can therefore better reflect the membership. The Steering Committee of the AAN will work closely with pertinent members of the Action Committees and Student Office Fellow to assist AMSA's ongoing education and advocacy efforts related to HIV/AIDS. The Steering Committee will serve as an HIV/AIDS policy resource for AMSA and play a major role in determining AMSA's HIV/AIDS legislative agenda for the year, either advising the GAF or, in years where the GAF position goes unfilled, working with the groups listed above. (2008)

The AAN Steering Committee will consist of

- the most recent GAF (where possible) (2008)
- the Chair of the Global Health Action Committee (2006)
- at least 8 other members of the AAN (2007)

Election to the AAN Steering Committee will be by nomination from within the committee. Seats on the AAN Steering Committee will be limited to no more than 3 years, beginning and ending in March. The AAN Steering Committee shall elect up to two Chairs from within the committee. The Steering Committee Chair(s) shall facilitate monthly conference calls of both the AAN Steering Committee and the AAN membership and work to maximize membership participation in AAN activities. Members of the Steering Committee shall provide expertise by topic or skill as designated by the Steering Committee Chair(s). (2007) National conference fees shall be waived for the Steering Committee chair(s). (2008)

The general function and work of the GAF shall include, but not be limited to, the following:

1. Utilize to the greatest extent possible the spirit and excellence of the health professions and mobilize the nation's physicians-in-training to address the Global HIV/AIDS, including, but not limited to, issues dealing with human rights, disparities, and poverty, pandemic through Education, Service, and Action. In this capacity, the GAF will work closely with national AMSA leadership and staff, the AIDS Advocacy Network coordinators, local chapter leaders and members, and local, national, and international organizations to develop strategy, educate and activate the grassroots, and build coalitions around fighting Global HIV/AIDS. The work to address the HIV/AIDS pandemic will reflect the need to eliminate global health disparities. (2006)
2. Utilize role to facilitate the development and implantation of strategies to achieve AMSA's Strategic Priorities, particularly as related to HIV/AIDS and global health. (2006)

3. Work closely, collaboratively, and responsively with the Global Health Action Committee, including acting as an ex-officio member of GHAC and participate fully in June and November GHAC meetings. (2007)
4. Direct national leadership in developing AMSA's Strategic Plan on Global AIDS. (2006)
5. Facilitate the creation of the organizational structures needed to achieve the goals of this Strategic Plan. (2007)
6. Connect AIDS activists with the resources within AMSA, possibly including but not limited to, the LAD, JRF, DSP and Global Health Action Committee. (2006)
7. Receive training in community organizing and strategic planning and assist the organization in designing and implementing grassroots campaigns supporting AMSA's Strategic Priorities. (2006)
8. Provide guidance and support, including but not limited to, coordination of monthly conference calls with the Membership and Steering committees of the AAN. (2007)
9. With the help of the AAN steering committee collaborate in development of the network's legislative agenda. (2007)
10. Implement AMSA's legislative agenda in regards to AIDS and Global Health in cooperation with the LAD. (2007)
11. Provide bi-weekly reports to AIDS Advocacy Network membership and the AAN Steering Committee. (2007)
12. Provide any and all available institutional resources to support AMSA national and grassroots efforts around Global AIDS. (2006)
13. Work with AMSA Foundation to develop and support health professional student educational and service opportunities in Global Health, including work/study abroad programs and the development and implementation of a Global AIDS / International Health medical curriculum. (2006)
14. Serve as primary liaison to national and international Global AIDS and global health advocacy organizations. (2006)
15. Continue existing and create new coalition partnerships with advocacy organizations to develop joint strategic plan and carry out joint advocacy efforts. (2006)
16. Partner with student and medical organizations to foster joint efforts and mobilize the student and medical community around Global AIDS. (2006)
17. Organize World AIDS Day events and other national AMSA events. (2006)
18. Educate medical students, policy makers, and other relevant individuals and groups on HIV/AIDS related topics. (2006)

The GAF will convene the AIDS Leadership Institute, a "grassroots organizing" institute modeled after AMSA's ongoing Political Leadership Institutes (PLI). (2006)

The GAF performance will be evaluated by the ED and the Board of Trustees at the Fall Board Meeting. The GAF shall prepare quarterly reports that shall be reviewed by AAN Steering Committee. Any member of the Board of Trustees and ED may request these reports. (2007)

Applications for the position of the Global AIDS Fellow will be solicited throughout the fall and winter of each year. Applicants for the fellowship must be pre-medical or medical students in good standing. (2007) The GAF will be selected by a hiring committee comprised of the ED, the National President, the current Global AIDS Fellow, a member of the AC Executive Committee appointed by the AC Executive Committee, and a full-time AMSA staff member designated by the ED. Any other members of the Association may also be appointed by the President, ED and current GAF as deemed appropriate. (2006)

In the event that a suitable pre-medical or medical student applicant is not located, the Board of Trustees shall establish eligibility guidelines and requirements for additional applications. (2007)

Members of the Board of Trustee and AC Executive Committee may request the application materials for review and to provide comments to the Hiring Committee. (2006)

## **Section 20—Issue Response Groups**

Issue Response Groups represent the interests and projects of a group of medical student members. They may be created time to time by the House of Delegates to address particular areas or issues of concern. The House of Delegates shall determine the mandate, leadership, structure and budget for each Issue Response Group. The Director of Student Programming shall administer Issue Response Groups and oversee their budgets and operations. Coordinators of individual Issue Response Groups will be selected at the Annual Meeting at which they are created. The Executive Board of the Action Committees has the power to create an Issue Response Group outside the House of Delegates, though that Issue Response Group must be ratified at the following House of Delegates or cease to exist. (1997) Their administration and Coordinators shall be chosen as set forth in Section I, Part B and F in the Internal Affairs section.

## **Section 21—International Exchange Standing Committee (2008)**

The responsibilities of The Standing Committees on Professional Exchange (SCOPE) and Research Exchange (SCORE) Leadership:

1. National Exchange Officers shall chair the SCOPE committee and the National Officers of Research Exchanges shall chair the SCORE committee, and :
  - a. Serve as the contact person for all Local Exchange Officers (LEO) /Local Officers of Research Exchanges (LORE) to process US student applications to complete an overseas exchange through the IFMSA.
  - b. Support the LEOs/LOREs and Development Exchange Officer (DEO) with local chapter development issues, and foster communication between the LEOs/LOREs nationally through regular communication using the best means possible (i.e. conference calls, emails or AMSA publications).
  - c. Work with the LEOs/LOREs and DEO to create, revise, and implement basic guidelines on how to develop the exchange program for dissemination to chapters currently supporting exchanges and chapters interested in starting exchanges.
  - d. Obtain evaluations from each US student returning from an exchange to remain on file at the AMSA national office.
  - e. Manage exchange contracts through attendance at biannual contract fairs and participating in their standing committees at the IFMSA General Assemblies.
  - f. Manage additional contracts via email/phone calls with other IFMSA National Member Organizations (NMOs) to coordinate exchange contracts.
  - g. Fulfill bilateral contracts by placing incoming international students with LEOs/LOREs able to accept these students locally in the US.
  - h. Facilitate the processing of visas or any other necessary travel documentation on the part of the incoming or outgoing student as possible.
  - i. Subscribe to and participate in their respective National Standing Committee email listserves.
  - j. Maintain respective Standing Committee AMSA email accounts, responding according to AMSA Leadership protocol to inquiries regarding the Standing Committee, local chapter, and international communications.
  - k. Update the IFMSA Exchange Conditions and the online IFMSA project database for SCOPE and SCORE, with assistance from the DEO.
  - l. Provide the AMSA Webmaster with pertinent updates and announcements for the AMSA website dealing with SCOPE and/or SCORE.
  - m. Report as needed to other AMSA leaders regarding the status of SCOPE and/or SCORE.
  - n. Run all national meetings of the Standing Committees in conjunction with the DEO.
  - o. Attend all required national AMSA leadership meetings. In cases of budgetary restrictions or the unavailability of a particular NEO or NORE, it may be acceptable to have only one (1) NEO and one (1) NORE present at said meetings.
2. Furthermore, the two (2) NEOs and two (2) NOREs, within their respective Standing Committees, may divide into an officer tasked to process incoming foreign students and another officer tasked to process

outgoing US students. These assignments may be determined by consensus between the NEOs/NOREs following their election at the AMSA Annual Convention. In such a case the NEO/NORE assigned to processing incoming foreign students will be otherwise referred to as “NEO/NORE Incoming” and the NEO/NORE assigned to processing outgoing US students will be otherwise referred to as “NEO/NORE Outgoing.”

3. The Development Exchange Officer (DEO) shall:
  - a. Maintain accurate contact information for all LEOs/LOREs and serve as the principal support source at the national level for questions that arise in the process of developing and maintaining a local exchange program.
  - b. Work closely with NEOs and NOREs on chapter development issues, updating and expanding the Exchange Officer Manual, and moderating any online forums.
  - c. Gather multiple annual reports from LEOs/LOREs to maintain an updated record of local chapter activities and file them at the AMSA National Office. The content and number of these reports shall be outlined below.
  - d. Work with NEOs/NOREs to publish updated exchange conditions for active exchange chapters.
  - e. Maintain close contact with LEOs/LOREs in leadership transition periods.
  - f. Provide the AMSA Webmaster with pertinent updates and announcements for the AMSA website dealing with local exchange chapters.
  - g. Be encouraged to maintain and moderate an online forum dedicated to serving as a platform for national/local exchange leaders and medical students participating in exchanges to discuss their experiences, post exchange evaluations, advertise exchange programs, and other activities meant to foster community within SCOPE and SCORE.
  - h. Report as needed to other AMSA leaders regarding the status of exchange chapters.
  - i. Run the national meetings of the Standing Committees in conjunction with the NEOs and NOREs.
  - j. Attend all required national AMSA leadership meetings.
4. LEOs and LOREs shall:
  - a. Be responsible for the local logistics of SCOPE and/or SCORE exchanges at their institutions, including, but not limited to: determining room and board options, program fees, and administrative and legal requirements for accepting incoming foreign students. Program fees charged for local expenses shall not be dictated by national AMSA leadership.
  - b. Delegate activities for the development and maintenance of the exchange program to medical student at-large members as needed.
  - c. Maintain a relationship with a local faculty mentor with interest in global health to provide a source of continuity for the local exchange program.
  - d. Approach and recruit clinicians (for SCOPE) and researchers (for SCORE) who may be interested in accepting and hosting incoming students.
  - e. Assess institutional involvement in similar projects that may overlap.
  - f. Seek out creative funding opportunities to keep outgoing exchange fees minimal for local students.
  - g. File reports to the DEO with the frequency and content specified in AMSA Internal Affairs document regarding the status of the exchange program.

#### LEO/LORE Reports to the DEO:

1. The reporting structure shall allow for the maintenance of updated resources, accurate contact information, additional assistance with chapter development, adherence to national/international deadlines, and follow-up for conferences, evaluations, workshops, and general assemblies. These reports shall address, but not be limited to, the following:
  - a. Officers (how many officers are at each local chapter, what role each plays, end-of-year transition),
  - b. Local housing situation (what type of housing is available, cost, dates of availability).

- c. Finances (what are the expenses and revenue for each local chapter, how much is the total outgoing exchange fee, what other sources of financial support does each local chapter have),
  - d. Clinical or Research status (how many projects are available at the local chapter, how satisfied are the professors with their incoming students, what are the possibilities for expanding the number of positions and ways to improve the overall program)
  - e. Institutional Relations (how the University regards the program, are there any attempts to publicize the IFMSA to the administration such as through end-of-summer incoming presentations, or through recruitment sessions for the incomings at the beginning of the summer)
2. The LEOs/LOREs shall file three formal reports to the DEO annually per the following calendar: one due by 11:59pm of January 2nd, one due by 11:59pm of May 1st, and one due by 11:59pm of September 1st.

#### Annual Meetings of SCOPE and SCORE Leaders:

1. The LOREs/LEOs and at-large medical student members active in exchange programs will convene both during the (1) AMSA Annual Convention for an organizational meeting and (2) for a separate leadership institute, a training and development meeting. The leadership institute for exchanges will be organized in a manner, which is cost-neutral to AMSA.
2. The SCOPE and SCORE meeting at the AMSA Annual Convention shall serve as a consultative body for the Standing Committee National Officers.
3. A NEO and a NORE shall present at AMSA's Chapter Officers Conference in order to train chapter leaders in developing and maintaining their local exchange program.

#### Content of the Annual Meetings of SCOPE and SCORE Leaders:

1. Activities SCOPE and SCORE leaders at the AMSA Annual Convention shall include, but not be limited to:
  - a. Presentations by local chapters.
  - b. Opportunities to address development questions and concerns, and allow for exchange of ideas to build individual local chapters.
  - c. Workshops to focus on specific areas of interest that parallel international working groups.
  - d. Distribution of updated Exchange Officer Manual. SCOPE and SCORE

#### Fees:

1. Outgoing US student fees will be the \$150 national application fee, a \$50 evaluation fee (refundable upon completion of the SCOPE/SCORE evaluation form), and the local chapter outgoing program fee (determined by the Local Member Organization Leaders).
2. The national application and refundable evaluation fee shall be paid to AMSA directly, with the appropriate AMSA officer disbursing evaluation refunds upon confirmation from the NEOs/NOREs that exchange evaluation have been completed and received.
3. The local chapter outgoing fee shall be paid to the sponsoring local chapter directly.

## ARTICLE VIII. ELECTIONS OF THE OFFICERS AND TRUSTEES

### **Section 1—President-Elect, Vice President for Membership, Vice President for Finance, Secretary, Vice President for Programming**

1. The House of Delegates shall elect the President-Elect, Vice President for Membership, Vice President for Finance, Secretary, and Vice President for Programming of the Association at its annual meeting. Prior to said meeting, the Secretary and Vice President for Internal Affairs shall appoint a Nominations Committee.

2. Candidates for the President-Elect, Vice President for Membership, Vice President for Finance and Vice President for Programming offices shall have had prior AMSA leadership experience as a past member of the Board of Trustees, as a Student Office Fellow, or as a regional director, regional programming coordinator, action committee chair, action committee coordinator, or any previously funded national leader. In the event no candidates with this experience requirement have been announced 30 days prior to the annual meeting of the House of Delegates, the candidacies of medical student members without this prior experience shall be accepted. (2008)
3. At the time designated in the order of business for the Annual Meeting of the House of Delegates, the Nominations Committee shall present the names of all nominees then known for each of the offices to the House of Delegates. Following the report of the Nominations Committee, additional nominations for each of the offices may be made from the floor of the House of Delegates. (2008)
4. Each nominee shall have the opportunity to appear before each region individually at the Annual Meeting. The candidates for each individual office will appear in a random order established by the Nominations Committee.
5. Challenges to offered credentials shall be received by the Nominations Committee and reviewed before 5:00 PM on the day preceding elections with the candidate, prior to which he/she may revise an offered curriculum vitae or statement of candidacy. If such revised credentials are subsequently found to be false, the candidate will be found to be disqualified, and the runner-up shall be elected in his/her place. The Board of Trustees will fill vacancies in such positions.
6. Challenges to the election results shall be reported to the Nominations Committee before the post-convention Board of Trustees meeting. The Nominations Committee will then investigate the challenge before the post-convention Board of Trustees meeting and will report their preliminary findings to the rising Vice President for Internal Affairs before that meeting. The Vice President for Internal Affairs will then be responsible for reporting all information on challenges to the Board of Trustees at the post-convention Board of Trustees meeting. (1994)
7. All national officers shall take office immediately upon their election, with the exception of the President-Elect, who will take office approximately 30 days prior to the Spring Board of Trustees meeting following his/her election.
8. No Member shall be permitted to run for more than one national office within a single session of the House of Delegates. (2003)

## **Section 2—Election Procedures**

1. Voting shall be made by secret ballot, with each delegate entitled to cast one vote for each office to be filled.
2. The candidates for each office receiving a majority of the votes cast for that office shall be elected. Elections for any national offices in which there are greater than two candidates use a system of instant runoff voting. Under this system, in which each chapter has as many votes as they have delegates to the HOD as outlined in Article IX of the Bylaws, each delegate ranks the candidates in order of preference. The counting of ballots simulates a series of runoff elections. All first choices are counted, and if no candidate wins a majority of first choices, then the last place candidate is eliminated. Ballots of voters who ranked the eliminated candidate first are redistributed to their next choice candidates, as indicated on each voter's ballot. Last place candidates are successively eliminated and ballots are redistributed to next choices until one candidate remains or a candidate gains a majority of votes. In case of a tie the candidates receiving the two (2) highest number of votes in the first ballot shall be included in the second balloting. Additional balloting for said office shall continue until one (1) candidate shall receive a majority of votes cast on a rebalot and he/she shall be elected to said office. (2002)

## **Section 3—Regional Directors**

Each established geographical region shall be responsible for determining the election of the Regional Director(s) from said region. Each chapter in said region shall be entitled to one vote in the election of said Regional Director(s), except in Regions II, III, VIII and X, where each chapter shall have one vote for each Co-Trustee. In all regions from which there are candidates running for national office, it is encouraged that regional elections shall be held after the national election results have been determined.

In regions with one Regional Director position, each chapter present from that region will cast one vote. Elections in which there are greater than two candidates shall use a system of instant runoff voting. Under this system, each chapter ranks the candidates in order of preference. The counting of ballots simulates a series of runoff elections. All first choices are counted, and if no candidate wins a majority of first choices, then the last choice candidate is eliminated. Ballots of voters who ranked the eliminated candidate first are redistributed to their next choice candidates, as indicated on each voter's ballot. Last place



candidates are successively eliminated and ballots are redistributed to next choices until one candidate remains or a candidate gains a majority of votes.

In regions with more than one position for Regional Director, the above method will be used to determine the one winning candidate. At this point, all ballots will effectively have the winning candidate's name removed. After doing this, the ballots will be counted again, using the same instant runoff method described above, until a second winning candidate is determined. The names of the two winning candidates will then be announced with no reference to which candidate received more votes.

In the case of a tie, regions are encouraged to hold a rebalot. During the rebalot, the individual conducting the election shall vote. This ballot will be counted only in which case of a tie on the revote, in which case it will be used to break the tie and determine the winner. (2002) Regional Programming Coordinator elections in regions shall be conducted in the same manner as Regional Director elections.

All ballots for Regional Director or Regional Programming Coordinator elections shall be turned in by the Regional Director to the Secretary and Vice President for Internal Affairs immediately following elections. Disputes of election procedure or challenges of election results shall be made to the Secretary and Vice President for Internal Affairs prior to the start of the post-convention meeting of the Board of Trustees. (2002)

#### **Section 4—Premedical Trustee and Premedical Regional Directors**

1. The Premedical Trustee and the Premedical Regional Directors shall be elected by the Association's premedical constituency at a meeting of the Premedical Caucus at the national convention. The candidates for the position of Premedical Regional Director shall attend a school or reside within the region that they wish to represent in the upcoming year. (2004) At least five (5) affiliate premedical chapters must be present at the time of the election or the positions shall be declared vacant (1991) (2000). Both the Premedical Trustee and Premedical Regional Director shall be members of the Premedical Caucus. (1991)

For election of the Premedical Trustee, each chartered premedical chapter attending shall be entitled to one (1) vote. If there are greater than two candidates, the election shall use a system of instant runoff voting. Under this system, each chapter ranks the candidates in order of preference. The counting of ballots simulates a series of runoff elections. All first choices are counted, and if no candidate wins a majority of first choices, then the last choice candidate is eliminated. Ballots of voters who ranked the eliminated candidate first are redistributed to their next choice candidates, as indicated on each ballot. Last place candidates are successively eliminated and ballots are redistributed to next choices until one candidate remains or a candidate gains a majority of votes. (2003)

For election of the Premedical Regional Directors, each chapter shall cast one ballot with votes for a number of candidates equal to that number of positions available. Those candidates who receive the highest number of votes shall be elected. (2003)

#### **Section 5—Premedical Representatives for the Action Committees and Interest Groups.** (2004)

1. The Premedical Representative shall be elected at the national convention during each Action Committee and Interest Group organizational time by the same method as the Action Committee and Interest Group Coordinators, as detailed in Article VIII, Section 10 and Internal Affairs, Section III, E. #5, respectively. (2005)
2. The newly elected Premedical Action Committee and Interest Group Representatives shall attend the national leader transition and Action Committee transition meetings on the Sunday after National Convention. (2008)

#### **Section 6—International Trustee and International Programming Coordinator** (2003)

The International Trustee and the International Programming Coordinator shall be elected by the Association's international constituency at a meeting of the International Caucus at the National Convention. At least five (5) international chapters must be present at the time of the election or the positions shall be declared vacant. (2002)

Each chartered international chapter attending shall be entitled to one (1) vote in the election of the International Trustee, and one vote in the election of the International Programming Coordinator. In each election, if there are greater than two candidates, the election shall use a system of instant runoff voting. Under this system, each chapter ranks the candidates in order of preference. The counting of ballots simulates a series of runoff elections. All first choices are counted, and if no

candidate wins a majority of first choices, then the last choice candidate is eliminated. Ballots of voters who ranked the eliminated candidate first are redistributed to their next choice candidates, as indicated on each ballot. Last place candidates are successively eliminated and ballots are redistributed to next choices until one candidate remains or a candidate gains a majority of votes.

### **Section 7—Alumni and Resident Trustee**

The Resident Caucus shall elect the Alumni and Resident Trustee at the Annual Meeting. Any candidate for Alumni and Resident Trustee must have already earned an M.D. or D.O. degree (2002) and be enrolled in a postgraduate training program. (2003) Each member of the Resident caucus present at the election shall be entitled to one (1) vote in the election of the Alumni and Resident Trustee. In instances when there are greater than two candidates for Alumni and Resident Trustee, the election shall use a system of instant runoff voting. Under this system, each chapter ranks the candidates in order of preference. The counting of ballots simulates a series of runoff elections. All first choices are counted, and if no candidate wins a majority of first choices, then the last choice candidate is eliminated. Ballots of voters who ranked the eliminated candidate first are redistributed to their next choice candidates, as indicated on each ballot. Last place candidates are successively eliminated and ballots are redistributed to next choices until one candidate remains or a candidate gains a majority of votes. (2003)

### **Section 8—National Leadership Code of Election Conduct**

Members of the AMSA national leadership, including Board of Trustees members, Regional Programming Coordinator, Action Committee Chairs and Coordinators, and Interest Group coordinators, shall not give unsolicited opinions about candidates for national or regional office or candidates for action committee or interest group positions. Upon being asked about a candidate, leaders may speak personally about a candidate if, and only if, they clearly state that they do not speak on behalf of the AMSA national leadership. At no time should an AMSA National Leader make a statement about a candidate when serving in his or her official capacity (e.g., running regional time, serving as a speaker on a panel, facilitating a session, etc.) (2002)

In addition, no AMSA National Leader or Student Office Fellow member shall take any action to unduly positively or negatively affect the election outcome of any candidate. If this occurs, any knowing individual is obligated to notify the nominations committee, who will determine the best course of action regarding the election by following the process governing violations of the Elections Code of Conduct. The nominations committee shall also immediately report the incident to the Secretary and Vice President for Internal Affairs to convey to the Board of Trustees who shall follow established procedures regarding violations of National Leader Standards of Conduct. (2007)

### **Section 9—Code of Election Conduct (2001)**

1. No distribution of campaign materials. The Nominations Committee chair, with the assistance of the Secretary and Vice President for Internal Affairs, will determine how the candidates will identify themselves as such.
2. No form of mass communication will be utilized by any candidate in efforts to “campaign” with the general membership. CVs and personal statements shall be submitted to the AMSA national office and must be postmarked 60 days prior to the convening of the HOD. Candidates entering the race after that time may submit a CV, which will be disseminated by the Secretary and Vice President for Internal Affairs to the HOD.
3. Nominees shall publicly address the membership only at times determined by the HOD Nominations Committee.
4. Receptions and/or hospitality should not be used for promotion of a candidate.
5. No member of AMSA shall recklessly or negligently disseminate information on behalf of a candidate about another AMSA member or candidate. In addition, no AMSA member shall take any action to unduly positively or negatively affect the election outcome of any candidate. If this occurs, any knowing individual is obligated to notify the Nominations Committee in writing immediately, preferably by 5 p.m. the night prior to the election. If it is submitted after 5 p.m., then the Nominations Committee shall have the power to postpone the election for that office to review the allegations. Any postponement of the election beyond the closure of the HOD requires approval of the HOD. If the allegation of misconduct is found to be valid or will discredit the organization, the Nominations Committee shall determine the best course of action. (2007)
6. The rising VICE PRESIDENT FOR INTERNAL AFFAIRS and the VICE PRESIDENT FOR INTERNAL AFFAIRS (if not running for a national office) shall advise the Nominations Committee as necessary and conduct the HOD as appropriate.
7. In all other circumstances, the Nominations Committee shall determine the appropriate course of action.

## **Section 10—Selection of Action Committee Chairs and Committee Coordinators (2002)**

- A. Candidate profiles: Each Action Committee Chair, with assistance from the Vice President for Programming and the Director of Student Programming, shall develop a candidate profile form for each Action Committee Chair and Coordinator position. This candidate profile form shall include the title of the position, a brief description and list of duties, all required meeting dates for the next year, and brief questions regarding the candidates' qualifications, past experience and vision for how they will contribute to the Association.
- These candidate profile forms shall be made available 60 days prior to the Annual Meeting, and should be advertised and made available on each Action Committee listserve and the AMSA Web site.
- B. Eligibility: Only full medical student members shall be eligible to run for Action Committee Chair. Full medical student members of the Association and premedical and international affiliate members shall be eligible to run for Action Committee Coordinator positions. (2006)
- C. Elections: Elections for Action Committee Chairs and Coordinators shall take place during organizational time during the Annual Meeting. The out-going Action Committee Chair will create and chair an election committee made up of the out-going Action Committee Chair and at least two out-going Committee Coordinators or other AMSA members that are not running for a position. If the out-going Action Committee Chair is running for a position on the Action Committee, one of the Committee Coordinators who is not running for a position shall be selected to chair the election. A two-minute minimum speaking time is suggested for all candidates. (2005)

All voters must be present for the duration of all candidate speeches to vote for a position. Votes shall be cast on a one-vote-per-member basis. Each medical and premedical chapter shall be limited to a maximum of three votes per position. If a chapter has more than three attendees at organizational time, they shall designate three voters to represent their chapter. No member shall vote in absentia.

The Secretary and Vice President for Internal Affairs shall develop a ballot system that is efficient and allows chairs to enforce the three-vote per chapter limit. All ballots shall be returned to the Secretary and Vice President for Internal Affairs immediately after the elections.

Elections for Chair or single Coordinator positions in which there are greater than two candidates shall use a system of instant runoff voting. Under this system, each voter ranks the candidates in order of preference. The counting of ballots simulates a series of runoff elections. All first choices are counted, and if no candidate wins a majority of first choices, then the last choice candidate is eliminated. Ballots of voters who ranked the eliminated candidate first are redistributed to their next choice candidates, as indicated on each voter's ballot. Last place candidates are successively eliminated and ballots are redistributed to next choices until one candidate remains or a candidate gains a majority of votes.

In elections for more than one coordinator position, the above method will be used to determine the first winning candidate. At this point, all ballots will effectively have the winning candidate's name removed. After doing this, the ballots will be counted again, using the same instant runoff method described above, until a second winning candidate is determined. The process will continue until all spots are filled. The names of the winning candidates will then be announced with no reference to the number of votes each candidate received.

Disputes of election procedure should be addressed to the Secretary and Vice President for Internal Affairs and the Nominations Committee before the post-convention Board of Trustees meeting.

## **ARTICLE IX. HOUSE OF DELEGATES**

The House of Delegates of the Association shall meet annually to elect the Officers, establish and amend the policy of the Association and conduct such other business as may be necessary.

### **Section 1—Representation of Full Medical, Resident and International Affiliate Members**

- A. Medical Chapters
- Each medical chapter of the Association that has received a charter, as described in Article IV of the Constitution and Bylaws, shall be entitled to representation in the House of Delegates on the basis of one (1) delegate for every two hundred fifty (250) medical student members, or majority fraction thereof. Each such delegate shall be an active member of the Association. In the absence of any such delegate, an alternate delegate shall be seated in his/her place. (2004)

The number of delegates to the House of Delegates for the degree granting institution shall be determined by the total number of student members at the main campus, plus those at all of the branch campuses which do not have separate chapter status.

The number of medical student members at any given chapter is determined seventy-five (75) days prior to the Annual Meeting by the national office so that chapters have adequate time to select the Delegate(s) and to solicit financial support for those members. Students who join the Association after the deadline date and prior to the Annual Meeting are considered in the following year's membership tabulation for each chapter. (2003)

**B. Resident Members**

Resident members of the Association as defined by Article III, Section 1B shall be entitled to representation in the House of Delegates on the basis of ten at-large votes. (2008) Each delegate must be a resident member of the Association. Medical students who have successfully matched and will be entering internship are not considered Resident members and may not vote as such in the HOD. (2006)

Resident delegates will be chosen at the beginning of the Annual Meeting by general caucus of all Resident members present at the Meeting in a ratio of 6:4 of primary care: specialty fields, unless not possible to do so due to lack of resident representation from these fields. Delegates will be selected by a majority vote. In the absence of any delegate, an alternate delegate may be seated. (2008)

**C. International Members**

Each chartered International Chapter shall be entitled to one (1) voting delegate in the House of Delegates of the Association for every two hundred (200) medical student members, or fraction thereof, of said chapter. The total number of delegates from all international chapters shall not exceed the total number of regions in the Association (10). If more than ten delegates wish to vote, designation of delegates shall be based firstly on the proportional number of delegates eligible from each chapter (according to the number of medical student members) and secondly on the order in which chapters register their official delegate(s) with the International Trustee for the annual meeting. (2003)

**Section 2—Ex-Officio Representation**

Ex-officio members of the House of Delegates shall include the international delegates, regional affiliate premedical delegates, members of the Board of Trustees, the Vice Chairs of the House of Delegates, the past presidents of the Association, and the chair people of the committees of the House of Delegates of the Association. Ex-officio members shall have the right to address the House of Delegates upon recognition by the Chair but shall not have the right to vote, unless they are a voting delegates as specified in Article IX, Section 1.

**A. Affiliate Premedical Sustaining Members**

Premedical Sustaining Members of the Association shall be entitled to ex-officio representation in the House of Delegates. Each Premedical affiliate region shall be entitled to one (1) ex-officio delegate to the House of Delegates.

**Section 3—Delegate Selection**

The Delegate(s) serve as the local chapter's formal representative(s) to the House of Delegates. Although the national organization cannot dictate the process of selection for Delegates at the local chapter level, all chapters are encouraged to maintain an open and fair policy of Delegate selection. As general guidelines, the House of Delegates encourages local chapters to call a meeting of the membership a minimum of thirty (30) days prior to the Annual Meeting to select their Delegate(s). Any active member may serve as a Delegate for a local chapter. Resident delegates may name three (3) alternates for each voting delegate. Alternates will be selected by the same method used for selection of delegates. Alternates must be participating in a residency or fellowship program in the region from which they are selected.

In addition to the Delegate(s), each chapter may name three (3) Alternate Delegates for each designated delegate. One (1) Delegates Handbook will be distributed to each Delegate, while extra copies and updated resolutions will be available from the Credentials Committee upon entering the floor of the House. During the proceedings of the House of Delegates, only one individual may be seated per authorized position. The national office is notified of the Delegate(s) and Alternate Delegates selected by local chapters through the "Delegate Certification Forms" distributed with the "Official Call." All the Delegates for a chapter must be certified by the Chapter President. Resident Delegates and Alternate Delegates will complete Delegate registration forms and be credentialed at the first opening session of the House of Delegates.

Each International Chapter shall be entitled to one ex-officio member in the House of Delegates of the Association as well as three (3) alternate delegates. One (1) Delegates Handbook will be issued for each designated nonvoting member. The caucus of AMSA members studying at international medical schools will certify their selection of nonvoting members and alternates to the Credentials Committee Chairperson. (2003)

#### **Section 4—Delegate Responsibilities**

The primary responsibility of each Delegate/Alternate Delegate is to present the views of his/her chapter before the House of Delegates. Each Delegate is sent information approximately twenty-five (25) days prior to the Annual Meeting about the organization and all proposed resolutions and amendments to be considered by the House of Delegates. Before the Annual Meeting, it is the responsibility of the Delegate(s) and Alternate Delegates to become familiar with the policy of the Association. It is the responsibility of the Delegates and Chapter Officers to call a meeting of the chapter at this time to review all pertinent items. All proposed amendments and resolutions must be reviewed with members of the Chapter in order to adequately represent their viewpoints. (2003)

#### **Section 5—Addressing the House of Delegates**

Only delegates and ex-officio members of the House of Delegates and members of the presenting reference committee shall have the right to address the House of Delegates, unless the House of Delegates grants an unauthorized member or guest the right to the floor by a simple majority vote. (2001)

#### **Section 6—Official Observer Status**

1. National Organizations may apply to the Board of Trustees of the American Medical Student Association for Official Observer Status in the House of Delegates. Applicants must demonstrate compliance with guidelines for official observers adopted by the House of Delegates, and the Board of Trustees shall grant Official Observer Status based on these criteria.
2. Official Observer Status shall be granted to all organizations to which AMSA has an official liaison relationship. (2005)
3. Organizations with Official Observer Status are invited to send one representative to observe the actions of the House of Delegates at the annual meeting. Official observers have the right to speak and debate on the floor of the House upon invitation from the Chair. Their debate time is limited and is left up to the discretion of the Chair of the House. Official observers do not have the right to introduce new business, introduce an amendment, make a motion or vote.
4. The guidelines for Official Observer Status for non-liaison organizations are as follows: (2005)
  - a. The organization and AMSA should already have an informal relationship established and have worked for the mutual benefit of both.
  - b. The organization should be national in scope and have similar goals and concerns about health issues.
  - c. The organization is expected to add a unique perspective and bring expertise to deliberations in the House.
  - d. The organization must submit their application for observer status at least two weeks before the AMSA Fall Board Meeting so that all applications can be reviewed at the Fall Board meeting and if approved, the student organization can participate as an official observer at the subsequent House of Delegates at the following annual meeting. (2001)

#### **Section 7—Voting Guidelines**

An affirmative vote of at least two-thirds (2/3) of the delegates present and voting shall be necessary for amendments to the Constitution or Bylaws as specified in Article XVIII of the Constitution and Bylaws. Otherwise, all questions shall be decided by a majority of the votes cast.

#### **Section 8—Order of Business**

The order of business of the House of Delegates shall be determined and published by the Board of Trustees and shall be distributed to the delegates at the commencement of the Annual Meeting of the House of Delegates. The order of business shall be changed only by a vote to that effect by at least two-thirds (2/3) of those voting.

## **Section 9—Quorum**

The right to vote shall be vested in the duly elected delegates from each chapter. In order for quorum to be established, a majority of the registered delegates must be present at the House of Delegates. Registered delegates will be defined as delegates that are registered at any time before the start of business on the first day of the House of Delegates. During the absence of a delegate from the floor of the House of Delegates, his/her vote shall be vested in the corresponding duly elected alternate delegate from said chapter. No other votes of a proxy nature shall be allowed.

## **Section 10—Meetings of the House of Delegates**

The House of Delegates shall meet during the Annual Meeting of the Association and at such other times and places as it may determine. The date of the Annual Meeting shall be announced at least one hundred twenty (120) days prior to such meeting. Special meetings of the House of Delegates may be called by a vote to that effect of at least two-thirds (2/3) of the chapters in the Association. Each chapter shall be given notice by registered mail of the special meeting and the business of the meeting within fifteen (15) days of the call. The special meeting shall be held not less than fifteen (15) days, or more than sixty (60) days, after notice has been sent to the chapter.

## **Section 11—Selection of the Chairperson and Vice Chairs**

The Vice President of Internal Affairs, who is in the second year of his/her term shall serve as Chairperson of the House of Delegates and shall preside at all sessions of the House of Delegates. The Secretary, who is in the first year of his/her term, shall serve as a Vice Chair. At least sixty (60) days prior to the Annual Meeting, the Vice President for Internal Affairs, serving as Chairperson, shall appoint a second Vice Chair, with the approval of the Board of Trustees, to assist in the smooth functioning of the House of Delegates.

The second Vice Chair shall be an active member of the Association at the time of his/her appointment and shall not be a candidate for national office, (2002) and said appointment shall be based on knowledge of parliamentary procedure and experience in conducting meetings similar to those of the House.

## **Section 12—Submission of Resolutions to the House of Delegates**

All resolutions from members or chapters must be postmarked or delivered in person to the national office of the Association no later than sixty (60) days prior to the opening session of the House of Delegates at the Annual Meeting at which they are to be considered. If this date falls on a Sunday or legal holiday in a given year, then the deadline is extended to the next regular business day. The Association shall distribute copies of these resolutions to members of the House of Delegates and local chapter contacts by thirty (30) days prior to the Annual Meeting at which they are to be considered. After the deadline for delivery of resolutions to the national office, resolutions may only be submitted to the House of Delegates for consideration with approval of the Board of Trustees. (2001)

## **Section 13—Committees of the House of Delegates**

In order to enable the House of Delegates to function smoothly and efficiently, the President and the Chairperson of the House appoint a number of Committees to serve for the duration of the Annual Meeting.

- A. Rules Committee. The Rules Committee consists of the President, the Chairperson of the House of Delegates and the Vice Chairs of the House of Delegates. The function of the Committee is to clarify the working rules of the House of Delegates for the official business sessions. The Rules Committee report is distributed prior to the Annual Meeting and consists of the following information:
  1. method of Delegate(s) registration;
  2. seating of the Delegate(s) in the House of Delegates;
  3. designation of ex-officio members of the House of Delegates;
  4. use of proxy votes during business sessions;
  5. voting procedures for the election of National Officers;
  6. length of speeches and debate;
  7. the procedure by which motions and resolutions are introduced for consideration by the House of Delegates; and,

8. special rules for the functioning of the House of Delegates.
- B. Credentials Committee. The Credentials Committee consists of medical student members of the Association, including a designated Chairperson, and functions to maintain the official roll of those entitled to vote in the official business sessions of the House of Delegates. The number of committee members will be determined by the Secretary and Vice President for Internal Affairs. (2002) The Committee also certifies that a quorum is present for the official business sessions of the House. One of the members of the Credentials Committee also serves as the Sergeant-at-Arms for the House of Delegates during the business sessions.
- C. Nominations Committee. The Nominations Committee consists of medical student members of the Association, including a designated Chairperson, who are not candidates for any national office. The number of committee members will be determined by the Secretary and Vice President for Internal Affairs. (2002) The functions of the Committee are to ensure that all candidates for national office are medical student members, to present all identified candidates to the House of Delegates during the Open Session and to oversee the electoral process.
- D. Reference Committees. All resolutions submitted before the appropriate deadlines will be referred to the Reference Committees and reported to the House of Delegates during the Annual Meeting in which they are introduced. All proponents and opponents of the resolutions will be given a reasonable opportunity to appear before the Reference Committee to bring testimony on their position. The Reference Committees will report to the House of Delegates the resolutions either as submitted, amended, or rejected, giving pertinent explanation for their recommendations. The House of Delegates will then adopt, defeat, or amend the committee report. The resolutions adopted then become the policy of the Association.
  1. Reference Committee Structure. Each Reference Committee consists of members, preferably with no more than two members from each region, including a designated Chairperson chosen by the President and the Chairperson of the House of Delegates, from applications solicited from the general membership. The number of committee members will be determined by the Secretary and Vice President for Internal Affairs. (2003) In order to avoid any conflict of interest, no person may be a member of any Reference Committee to which he/she has submitted a resolution. Reference Committee members are selected on the basis of their objectivity, past experience and geographic representation.
  2. Reference Committee Responsibilities. Each Reference Committee holds “open” sessions to hear testimony on the amendments and resolutions referred to it. In addition, Reference Committees will be assigned reports submitted to the House of Delegates on a “For Information Only” basis, for review and comment. The Reference Committees will post an “agenda” so that members can plan their attendance at the various hearings. The Chairperson of the Reference Committee generally calls for testimony from regional representatives prior to hearing other testimony, in order to receive input from the greatest number of members.

Any individual is invited to contribute, whether he/she speaks for a region, a chapter or simply for themselves. Each Reference Committee must recommend specific action to the House of Delegates on each referred amendment or resolution. The Committees may not change the intent of any resolution; however, they may modify the wording of resolutions in concert with opinions expressed in testimony. The Committee may consolidate resolutions with similar intent. If the Committee members disagree with the intent of the resolution based on the testimony presented to them, they may recommend rejection to the House of Delegates. The Reference Committee reports should reflect the testimony presented, plus a consideration of the resolution in light of existing policy and other resolutions submitted for consideration by the House of Delegates. (2003)

#### **Section 14—Special Rules of Order**

Prior to voting on any resolution or amendment before the House of Delegates, at least one (1) “con” spokesperson and one (1) “pro” spokesperson shall be allowed to give testimony before an immediate vote motion may be made. If such spokespersons are not waiting to give testimony, a motion for an immediate vote may be entertained. (2003)

## **ARTICLE X. REGIONAL CONFERENCES (2002)**

1. In the fall of each year, the Board of Trustees shall organize and hold Regional Conferences at several locations across the country. These conferences shall involve members for the purpose of orienting them to the national and regional organization and developing mechanisms for local implementation of national policy actions set by the previous House of Delegates. Regions are encouraged to hold Regional Conferences at fully accessible locations, as defined by the Americans with Disabilities Act of 1990. (1997)
2. During regional meetings at conferences, members of the region will provide feedback to the Regional Directors and regional programming coordinator regarding their performance and responsiveness to the membership. Via the feedback given at the conference, the Regional Director and regional programming coordinator can direct future action to meet the needs of the region.
3. Regions I, II, and III as well as Regions V, VII, and IX shall hold joint conferences to be hosted on a rotating schedule. For the Region I, II, and III conference, the rotating schedule will begin with Region I in 2007, Region II in 2008, and Region III in 2009, and thereafter continuing to rotate through Regions I, II, and III in that order. For the Region V, VII, and IX conference, the rotating schedule will begin with Region V in 2006, Region VII in 2007, and Region IX in 2008, and thereafter continuing to rotate through Regions V, VII, IX, in that order. (2003) Regions IV and VI shall also hold joint conferences to be hosted on an alternating schedule. This alternating schedule will begin with Region IV in 2006, Region VI in 2007, and thereafter continuing to alternate between Regions IV and VI in that order. (2005)

## **ARTICLE XI. DISCRIMINATION**

Neither the Association, nor its chapters, may refuse membership on the basis of race, religion, color, gender (1993), sexual orientation and gender identity, national origin, creed or disabilities (1993), but chapters shall otherwise determine the qualifications of their own members where not inconsistent with the Constitution and Bylaws of the Association. Organizations that discriminate in recruitment and for employment on the basis of gender, race, religion, sexual orientation and gender identity, national origin, or creed or disabilities (1993) be prohibited from recruitment or offering employment in AMSA's exhibit hall, *The New Physician*, or in other books or items which are, in part or whole, published or endorsed by AMSA (1993).

In the event that there is a suspected or known violation of the antidiscrimination policy or the principles regarding advertisement in AMSA's exhibit hall, in *The New Physician*, or in other books or items which are, in part or whole, published or endorsed by AMSA (1993), the member(s) are to register their complaint to the Board of Trustees who will then follow the appropriate and established organization protocols to address such complaints.

## **ARTICLE XII. FINANCES**

### **Section 1—Dues**

Dues for all AMSA members, including medical students enrolled in standard MD/DO programs in the United States or Canada, international students, premedical members and non-physician providers, shall be set by the Board of Trustees in conjunction with input from the ED and membership department staff. (2007)

The dues will not increase by more than \$10 in any given year, unless authorized the HOD, with no dues increase in two successive years. (2007)

Any change in dues will be reported to the HOD by the National Vice President for Finance, in his/her year-end report, citing the reasons for the change and the proposed fiscal impact. (2007)

### **Section 2—Fund-raising Guidelines**

No funds may be raised for activities and publications of the Association from sources disapproved by the House of Delegates or the Board of Trustees.

AMSA Board of Trustees and national level of Action Committees shall not accept unrestricted funds from any commercial or for-profit source. When AMSA accepts restricted funds from any commercial or for-profit source, letters of understanding must be drafted and signed by AMSA and the funding source to specify:



1. recognition of commercial support should be limited to publication of corporate name only and information about the project not be used in commercial advertising by the sponsoring source;
2. funding sources shall not control the content, planning administration or other aspects of each project beyond the appropriate administrative review, to include a summary report that AMSA will provide to the sponsoring source;
3. no project should directly generate sales of products of the sponsoring company and that, if appropriate, there should be information provided to the participants and public that there is no commercial obligation implied;
4. any relevant AMSA policy concerning such an activity.

AMSA will publish, on a yearly basis, a list of its current sources of funds from commercial and for-profit sources, which will be available from the national AMSA office upon request.

### **Section 3—Authority to Expend Funds**

Funds may only be expended by order of the Board of Trustees on checks signed by the ED, or his appointee, to defray expenses of the Association, its publications, and to further the purposes of the Association.

### **Section 4—Copyright Guidelines**

AMSA retains the right to copyright any materials or products produced or published under the auspices of AMSA. Such products may be published and marketed only by AMSA, unless otherwise agreed to by the Board of Trustees. The author(s) may continue to use and reproduce the product for personal use, and will retain proprietary rights other than copyright, provided that:

1. the copies are not used to imply AMSA endorsement;
2. the sources, AMSA, and the copyright date are listed;
3. the copies are not offered for sale.

AMSA may require recipients of project funds to sign a copyright release form approved by the Board of Trustees.

## **ARTICLE XIII. OFFICIAL RECORDS**

The minutes of the proceedings of the Board of Trustees and the House of Delegates, the membership rolls and the Books of Accounts shall be open to inspection at the national office of the Association upon the written request of any active member within thirty (30) days of the receipt of the request and shall be produced at any time when requested by a simple majority vote of the delegates at any meeting of the House of Delegates. Such inspection may be made by an agent or attorney, and shall include the right to make extracts thereof. Demand of inspection, other than at the meeting of the House of Delegates, shall be in writing addressed to the President of the Association and shall be at the member's expense.

## **ARTICLE XIV. PARLIAMENTARY AUTHORITY**

The rules contained within the current edition of Robert's Rules of Order shall govern this Association in all cases to which they are applicable, and to which they are most consistent with the Constitution, these Bylaws or the special Rule of Order of this Association.

## **ARTICLE XV. INSIGNIA**

There shall be a seal and such other insignia as are adopted by the Board of Trustees, and these shall be recognized as the official seals of the Association.

## ARTICLE XVI.

## PUBLICATION

### **Section 1—The New Physician**

*The New Physician* shall be the official journal of the Association. The editorial policy of the journal shall be determined by the Board of Trustees and administered by the editor, who shall be an employee, but not necessarily a member, of the Association. The editor shall be appointed by the Executive Director (ED) of the Association, with the advice and consent of the Board of Trustees, and the term shall be indeterminate.

### **Section 2—Managing Publisher**

The ED of the Association, or his/her designee, shall be the Managing Publisher of the journal.

### **Section 3—Student Editor**

While *The New Physician* is a professionally produced publication, it seeks to serve the information needs of medical students. Formalized student input is required to provide a complementary and necessary perspective for the professional staff. The journal shall have a Student Editor who shall be an active member of the Association and shall be chosen based on both editorial experience and AMSA involvement. He/she shall be appointed by the outgoing Editorial Advisory Board for a renewable term of one year to begin at the May BOT meeting. The Student Editor's duties shall include, but are not limited, the following: (2008)

- a. Coordination of the Editorial Advisory Board (EAB) in its efforts to critique *TNP* and relaying the EAB's commentary to the Executive Editor. In this regard, the Student Editor must attend the annual planning meeting of the *TNP* staff and the Student Office Fellows. (2005)
- b. Shall carry out the policy of the House of Delegates as a member of the Board of Trustees and serve as the liaison between the EAB, Executive Editor and the Board of Trustees. (2008)
- c. Reporting out at Board meetings for the purpose of information. The Student Editor must submit a written report no later than two weeks before each Board meeting to the ED and the National President. This report will contain updates on *TNP*, concerns regarding student involvement, and any other issues that need to be addressed by the Board of Trustees. The report shall contain input from the Editorial Advisory Board. (2008)
- d. Periodic and regular review of manuscripts at the discretion of the Executive Editor.
- e. Providing input into the long-range goals, content, and direction of *TNP* in conjunction with the EAB.
- f. Seeking out students with interesting experiences and perspectives for interview at the discretion of the Executive Editor.
- g. Seeking out students with journalistic skills and an interest in writing for publication assignments at the discretion of the Executive Editor.
- h. Solicitation and formulation of manuscript topics in conjunction with the EAB for use by the Executive Editor.
- i. Submission of a year-end report for inclusion into the Delegates Handbook for the review of the House of Delegates.

### **Section 4—Advisory Board**

*The New Physician* shall have an Advisory Board. The composition of the Board shall be the Student Editor and four members of AMSA as approved by the Board of the Trustees in their Spring Board of Trustees meeting. This Advisory Board can include both medical students, premedical students and residents, and will be selected on the basis of editorial and journalistic experience as well as significance of AMSA involvement. Board members will serve one-year terms to begin every June. Additional members of the Advisory Board can be appointed by a 2/3rds majority vote of the Board of Trustees as needed. (2005)

The Advisory Board's duties will be as follows:

- a. Serving as the liaison between the Board of Trustees and *The New Physician*. Members of the Advisory Board must each submit a written report to the Board of Trustees by the Fall Board of Trustees meeting that contains updates on *TNP*, concerns regarding student involvement, and any other issues that need to be addressed by the Board of Trustees. (2005)

- b. Bringing up issues of concern to the EAB on behalf of AMSA members. In this regard, members of the Editorial Advisory Board must attend the annual planning meeting of the *TNP* staff and the Student Office Fellow. (2005)
- c. Improving communication of AMSA's priorities through *TNP*. (2005)
- d. Working with the Student Editor to seek out students with journalistic skills who are interested in writing for *TNP* and who are interested in sharing their experiences and perspectives. (2005)
- e. Providing input to the Executive Editor as to the long-range goals, content, and direction of *TNP*.
- f. Ensuring that advertisements in *The New Physician* are in keeping with the advertising guidelines in the Internal Affairs.

## **Section 5—AMSA Focus**

AMSA Focus shall be the official newsletter of the Association. It shall provide information about member opportunities and activities.

## **ARTICLE XVII. REPORTS**

### **Section 1—Reports of the Board of Trustees**

In the interest of increasing the benefits to the Membership-at-Large from general interest Association programs, as well as increasing the information available to the Membership-at-Large as to the functioning of the Board of Trustees, the following reports will be published in an official publication of the Association which circulates to the Membership-at-Large at the indicated times:

1. Association Activities Report. The Board of Trustees will ensure publication of a report of the Association's general interest activities, including all trips to foreign countries. Every effort shall be made to have these reports published within three (3) months following the events.
2. Financial Report. The Vice President for Finance shall prepare an annual financial report, which shall include income and expenditures for the current and previous fiscal year. The report shall be in an easily understandable form with special itemization of National Officer, Regional Director, Regional Conference and Action Committee budgets. This financial statement shall be reviewed by the Board of Trustees and published between thirty and sixty days prior to the Annual Meeting.
3. Board of Trustees' Actions Report. The Vice President of the Association will be responsible for communicating the most recent Board of Trustees' plans, actions, and deliberations as specified in Article VII, Section 14, Subsection F. (2002)

In addition, each Regional Director is urged to communicate to his/her region how he/she voted on particular issues that come before the Board of Trustees; and the Board of Trustees shall have the power to waive the above-stated requirements for issues of a sensitive nature when it is in the Association's best interests to keep the information at the level of the Board of Trustees. (2002)

### **Section 2—Annual Activities Reports**

All of AMSA's national leadership including, but not limited to, National Officers, Regional Directors, Regional Programming Coordinators, Premedical Trustee, Premedical Regional Directors, Alumni and Resident Trustee, Vice President for Programming, Action Committee Chairs, and Student Office Fellows shall compose an Annual Activities Report that summarizes his/her activities and details his/her financial expenditures. This report is to be submitted no later than 60 days postmarked before the Annual Meeting. Funding of travel to the Annual Meeting shall be contingent on timely submission of this Annual Report to the National Office. Failure to submit the report by 60 days postmarked before the Annual Meeting will be grounds for withholding funding.

In the case of the National Officers, this report shall be included in the Delegates Handbook. In the case of the Regional Directors, this report, one per Director, will be included in the Delegates Handbook and published as a final edition of the Regional newsletter to be received by the Regional contacts at least thirty (30) days prior to the Annual meeting. A copy of the report shall be placed in a notebook, one per Region, containing copies of past reports of Regional Directors from that

Region. The notebook will be retained by the Regional Director during the year and passed on to his/her successor at the Annual Meeting. In Regions with more than one Director, one report may be submitted, provided this report accurately reflects the activities and expenditures of all Directors in the Region. In addition to a summary of activities and expenditures, the report of the Regional Director should contain an assessment of the general state of the Region and should reflect the Directors dealings with each of the chapters in the Region. (2003)

In the case of the Regional Programming Coordinators, their year-end reports will be submitted in January and included in the Delegates Handbook. In addition, the Regional Programming Coordinators will submit an interim report to the Board of Trustees before the Fall Board meeting. In the case of the Vice President for Programming to the Board of Trustees, this report shall be included in the Delegates Handbook and be distributed to national leadership at least thirty (30) days prior to the Annual Meeting. One copy of each report shall be retained at the National Office for reference. (2003)

## **ARTICLE XVIII. AMENDMENTS TO THE CONSTITUTION and BYLAWS**

Proposed amendments to this Constitution and Bylaws shall be considered at the annual meeting of the House of Delegates. Any five (5) or more medical student members or affiliate members of the Association may propose amendments to this Constitution and Bylaws by submitting such proposals in writing to the ED at the National Office. These proposals must be postmarked or delivered in person no later than sixty (60) days prior to the opening session of the House of Delegates at the annual meeting at which they are to be considered. If this date falls on a Sunday or legal holiday in any given year, then the deadline is extended to the next regular business day. Written notice of such proposed amendments shall be sent to all chapters by thirty (30) days prior to the Annual Meeting at which they are to be considered. An affirmative vote of at least two-thirds (2/3) of the delegates present and voting shall be necessary for the adoption of any such proposed amendments.

In addition, any delegate may propose amendments to these Constitution and Bylaws on the floor of the House of Delegates without prior notice, except that in such cases, an affirmative vote of at least two-thirds (2/3) of the delegates present and voting shall be necessary for the adoption of any such proposed amendments.

For all resolutions seeking to amend these Constitution and Bylaws, the actual vote counts shall be tabulated and maintained as part of the official record of that session of the House of Delegates. (2003)

## **ARTICLE XIX. CLOSURE OF MEDICAL SCHOOLS & OTHER EMERGENT SITUATIONS**

### **Section 1—Establishment of an Emergency Committee**

In the event of a medical school closure, a committee consisting of a representative from the affected school, the Regional Director from the region of the affected medical school, an Action Committee Chair, the National President, the Director of Student Programming, the Legislative Affairs Director and the Vice President for Programming will be created. (2007)

### **Section 2—Responsibilities of the Emergency Committee**

The purpose of this committee shall be to give support and guidance to the students of an affected medical school as deemed appropriate by the members of the committee. This committee shall, by consensus, compose a report to the membership of AMSA that will be published with the reports of other AMSA subcommittees in the appropriate annual House of Delegates program. (2000)

## **ARTICLE XX. IFMSA (2008)**

### **Section 1—AMSA as the National Member Organization (2008)**

AMSA as the National Member Organization representing the USA within the International Federation of Medical Students' Associations:

1. AMSA shall be the official National Member Organization (NMO) representing medical students at USA medical schools to the International Federation of Medical Students' Associations (IFMSA).
2. AMSA's official title within the IFMSA shall be AMSA-IFMSA.

#### Obligations of AMSA to IFMSA:

1. AMSA shall send a minimum of seven (7) delegates to the IFMSA's biannual General Assemblies (GA) in March and in August: one (1) delegate filling the role of NMO president, six (6) delegates filling the roles of the chairs of the six (6) IFMSA Standing Committees (Standing Committees on: Professional Exchange, Research Exchange, Public Health, Medical Education, Reproductive Health including AIDS, and Human Rights and Peace).
2. AMSA shall make a good faith effort to pay the registration fees and travel expenses of its delegates to the GAs.
3. AMSA shall submit the biannual National Member Organization report in a timely fashion, and pay its yearly dues to the IFMSA to maintain its NMO status and plenary session voting rights as delineated by the IFMSA Constitution and Bylaws.
4. In times of budget restrictions that might otherwise threaten AMSA's ability to pay yearly dues and/or the cost of sending delegates to the GAs, exchange fees and other revenue generated by IFMSA-specific AMSA programs shall be firstly applied to paying the IFMSA dues, then secondly to paying the cost of sending delegates to the IFMSA GAs, before being applied to other areas of the AMSA budget.

#### **Section 2—AMSA and IFMSA-USA Merger (2008)**

The American Medical Student Association (AMSA) and the International Federation of Medical Students' Associations—USA (IFMSA-USA) shall merge under the organization of AMSA. (2008)

AMSA membership shall be conferred on all IFMSA-USA members at the start of the AMSA Annual Convention of March 2008, without requiring any additional membership dues. (2008)

In situations where conflicts between the leadership of AMSA and IFMSA-USA local chapters make a merger of those local chapters difficult or impractical, the AMSA national leadership shall refrain from attempting to impose integration. (2008)

Where AMSA and IFMSA-USA local chapters cannot reach a consensus for a unified leadership structure, it shall be permissible to allow the two groups to operate independently with the understanding that all their members enjoy the same benefits as AMSA members, and that the national AMSA leadership encourages unification at the earliest possible point. These situations shall be followed closely by the appropriate AMSA Regional Director and the IFMSA-USA Vice-President for Membership Development. (2008)

#### **Section 3—Defining the Transitional Year for the AMSA/IFMSA-USA Merger (2008)**

The transitional year for the merger of AMSA and IFMSA-USA shall last from the final meeting of the AMSA House of Delegates in March of 2008, until the final meeting of the AMSA House of Delegates in March of 2009.

#### **IFMSA-USA Leadership Within AMSA During the Transition Year :**

##### **Appointment and Tenure of IFMSA-USA Leaders Within AMSA:**

1. All current IFMSA-USA officers shall be adopted into the leadership of AMSA by appointment, with tenure until the AMSA leadership elections of March 2009 to help assure a smooth integration of IFMSA-USA local chapters, members, and projects. To that end, they shall be encouraged to attend all AMSA national leadership meetings throughout the transitional year.
2. With the national AMSA leadership elections of March 2009, the positions of National Exchange Officer (NEO), National Officer for Research Exchange (NORE), Developmental Exchange Officer (DEO), and AMSA-IFMSA Chair (vis-à-vis the election of the GHAC Chair) shall be elected in a matter consistent with existing AMSA leadership elections.
3. Positions not listed above being filled by IFMSA-USA officers will be dissolved upon the completion of the national AMSA leadership elections of March 2009, and not refilled by election.

4. The President of IFMSA-USA shall serve as the AMSA-IFMSA co-Chair in conjunction with AMSA's Global Health Action Committee Chair throughout the transitional year.
5. The AMSA-IFMSA co-Chairs, drawing on their knowledge of their respective organizations, shall work with the AMSA National President and Board of Trustees to:
  - a. Integrate IFMSA-USA's leaders and projects into AMSA
  - b. Integrate AMSA's projects and leaders into IFMSA
6. The two (2) IFMSA-USA NEOs serving at the start of the AMSA National Convention in March of 2008 shall continue as the two (2) NEOs within AMSA throughout the transitional year.
7. The two (2) IFMSA-USA NOREs serving at the start of the AMSA National Convention in March of 2008 shall continue as the two (2) NOREs within AMSA throughout the transitional year.
8. The one (1) IFMSA-USA Book Aid Project Coordinator serving at the start of the AMSA National Convention in March of 2008 shall continue as the Book Aid Project Coordinator and the chair of the Standing Committee on Medical Education (SCOME)—known as the National Officer for Medical Education (NOME)—within AMSA throughout the transitional year.
9. The one (1) IFMSA-USA Equip Project Coordinator serving at the start of the AMSA National Convention in March of 2008 shall continue as the Equip Project Coordinator and the chair of the Standing Committee on Public Health—known as the National Public Health Officer (NPO) – within AMSA throughout the transition year.
10. The one (1) IFMSA-USA Secretary General serving at the start of the AMSA National Convention in March of 2008 shall serve as the DEO, within AMSA throughout the transitional year.
11. The two (2) IFMSA-USA Vice-Presidents for Membership Development serving at the start of the AMSA National Convention in March of 2008 shall serve to facilitate local IFMSA-USA chapter integration into AMSA throughout the transitional year in conjunction with the appropriate AMSA regional trustees.
12. The one (1) Vice President for Membership Support serving at the start of the AMSA National Convention in March of 2008 shall facilitate IFMSA-USA member-at-large integration into AMSA throughout the transitional year.
13. The one (1) IFMSA-USA Vice President for Finance serving at the start of the AMSA National Convention in March of 2008 shall serve to facilitate the merger of IFMSA-USA financial accounts into AMSA throughout the transitional year in conjunction with the AMSA Executive Director and Board of Trustees.

#### IFMSA-USA Projects:

1. AMSA affirms that it will continue to support all current IFMSA-USA projects throughout the transitional year and beyond, and will expand upon those projects as it is able.

#### The Book Aid Project:

Definition of Book Aid: Book Aid is a medical text book donation program recognized by the International Federation of Medical Students' Associations (IFMSA), designed to help US medical students give used textbooks to medical student colleagues in resource-poor countries, where such texts are much more difficult to come by. Book Aid falls under the organization of the Standing Committee on Medical Education (SCOME) within the IFMSA standing committee framework.

Book Aid Project Leadership: The Book Aid project leadership shall consist of:

1. One (1) Book Aid Project National Coordinator
2. Local Chapter Coordinator, at least one (1) for each participating chapter.

#### Election/appointment of Book Aid Project Leadership:

1. Following the transitional year, The Book Aid Project National Coordinator shall be filled by a process to be determined by the March 2009 national AMSA Convention.

2. Local chapter coordinators, following their designation within their local chapter by an appropriate local process, shall identify themselves to the Book Aid Project National Coordinator to certifying their responsibilities at the local level.

The responsibilities of the Book Aid Project Leadership:

1. The Book Aid Project National Coordinator shall:
  - a. Coordinate medical textbook donation drives in participating local chapters across the country.
  - b. Provide concrete information to the participating medical schools on how the collected books can be distributed using the project's partnerships.
  - c. Be available to local coordinators and respond to requests within the AMSA allotted time-frame (72 hours).
  - d. Submit a report as required by IFMSA to the international SCOME chair.
  - e. Attend, as able, IFMSA General Assemblies and give a presentation pertinent to Book Aid before a SCOME meeting.
  - f. Provide the AMSA webmaster with pertinent updates and announcements for the AMSA website dealing with the Book Aid Project.
  - g. Report as needed to other AMSA leaders regarding the status of the Book Aid Project.
  - h. Attend all required national AMSA leadership meetings.
  - i. Maintain up-to-date contact information for the local chapter coordinators.
  - j. Work to increase participation in the Book Aid Project to as many AMSA chapters as possible.
2. The Local Chapter Coordinators shall:
  - a. Be responsible for the local logistics of the Book Aid project at their institutions.
  - b. Assess institutional involvement in similar projects that may overlap.
  - c. Provide the Book Aid Project National Coordinator with up-to-date contact information, especially at periods of leadership transition to ensure continuity of the local program.

Book Aid Project Partnerships:

1. The official professional partner organization of the Book Aid Project shall be Better World Books ([www.betterworldbooks.com](http://www.betterworldbooks.com)).
2. The Book Aid Project National Coordinator shall be the official liaison to Better World Books in orchestrating the shipment of books donated by local chapter programs.
3. Local book donation drives shall be organized by the Book Aid Project National Coordinator in concert with local chapter coordinators to allow maximum book donation shipments via Better World Books at least twice yearly (i.e. October and in March).
4. Local chapters with already existing book donation programs (e.g. International Health Programs, whereby students could deliver books to resource-poor countries in person) shall be allowed to follow different protocol than outlined above.

The Equip Project:

Definition of Equip: Equip is an IFMSA recognized national recognized by the International Federation of Medical Students' Associations (IFMSA) effort to engage US medical students in medical supply collection and donation programs. The objectives are to raise awareness of medical surplus, establish equipment recovery programs within US hospitals, and distribute equipment to clinical facilities in resource-poor countries. Equip falls under the organization of the Standing Committee on Public Health (SCOPH) within the IFMSA standing committee framework.

Equip Project Leadership:

The Equip project leadership shall consist of:

1. One (1) Equip Project National Coordinator
2. Local Chapter Coordinator, at least one (1) for each participating chapter.

Election/appointment of Equip Project Leadership:

1. Following the transitional year, The Equip Project National Coordinator shall be filled by a process to be determined by the March 2009 national AMSA Convention.
2. Local chapter coordinators, following their designation within their local chapter by an appropriate local process, shall identify themselves to the National Equip Project Coordinator to certify their responsibilities at the local level. The responsibilities of the Equip Project Leadership:

1. The Equip Project National Coordinator shall:

- a. Promote awareness of medical surplus among US medical students, emphasizing opportunities for involvement through local hospital equipment recovery programs and transport of supplies abroad.
- b. Provide concrete information to the participating medical schools on how to start an equipment recovery program.
- c. Be available to local coordinators and respond to requests within the AMSA allotted time-frame (72 hours).
- d. Submit reports as required by IFMSA to the international SCOPH chair.
- e. Attend, as able, IFMSA General Assemblies and give a presentation pertinent to Equip before a SCOPH meeting.
- f. Provide the AMSA webmaster with pertinent updates and announcements for the AMSA website dealing with the Equip Project.
- g. Report as needed to other AMSA leaders regarding the status of the Equip Project.
- h. Attend all required national AMSA leadership meetings.
- i. Maintain up-to-date contact information for the local chapter coordinators.
- j. Work to increase participation in the Equip Project to as many AMSA chapters as possible.

2. The Local Chapter Coordinators shall:

- a. Be responsible for the local logistics of Equip at their institutions, including promoting awareness of medical surplus, developing equipment recovery programs, and training students on transporting supplies.
- b. Assess institutional involvement in similar projects that may overlap.
- c. Provide the Equip Project National Coordinator with continually up-to-date contact information, especially at periods of leadership transition to ensure continuity of the local program.

Equip Project Partnerships:

1. The official professional partner organization of the Equip Project shall be REMEDY (Recovered Medical Equipment for the Developing World) – [www.remedyvnc.org](http://www.remedyvnc.org).
2. The Equip Project National Coordinator shall be the official AMSA liaison to REMEDY in orchestrating the development of new equipment recovery programs and related initiatives by local chapters.
3. In the case where local chapters have hospitals with existing recovery programs, the Equip Project National Coordinator shall remain informed of program progress and share expertise from these local chapters with REMEDY and local chapters with newly formed Equip programs.
5. The Equip Project National Coordinator shall relay information prioritized by REMEDY that is relevant to medical students through appropriate communication channels.



#### **Section 4—AMSA-IFMSA Leadership (2008)**

**A. National Member Organization (NMO) President:**

1. The AMSA National President shall serve as the NMO president.
2. As the NMO president, the AMSA president shall fulfill the following responsibilities or delegate their completion to the AMSA-IFMSA Chair:
  - a. Attend both the IFMSA General Assemblies (GAs) each year.
  - b. Actively participate in the Presidents' Sessions and plenary sessions at GAs.
  - c. Complete the biannual NMO report and ensure NMO dues are paid.
  - d. Be an active participant on the IFMSA-NMO listserves.
  - e. Be subscribed to the individual Standing Committee listserves.

**B. AMSA-IFMSA Chair:**

1. The Global Health Action Committee (GHAC) Chair shall serve as the AMSA-IFMSA Chair.
2. As the AMSA-IFMSA Chair, the GHAC chair shall:
  - a. Fulfill any of the duties of the NMO president delegated to him/her by the AMSA National President.
  - b. Be responsible for alerting transnational projects with regards to reporting deadlines and opportunities to present their work at the IFMSA GAs.
  - c. Maintain a thorough knowledge of the workings of all the IFMSA Standing Committees within AMSA.

**C. Standing Committee Representatives:**

1. AMSA's Executive Committee of the Action Committees shall appoint representatives to each of IFMSA's six (6) Standing Committees (Standing Committees on: Professional Exchange, Research Exchange, Public Health, Medical Education, Reproductive Health including AIDS, and Human Rights and Peace) with appointment based on the AMSA leader's scope of work and ability to fulfill the below described duties:
2. Standing Committee Representatives shall:
  - a. Be active on their corresponding listserves.
  - b. Serve as the IFMSA liaison for his/her respective Standing Committee within AMSA, and be well informed about the workings of other AMSA projects within his/her respective Standing Committee.
  - c. Attend both GAs each year, or verify that a surrogate is sent on his/her behalf if he/she is unable.

**D. IFMSA Transnational Projects:**

**Definition of an IFMSA Transnational Project:**

1. The IFMSA defines transnational projects as projects that involve more than one organization out of which at least one is an NMO.

**AMSA's Current Transnational Projects:**

1. AMSA shall support the following transnational projects by providing promotion for and URL links to these projects on the AMSA Web site as well as keeping the transnational projects leaders informed about reporting deadlines and opportunities to present their work at the IFMSA GAs. In addition, AMSA shall allow transnational projects to utilize AMSA's non-profit umbrella, as needed and in a manner which corresponds to USA tax laws.
  - a. Ghana Health and Education Initiative (partner: local non-governmental organization [NGO])

- b. Kenya Village Project (partner: local NGO)
  - c. Malaika Project (partner: TAMSA-Tanzania)
  - d. Native Health Initiative (partners: IFMSA-Norway, North Carolina Commission on Indian Affairs, and Gesundheit! Institute)
  - e. Peace Test (partners: FimSIC-Finland , AMSP-Armenia, SloMSIC-Slovenia, and IFMSA-Poland)
  - f. Uganda Village Project (partner: local NGO)
  - g. Unite for Sight (partners: GHEI, UVP, and Malaika Project).
2. AMSA national leadership shall not be held responsible for maintaining these organizations, beyond the support functions outlined above.

#### AMSA's Future Transnational Projects:

AMSA shall support the proposals of potential transnational projects to the IFMSA that are consistent with AMSA's strategic priorities.

#### International Guidelines for the IFMSA Transnational Projects:

- 1. All AMSA transnational IFMSA project leaders shall submit biannual reports to the General Secretariat of the IFMSA and the IFMSA Projects Support Division Director by the following deadlines: May 1st and December 1st.
- 2. Transnational Project Reports shall include:
  - a. An activity report of the past half-year.
  - b. An evaluation (e.g. a comparison with the plan of action and/or summary of student reports).
  - c. An update on the present political and security situation in the country of the project.
  - d. An updated general plan of action.
  - e. A detailed plan of action for the coming half year.
  - f. An updated general budget.
  - g. A detailed budget for the coming half-year.
  - h. Reports from partner organizations, if any.
- 3. The IFMSA endorsement shall automatically be removed from transnational projects if the project's leaders fail to deliver the aforementioned biannual reports within one (1) month after the deadlines.

### **Section 5—International Exchange Standing Committee (2008)**

- A. The Standing Committees on Professional Exchange (SCOPE) and Research Exchange (SCORE):
  - 1. AMSA shall participate in IFMSA clinical exchanges by instituting the Standing Committee on Professional Exchange (SCOPE).
  - 2. AMSA shall participate in IFMSA research exchanges by instituting the Standing Committee on Research Exchange (SCORE)
- B. SCOPE and SCORE Leadership:

The Exchange Standing Committees shall consist of

- 1. Standing Committee National Officers:
  - a. Two (2) National Officers of Exchange (NEOs) leading SCOPE
  - b. Two (2) National Officers of Research Exchange (NOREs) leading SCORE
  - c. One (1) Development Exchange Officer (DEO) serving both SCOPE and SCORE.
- 2. Local Chapter Officers:

- a. Local Exchange Officers (LEOs), coordinating SCOPE efforts at the local chapter level
  - b. Local Officers of Research Exchange (LOREs) coordinating SCORE efforts at the local chapter level.
  - c. The number of local chapter leaders needed at each chapter may be determined locally depending on the number of exchanges and work required to maintain them.
3. An unlimited number of medical student at-large members who participate in exchanges and who work to develop and maintain exchange chapters at their local institutions.

Election/appointment of SCOPE and SCORE Leadership:

1. The five (5) National Officers shall be elected at each AMSA Annual Meeting for one (1) year terms. National Officers shall not have term limits to encourage continuity within SCOPE and SCORE at the national level.
2. Local chapter officers, following their designation within their local chapter by an appropriate local process, shall complete a registration process with the DEO to serve one (1) year terms, certifying their responsibilities at the local level. Local chapter officers shall not have term limits imposed by national AMSA leadership to encourage continuity within SCOPE and SCORE at the local level.

# **INTERNAL AFFAIRS**



# INTERNAL AFFAIRS

## OF THE

### AMERICAN MEDICAL STUDENT ASSOCIATION

#### **Section I. Action Committees and Issue Response Groups of the Association**

##### **A. Action Committees**

1. **Action Committee Formation:** Action Committees represent the long-term, broad, ongoing organizational priorities of the Association, as defined in the Constitution and Bylaws. Action Committees may be created through a constitutional amendment submitted to the House of Delegates by five (5) or more medical student members of the Association. Creation of a new Action Committee must be accompanied by a Statement of Goals, Means and Purpose, as well as a justification to the House of Delegates of the institutional need for and fiscal impact of a new Action Committee. The constitutional amendment must receive an affirmative vote of at least two-thirds (2/3) of the delegates present and voting. Membership is open to all members of the Association.
2. **Action Committee Maintenance:** It is the responsibility of the Vice President for Programming and DSP to maintain quality assurance of the Action Committees. As such, the DSP and Vice President for Programming shall review the performance of each Action Committee at each meeting, and shall make recommendations and actions needed to maintain the viability of each Action Committee. (2002)
3. **Action Committees of the Association:** The Action Committees of the Association shall be—the Committee on Community and Environmental Health; the Culture of Medicine Committee; the Committee on Gender and Sexuality; the Committee on Global Health; the Committee on Race, Ethnicity and Culture in Health; the Committee on Student Life; the Education Team; the Grassroots Leadership Team; the Humanism in Medicine Team; the Policy Team.

##### **B. Issue Response Groups**

1. **Issue Response Group Formation:** Issue Response Groups represent the short-term priorities of medical student members of the Association. Issue Response Groups are created through majority passage of a Resolution of Internal Affairs submitted to the House of Delegates accompanied by a “Statement of Purpose, Goals and Means.” Membership is open to all members of the Association. An Issue Response Group may also be created during the year with unanimous agreement of the Executive Board of the Action Committees, with such funding as is necessary coming from a discretionary pool maintained by the Board. The resolution which creates the Issue Response Group must specify the positions needed for operation of the Issue Response Group, a timeline for any activities or projects to come to completion and a detailed budget with resources thought to be necessary for the efficient operation of the Issue Response Group.
2. **Issue Response Group Maintenance:** Issue Response Groups will be authorized for a one-year period, during which time they are expected to accomplish their stated goals through those means outlined in their enabling statement of Purpose, Goals and Means. Issue Response Group maintenance is the responsibility of the Executive Board of the Action Committees, and their reports shall be processed and monitored as stated above for Action Committees. Additionally, the Director of Student Programming shall act as the Chair of all Issue Response Groups created for the current year, and shall be responsible for selecting those Issue Response Group Coordinators who shall attend meetings, as well as assisting the Executive Board of the Action Committees in the budgeting for the Issue Response Groups.

3. Issue Response Group Reauthorization: To instill within the Issue Response Groups the energy, enthusiasm, and commitment of the membership-at-large, and to avoid possible stagnation effects of institutionalization, those seeking reauthorization after one year must submit a new statement of Purpose, Goals and Means to the House of Delegates.
  - a. Legislation to reauthorize an Issue Response Group should address the manner in which the group's responsibilities have been met. It must outline what aspects of the Issue Response Group mandate another year, and are sufficiently important to require extension beyond the initial year. The resolution must also address whether the initiatives of the Issue Response Group cannot be better represented within the framework of an Action Committee. Lastly, the Executive Board of the Action Committees must concur in their report that the Issue Response Group should be reauthorized. All of these criteria must be met in order to justify to the House of Delegates an extension of one year.

C. Statement of Purpose, Goals and Means (PGM)

1. Definition of PGMs: A Statement of "Purpose, Goals and Means" will define the Issue Response Group's mission. It will include at a minimum, but is not limited to:
  - a. A clearly stated "Purpose," using newly legislated or currently existing Principles to define specific health-related, medical, social, educational, etc. issue(s) that the Issue Response Group plans to address. In essence, the Purpose will define the Issue Response Group's mandate.
  - b. A "Goal" stating anticipated objectives. Goal, as used here, refers to projected accomplishments.
  - c. An explanation of the "Means" and methods by which the above-mentioned goal is expected to be realized.
  - d. Documentation demonstrating that issues which the Issue Response Group addresses are met best under the aegis of an Issue Response Group, and showing that other means, including existing Issue Response Groups, Action Committees, AMSA Foundation projects and other structures have been reasonably examined and determined to be unsuitable.
  - e. A schedule of deliverables, listing timelines and activities to be completed by such time, to measure the progress of the Issue Response Group.
2. Uses of PGMs: A statement of "Purpose, Goals and Means" shall be required for:
  - a. Creation of new Issue Response Groups.
  - b. Reauthorization of Interest Response Groups.

D. Functions of Action Committees

1. Required Functions: Action Committees shall function to provide opportunities for becoming involved in the Association in areas of general concern to AMSA. They shall be obligated to fulfill the minimal responsibilities listed below:
  - a. promotion of the projects and activities of the Action Committee through maintenance and update of the Action Committee's website, and articles for AMSA Focus; (2004)
  - b. provision of educational programming at the Annual Meeting;
  - c. promotion and review of AMSA's Policies as specified in the PPP, specifically as they relate to the Action Committee's area(s) of interest;
  - d. promotion of AMSA Foundation projects relating to the Action Committee's area(s) of interest through newsletters, programming and/or *The New Physician*;

- e. submission of year-end reports by Action Committee Chairs for inclusion in the Delegates' Handbook;
  - f. attendance of the Chairs at two (2) general meetings of the Action Committees, in conjunction with meetings of the Board of Trustees, as well as two (2) meetings of the Executive Board of the Action Committees and the Chapter Officers Conference; (2004)
  - g. attendance of Project Coordinators at two (2) general meetings of the Action Committees and Issue Response Groups, in conjunction with meetings of the Board of Trustees and National Convention; (2004)
  - h. provision of a forum for networking at organizational meetings at Annual Meetings and regional conferences;
  - i. development of and funding for projects that reflect the mandate of the Action Committee.
2. Optional Functions: In addition, Action Committees may have other functions. In evaluating them, optional consideration may be given, but is not limited to:
- a. provision of a forum for open discussion of AMSA's Principles related to the Action Committee's interest, with a focus on revising obsolete ones and contributing to the development of new ones for consideration in the House of Delegates;
  - b. provision of a vehicle for social support and opportunities to identify other medical students having common interests;
  - c. provision of opportunities to edit or contribute written articles to the newsletter of *The New Physician*;
  - d. familiarizing members with other organizations related to the Action Committee's interest;
3. Advocacy Board: A special function of the Action Committees shall be to coordinate an Advocacy Board. This Board, made up of one Action Committee Chair, an Action Committee Coordinator relevant to the subject matter, the Director of Student Programming, the National President and one representative from the Board of Trustees, shall function in the evaluation of and extension of resources available for student advocacy within the Association. They shall also investigate legitimate complaints by students to the Association, and provide whatever means possible for redress.
4. Newsletters and Publications: Each Action Committee shall have the opportunity to publish newsletters as they see fit throughout the year. The number and timing of such newsletters shall be determined by the budgetary resources available. In addition, space will be set aside in *The New Physician* for articles of interest to the general membership. Where applicable, confidentiality shall be maintained for the mailing lists of Committee newsletters.

E. Functions of Issue Response Groups

1. Required Functions: The functions of each Issue Response Group shall be specifically stated in their statement of Purposes, Goals and Means. Certain basic functions shall be required of each Issue Response Group:
- a. supervision by the Director of Student Programming, who shall serve as the Chair of all Issue Response Groups;
  - b. submission of a year-end report to the House of Delegates detailing the progress made in fulfilling the PGM statement;
  - c. submission of resolutions appropriate to the work completed by the Issue Response Group during the year;
  - d. attendance at those meetings the Director of Student Programming deems necessary for the completion of the goals of the Issue Response Group.



2. Optional Functions: These functions shall be designated by the resolution creating the Issue Response Group, in conjunction with the support of the Director of Student Programming.

F. Action Committee/Issue Response Group Liaison Position

1. Description of Action Committee/Issue Response Group Liaison Position
  - a. The Action Committee/Issue Response Group Liaison must be a current member of AMSA and, preferably, an active member of a Action Committee/Issue Response Group of AMSA.
  - b. The Action Committee/Issue Response Group Liaisons will be appointed by each local medical and premedical chapter. The Vice President for Programming and the Director of Student Programming will be responsible for recruiting these individuals from chapters, which do not appoint liaisons.
  - c. The Director of Student Programming will coordinate the Action Committee/Issue Response Group Liaison mailings, including collating the information, soliciting reports, and making mailings as necessary from the National office.
  - d. A meeting of all Action Committee/Issue Response Group Liaisons will be held at the Annual Meeting of the Association and will be attended by the Executive Board of the Action Committees. The Vice President for Programming and the Director of Student Programming will direct this meeting and facilitate interaction between the Issue Response Group and Action Committee leaders and the chapter Action Committee/Issue Response Group Liaisons.
2. Action Committee/Issue Response Group Liaison Timeline

The Director of Student Programming shall construct a timeline for communication with and selection of Action Committee/Issue Response Group Liaisons, and shall submit this timeline to the Steering Committee at their initial meeting for approval.

**Section II. Action Committee Chairs**

- A. Selection of Chairs. One (1) Chair for each Action Committee shall be selected at the Annual Meeting as specified in the Constitution and Bylaws, Article VIII, Section 10.
- B. Responsibilities of the Chair. The Chair of each Action Committee shall function as an administrator and information source for each Action Committee. Their responsibilities include, but are not limited to the following:
  1. Representing the interests of their individual Action Committees to the Board of Trustees; (2003)
  2. Attendance at the meetings of the Board of Trustees when the budget and strategic priorities are discussed and otherwise as deemed necessary by the President and Vice President for Programming; (2003)
  3. Attendance at two (2) general meetings of the Action Committees, in conjunction with meetings of the Board of Trustees, as well as two (2) meetings of the Executive Board of the Action Committees;
  4. Developing a budget and resource allocation scheme for the committee prior to the first meeting of the Executive Board of the Action Committees, and assuring that these guidelines are adhered to; (2004)
  5. Solicitation and editing of materials for newsletters and *The New Physician*;
  6. Reporting to the Board of Trustees both orally and in writing at each general meeting the status of all Action Committee Projects;
  7. Submission of a final report to the House of Delegates, detailing the accomplishments of the Action Committee throughout the year;
  8. Communication with Action Committee Coordinators in a timely fashion;
  9. Coordinating all activities of the Action Committee for the Annual Meeting, including speakers and programming time;
  10. Bringing forward all views of members to the Board of Trustees

11. Attendance at Strategic Planning meetings of the Board of Trustees. (1998)
12. Sitting on committees of the Board of Trustees, as deemed appropriate by the Board of Trustees. (1998)
13. Attendance at the Chapter Officers Conference and coordination of all activities and programs related to their Action Committee at the Chapter Officers Conference. (2004)
14. Disseminating relevant and timely information regarding upcoming projects to the Regional Programming Coordinator for publicity to local AMSA chapters. (2005)

### **Section III. Administration, Projects and Interest Groups of the Action Committees**

- A. Action Committee Administration. Each Action Committee shall be administered by a board consisting of the Action Committee Chair and up to five Committee Coordinators. This board will oversee projects and activities pertaining to the Action Committee, as mandated by a consensus of the board. (2007)
- B. Selection of Committee Coordinators and Projects.
  1. Applications for the Action Committee Coordinator positions will be solicited as part of the Official Call, with the selection process occurring at the Annual Meeting during each Action Committee's organizational time, facilitated by the Action Committee Chair; (2004)
  2. The coordinator selection process will be consistent with the process outlined in Article VIII of the Constitution & Bylaws. (2004)
  3. The focus area and responsibilities of each coordinator position will be determined by the board of each committee, will be reviewed and approved by the Action Committee Chair and Coordinators, and will be delineated and advertised prior to the Annual Meeting; (2004)
  4. In the event that a coordinator cannot be found for a particular focus group, the chair will be responsible for appointing a coordinator and, until then, continuing any projects that the focus coordinator oversees. (2004)
- C. Responsibilities of Action Committee Coordinators.
  1. Communicate with the members active in the Action Committee; (2004)
  2. Communicate with the Director of Student Programming, other Coordinators, Action Committee Chairs and National Officers in a timely fashion regarding AMSA projects, policy and related matters; (2004)
  3. Promote Action Committee policies, themes, programs and projects to the AMSA membership; (2004)
  4. Attend two (2) general meetings of the Action Committee leadership in conjunction with the meetings of the Board of Trustees and National Convention; (2004)
  5. Coordinate Action Committee activities at the Regional Conferences and the Annual Meeting; (2004)
  6. Publish Action Committee resources and information via the Internet and in AMSA newsletters/publications. (2004)
  7. In conjunction with the Action Committee Chair, submit a section of an annual report to the House of Delegates for consideration on a "For Information Only" basis. (2004)
  8. Develop a plan and budget for their project within thirty (30) days of the Annual Meeting that will be approved and modified by the Action Committee Chair as deemed appropriate. (2004)
- D. Action Committee Coordinator Replacement (2006)
  1. In the event of a resignation by an Action Committee Coordinator, the Chair shall notify the members of the AC Executive Board of the vacancy in a timely manner. (2006)
  2. With input from the Vice President for Programming and the remaining members of the Action Committee, the Chair shall determine, depending on the time at which the resignation occurred in the year, whether the Committee should replace the vacancy or leave it unfilled. (2006)

3. If replacing the coordinator, the Chair shall publicize the vacancy on the appropriate listserves and additionally have the option of personally contacting one or more possible candidates: (2006)
  - a. The candidate's interest and experience in the coordinator topic as well as the overall committee topic. (2006)
  - b. The candidate's experience in AMSA and commitment to AMSA's values. (2006)
  - c. The candidate's leadership skills. (2006)
4. The Action Committee in question shall review the Chair's nominations and, using Instant Run-off Voting (IRV), elect a replacement. (2006)
5. The Chair, along with the Vice President for Programming, shall assist in orienting the new AC Coordinator with the duties and responsibilities of the position. (2006)

E. Interest Groups. Since there are many situations in AMSA where a small group of students requiring limited resources come to the Association, asking for help, the House of Delegates may create at its discretion Interest Groups through resolutions.

1. Each Interest Group shall be authorized by the House for a period of no more than two years. During the interim period between meetings of the House of Delegates, Interest Groups may be formed by a 2/3 vote of the Executive Board of the Action Committees. Any Interest Group formed in this manner must submit a resolution for authorization to the House of Delegates at the next Annual Meeting. Approval of this resolution is necessary to continue as an Interest Group. (1998)
2. Interest Groups shall be provided these resources:
  - a. Access to AMSA Web resources (Web pages, list serves) as necessary for communication;
  - b. Dissemination of information through AMSA publications
  - c. One hour of organizational time at the Annual Meeting and may apply to fund otherwise unfunded programming. (2008)
3. The Specialty Forum serves as the home for all relevant Specialty Interest Groups, which shall be subgroups of this Forum. Specialty Interest Groups shall have the same access to Web space and a listserve as other interest groups and may apply to fund otherwise unfunded programming. (2008) The Director of Student Programming oversees the Specialty Forum, and each of the Specialty Interest Groups that make up the Forum shall have one coordinator. The Executive Board of the Action Committees shall be charged with the responsibility of determining whether an interest groups falls into the category of a Specialty Interest Group. Each Specialty Interest Groups must be reauthorized every two years in the same manner as other interest groups. (2002)
4. Lists of interest groups shall be advertised through AMSA publications to the membership. (2002)
5. All Interest Groups must have a designated coordinator. Specifically:
  - a. Interest Group Coordinators will be elected by a majority during organizational time at the Annual Meeting. Each active or affiliate member of AMSA present at the meeting shall have one vote. If an Interest Group does not select a coordinator in this manner, the Director of Student Programming (DSP) will appoint one. If the DSP cannot find a member willing to serve as the Interest Group Coordinator, the Interest Group will be considered defunct. (2003)
  - b. The duties of the Interest Group Coordinator include, but are not limited to, periodically updating the AMSA Web page, organizing group elections at the Annual Meeting, making any necessary announcements within the AMSA listserves and publications, and reporting to the DSP. (2008)
  - c. Interest Group Coordinators shall report directly to the DSP through email monthly reports and written year-end summary. (2002)

6. The Executive Board of the Action Committees will evaluate the activity of each Interest Group quarterly. Upon submission of reauthorization of a particular Interest Group, this Board will issue recommendation to the House of Delegates based on their evaluation. (2002)
7. Interest Groups of the Association: the Interest Groups of the Association shall be Death & Dying, Direct Action, Child & Adolescent Health, Geriatrics, Neurology, Osteopathy, Primary Care, Surgery, Military Medicine, Naturopathic Medicine, Preventive Medicine, Mental Health and Business in Medicine. Interest groups are reauthorized every two years, with Child & Adolescent Health, Direct Action, Osteopathic Medicine, Military Medicine, Naturopathic Medicine and Preventive Medicine up for reauthorization on odd years and Death & Dying, Geriatrics, Neurology, Primary Care, Surgery, Mental Health and Business in Medicine on even years. (2005) (2007) (2008)
8. Naturopathic students from CNME accredited schools, along with full AMSA members, be allowed to participate in organizing and coordinating a Naturopathic Medicine Interest Group. (2007)

**F. Funding to Attend Leadership Meetings**

1. The action committees reserve the right to invite non-elected or unfunded elected leaders to participate in AC leadership meetings. Non-invited individuals may not participate in such meetings. However no invitees should utilize personal funds to attend such a meeting. Instead AC funds or grants must be guaranteed in order to provide equitable access to opportunities. Creative funding options may be explored as well. Potential invitees will also be encouraged to participate in scheduled conference calls as deemed appropriate to AC chairs. (2008)
2. Meeting attendance cannot be required unless supported by appropriate budget allocations. (2008)

**Section IV. Executive Board of the Action Committees**

- A. Purpose: The Action Committee Chairs, Vice President for Programming and Director of Student Programming shall form an Executive Board for the purpose of administration of Action Committees and Issue Response Groups. This Executive Board shall function in the budgeting of funds for the coming year, as well as strategic planning for future issues. The Executive Board shall also be responsible for oversight of the budgeting and resource allocation for the Action Committees and Issue Response Groups. Lastly, the Executive Board shall function in the planning and facilitation of general meetings of the Action Committees and Issue Response Groups.

**B. Structure, Meetings and Responsibilities**

1. The Executive Board of the Action Committees shall be composed of the Action Committee Chairs, the Vice President for Programming, and the Director of Student Programming. The President of the Association shall be an *ex officio* member of the Executive Board, empowered to break ties when necessary in voting.
2. The Executive Board shall meet in conjunction with all general meetings of the Action Committees and Issue Response Groups in order to monitor the function and effectiveness of the Action Committees and Issue Response Groups. (2008)
3. The Executive Board shall be responsible for these areas:
  - a. Projects
    1. Allocation of funding and other resources to projects within each Action Committee.
    2. Monitoring of function of Action Committee projects.
    3. Coordination of a report of all project status for the Action Committees and Issue Response Groups and the Board of Trustees at every meeting.
    4. Assistance with the development of inter-Action Committee projects.
    5. Evaluation and selection of applicants to the Local Project Grant Program. The Executive Board will also be responsible for sending response letters to each applicant and communicating this information with the appropriate Regional and Premedical Trustees within two weeks of local project grant selection. (2004)

6. Appoint adjunct leaders as needed to oversee smaller, short term, and/or urgent projects, especially those that do not require funding for such leaders to attend leadership meetings. These Affiliate Leaders have all the rights and privileges of other Action Committee leaders as required to carry out their respective projects, and are also subject to the same codes of conduct and professionalism expected of any leader representing AMSA. These leaders could apply for funding from their committee or the Action Committee Grant Pool. (2008)

b. Programming

1. Coordinate overall Action Committee programming for the Annual Meeting.
2. Contact and coordinate programming by the Action Committees and Issue Response Groups at Regional Conferences.
3. Allocate funds for programming and activities at the Annual Meeting.
4. Advertise and oversee elections of new Action Committee Chairs and Coordinators at the Annual Meeting. (2004)

c. Communications

1. Establish and maintain an Action Committee/Issue Response Group network for use in quick dissemination of information.
2. Contact with each Action Committee Coordinator before meetings to identify urgent needs or complaints. (2004)
3. Overall coordination of submissions to *The New Physician*.
4. Oversight of the publication of individual Action Committee newsletters.
5. Facilitating creation of new Interest Groups and Issue Response Groups when necessary.

The Executive Board of the Action Committees shall bear the responsibility of assuring the Membership-at-Large that it is functioning responsibly, and shall strive to increase the benefits to the Membership-at-large from Action Committee programs and to increase the information available to the Membership-at-large as to the functioning of the Action Committees. This function will be accomplished by the preparation of a report by the Vice President for Programming, with assistance from the Director of Student Programming, within two weeks following each meeting or substantive action of the Executive Board of the Action Committees outlining the Action Committees' plans, actions, and deliberations. This report shall be disseminated to the Membership-at-large through electronic mail, on the AMSA web site, and/or through an official Association publication. (2003)

## **Section V. Liaisons of the Association**

The Association maintains formal liaisons with several organizations to promote effective cooperation and to provide them with the medical student perspective.

A. Purposes of the Relationship

1. to promote broad consideration of issues in medical education, health care and health-care delivery;
2. to promote the consideration of policy of the Association as set forth in the Preamble, Purposes and Principles of the American Medical Student Association;
3. to gather information concerning the purposes and activities of these organizations; and
4. to facilitate the development of inter-organization programs and activities of mutual benefit.

B. Administration of Liaisons

1. The panel of Liaisons shall be divided into two (2) groups by the BOT, which is responsible for overseeing those liaisons to organizations designated as “Professional Relationships.” The Public Relations Director shall be responsible for overseeing those liaisons to organizations designated as “Issue Based Collaborations/Specialty Organizations.” Specific responsibilities of the overseers shall include: (2006)
  - a. The joint coordination of a liaison training session, at the end of national convention, the Spring meeting of the BOT, or at another time deemed appropriate by the Public Relations Director and the BOT. This training should include introduction to the structure of the liaison program, roles of the liaison position, and instruction on distribution of the annual liaison packets to partner organizations, content of reports and methods of reporting, and any additional training by the Public Relations Director and the BOT. (2007)
  - b. Maintaining the list and contact information of all partner organizations and assigned AMSA liaisons.
  - c. Receiving and organizing reports submitted by liaisons, and facilitating the publication of reports, when appropriate, to the AMSA website.
  - d. Assigning certain liaison positions to the BOT and Staff members; and managing the solicitation of applications and selection of liaisons for positions potentially left unfilled by the mechanisms described in section D (below).
  - e. Distribute funds to liaisons, for the purposes described in section F (below).
2. Liaison reports shall be submitted to the Public Relations Director or the BOT via mail, e-mail, or the AMSA Web site; thus, a form on the Web site shall be made available to liaisons for the submission of these reports. (2007)
3. Termination of liaison positions will be at the request of either organization with which the liaison is involved (1998). Liaisons who fail to fulfill their responsibilities may be removed at the discretion of the BOT. If a liaison to an organization with which communication is deemed vital to the Association is removed, a replacement liaison shall be assigned from among the BOT and Staff members, at the discretion of the DSP and National President. (2007)
4. The BOT shall annually review the liaison program—including the list of partner organizations, the methods of reporting and information distribution, and the funding of liaison activities—and make recommendations to the BOT regarding the continued development and success of the program.

C. Liaison Organizations

1. The Association recognizes the importance of maintaining a working relationship with the following organizations and resolves to maintain a current liaison position with each of these organizations:

Professional Relationships

AAMC—Association of American Medical Colleges  
ACGME—Accreditation Council of Graduate Medical Education  
AMA—American Medical Association  
AOA—American Osteopathic Association  
CFMS—Canadian Federation of Medical Students  
ECFMG—Education Commission for Foreign Medical Graduates  
IFMSA—International Federation of Medical Students’ Association  
LCME—Liaison Committee on Medical Education  
NBME—National Board of Medical Examiners  
NMA—National Medical Association  
NRMP—National Residency Matching Program  
NMSA—Naturopathic Medical Student Association (2008)  
PCOC—Primary Care Organizations Consortium (2006)  
SHA—Student Health Alliance

SNMA—Student National Medical Association  
SOMA—Student Osteopathic Medical Association

#### Issue-Based Collaborations/Specialty Organizations

AAFP—American Academy of Family Physicians  
AAP—American Academy of Pediatrics  
AANM—American Association of Naturopathic Medicine (2008)  
ACAM—American College for Advancement in Medicine (2006)  
ACOG—American College of Obstetricians and Gynecologists  
ACP—American College of Physicians  
ACPM—American College of Preventive Medicine  
ACS—American College of Surgeons  
AHMA—American Holistic Medical Association (2006)  
AMWA—American Medical Women’s Association  
APMSA—American Podiatric Medical Students’ Association (2008)  
APA—American Psychiatric Association  
APGO—Association of Professors of Gynecology & Obstetrics  
APHA—American Public Health Association  
ATPM—Association of Teachers of Preventive Medicine  
GLMA—Gay and Lesbian Medical Association  
NANA—National Alliance for Nutrition and Activity (2008)  
PHR—Physician for Human Rights  
PNHP—Physicians for a National Health Program  
PSR—Physicians for Social Responsibility

2. As the effectiveness of these relationships may change, and as new liaison relationships may be created, this list of organizations and liaison positions shall be reviewed annually by the BOT and amended through resolutions to the House of Delegates. New liaison relationships may be proposed in the form of a resolution to the House of Delegates. The proposal must include a description of the organization’s operating purposes and a statement of the reasons for and goals of an AMSA liaison position, in addition to a synopsis of past or current collaboration with the organization. (2006)
3. Any outside organization may solicit AMSA for possible establishment of a liaison relationship with their organization. Such proposal will be reviewed by the BOT and a resolution as described above will be drafted for submission to the House of Delegates. (2006) Until such time as the liaison position is approved and filled, communication with the organization will be maintained through the office of the DSP and the National President. (1998)

#### D. Assignment of Liaisons

1. Applicants for liaison positions shall be solicited at the National Convention with the cooperation of Regional and Action Committee leaders. Appointments to the various liaison positions will be made as soon as possible thereafter but no later than the June meeting of the Board of Trustees (BOT). (2006)
2. Regarding the AAFP, AAMC, ACGME, ACOG/APGO, ACP, AMA, IFMSA, LCME, NBME, NRMP, and SHA: An Executive Committee or staff member of the Association (President, Vice President for Membership, Vice President for Internal Affairs, ACT, Vice President for Finance, DSP, LAD, GAF and JRF) (2007) shall serve as liaison to these organizations. The National President, taking into account the interests and availabilities of these colleagues, shall formalize liaison appointments to each of these organizations by the end of the June BOT meeting. The NANA liaison is to be assigned by the Director of Student Programming to an Action Committee Chair or committee member. (2008) In the event that a liaison position to any of these organizations is not assumed by one of these national leaders, the BOT (2006) shall solicit applications and select a qualified member to fill the position, at the discretion of the Board of Trustees. (2005) (2007)
3. Regarding the AANP, AAP, ACAM, ACPM, ACS, AHMA, AMWA, AOA, APA, APHA, ATPM, ECFMG, GLMA, NMA, NMSA, PCOC, PHR, PNHP, PSR, SNMA and SOMA: Liaison roles shall be

formalized as responsibilities of existing AMSA leadership positions, and made known as such in the election process for each of the corresponding positions, as follows:

AANP— IG Coordinator for Naturopathic Medicine  
AAP— IG Coordinator for Child and Adolescent Health  
ACAM—AC Coordinator for Integrative, Complementary and Alternative Medicine (HuMed AC) (2006)  
ACPM—AC Chair for Community and Public Health  
ACS—IG Coordinator for Surgery  
AHMA—AC Coordinator for Humanistic Medicine (2006)  
AMWA—AC Coordinator(s) for WIM  
AOA— IG Coordinator for Osteopathy  
APA—IG Coordinator for Psychiatry  
APHA—AC Chair for Community and Public Health  
ATPM—AC Chair for Community and Public Health  
ECFMG— International Trustee  
GLMA—AC Coordinator(s) for LGBTPM  
NMA—AC Coordinator(s) for MAC  
NMSA—IG Coordinator for Naturopathic Medicine  
PCOC—National President (2006)  
PHR—AC Coordinator for Health and Human Rights  
PNHP—AC Coordinator Health Policy, Universal Healthcare Coordinator  
PSR—AC Coordinator for Global Health  
SNMA—AC Coordinator(s) for MAC, as above  
SOMA— IG Coordinator for Osteopathy

In the event that the AC or IG, or coordinator position, listed above does not exist, or the position holder is not available to serve as liaison, the BOT shall solicit applications and select a qualified member to fill the position, appointed by the Board of Trustees by the end of the June BOT meeting. (2007)

4. Regarding the CFMS: the President is encouraged to strongly consider the Region I Trustee for this position, as this trustee's jurisdiction includes all chartered Canadian medical school chapters of AMSA. (2004)
5. The term of each liaison position shall thus be one (1) year; from the time of election or assignment following the national convention until the election or assignment of his or her successor the following year.

#### E. Roles and Responsibilities of Liaisons

An AMSA liaison, upon assignment as described in section D (above), shall have the following qualifications, roles and responsibilities:

1. Be a current or former elected or hired national AMSA leader;
2. Be familiar with the history, mission, organization, and strategic priorities of AMSA, and be able to engage others in a discussion on any of these topics;
3. Attend a liaison training session, as described in section B, (above);
4. Make immediate contact with the assigned organization, consisting of at least the following:
  - a. identify primary contact(s) in the partner organization;
  - b. notify the organization of his or her position and role as AMSA liaison, including shipment of the introductory liaison packet;
  - c. discuss and set mutual expectations and goals of the liaison relationship; and,
  - d. if the organization has a liaison to AMSA, make contact with that person.
5. Provide the Public Relations Director or BOT with the contact information of key contact persons in assigned partner organization(s); (2007)
6. Become familiar with the history, mission, organization, and current goals of the partner organization(s);
7. Attend and participate in conferences, meetings, or other events of the organization, whenever possible; and



8. Submit written reports to the Public Relations Director or the BOT; as outlined in liaison training and consisting of at least: (2007)
  - a. name(s) and contact information for primary contact(s) in the organization;
  - b. general purposes and current activities of the organization, for the purpose of informing the AMSA general membership; and
  - c. decided mutual goals of the liaison relationship, and status of efforts to meet those goals.
  - d. The specific format of and exact information contained in these reports will vary by organization. Such details will be mutually agreed upon by the incoming liaison, outgoing liaison and either the DSP or the BOT as appropriate at the liaison training at the Spring BOT meeting. (2006)

Given the intent to inform the AMSA general membership, and in order to be sufficiently reviewed by the Public Relations Director and the BOT, these reports shall include at least: (2007)

- a. one mid-year report submitted before the Chapter Officers Conference in July (2006); and
- b. one year-end summary submitted by the deadline for HOD resolutions of that year.

These and any other reports may be published on the AMSA website, at the discretion of the BOT, for the purpose of accessibility by the general membership. (2007)

#### F. Funding of Liaisons

1. Liaisons shall receive funding for travel, attendance and participation in professional meetings and functions of their assigned organization. These funds shall be distributed at the discretion of the Public Relations Director with approval from the BOT, based on the following criteria: (2007)
  - a. attendance of a liaison training session and submission of required liaison reports to the Public Relations Director, as outlined in Section E, Roles and Responsibilities of Liaisons; (2007)
  - b. timely submission of a request by the liaison, including the amount required for travel to and participation in the event, details of the event, and perceived benefits to the liaison and the Association;
  - c. role of the liaison in the functioning of the partner organization and/or specific event.
2. As incentive, liaisons who have fulfilled their responsibilities, as described in Section E (above), shall be granted a waiver of their AMSA national convention registration fee. These waivers shall be granted by the BOT, with approval from the Vice President for Finance, and at the discretion of the BOT. (2007)
3. Liaisons of the organizations listed in Section C to AMSA may be granted waivers of the AMSA national convention registration fee, if they wish to attend, at the discretion of the BOT. AMSA shall continue to seek from these organizations reciprocal waiving of fees for liaisons to attend each other's national meetings. (2007)

### **Section VI. Structure of the Regions**

The geographic breakdown of the regions is determined by the House of Delegates. The region serves as the focal point for articulating the concerns of medical students from a given geographic area of the country. The ten (10) regions of the Association are geographically distributed as follows:

|          |                                              |
|----------|----------------------------------------------|
| Region I | Boston University                            |
|          | Brown University                             |
|          | University of Connecticut                    |
|          | Dartmouth University                         |
|          | Harvard University                           |
|          | University of Massachusetts                  |
|          | McGill University - Montreal, Quebec, Canada |
|          | New England COM*                             |
|          | Tufts University                             |
|          | University of Vermont                        |

|            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|            | Yale University<br>Memorial University of Newfoundland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Region II  | Albany Medical College<br>Albert Einstein College of Medicine<br>Columbia University<br>Weill Medical College of Cornell University<br>Mount Sinai SOM of SUNY<br>UMDNJ New Jersey Medical School—Newark<br>New York Medical School<br>New York University<br>University of Puerto Rico SOM<br>University of Rochester SOM and Dentistry<br>UMDNJ RWJ Medical School—Piscataway<br>UMDNJ Robert Wood Johnson—Camden<br>State University of New York—Buffalo<br>SUNY Downstate Medical Center COM—Brooklyn<br>SUNY Health Science Center—Stony Brook<br>SUNY Upstate Medical University—Syracuse<br>CUNY City College/Sophie Davis<br>Ponce SOM<br>Universidad Central Del Caribe SOM<br>New York COM of New York Institute of Tech*<br>UMDNJ SOM*<br>Touro University College of Osteopathic Medicine/New York* |
| Region III | George Washington University SOM & Health Center<br>Georgetown University SOM<br>Howard University COM<br>Jefferson Medical College of Thomas Jefferson University<br>Johns Hopkins University SOM<br>University of Maryland SOM<br>University of Pennsylvania SOM<br>Drexel University COM (MCP Hahnemann SOM)<br>University of Pittsburgh SOM<br>Pennsylvania State University COM<br>Temple University SOM<br>Uniformed Services University of the Health Sciences<br>Philadelphia COM*<br>Eastern Virginia Medical School<br>University of Virginia SOM<br>Virginia Commonwealth University SOM<br>Joan C. Edwards SOM at Marshall University<br>West Virginia University<br>West Virginia SOM*                                                                                                             |
| Region IV  | Case Western Reserve University SOM<br>University of Cincinnati COM<br>Northeastern Ohio Universities COM<br>Medical College of Ohio—Toledo<br>Ohio State University COM<br>Wright State University SOM<br>Ohio University COM*<br>University of Michigan Medical School<br>Michigan State University College of Human Medicine<br>Wayne State University SOM<br>Michigan State COM*                                                                                                                                                                                                                                                                                                                                                                                                                            |

|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Region V    | <p>Wake Forest University School of Medicine (Bowman Gray SOM)</p> <p>Duke University SOM</p> <p>Brody SOM at East Carolina University SOM</p> <p>Emory University SOM</p> <p>University of Florida COM</p> <p>Medical College of Georgia SOM</p> <p>Mercer University SOM</p> <p>University of Miami SOM</p> <p>Morehouse School of Medicine</p> <p>University of North Carolina—Chapel Hill SOM</p> <p>Medical University of South Carolina—Charleston</p> <p>University of South Carolina—Columbia</p> <p>University of South Florida—Tampa</p> <p>NOVA Southeastern University SOM*</p> <p>Florida State University COM (2004)</p> |
| Region VI   | <p>Rosalind Franklin University of Medicine &amp; Science</p> <p>University of Chicago, Pritzker SOM</p> <p>University of Illinois—Urbana/Champaign</p> <p>University of Illinois—Chicago</p> <p>University of Illinois—Peoria</p> <p>University of Illinois—Rockford</p> <p>Indiana University SOM</p> <p>Loyola University Chicago Stritch SOM</p> <p>Northwestern University Medical School</p> <p>Rush Medical College of Rush University</p> <p>Southern Illinois University SOM</p> <p>University of Wisconsin Medical School</p> <p>Medical College of Wisconsin</p> <p>Chicago COM* (Midwestern University)</p>                |
| Region VII  | <p>University of Alabama SOM</p> <p>University of Arkansas SOM</p> <p>Louisiana State University SOM—New Orleans</p> <p>Louisiana State University SOM—Shreveport</p> <p>Meharry Medical College SOM</p> <p>University of Mississippi SOM</p> <p>University of South Alabama COM</p> <p>University of Tennessee—Memphis COM</p> <p>Tulane University SOM</p> <p>Vanderbilt University SOM</p> <p>East Tennessee State University James H. Quillen COM</p> <p>University of Kentucky SOM</p> <p>University of Louisville SOM</p> <p>Pikeville College—SOM*</p>                                                                          |
| Region VIII | <p>Creighton University SOM</p> <p>University of Iowa COM</p> <p>University of Kansas—Kansas City</p> <p>University of Kansas—Wichita</p> <p>Mayo Medical School</p> <p>University of Minnesota—Duluth</p> <p>University of Minnesota—Minneapolis</p> <p>University of Missouri—Columbia</p> <p>University of Missouri—Kansas City</p> <p>University of Nebraska COM</p> <p>University of North Dakota SOM</p>                                                                                                                                                                                                                         |

University of South Dakota SOM  
 Saint Louis University SOM  
 Washington University SOM—St. Louis  
 Des Moines University Osteopathic Medical Center\*  
 Kirksville COM\*  
 Kansas City University of Medicine and Biosciences COM\*

Region IX

Baylor College of Medicine  
 University of Oklahoma COM—OKC  
 University of Oklahoma COM—Tulsa  
 University of Texas Medical Branch—Galveston  
 University of Texas Medical School—Houston  
 University of Texas Medical School—San Antonio  
 University of Texas—Southwestern Medical School  
 Texas A&M University Health Science Center  
 Texas Tech University Health Sciences Center SOM  
 Oklahoma State University COM\*  
 University of North Texas Health Science Center\* (Texas COM)

Region X

University of Arizona COM  
 University of California SOM—Davis  
 University of California COM—Irvine  
 David Geffen SOM—UCLA  
 University of California SOM—San Diego  
 University of California SOM—San Francisco  
 University of Colorado SOM  
 University of Hawaii John A. Burns SOM  
 Loma Linda University SOM  
 University of Nevada SOM  
 University of New Mexico SOM  
 Oregon Health Sciences University SOM  
 Keck SOM The University of Southern California  
 Stanford University SOM  
 University of Washington SOM  
 University of Utah SOM  
 Western University of Health Sciences COM\*  
 Touro University College of Osteopathic Medicine/California\*  
 Arizona College of Osteopathic Medicine\* (2004)  
 Touro University College of Osteopathic Medicine/Nevada\*

\*denotes Osteopathic School

Premedical Chapters

Region I

Harvard University (1996)  
 Radcliffe College (1996)  
 Boston University (1998)  
 Massachusetts Institute of Technology (2000)  
 University of New Hampshire (2001)  
 Trinity College—Connecticut (2001)  
 Tufts University (2001)  
 Northeastern University (2001)  
 Brown University (2004)  
 College of The Holy Cross (2005)  
 Simmons College (2007)

Region II

Princeton University  
 State University of New York—Binghamton

Brooklyn College (1993)  
 Columbia University (New York, NY) (1994)  
 Rutgers University—New Brunswick (1995)  
 University of Puerto Rico—Rio Piedras (1996)  
 Hunter College—CUNY (1996)  
 New York University (1997)  
 Rider University (1999)  
 University of Puerto Rico—Bayamon University College (2000)  
 Cornell University (2001)  
 State University of New York—Stony Brook (2001)  
 Rutgers—Newark (2001)  
 Rutgers—Camden (2002)  
 Ithaca College (2002)  
 Polytechnic University (2002)  
 College of New Jersey (2003)  
 New York Institute of Technology @ Manhattan (2005)  
 Universidad Del Sagrado Corazon (2005)  
 University of Puerto Rico @ Mayaguez (2005)  
 Wagner College (2005)  
 University of Delaware (2008)  
 San Juan Bautista School of Medicine—Puerto Rico (2008)

### Region III

University of Pittsburgh  
 George Washington University (1994)  
 University of Pennsylvania (1994)  
 Haverford College (1995)  
 Johns Hopkins University (1999)  
 University of Virginia (2000)  
 Eastern College (2000)  
 Indiana University of Pennsylvania (2001)  
 Temple University (2001)  
 American University (2002)  
 Bucknell University (2002)  
 Morgan State University (2004)  
 Virginia Polytechnic Institute and State University (2004)  
 Georgetown University (2005)  
 Marshall University (2005)  
 University of Richmond (2006)  
 Howard University (2006)  
 Montgomery College (2006)  
 West Virginia University (2007)  
 University of Maryland—College Park (2008)  
 University of the Sciences in Philadelphia (2008)  
 Drexel University (2008)  
 Jefferson College of Health Science (2008)

### Region IV

University of Michigan  
 Case Western Reserve University (1993)  
 Miami University (Ohio) (1993)  
 Michigan State University (1995)  
 Ohio State University (1995)  
 Ohio University, College of Osteopathic Medicine (1996)  
 Cleveland State University (1997)  
 Western Michigan University (2000)  
 Wilmington College (2001)  
 Wayne State University (2001)  
 Albion College (2004)  
 University of Michigan @ Flint (2005)  
 Kent State University Main Campus (2005)

Baldwin-Wallace College (2006)  
 Youngstown State University (2006)  
 University of Cincinnati (2006)  
 Bowling Green State University (2006)

Region V

Georgia Institute of Technology  
 University of Florida—Gainesville  
 University of Central Florida (Orlando) (1993)  
 Barry University (1994)  
 Florida International University (1995)  
 Nova Southeastern University (1995)  
 University of South Florida (1995)  
 University of Georgia (1999)  
 University of Miami (2000)  
 State University of West Georgia (2000)  
 Emory University (2000)  
 University of North Florida (2000)  
 Florida State University (2000)  
 Columbus State University (2001)  
 Berry College (2001)  
 University of North Carolina @ Chapel Hill (2002)  
 Georgia Southwestern State (2002)  
 Georgia State University (2002)  
 Kennesaw State University (2002)  
 East Carolina University (2002)  
 Rollins College (2003)  
 Gulf Coast Community College (2003)  
 University of North Carolina—Charlotte (2003)  
 Clayton College and State University (2004)  
 Echerd College (2004)  
 Florida Atlantic University (2004)  
 Florida Institute of Technology (2005)  
 University of North Carolina at Wilmington (2006)  
 Brenau University (2006)  
 Wake Forest University (2006)  
 Duke University (2007)  
 Daytona Beach Community College (2007)  
 Winthrop University (2008)

Region VI

Northwestern University  
 University of Wisconsin—Milwaukee  
 Illinois Benedictine College (1995)  
 Marquette University (1997)  
 Tri-State University (1997)  
 University of Wisconsin—La Crosse (1999)  
 Loyola University of Chicago (1999)  
 Butler University (1999)  
 Indiana University/Purdue University @ Indianapolis (2000)  
 Southern Illinois University—Carbondale (2000)  
 University of Illinois @ Urbana/Champaign (2001)  
 Indiana University/Purdue University—Fort Wayne (2001)  
 Knox College (2002)  
 University of Notre Dame (2004)  
 University of Chicago (2007)  
 Augustana College (2007)  
 Earlham College (2008)  
 Lawrence University (2008)

Region VII

Vanderbilt University

|             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|             | University of Kentucky (1997)<br>Mississippi State University (1999)<br>Tennessee State University (2001)<br>Our Lady of Holy Cross College (2002)<br>University of Alabama—Birmingham (2003)<br>University of Arkansas—Fort Smith (2003)<br>Louisiana State University (2004)<br>Spring Hill College (2004)<br>University of Central Arkansas (2004)<br>University of Mississippi (2004)<br>Roane State Community College (2006)<br>University of Southern Mississippi (2006)<br>East Tennessee State University (2007)<br>Our Lady of the Lake College (2007)<br>Berea College (2008)<br>University of Memphis (2008)<br>University of Tennessee—Knoxville (2008)        |
| Region VIII | University of Missouri—Kansas City (1995)<br>University of Missouri—Columbia (1997)<br>Creighton University (1996)<br>University of Iowa (1998)<br>University of Minnesota (1998)<br>Truman State University (1999)<br>Carleton College (2000)<br>University of Nebraska—Lincoln (2001)<br>Fort Hays State University (2002)<br>North Dakota State University (2003)<br>University of South Dakota (2006)<br>Washburn University (2008)<br>William Jewell College (2008)                                                                                                                                                                                                   |
| Region IX   | Texas A&M University (1996)<br>University of Texas—Austin (1997)<br>Abilene Christian University (1999)<br>Texas Tech University (1999)<br>Oklahoma State University (2000)<br>Lamar University (2000)<br>Texas A&M University—Kingsville (2001)<br>Denton Pioneer (2003)<br>University of Houston (2005)<br>Trinity University (2005)<br>Tarleton State University (2005)<br>Rogers State University (2006)<br>Baylor University (2006)<br>Rice University (2006)<br>University of Houston—Downtown (2007)<br>St. Edward's University (2007)<br>Stephen F. Austin State University (2008)<br>Texas A&M International University (2008)<br>University of St. Thomas (2008) |
| Region X    | University of California, Berkeley<br>University of California, Davis<br>University of California, Los Angeles (1995)<br>University of California, San Diego (1997)<br>University of Colorado at Denver (1995)<br>California State University—Fullerton                                                                                                                                                                                                                                                                                                                                                                                                                    |

California State University—Sacramento (1995)  
 Sacramento City College (1996)  
 University of Puget Sound (1997)  
 California Polytechnic State University (1997)  
 San Diego State University (1998)  
 University of Southern California (1998)  
 California State University—Los Angeles (2000)  
 California State University—Northridge (2000)  
 University of California—Irvine (2001)  
 Arizona State University (2001)  
 University of California—Riverside (2001)  
 University of Washington—Seattle (2002)  
 University of Utah (2002)  
 American River College (2003)  
 Mills College (2003)  
 La Sierra University (2003)  
 California State University—San Bernardino (2004)  
 City College of San Francisco at Alameda (2004)  
 Claremont McKenna Colleges (2004)  
 Colorado State University (2004)  
 Monterey Peninsula College (2004)  
 University of Colorado at Boulder (2004)  
 University of New Mexico (2004)  
 University of Wyoming (2004)  
 Occidental College (2005)  
 University of Alaska @ Fairbanks (2005)  
 Arizona State University East (2005)  
 Arizona State University West (2005)  
 San Francisco State University (2005)  
 University of Colorado @ Colorado Springs (2005)  
 Stanford University (2005)  
 University of California at Santa Cruz (2006)  
 George Fox University (2006)  
 University of California at Merced (2006)  
 Chapman University (2006)  
 Cabrillo College (2006)  
 University of Judaism (2006)  
 San Joaquin Delta College (2006)  
 University of Arizona (2007)  
 University of Nevada—Reno (2007)  
 Saint Mary's College of California (2007)  
 Mt. San Antonio College (2007)  
 Reedley College and the North Centers (2007)  
 California Lutheran University (2008)  
 California State University at Bakersfield (2008)  
 California State University at Fresno (2008)  
 Ohlone College (2008)  
 Southern Oregon University (2008)  
 Southwestern Community College (2008)  
 University of San Diego (2008)  
 San Jose State University (2008)

#### International Chapters

Ross University School of Medicine—Dominica (1993)  
 St. George's University School of Medicine—Grenada (1993)  
 American University of the Caribbean—St. Maarten/Netherlands Antilles (1995)  
 Universidad Autonoma de Guadalajara, School of Medicine—Mexico (1997)  
 SABA University School of Medicine—Saba/Netherlands Antilles (1998)



Universidad Central del Este—Dominican Republic (1998)  
 Flinders University of South Australia—Australia (1998)  
 University of the West Indies Faculty of Medical Sciences SOM—Trinidad and Tobago (1998)  
 Tel Aviv University Sackler Faculty of Medicine—Israel (1999)  
 Ben Gurion University—Israel (1999)  
 Spartan Health Science University—St. Lucia (2000)  
 University College of Dublin SOM & Medical Sciences—Ireland (2000)  
 Kigezi International SOM—Uganda (2000)  
 Universidad Iberoamericana SOM—Dominican Republic (2000)  
 St. Matthew's University—Cayman Islands (2000)  
 Central America Health Sciences University/Belize Medical College—Belize (2000)  
 University of Health Sciences Antigua—Antigua (2000)  
 Universidad de Monterrey—Mexico (2000)  
 Ankara University Faculty of Medicine—Turkey (2000)  
 Istanbul Universitesi Cerrahpasa Medical Faculty—Turkey (2000)  
 Hacettepe University Faculty of Medicine—Turkey (2000)  
 American International School of Medicine—Guyana (2001)  
 Medical University of the Americas—Nevis (2001)  
 University of Dublin Trinity College SOM—Ireland (2001)  
 Royal College of Surgeons—Ireland (2001)  
 International University of the Health Sciences—St. Kitts (2001)  
 Medical University of Silesia—Poland (2002)  
 St. Christopher Iba Mar Diop College of Medicine—Senegal (2002)  
 Poznan University of Medical Sciences—Poland (2003)  
 The University of Sydney FOM—Australia (2004)  
 Medical University of Lublin/Akademia Medyczna Lublin—Poland (2004)  
 King Edward Medical University—Pakistan (2004)  
 Medical University of the Americas—Belize (2004)  
 Xavier University School of Medicine—Bonaire/Netherlands Antilles (2005)  
 American University of Antigua College of Medicine—Antigua (2005)  
 St. James School of Medicine—Bonaire/Netherlands Antilles (2005)  
 University of Balamand FOM & Medical Sciences—Lebanon (2005)  
 National Defense Medical Center—Taiwan (2006)  
 International American University—St. Lucia (2006)  
 St. Martinus Faculty of Medicine—Curacao/Netherlands Antilles (2006)  
 The University of Sint Eustatius School of Medicine—Sint Eustatius/Netherlands Antilles (2007)  
 All Saints University School of Medicine—Dominica (2007)  
 National University of Rwanda—Rwanda (2008)  
 Weill Cornell Medical College in Qatar—Qatar (2008)  
 Windsor University School of Medicine—St. Kitts (2008)

#### International Affiliate Chapters

St. Luke SOM—Liberia (2004)

#### **Section VII. Structure of Local Chapters**

The local chapter serves as the official representative body of constituent members to the national organization. All medical students enrolled in a LCME, AOA or ECFMG accredited allopathic or osteopathic medical school are eligible for “active” membership (Constitution and Bylaws—Article III, Section 1, Subsection A). The structure of the local chapter is determined by the local members; however, chapters are encouraged to formulate an organizational structure according to guidelines set forth by the House of Delegates.

- A. **Chapter Officers.** Although the chapter structure varies according to local need, the House of Delegates requires that each chapter of the Association select a Chapter President, a Recruitment Coordinator and a Chapter Legislative Representative. Each chapter is recommended to designate Liaisons for each of the Action Committees and Interest Groups as well as National Primary Care Week Coordinator and coordinators of other national initiatives. The creation of other offices and positions is at the discretion of the local chapter. (2005)

- B. Responsibilities of Chapter Officers. All duties and responsibilities for each of the chapter officers are determined by members of the local chapter. However, the House of Delegates, in order to maintain communication and facilitate activities of the Association, requires certain minimal functions to be accomplished by the local officers. The functions of the chapter officers are as follows:
1. provide ongoing feedback to the Regional Director and national officers on the concerns of chapter members relative to policy, programs and activities of the Association;
  2. serve as the focal point for communicating local chapter activities to the national office and Regional Director;
  3. coordinate programs and activities at the chapter level;
  4. coordinate the annual membership drive;
  5. facilitate activity within the chapter and communicate through periodic chapter meetings to discuss and review issues of concern to medical students; and
  6. be medical student members of the Association in good standing at the time of or within 30 days of their election and during their term of office. (1998)
- C. Responsibilities of Chapter President. The primary functions of the Chapter President are as follows:
1. serve as primary contact for the national office in the receipt and distribution of pertinent information and materials relating to the organization and issues of concern to medical students: (2005)
  2. coordinate local chapter activities and work with other local chapter officers to accomplish responsibilities delineated above; (2005)
  3. attend the Chapter Officers Conference and the National Convention. (2005)
- D. Responsibilities of the Chapter Legislative Representative. The Chapter Legislative Representative serves as the primary contact for the Legislative Affairs Director and other National Leaders who address legislative issues on the national, state and local levels. The functions of the Chapter Legislative Representative include, but are not limited to:
1. distribution of information relative to all aspects of legislation received from the national office to members of the Association and other medical students;
  2. serve as the focal point for communicating all pertinent legislative proposals introduced at the local and state level to the national office; and,
  3. facilitate activity by members of the Association at the chapter level relative to legislation proposed at the national, state and local level.
- E. Responsibilities of the Chapter Liaisons for Action Committees and Interest Groups
1. subscribing to the appropriate Action Committee or Interest Group listserv to receive all updates concerning the activities of the Action Committees and Interest Groups;
  2. serving as the focal point for information gathering and distribution to the local chapter of information concerning the national and local activities of the Action Committees and Interest Groups;
  3. regularly perusing the information available on the AMSA Web site and distributing and promoting that information at the local level; and,
  4. attend the Annual meeting, become familiar with the activities, projects and policies of the Action Committees and Interest Groups.
- F. Responsibilities of Chapter Recruitment Coordinator. (2005)
1. serve as primary contact for national office for distribution of recruitment materials; (2005)
  2. coordinate local chapter recruitment drive; (2005)
  3. report to Regional Director regarding success of recruitment drive; (2005)
  4. attend the Chapter Officers Conference in the event that the Chapter President is unable to attend. (2005)

- G. Responsibilities of National Primary Care Week Coordinator. (2005)
1. serve as primary contact for national office regarding NPCW events; (2005)
  2. coordinate local NPCW; provide ongoing feedback to national office regarding success of implementing NPCW. (2005)
- H. Chapter Officer Selection. The House of Delegates encourages the election of all chapter officers in an open meeting of local members. The national office should be notified by the outgoing chapter liaison immediately upon the election of new chapter officers in order to expedite the flow of information to the official chapter representative.

## **Section VIII. Annual Meeting**

The purpose of the Annual Meeting is to provide a forum for the consideration of issues pertinent to health care, medical care, medical education and health care delivery. Numerous educational programs, often participatory in nature, are offered. This is a major opportunity for the members of the Association to meet other medical and health science students from throughout the United States. From time to time, other student health professional groups and health-oriented groups schedule their conventions and/or annual meetings to coincide with AMSA's Annual Meeting, which serves to enrich the discussions that take place. All AMSA members are encouraged to attend and participate in the Annual Meeting. In addition, the House of Delegates meets during the Annual Meeting to formulate the policy of the Association and elect the national officers.

- A. Annual Meeting Site and Date Selection. After reviewing possible sites for the Annual Meeting, the Board of Trustees selects a date and location three years in advance. The need for such advance selection is due to the number of participants and the actual physical needs for holding such a large meeting. Every attempt is made to offer the membership geographic parity in site selection. Any member may submit suggestions to the Board of Trustees as to possible sites for the Annual Meeting.

The Annual Meeting is usually held in March and, whenever possible, is scheduled so as to avoid religious holidays. The Annual Meeting will be held at fully accessible locations, as defined by the Americans with Disabilities Act of 1990. (1997)

- B. The Official Call. All chapter officers and chapter liaisons receive the "Official Call" one hundred and twenty days (120) days prior to the scheduled date of the Annual Meeting (Constitution and Bylaws—Article IX, Section 10). The purpose of the "Official Call" is to provide information on functional aspects of the meeting. Contents include: general convention information; the process for policy formulation; examples of resolution formats; information for potential candidates for national and regional office; the functions of the Delegate(s) and reference committees; the process for Delegate/Alternate Delegate certification and representation in the House of Delegates; and a calendar of events, including deadline dates for submission of amendments and resolutions.

In the event any chapter fails to receive the "Official Call" according to the above guidelines, that chapter shall be granted a minimum of thirty (30) days to meet any deadline set forth within the "Official Call."

- C. Financial Assistance to Members Attending the Annual Meeting. The Association attempts to assist with available resources the Delegate(s), Alternate Delegates and/or individual members in defraying costs to attend the Annual Meeting. The Association does make every effort to obtain reasonable housing rates and provide some meals. In addition, the Association will provide the option of food that does not contain meat at those meals provided. Information on possible sources of revenue is provided to the local chapters, through the "Official Call." To avoid undue burdens on local chapters, the Association does incur the costs for Regional Directors and National Officers.

## **Section IX. Policy of the Association**

The policy of the House of Delegates is contained in three separate documents, entitled The Constitution and Bylaws, The Preamble, Purposes and Principles, and The Structure, Functions and Internal Policy of the American Medical Student Association. These documents may be amended by resolutions submitted to the House of Delegates at the Annual Meeting.

- A. The Constitution and Bylaws. The governing document of the Association is The Constitution and Bylaws. Amendments to The Constitution and Bylaws are submitted to the House of Delegates for consideration and action at the Annual Meeting.

- B. Internal Affairs of the American Medical Student Association. This document contains guidelines and readily available explanations of how the Association operates. Like The Preamble, Purposes and Principles, the document is the official policy of the House of Delegates on matters related to the “internal” affairs of the Association. The guidelines set forth under the direction of the House of Delegates are implemented by the Board of Trustees. Amendments are submitted to the House of Delegates and are referred to as Resolutions of Internal Affairs.
- C. The Preamble, Purposes and Principles. Adopted in 1976 by the House of Delegates, this document contains major “external” policy positions of the Association and should be referred to whenever members or staff represent AMSA in an official capacity. Amendments are submitted to the House of Delegates and are referred to as Resolutions of Principle.

## **Section X. Policy Formulation of the Association**

The “Official Call” details the process by which members may make amendments to the Constitution and Bylaws and the two policy documents. Deadlines are maintained to allow adequate time for local chapters to review all resolutions, amendments and reports submitted to the House of Delegates for consideration. The Board of Trustees accepts only those resolutions of an emergency nature after the deadline date, since chapters and members must be given adequate time to review the issues under consideration by the House of Delegates.

- A. Referral of Resolutions. All amendments and resolutions will be referred by the Chairperson of the House to an appropriate Reference Committee. The Reference Committees then hold “open” sessions to hear testimony on all proposed amendments and resolutions.
- B. Participation by Members in the Reference Committee Hearings. The importance of member participation in testimony before Reference Committees cannot be over emphasized. The Reference Committee sessions are used for in depth discussion of the issues reflected in amendments, resolutions and reports submitted to the House of Delegates. A policy of openness is maintained in hearings of the Reference Committees, and any individual may present viewpoints for consideration at the designated “open” sessions. During “closed” sessions, any individual may be present to hear the deliberations of the Reference Committee. However, individuals not on the Reference Committee may not participate or make comments until subsequent “open” sessions. Furthermore, the deliberations following the “open” sessions will be “closed.”
- C. Regional Responsibilities in Policy Deliberations. At one of the regional meetings prior to the Opening Session of the House of Delegates, each region shall review all submitted amendments, resolutions, and reports. Regions shall assign members to attend specific Reference Committee sessions in order to optimally provide input into the deliberations on the issues under consideration. (2003)
- D. Delegate(s) Responsibilities in the House of Delegates. It is the responsibility of the official Delegate(s) to take final action on the Reference Committee reports. Although any Delegate may speak out in support of or opposition to any part of any Reference Committee report, it is primarily within the chapter meetings prior to the Annual Meeting and within the regional meetings and Reference Committee hearings at the Annual Meeting that in depth discussion and debate of the issues takes place. No smoking is allowed on the floor of the House of Delegates.
- E. Reports to the House of Delegates. The House of Delegates annually receives, from the President, Vice President for Finance, Board of Trustees, Coordinators and/or Committees and the ED, reports of pertinence to their responsibilities. Reports are submitted “For Information Only” to the House of Delegates. The House of Delegates does not consider “recommendations” as listed in the reports. Recommendations must be submitted to the House of Delegates as separate Constitution and Bylaws amendments, Resolutions of Principle or Resolutions of Internal Affairs.
- F. Implementation of Association Policy. In order to allow the policies of AMSA to be implemented in a manner appropriate to its resources, the House of Delegates entrusts the Board of Trustees (BOT) with the responsibility for implementation of all policies established by the House of Delegates. In cases where the Association’s resources do not allow for immediate implementation of policies, the BOT will implement such policies as soon as adequate resources are obtained. In addition, funding the newly passed policy will be discussed and voted upon at the

budgetary discussions at June BOT or AC Exec meeting. If a 2/3 majority vote decides to deny funding due to lack of resources, this decision will be communicated to members in the ensuing BOT June Action Report, (as listed in the Constitution and Bylaws, Article XVII, Section 1). At the following HOD, a statement regarding lack of implementation due to inadequate funding, will also be included in the Vice President for Finance' Report to the HOD. (2008) These policies in addition will guide the legislative action of the Association, as implemented below.

1. The Legislative Agenda of the Association will consist of the following issues, which are most pertinent to medical students,: (2005)
  - a. Access to Health Care: AMSA will address the inequities and shortfalls of the U.S. health care system. This effort will include, but are not limited to, advocating for a single-payer-national health insurance plan, working for improved Medicare and Medicaid regulations, resolving physician supply issues and reforming the malpractice liability insurance system, and advocating for greater access for insured individuals. (2005)
  - b. Global AIDS pandemic: AMSA will address the Global AIDS pandemic through advocacy and lobbying efforts. We recognize this pandemic to be one of the greatest tragedies of our time, and our efforts will include, but are not limited to, educating the public and medical professionals about HIV and HIV-related illnesses, developing systems of coordinated volunteer and government agencies to distribute resources to AIDS-afflicted countries, creating mechanisms to provide access to essential medications, encouraging research on developing a cure and better treatments for HIV/AIDS, and advocating for increased funding to countries stricken by HIV and AIDS. (2005)
  - c. Medical Education: AMSA will address the undergraduate and graduate medical education process, structure, and curriculum. This effort will include, but is not limited to, adjusting the medical education process to provide the most relevant and beneficial curriculum and atmosphere for physicians-in-training, revising medical board examination methods when necessary, advocating for diversity in medicine, training culturally-competent physicians, and encouraging a public health and community-based curricula. (2005)
  - d. Residency Work Hours: AMSA will address the particular issue of residency work hours. This effort will include, but is not limited to, supporting efforts to implement the safe resident work hour regulations, including those at the federal level, instituting whistleblower protection, educating physicians-in-training on the effects of acute and chronic sleep deprivation, and establishing independent review committees to monitor residency program compliance. (2005)
  - e. Medical Education Costs: AMSA will address the cost of medical education and student debt by improving the availability of adequate student financial support including, but not limited to, tax credits for student loan interest, improved methods of loan repayment, merit-based scholarships, grants for disadvantaged students, and innovative student and school-based financing strategies. AMSA will also seek to limit rising medical school tuition that is increasingly discouraging qualified students from entering the field of medicine. (2005)
2. Any additions, amendments, or alterations to this legislative agenda shall require a two-thirds affirmative vote in the House of Delegates. (1997)
3. However, given the volatility of political agendas, AMSA's daily legislative efforts will be determined by the LAD based on the prevailing political issues. (1997)

G.. Change to Established Association Policy. Individuals who seek to change established association policy are encouraged to write resolutions to the contrary.

## **Section XI. Advertising Policy Formulation**

The following guidelines are to be used by the Association in formulating advertising policy:

1. There should be no statements, verbal or pictorial, that are misleading.
2. Patients and providers should be portrayed in a respectful and humane manner and not in a stereotyped or demeaning fashion with respect to age, sex, sexual orientation and gender identity, race or disability.
3. Statements of properties, performance, content values, beneficial results, etc. of products should be such that they can be verified by adequate data in the literature. (2004)
4. AMSA recognizes the valuable role the United States Armed Forces and its service people play in defending our country and keeping peace; however, AMSA bans all advertising, including but not limited

- to print advertisements in AMSA publications and exhibition space at national or regional events, from any program under the administrative umbrella of the Department of Defense, except the Uniformed Services University of the Health Sciences and military residency programs, until such a time that it allows people of all sexual orientations to serve openly in the United States Armed Forces. All other branches of the United States Armed Forces are prohibited from advertising in its publications. Uniformed services that do not fall under the Department of Defense are permitted to advertise and exhibit. (2006)
5. AMSA bans all pharmaceutical ads in its publications and events. (2004)
  6. AMSA bans all campaign advertisements for political candidates and/or political parties. (2005)
  7. Support documentation verifying claims must be submitted to publisher upon request before an advertisement will be accepted for publication.
  8. Nutritional advertisements should not conflict with the U.S. Dietary Guidelines.
  9. Advertisements for special purpose foods must include a list of ingredients and the quantitative nutrition analysis of the product or offer to supply this information on request. If the advertiser elects to state the nutrition value in terms of RDA's, as well as the quantitative nutrition analysis, current federal regulations governing nutrition labeling should be followed or this information offered on request.
  10. The implementation of the above guidelines will be the responsibility of the BOT.

## **Section XII. Review of Association Principles**

- A. The responsibility for review and revision of Association Principles is a general one falling to all the members of AMSA. However, it shall be a specific duty of the Action Committees to periodically review those Principles, which might apply to them, and assure they reflect the current views of the membership.
- B. The Chairs of the Action Committees shall present in their first report to the Board of Trustees a short summary of sections of the Principles which apply to them and which will be reviewed during the year.
- C. In their year end report, Chairs of the Action Committees shall list these Principles and note any action taken—whether it be a project, interest group, or resolution—that concerned those Principles in question.
- D. It shall be the responsibility of the Secretary and Vice President for Internal Affairs to periodically reformat the Principles of the Association in order to make the organization of them more relevant to the membership.
- E. The Action Committees shall be responsible for annually reviewing the Principles for outdated terms and obsolete issues or entries. The Secretary and Vice President for Internal Affairs shall annually update the Principles of the Association with the approval of the BOT. These updates may include the following:
  1. Substitution of outdated terms with up-to-date terms (2003)
  2. Deletion of Principles that address issues or entities that are obsolete (2003)
- F. Any Principles that are deleted for being obsolete shall be kept on file by AMSA for historical purposes. (2003)

## **Section XIII. Format of Resolutions**

All resolutions submitted to the national office for consideration by the House of Delegates are classified as either: (1) Resolutions of Principle; (2) Resolutions of Internal Affairs; or (3) Constitution and Bylaws Amendments. The House of Delegates requires that the following guidelines be adhered to for all resolutions submitted for consideration:

1. If a member desires to submit a proposal with aspects pertaining to both “principles” and “internal affairs,” two separate resolutions must be submitted;
2. All proposed resolutions must be accompanied by at least a summary of information supporting the feasibility of, need for and interest in all activities delineated within the body of the resolution;
3. Amendments to the three documents must adhere to the “Format of Resolutions” section outlined in the “Official Call”;

4. All proposed resolutions must be neutral in vocabulary with regard to gender, unless a particular gender is specifically intended; and,
  5. The source of all statistics in resolution proposals must be footnoted and a single copy of that source be available to the Reference Committee on request.
- A. Resolutions of Principle. Any resolution pertaining to a particular issue or problem related to the external interests of the Association will be classified as a “Resolution of Principle.” All such resolutions accepted at the sessions of the House of Delegates are compiled in The Preamble, Purposes and Principles of the American Medical Student Association.
  - B. Resolutions of Internal Affairs. Any resolution pertaining to goals, priorities, suggested activities, programs or projects and mandates requiring resources of the Association will be classified as a “Resolution of Internal Affairs.” All Resolutions of Internal Affairs passed at the sessions of the House of Delegates will be referred to the Board of Trustees for consideration and action. The Board of Trustees is responsible for reporting back to the House of Delegates, at the next Annual Meeting, on action taken regarding each Resolution of Internal Affairs. The report will be presented to the Delegates by the Chairperson of the House as the Board of Trustees’ representative.
  - C. Resolved Sections of Resolutions. The House of Delegates requires that all resolved sections of resolutions be “freestanding” and without reference to the preceding introductory statement and/or compendium of information. The House of Delegates also requires that the specific section of the document to be amended be clearly articulated within the body of the resolved section of the resolution and portions to be superseded be clearly identified for deletion.
  - D. Preservation of Introduction Clauses and Indexing of Resolutions. Since the introduction to resolutions often contains valuable information about the author’s intent, the introduction clauses shall be preserved by the AMSA national office on the AMSA Web site, beginning with the 2002 House of Delegates. This info will be password protected and accessed only with a valid AMSA i.d. number. (2002) The PPP shall be indexed by subject. In addition, beginning in 1985, the year of adoption and amendment should be appended to each statement or principle so that one can refer to The Preamble, Purposes and Principles and see in which year any principle was adopted or amended. The above mentioned subject index, as well as the year of principle adoption shall be included within The Preamble, Purpose and Principles.
  - E. Compilation and Distribution of AMSA Policy. The three documents of the Association will be compiled on an annual basis and distributed to Chapter Officers and other interested individuals.

#### **Section XIV. Environmental Health and AMSA-Sponsored Activities**

AMSA endorses promoting well-being and health through improvements to and harm reduction in the built, natural, social and physical environment. To promote the highest quality of health for those attending AMSA events, AMSA-sponsored regional or national meetings and programs will adhere to the following guidelines: (2008)

1. Use of any tobacco product is not allowed during any AMSA-sponsored regional or national meetings or local programs, within an environment under the temporary or permanent control of local or National AMSA. AMSA encourages local, regional and national event organizers to promote a smoke-free environment within areas not under AMSA control. (2008)
2. Weapons of any kind are not permitted at AMSA events unless special permission has been given in advance by the Board of Trustees for a compelling reason or the individual is on duty as a law enforcement officer or active-duty military personnel. Those possessing or carrying weapons without permission will not be permitted to attend future AMSA events or participate in AMSA leadership. (2008)
3. If noxious or harmful exposures are noted at an AMSA event, event organizers are accountable for informing attendees and mitigating harm. (2008)
4. AMSA will specifically request recycling and other energy conservation services when booking any commercial meeting sites and contractors. The use of environmentally harmful practices or businesses by AMSA funding should be strongly discouraged. Special consideration may be given to environmentally friendly businesses and cost should not be the only consideration in the selection of such a business. (2008)
5. Recycling and energy conservation measures are required in all national AMSA properties and rentals. When cost-effective, energy audits and energy-saving measures must be employed. Other energy-saving measures should be explored and encouraged. (2008)

6. AMSA will offer carbon offsetting to attendees and participants traveling to national and regional meetings at additional cost to attendees and strive to use low impact methods for AMSA-sponsored travel. (2008)
7. All AMSA leaders and staff will minimize the amount of paper and copying for all activities, meetings and programming. Alternatives such as digital documents, online forms, shared programs, and recyclable materials are strongly encouraged. (2008)

#### **Section XV. Regarding Public Advocacy of the Association's Principles**

We, the members of AMSA, expect that resolutions passed in the House of Delegates and integrated into the Preamble, Purposes and Principles (PPP), will be more than just a written document. We fully expect that persons representing AMSA will actively pursue the goals and policies stated in the PPP. Persons representing AMSA have both the right and the responsibility, and are encouraged, to publicly express the convictions of the Association, so long as their actions do not endanger the Association's legal standing, while at the same time keeping the Association informed of their actions and their intent communicated to the Board of Trustees.

#### **Section XVI. Regarding *The New Physician Magazine***

The American Medical Student Association adopts the following set of management principles for *The New Physician*: (1999)

1. The magazine shall act as the primary and official publication of the American Medical Student Association (AMSA).
2. The magazine shall be provided to each member who elects to receive the journal, to each individual subscriber and to related complementary readership as determined by the Managing Publisher.
3. The magazine shall be supported by appropriate allocation of dues, as set by the Board of Trustees (BOT) and the Managing Publisher, each individual reader subscription, display and classified advertising and gifts and contributions as solicited by the BOT.
4. The magazine shall contain commercial advertising (display and classified) depicting goods and services of personal and professional use to physicians-in-training, i.e., the readership.
5. All advertising shall be represented in a tasteful manner, inoffensive to any human group, and represent a quality and truthful product or service.
6. AMSA, through the Managing Publisher, shall retain the right to reject any advertising deemed to be untruthful or misleading, offensive, or presented in bad taste.
7. The magazine shall carry AMSA program promotional advertising, based on availability of space, as determined by the Managing Publisher to promote AMSA's membership services, educational products or educational programs.
8. The magazine shall be viewed and managed by the organization as an "objective journalistic instrument," having protected integrity and sole purpose to provide the readership with unbiased and truthful research and reporting.
9. The magazine's editorial mission shall be to pursue and present news and issues of interest and importance to the readership and the organization in an unbiased manner through objective research and reporting.
10. The magazine shall serve as a primary educational tool for the readership and will provide educational aids of high quality and utility to physicians-in-training of a clinical or nonclinical nature.
11. The magazine shall not carry any political messages or advertising reflecting the opinions of any internal or external group, with the exception of information contained in "AMSA Focus." There shall not be advertising for specific campaigns, including advertising for political candidates and political parties. (2005)
12. The magazine shall routinely carry timely and important news concerning the AMSA and its affiliates. Such organizational news shall be presented in a separate and special section of the magazine ("AMSA Focus") easily identifiable by the readership.
13. The magazine shall not be used by the organization and any subgroup of the organization or any group external to the organization for the purpose of pursuing or presenting, in any format, issues of special interest.
14. The magazine shall have an Editorial Advisory Board (EAB) appointed by the Board of Trustees in accordance with the Bylaws of the American Medical Student Association. The EAB shall be responsible for assisting the organization with the planning and development of the magazine's editorial mission.



15. The magazine shall have a Student Editor appointed in accordance with the Bylaws of the American Medical Student Association. The Student Editor will be accountable to the BOT for conducting liaisons between the Board and the magazine and assisting the Managing Publisher and magazine Editor with the planning, development, pursuit and execution of the magazine's editorial mission.
16. The magazine shall have a Managing Publisher, who shall be in common with the office of the Executive Director of the Association and shall be appointed by the BOT of AMSA. The Managing Publisher shall be responsible for all aspects of the magazine's planning, development and management and shall be accountable to the BOT for such duties. The Managing Publisher shall establish an editorial and management staff for the magazine and delegate such duties as appropriate.
17. The magazine shall have a full time Editor, hired by the Managing Publisher. The Editor of the magazine shall be responsible to the Managing Publisher for planning, pursuing and executing the editorial mission of the magazine and any other duties delegated by the Managing Publisher.
18. The Student Editor, National President, Managing Publisher and Editor of the magazine shall comprise an executive team for the purpose of planning and developing the magazine. This team shall have the responsibility to referee issues arising concerning the pursuit, preservation of integrity and any infringement upon the editorial mission of the magazine and management principles of the magazine as approved by the House of Delegates.
19. The Managing Publisher and executive team shall have the responsibility of evaluating the progress of the magazine each year in terms of effectiveness and stability and develop an annual report for the BOT to be submitted to the House of Delegates. This report shall make recommendations regarding pending issues, strategies, needs and changes in the magazine or its managing principles.

#### **Section XVII. Strategic Planning and Strategic Priorities**

The President shall oversee a process of strategic planning for the Association during November Meetings of the Board of Trustees and Executive Board of the Action Committees every four years for external priorities and every two years for internal priorities or sooner, if deemed necessary by the Board of Trustees and Executive Board of the Action Committees. (2004) During this time, the leadership shall designate strategic priorities of the Association. These priorities shall serve as issues around which AMSA shall focus its time, resources, and energies. The Board of Trustees may supersede these regulations if deemed necessary. Updates on each Strategic Priority shall be presented and reviewed at all meetings of the Board of Trustees and Executive Board of the Action Committees. (2003)

# PREAMBLE



**PREAMBLE**  
**of the**  
**AMERICAN MEDICAL STUDENT ASSOCIATION**

The American Medical Student Association is dedicated to the improvement of medical education, health care, and health care delivery so that health care may become more personal and holistic in a world of increasing technology and efficiency. We define health as a positive, dynamic state of physical, mental and environmental well-being, and therefore, believe that health care should be oriented toward the achievement of health and not solely a treatment of disease. Health maintenance, then, becomes a basic responsibility of all individuals, and health professionals become the colleagues of patients in the management and maintenance of health.

We believe that access to quality health care is a right, not a privilege. This implies equal access to equally high standards of health care regardless of economic status, political beliefs, cultural background, geographic position, race, creed, national origin, age, sex, sexual orientation and gender identity, physical handicap, mental handicap or institutionalization for criminal, medical or psychiatric reasons. Since resources are limited, they should be allocated so that they equitably promote the public health; thus, health-care issues must be addressed in the public forum.



# PURPOSES



**PURPOSES**  
**of the**  
**AMERICAN MEDICAL STUDENT ASSOCIATION**

The Purposes of the American Medical Student Association are:

- I. To promote improvements in health sciences education so that:
  - A. medical education is sensitive and responsive to actual health care needs;
  - B. students are treated and trained as individuals interested in health care, not as technicians;
  - C. a multiplicity of personal backgrounds and approaches to health care are encouraged;
  - D. advances in the biological, natural, and social sciences and their clinical applications are recognized as fundamental to medical progress and crucial to the delivery of quality medical care;
  - E. the educational environment fosters growth of the student as an integrated mental, physical and spiritual being;
  - F. the education environment is non-biased towards medical students and other health care professionals based on their economic status, political beliefs, race, creed, ethnicity, sexual orientation and gender identity, disability or health status;
  - G.. creative learning opportunities are provided through experimental, self-directed and interdisciplinary programs;
  - H. medical education is more accessible to traditionally underrepresented segments of our society;
  - I. the rights, dignity and responsibility of the patient are emphasized;
  - J. the medical education process helps foster individual commitment to public service;
  - K. the importance of the role of political processes in formulating health care-policy is understood;
  - L. there is a deeper understanding of the relationship between pathology and the personal experience of disease;
  - M. the ethical and philosophical dilemmas inherent in scientific medical technology are fully and freely explored;
  - N. medical education fosters a compassionate understanding of substance abuse problems and mental illness, with a goal toward reducing their stigma in the profession and for the public at large;
  - O. students are encouraged to explore global health issues and gain international and cross-cultural health care experience;
  - P. students are treated as respected members of the medical school community, with distinct rights and positions of responsibility in that community;
  - Q. students are exposed to varying models of health-care delivery and to the trends influencing health care.



II. Improve health services so that:

- A. quality health-care services are readily available and accessible to all regardless of economic status, political beliefs, race, creed, national origin, age, sex, sexual orientation and gender identity, physical handicap, mental handicap or institutionalization for criminal, medical or psychiatric reasons;
- B. health services provided are responsible to cultural-geographical needs;
- C. health-care planning involves participation by recipients and providers;
- D. resources are allocated such that they promote human rather than technological priorities;
- E. the delivery of health care is reviewed to ensure cost and quality effectiveness;
- F. the patient becomes an informed, active participant in health management;
- G. preventive and longitudinal care are accorded high priority;
- H. health care becomes more personal and holistic in a world of increasing technology and efficiency.

# PRINCIPLES



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## **PRINCIPLES REGARDING MEDICAL EDUCATION— CURRICULUM DESIGN**

The American Medical Student Association:

1. In regards to Curriculum Design:

- a. ENCOURAGES substantive participation of medical student representatives on curriculum committees and other advisory bodies involved in curricular oversight. (2005)
- b. SUPPORTS using a framework of competencies and objectives to guide curricular design and development. (2005)
- c. SUPPORTS the use of pass/fail grading in the preclinical years of medical school. (2001)
- d. SUPPORTS any effort to increase meaningful patient contact in the preclinical years. (2005)
- e. DISCOURAGES the excessive use of passive learning (i.e., lectures) in medical schools and URGES that active educational techniques (e.g., problem-solving, small group discussions, computer aided instruction) be more widely utilized. (1988)
- f. BELIEVES that hands-on training opportunities in undergraduate medical education are necessary to achieve a level of proficiency in medical procedures, and thus the earlier that this is begun, the greater the level of proficiency that is attained. (1988)
- g. SUPPORTS the development of federal and state grants and contracts with medical schools to meet the costs of curriculum development projects to improve the teaching of medical students on subjects of emerging national concern, such as preventive medicine, nutrition, occupational health and the health needs of the aged;
- h. SUPPORTS a medical school curriculum that provides appropriate faculty training in the areas of curriculum design and communication techniques, the adequacy of which to be reviewed through student evaluations and the accreditation process;
- i. ENCOURAGES the formation of student/faculty groups to address the evaluation and formulation of curriculum, to clearly define curricula objectives, and to improve indices of student performance;
- k. SUPPORTS a medical school curriculum that develops and supports the interdisciplinary approach through interdisciplinary courses and experiences, so that members of the various health disciplines can develop habits of cooperation and mutual respect and understanding with regard to roles, training, education, and expertise;
- l. SUPPORTS a curriculum that incorporates formal and effective interpersonal skills training as an integral part of the preclinical and clinical instruction of medical students and residents;
- m. BELIEVES that cost-of-living stipends for clerkships and other experiences away from a student's home medical center are not inconsistent with sound educational principles and should be provided for students engaging in such experiences;



## **PRINCIPLES REGARDING MEDICAL EDUCATION— CURRICULUM CONTENT**

1. In regard to Preventive and Community Medicine in the curriculum:
  - a. URGES that every medical school have required preclinical and clinical curricula in Preventive and Community Medicine, that content to include, at the minimum, Epidemiology, Biostatistics, Clinical Preventive Medicine, Community Medicine and Emergency Medicine; that this curricula:
  - b. In regard to Preventive and Community Medicine, Epidemiology and Biostatistics:
    1. emphasizes prevention and health maintenance with holistic medicine as its core;
    2. provides instruction in health care economics and, in particular, increases students' awareness of the cost of the care they provide;
    3. addresses the issues and relevancy of occupational disease by incorporating instruction in such areas as occupation, history-taking, common occupational illnesses and fundamentals of industrial toxicology, including field projects that introduce students to these issues;
    4. provides, in the core curriculum, a structured practical nutrition course, including diet counseling centered around the patient/student educational aspect of nutrition in health and disease;
    5. recognizes the relevancy of applying preventive and community medicine principles to the medical problems of Third World countries;
    6. offers quality experiences in the areas of medical ethics, cultural and linguistics barriers to health care, medical jurisprudence, health-care economics and health-care planning, organization and management;
    7. includes relevant information on the association between cancer, genetic damage and radiation—including exposure from x-rays, the uranium mining and waste disposal, nuclear fallout and general background radiation;
  - c. In regard to Emergency Medicine:
    1. provides, in the core curriculum, training in Basic and Advanced Cardiac Life Support, management of life threatening emergencies, basic first aid, awareness of Poison Control or other available references regarding toxic and psychosocial emergencies;
    2. SUPPORTS a medical school curriculum that provides instruction in emergency medical techniques and basic first aid during the first year, so that the medical student may be prepared to provide a service needed in the event of a medical emergency occurring inside or outside the hospital facilities.
    3. SUPPORTS development of Emergency Medicine curriculum (per American College of Emergency Physicians guidelines) to be available at all medical schools on at least an elective basis.
  - d. In regard to Violence:
    1. provides, in the core curriculum, information regarding violence as a public health issue. (1992)
    2. stresses:
      - a. the physician's unique position of and, thus, responsibility for recognition and initial intervention in cases of child and spouse abuse;
      - b. education in the prevalence, incidence and interrelatedness of these problems, in presenting signs and symptoms, and in counseling skills for use in conjunction with available social services.
  - e. URGES that at least 5 percent (or 250 hours) of the curriculum be allotted specifically to teach Preventive and Community Medicine;
  - f. URGES that all medical schools have a department of Preventive and Community Medicine, or its equivalent, with a sufficient number of qualified faculty and adequate financial support to effectively teach the material;

- g. SUPPORTS efforts to increase the teaching of clinical medicine in ambulatory settings, and encourages the linkage of such efforts with programs to provide care to the underserved populations and the medically indigent. (1986)
  - h. SUPPORTS the introduction of cost awareness into undergraduate and graduate medical education only if it is integrated with formal instruction on the physician's ethical responsibilities to the patient and the community. (1986)
2. a. In regard to medical school curriculum and aging:
- 1. SUPPORTS efforts by American Medical Schools (Allopathic and Osteopathic) to make substantial improvements in preparing future physicians to serve the needs of this country's older population by: (1989)
    - a. Offer a general, interdisciplinary introduction to Geriatrics and Gerontology during the preclinical years of medical school, including the cultural and sociobehavioral aspects of normal aging, (1986)
    - b. subsequently highlight pertinent information regarding the older (both normal and ill) person with specific lectures in existing courses, (1986)
    - c. include active teaching components devoted to the acute and chronically ill elderly patient during the clinical clerkships, as well as post-geriatric training, (1986)
    - d. offer elective(s) in clinical Geriatrics, (1986)
    - e. include Geriatrics as a part of CME courses in practicing physicians. (1986)
  - 2. incorporates information about aging and health care for the elderly;
- b. incorporates training in the special health-care needs of the terminally ill, including concerns for psychosocial issues and symptom control;
- c. In regard to medical school curriculum and the disabled and rehabilitation;
- 1. incorporates training of health care professionals in the special needs of the disabled, including skills required to care for the disabled patient;
  - 2. RECOGNIZES that the physical medicine and rehabilitation is a specialty with a shortage of physicians; and therefore, URGES: (1986)
    - a. all medical schools to teach students medical and psychosocial problems of the disabled. (1986)
    - b. all medical schools to consider establishing a department of physical medicine and rehabilitation. (1986)
    - c. federal funding for the training of physiatrists and for research in physical medicine and rehabilitation. (1986)
- d. In regard to human sexuality and reproduction:
- 1. teaches in third or fourth year rotations in OB/GYN the abortion procedure to medical students, with exemption on the basis of personal principles, in the same manner as other surgical procedures within that field. (1994)
  - 2. incorporates the use of female and male Professional Teaching Associates during the initial instruction of medical students in pelvic, breast, rectogenital, testicular and prostate examinations; (1995)
  - 3. incorporates, in the core curriculum, a comprehensive human sexuality course that:
    - a. provides facts about human sexuality, sexual problems and options for treatment;
    - b. equips the student with adequate diagnostic and therapeutic skills, including the ability to assess the degree of severity of a patient's sexual problems;
    - c. enables the student to take a sensitive and appropriate sexual history, and talk comfortably about specific sexual behavior;
    - d. clarifies the student's own values regarding sexual behavior, enabling the student to be comfortable with value differences in patients.
  - 4. URGES the LCME to accredit only those medical schools, which offer the following:

- a. Didactic training, which excludes observation or participation, in reproductive health including, but not limited to abortion, in Ob/Gyn clerkships and in preclinical years; (1995)
      - b. Experience in the surgical procedure of abortion, including observation of the procedure itself and the pre-abortion and post-abortion counseling, with exemptions for students based on personal principle; (1995)
      - c. The aforementioned training can be received either on or off campus. (1995)
    5. URGES the USMLE to include items regarding abortion in the Ob/Gyn “shelf” examinations, and in the USMLE Step II and Step III examination. (1995)
  - e. In regard to mental health:
    1. incorporates in the core curriculum training which:
      - a. emphasizes the influence of patients' lifestyle and behavior on widely prevalent chronic conditions such as obesity, hypertension, atherosclerotic heart disease, non-insulin dependent diabetes mellitus, and violent trauma and the importance of this interrelationship in providing comprehensive, quality medical care to all patients; (1997)
      - b. emphasizes the centrality of patients' lifestyle and behavior in the treatment and recovery from widely prevalent chronic conditions such as those named above;
      - c. emphasizes instruction in how to discuss with patients the role of behavior in recovery from medical illness including improving diet, reducing stress, maintaining medication compliance, and avoiding high-risk behaviors such as unprotected sex and gang membership; (1997)
      - d. instructs students during the Physical Diagnosis course in the proper techniques of obtaining a psychiatric history, including a psychosocial review of systems and performing a complete mental status examination. (1987)
    2. informs students of the markedly increased incidence of depression among medical students at the end of the second year and the beginning of the third year and the generally high risk for medical students, house officers, and practicing physicians of mental illness and its consequences, e.g., alcoholism, drug abuse, divorce and suicide, and provides elective small-group experiences to offer interested students peer group support and instruction in stress reduction techniques. (1997)
    3. recognizes that the third year psychiatry clerkship has been shown to have the greatest impact on career choice but that the second year course plays a critical role in educating medical students about the behavioral aspects of medicine as described above. (1997)
  - f. In regard to palliative care and pain management:
    1. URGES the eventual establishment of palliative medicine and pain management programs and departments at US accredited academic medical institutions that currently do not have such programs; (2003)
    2. ENCOURAGES the active recruitment of specialists in palliative care to the faculty; (2003)
    3. INCORPORATES concepts of palliative care (which include good communication skills, and sensitivity to patients' pain and symptoms) into all courses; (2003)
    4. SUPPORTS a practical, case-based training in end of life issues; (2003)
    5. ENCOURAGES medical students to consider palliative medicine as a career specialty. (2003)
3. SUPPORTS a medical school curriculum that:
    - a. allows advance placement in the basic sciences;
    - b. allows advancement at the student's own rate, based on learning and achievement rather than on time spent in a particular area;
  4. Regarding the National Board Examinations:
    - a. URGES the National Board of Medical Examiners (NBME) to report student performance as simply Pass/Fail to both students and state licensing boards, and provide medical schools with only a Pass/Fail statistical evaluation of the performance of their student population as a whole, with no documentation of individual student scores;

- b. URGES each medical schools' faculty to develop its own internal evaluation process, other than exclusive use of National Board examinations, utilizing a variety of testing devices to assess both the cognitive and noncognitive aspects of student performance and curriculum quality;
  - c. OPPOSES the use of National Board Examinations for medical school accreditation, residency selection, student promotion, and as the exclusive mode of curriculum evaluation;
  - d. BELIEVES that the NBME must guarantee student representation in decisions regarding present and future USMLE examinations and future proposed licensing exams. (2005)
  - e. OPPOSES the addition of the Clinical Skills Examination (CSE) to the United States Medical Licensing Exam (USMLE). Recognizing the existence of the CSE requirement for licensure despite our opposition, AMSA: (2005)
    - 1. strongly SUPPORTS pass/fail grading of the CSE; (2005)
    - 2. strongly SUPPORTS making the CSE available free or at a nominal cost to all medical students at U.S. medical schools; (2005)
    - 3. strongly SUPPORTS making CSE testing locations available in every U.S. city with a medical school; (2005)
    - 4. strongly SUPPORTS the creation of national standards for clinical skills examinations to be implemented at all US medical schools; (2000)
    - 5. strongly SUPPORTS the requirement for constructive feedback to students regarding their performance. (2000)
5. Regarding research in health professions education:
- a. SUPPORTS the creation and federal funding of a National Center for Health Professions Education Research; (1992)
  - b. BELIEVES that physicians-in-training and other health professions-in-training should play an active role in the planning and execution of all initiatives for research in health professions education; (1992)
  - c. SUPPORTS a national research agenda for health professions education that includes research on specialty choice and primary care, the impact of student indebtedness on education and careers, the recruitment and retention of under represented minority students and those of low-income backgrounds, and the impact of community-responsive training on eventual career choices. (1992)
6. SUPPORTS requiring every medical school to include rotational exposure to community service and practice in an underserved community in their curriculum. (1994)
7. In regard to primary care:
- a. ENCOURAGES every medical school to include in their mission statement a commitment to primary care. (1994)
  - b. SUPPORTS improving and strengthening primary education through having an appropriate number of primary care physician faculty in every medical school. (1994)
  - c. offers and encourages a variety of quality primary care experiences, including educational programs and preceptorships in regional medical centers or other primary care settings outside of large teaching institutions, preferably in shortage areas;
  - d. provides primary care educational experiences in the classroom and community setting taught by community-based physicians to supplement the existing curricula, which are often limited to the academic setting. (1991)
8. SUPPORTS and PROMOTES the inclusion of medicolegal topics such as medical malpractice and tort processes in medical school and continuing education curricula. (1996)
9. SUPPORTS the integration of public health into undergraduate and graduate medical education by:
- a. Encouraging state and federal funding of public health education and practice, particularly in an era of market-driven health care; (1996)
  - b. Reframing public health as a basic science in the personal and clinical health sciences by incorporating the knowledge, skills and competencies related to the analysis of health care as a system into medical education; (1996)

- c. Creating programs at the federal, state and managed-care organizational levels to continue and enlarge the support base for a broad range of psychosocial-behavioral research and training;
  - d. Developing research, service and training partnerships to apply population-based health management skills to the problems now faced by highly managed and integrated systems of care;
  - e. Creating, in conjunction with federal, state and local government, managed-care organizations, and other nonacademic institutions, new public health programs that bring together the traditional public health disciplines with the clinical professions. (1996)
- 10. In regard to managed care:
  - a. SUPPORTS and ENCOURAGES medical schools and residency programs to form arrangements with managed care organizations such that schools may offer numerous clinical clerkships and other opportunities in managed care settings, not limited to clinical rotations in managed-care clinics, staff-model health maintenance organizations, etc.; (1997)
  - b. SUPPORTS and ENCOURAGES managed care organizations to participate actively in medical education by forming arrangements with medical schools and academic health centers such that medical students and residents may participate in numerous clinical clerkships and other opportunities in managed care settings, not limited to clinical rotations in managed-care clinics, staff-model health maintenance organizations, etc.; (1997)
  - c. SUPPORTS requiring managed care organizations to contribute financially to academic health centers for the education and training of physicians in medical school and in residency programs. Medical schools must retain autonomy over their curriculum and training programs. (1997)
- 11. In regard to complementary medicine:
  - a. SUPPORTS the establishment of elective courses in medical school curricula that educate physicians-in-training about complementary and alternative medical modalities so that physicians can more effectively guide the healing process. (1998)
- 12. In regard to medical student work hours:
  - a. STRONGLY SUPPORTS the same limits on medical student work hours that it does for resident work hours as stated the Principles Regarding Resident and Student Work Hours. (2005)
- 13. In regard to LGBTI health in medical school curricula:
  - a. RECOGNIZES that culturally competent medical students and medical residents improve the healthcare environment experienced by LGBT patients. (2006)
  - b. BELIEVES that learning the specific healthcare needs of LGBT patients during undergraduate medical education is a critical component of professional development as a physician. (2006)
  - c. URGES Medical Schools to seamlessly integrate LGBT Health into their core curricula as part of mandatory coursework, and not sequester LGBT Health as a subject disconnected from other essential cultural topics in medicine. (2006)
  - d. FURTHER RECOGNIZES that by working to ensure LGBTI patients feel less threatened in healthcare settings, LGBTI medical students, residents, and physicians will also feel more comfortable to draw on their own experiences to advocate on behalf of all their patients. (2006)
- 14. In regard to medical errors and patient safety:
  - a. URGES the LCME to require all medical schools to include curriculum about medical errors and patient safety, including but not limited to:
    - 1. disclosure of risks, medical errors and poor outcomes to patients and families (2007)
    - 2. understanding the science that underlies patient safety, including the multifactorial nature of errors, high-risk situations, root cause analysis and appropriate reporting of mistakes and near misses (2007)
    - 3. teamwork including interaction with non-physician members of the medical team (2007)
    - 4. communication and conflict resolution skills between health professionals, including what to do if an error goes unreported or is suppressed and how to disclose to supervisors if the student does not feel competent to perform a procedure or duty (2007)

5. appropriate medical record keeping, informed consent, defensive medicine, appropriate standards of care, and what constitutes malpractice including examples of each. (2007)
6. Identifying mistakes, learning how to analyze mistakes, identifying potential ways to reduce risk, and exploring how to implement risk reduction strategies. (2007)

## **PRINCIPLES REGARDING MEDICAL EDUCATION AND THE PHARMACEUTICAL INDUSTRY**

1. Regarding medical education and the pharmaceutical industry and pharmacy, SUPPORTS a medical school curriculum that:
  - a. provides formal instruction about the pharmaceutical and medical products industry, including critical evaluation of the issues of drug development incentives, research quality and independence, regulation, and communication;
  - b. provides full disclosure about commercial sources of sponsorship of any medical education program, whether Grand Rounds or CME;
  - c. establishes pharmacy and therapeutics committees in all teaching hospitals to encourage the following:
    1. active team practice (joint bedside rounds, pharmacy chart reviews, etc.) involving clinical pharmacists and physicians in drug use decision-making;
    2. establishment of oversight and evaluation mechanisms for prescribing practices of students, housestaff, and physicians; these mechanisms to include guidelines for interaction with industry representatives in teaching institutions;
    3. establishment of hospital formularies which specify drugs, their indications, mode and cost of administration, and complications;
  - d. PROHIBITS pharmaceutical industry representatives from marketing to medical students, including, but not limited to, distributing paraphernalia advertising pharmaceuticals or pharmaceutical companies to students, detailing students about a particular prescription drug, and inviting students to pharmaceutical industry-sponsored meals. (2005)

## **PRINCIPLES REGARDING ADMISSION TO MEDICAL SCHOOL**

The American Medical Student Association:

1. SUPPORTS the broadening of qualifications for admission to include differences in socioeconomic class, race and social experience; (2007)
2. SUPPORTS a greater use of noncognitive selection criteria such as those that assess an applicant's motivation, social awareness and ability to communicate with others, and supports the expansion of admission committees to include students and other persons qualified to assess such criteria;
3. SUPPORTS the revising of the Medical College Admission Test (MCAT) to exclude culturally biased questions and to include, where possible, sections which measure noncognitive criteria;
4. OPPOSES the requirement of forced practice within the state as a prerequisite for admission;
5. SUPPORTS special incentives and admission consideration for medical school applicants for rural areas in need of physicians;
6. OPPOSES admission to medical school by any means other than the regular admissions process accepted by the governing body of the medical school without objecting to admissions committee criteria of residency or affirmative action programs.
7. STRONGLY URGES the LCME to amend the "Standards for Accreditation of Medical Education Program Leading to the MD degree, Part 2, Medical Students, Admissions" to read "In addition, there must be no discrimination on the basis of sex, age, race, creed, national origin or sexual orientation and gender identity." (1989)
8. STRONGLY URGES the American Osteopathic Association to amend the "Accreditation Standards and Procedures for Colleges of Osteopathic Medicine (COM), Part 2.4.A.2.(f)" to read "The selection of students for admission to a COM shall not be influenced by race, color, sex, religion, creed, national origin, age, handicap or sexual orientation and gender identity." (1989)
9. SUPPORTS the concept that information regarding applicants' ability and/or means to finance their medical education should not be requested prior to their acceptance, nor should such information be considered as a criteria for acceptance.
10. ENCOURAGES institutions of higher education, including graduate and professional schools, to explore alternative admission processes, which would foster a diverse student population. (1998)
11. BELIEVES that secondary application fees should not serve as a barrier to medical school admission. Therefore, AMSA SUPPORTS that secondary application fees be minimized and standardized as in the primary AMCAS application. (2007)



## **PRINCIPLES REGARDING MINORITY REPRESENTATION IN MEDICAL SCHOOLS**

The American Medical Student Association:

1. SUPPORTS the increased representation of racial minority students in medical schools, not only as a result of concern for social equity, but also because such representation leads to positive and necessary changes in the attitudes of students, faculty and administrators, and hence to positive improvements in the health of society and in the health-care delivery systems;
2. URGES that, in order to achieve equal minority representation, U.S. medical schools recognize the goal of graduating a nationwide average of underrepresented ethnic minorities (Black, Latin and Native American) reflecting, at a minimum, the most recent census (i.e., 1.0% Native American, 12.3% Hispanic and 12.5% African-American according to the 2000 census); (2005)
3. SUPPORTS an individual school graduating class' minority percentage at least equal to the proportional numbers of that minority in the population of the region in which the medical school is located;
4. SUPPORTS the development, funding and continued emphasis toward strengthening of programs to identify and prepare minority students from the high-school level onward and to enroll, retain and graduate increased numbers of minority students;
5. URGES that special attention be paid to the financial needs of minority medical students;
6. URGES increased efforts by medical schools to hire minority group faculty and administration.
7. SUPPORTS the American Association of Medical Colleges' initiative "3000 by 2000" and shares the commitment to increase underrepresented minority student enrollment and retention in U.S. medical schools. (1994)

## **PRINCIPLES REGARDING ACCREDITATION**

The American Medical Student Association:

1. BELIEVES the accreditation reports issued by the Accreditation Council for Graduate Medical Education (ACGME) (2005) and the Liaison Committee on Graduate Medical Education should be open to public scrutiny;
2. URGES the LCME to require medical schools, as a prerequisite for accreditation, to provide comprehensive professional liability coverage for each medical student while participating in intramural and extramural clinical programs accredited by or affiliated with the medical school;
3. URGES that students be allowed full participation in all aspects of the accreditation process of the LCME:
  - a. full participation by students in the self-study portion of the accreditation process at each school;
  - b. the inclusion of students as members of site visit teams;
  - c. full voting privileges for the student participants on the Liaison Committee on Medical Education.
4. URGES the LCME to require medical schools, as a prerequisite for accreditation, to have in place programs promoting medical student well being. (1992)

## **PRINCIPLES REGARDING TUITION**

The American Medical Student Association:

1. SUPPORTS the concept that medical schools should guarantee a maximum level of tuition to students prior to enrollment and provide their students with a justification (including specific data) for all proposed tuition increases;
2. SUPPORTS the concept that medical schools have a moral obligation to assist all enrolled students in meeting the increased financial burdens if tuition is increased;
3. STRONGLY URGES medical schools to disclose their financial reports such that both medical students and applicants are informed of:
  - a. how funds are obtained through tuition and other revenue sources are used; (1999)
  - b. the medical school's affiliation with hospitals and other for-profit and nonprofit organizations that share financial obligations; (1999)
  - c. how to obtain their medical institution's annual report containing information on the operating budgets and expenses of the institution. (1999)
4. STRONGLY URGES medical schools to promptly inform current and matriculating students of any financial events involving the school, affiliated hospitals, affiliation with hospitals and other for-profit and nonprofit organizations in which financial obligations are shared that can substantially affect both a matriculating student's decision to enter the medical school and the finances of current medical students; (1999)
5. URGES efforts by medical schools to prevent an increase in tuition caused by reduced research reports and financial risks initiated by affiliation with hospitals and other for-profit and nonprofit organizations in which financial obligations are shared. (1999)
6. STRONGLY SUPPORTS the rights of all students to seek medical education regardless of financial situation. (1999)

## PRINCIPLES REGARDING THE FINANCING OF MEDICAL EDUCATION

The American Medical Student Association:

1. RECOGNIZES that equitable access to medical education is essential to guarantee diversity of the physician workforce. Medicine will not be able to provide for the health needs of our complex society if it does not reflect society's demographics. (2006)
2. BELIEVES that equitable access to medical education is not simply a matter of providing college-graduates with adequate financial aid, it is also important to consider the pipeline to medical school and prioritize equitable access to undergraduate college education. (2006)
3. FURTHER BELIEVES that access to higher education is a right and should only depend on a student's performance, not on her or his ability to pay tuition. (2006)
4. SUPPORTS increased financial education for medical students in order to better prepare students to make more advantageous financial decisions, (2006)
5. In regard to "Aid-for-Service" Programs
  - a. SUPPORTS the National Health Services Corps (NHSC) and other loan repayment programs, such as the NIH Scholars program, (2006)
  - b. CALLS FOR an increase in the number of young physicians that can receive NHSC loan repayments. (2006)
  - c. SUPPORTS the additional expansion of the NHSC to include medical specialties outside of primary care that are also in shortage in underserved areas, such as general surgery and mental health services, (2006)
  - d. ENCOURAGES the creation of other loan repayment programs to expand the reach of existing programs. These include a "Global Health Services Corps" where students may receive loan repayments for providing service abroad, and state- and municipal-based loan repayment programs for needed physicians, (2006)
  - e. RECOGNIZES that loan repayment programs are optimal because they have less attrition than scholarship programs, but ACKNOWLEDGES that programs must be able to provide an initial "up-front" scholarship to offset the high costs of starting medical school. (2006)
  - f. BELIEVES that "Aid-for-Service" programs not only increases access to medical education, but also directly addresses issues of disparities in access to healthcare. (2006)
6. RECOGNIZES the importance of establishing coalitions and close working relationships with other national student organizations working on the issue of equitable access to education. (2006)
7. In regard to loan repayment:
  - a. SUPPORTS the concept of an educational opportunity bank for medical students where educational loans, interest and administrative costs can be repaid, once in practice, on an income contingent basis;
  - b. SUPPORTS the deferment of payment on the principal and accrued interest of educational loans incurred for premedical and medical education until the completion of medical training, including internship and residency;
  - c. SUPPORTS the concept of availability of student loan consolidation, refinancing and graduated repayment; (2004)
8. URGES that medical schools cooperate with the federal government to improve collection practices on student loans;
9. In regard to loan source, amount, and development:
  - a. SUPPORTS the concept that a multiplicity of sources for financing medical education be available;
  - b. URGES that ceilings on federally issued loans must be sufficient to meet the actual needs of students and their dependents, as determined by the financial aid officer at each medical school;
  - c. URGES the continued support and development of low interest loan programs, such as the Health Professions and Federal Insured Student Loan programs, which offer the medical student a fair and practical solution to the funding of medical education, and further URGES that high interest loan programs,

- such as the Health Education Assistance Loan, established by PL 94-484, be revamped so that they, too, can provide reasonable sources of money;
- d. SUPPORTS federal direct lending programs for students enrolled in medical schools, and for medical students pursuing other advanced degrees. (1997)
  - e. BELIEVES that in-school loan consolidation would substantially improve the ability of medical school graduates to manage their debt, thus allowing them more financial flexibility to choose primary care specialties and to work in underserved communities; (2005)
  - f. URGES the federal government to allow in-school consolidation of student loans for students enrolled at Federal Family Education Loan Program (FFELP) medical schools and Direct Lending (DL) medical schools. (2006)
10. CONDEMNS any use of a student's military draft registration status as a criterion in the eligibility for, or awarding of, financial aid.
    - a. SUPPORTS the continuation of the Department of Defense's Armed Forces Health Professions Scholarship Program;
  11. In regard to taxation:
    - a. SUPPORTS the tax deductibility of interest paid on student loans; (2005)
    - b. SUPPORTS legislation, which would make the cost of tuition, books and essential educational materials tax deductible for students engaged in graduate and professional education;
  12. URGES that childcare expenses be included in the assessment of financial aid needs for all medical students;
  13. SUPPORTS the funding, by state governments, of a substantial portion of the costs of private medical schools within their jurisdiction;
  14. SUPPORTS a special, permanent line item within the overall Department of Health, Education and Welfare budget for both Georgetown and George Washington University medical schools, in addition to the line item already included for the Howard University School of Medicine, due to the unique stateless status of these schools;
  15. ESTABLISHES the goal of increasing involvement and financial support from physicians to help create affordable financing of medical education, especially for the financially disadvantaged; (1985)
  16. BELIEVES THAT in the event of the acquisition or management of medical school teaching hospitals and affiliate teaching hospitals by for-profit health-care corporations, the corporation should:
    - a. Demonstrate sufficient concern for the care of the medically indigent and other medically underserved populations.
    - b. Demonstrate interest in maintaining graduate and undergraduate teaching programs in health sciences through adequate monetary commitment.
    - c. Uphold an emphasis on patient advocacy and medicine's humanitarian ideals. (1986)
  17. SUPPORTS the interest exemption on subsidized loans during the time period a student is attending either undergraduate or graduate medical school. (1995)
  18. In regard to the use of endowments:
    - a. CONDEMNS the use of research and medical endowment funds or its interest to finance activities outside the endowment's original purposes when those purposes have not been achieved; (1999)
    - b. STRONGLY SUPPORTS states' attorney generals to vigorously pursue institutions and any of their individuals that engage in such activities; (1999)
    - c. SUPPORTS legislation that:
      1. restricts the use of interest income from endowments to fund activities outside the medical institution; (1999)
      2. bans the use of interest income from research and scholarship endowments for any activity outside of its original intent; (1999)
      3. makes institutions and individuals involved in such activities financially liable for misappropriated funds. (1999)
  19. CONDEMNS federal or state government cuts to programs aimed at increasing access to medical education; (2006)

20. CONDEMS the practice of retroactive tuition hikes; (2006)
21. DEMANDS renewed funding for the Federal Perkins Loan Program and increased funding for the Federal Stafford Loan Program; (2006)
22. SUPPORTS inclusion of tuition transparency into the LCME's accreditation criteria of medical schools; (2006)
23. URGES the creation of State and Federal grant-based financial aid programs for medical students. (2006)

## **PRINCIPLES REGARDING SERVICE IN UNDERSERVED AREAS AND SERVICE OBLIGATIONS**

The American Medical Student Association:

1. SUPPORTS the concept that each physician should volunteer for a minimum of two years in an area of geographic or specialty need, such service preferably to take place following completion of graduate training;
2. In regard to financing service obligations and initiatives;
  - a. SUPPORTS legislation providing tax exemptions, financial support, or other incentives for health professionals going into shortage areas;
  - b. Regarding service obligations in underserved areas:
    1. SUPPORTS the Public Health Service, Indian Health Service and National Health Service Corps programs and URGES increased funding for such programs to make positions available to any qualified applicant; (1994)
    2. STRONGLY URGES the development of loan programs with loan forgiveness features tied to service in areas of geographic and specialty need; and URGES that such forgiveness be available to all individuals desiring such mechanisms and for loans from any source used to finance medical and premedical education; and further URGES that the level of such loans be commensurate with the real costs of medical education;
    3. ENCOURAGES private sector efforts, such as a physician-poor community contracting with a student to provide later service in return for financial support while in medical school;
    4. URGES all scholarship programs with service obligations to have hardship provisions, since the needs, motivations and family commitments of a student may change between the time the obligation is incurred and repayment in service is expected;
    5. URGES the adoption of legislation to exempt from taxation income due to service-dependent forgiveness of educational loans and scholarships;
    6. SUPPORTS the concept of federal and state incentive grants directed at meeting national health work-force objectives;
3. URGES those administering programs, which place physicians in areas of need, such as the National Health Service Corps, to include provisions for:
  - a. adequate ancillary personnel, equipment and facilities
  - b. optimal utilization of allied health professionals;
  - c. continuing medical education;
  - d. shared responsibilities for patient care among health-care providers;
  - e. consideration of the desires of both physician and spouse with regard to location and spouse employment.
4. SUPPORTS the National Health Service Corps in its efforts to deal with the problem of placing medical resources and personnel in needy urban areas in addition to needy rural areas;

5. OPPOSES compulsory postgraduate service in a government designated area, but believes that, should such service be imposed:
  - a. all students should be at risk for service;
  - b. students should receive tuition and cost-of-living expenses in exchange for service;
  - c. the service program should meet the standards suggested for voluntary service programs in point 3;
  - d. an equal choice between military and civilian service, with equal pay privileges, should be offered;
  - e. male and female physicians should receive equal consideration and equal obligations commensurate with their professional capabilities.
6. In regard to primary care
  - a. RECOGNIZES the value of community-oriented primary care as a tool for recruitment and retention of physicians in underserved areas. (1987)
  - b. URGES medical schools, graduate medical programs, community health centers, and the federal government to incorporate the concept of community-oriented primary care into their programs. (1987)
  - c. SUPPORTS the development of a comprehensive career track in community-oriented primary care by expanding on the Health Promotion/Disease Prevention and National Health Service Corps models. (1987)
7. URGES efforts to be made to increase incomes of providers serving in underserved communities to a level that is on par with providers not practicing in shortage areas. (1994)
8. In regard to an HIV/AIDS Service Corps:
  - a. STRONGLY SUPPORTS the creation of a federally funded HIV/AIDS Service Corps that links United States health professionals with local health care providers in nations overwhelmed by HIV/AIDS, with the goals of accelerating the implementation of comprehensive, coordinated prevention, treatment, education and health promotion programs adapted to local conditions; and working closely with people in heavily affected areas to develop human, medical and public health infrastructure over the long term. Such a program should include the following components:
    1. U.S. and host-country institutional coordination of the Corps, and training of Corps members and host-country nationals in chosen host countries. (2003)
    2. Reliable supply of medical, pharmaceutical, and public health materials, as well as other necessary supplies, to host countries through Corps members. (2003)
    3. Placement of Corps members in teams that include physicians, nurses, public health specialists, and informatics specialists. (2003)
    4. An educational loan repayment and stipend plan for the U.S. volunteers. (2003)
  - b. BELIEVES that an HIV/AIDS Service Corps will only be successful in saving lives when it is explicitly tied to other funding streams for essential medicines and made part of a broader scheme to stimulate equitable development. (2003)



## PRINCIPLES REGARDING HEALTH-CARE DELIVERY AND DELIVERY SYSTEMS

The American Medical Student Association:

1. SUPPORTS a coordinated, cohesive health-care delivery system that maximally meets diverse health needs and efficiently achieves such needs, and within such a system, SUPPORTS a multiplicity of approaches to delivering health care and ENDORSES structuring services to meet local needs, including special needs arising due to geographic, cultural, economic, social and/or historical differences between areas;
2. In regard to managed care:
  - a. OPPOSES the concept that fee-for-service practice, in the context of medical care as a market commodity, is the only system to provide the highest quality and availability of medical care;
  - b. SUPPORTS the concept of prepaid group practice as a model able to increase the quality of health-care delivery to all people;
  - c. SUPPORTS the establishment of a community-based, community-controlled health-care system, publicly financed through general revenues and progressive taxes, employing a full range of health workers and providing complete health services;
  - d. OPPOSES the current profit-based fractionalized health-care delivery system. (1989)
3. In regard to primary care, community and public health care:
  - a. URGES that an emphasis be placed on the development of primary care, ambulatory care and mental health facilities to increase access to and availability of needed health-care services, with such facilities serving as patient health education centers with extensive programs in health education for the public as teaching bases for health professional students;
  - b. SUPPORTS the concept of Area Health Education Centers, i.e., regional medical centers established by academic medical centers that work in conjunction with both community groups and regional health planners;
  - c. BELIEVES that states must increase efforts to evaluate and, if indicated, divert offenders with long-term medical problems to alternate forms of confinement, such as halfway houses, work releases, educational releases or group homes, to more effectively deal with their medical problems;
  - d. ENCOURAGES development of adequate screening, maintenance and emergency health-care facilities in jails, prisons and rehabilitation centers, and that medical schools should be instrumental in developing these programs;
  - e. SUPPORTS the maintenance and improvement of public sector health-care with the aim of eliminating any disparity in the quality of care between the public and private sectors, and further, SUPPORTS the use of the public health-care sector, when possible, by publicly elected officials as an incentive toward upkeep of the public health system;
  - f. BELIEVES that hospitals and other health-care institutions, physicians and other health-care workers have an historical and continuing obligation to meet the needs of the communities in which they are located. This obligation stems from:
    1. their membership in the community,
    2. the benefits and support they derive from belonging in the community, and
    3. the humanitarian origins of the health-care profession. (1986)
  - g. SUPPORTS a patient initially accessing a subspecialist physician of his/her choice only through primary care physician referral; (1994)
  - h. calls for the integration of health services with social welfare and community resources, including housing and employment opportunities for the persistently mentally ill, under the umbrella of community mental health services; (1997)
  - i. URGES that state mental health agencies enforce minimum standards of care based on peer reviewed psychiatric criteria in order to insure that private HMOs do not provide substandard care to Medicare and

- Medicaid populations. These minimum standards of care should be guided by the principles of accessibility to care, continuity of care and prevention as well as rehabilitation; (1997)
- j. SUPPORTS legislation to require parity for mental health benefits such that co-payments, deductibles and degree of coverage for mental illness be comparable to physical illness; (1997)
  - k. SUPPORTS legislation to require coverage for preventive mental health-care services such as counseling for at risk pregnant mothers and in school counseling for at risk teenagers. (1997)
4. In regard to quality assurance:
- a. SUPPORTS the concepts of peer review and quality assurance as embodied in Section 249F of Public Law 92-603 (Professional Standards Review Act) as effective and beneficial means of improving the quality and decreasing the costs of medical care with the following recommendations for improvement of the existing statutes:
    - 1. more flexibility and local innovation be allowed so as not to restrict alternative, unique and innovative systems that could equally well accomplish the review objectives;
    - 2. measures be incorporated to ensure that the administration of the program and its guidelines not be dominated through control of federal monies;
    - 3. continuing education be given greater emphasis than punitive controls;
    - 4. efforts be undertaken to ensure that implementation does not compromise quality medical care in favor of cost control or administrative efficiency;
    - 5. physicians-in-training be included at all levels of planning and implementation;
    - 6. sufficient evaluation of the hospital-based Professional Standards Review Organization (PSRO) system and its impact on cost, personnel, consumers, and quality of health-care delivery be undertaken before any extension of the PSRO concept to private office practice;
  - b. URGES the Department of Health and Human Services to periodically undertake special investigations into increases in surgical procedures such as, but not limited to, hysterectomy, Cesarean section, mastectomy and forced sterilization;
5. In regard to patient rights:
- a. SUPPORTS health care as a basic human right for all people regardless of ability to pay. (1986)
  - b. URGES all health care institutions to seek improved ways to limit access to patient records, especially with regard to computerized record systems where retrieval controls are often inadequate;
  - c. OPPOSES any local, state, or national legislation that would deny health care, education, or social services based on real or perceived immigration status. (1996)
  - d. OPPOSES
    - 1. the denial of health or life insurance based on a history of domestic violence; (1996)
    - 2. the denial of coverage for injury or illness incurred through domestic violence. (1996)
6. URGES that reimbursement policies of private health insurance carriers and federal health-care programs, such as Medicare and Medicaid, be revised to include provisions for:
- a. prepayment on a capitation basis;
  - b. equivalent reimbursement for services rendered, regardless of geographic locale of the practitioner;
  - c. equivalent reimbursement for performance of identical services by all physicians;
  - d. direct reimbursement of properly trained and supervised health-care professionals, such as physician assistants and nurse practitioners, or the clinics for which they work;
7. OPPOSES the accrual of profits by health-care-related industries and providers at the expense of medically indicated quality patient care;
8. In regard to access:
- a. SUPPORTS an individual's unrestricted access to the provider, clinic or hospital of his/her choice in an emergency situation; (1994)

- b. OPPOSES the requirement of health professionals to identify and report any patient believed to be an illegal immigrant and further opposes the requirement of health professionals to ask any patient their immigration status in order to deny care. (1995)
  - c. STRONGLY URGES that health-care legislation for all persons, regardless of immigration status, include provisions for: (1996)
    - 1. emergency care and treatment;
    - 2. pregnancy related services, including but not limited to family planning, prenatal care, labor and delivery;
    - 3. preventive services, including:
      - a. immunizations,
      - b. infectious disease screening and treatment, especially for tuberculosis,
      - c. sexually transmitted diseases, including voluntary and anonymous HIV testing
      - d. breast exams,
      - e. pap smears.
9. In regard to funding for medically underserved and indigent:
- a. URGES that in the establishment of priorities for health-care funding, resources be allocated to maintain services for the economically deprived;
  - b. SUPPORTS federal legislation, such as Medicare disproportionate share adjustment, which will provide financing to allow increased opportunities for hospitals to provide care to those unable to pay. (1986)
  - c. SUPPORTS efforts by state legislatures to consider and implement bills designed to increase health-care access for the medically indigent, through:
    - 1. development of a state all-payer system,
    - 2. taxation of hospitals to develop uncompensated care pools,
    - 3. requirement of specific levels of indigent care for Certificate of Need approval. (1986)
10. In regard to Certificate of Need (CON) legislation:
- a. SUPPORTS the concept of Certificate of Need (CON) legislation as mandated in the National Health Planning and Resources Development Act of 1974 (PL-93-641); and, ENCOURAGES the continued future support by the DHHS of statewide implementation of the law, including:
    - 1. development by the Secretary of HHS of a uniform National Health Policy Statement, incorporating the medical care priorities outlined in PL-93-641;
    - 2. insurance that Health Systems Agencies are declared the primary implementers of the policies set forth in the National Health Policy Statement.
  - b. SUPPORTS the inclusion of physicians' offices in CON legislation with the following provisions:
    - 1. that Certificate of Need review be mandatory for capital expenditures of \$150,000 and over by physicians for their private facilities which involves only the acquisition of a unit of major medical equipment used in patient diagnosis and/or treatment;
    - 2. that Certificate of Need review of private physician offices for such capital expenditure takes into serious consideration the geographic proximity of the physician's offices to any other clinical facility, for it is important to note that the location of physician offices (e.g., rural/isolated areas vs. numerous clustering of urban facilities), in addition to the clinical capacities of already existing medical facilities in the area, are two critical determinants of the potential for expensive and inefficient duplication of medical services;
11. In regard to health care costs:
- a. SUPPORTS efforts to eliminate unnecessary health care expenditures, and SUPPORTS voluntary efforts to limit increases in health care costs.

- b. URGES that the impact on the individual, community, and the nation of non-medical factors, such as life-style and the environment (physical, social, occupational, and economic), should be reflected in the allocation of fiscal and other resources available for health;
- 12. ENDORSES efforts to provide older Americans with special health maintenance programs such as, but not limited to, home health services, visiting nurses, therapists, nutritional services and other alternatives to institutional care;
- 13. SUPPORTS public and private funding of preventive, as well as remedial, health-care services for all age groups;
- 14. In regard to portability:
  - a. URGES the guaranteed continuation of health insurance coverage regardless of change in health status or change in family relationship to the initial health insurance liaison or place of employment, such that all individuals initially covered may retain desired coverage and be notified of the necessity of making new payment arrangements at least 30 days before coverage may be discontinued;
- 15. CONDEMNS health-care fraud, specifically the mispromotion of remedies, and calls for:
  - a. increased enforcement against fraud at all levels of government;
  - b. increased criminal penalties for promoters of such medical quackery;
  - c. the establishment of a national, public clearinghouse on inappropriate remedies for illness and disease. (1985)
- 16. In regard to transferring a patient:
  - a. SUPPORTS “antidumping” legislation, which requires that patients not be transferred unless stabilized, including adequate evaluation and treatment to reasonably assure that transfer will not result in death, or loss or serious impairment of bodily parts or organs. (1986)
  - b. URGES that, in cases of inappropriate transfer of a patient in a life-threatening emergency or active labor, where screening and stabilizing treatment are not carried out, civil monetary penalties be imposed against both the hospital and the responsible physician. (1986)
  - c. SUPPORTS the involvement of a third party to act as a patient advocate in this process. (1986)
  - d. CONDEMNS as inappropriate any and all patient transfers that do not meet the following guidelines as developed by the American College of Emergency Physicians.
    - 1. The patient should be transferred to a facility appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.
    - 2. A physician or other responsible person at the receiving hospital must agree to accept the patient transfer prior to the transfer-taking place. An acceptable “other responsible person” should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.
    - 3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally, this communication should be physician to physician.
    - 4. Once a patient is accepted for transfer, an appropriate medical summary and other records should be sent with the patient.
    - 5. A patient should be transferred via a vehicle that has appropriately trained personnel and life-support equipment. (1986)
- 17. RECOGNIZES that a significant influx of sick and injured people may occur after military confrontations, natural disasters, or unforeseen emergencies, and REALIZES that hospitals, including the Veterans Administration, are often unable to adequately serve such an influx of patients, and therefore URGES:
  - a. volunteerism by physicians-in-training as health-care providers for use in such special and exceptional situations; (1991)

- b. the hospitals, in need of support, to allow medical student to serve in roles consistent with their level of training; (1991)
  - c. the deans of medical schools to support their students in this initiative, and to allow for a wider latitude of attendance and participation in school-related activities (lectures, night-call, etc.). (1991)
18. SUPPORTS the establishment of a national health care budget, as part of a coordinated approach to effectively and equitably constrain health-care costs, thereby setting enforceable expenditure targets for health-care services. (1993)
19. In regard to employer-based insurance:
- a. SUPPORTS a universal health insurance system in which insurance status is not linked with employment status; (2006)
  - b. URGES all employers to provide health insurance to all employees in the absence of such a universal health care system. This health insurance should be affordable, comprehensive, and available to all employees and their dependents, spouses and domestic partners immediately upon hiring, regardless of full-time or part-time status; (2006)
  - c. OPPOSES increasing the employee portion of health insurance premiums from year to year; (2006)
  - d. SUPPORTS measures that maximize the portability of health insurance, such that individuals do not experience interruptions in coverage when they are between jobs. (2006)
20. In regard to neonatal patients:
- a. STRONGLY URGES the federal government to require health insurers to provide hospital care for neonates and their mothers for a 48-hour period postpartum after a normal vaginal delivery and for a 96-hour period postpartum after a c-section. (1996)
21. In regard to physician gag-rules:
- a. OPPOSES any law, contract provision, or incentive that prohibits physicians from disclosing all available medical options for a patient. (1997)
  - b. OPPOSES any law, contract provision, or incentive that prohibits physicians from disclosing all financial incentives, which affect the physician's practice. (1997)
  - c. SUPPORTS and ENCOURAGES federal, state and local legislation that prohibits health plans from prohibiting physicians from disclosing all available medical options for a patient and/or prohibits physicians from disclosing all financial incentives that affect the physician's practice. (1997)
22. In regard to health-care system guidelines and incentives:
- a. STRONGLY URGES that private and public health-care system guidelines serve the interest of the patient and the ethical practices of medicine; (1997)
  - b. OPPOSES private and public systems that employ guidelines, apply pressures, or institute salary incentive programs that promote negligent health-care practices; (1997)
  - c. SUPPORTS the due moral and legal accountability of any party who devises or enforces such guidelines, applies pressures, or institutes salary incentive programs, which are directly proven to cause negligent patient care. (1997)
23. In regard to consumer-driven health plans:
- a. RECOGNIZES that consumer-driven health plans establish tax-exempt investment health savings accounts that primarily benefit healthy individuals, discourage preventive care, discriminate against sick and low income individuals, constitute an unfair and regressive tax subsidy for high income individuals, serve little benefit for low-income or uninsured individuals, reduce the overall level of insurance in the population, increase the fragmentation of the health insurance risk pool, and decrease the affordability of traditional, comprehensive health insurance. (2006)
  - b. OPPOSES the creation of high-deductible health plans that shift the cost of health care to consumers, many of whom cannot afford such a deductible; (2006)

- c. URGES employers to continue to offer traditional health insurance for employees and to refrain from offering consumer-driven health plans, including plans with health savings accounts and variations of health savings accounts. (2006)
  - d. URGES the repeal of health savings account provisions from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. (2006)
24. STRONGLY URGES that all insurers fully cover rehabilitation for the purpose of optimizing adaptation to and improvement of cognitive deficits. (1999)
25. In regards to hospital billing of the uninsured: (2005)
- a. SUPPORTS the establishment of free care provisions for un- or underinsured patients up to at least 200% of the Federal Poverty Level (FPL), and partial free care (sliding scale fee schedule) for un- or underinsured patients up to at least 400% FPL;
  - b. SUPPORTS limitations on charges for the uninsured above 400% FPL that do not exceed either the actual cost of care or the negotiated price for insured patients, whichever is lower;
  - c. SUPPORTS community oversight and transparency into the administration of free care to the uninsured;
  - d. ENCOURAGES hospitals and health care providers to enhance their outreach and publicity regarding free care funds and programs for the uninsured;
  - e. SUPPORTS a free care application process that is easily understandable, language accessible, and efficient;
  - f. OPPOSES the use of aggressive debt collection tactics, including, but not limited to, body attachments, garnishment of wages, and the placement of liens on homes of the uninsured who are unable to pay their medical bills;
  - g. OPPOSES the accrual of interest on involuntary medical debt incurred due to illness.
26. In regard to the individual insurance market:
- a. URGES private insurers to ensure that plans on the individual market are affordable; (2006)
  - b. URGES private insurers to offer coverage to all individuals regardless of health status or pre-existing conditions; (2006)
  - c. OPPOSES the practice of excluding coverage for health care related to a patient's pre-existing condition; (2006)
  - d. BELIEVES that proposals to expand access by building on the individual market, such as tax credits for the uninsured or individual mandates, are inferior to proposals that institute a comprehensive national health insurance system. (2006)

## PRINCIPLES REGARDING UNIVERSAL HEALTH CARE

The American Medical Student Association:

1. SUPPORTS establishing Universal Health Care in America, as defined by guaranteeing access to quality and affordable health care for all persons living in the United States. This coverage should be provided regardless of a person's socioeconomic status, geographic location, race/ethnicity, employment status, age, sexual orientation and gender identity, disability or occupation. Furthermore, special provisions should be made to ensure that no persons residing in the United States are discriminated against based upon the legality or documentation of their citizenship/residency status; however, this specifically excludes persons who enter the United States for the sole purpose of obtaining medical care. Such a program should include: (2005)
  - a. In regard to benefits and services:
    1. coverage for a comprehensive range of services, including but not limited to: (1994)
      - a. primary care services; (1994)
      - b. preventive services, including but not limited to immunizations; (1994)
      - c. reproductive services, including but not limited to prenatal and postnatal care, birth control, abortion counseling and services, pap smears and gynecological exams and sterilization; (1994)
      - d. acute care services and hospitalization; (1994)
      - e. chronic care services, including but not limited to home health care, rehabilitative service, nursing home care; (1994)
      - f. preventive, acute and chronic dental care; (1994)
      - g. mental health services and substance abuse treatment; (1994)
      - h. inpatient and outpatient prescription drugs (2006) and medically necessary supplies and devices; (1994)
      - i. ophthalmic care; (1994)
      - j. supportive services for the disabled; (1994)
      - k. palliative, hospice and end of life care. (2005)
      - l. physical therapy and occupational therapy. (2006)
      - m. hearing care. (2006)
    2. an emphasis on preventive medicine and primary care; (2006)
  - b. In regard to portability and pre-existing conditions:
    1. guaranteed annual renewal of coverage regardless of change in health status;
    2. absolute freedom from denial or limitations of coverage for any individual based upon medical history or current medical status, and further absolute freedom from increased payments or premiums based upon medical history or current medical status. (2005)
    3. absolute portability of coverage, including but not limited to travel, changes in residence and changes in employment. (2005)
  - c. In regard to individual patients: (2006)
    1. a delivery system that is responsive to the individual patient needs with regards to accessibility, availability and cultural suitability;
    2. free choice of physician, hospital and allied health professional provider; (2006)
  - d. In regard to quality assurance:
    1. mechanisms to guarantee quality, cost-consciousness and cost-efficiency through peer review and the participation of the public and financiers; (2006)

2. expansion of clinical research protocols, such as work at the Agency for Healthcare Research and Quality (2005), to determine appropriate utilization and usage of new and existing technology to counter increases in medical costs associated with the use of technology; (1992)
  - e. sufficient flexibility and innovation so as to allow for the investigation of alternative forms of health-care delivery;
  - f. In regard to work-force issues:
    1. provisions for maintaining and training an adequate supply of health professionals, especially underrepresented minorities in medicine; (2006)
  - g. the option for providers to choose fee-for-service, capitation or salary as their means of reimbursement; (2006)
  - h. In regard to cost sharing, AMSA supports:
    1. cost-sharing measures that do not deter patients from seeking necessary care; (2006)
    2. measures to waive or reduce cost-sharing requirements for low-income individuals; (2006)
    3. measures that protect patients against catastrophic out-of-pocket medical costs. (2006)
    4. these recommendations as a secondary resort to a single payer national health insurance system. (2006)
2. BELIEVES that a national health insurance program would be the most equitable and effective method to achieve universal access to health care for all people living in America. (2005)
- a. Regarding financing, AMSA SUPPORTS:
    1. a single-payer health insurance program with one method of billing (1992).
    2. a multi-source, progressive financing structure, including, but not limited to, income and payroll taxes; (1994),
    3. the elimination of tax deductions for the purchase of additional, supplemental health insurance;
    4. provisions to protect individuals from the financial repercussions of catastrophic illness;
    5. the use of revenue from the sale of tobacco products, alcohol, firearms and firearm ammunition to finance a national health plan. (1994)
    6. compulsory participation by individuals with respect to financing National Health Insurance; however, optional participation with respect to use of services provided under National Health Insurance; (2005)
  - b. Regarding the establishment, implementation, administration and regulation of a national health insurance plan, AMSA:
    1. SUPPORTS public participation in the planning and implementation of a universal health care plan, with a particular emphasis on the involvement of minority organizations and leadership. (2003) (2006)
    2. MAINTAINS that any plan for national health insurance implementing the above principles, be established, administered and regulated as a result of cooperative efforts by the representatives of the medical profession, the federal government and the public. (2006)
    3. SUPPORTS phased implementation so that needed changes in the organization and utilization of health personnel and facilities can occur smoothly without disruption of services and spiraling inflation due to increases in demand;
3. SUPPORTS the Proposal of the Physicians' Working Group for Single-Payer National Health Insurance as a framework for public debate on fundamental health policy reform. (1989) (2006)
4. With regard to health-care reform other than national health insurance (2006):
- a. SUPPORTS other forms of comprehensive local, state and national health reform to address immediate gaps in access to care that abide by the above principles. (2005)



- b. SUPPORTS state and national improvements to public programs, including, but not limited to, expansions in eligibility and/or services in Medicaid, Medicare, State Children's Health Insurance Program, and uncompensated care pools. (2005)
  - c. SUPPORTS the establishment of single payer systems in individual states; (2006)
  - d. BELIEVES that individual mandates and tax credits are inadequate solutions to increase health care access and will refrain from supporting such proposals; (2006)
  - e. BELIEVES that employer mandates are an imperfect yet potentially helpful method to increase health care access, but only in the absence of a national health insurance plan; (2006)
  - f. SUPPORTS legislation that would set up commissions to study the feasibility of universal health care in a state or to make recommendations on how to achieve universal health care in a state. (2006)
5. With regard to the federal-state partnership model:
- a. SUPPORTS the federal-state partnership model only in the absence of a national health insurance system; (2006)
  - b. ENCOURAGES states that take advantage of federal monies in this model to design comprehensive public insurance programs for all of their citizens, and conversely DISCOURAGES states to design solutions that build upon the current system of employer-based, for-profit health care; (2006)
  - c. BELIEVES that the criteria for state participation in the federal-state partnership model should include, but not be limited to, the following features of a health care system: universality, affordability, quality, comprehensiveness and portability. (2006)

## PRINCIPLES REGARDING PRIMARY CARE AND FAMILY MEDICINE

The American Medical Student Association:

1. DEFINES primary care to include medical care delivery that incorporates and emphasizes the four principles of first contact, ongoing responsibility, comprehensiveness of scope and overall coordination of the patient's health problems, be they biological, behavioral, or social;
2. In regard to undergraduate medical education:
  - a. URGES the creation and maintenance of family medicine departments at each medical school equivalent in status and financial support to other major clinical departments of that school;
  - b. ENCOURAGES medical schools to support the formation, by students and faculty, of family medicine interest groups to maintain and stimulate interest in family medicine;
  - c. URGES the Liaison Committee on Medical Education and accredited schools of medicine to require all U.S. medical schools to establish a mandatory family medicine clerkship of at least four weeks' duration, by the end of the third year of undergraduate medical education. (1993)
3. In regard to graduate medical training/residency programs:
  - a. SUPPORTS the goal of having 50 percent of the nation's medical school graduates choosing primary care fields and 50 percent of all residencies in primary care no later than the year 2005. (1994)
  - b. SUPPORTS the continued improvement of the quality of primary care residency programs, particularly family medicine programs;
  - c. BELIEVES that federal money for the development of primary care residency programs should give priority to programs in family medicine and also fund those programs in internal medicine, pediatrics and ob/gyn that are specifically oriented toward primary care training;
  - d. URGES primary care training programs to offer their residents training in public health and preventive medicine. (2006)
  - e. ENCOURAGES primary care residency programs to create opportunities for resident involvement in prevention-based community programs. (2006)
4. In regard to Ob/Gyn and Primary Care:
  - a. RECOGNIZES the important role that obstetrician-gynecologists play in the primary care of women, and, therefore, ENCOURAGES the development of primary care training within existing ob/gyn residency programs that emphasizes curricula in comprehensive care, continuity of care, appropriate referral, and psychosocial and behavioral components of sexual and reproductive medicine to prepare obstetrician-gynecologists to meet fully the needs of the patients they serve;
5. SUPPORTS the development of Primary Care Networks in order to increase quality and access of health care for the medically indigent while effectively containing costs.
6. ENCOURAGES that any efforts to increase the number of primary care physicians include removal of disincentives and creation of adequate incentives to choose primary care in the undergraduate and graduate medical environments and the practice environment. (1994)
7. In regard to financing:
  - a. SUPPORTS the Primary Care Loan Program, but URGES Congress and the Health Resources and Services Administration to ensure that health professions students from low-income backgrounds have adequate access to low-interest loans that do not restrict their career choices. (1993)

- b. SUPPORTS creating loan-repayment programs and lowering the interest level for repayment of federal student loans for those physicians practicing in primary care. (1994)
8. Regarding Family Medicine Residency Training programs:
- a. URGES the Council on Resident Education in Family Medicine to mandate training in abortion and pregnancy options counseling in its design for resident education. Residents could forego training based on personal principle. (1995)
  - b. ENCOURAGES Residency Directors to coordinate abortion training at the teaching institution, a clinic, or office in the community. (1995)
  - c. URGES the American Board of Family Medicine to include questions on abortion procedures in written and oral exams. (1995)
  - d. ASKS the Residency Review Committee for Family Medicine to only recommend accreditation to programs that offer abortion training and management on and/or off site. (1995)
  - e. URGES the Accreditation Council on Graduate Medical Education to address pregnancy termination and related options in its Special Requirements for Residency Training. (1995)
  - f. ENCOURAGES the American Academy of Family Physicians to provide CME training and credits for the management of abortion. (1995)
9. SUPPORTS a strengthened system of primary care research to be defined as research in the biological, social and behavioral sciences as relevant to the delivery of medical care in the primary care setting. Specific areas may include health outcomes, effects of medical interventions and organization and management of health care services. Such studies would ideally focus on illnesses as commonly experienced or on the prevention of common causes of morbidity and mortality; (1996)
10. ENCOURAGES the Department of Health and Human Services and the Public Health Service to increase support for research in primary care; that the federal government and private foundations expand primary care research fellowships; and that Congress appropriate funds to provide support for institutions to develop a culture and infrastructure that is conducive to primary care research. (1996)

## **PRINCIPLES REGARDING GRADUATE MEDICAL EDUCATION AND SPECIALTY DISTRIBUTION**

The American Medical Student Association:

1. URGES the development of a universal qualifying exam for all medical school graduates for admission into U.S. graduate medical programs; this examination should:
  - a. contain mechanisms to directly measure the ability of physicians to care for patients; and
  - b. provide a criterion-reference rather than a norm-reference standard in evaluation of examinees.
2. URGES the inclusion of the following information in the AMA Directory of Approved Residencies and in the American Osteopathic Association (AOA) Opportunities Directory:
  - a. remuneration (stipend, cash living out allowance, cash for attending educational conferences);
  - b. night call schedule;
  - c. minimum number of positions available for each year of any sequential residency program.
3. ENCOURAGES the use and expansion of flexibly-scheduled or part-time internships and residencies in all fields of medicine and further ENCOURAGES such programs to be fully described and included in the AMA Directory of Approved Residencies and in the AOA Opportunities Directory and in the computer match program of the National Resident Matching Program (NRMP);
4. RECOGNIZES the NRMP as a valuable service but SUPPORTS improvements to the NRMP or alternative models that would provide more choice and increased negotiating abilities for applicants; (2000)
5. URGES all participants in the NRMP to adhere to the spirit, as well as the letter, of the NRMP, and SUPPORTS the attempts of groups, such as the Organization of Student Representatives, to monitor and report NRMP violations;
6. URGES the NRMP to investigate alternatives that will expedite the selection process and will allow adjustments for working spouses and those students who graduate earlier than the traditional May or June dates;
7. SUPPORTS the student-optimal algorithm as implemented in 1997 along guidelines proposed by AMSA; (2005)
8. SUPPORTS the input of medical students in all decisions regarding the Match by including a seat for medical students, with full voting privileges, on the NRMP Board; (1996)
9. SUPPORTS the concept of increased postgraduate programs in primary care on a national scale, though not to a uniform extent, recognizing unique goals, priorities and resources of individual institutions, and, further, SUPPORTS the regulation of the number of residency programs to affect a more significant redistribution of specialties, again recognizing the unique specialty institutions;
10. SUPPORTS more active involvement by State Licensing Boards in determining physician needs by specialty and geography within each state, such information to be distributed to physicians desiring licensure in that state;
11. URGES that medical students be allowed to take Part 3 of the National Boards and further URGES each Specialty Board to reevaluate current programs leading to certification with the goal of reducing the time required by the formal education program (i.e., allowing credit for electives taken in the specialty during medical school and/or internship);
12. OPPOSES delayed licensure of house staff;
13. BELIEVES that the resident duty hour regulations as adopted by the ACGME in July 2003 are currently insufficient to ensure maximized patient and resident safety and health, and URGES the ACGME to implement more thorough and comprehensive regulations as described in detail in the Principles Regarding Resident and Student Work Hours. (2005)
14. SUPPORTS efforts of house staff officers throughout the country to secure improved working conditions and improved standards of patient care;

15. SUPPORTS moonlighting as a beneficial and legitimate practice but does not regard it as an adequate solution to either inadequate house staff salaries or the maldistribution of health care;
16. SUPPORTS the recognition of interns, residents and clinical fellows as “employees” within the context of the National Labor Relations Act; and, that house staff organizations be recognized for collective bargaining;
17. SUPPORTS the concept of recertification of physicians by specialty boards requiring additional study in the respective area and periodic recertification exams;
18. URGES all institutions providing graduate medical education to establish standard maternity and paternity leave policies for house officers, which allow variation with the personal and medical needs of the individual but assure the individual a reasonable minimum time away from ward and clinic responsibilities if desired; and URGES the inclusion of these policies in all recruitment materials and contracts;
19. Regarding Emergency Medicine:
  - a. URGES creation and maintenance of emergency medicine departments at each medical school equivalent in status and with adequate financial support as to ensure quality similar to other major clinical departments of that school;
  - b. SUPPORTS the continued improvement and development of quality Emergency Medicine residency programs.
20. SUPPORTS continued funding of house staff salaries in teaching hospitals through patient care revenues, and BELIEVES that Medicare should pay its proportionate share of these services; (1985)
21. SUPPORTS efforts on the part of the federal government to influence the specialty distribution of physicians through allocation of funds to residency programs based on the projects need of certain medical specialties; (1985)
22. OPPOSES cuts in the funding of graduate medical education until studies presently underway are able to identify what accounts for the higher costs associated with being a teaching facility, and what effects these cuts would have on patient care and medical education. (1985)
23. STRONGLY URGES the Accreditation Council for Graduate Medical Education (ACGME) to amend the General Essentials of Accredited Residencies, Eligibility and Selection of Residents to read, “There must be no discrimination on the basis of sex, age, race, creed, national origin or sexual orientation and gender identity.” (1989)
24. STRONGLY URGES the AOA to incorporate in its Intern Training Program Policies and Procedures and its Residency Training Requirements a nondiscrimination policy to read “There must be no discrimination on the basis of race, color, sex, religion, creed, national origin, age, handicap or sexual orientation and gender identity.” (1989)
25. BELIEVES that all educational and professional opportunities should be equal for both allopathic and osteopathic students and professionals, including but not limited to, preceptorships. To this end, a single national match should be developed which would incorporate all ACGME and AOA approved graduate training programs. Such a match would eliminate the problem of osteopathic medical students reneging on AOA commitments to seek ACGME training; but would also allow osteopathic medical students to apply to BOTH AOA and ACGME approved programs, which the current AOA proposal (approved by the NRMP) would not. (1992) (2000)
26. ENDORSES the Third Report of the Council on Graduate Medical Education (Improving Access to Health Care Through Physician Work Force Reform: Directions for the 21st Century) and its recommendations, believing that on a nationwide level, the needs of society (as defined by AMSA’s policies) should be a factor in determining the overall distribution of physicians by specialty and by practice location. (1993)
27. SUPPORTS the creation of residency programs in underserved communities. (1994)
28. SUPPORTS requiring primary care residencies to offer rotations in underserved communities. (1994)
29. SUPPORTS increased federal funding for primary care residencies. (1994)

30. BELIEVES that abortion care should be a required component of Ob/Gyn residency training, with exemption on the basis of personal principles, and BELIEVES that Ob/Gyn and family medicine residents should have adequate opportunity to obtain experience in abortion care with a sufficient number of cases to obtain proficiency. (1994)
31. SUPPORTS the creation of a public all-payer pool for funding graduate medical education. This public all-payer fund should be tied to all public and private insurance premiums and should be designed to achieve policy goals serving the public's health. (1997)
32. SUPPORTS changing immigration law to tighten the visa process for foreign medical graduates ensuring that they return to their native countries for service upon completion of training. (1997)
33. SUPPORTS relocating the training of physicians at the undergraduate and graduate levels into accredited community, ambulatory and managed care based settings for a minimum of 25 percent of clinical experience. (1997)
34. ENCOURAGES the surgical, medical, and pediatric subspecialty groups and the ACGME to create and accredit, for each subspecialty, single-track residencies which will begin directly upon completion of medical school. (1997)
35. RECOGNIZES the value of the AOA osteopathic rotating internship and ENCOURAGES osteopathic graduates to enter such internships, but OPPOSES the requirement of completion of such an internship as a prerequisite to state licensure for D.O.s. (1998)
36. ENDORSES the 2005 COGME Report (COGME's 16<sup>th</sup> Report to Congress) and RECOGNIZES that there is a growing physician shortage in the United States that will reach the level of at least 90,000 full-time physicians by 2020 unless action is taken to address the shortage immediately; (2006)
37. ENCOURAGES medical schools to expand capacity and increase building of new medical schools to fill shortage of physicians; (2006)
38. ENCOURAGES continued federal and independent study on how to project trends in the physician workforce, especially in regards to specialty choice among medical school graduates. (2006)
39. URGES legislation that expands Medicare funds to support the expansion of undergraduate medical education in the United States. (2006)
40. SUPPORTS increase supply and distribution of physician/PA teams to meet anticipated shortage of healthcare service. (2006)

## PRINCIPLES REGARDING INTERNATIONAL MEDICAL SCHOOLS AND GRADUATES

The American Medical Student Association:

1. In regard to international medical schools:
  - a. OPPOSES the certification of international medical schools by any state that results in the circumvention of established national guidelines for the return of U.S. citizens and the entry of non-U.S. citizens studying in international medical schools;
  - b. URGES the federal government to initiate a comprehensive evaluation and accreditation process for all international medical schools that enroll significant numbers of American students, and especially the proprietary medical schools in the Caribbean. Such an evaluation should assess both basic science education and clinical training, using standards comparable to those utilized within the United States, and the information gained and conclusions reached should be made available to state licensing boards and residency programs. (1986)
2. In regard to international medical graduates and residencies:
  - a. RECOGNIZES the value of international medical graduates to the U.S. physician workforce; (2006)
  - b. OPPOSES drawing qualified international medical graduates away from their country of citizenship, contributing to workforce shortages around the workforce and decreasing health status of nations; (2006)
  - c. URGES the United States to fulfill its own medical work-force needs through the education of its own citizens and legal, permanent residents for the practice of medicine; (2006)
  - d. RECOMMENDS looking into ways to educate international physicians through exchange programs without a full residency; (2006)
  - e. URGES fulfilling the U.S. physicians workforce shortage through expanding the U.S.'s own medical school capacity instead of relying on the pipeline of internationally trained physicians; (2006)
  - f. Recommends the development of support systems to facilitate return of international medical graduates to their own countries, if they desire. (2006)
3. SUPPORTS continued graduate medical education funding through Medicare for those graduates of international medical schools who have passed both parts of the International Medical Graduate Examination in the Medical Sciences; (1986)
4. URGES that any phase out of graduate medical education funding through Medicare for graduates of international medical schools be implemented gradually, and ENCOURAGES the federal government, in the event of a phase out, to maintain federal funding for a limited number of residency slots available to qualified international medical graduates at the discretion of the residency program. International Medical Graduate enrollees should be under strict visa requirements such that they shall return to their country of origin following training; (1986)
5. URGES that postgraduate training be a truly educational experience for both foreign-trained physicians and United States graduates;
6. RECOGNIZES the difference between International Medical Graduates who are citizens or legal, permanent residents of the United States (US-IMGS) and International Medical Graduates who are not citizens of the United States (non-US-IMGS). (2000)
7. SUPPORTS the US-IMGS in the event of a reduction in the number of residency positions if the applicants are equally qualified. (2000)

## PRINCIPLES REGARDING PROFESSIONALISM AND PROFESSIONAL LIABILITY

The American Medical Student Association:

1. BELIEVES that physicians must prioritize patient care in order to gain public trust; (2007)
2. BELIEVES that physicians should prioritize patient care and strive to uphold high ethical standards in their practice; (2007)
3. FURTHER RECOGNIZES that physicians-in-training must also strive to work according to a professional ethos that will strengthen the public's trust in our profession; (2007)
4. BELIEVES patient well-being must always be the first concern of physicians and physicians-in-training—all other interests, commercial, career, etc. must not compromise patient care; (2007)
5. BELIEVES physicians and physicians-in-training must work to eliminate commercial influence in clinical practice, on medical education, and in scientific research; (2007)
6. BELIEVES physicians and physicians-in-training must be at the forefront of creating social systems that promote public health; (2007)
7. FURTHER BELIEVES physicians and physicians-in-training must always fight for universal access to quality healthcare and always work to identify and eliminate disparities in health; (2007)
8. BELIEVES patient autonomy over their own healthcare must always be respected, but physicians are never obligated to provide care they believe is contrary to maintaining the patient's health or dignity; (2007)
9. BELIEVES physicians and physicians-in-training must always strive to provide care that is based on the best scientific evidence and founded on solid basic science, clinical and social knowledge; (2007)
10. BELIEVES honesty with patients and maintaining patient confidentiality are critical to good patient care; (2007)
11. FURTHER BELIEVES physicians and physicians-in-training should always remain cognizant of their own power relative to patients and must never do anything to abuse this power; (2007)
12. SUPPORTS continuous research on healthcare delivery and efforts to improve patient care; (2007)
13. FURTHER SUPPORTS physicians and physicians-in-training to actively participate in conducting this research and taking leadership roles in implementing improvements; (2007)
14. BELIEVES physicians should take an active role in medical education and include training medical students and residents as a central part to their careers; (2007)
15. BELIEVES physicians should collectively ensure that the physician workforce be representative of the diversity found in the general population. (2007)
16. Regarding Medical Liability Reform:
  - a. BELIEVES that the primary goals of the medical liability system are to encourage the reduction of preventable medical errors, provide timely and fair compensation to injured persons, and to ensure physician accountability and professionalism. (2006)
  - b. SUPPORTS a comprehensive, multifaceted approach to medical liability reform that incorporates innovative and widespread strategies at the federal and state levels to reduce geographic disparities in medical liability policy. (2006)
  - c. BELIEVES that solutions to medical malpractice must be determined in collaboration among physicians, plaintiff and defense attorneys, patients, and other vested parties; (2006)
  - d. RECOGNIZES that the current medical liability system may affect the decisions of medical students, residents, and physicians with regards to specialty selection, job location, and the reduced provision of high-risk services. (2006)
  - e. BELIEVES that any medical liability reform needs to include both the legal system and the insurance markets because of state requirements for every physician to hold medical liability insurance. (2006)
  - f. RECOGNIZES that caps on non-economic damages represent simplified approaches that alone are not sustainable solutions to malpractice reform. (2006)



- g. RECOGNIZES that the medical liability “crisis” is a symptom of larger systemic problems in health care and should not be our sole focus of reform. (2006)
  - h. SUPPORTS reforms that provide for increased competition in insurance markets so that physicians are not left captive to single insurers or premium increases that lack public oversight. (2006)
  - i. SUPPORTS evidenced based reforms that include elements such as alternative dispute resolution, screening mechanisms that identify appropriate cases, deterrence of negligent acts with regards to physicians that commit malpractice frequently, increased efforts at transparency and medical error surveillance.(2006)
  - j. SUPPORTS tort reform policies that ensure patient’s timely and fair compensation and manageable costs to the healthcare system through limits on attorney fees and/or classification of avoidable injuries by State Boards. (2006)
  - k. SUPPORTS patient safety efforts that provide for early disclosure of health care errors and policies for improved adverse event surveillance, reporting, and subsequent quality improvement. (2006)
17. Regarding Injury Prevention:
- a. SUPPORTS research and other efforts to develop improved systems to detect medical injury and collect information about medical injury; (1992)
  - b. SUPPORTS efforts to reduce the incidence of preventable medical injury, including quality assurance and risk management activities. (1992)
18. URGES that there be no professional discrimination against equally qualified physicians based upon degree (M.D. or D.O.) in consideration for staff privileges and SUPPORTS a strong referral network between D.O.s and M.D.s.; (1989)
19. OPPOSES sexual contact between physicians and patients under any circumstances;
20. BELIEVES that out of professional concern for one’s patients, a physician or medical student should not smoke in a professional setting and CONDEMNS the practice of working under the influence of alcohol or other substances that impair their ability to adequately assess and treat patients. (1997)
21. BELIEVES it is the obligation of all physicians to attempt to educate their patients as to their conditions, the goals or various forms of treatment, and the patient’s role in his/her own treatment.
22. SUPPORTS a comprehensive, federal, no-fault system of childhood vaccine injury compensation, such as is provided by the National Childhood Vaccine Injury Compensation Act of 1986. (1987)
23. SUPPORTS an excise tax on vaccines, proportional to their incidence of adverse outcomes, as a mechanism for funding childhood vaccine injury compensation. (1987)
24. ENCOURAGES the development of a strict, formal and frequent peer-review system for physicians. A non-discriminatory system of due process should be created to address instances in which physicians have practiced negligent care. (1994)
25. OPPOSES the ranking of hospitals that is not based upon fully disclosed criteria, which are both objective and comprehensive. (1996)
26. URGES members to use only licensed software on handheld computers or personal digital assistants (PDAs) and ENCOURAGES further collaboration with the software industry to develop cost-effective solutions. (2005)

## **PRINCIPLES REGARDING ALLIED HEALTH-CARE PROFESSIONALS AND PERSONNEL**

The American Medical Student Association:

1. URGES that state certified nurses, nurse midwives and midwives be given more responsibility in the care of patients;
2. URGES the increased training of paraprofessionals within each medical field and specialty, such persons to be certified by a national examination and licensed by the states to aid physicians under close legally sanctioned supervision in the more efficient rendering of diagnostic and therapeutic techniques;
3. SUPPORTS increased funding of training of nurse practitioners, physician's assistants, nurse midwives, midwives and similar professionals, and ENCOURAGES that their collective expertise be employed to maximum efficiency; (1997)
4. SUPPORTS non-physician health and hospital workers in their efforts to organize for the purpose of collective bargaining;
5. URGES the strengthening of cooperative efforts between Medicine and Nursing to collaborate on a joint solution to hospitals' nursing shortages. (2005)

## PRINCIPLES REGARDING PHARMACEUTICALS AND MEDICAL DEVICES

The American Medical Student Association:

1. Regarding Government Policy:
  - a. URGES increased funding and regulatory power for the Food and Drug Administration (FDA) to enable it to ensure that pharmaceutical, diagnostic and other medical products are of the highest quality and safety; (2006)
  - b. SUPPORTS legislation that provides for the classification, testing and pre-market clearance of medical devices and encourages the development and use of new, approved devices; (2006)
  - c. SUPPORTS the incorporation of the National Drug Code into various drug compendia, SUPPORTS the mandatory utilization of the National Drug Code, its imprintation with bar codes on all drug containers and solid dosage forms, and ENCOURAGES the increased use of automated bar code systems at point of dispensation to reduce drug errors; (2006)
  - d. URGES adequate funding of the FDA or a federal agency to be charged with:
    1. coordinating and reviewing evaluative testing of bioequivalence and bioavailability of products and requiring it where indicated; (2006)
    2. requiring and reviewing comparative testing between new products and existing products in addition to placebo when such products already exist within the same class to determine if the new product is superior or equivalent to existing therapy; (2006)
    3. publishing lists of products it judges to be bio-equivalent or comparatively efficacious; (2006)
    4. receiving and evaluating challenges to previous bio-equivalency and comparative efficacy decisions. (2006)
  - e. URGES the FDA and pharmaceutical manufacturers to make widely available to physicians and pharmacists definitive reports on bioavailability and therapeutic equivalence and bulletins indicating current trends where studies are not yet conclusive;
  - f. OPPOSES efforts to allow the use of uncertified or unapproved drugs in the treatment of a medical condition without emergency approval; (2006)
  - g. SUPPORTS government programs or legislation to encourage innovation of new pharmaceutical products especially new molecular entities (NME), biologics, and medical devices, particularly for neglected, communicable, or life-threatening diseases in the United States and worldwide. (2006)
2. Regarding physician/industry interaction:
  - a. SUPPORTS the concept that the physician's role in pharmaceutical product selection remain primary;
  - b. ENDORSES the objective sources of therapeutic information on pharmaceuticals, such as the "Medical Letter of Drugs and Therapeutics," "Facts and Comparisons," "The American Hospital Formulary," and ENCOURAGES all institutions to provide independent sources, rather than relying upon industry sponsored sources such as the *Physician's Desk Reference*;
  - c. OPPOSES the use of promotional gimmicks and inappropriate gifts serving no educational or informational purpose to influence medical students or physicians; (1992)
  - d. OPPOSES the process by which the AMA's guidelines on gifts to physicians from industry were adopted by members of the medical community and its related industries; (1992)
  - e. OPPOSES the policy of giving training institutions sole control over the allocation of industrial funds for the purpose of physicians'-in-training participation in extracurricular educational activities; (1992)
  - f. ENCOURAGES the pharmaceutical industry, in cooperation with AMSA and other organizations representing physicians-in-training, to begin a continuing dialogue on the role of industry in medical education and in supporting legitimate medical education activities; (1992)

- g. BELIEVES that practicing physicians should maintain an independent financial posture vis-à-vis the pharmaceutical industry to avoid the potential of conflict of interests in prescribing for and treating their patients; (2002)
  - h. URGES all physicians, residents and medical students not to accept as end recipients any promotional gifts from the pharmaceutical industry. (2002)
  - i. URGES all hospitals and residency programs to discontinue the practice of pharmaceutical company-funded lectures and lunches. (2002)
  - j. URGES all hospitals and residency programs to discontinue the practice of disseminating information about off-site drug-company sponsored events. (2002)
  - k. OPPOSES granting CME credit for pharmaceutical company-sponsored events. (2002)
  - l. URGES all physicians not to accept honoraria on behalf of pharmaceutical companies for speaking at educational conferences and not to accept compensation for token consulting or advising. (2002)
  - m. OPPOSES the tracking of prescriptions by commercial entities and SUPPORTS legislation to limit access to individual prescription patterns of physicians by the sales and marketing departments of pharmaceutical companies. (2006)
  - n. SUPPORTS including curricula in medical school education concerning the ethics of physician-industry interactions, particularly in relation to pharmaceutical research and marketing. This curriculum may include: (2004)
    - 1. the research and development process for new drugs, including the cost of creating new medications and the role for physician-researchers; (2004)
    - 2. the decision-making process for prescribing medications, as it relates to the economics and bioequivalence of using brand name versus generic drugs; (2004)
    - 3. the impact of direct-to-consumer and direct-to-physician marketing practices employed by the pharmaceutical industry, as they relate to the physician-patient relationship; (2004)
    - 4. a review of the various guidelines concerning gifts from the pharmaceutical industry, including those issued by AMSA, AMA, and the Pharmaceutical Researchers and Manufacturers of America (PhRMA). (2004)
  - o. Strongly ENCOURAGES physicians and physicians-in-training to refuse pharmaceutical samples in cases in which equally effective, low-cost alternatives exist and utilize samples only in cases in which other lower cost therapies have been unsuccessful or are contraindicated. (2007)
3. Regarding Pharmaceutical and Medical Device Pricing:
- a. SUPPORTS efforts to reduce the cost of medications and medical devices for patients. Possible mechanisms to achieve lower prices include: (2006)
    - 1. Bulk purchasing by federal and state governments to allow the negotiation of lower prices; (2006)
    - 2. Compulsory licensing of pharmaceuticals and devices under patent protection; (2006)
    - 3. Re-importation of medications from industrialized countries, when the medications are approved for use in the United States; (2006)
    - 4. Maximum Allowable Cost (MAC) programs, only if all the following provisions are met:
      - a. that the physician be able to get a brand-name drug simply by certifying that it is his/her opinion that a specific product is needed; (2006)
      - b. that the pharmacist be reimbursed for a prescribed brand name-drug if he/she cannot reach the physician for permission to substitute; (2006)
      - c. that stringent quality controls be instituted regarding all substituted products to ensure they are, indeed, as safe and efficacious as the standard product. (2006)
    - 5. Mechanisms to encourage research and development through government grants and awards, including rewards for innovation with one-time monetary compensation in exchange for open patents on novel medications. (2006)
  - b. AMSA OPPOSES any limitations on bulk purchasing, especially for public healthcare agencies. (2006)

- c. SUPPORTS legislation to require physicians to prescribe pharmaceutical products by generic name and then to note in parentheses the name of a specific brand name or company whenever the physician will not allow substitution, and which requires pharmacists to pass along to the consumer any wholesale price differences between generic and brand-name drugs when the generic drug is dispensed;
- d. ENCOURAGES physicians to consider and make students aware of cost-effectiveness when recommending or prescribing commonly used drugs and to educate about affordable alternative therapies for patients who have financial limitations to pharmaceutical access; (2006);
- e. SUPPORTS legal action against pharmaceutical companies to mandate fair pricing in cases where essential medications are unaffordable to the general public and pricing is disproportionate compared with other national or international prices. (2006)

4. Regarding pharmaceutical advertisement:

- a. URGES that the advertising of all pharmaceutical and OTC products be maximally educational for both the public and physicians and meet the following criteria:
  - 1. medications should be portrayed as medicines with a specific purpose and not as cure-all panaceas;
  - 2. the advertising should not define a need that does not exist in a medical sense nor create a new need;
  - 3. the advertising should be factual and without pictorial or verbal representations which appeal to emotions rather than intellectual reasoning;
  - 4. patients and providers should be portrayed in a respectful and humane manner and not in a stereotyped or demeaning fashion with respect to age, sex, sexual orientation and gender identity, race and disability;
  - 5. the promotional content should be clearly identifiable as such and be as separate from the educational content as possible;
  - 6. a suggested retail price should be included in all detail advertisements;
  - 7. the statement, "If you are presently taking any other medicines, consult your pharmacist or doctor before using our product," should be included in all OTC drug advertisements. (2006)
- b. SUPPORTS required labeling of all cosmetic ingredients;
- c. OPPOSES drug industry-sponsored direct-to-consumer (DTC) advertisements. (2005)

5. Regarding pharmaceuticals and international health:

- a. CONDEMNS pharmaceutical companies that produce and export dangerous and controlled drugs to countries in quantities much greater than is used in those countries, and other parties contributing to illicit smuggling and sale of these drugs. (2006)
- b. SUPPORTS the use of the World Health Organization (WHO) Model List of Essential Drugs as a reference base which countries may use in developing national essential drug policies, while recognizing that what medicines are considered essential should be determined on a country-by-country basis by national authorities and that this may include medications not found on the WHO Model List of Essential Drugs. (2008)
- c. URGES the pharmaceutical industry to adopt policies of research, development, manufacture and pricing that support developing countries in making essential drugs and vaccines available to their peoples, without promoting use of drugs and vaccines not included on the WHO List of Essential Drugs. (2006)
- d. STRONGLY CONDEMNS any efforts by the pharmaceutical industry to reduce access to essential medications including by means of intimidation or boycott when a country uses flexibilities found in international trade agreements (such as compulsory licensing) to generically produce medications essential to that country's public health; (2008)
- e. SUPPORTS worldwide efforts, such as the Global Fund, to increase access to essential medicines to all people of the world suffering morbidity or mortality due to treatable life-threatening or disabling diseases

without discrimination due to gender, race, nationality, sexual orientation and gender identity, age or socioeconomic status. (2006)

6. Regarding research, intellectual property and access to essential medicines in resource-poor settings:
  - a. RECOGNIZES that Universities, as intellectual property holders, play a crucial role in the development of new medicines and medical technologies, and that how they patent and license these technologies can help determine whether individuals in developing countries have access to the end products of university research. (2003)
  - b. URGES Universities to utilize the following Principles, suggested by the institutional ethos of universities, when making patenting and licensing decisions that have potential impacts on access to essential medicines and medical technologies worldwide:
    1. University research is intended to advance the common public good, a primary element of which is the advancement of health.
    2. Global public health concerns need to be an important part of patenting and licensing decisions.
    3. The success of patenting and licensing programs should be measured according to their impact upon public health.
    4. University intellectual property policies should be implemented in a manner supportive of developing countries' right to protect public health and, in particular, to promote access to medicines for all.
    5. Technology transfer to develop capacity in developing countries is an important part of universities' mandate to advance knowledge and the social good. (2003)
  - c. URGES Universities to consider different strategies to implement these Principles, including not patenting or allowing their licensees to patent in developing countries, and issuing non-exclusive licenses for developing country markets. (2003)
  - d. RECOGNIZES that changes in University practices, with regards to intellectual property, will require collective action and leadership amongst Universities worldwide. (2003)
  - e. URGES Universities to act together to establish norms and implement strategies and best practices to promote access to essential medicines in developing countries. (2003)
  - f. URGES the pharmaceutical and medical device industry to respect the scientific process of research and discovery, including the following:
    1. SUPPORTS the right of researchers to freely publish their results without prior approval from sponsoring entities; (2006)
    2. OPPOSES publishing partial and incomplete results of studies, using ghostwriters and otherwise bypassing the peer-review process; (2006)
    3. OPPOSES the use of Contract Research Organizations (CRO) to conduct research outside of academic institutions; (2006)
    4. STRONGLY OPPOSES attempts by industry to retaliate against and/or intimidate individuals and groups working to improve pharmaceutical safety or government pharmaceutical policies. (2006)
7. Regarding Prescription Drug Reimportation: (2004)
  - a. BELIEVES that Canadian pharmacies, which are subject to similar quality control and chain of custody standards as the United States, have the ability to ensure the safety of prescription drugs. (2004)
  - b. RECOGNIZES that the reimportation of drugs from Canada is a temporary step towards improving access to affordable drugs from pharmaceutical companies within the United States. (2004)
  - c. SUPPORTS the reimportation of drugs from Canada as a temporary solution, until equivalent pharmaceuticals are available at equal or lower prices in the United States through bulk purchasing and price negotiation. (2006)
8. Regarding Liability of Pharmaceutical Companies:
  - a. SUPPORTS increasing the enforcement of pharmaceutical regulation and penalties on pharmaceutical companies for failing to disclose to the FDA any information concerning harmful effects of their products. (2006)

- b. OPPOSES legislation that would exempt pharmaceutical manufacturers from legal liability stemming from known harmful effects of their products. (2005)
9. Regarding Neglected Tropical Diseases:
- a. SUPPORTS increasing the priority of the so-called neglected tropical diseases on the global public health agenda. (2008)
  - b. CALLS UPON governments, non-governmental organizations, and industry to create a need-based drug research and development model for the neglected tropical diseases which could include, but shall not be limited to, the following interventions: (2008)
    - 1. Provide long-term, committed funding for basic science research into the neglected tropical diseases (2008)
    - 2. The use of transferable intellectual property rights (2008)
    - 3. Implementation of advanced purchase commitments (2008)
    - 4. The introduction of prize funds for drugs effective against the neglected tropical diseases (2008)
    - 5. Providing start-up monies for pharmaceutical research and development in developing countries. (2008)
    - 6. Providing start-up capital for small biotechnology firms both in developing countries and in the West whose business models aim to address neglected tropical diseases (2008)
    - 7. Development and implementation of “corporate social responsibility” policies by multinational pharmaceutical companies to address the need for a need-based model of pharmaceutical research and development (2008)
    - 8. The creation of Product Development Public-Private Partnerships (2008)
    - 9. The creation of open compound libraries (2008)
  - c. SUPPORTS the efforts of the Drugs for Neglected Diseases Initiative (DNDi) and the Institute for One World Health (IOWH) toward creating effective drugs against the neglected tropical diseases. (2008)
  - d. URGES monetary investment from governments, non-governmental organizations, and charitable giving to programs and initiatives working toward creating treatments for neglected tropical diseases. (2008)
  - e. URGES monetary investment from governments, non-governmental organizations, and charitable giving to programs and initiatives working toward developing public health initiatives for prevention of neglected tropical diseases. (2008)

## PRINCIPLES REGARDING HUMAN RESEARCH PARTICIPANTS

The American Medical Student Association:

1. SUPPORTS the concept that extra precautions must be undertaken to ensure that human participants in experiments give fully voluntary and informed consent and be educated as to the foreseeable consequences of such experiments;
2. SUPPORTS the concept that the welfare of the person must be considered as more valuable than experiment results;
3. ENDORSES the continuing efforts of the Department of Health and Human Services to review and recommend comprehensive research policies where human experimentation is involved;
4. AFFIRMS, in principle, nontherapeutic experimentation on human volunteers; however, URGES the prohibition of nontherapeutic experimentation involving prisoners and/or patients involuntarily committed to mental hospitals; all therapeutic experimentation must receive prior review and full approval from a board, complying with federal guidelines on human experimentation, charged with assessing the adequacy of scientific controls and the satisfaction of recognized ethical standards for research;
5. OPPOSES the use of Third World populations as experimental subjects to test devices, drugs, or procedures, such as contraceptives, without adherence to the guidelines of Human Experimentation, including informed consent in the patient's native language, as established by the U.S. Department of Health and Human Services.
6. REGARDS notification of affected individuals to be a right of the individual and a responsibility of the scientific investigator whenever significant scientific study, as reviewed by the National Institute of Occupational Safety and Health, finds individuals to be at increased risk of disease. Notification must include adequate explanation of the meaning of these results to the patient in language that the patient understands within the limits of available knowledge, along with referral to an appropriate health-care professional who can provide this explanation. (1985)
7. OBJECTS to the treatment of human research subjects in such a way as to be substandard to currently accepted treatment. No one should be denied such treatment based on the economic conditions of the region of study or inability to obtain such treatment whether or not the study was conducted. (1998)
8. ENCOURAGES the struggle of all health professionals to uphold in principle the highest standards of health care through combining beneficial advances in the art and science of medicine sensitive to the specific culture of the people whom they are serving. (1998)



## **PRINCIPLES REGARDING THE USE OF ILLEGAL DRUGS, ALCOHOL AND TOBACCO**

The American Medical Student Association:

1. In regard to education:
  - a. Regarding drug and alcohol use:
    1. SUPPORTS efforts to educate the public—especially school-aged persons—regarding drug use and addiction and alternatives to drug use; (2006)
    2. SUPPORTS drug education efforts, especially for school-aged persons, which encourage decision-making based on accurate information, self-knowledge and scientific data. These efforts should include, but not be limited to, abstinence from all substances. (2006)
    3. ENCOURAGES continued efforts in health education, which would inform children, adolescents and adults of the dangers involved in alcohol use, including its effects on decision-making and judgment. (1995)
    4. SUPPORTS educational programs for medical students, physicians and other health professionals concerning drug use and addiction. ENCOURAGES educational programs to provide adequate information about licit and illicit substances and their effects; discuss the consequences of overdose, withdrawal and addiction surrounding different substances; include harm reduction principles such as safer-use strategies for patients who are unwilling to stop using entirely; and examine the social contexts in which substance use occurs. (2006)
    5. Furthermore, since alcoholism constitutes a major health problem, AMSA ENCOURAGES all medical schools to include programs in the multifactorial disease/disorder of alcoholism in their curriculum with emphasis on early recognition and treatment of medical and behavioral manifestations, as well as the pathogenesis and epidemiology. All such programs should provide both factual knowledge and compassionate attitude with which to help persons in need of such treatment and include the components described in (4) above (2006);
    6. STRONGLY SUPPORTS efforts to educate the public regarding Fetal Alcohol Syndrome, its causes and effects, and that such efforts should include but not be limited to educational advertisements paid for by manufacturers of alcoholic beverages and appropriate warning labels on all alcoholic beverages. (1988)
  - b. Regarding tobacco use:
    1. STRONGLY ENCOURAGES all medical schools to include tobacco cessation in training for medical students, residents and practicing physicians. (1998)
    2. SUPPORTS physicians and physicians-in-training in becoming knowledgeable about current tobacco cessation techniques, in identifying tobacco users in their clinical encounters and in assisting these users to quit. (1998)
2. Regarding research:
  - a. URGES that additional funding be provided for research regarding the medical and psychological nature of addicting drugs and the epidemiology and appropriate treatment of addicted persons, including the psychological needs of female and male substance abusers and the fetal alcohol syndrome;
  - b. ENCOURAGES research regarding the feasibility of the prevention of the Wernicke-Korsakoff Syndrome by the addition of Thiamine to alcohol; (1985)
  - c. SUPPORTS appropriate clinical research in regard to the efficacy of therapeutic cannabis use in smoked, pill or other forms; (1999)

- d. SUPPORTS appropriate research into the potential to treat disease with psychedelic/entheogenic substances including, but not limited to, mescaline, LSA/LSD, psilocybin and harmaline. (2005)
3. Regarding health and treatment:
  - a. BELIEVES that drug abuse and addiction are not primarily criminal problems, but are health problems with socioeconomic and legal implications, and as such, should be dealt with by health professionals and, therefore, OPPOSES any legislation and/or actions by the Justice Department that fail to deal with drug abuse and addiction as health problems;
  - b. URGES that comprehensive, community-based drug treatment centers be widely available, including culturally competent treatment programs to meet the special needs of women, people of color, lesbian, gay, bisexual and transgender people, people with disabilities and other marginalized populations; (2006)
  - c. RECOGNIZES that there are many alternatives to problematic substance use, and that complete abstinence from all substance use is one, but not the only, solution; and therefore SUPPORTS the creation of community-based treatment modes that advocate self-determination, rational decision-making, and total health as defined by the patient, and which therefore may or may not include complete abstinence as part of a patient's treatment program. (2006)
  - d. SUPPORTS harm-reduction-based modalities, including but not limited to needle exchange programs, as proven and effective methods of promoting health and reducing harm among substance users who may not be ready to stop using entirely; (2006)
  - e. RECOGNIZES that the health needs of alcoholics and other substance users merit the same degree of attention and concern as the needs of any other segment of society and ENCOURAGES health professionals to provide compassionate and competent care to all patients, regardless of whether or not they use substances; (2006)
  - f. ENDORSES the addition of thiamine to alcoholic beverages as a preventive measure against Wernicke-Korsakoff Syndrome, but RECOGNIZES that this is neither a treatment nor a cure for alcoholism. (1986)
4. Regarding Advertisement and Manufacture:
  - a. URGES pharmaceutical companies, physicians and other health providers to exert greater discretion with regard to the manufacture, advertising, supply and distribution of often-abused prescription drugs such as amphetamines and barbiturates;
  - b. SUPPORTS legislation to ban all advertising for alcoholic beverages on radio and television, or require these advertisers to provide equal and comparable time for health messages about alcohol; (1985)
  - c. URGES alcohol companies to change their advertising campaigns to use only models who appear older than the drinking age, to eliminate advertisements promoting underage, irresponsible, or excessive drinking, and to include high contrast warning messages in all print ads and verbal warnings on television and radio ads. (1922)
  - d. URGES alcohol companies to include the drinking age on all packaging and advertisements in bold contrast print. (1992)
  - e. URGES stricter laws and law enforcement in an effort to reduce death and injury from automobile accidents, including the following provisions; labeling of alcohol products as not to be consumed immediately before or during driving;
5. Regarding government policy:
  - a. RECOGNIZES that drug use occurs within all segments of the population, regardless of race, economic status, culture, ethnicity, gender, sexual orientation and gender identity, or nationality, and therefore STRONGLY OPPOSES drug-related legislation and/or law enforcement tactics that selectively target poor people and people of color. (2006)
  - b. SUPPORTS a shift of emphasis of federal drug policy away from expensive and ineffective international interdiction policies and overly harsh, punitive policies that tend to disproportionately affect people of color and poor people, and toward innovative, community-based approaches, including, but not limited to alternatives to traditional incarceration, such as rehabilitation and community service; and community-based approaches to drug control, which may include community policing, restorative justice, and other

sustained coalitions between communities, healthcare workers, policy makers, law enforcement and other constituencies concerned with the public welfare. (2006)

- c. SUPPORTS appropriate measures to control alcoholism and other forms of addiction; including but not limited to: culturally competent, community-controlled prevention and treatment models; accessible and accurate drug and alcohol education programs; and adequate, nationally-standardized, labeling and packaging of legally-sold drug and alcohol products. RECOGNIZES that incarceration has not been shown to reduce rates of addiction, and therefore DISCOURAGES a criminal justice response to drug use instead of health-based approaches. (2006)
  - d. SUPPORTS efforts directed toward the prevention of intoxicated driving, especially innovative, community-based approaches (such as designated driver programs) that do not solely rely upon criminal justice-based solutions. (2006)
6. In regard to preventive issues:
- a. STRONGLY SUPPORTS increased public education programs regarding the health hazards of cigarettes and other tobacco products;
  - b. SUPPORTS those efforts aimed at preventing cigarette smoking in children, adolescents and other high-risk groups, as well as future research into discovering behavioral motivation behind smoking; (1995)
  - c. SUPPORTS a cigarette safety act that would authorize the Consumer Product Safety Commission to establish performance standards to ensure that cigarettes and little cigars have a minimum capacity for igniting smoldering upholstered furniture and mattress fires;
  - d. SUPPORTS the goal of the Surgeon General and of Healthy People 2010 to reduce the rate of smoking in America by 2010 to only 12% of adults and 16% of teenagers. (2003)
7. In regard to marketing and advertising:
- a. STRONGLY URGES the use of federal, state and local funds for television and radio anti-smoking messages as a major component of the anti-smoking effort, and URGES that an increased federal tax on all tobacco products be specifically used to supplement such funds.
  - b. SUPPORTS mandatory disclosure of the levels of tar, nicotine, and carbon monoxide produced by each brand of cigarette when smoked, such information to be included both on packages and in all cigarette advertising;
  - c. SUPPORTS a comprehensive policy both here and abroad discouraging the promotion, sales and use of tobacco products; (1986)
  - d. SUPPORTS Truth in Advertising where advertisers must explain to the public that nicotine intake depends on how they smoke and that nicotine can become an addictive drug; (1986)
  - e. OPPOSES any form of media advertising of tobacco products and SUPPORTS federal legislation prohibiting such advertising. (1987)
  - f. STRONGLY SUPPORTS legislation banning the advertisement of all tobacco products in government regulated media or requiring these media to give equal and comparable time for health messages related to tobacco use, and STRONGLY URGES the reduction of such advertising in nonregulated media. (1985)
  - g. SUPPORTS regulations requiring full disclosure of the constituents and additives of each brand of tobacco product. (1990)
  - h. SUPPORTS legislation outlawing the distribution of tobacco products as free samples or with coupons. (1990)
  - i. OPPOSES the sale of out-of-package cigarettes and BELIEVES this practice should be made illegal. (1992)
  - j. OPPOSES the sale of tobacco products in vending machines and BELIEVES this marketing method should be eliminated. (1992)
  - k. SUPPORTS a federal regulation requiring licensure for the sale of tobacco, increasing the legal age for tobacco purchase in all states to 18 years old and local enforcement of this age limit by requiring proof of identification. AMSA further SUPPORTS fines for vendors who do not comply and revocation of tobacco licenses upon multiple violations. (1992)

- l. SUPPORTS that the revenue from these fines fund anti-smoking education programs. (1992)
8. In regard to women and pregnancy:
  - a. SUPPORTS the increased funding and support of research of harmful effects of maternal smoking on the fetus; (1986)
  - b. URGES women who intend to become pregnant to stop smoking and urges physicians who care for such women to assist them in smoking cessation; (1986)
9. In regard to worldwide tobacco use:
  - a. SUPPORTS legislation prohibiting the U.S. Trade Representative, the Departments of State and Commerce, or any other U.S. agency from actively encouraging, persuading, or compelling any foreign government to import, market, promote, advertise, or distribute tobacco products. (1990)
  - b. SUPPORTS legislation requiring any manufacturer who sells tobacco products in the United States to place the same health warnings that are required in the United States in advertisements and on packages sold abroad, in the native language. (1990)
  - c. SUPPORTS restricting the use of U.S. funds by international trade and monetary agencies such as the World Bank and the International Monetary Fund from being used to provide financial or technical support for tobacco agriculture and manufacture. (1990)
  - d. ENCOURAGES increased U.S. funding and participation in international smoking control efforts. (1990)
  - e. ENCOURAGES the United States to organize an international collaborative project to gather health data on the health, economic and environmental consequences of worldwide tobacco use. (1990)
  - f. SUPPORTS a Framework Convention on Tobacco Control, which will strongly promulgate concrete methods to control tobacco corporate commerce and marketing in order to protect the health of all peoples from the carcinogenic effects of primary and secondary tobacco smoke. (2002)
10. SUPPORTS increasing insurance premiums for known, active smokers to shift the economic responsibility and cost back to those demanding more health services secondary to their tobacco-related illnesses;
11. STRONGLY SUPPORTS the use of federal tax on cigarettes to fund increased research on the prevention/treatment of cancer and cardiovascular disease and increased disease prevention programs; and URGES the discontinuation for tobacco production and the Tobacco Support Program, with said funds being used to finance a transition to the production of more healthful crops;
12. STRONGLY OPPOSES the continuation of federal price supports of tobacco crops;
13. SUPPORTS efforts to ban or restrict smoking in all public places, and that:
  - a. “public places” shall include public transportation vehicles and terminals, elevators, enclosed public places of recreation and entertainment, public waiting rooms of health facilities, public rest rooms, public schools and institutes of higher education, department stores, restaurants, bars, clubs, (2003) public meetings, public places of business and government-owned buildings; (1995)
  - b. smoking shall be banned in public places and until that time, provisions should be made for smoking and no-smoking areas with separate ventilation; (1995)
  - c. “no smoking” areas be large enough to comfortably accommodate all who wish to utilize them;
  - d. legislation in this area satisfy the following four elements identified by the American Lung Association as important in assuring the effectiveness of anti-smoking legislation:
    1. definition of terms, particularly those words which have more than one connotation (e.g., “public places”);
    2. requirement that plainly visible signs be posted in all areas where smoking is restricted or prohibited to alert everyone to the regulations in effect;
    3. clear delegation of authority: identification of the officials and/or agencies responsible for the publicity, posting and enforcement;
    4. designation of penalties for violations to provide incentives for adhering to the regulation;

14. URGES the Federal Trade Commission and the Food and Drug Administration (FDA) to recognize that low-yield cigarettes cannot be supported as being “better” for one’s health; (1986)
15. SUPPORTS research and public education on the deleterious effects of smokeless tobacco; (1986)
16. SUPPORTS the development of multi-component public programming and support groups to help tobacco users stop the destructive use of these products; (1986)
17. BELIEVES that out of mutual professional courtesy and respect, physicians and medical students should not smoke at professional meetings;
18. STRONGLY SUPPORTS regulation of all tobacco containing products under the statutes of the Food, Drug, and Cosmetics Act and the Consumer Product Safety Act, as are all other substances taken into the human body. (1989)
19. SUPPORTS the establishment of a Center for Tobacco Products at the Centers for Disease Control and Prevention to coordinate educational and research activities, launch a national counter advertising campaign, and provide grants to reduce tobacco usage among pregnant women, children and blue-collar workers, but SUGGESTS establishing the FDA as a regulatory authority on tobacco containing products. (1990)
20. OPPOSES exposing children to any form of tobacco whether inside or outside the home and SUPPORTS banning smoking in areas outside the home where children are, including, but not limited to schools, day care-centers and play areas; (1995)
21. STRONGLY OPPOSES any government subsidies for the growth, production, distribution or sales of tobacco and RECOGNIZES the potential economic impact of this resolution, and URGES federal action to facilitate developmental conversion of tobacco-dominated regional economies to alternative production. (1995)
22. ENCOURAGES state and local legislatures, state medical societies, medical professional societies, student groups, and other anti-tobacco organizations to support the introduction of local and state legislation to ban tobacco use in public places and businesses as a public health worker’s rights issue. (2003)
23. URGES businesses that serve alcohol to offer incentives to patrons who elect to be designated drivers. (2005)

## PRINCIPLES REGARDING REPRODUCTIVE RIGHTS, FAMILY PLANNING AND SEX EDUCATION

The American Medical Student Association:

1. BELIEVES that reproductive health services, reproductive rights and reproductive health education—as a means for women and adolescents to have self-determination in all aspects of their reproductive lives, including sexuality, health, and parenthood—are essential to women’s and families’ overall health and well-being; and SUPPORTS universal and ready access to men’s and women’s reproductive health services and education as a means for improving health disparities. (2006)
2. In regard to reproductive rights, AMSA:
  - a. SUPPORTS full access to the entire range of reproductive services, and improving access in rural and urban areas; (2006)
  - b. BELIEVES matters of reproductive health to be private and sensitive, and SUPPORTS the right of patients to make these decisions in confidence with their physician without the interference of any third party; (2006)
  - c. RECOGNIZES patients’ right to have accurate, unbiased information regarding the full range of their reproductive health options, and STRONGLY URGES all physicians to provide evidence-based, scientifically accurate information and to counsel patients on the entire range of options available for any reproductive health issue, regardless of any moral or religious beliefs about particular options. (2006)
3. In regard to contraception:
  - a. BELIEVES that unintended pregnancies can place an undue burden on women and their families; (2008)
  - b. BELIEVES birth control to be a form of preventive medicine;
  - c. SUPPORTS responsibly safe and cost-effective birth control, as follows:
    1. primary forms of birth control methods that prevent conception should be encouraged through:
      - a. education, which should include the potential and limits of varying contraceptive methods in preventing pregnancy as well as protecting from sexually transmitted diseases, and (1997)
      - b. increasing availability of those methods; (1997) including legislation that would increase subsidies for birth control for low-income women and students or that would provide safe birth control prescriptions over the counter; and (2008)
    2. as a secondary means, emergency contraception and/or abortion, with totally informed consent, should be fully accessible to all. (2008)
  - d. BELIEVES that the display and sale of contraceptive devices and the distribution of contraceptive information to all persons should be legal;
  - e. SUPPORTS the proposal that cost be no barrier in the availability of birth control information, devices and medications;
  - f. SUPPORTS contraceptive equity—insurance coverage for contraceptive devices and medications, including emergency contraception, at the same rate as other covered medications—for both private and public insurance, to achieve fair access and lower costs to patients; (2006)
  - g. URGES the strong opposition of legislative initiatives, which impair a physician’s capacity to respect the right of a woman to self-determination in matters of reproduction;
  - h. SUPPORTS over-the-counter availability of emergency contraception, and other contraceptive medications deemed as safe and effective by the FDA for over-the-counter use, to all women regardless of age; (2006)
  - i. OPPOSES the infiltration of politics into the scientific decision-making process of the FDA, especially with regard to contraceptive devices and medications; (2006)
  - j. URGES counseling about and access to emergency contraception as the standard of care for victims of sexual violence; (2006)

- k. TAKES THE POSITION and STATES publicly that a convenient, effective, and safe form of contraception for either men or women has not yet been produced and should become the goal of government and industry co-sponsored development programs; (2006)

4. In regard to abortion:

- a. BELIEVES that all women, regardless of age, social status or marital status have the right to obtain a legal, safe, voluntary abortion; (2006)
- b. SUPPORTS the use of federal, state, and local funds to provide abortions for women who are unable to afford them; and OPPOSES restrictions on the availability of funds for family planning clinics that offer, counsel for, or refer for abortion; (2006)
- c. BELIEVES that voluntary induced abortions should be available from all public hospitals on the same basis as any other medical or surgical procedure;
- d. OPPOSES policies that restrict funding for training residents and medical students in abortion procedures at federally funded institutions; (2006)
- e. BELIEVES that all medical schools should include education on abortion as part of their mandatory curricula, as set forth in AMSA's Principles on Medical Education; (2008)
- f. BELIEVES that all Obstetrics/Gynecology and Family Medicine residencies should offer training in abortion procedures; (2008)
- g. OPPOSES any policy at the local, state, or federal level that causes delay and increased medical risk in the delivery of abortion services to women of any age, including but not limited to, prohibiting abortion counseling and referral in health care settings which receive federal funds. (1992)
- h. OPPOSES the use of explicit visual and/or verbal representation of the products of abortion that tend to produce emotional trauma rather than provide useful information to a woman considering an abortion; (2003)
- i. BELIEVES that the question of when a conceptus acquires personhood is a complex, religious, moral and personal question that cannot be answered by medical science, and OPPOSES all legislation attempting to define personhood of a conceptus;
- j. Regarding clinic violence, AMSA:
  - 1. SUPPORTS a woman's right to an abortion performed in a safe and secure environment;
  - 2. CONDEMNS the violence directed against abortion clinics and family planning centers as a violation of the right of access to health care; (1985)
  - 3. SUPPORTS the Freedom of Access to Clinic Entrances law, and urges its enforcement to the fullest extent wherever possible; (1995)
  - 4. CONDEMNS any inflammatory rhetoric that encourages violence surrounding the abortion debate; (1995)
  - 5. STRONGLY URGES all health professional organizations/associations to publicly condemn violence directed against abortion providers, clinic workers and patients; (1995)
  - 6. STRONGLY URGES all health professional organizations/associations to demand the investigation and prosecution of perpetrators of clinic violence by all appropriate law enforcement agencies, including federal, state and local governments. (1995)
- k. OPPOSES the prohibition of intact dilation and extraction abortion. (1999)
- l. In regard to medical abortifacients:
  - 1. SUPPORTS the continued research and clinical use of all pharmaceutical abortifacients. (1998)
  - 2. RECOGNIZES that pharmaceutical abortifacients, although effective, do not replace the need for surgical abortion. (1998)

5. In regard to sex education:

- a. BELIEVES that appropriate, evidence-based sex education will contribute to health and well-being by improving adolescents' understanding of sex and sexuality and by reducing risky sexual practices,

unintended pregnancy, and the transmission of sexually transmitted infections among adolescents; and that sex-education programs should be evaluated on these outcomes to determine their effectiveness. (2006)

- b. BELIEVES that educating children and adults about sexuality from birth to adulthood should come from many sources including, but not limited to, schools, health professionals and home. (1995)
  - c. BELIEVES that sex and sexuality education should be based on, though not limited to, the following principles:
    - 1. enhancing self-esteem, such that young people feel good about themselves and are not available for exploitation and do not exploit others;
    - 2. understanding love and self-respect as the basic components of a person's sexuality;
    - 3. preparation for making responsible decisions in critical areas of sexuality, based on a universal value of not hurting or exploiting others;
    - 4. contributing to knowledge and understanding of the sexual dimension of our lives, focusing on feelings, communication and values;
    - 5. emphasizing situational and life skills; (1995)
    - 6. using honest and open communication and avoiding scare tactics to help young people develop knowledge of human sexuality; (2006)
    - 7. helping young people understand that lesbian, gay, bisexual and transgender people exist in their communities and should be treated with respect regardless of their sexual orientation or gender identity; (2008)
    - 8. recognizing that lesbian, gay, bisexual and transgender youth are students as well, and provide a safe environment for young people to be open about sexual orientation and gender identity; (2008)
    - 9. increasing knowledge of the unique health needs specific to adolescents, including lesbian, gay, bisexual and transgender youth; (2008)
    - 10. helping young people understand the need for equal opportunities for men and women; (2006)
    - 11. understanding that parenthood requires responsibilities and interpersonal skills that strengthen family life, such as communication and compromise. (2006)
  - d. SUPPORTS the establishment and the administration of comprehensive, evidence-based sexual education programs that include adequate information on and discussion of abstinence, contraception, barrier methods and other evidence-based safer sex and family planning practices; and strongly URGES the federal government and local school boards to provide preferential funding for such programs; (2006)
  - e. SUPPORTS education that is age appropriate, nondirective and starts at a young age; (1995)
  - f. SUPPORTS the establishment of programs for parents regarding adult sexuality, adolescent sexuality and their role as sex educators, with funding not compromising existing sex education programs;
  - g. URGES that physicians and medical students play a more integral role in teaching youth about sexuality. (1992)
  - h. SUPPORTS the use of randomized controlled trials to determine the effectiveness of sexual education programs (as outlined in 5.a) and refuses to support any additional federal funding for abstinence-only programs—as allowed under Section 510 of Title V of the Social Security Act or otherwise—as long as these programs are found to be either ineffective or less effective than comprehensive sexual education programs. (2002)
  - i. STRONGLY recommends that individuals conducting sexual education programs receive standardized training and material to be distributed to students and that students should be randomly polled on the amount and type of information received to insure the program meets its original goal: increasing comprehensive sexual education. (2002)
  - j. STRONGLY URGES neutral, third party scientific oversight of the content of federally- or state-supported sex education curricula. (2006)
6. In regard to fertility and sterility:
- a. BELIEVES that every person has the right to control his/her own fertility;



- b. SUPPORTS sterilization as an acceptable form of birth control when totally informed consent has been given by the individual involved;
  - c. SUPPORTS the availability of sterilization of adults without requirements concerning parity and marital state;
  - d. BELIEVES that it is preferable, but not required, that a marital partner give informed consent for his/her spouse's sterilization;
  - e. OPPOSES sterilization by other than free, uncoerced choice or as a genocidal or discriminatory device;
7. In regard to sexually transmitted infections:
- a. SUPPORTS the reporting to proper authorities of each case of a sexually transmitted infection in accordance with the laws of each state, and URGES the medical community to recognize its contribution to the incidence of sexually transmitted infections as a consequence of laxity in such required reportings. (2003)
  - b. SUPPORTS the widespread availability of safe and effective vaccines for sexually transmitted infections when and if they become available; (2006)
8. In regard to the rights of pregnant women:
- a. STRONGLY URGES pregnant women to avoid practices, which may be hazardous to themselves or their fetuses; (1987)
  - b. ENCOURAGES women to consult with a health care professional, but SUPPORTS the legal right of women to make the ultimate decisions regarding their pregnancies and births; (1987)
  - c. OPPOSES any new legislation or interpretation of existing laws, which would criminalize any otherwise legal actions by pregnant women, whether or not such actions are deemed to be medically injurious to a fetus; (1987)
  - d. OPPOSES any policies that excessively punish pregnant women, above and beyond non-pregnant women, who commit criminal acts that may also harm their fetus based on concern for/injury to the fetus, including, but not limited to, illicit drug use; (2006)
  - e. OPPOSES court ordered medical interventions, irrespective of the indications for such procedures, where the woman is legally competent of informed consent; (1987)
  - f. URGES the active support of legislation designed to expand options available to childbearing women, including federal financial support for those unable to provide for a child, federal support of child-care programs for working and student mothers, and federal financial support for prenatal and postnatal health care; (1988)
  - g. BELIEVES every pregnant woman in the United States has the right to and must be guaranteed access to comprehensive maternity and infant care regardless of location or ability to pay. Where:
    - 1. Comprehensive maternity and infant services should be defined as the full range of maternity and well child services, including but not limited to early and continuing prenatal care, medical, psychosocial, educational and nutritional services, and postpartum care including family planning services, inpatient neonatal services and well-child services up to the age of 5 years.
    - 2. The pregnant woman has choice of providers from among all types of licensed medical and health providers, including physicians and state licensed midwives and certified nurse midwives, health departments and community health centers.
    - 3. Pregnant women should have the choice of licensed facilities in which to deliver, including Joint Commission on Accreditation of Hospitals, certified hospitals and accredited birthing centers.
    - 4. In providing for such services, it must be recognized that early prenatal care is for the benefit of the child and that early care is of the essence. Therefore, incentives and education on the issue of the importance of prenatal health care to encourage the mother's early participation should be considered.
    - 5. Pregnant women should have the choice to deliver at home and be attended by their choice of consenting physicians, state licensed midwives and certified nurse midwives.

## PRINCIPLES REGARDING STUDENT HEALTH SERVICES

The American Medical Student Association:

1. SUPPORTS the provision of complete preventive medical care by the student health services at all schools of higher education to enrolled students, such care to include, but not limited to:
  - a. periodic Pap Tests at intervals recommended by the American Cancer Society;
  - b. instruction in the standard techniques of breast and testicular self-examinations; (1995)
  - c. complete contraceptive information and provision of contraceptive devices and medications;
  - d. pregnancy testing and counseling services, including referral for abortion, if desired, by the patient;
  - e. HIV and sexually transmitted disease information, testing, treatment, and pre- and post-test counseling; anti-HIV antibody testing should be performed in a manner consistent with the Principles Regarding HIV, including its voluntary nature, the maintenance of confidentiality, and the provision of informed consent. In addition, information as to where to obtain anonymous testing, if desired, should be available;
  - f. psychiatric counseling and/or other mental health services, which may include provisions for outside services, that is discreet and confidential to protect the student, that is easily accessible to the student to insure timely, acute intervention if necessary, and that is familiar with difficulties experienced by medical students such as depression, anxiety, substance abuse and eating disorders; (1997)
  - g. provision, with informed consent and priority allocation based on relative risk of infection, medically appropriate testing for prior immune status of vaccines for all preventable infectious diseases, including, but not limited to Hepatitis B, to students who participate directly in the delivery of health care as a part of their educational program. In the absence of third party reimbursement or free provision of vaccines by governmental agencies or private companies, the institution should assist the individual by providing a payment schedule that will allow the prompt administration of the vaccine;
  - h. should offer voluntary and confidential screening to the medical student population for mental illnesses that commonly occur in that population; (1997)
  - i. should provide accessible education about mental illness among medical students and provide information on time management and stress reduction. (1997)
2. URGES that all care be available without parental consent and without the disclosure of care being communicated to parents, guardians or school officials;
3. URGES that all records be maintained in a strictly confidential manner, subject to release or other access only upon written consent of the patient involved.
4. URGES all medical schools to offer an affordable group health insurance policy to its students that includes tail and disability components and without caps. (1991)

## PRINCIPLES REGARDING FOOD AND NUTRITION

The American Medical Student Association:

1. RECOGNIZES freedom from hunger as a basic human right;
2. ENDORSES the Surgeon General's report, Healthy People 2010 (2003) and the Departments of Agriculture and Health and Human Services "Dietary Guidelines for America," and SUPPORTS the following nutritional guidelines as general recommendations for the public in pursuit of health promotion and disease prevention:
  - a. reduce consumption of saturated fat, hydrogenated oils and cholesterol, replacing these with an increased proportion of unsaturated fats, especially mono unsaturated fats; (2005)
  - b. reduce the intake of sodium salts, of sugar, other caloric sweeteners, caffeine and processed foods; (1995)
  - c. to avoid being overweight, consume only as many calories as expended; if overweight, decrease caloric intake and increase energy expenditure; (1995)
  - d. increase the consumption of unrefined low glycemic index carbohydrates in an overall plan to decrease the glycemic load of the diet; (2005)
  - e. increase the consumption of unsweetened fruits and vegetables to at least five servings a day; (1995)
  - f. increase the consumption of fiber and antioxidants;
  - g. decrease the consumption of meat and meat products to no more than two to three servings per week, and increase the consumption of vegetable proteins and fish rich in omega fatty acids, unless the health of the individual would be negatively impacted (as with the risk of mercury poisoning in pregnant women) or the health of the species (as with over-fished and threatened populations). (2005)
3. SUPPORTS federal food safety laws, which prohibit the addition of any carcinogenic coloring, flavoring or texturizing agent to processed food products;
4. SUPPORTS the promulgation of federal regulations that require the exact quantitative nutritional labeling of calories, protein, fats, sodium and fiber content in all processed foods, food supplements, over-the-counter drugs, and products of national fast food chain restaurants, defined as those restaurants that have at least 20 franchise or chain restaurants and have restaurants in greater than one state. (2003)
5. In regard to infant nutrition:
  - a. STRONGLY SUPPORTS patient education about breast feeding; DISCOURAGES substituting infant formula for human breast milk unless indicated by medical or personal reasons not influenced by promotional methods; (1995)
  - b. SUPPORTS the establishment of mandatory nutrient standards and pre-market testing requirements for all infant formulas;
  - c. SUPPORTS federal legislation to ensure achievement of such standards by all infant formulas produced and marketed in the United States;
  - d. SUPPORTS the International Code of Marketing of Breast Milk Substitutes adopted by the 34th World Health Assembly of the World Health Organization (WHO);
  - e. OPPOSES the vote cast by the United States against the International Code of Marketing of Breast Milk Substitutes at the 34th World Health Assembly of the WHO;

- f. URGES all companies manufacturing, distributing, and promoting breast milk substitutes to comply voluntarily with all articles of the International Code of Marketing of Breast Milk Substitutes;
  - g. URGES professional medical associations, especially the American Medical Association and the American Academy of Pediatrics, to support the International Code of Marketing of Breast Milk Substitutes, to oppose the U.S. vote against the Code, and to urge industry to voluntarily comply with all articles of the Code.
  - h. SUPPORTS a renewed boycott of products manufactured or marketed by Nestle and American Home Products, which will be terminated when the companies' marketing practices conform to WHO policy. (1990)
  - i. URGES the U.S. government to support UNICEF and WHO in their call for health professionals worldwide to implement the measures required to protect, promote and support breast feeding, and to refrain from promoting individual brands of infant formula. (1990)
6. URGES that Congress and the administration recognize the growing threat of hunger in America and establish fulfillment of basic nutritional needs for all persons as a priority in their health policy goals. (1987)
  7. URGES that the federal, state and local governments enable individuals receiving welfare, families and individuals below the poverty line, those at risk of needing welfare, and the working poor to receive adequate nutrition through:
    - a. Providing sufficient funding for assistance programs and increasing the monthly benefits to an adequate level. (1995)
    - b. Development of innovative methods such as electronic card systems instead of vouchers or money, to prevent fraud, reduce cost and simplify the process of application and distribution of benefits. (1995)
    - c. Expanding school meals to include breakfast and lunch at all schools, considering innovative programs such as privatization. Improving the nutritional value to meet AMSA's nutrition policy as designated above, for all school meals. (2005)
    - d. Modeling the Food Stamp Program after the Women, Infants and Children program (WIC) to provide nutritional counseling for participants. (1995)
    - e. Encouraging independence and transition from the system through improvement in employment opportunities and providing benefits on a sliding scale to the working poor. (1995)
  8. URGES that congress establish a comprehensive national nutrition monitoring system that will provide data on nutritional status of the U.S. population at large, and of high-risk groups in particular. (1987)
  9. OPPOSES the irradiation of food as a preservative process until such time as it has been scientifically demonstrated that such processing; (1988)
    - a. does not diminish the nutritive properties of the food more than other preservation processes, (1988)
    - b. does not lead to harmful effects in the persons who consume such food, and (1988)
    - c. does not impose a health or safety threat to workers in processing plants, nor does such processing or production, transportation and storage of the needed radioactive elements and by-products of such processing pose significant risk of polluting the environment. (1988)
  10. SUPPORTS the application of uniform standards for "organically" grown food, requiring that to be labeled organic: (1991)

- a. Products be produced without pesticides, except for a limited number of specified natural or biological substances that are proven to be safe.
  - b. Products be produced without synthetic fertilizers.
  - c. Crops be grown on soil free of pesticide application for three years and free from synthetic fertilizer application for two years.
  - d. Farms use “integrated” soil management and “integrated” pest management practices, which include methods of crops rotating, use of natural predators and organic fertilizers in farming practices.
  - e. Food processors use no artificial food additives or ingredients, synthetic materials or irradiation in their products.
11. SUPPORTS the labeling of all genetically modified foods, in which genes from one species are transferred to another in an effort to increase the expression of ‘desirable’ traits. (2001)
  12. OPPOSES the marketing of foods poor in nutritional value to children in schools and through media outlets, (2006)
  13. ENCOURAGES communities to urge the prevention and termination of such marketing efforts. (2006)
  14. URGES the food and media industries to discontinue this practice and instead use its power to promote healthy food choices. (2006)
  15. SUPPORTS legislative action aimed at decreasing unhealthy food marketing to children. (2006)
  16. SUPPORTS measures that would protect students from exploitation by prohibiting a business from bringing into the school any program that would require students to view advertising of foods poor in nutritional value or to study specific instructional programs as a condition of the school receiving a donation of money or donation or loan of equipment. (2001)
  17. SUPPORTS the use of any revenues from taxes on sugar-sweetened beverages to be used for nutrition education and advertising of healthy foods. (2005)
  18. URGES the phase-out of all non-therapeutic uses of medically important antibiotics in animal agriculture, unless the Food and Drug Administration concludes that continued use of a drug will not contribute to resistance affecting humans. (2005)
  19. URGES the US Government to pursue a policy to increase the consumption of fruits and vegetables through various means such as decreasing the price of fruits and vegetables, healthy food stamp programs, and advertisement and awareness campaigns. (2006)
  20. URGES the US Government to pursue a policy to increase access of fruits and vegetables to lower income citizens. (2006)

## **PRINCIPLES REGARDING THE FOOD INDUSTRY**

The American Medical Student Association:

1. In dealing with companies from the food industry
  - a. **REQUIRES** that all money be used with the understanding that this is not direct product promotion or endorsement. (1990)
  - b. There is no right of approval or censorship given to the donor. (1990)
  - c. All nutritional information should not conflict with the U.S. Dietary Guidelines. (1990)
2. **ENCOURAGES** that the food provided at AMSA events at the national, regional and chapter level abides by the following guidelines as best as possible given budgetary constraints: (2005)
  - a. **EMPHASIZES** healthy eating choices by offering foods that meet the nutritional standards as outlined in the Principles Regarding Food and Nutrition, which includes but is not limited to: (2005)
    1. Providing fresh fruits and vegetables; (2005)
    2. Increasing the amount of healthy carbohydrates; (2005)
    3. Decreasing the amount of foods with saturated and trans-fats; (2005)
    4. Avoiding beverages with added sugar. (2005)
  - b. **REFLECTS** the dietary customs of the persons in attendance by offering vegetarian, vegan, Halal, Kosher and other specialized diets, as determined by request or reasonable expectation of the persons at the event. (2005)

## PRINCIPLES REGARDING WORK AND THE WORK ENVIRONMENT

The American Medical Student Association:

1. SUPPORTS the premise that any level of radiation exposure may have serious health effects and that all x-ray practices be continually reviewed by medically or technically qualified officials in that patient and employee exposure occur only when medically necessary;
2. SUPPORTS efforts to provide adequate compensation, if need be, by arbitration, for workers and their families who have suffered injury or death from occupationally related health hazards such as asbestos, and CONDEMNS the use of Chapter 11 of the Federal Bankruptcy Code as a means of escaping legitimate responsibility for providing such compensation;
3. ENDORSES the efforts of those groups seeking to compel Occupational Safety & Health A to establish field sanitation standards for migrant and temporary field workers, either through court challenges or legislation.
4. In regard to drug screening and drug impairment:
  - a. OPPOSES random drug screening on principle, but wishes to recognize that it exists, and suggests appropriate limits to its use; (1987)
  - b. BELIEVES that drug testing is a screening measure only and that positive results must be confirmed by a second, more accurate testing method before being used as the basis for any action taken by the employer. Additionally, the employee has rights to due process and to appeal positive test results; (1987)
  - c. BELIEVES that a positive test result merely indicates possible use of a particular drug and not necessarily impairment, and that any test result should be interpreted by a health-care professional who has access to a thorough, confidential drug history of the person whose sample is being analyzed; (1987)
  - d. URGES that urine drug screening and confirmation of positive results be performed by certified medical technicians in licensed laboratories using nationally accepted levels of quality assurance, security. Also, it is of paramount importance that confidentiality be maintained. Testing shall be done by an independent lab paid by the employer. Notification of first result will be provided only to the employee. Both employee and employer will be notified of second test results; (1987)
  - e. URGES that employers, both in the public and private sector, refrain from instituting policies calling for mandatory random urine drug screening, and that employers reserve such tests for employees for whom there is strong cause to suspect abuse of drugs which impair the employee's performance of expected duties; (1987)
  - f. URGES all employers, both in the public and private sector, to allow, if not encourage, employees who are found to be impaired as a result of substance abuse to participate in treatment programs, with medical leave, in lieu of termination of employment, and that upon successful completion of such treatment programs, that the employee have the opportunity to return to his/her former position; (1987)
  - g. OPPOSES categorically the use of pre-employment drug screening as an unwarranted search and seizure and invasion of privacy; (1987)
  - h. URGES all employers, both in the public and private sector, to publicize to all employees the policy on drug use and impairment, drug screening, consequences of refusing to be tested, and consequences of a positive confirmed test; (1987)
  - i. URGES pre-notification of all potentially affected employees that such a program is to be instituted. (1987)

5. SUPPORTS the right of workers to be informed of the specific, adverse health effects they may be at risk for as a consequence of their occupation and/or work environment, and furthermore; (1989)
6. SUPPORTS the development and implementation of programs to notify workers of their occupational disease risk and to provide medical surveillance for the occupational diseases such workers are potentially at risk for developing; (1989)
7. URGES the Department of Energy to release and make public health records of workers at nuclear weapons production facilities so that these workers are informed about past exposures to radiation and toxic substances and may then take appropriate medical actions depending on the level and extent of exposure to said substances; (1990)
8. URGES the government to mandate that businesses provide unpaid leave to employees for the birth or adoption of a child or the serious illness of the worker or an immediate family member (including nontraditional family members), if such leave does not create undue economic hardship for the business. (1992)



## PRINCIPLES REGARDING PHYSICIANS AND THE ARMED FORCES

The American Medical Student Association:

1. OPPOSES national registration or conscription for military purposes;
2. ENDORSES the concept that all medical personnel of the uniformed military services are, and should remain, noncombatants as defined by the Geneva Convention;
3. BELIEVES that in the event of physician conscription, it should be without regard to sex; and the period of draft eligibility should be in the premedical years and immediately after completion of the Postgraduate Year 1 for a sum total of years not to exceed that of the general nonphysician population;
4. BELIEVES that if, and only if, obligatory conscription becomes a governmental policy, that conscription be universally applied without regard to sex, race, income, or sexual orientation and gender identity and allows for the individual's participation in choosing a program that responds to the nation's need;
5. With regard to the Health Professions Scholarship Programs: (2008)
  - a. FAVORS Health Professions Scholarship Programs to branches of the United States Uniformed Services that do not discriminate based on race, gender, economic status, or sexual orientation and gender identity. (2004)
  - b. SUPPORTS individual AMSA members who are able to participate in all scholarship programs within the Uniformed Services, regardless of the scholarships own policies. (2004)
6. URGES the repeal of all Department of Defense directives and regulations requiring the discharge or prosecution of members of the armed forces for reasons of sexual orientation and gender identity; (1985)
7. BELIEVES that the ability of a patient to fully disclose information regarding her/his sexual orientation and gender identity is crucial to a successful physician-patient relationship and to the provision of quality healthcare and OPPOSES the practice of military physicians reporting the sexual orientation of their patients to commanding officers or to anyone else when it is not necessary for health purposes; (2008)
8. OPPOSES admissions discrimination by the Uniformed University of the Health Sciences and hiring discrimination by all military residency programs on the basis of sexual orientation and gender identity. (1985)
9. URGES the Director of Advertising for The New Physician to search for other sources of advertising income other than the Armed Forces of the United States, until such time that the Armed Forces are in compliance with the stated principles of American Medical Student Association with regard to discrimination.
10. SUPPORTS the efforts of groups within AMSA to increase awareness of discrimination in the military through fall workshops, convention planning and *The New Physician*. (2008)

## **PRINCIPLES REGARDING STUDENT RIGHTS AND RESPONSIBILITIES**

The American Medical Student Association:

1. ENDORSES the following Code of Medical Ethics for medical students and ENCOURAGES students to abide by it (1999)
  - a. A medical student shall be dedicated to learning the art and the science of medicine, and shall pursue this course of study with compassion and respect for human dignity;
  - b. A medical student shall approach the study of medicine with the utmost academic integrity, deal honestly with patients and members of the health care team, and shall seek to promote these virtues in one's colleagues;
  - c. A medical student shall respect the directives of one's superiors and recognize a responsibility to seek changes in those requests that seem contrary to the wishes or best interests of the patient;
  - d. A medical student shall respect the rights of patients, of fellow students and of members of the health-care team, and shall safeguard patient confidences within the constraints of the law;
  - e. A medical student shall not accept patient care responsibility, perform any action, nor allow oneself to be identified in a manner that is beyond one's level of training or competence; one shall ask for supervision when appropriate, assistance when necessary, and never allow patients or patients' families to believe that one is anything but a medical student;
  - f. A medical student shall recognize the importance of participation in activities contributing to an improved community;
  - g. A medical student shall acknowledge the importance of social, economic and psychological factors impacting upon health;
  - h. A medical student shall serve patients to the best of one's ability regardless of diagnosis, race, sex, ethnicity, national origin, sexual orientation and gender identity, physical or mental disability, socioeconomic status, religion, or political beliefs;
  - i. A medical student shall not allow competitiveness with colleagues to affect patient care in an adverse manner;
  - j. A medical student shall guard one's own health and well being; likewise, one should strive to promote wellness in one's colleagues, including assisting impaired colleagues to seek professional help, and accepting such help if one is impaired.
2. ADOPTS the following Medical Student Bill of Rights and Responsibilities: (1999)

### **A CONCISE STATEMENT OF MEDICAL STUDENTS RIGHTS AND RESPONSIBILITIES:**

**A working draft proposed by AMSA Working Group on the Medical Student Bill of Rights (MSBR).**

**MEDICAL STUDENTS HAVE THE RIGHT TO:**

1. a high-quality training program in an institution committed to their mentoring and education, which will prepare them to become competent, compassionate and ethical physicians.
2. shape the content of their education.

3. meaningful and significant representation at their individual institutions and on state/national organizations on matters concerning all aspects of their training.
4. learn in a safe and humane environment where education is the primary goal, without compromising patient care.
5. be informed of their institution's policies and procedures pertaining to promotion, graduation and student well being.
6. take a leave-of-absence for personal reasons (e.g., which includes gender-neutral child and family leave, etc.) without fear of recrimination, dismissal, or retribution.
7. access confidential, timely and appropriate health care and/or support systems in the event of personal and/or health related difficulties.
8. confidential, timely and fair systems for evaluation/feedback regarding academic and clinical performance and to address individual/systemic grievances without fear of recrimination, dismissal, or retribution.
9. due process at their home institution with fair representation in hearings, mediations and appeals.
10. complete their education and training if in good standing and to continue their medical education in the event that their home institution ceases to operate.
11. not to be penalized for their moral ethical or religious objection to participation in the procedure. Such refusal to participate shall not be based on the patient's race, age, religion, sex, disability, ethnicity, socioeconomic status and sexual orientation and gender identity.
12. be provided an adequate testing environment with appropriate accommodations. (2000)

#### MEDICAL STUDENTS HAVE THE RESPONSIBILITY TO:

1. commit themselves to the conscientious, respectful and thoughtful service of their patients.
2. vigorously and independently pursue excellence in their lifelong education.
3. educate their patients and colleagues.
4. conduct themselves in a professional and ethical manner.
5. notify the appropriate body in a timely manner of any problems, which adversely affect their training, and participate in the process of program improvement and development.
6. pursue mental and physical support for any conditions that might compromise their educational goals or patient care.

THIS MEDICAL STUDENT BILL OF RIGHTS APPLIES TO ALL STUDENTS REGARDLESS OF RACE, AGE, RELIGION, SEX, DISABILITY, ETHNICITY, SOCIOECONOMIC STATUS, SEXUAL ORIENTATION AND GENDER IDENTITY,.

3. ENDORSES the Joint Statement of the Academic Freedom of Students of the American Association of University Professors and the National Student Association as a description of the rights, privileges and responsibilities of students in general;
4. URGES each medical school to adopt guidelines and provide counseling in the event of an accidental blood product exposure with HIV transmission, including needle stick, laceration and eye splash. These guidelines should ensure confidentiality. The medical schools should be responsible for the medical cost resulting from the exposure. (1991)
5. Regarding student representation and voice:
  - a. BELIEVES that a representative number of students, selected by their peers, should be included on all decision making bodies within a medical school, such students to be active participants with full voting privileges;

- b. SUPPORTS the concept that the granting of tenure for medical school teaching faculty be dependent, in part, upon favorable student evaluations of teaching performance;
  - c. SUPPORTS the recognition by all governments of students basic rights, privileges and responsibilities, especially the right to actively participate in their own governing. (1990)
  - d. DEPLORES the use of violence to repress nonviolent student democratic movements. (1990)
6. Regarding student evaluations and records:
- a. URGES that all medical school personal data and record-keeping systems have safeguard requirements that:
    - 1. prohibit any such system whose very existence is secret;
    - 2. prohibit the release of student records without the student's written consent;
    - 3. allow an individual to know what personal information is stored and how such information is used;
    - 4. allow an individual to correct or amend personal data and records;
    - 5. ensure the reliability of data stored and prevent the misuse of such data.
  - b. BELIEVES that nationally administered standardized educational testing should be subject to public scrutiny and should serve as a learning experience for examinees;
  - c. ENDORSES the principles of Truth-in-Testing by which test subjects are provided equal access to their test responses, scores, test questions, correct answers and the protection of appeal, including tests which report results as pass or fail. In such cases, the above information will be provided upon written request from the test taker, with the stipulation that the use of these scores are prohibited by any person or institution for purposes other than the test subject's own edification/verification;
7. Regarding Medical School Policy:
- a. URGES schools to publicize clearly, in readily accessible catalogues, student handbooks, etc., all policies and procedures concerning both academic performance and nonacademic disciplinary decisions including, but not limited to, the following:
    - 1. rules for conduct of students, faculty and staff, including criteria justifying nonacademic dismissal;
    - 2. a clear definition of its procedures for evaluation, advancement and graduation of students, specifying criteria that justify academic dismissal;
    - 3. a clear delineation of what the school interprets to be the distinctions between academic and nonacademic criteria;
    - 4. all procedures of due process and appeal;
  - b. URGES that no later than the first class meeting in each course:
    - 1. academic requirements should be specified and publicized, in writing, for that course;
    - 2. regulations, such as compulsory attendance, tardiness, etc., should be precisely stated for that course;

3. standards of evaluation should be precisely stated in writing, including procedures for submitting work, penalty for exceeding deadlines, weight of various course components, and the exact procedure for grading;
- c. BELIEVES that as a fundamental aspect of due process, any and all policies, communications and decisions regarding a student must be put in writing or they cannot be considered binding. The school must have evidence of delivery. All meetings concerning an accused student shall have minutes taken, and such minutes shall be made available to the student upon request. This includes all meetings on academic or nonacademic matters that pertain to the student's proposed punishment, suspension or dismissal;
8. Regarding disciplinary proceedings and hearings:
  - a. BELIEVES that proceedings can be initiated against a student only when the charge concerns a violation of written standard of conduct. The expulsion or suspension of a student for academic reasons is without justification where the school has not, early in the course of instruction, clarified in writing those standards of academic performance and behavior that it considers essential to the integrity of its educational mission (i.e., passing). Students close to academic termination should be so advised, well in advance, drawing attention to the specific deficiencies;
  - b. BELIEVES that severance from school, including any "leave of absence" where the student is not allowed to return to school when ready to do so, is effectively a suspension. Where the separation is effectively permanent, regardless of what it may be termed, it is an expulsion. The forced imposition of any extended leave of absence from medical school results in irreparable lifetime harm to the student, and deserves the same degree of due process that is required in serious civil or criminal proceedings. The student has the absolute right to attend classes until a hearing is held to decide otherwise;
  - c. BELIEVES that violation of a law need not imply professionally unethical behavior, proof of guilt should not excuse a school from its obligation to provide a fair, impartial hearing for the accused;
  - d. BELIEVES that when a faculty member (or the relevant committee) believes that a student has demonstrated a deficit or violated a rule, an informal hearing may be held in the presence of an impartial third party;
    1. The third party should be agreed upon by the student and the faculty member, and may not be the dean of the medical school;
    2. The purpose of the informal hearing shall be to inform the student of his/her alleged deficit or violation, to allow the student to present his/her version, and to work out, with the help and advice of the third party, a mutually satisfactory remedy;
    3. Any remedial plan devised may be put into writing and placed in the student's file;
    4. In the event that the outcome of this hearing is unsatisfactory to the student or the faculty member, a formal hearing may be requested;
    5. If the deficiency or violation is of sufficient gravity to impair the student's academic progress or to require the student's dismissal from the school of medicine, a formal hearing will be convened;
  - e. URGES that medical schools follow these guidelines in developing procedures for formal hearing committees regarding both academic and nonacademic alleged violations:
    1. it is an essential aspect of due process that a student be notified, through timely and progressive notification, that the case is being considered. The formal notice should satisfy, at a minimum, the following criteria:

- a. list the exact charges, citing the specific, published regulations, codes or bylaws that have allegedly been violated;
  - b. outline the action that will be taken if the charges are supported;
  - c. identify all adverse witnesses, if applicable, and outline the facts to which each will testify; this information must be made available upon request of the student;
  - d. inform the student of the right to a formal, impartial and objective hearing;
  - e. inform the student of the right to appeal the outcome of any hearing, ultimately to a court of law;
  - f. inform the student of the right to be represented by an advisor of choice, or by legal counsel, at every stage of the proceedings, and prior to responding to any charges;
  - g. inform the student of the right to not self-incriminate;
  - h. indicate the time and place of the hearing and how to get there, if the location is not known to the student;
  - i. inform the student of the right to request a reasonable postponement of the hearing date for due cause;
  - j. include a copy of the school's:
    1. due process procedures;
    2. code of conduct or academic regulations;
    3. hearing procedures;
    4. formal hearing appeal process;
    5. policy with regard to student records;
  - k. describe the composition of the judicial body responsible for hearing the case;
2. The burden of proof rests with the party bringing the charges. All matters upon which a decision may be based should be introduced into evidence at the hearing. Any recommendations resulting from the hearing should be based solely upon the legal rules and evidence introduced at the hearing. The party bringing the charges should present all evidence in its entirety before the accused is called to testify;
  3. Consideration of evidence will be allowed when the accused student has:
    - a. been previously advised of their content;
    - b. been previously advised as to who made them;
    - c. the full opportunity to refute unfavorable inferences drawn as a result of such statements;
  4. The student has the full right to:
    - a. testify and present a defense;
    - b. produce oral or written affidavits and evidence on his/her behalf;
    - c. present witnesses;
    - d. raise questions at a hearing concerning the inherent fairness of a rule or regulation he/she is accused of violating;
  5. The hearing must be held before the entire body that will decide the issue. Any and all individuals sitting in judgment of an accused student must be free from conflict of interest or personal

involvement. It is the student's right to have a panel that is acceptable to him/her as well as to the school;

6. The hearing should be private unless the student requests otherwise. News media should not be permitted at the hearing unless their presence is agreed upon by the student and the school;
  7. The hearing should be scheduled such that the student has sufficient time to consult with advisors and prepare a defense;
  8. The student has a right to a written statement of any decision and the grounds upon which it is based. The student should be advised again, at that time, of the right to appeal and the appeal process;
- f. BELIEVES that should there be strong evidence that the continued presence of an accused student poses a threat to the safety of himself/herself or of others, an informal hearing may be held to evaluate the merits of a temporary, interim suspension until a formal hearing can be granted. Such a temporary suspension cannot be based upon an assumption of guilt. It must be based solely upon the specific concerns of safety. The student should be notified, in writing, of the time and place of the informal hearing and the reasons for the interim suspension. If it is impossible to hold an informal hearing before the interim suspension, it must be held as soon as possible (in a matter of days) thereafter. The accused must be fully advised of all of his/her rights as per notice in a regular formal hearing. Following an interim suspension, a formal hearing, with notice, must be held as soon as the accused is able to prepare a defense;
- g. BELIEVES it is a fundamental obligation of every medical student to appear and cooperate in any hearing or proceeding where one of the involved parties calls him/her as a witness. Failure to do so should be grounds for nonacademic discipline. It should follow that the truthful testimony provided by any witness will not be used against that witness in current or subsequent proceedings;
9. Regarding use of student records:
- a. URGES that any finding, other than guilty, that results from any school hearing, will cause all records and mention of the charges and the hearing to be expunged from the records of that student. No mention of the event will be made to any other party without the student's specific, express, written permission.
  - b. BELIEVES psychological and medical records are privileged information;
    1. Medical and psychological information can only be used as evidence in a due process proceeding when such information concerns the safety of the accused or of others. Only under these circumstances does the school have a right to examine the accused student's medical and psychological records;
    2. Unless there is a clear threat to life or safety, no student should ever be forced to submit to any medical or psychological examination as an element in a disciplinary proceeding;
    3. The student must be free from psychological intimidation or coercion.
10. Regarding discrimination and harassment:
- a. BELIEVES all students have the right to learn in an environment free from harassment and discrimination based on ethnicity, sex, sexual orientation and gender identity, religion or disability,;
  - b. URGES medical schools to support this right by methods including, but not limited to, the following:
    1. forming committees to investigate harassment, discrimination and diversity policies that already exist; (1997)

2. making available uninvolved persons to discuss harassment and discrimination issues with students; (1997)
  3. establishing procedures by which students may make formal or informal complaints regarding harassment or discrimination; (1997)
  - c. SUPPORTS this right with all available means, including referral to legal services. (1997)
11. Regarding needle-stick protocol:
- a. Needle-stick protocols should be written out in their entirety and provided to students during their initial orientation to the protocol preferably during freshmen orientation; (1997)
    1. Students should receive reminders/reoriented to the protocol yearly.
    2. Students should be provided with a card for their pocket with instructions on initial injury management (washing wound) and the phone number for the case manager.
    3. The same protocol should be instituted at all facilities students are working during their clinical training (except away rotations in which a separate clause should provide coverage.
  - b. Medical schools should establish a case manager specifically for blood and body fluid exposures who would have the following duties: (1997)
    1. They should be available 24 hours/day.
    2. They would fill out all necessary paperwork in reporting the incident.
    3. They would assess the exposure risk.
    4. They would question and initiate testing of source patient (when appropriate) utilizing confidential number systems.
    5. They would provide the student with an initial examination of the injury and further examination or tests necessary for prophylactic treatment.
    6. They would initiate appropriate antiviral prophylactic therapy as recommended by the CDC. It is also necessary that they discuss the risks and benefits of therapy.
    7. They would ensure long-term follow-up care. Long-term care includes any necessary testing (HIV antibody testing to cover the window period of detection and any test necessary for antiviral prophylactic treatment), counseling, continuation and any necessary changes in antiviral therapy.
  - c. Documentation of the incident should be thorough, concise and ensure confidentiality;
    1. Confidentiality can be ensured through establishing separate files for student exposure incidents and/or utilizing confidential number systems.
    2. Complete documentation of the exposure incident (type of injury, amount of blood or body fluid involved, depth of injury, HIV status of source patient, source patient risks, source patient antiretroviral medications, etc.) can provide necessary information for determining exposure risk as well as provide necessary information for determining accurately the exposure risk for medical students.
  - d. Financial responsibility for all follow-up care including, but not limited to, prophylactic antiviral therapy, should be provided by the medical school, university hospital, or a special fund established between the school and medical student tuition. The student's individual insurance should not be utilized for any post-



exposure care. This is to ensure that students are not discriminated by their insurance company and receive all follow-up care that may not be provided by their insurance carrier; (1997)

e. Short-term and long-term follow-up care should include: (1997)

1. baseline and follow-up HIV testing for the student (the initial test should be offered at a facility that can provide anonymous testing). (1997)
2. prophylactic antiviral therapy and associated laboratory tests. (1997)
3. Counseling. (1997)

12. In regard to a medical school closure:

- a. SUPPORTS the right of medical students to complete the medical education they have initiated;
- b. SUPPORTS the AAMC policy that, in the event of a medical school closure, students will be transferred to other medical schools; (1999)
- c. RECOMMENDS that medical students be transferred to schools such that:
  1. students currently involved in pre-clinical courses be transferred to institutions with similar curricular format; and,
  2. students should be transferred to schools that are as geographically close as possible to the closed medical school or city so as to minimize the stress of moving families.
- d. URGES schools not to penalize relocated students by having them retake courses they have completed; (1999)
- e. URGES medical schools to treat students, relocated secondary to medical school closure, financially as they would their own in-state students as allowed by state law; (1999)
- f. SUPPORTS students currently on clinical rotations to continue their clinical education, if possible, in the same hospital but change medical school affiliation with one that is geographically closest to the affected institution. (1999)

13. SUPPORTS the right of medical students to form groups and meet on-site to further their medical education or enhance patient care-without regard to their gender, sexual orientation and gender identity, race, religion, disability, ethnic origin, national origin or age. (2006)

14. OPPOSES any attempt by a medical school to infringe upon the rights of medical students to organize on the basis of their gender, sexual orientation and gender identity, race, religion, disability, ethnic origin, national origin or age. (2006)

## PRINCIPLES REGARDING WELLNESS OF MEDICAL STUDENTS AND HOUSESTAFF

The American Medical Student Association:

1. Regarding wellness and wellness policy:
  - a. RECOGNIZES that patient care and medical education suffer when students and housestaff lack proper rest, and, therefore, BELIEVES that:
    1. students should be allowed to negotiate issues in patient care, as well as working hours and conditions, with their respective medical schools and hospitals;
    2. call should primarily be a learning experience;
    3. student work hours should not be greater than those worked by residents, as described in detail in Principles Regarding Resident and Student Work Hours. (2005)
  - b. ENCOURAGES medical schools and medical centers to provide facilities for physical conditioning and recreation for its students and housestaff who have less opportunity than the general population to use often times expensive, inconvenient, and inadequate facilities elsewhere because of severe limitations on time and the pressures of the profession;
  - c. BELIEVES that the performance of repetitive scut work, past the point where such work is a learning experience, is an infringement upon the medical student's educational time and should not be required of the student;
  - d. URGES all medical schools to establish standard maternity and paternity leave policies for students which allow variation with the personal and medical needs of the individual, but assure the individual a reasonable minimum time away from school, if desired; and URGES that these policies be published in university catalogs and admission brochures;
  - e. SUPPORTS the development of high quality, confidential counseling services for students desiring such services and ENCOURAGES efforts to educate both students and faculty as to the existence and benefits of such counseling so as to dispel the myth that recourse to counseling is an indication of weakness in the student; (2006)
  - f. SUPPORTS the confidentiality of medical student health and counseling records and AFFIRMS that the student, as patient, deserves, as does anyone, the privilege of confidentiality between doctor and patient;
  - g. SUPPORTS the establishment of a confidential faculty and student adviser program for every medical student with established guidelines for selection, purpose and evaluation of the advisors;
  - h. URGES that medical schools and hospitals take responsibility for the ready availability of quality child-care facilities for all medical students and housestaff;
  - i. ENCOURAGES medical schools to integrate programming that encourages students to be mindful of self-care and engage in self-reflection into their existing curriculum. (2006)

## PRINCIPLES REGARDING PATIENTS' RIGHTS

The American Medical Student Association:

1. RECOMMENDS that physicians strive to incorporate the following patients' rights within the scope of the professional relationship:
  - a. The patient should be informed of his/her rights;
  - b. The patient has the right to considerate and respectful care;
  - c. The patient has the right to obtain from his/her physician complete information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. He/she also has the right of access to his/her medical record and the right to copy his/her medical record. When it is not medically advisable to give such information to the patient, this information should be made available to an appropriate person on his/her behalf;
  - d. The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information;
  - e. The patient has the right to know, by name, the physician responsible for coordinating his/her care, to be informed as to the status of his/her providers (medical student, house officer, attending, etc.) and to know his/her participation in the education of medical students;
    1. AMSA believes that all medical students in contact with any patient must be identified through the use of a nametag, including their name, the words "medical student" and their school affiliation.
    2. AMSA encourages medical students to resist being introduced as "doctor" to the patients and suggests that all medical schools and teaching facilities actively discourage residents, attending physicians and other medical educators from introducing medical students as doctors to patients.
    3. AMSA strongly encourages medical students to make clear their status to patients.
    4. Students must commit themselves to ethical behavior in regard to patient care with honesty at the forefront.
  - f. The patient who does not speak English has the right to an interpreter and all reasonable efforts should be made to obtain access to an interpreter for the patient;
  - g. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such action;
  - h. The patient has the right to every consideration of his/her privacy concerning his/her own medical care.
    1. Case discussion, consultation, examination, treatment, records and communication are confidential and should be handled discreetly.
    2. Those not directly involved in his/her care must have the permission of the patient to be present;
    3. Insurance companies and employers have the right to access only that information from the patient medical record, which is directly related to the claim or job description, respectively. (2001)

- i. The patient has the right to expect that within its capacity a hospital must make reasonable efforts to respond to the request of a patient for service. The hospital must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer;
  - j. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects;
  - k. The patient has the right to expect reasonable continuity of care. He/she has the right to know in advance what appointment times and physicians are available, and where. The patient has the right to be informed of, and provided with, a mechanism for his/her continuing health-care requirements following discharge;
  - l. The patient has the right to examine and receive an explanation of his/her bill regardless of source of payment. The patient has the right to privacy regarding the source of payment for treatment and care. This right includes equal access of care to all, without regard to the source of payment;
  - m. The patient has the right to know what hospital rules and regulations apply to his/her conduct as a patient;
  - n. The patient has the right, within twenty-four (24) hours, of access to a patient's rights advocate who may act on behalf of the patient to assure and protect the rights set out in this document;
  - o. AMSA encourages medical students to resist being introduced as "doctor" to patients. AMSA believes that this practice is an unethical misrepresentation to the patient that denies informed consent in the patient's decision to participate in medical education; (1995)
  - p. AMSA suggests that all medical schools and teaching hospitals actively discourage residents, attending physicians, and other medical educators from introducing medical students as doctors to patients; (1995)
  - q. AMSA demands that teaching hospitals provide equal care to all patients, whether or not they choose to participate in medical education; (1995)
  - r. AMSA strongly encourages students to make clear their student status to patients. Students must commit themselves to ethical behavior in regard to patient care and honesty is at the forefront; (1995)
- 2. OPPOSES the treatment of a patient by any health professional whose language deficiencies would interfere with effective communication, diagnosis and/or treatment of that patient.
  - 3. SUPPORTS HHS regulations that allow medical students access to a patient's complete medical record under the supervision of that patient's treating physician. (2002)
  - 4. OPPOSES Making patient identifiable information available to pharmaceutical companies and other businesses for the express purpose of marketing products directly to patients without patient approval. (2002)

## PRINCIPLES REGARDING DEATH AND DYING

The American Medical Student Association:

1. BELIEVES that patients have the right to refuse treatment when they have been fully informed of the consequences, even if such refusal results in the patient's death;
2. BELIEVES that patients who are comatose, and in whom there is no reasonable expectation of recovery, have the right, through prior written documents such as living wills, to refuse treatment and to be allowed to die and not be kept alive by artificial means;
3. SUPPORTS a statutory definition of death, and BELIEVES that such a definition should consist of a dual system of criteria, including the cessation of circulatory and respiratory function or brain death criteria, as outlined in the United States Collaborative Study of Cerebral Death and the so-called Harvard Group Study, which should only be applied when all reversible causes and conditions such as hypothermia and drug intoxication have been excluded;
4. BELIEVES that the quality of life is an important parameter in the health care management of the patient with terminal or severe chronic illness and, further, SUPPORTS the use of medications that are necessary to relieve a terminally ill patient's suffering despite their having an inseparable dual effect of hastening the patient's death. (1993)
5. BELIEVES that the role of the physician primarily responsible for the care of the terminally ill should extend beyond the patient to those close to the patient when his/her needs for counseling and support arise;
6. BELIEVES that counseling and support services should be offered to immediate family members or significant others by staff and physicians in cases of sudden or emergency room deaths.
7. STRONGLY URGES all medical schools and residency programs to offer electives to educate medical students and residents in issues of death and dying. (1996)
8. BELIEVES that all patients have the right to know all options available to them before they make end of life decisions. These options include, but are not limited to, hospice care, withdrawal of treatment, continuation of treatment, comfort measures and self-deliverance. The patient should be made aware of the implications of each of these options. (1996)
9. BELIEVES that counseling and support services should be made available to physicians and medical students who are dealing with issues of death and dying, whether the issues are related to patient care or their personal lives. (1996)
10. SUPPORTS an interdisciplinary approach to the study and care of patients with active, progressive, far advanced disease for whom the prognosis is limited and the focus of care is the quality of life. AMSA further RECOGNIZES the multidimensional nature of suffering, with an ultimate goal of responding to this suffering with care that addresses all of these dimensions and communicates in a language that conveys mutuality, respect and independence. (1997)

## PRINCIPLES REGARDING BIOETHICS

The American Medical Student Association:

1. In regard to the allocation of health resources:
  - a. ENCOURAGES efforts on the part of health care practitioners to identify the benefits that patients receive from various treatments, from new technologies and facilities, and to decide when costs are not justified by benefits;
  - b. SUPPORTS careful, reasoned and full public debate before decisions are made regarding the allocation of health care resources;
  - c. BELIEVES rationing must occur in a fair and equitable manner, regardless of a patient's ability to pay. Data obtained in outcomes research should be considered along with other factors in a national discourse regarding allocation of limited health-care resources. (1994)
2. In regard to organ transplantation:
  - a. SUPPORTS the notion that policies to insure an adequate supply of cadaver donor organs, including bone marrow, should be thoroughly investigated;
  - b. URGES that efforts be directed by the medical, governmental and lay communities toward development of procedures that will educate the public toward the need for donor supply and to initiate and facilitate means for allowing himself/herself or his/her loved ones to become organ donors;
  - c. URGES that acceptance of an organ, including bone marrow, for transplant from a live donor be based on the high motivation of the donor and the improved success of the recipient;
  - d. OPPOSES the morally reprehensible "free market" sale concept by unrelated donors whose primary incentive is economic. (1985)
  - e. URGES the continued research into artificial and/or animal transplant models for safe use in transplant candidates; (1997)
  - f. SUPPORTS the use of animal organs for transplants according to the medical and governmental guidelines until a suitable cadaver, living and/or artificial supply can be procured; (1997)
  - g. STRONGLY SUPPORTS the consideration for the welfare of the animals used for organ donation. (1997)
3. SUPPORTS the establishment of a standing hospital ethics committee authorized to recommend treatment or other procedural decisions during situations that are complicated by dilemmas of medical ethics. Such a committee would be available upon request by either the patient or the physician.
4. In regard to fetal tissue research and transplantation: (1990)
  - a. RECOGNIZES the therapeutic potential of fetal tissue transplantation for diseases such as Parkinson's and Type I Diabetes Mellitus; (1990)
  - b. BELIEVES that the use of fetal tissue in research is an acceptable public policy because it is intended to achieve significant medical goals; (1990)
  - c. BELIEVES that using fetal tissue for research purposes does not signify approval of or encourage abortion; (1990)
  - d. OPPOSES the transplantation of tissue from spontaneously aborted fetuses into human subjects because such tissue is associated with genetic abnormalities, infectious agents and other abnormalities; (1990)

- e. OPPOSES abortion performed solely for the specific purpose of donating fetal tissue for research and transplantation; (1990)
- f. OPPOSES the role of politics of abortion in influencing the course of research that is done by government scientists and funded with federal money; (1990)
- g. URGES the Secretary of the Department of Health and Human Services to lift the moratorium on federal funding of human fetal tissue transplantation research utilizing tissue from induced abortions; (1990)
- h. URGES that the National Institutes of Health develop policies designed to insulate a woman's consent to abort from her consent to donate tissue; prevent monetary or other gains for the donation; require that procurement agencies not profit from such transactions; reaffirm that the primary concern in obtaining fetal tissue should continue to be the health of the pregnant women; and emphasize that the properties of fetal tissue, such as the optimum gestational age for use in research, should not be a factor in deciding the timing or the procedure of an abortion; (1990)
- i. URGES that medical personnel who participate in an abortion should not receive any direct benefit from the subsequent use of fetal tissue from that abortion; (1990)
- j. URGES that compliance with the above mentioned policies be required for receipt of federal funds. (1990)

## PRINCIPLES REGARDING PHYSICIAN AID IN DYING

The American Medical Student Association:

1. SUPPORTS passage of aid in dying laws that empower terminally ill patients who have decisional capacity to hasten what might otherwise be a protracted, undignified or extremely painful death. Aid in dying should not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide. It should be a last resort option in patient care if the following criteria are met. This includes, but may not be limited to: (2008)
  - a. There must be a request from the patient that is voluntary and free of coercion of any type, including financial. If the patient is an inpatient or a nursing home resident, the voluntary nature of the request must be verified by a patient advocate, i.e., ombudsperson. (1998)
  - b. The explicit nature of the patient's request must be documented and persist throughout a specified waiting period. (1998)
  - c. The patient must be determined to have capacity, based on current standards of capacity. (2008)
  - d. The patient must be terminally ill, as defined by current standards. (1998)
  - e. The patient must have unbearable physical, mental and/or emotional suffering, as defined by the patient, whereby the patient feels that his/her quality of life is such that life is no longer worth living. (1998)
  - f. Physician-aid-in-dying must be considered only as a last resort, after the following issues have been thoroughly explored by the patient: (2008)
    1. All appropriate standard and experimental allopathic and osteopathic therapies.
    2. All relevant culturally sensitive alternative therapies.
    3. All palliative care options, such as hospice.
    4. Comprehensive pain management.
    5. Comprehensive psychiatric, psychosocial and spiritual support.
  - g. Assistance in death must be carried out only by a physician, through the prescription of a lethal dose of medication, as determined jointly by the patient and physician.
  - h. No health care provider who is morally or otherwise opposed to the participation in physician-aid-in-dying will be obliged to assist.
  - i. The physician to whom the request is made should be familiar not only with the patient's medical condition, but also the patient's experience of his/her illness and present state of mind. The patient and physician must enjoy a lasting, mutually trusting and open relationship, including but not restricted to ongoing discussion about issues of death and dying.
  - j. A thorough psychiatric consultation must be included in evaluating the patient's request. This must include, but not be restricted to, ruling out treatable affective conditions, such as clinical depression.
  - k. Hospital ethics committees and ethicists may be consulted to address specific ethical concerns and areas of conflict resolution.
  - l. An independent physician must be consulted to review the entire case to determine that the above criteria have been met and that the request is a reasonable option.
  - m. All cases of physician-aid-in-dying must be documented on an aid-in-dying report form. This form should include, but not be restricted to, information pertaining to the nature of the request, patient demographics,



the patient's medical and psychosocial history, and surrounding circumstances, and documentation of how the criteria have been met.

- n. A system of safeguard review must be established at both institutional and state levels. Data on practices and patient characteristics must be made available to the public, while maintaining individual patient privacy. (1993)
- 2. RECOGNIZES that the practice of physician-aid-in-dying and its safeguards must be continually evaluated by doctors, patients, families and the public, and that criteria may be adjusted according to evolving opinion among these groups. (1993)
- 3. SUPPORTS enhancing public awareness of the above safeguards. (1993)
- 4. RECOGNIZES a concern for vulnerable populations with regard to potential abuses and, therefore, emphasizes the importance of the above safeguards. (1993)
- 5. RECOGNIZES that throughout the process outlined above, all involved parties must safeguard against the possibility that the wish to die reflects the patient's desire to not burden others, emotionally, financially, or otherwise. (1993)
- 6. RECOGNIZES that equal access to health care is one relevant issue in the aid-in-dying debate. These guidelines are an effort to guard against potential abuse based on inequities with regard to health care access. Therefore, it is important for AMSA to simultaneously advance its efforts in addressing both issues of health care as a right, as well as aid-in-dying. (1993)
- 7. SUPPORTS open and complete communication, free from coercion, between physician and patient regarding all possible end-of-life care options for the terminally ill patient. (2008)

## **PRINCIPLES REGARDING REPRESENTATION OF WOMEN IN MEDICINE**

The American Medical Student Association:

1. SUPPORTS and ENCOURAGES the increased application and admission of qualified women to all medical schools, and DISCOURAGES disqualification of applicants solely according to sex, sexual orientation and gender identity and/or marital status;
2. URGES federal support to encourage more women to enter the field of medicine and for recruitment of women as medical school faculty and administrators;
3. SUPPORTS financial incentives for schools to progress toward achieving a percentage of women physician faculty and physician administrators at each rank equal to the percentage of women in the general population;
4. URGES the AAMC to make available data from its faculty register which will show the status of each school with regard to the number of women in tenured teaching positions.

## **PRINCIPLES REGARDING PHYSICIAN COMPETENCE**

The American Medical Student Association:

1. SUPPORTS a national system of physician licensure and relicensure with the goal of improving physician competence in all areas of medicine;
2. URGES substantial research on new practice evaluation techniques such as peer review;
3. BELIEVES the reviewing of physician competence should be a learning experience with feedback on areas of strength and weaknesses. Correction of deficiencies should have an emphasis on education and rehabilitation rather than punishment;
4. SUPPORTS continuing medical education as a voluntary mechanism of staying current in medical knowledge.
5. ENDORSES establishment of the physician clearinghouse for the purpose of uncovering individuals practicing medicine without proper licensure. The law requires that hospitals routinely check staff physicians with the clearinghouse. (1987)
6. OPPOSES the disclosure of information regarding malpractice suits to the public, as the information has little correlation with physician competence. (1987)
7. ENCOURAGES hospitals, health-care professionals, and patients to use the clearinghouse responsibly and in the best interest of the community. (1987)
8. BELIEVES that strong penalties for those convicted of practicing medicine without a license will discourage individuals practicing medicine with proper licensure from practicing and potentially harming people. (1987)

## PRINCIPLES REGARDING PREVENTIVE MEDICINE AND PUBLIC HEALTH

The American Medical Student Association:

1. DEFINES preventive medicine to be the application of biomedical, epidemiological and socioeconomic science to the promotion of mental and physical health and social well being and the prevention or early detection of disease in individuals or populations;
2. In regard to research:
  - a. URGES the government, universities and businesses to focus medical research on ways to prevent or reduce disease burden, especially the leading causes of mortality and morbidity. Due consideration should be given to all systems of healing. (2006)
  - b. SUPPORTS continued federal funding of the National Center for Injury Prevention and Control; (1996)
3. In regard to the community:
  - a. URGES physicians and other health professionals to educate, screen, refer, treat and provide follow-up programs for the public with regard to preventive medicine;
  - b. URGES the physician to work with the patient to help him/her become informed, active and responsible to participate in health maintenance and the prevention of disease;
  - c. URGES the development of community programs in the education and screening of individuals to aid in the prevention of disease;
  - d. ENCOURAGES planners, advocates and practitioners of health promotion and preventive medicine to design programs effective for and relevant to the entire population, and in doing so, consider economic, racial, gender, sexual orientation and gender identity, ethnic, and/or religious determinants of health care seeking behavior as they relate to the adoption of positive health behaviors. (1985)
  - e. SUPPORTS coverage of routine childhood vaccinations as one aspect of preventive care in all types of health insurance policies and prepaid health plans. (1987)
  - f. In regard to circumcision:
    1. URGES the education of communities and medical professionals regarding the aspects of circumcision and infant care; (1987)
    2. URGES that these procedures be undertaken only after informed consent from parents or legal guardians is obtained; (1987)
    3. URGES the incorporation of appropriate anesthetic techniques in all newborn circumcisions. (1999)
4. In regard to education:
  - a. URGES the American medical profession to make preventive medicine, including clinical preventive medicine and epidemiology, an integral part of the core education of students, residents, practicing physicians and other health professionals; (1995)
  - b. URGES physicians and other healthcare professionals to educate themselves on the use of evidence-based ICAM regarding lifestyle practices, foods and herbal medicines, towards prevention and reduction of disease, particularly in a primary care setting. (2006)
5. Regarding Safety:

- a. URGES stricter laws and law enforcement in an effort to reduce death and injury from automobile accidents, including the following provisions:
    1. car safety inspection be required in all states;
    2. annual examination of ability to drive be required of all drivers 70 years of age or older;
    3. in order to obtain a license, permission be granted to submit to a chemical test of sobriety whenever intoxication while driving is suspected;
    4. driving a motor vehicle with a blood alcohol level greater than .05% (50 mg. alcohol/100 ml. of blood) be illegal;
    5. laws that would provide for mandatory punishment and license suspension of any individual, at least upon the second conviction for driving while intoxicated;
    6. upholding of the posted speed limit;
    7. mandatory infant care restraints, mandatory air bags as a passive restraint, and mandatory wearing of adult seat belts or other protective devices, as well as mandatory wearing of motorcycle helmets. (1988)
  - b. In regard to automobile safety:
    1. URGES all parents, community leaders, health professionals and governmental and private sector agencies to do everything possible to ensure that every child in the United States is protected from injury by safe infant car restraints and child car seats when being transported in a motor vehicle;
    2. URGES all governmental and private agencies that provide transportation for children to accept responsibility for their safety and to adopt policies ensuring proper restraint for those children to reduce injury;
  - c. URGES legislation, community programs and education from health-care professionals regarding gun safety, bicycle helmets, smoke detectors and other safety aspects and SUPPORTS addressing these areas by medical training; (1995)
6. In regard to day care:
- a. URGES health professionals to actively provide educational and consultation services to families using community day care centers, URGES requiring all programs to meet federal standards including ratios of caretakers to children, and URGES requiring that all standards are applied equally; (1995)
  - b. SUPPORTS increased funding to day care centers, ENCOURAGES expanding the successful programs such as Head Start Program and ENCOURAGES further development of innovative programs to establish child care facilities to address the community needs; (1995)
  - c. SUPPORTS the concept of federal, state, local and private investment in these programs and ENCOURAGES improved consistency between funding programs and the provision of a seamless system on the state and local level; (1995)
  - d. ENCOURAGES improved child care options for all welfare recipients, at risk working poor, and children of high school age and younger parents, by the following:
    1. Provide services or funds for childcare at the community's market rate. (1995)
    2. URGES the establishment of these centers within the schools, if applicable, that the parent or parents attend. (1995)
    3. Provide services for the duration of participation in Temporary Assistance to Needy Families (TANF) program and train individuals in the TANF program to be child care providers. (1995)

4. Provide services to the working poor based on a sliding scale. (1995)
- e. ENCOURAGES programs that address the needs of 0 - 3-year-olds in addition to those of older children. (1995)
7. SUPPORTS legislation requiring the U.S. Bureau of Census to adjust for undercount in the 1990 census and all decennial censuses thereafter. (1990)
8. BELIEVES that health is determined by many factors other than medical care, including genetic predisposition to pathology, lifestyle and the environment (physical, social, occupational and economic);
9. SUPPORTS programs such as Healthy People 2010, a program of the U.S. Department of Health and Human Services, in systematic efforts to determine measurable goals and objectives for improving the public health by the promotion of health and the prevention of disease.
10. ENCOURAGES communities, professional organizations and states to utilize Healthy People 2010 to develop programs to improve the public health.
11. URGES the American health profession to exchange information on preventive medicine with any available health agencies, including the World Health Organization;
12. In regards to universal coverage of recommended vaccines:
  - a. SUPPORTS the HP2010 goal of immunizing 90% of children under the age of 3 with 4 doses diphtheria-tetanus-acellular pertussis vaccine; 3 doses Haemophilus influenzae type b vaccine; 3 doses hepatitis B vaccine; 1 dose measles-mumps-rubella vaccine; 3 doses polio vaccine; and 1 dose varicella vaccine by the year 2010. (2004)
  - b. URGES that any new universally recommended vaccine not listed above be supported in reaching a 90% coverage level within 5 years of the recommendation by the ACIP as stated as revised, much like the newly recommended 3 doses of pneumococcal conjugate vaccine that was first recommended in 2002. (2004)
  - c. URGES that federal, state, local and non-governmental programs aimed at increasing vaccination rates be made a top priority and be sufficiently funded every fiscal year to attain and maintain a 90% coverage level as determined and revised by the ACIP. (2004)
13. SUPPORTS mandated coverage in all types of health insurance policies and prepaid health plans for preventive medicine and public health efforts including: (2004)
  - a. Universally recommended childhood vaccines; (2004)
  - b. Influenza and pneumococcal vaccination of high-risk adults (as deemed by the Centers for Disease Control and Prevention); (2004)
  - c. Family planning and pregnancy prevention efforts including but not limited to Oral Contraceptive Pills; (2004)
  - d. Smoking cessation efforts; (2004)
  - e. Mental health services; (2004)
  - f. Nutrition, sexually transmitted disease and exercise counseling; (2004)
  - g. Pap smears and mammograms as indicated ; (2004)
  - h. Colonoscopies as indicated; (2004)

and any other Evidence Based Preventive Medicine practices as deemed by the United States Preventive Health Services Task Force. (2004)

## PRINCIPLES REGARDING WAR AND MILITARY ACTION

The American Medical Student Association:

1. Regarding embargoes:
  - a. OPPOSES an embargo of food, medicine, or medical supplies and equipment to any nation. (1992)
  - b. OPPOSES any efforts to force or pressure countries into complying with an embargo of food, medicines, or medical supplies and equipment. (1992)
2. Regarding economic sanctions:
  - a. CONDEMNS those economic sanctions that deny human rights and/or severely impact the health of noncombatant civilian populations; and (2001)
  - b. CALLS for the de-linking of food, medications, diagnostic/therapeutic equipment and medical educational materials from all economic sanctions; and (2001)
  - c. CALLS for the exclusion of public health equipment and supplies from economic sanctions, specifically materials involved in water purification and sewage treatment; and (2001)
  - d. SUPPORTS and encourages medical relief efforts to nations under economic sanctions by American physicians and medical students. (2001)
3. Regarding alternatives to war:
  - a. URGES re-examination of national priorities and restoration of funds to organizations that support public health;
  - b. SUPPORTS the rechanneling of funds from nuclear spending reduction achieved through arms treaties to domestic health and human welfare programs as opposed to military expenditures of a non-nuclear nature.
  - c. URGES superpower military restraint during escalating foreign conflicts, recognized to be scenarios for nuclear threat and possible first use.
  - d. SUPPORTS a more humane approach than war to the resolution of international crises. (1991)
  - e. ENDORSES the use of political and economic diplomacy and, until all such options are thoroughly exhausted, opposes the use of military force in attempting to solve international disputes. (1991)
4. Regarding nuclear war:
  - a. SUPPORTS efforts to provide the medical community and general public with accurate scientific data about the health dangers of the nuclear arms race and the medical effects of nuclear war;
  - b. BELIEVES that nuclear war is the greatest global threat to public health, that no meaningful medical response could be mounted in the aftermath of such a war, and that working for the prevention of nuclear war is a basic medical responsibility;
  - c. OPPOSES any plan or system in which any civilian medical facility or civilian medical personnel participate in planning in any way for a nuclear war;
  - d. RECOMMENDS some active instruction on the medical consequences of nuclear war in the curriculum of all medical schools;
  - e. BELIEVES that there should be added to our long tradition of ethical statements: "As a physician of the 21st Century, I recognize that nuclear weapons have presented my profession with a challenge of unprecedented proportions, and that a nuclear war would be the final epidemic for humankind. I will work peacefully and constructively for the prevention of nuclear war."
  - f. SUPPORTS the inclusion of the preceding statement (e) in medical school graduating ceremonies;
  - g. SUPPORTS the ratification of treaties that reduce the threat of nuclear war. (2007)
  - h. BELIEVES that principles concerning nuclear war must address the issue of conventional weapons as a possible hindrance to the stated goal of prevention of nuclear war; (2007)
  - i. OPPOSES the sale of nuclear weapons or nuclear weapons technology to other nations. (1995)

- j. URGES that all nuclear weapons be removed from hair-trigger alert status. (2001)
  - k. ENCOURAGES the U.S. government to enter into serious negotiations with other nations who have newly acquired nuclear weapons technology, specifically the Middle East, to work toward a ban on all nuclear weapons and all nuclear weapons testing. (1994)
5. Regarding armament and the arms race:
- a. CONDEMNS the development of nuclear weapons that subserve a first strike capability;
  - b. URGES an immediate halt to the research, development and deployment of all new nuclear weapons and all weapons in space;
  - c. URGES the multilateral cessation of all nuclear weapons testing, and URGES disassembly of all nuclear warheads to be followed by a Comprehensive Test Ban Treaty as an example to all non-nuclear countries, and RECOMMENDS the supervision of an impartial third party such as the United Nations. (1992)
  - d. URGES the U.S. government to pledge and maintain a ban on space weapons; (2005)
  - e. CONDEMNS any development, production, sale or use of biological or chemical warfare agents, and URGES the nations of our world to draft and sign a treaty that would prohibit the development, production, sale or use of such agents.
  - f. URGES, in the strongest terms, active and committed efforts to continue the nuclear arms reduction process initiated by the INF Treaty, among all nations with nuclear capability. (2005)
  - g. RECOGNIZES that strong cultural, historical and ideological differences underlie the arms race and superpower conflict, and that proper address of the arms race must include dialogue on issues of political and cultural understanding.
  - h. SUPPORTS efforts of citizen diplomacy to bridge the gaps of mistrust and misunderstanding that feed into the arms race, particularly programs within the health-care professions such as medical student exchanges.
  - i. OPPOSES the installation and the further allocation of resources into research in developing a National Missile Defense.
6. URGENTLY CALLS FOR a renewed long-range United Nations-sponsored diplomatic effort to solve the difficult problems of the Gulf region; (1991)
7. SUPPORTS a complete ban on the production, use, trade and export of antipersonnel landmines. (1996)
8. OPPOSES the current war in Iraq, and all other offensive wars and military action presently underway or undertaken in the future. (2005)
9. AMSA recognizes that there may be situations in which military intervention may be morally necessary in order to restore peace and preserve life in areas already involved in military conflict or war. If such intervention is supported by the UN, the BOT or HOD reserves the right to consider support for such intervention on a case-by-case basis. A decision to voice support would require a 2/3 vote in the BOT or HOD. (2005)
10. OPPOSES preemptive action against Iraq or any other nation without the backing of the United Nations. (2003)
11. RECOGNIZES and SUPPORTS the constitutional right of Congress to have the *sole power* to declare war and willfully RECOGNIZES that in the future the declaration of war should *only* reside with Congress. (2003)
12. RECOGNIZES the negative health impacts of war on US citizens, on US troops, and on the civilians directly affected by military force. (2003)
13. RECOGNIZES that the use of military diverts resources from other critical needs. (2003)
14. SUPPORTS economic and medical relief to countries devastated by war. (2003)
15. SUPPORTS the members of the US Armed Forces in their devotion and service to the preservation of world security and peace. (2003)
16. BELIEVES that engaging in any war or large-scale military action represent significant threats to public health and the environment both in and around the arena of said war or action as well as here in the U.S. (2006)



## PRINCIPLES REGARDING HUMAN RIGHTS

The American Medical Student Association:

1. BELIEVES in the following general principles regarding human rights:
  - a. Human rights are in essence the protection of human dignity, per the UN Declaration of Human Rights. (2004)
  - b. Human rights principles include:
    - i. Civil and political rights enumerated in the International Covenant on Civil and Political Rights;
    - ii. Economic, social and cultural rights enumerated in the International Convention on Economic, Social, and Cultural rights. (2004)
2. With regards to health care:
  - a. BELIEVES that every individual has the right to the highest attainable standard of health; (2004)
  - b. RECOGNIZES the principle in Article 12 of the International Covenant on Economic, Social, and Cultural Rights that states that health care must fulfill the following criteria to attain the highest standard of health: accessibility, availability, acceptability, and quality; (2004)
  - c. RECOGNIZES that the right to health is closely related and dependent upon the realization of other human rights, including the right to food, housing, work, education, participation, the enjoyment of the benefits of scientific progress and its applications, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly, and movement. (2004)
3. With regards to the application and enforcement of rights:
  - a. BELIEVES that governments and third-party entities have an obligation to uphold human rights principles. Third-party entities include transnational corporations, financial institutions, and third-party governments. (2004)
  - b. BELIEVES that governments, both national and international, are primarily responsible for enforcement. (2004)
  - c. DENOUNCES governments engaging in acts that violate human rights and UPHOLDS the principle of positive rights, such that governments are responsible for providing certain services in order to fulfill the right of individuals to certain necessities, such as education, health, shelter; (2004)
  - d. BELIEVES that inaction by a government to eradicate health disparities exhibits a failure to adhere to international human rights law. (2006)
4. BELIEVES that human rights are applicable to all individuals, regardless of sex, health status, race, ethnicity, religion, beliefs, politics, or other characteristics. Rights shall therefore not be denied or abridged on account of individual characteristics. (2004)
5. RECOGNIZES that the above general principles are incorporated in:
  - a. The United Nations' Universal Declaration of Human Rights which states in Article I that "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood." (2004)
  - b. The 1966 twin documents of the International Covenant of Political and Social Rights, and the International Covenant of Economic, Social, and Cultural Rights; (2004)
  - c. The 1975 Helsinki Agreement;
  - d. The 1975 Declaration on the Protection of All Persons from Torture and Other Cruel, Inhumane, or Degrading Treatment or Punishment;
  - e. The 1978 Declaration of Alma Ata; (2004)
  - f. Convention of the Elimination of Discrimination Against Women; (2004)
  - g. Convention on Rights of the Child; (2004)

- h. International Convention on the Elimination of all Forms of Racial Discrimination. (2004)
6. BELIEVES that health and human rights are integral to one another, such that:
    - a. The protection of human rights is integral to health. (2004)
    - b. The right to accessible, quality health care is a human right. (2004)
    - c. Poor health is both a reflection and symptom of social inequities and disparate provisions of social services. (2006)
  7. BELIEVES that physicians should be free to fulfill their ethical obligations to patients and society according to the World Medical Association (WMA) Declaration of Geneva. Thus, the American Medical Student Association:
    - a. CONDEMNS the participation by an MD, DO, healthcare worker or medical student in state or third-party violations of human rights, including but not limited to torture, and eugenics (as described below); (2004)
    - b. CONDEMNS the use of medical knowledge contrary to the international human rights laws; (2004)
    - c. BELIEVES that the nature of professionalism, reinforced by the authority given through licensing, bestows on health professionals a particular obligation to respect their patients' human rights; (2004)
    - d. BELIEVES that states should structure their relationships to health professionals to protect the independence of the health professional from state demands or pressures, and put in place mechanisms to protect physicians who seek to comply with their ethical and human rights obligations in the face of state demands to the contrary; (2004)
    - e. URGES medical schools to educate students about their accountability to international law, which promotes health as a human right. (2006)
  8. In regard to genetic discrimination:
    - a. OPPOSES discrimination in any form solely on the basis of any biologically or genetically determined trait; (1996)
    - b. SUPPORTS the development by scientists, physicians and bioethicists of guidelines governing the use of genetic technology and access to individual genetic profiles; (1996)
    - c. SUPPORTS nondirective genetic counseling and BELIEVES that individuals must be allowed to make educated health-care decisions without undue persuasion by outside parties; (1996)
    - d. OPPOSES eugenics, the practice of artificially increasing the frequency of "desirable" individuals while decreasing the frequency of "undesirable" individuals in a population, and ENCOURAGES the inclusion in medical school curricula the history of the eugenics movements of the United States and Nazi Germany, and the potential for abuse of developing genetic technologies. (1996)
  9. In regard to third-party payers:
    - a. SUPPORTS the right of a couple to have children despite known genetic risks and OPPOSES the practice of insurers refusing to pay for the care of children born with congenital malformations or a disease of which the parents are identified carriers. (1996)
  10. STRONGLY URGES the United States government to ratify the United Nations Convention on the Rights of the Child. (1996)
  11. SUPPORTS timely progressive realization of the proactive fulfillment of health and human rights. (2006)
  12. ENCOURAGES amendments to the equal opportunity language in international human rights law that reflects an appreciation for the growing diversity of our global population. (2006)
  13. In regard to capital punishment:
    - a. BELIEVES in the sanctity of life and therefore OPPOSES the use and concept of capital punishment and physician involvement in executions, specifically:
      1. Administration of lethal injection; (1996)
      2. Witnessing execution; (1996)

3. Pronouncing death after execution. (1996)
- b. CONDEMNS in all its aspects the concept of execution by intravenous injection. This includes support for:
  1. the repeal of laws authorizing execution by lethal injection where these laws exist, working to prevent the passage of such laws where they are being considered, and educating the public in general as to dangers and ethical objections to these laws under all circumstances;
  2. a boycott on the prescription to penal institutions or to individuals associated with such institutions, of substances one suspects will be used in lethal injections;
  3. a boycott on preparing or supervising the preparation of substances that one suspects will be used in lethal injections;
  4. a boycott on initiating, supervising the initiation of, or aiding the maintenance of an intravenous injection site one suspects will be used for lethal injection;
  5. a boycott on witnessing executions by lethal injections;
  6. a boycott on participating in or supervising the actual execution by injection procedure;
  7. physician refusal to pronounce death in cases one suspects occurred due to execution by lethal injection.
14. In regard to female genital mutilation: (1995)
  - a. OPPOSES the practice of female genital mutilation in the United States, and; (1995)
  - b. ENCOURAGES physicians, midwives, nurse practitioners and folk healers to be aware of the cultural context in which female genital mutilation is practiced, and to inform people contemplating the procedure for themselves or their daughters about the health risks and emotional trauma. (1995)
15. In regards to torture:
  - a. BELIEVES that the physician's professional obligation is to the patient's health, and therefore OPPOSES the use and concept of torture and physician involvement in torture, including deliberate, systemic or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment. Participation in torture includes, but is not limited to, providing or withholding any services, substance or knowledge to facilitate the practice of torture. (2005)
  - b. AFFIRMS the World Medical Association's (WMA) support of the physician's ethical obligation to report cruel, inhuman or degrading treatment of which they are aware; (2005)
  - c. RECOGNIZES the general principles established in the following:
    - i. The United Nations Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the "Istanbul Protocol"); (2005)
    - ii. The United Nations Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. (2005)
  - d. SUPPORTS the training of medical professionals in the identification of different modes of torture and their sequelae for the purpose of better patient care. (2005)

## PRINCIPLES REGARDING VIOLATIONS OF MEDICAL NEUTRALITY

The American Medical Student Association:

1. BELIEVES that, in any violent conflict or war, medical personnel have the moral and professional right to provide health care to all who need it;
2. OPPOSES any attempt by individuals, private groups, or governments to compel medical personnel to disregard the above principles regarding medical neutrality and specifically:
  - a. OPPOSES U.S. government aid in any form to parties, notably governments, in violation of the above principles;
  - b. URGES national and international health organizations to condemn violations of medical neutrality on the part of such parties that commit them;
  - c. PETITIONS those governments bearing influence on violations of medical neutrality to insure the right and safety of health personnel to treat any person in need without fear of reprisal; maintain medical, as well as higher education, under democratic leadership and without a military or paramilitary presence; prevent any import restrictions on medicinals and medical supplies designated for relief agencies;
  - d. URGES international relief organizations to send medical supplies to refugee camps and health facilities to be distributed through appropriate nongovernmental relief organizations;
  - e. DEPLORES the incarceration of political dissidents in psychiatric hospitals for the purpose of torture in the guise of medical treatments;
  - f. ENCOURAGES psychiatrists of all nations to discontinue the misuse of psychiatric hospitals through inappropriate treatments and procedures for political purposes;
  - g. URGES all psychiatrists to resist efforts by any government to force them to disregard their responsibilities as health-care professionals;
  - h. EXPRESSES its SUPPORT for health professionals who have fled from countries where the ruling government is engaged in perpetrating acts that disregard the above principles of medical neutrality.
3. In the case of armed civil conflict in countries with extensive violation of medical neutrality, ENCOURAGES negotiation between parties to minimize loss of human life; (1990)
4. URGES the U.S. government to insist that the Central American governments receiving its aid respect medical neutrality and abide by the Geneva Conventions to which they are a signatory. (1990)

## **PRINCIPLES REGARDING CHILD AND ADOLESCENT HEALTH CARE**

The American Medical Student Association:

1. BELIEVES that adolescent health care delivery is best carried out in a primary care setting that is also committed to the adolescent's health maintenance needs;
2. BELIEVES the guidelines for health care policy and programs, based on the unique aspects of adolescence, should encourage self-directed action and choice supported by the counsel of parents and/or other responsible adults;
3. BELIEVES that adolescent health services and decisions regarding such services should be rendered by professionals trained in developmental counseling and adolescent health;
4. BELIEVES that adolescents should have the right to confidential health services, including the right to seek and obtain psychiatric care and treatment for substance abuse without obtaining consent from a legal guardian; (1995)
5. BELIEVES that adolescents receiving confidential care should be encouraged to involve their family or an equivalent support system;
6. BELIEVES that when confidentiality regarding the medical problem is not an issue between adolescent and parents:
  - a. adolescents who are clearly mature or emancipated should have the option of representing themselves in the health-care system;
  - b. adolescents who are not fully mature or have just begun the emancipation process should be encouraged to actively participate in their health-care decisions.
7. BELIEVES every child has the right to and must be guaranteed access to at least an adequate level of preventive and curative care, not to be dictated by the socioeconomic status of his/her family or the region of the country in which the child happens to reside. The care mentioned in 1 and 2 above should be provided through a uniform nationwide system. (1988)(1990)
8. In regard to sexuality and reproductive rights:
  - a. BELIEVES that adolescents are, indeed, sexual beings whose sexuality comprises a major aspect of their lives;
  - b. BELIEVES that sexuality of adolescents contributes to major health concerns, such as pregnancy and abortion, contraception, sexually transmitted diseases and mental health;
  - c. BELIEVES that a minor should not be required to have consent of a legal guardian to authorize access to contraceptive information or methods, prenatal care, abortion, diagnosis and treatment of sexually transmitted diseases, and counseling for problems dealing with sexual orientation and gender identity, and SUPPORTS the enactment of laws that give minors legal access to the above mentioned services without the consent of a legal guardian;
  - d. BELIEVES that the adolescent has a right to confidentiality on the part of the health-care provider concerning sexual and sexually related medical problems;
  - e. BELIEVES that an adolescent has the right to express his/her sexual orientation and gender identity and have this preference respected;
  - f. OPPOSES the threat of prosecution for contributing to the delinquency of a minor against adults counseling minors on sexual matters, especially in the cases of counseling on gay/lesbian sexual orientation;
  - g. BELIEVES that the long-term effects of adolescent pregnancy, such as the extremely high dropout rate, severely decreased wage earning capacity, high dependency upon public assistance, and the devastating chronic effects upon the children of adolescent parents, can be substantially reduced by preventive social programs, and OPPOSES reductions in federal funding of such programs;
  - h. BELIEVES that the creation of barriers to access to sexually related health-care services and information will not decrease the level of sexual activity among adolescents, and OPPOSES social programs that are based upon the principles of "abstinence and self-discipline" as the only solution to the consequences of adolescent sexual activity which could create an access barrier;

- i. BELIEVES that the pregnant adolescent has the right to continue her education and not be forced either to change schools or discontinue her education due to her pregnancy;
  - j. RECOGNIZES that pregnant adolescents should receive adequate prenatal care regardless of age, and URGES the establishment, in clinics, of programs that provide comprehensive prenatal care geared toward the special needs of the pregnant adolescent and her partner;
  - k. SUPPORTS efforts that will lead to contraceptive methods specifically designed for the needs of adolescents.
  - l. BELIEVES that sex education and pregnancy prevention counseling must be provided to boys and girls. (1995)
  - m. ASSERTS that in order for any adolescent pregnancy prevention program to be successful, adolescents must be educated about and have convenient and confidential access to culturally appropriate and age-appropriate contraceptive methods and family planning services. (1995)
  - n. SUPPORTS parenting classes for all pregnant and parenting teenagers. (1995)
  - o. BELIEVES that bearing a child during adolescence may place teenagers at a high risk of later poverty and low educational achievement, and imposes upon them a significant risk for needing public assistance. (1995)
  - p. URGES the provision of support services to all pregnant and parenting teenagers to enable them to participate in appropriate educational/vocational activity or to find and maintain employment. These support services include, but are not limited to: (1995)
    - 1. child care;
    - 2. health care;
    - 3. transportation;
    - 4. family planning and parenting classes;
    - 5. supplemental food programs and nutrition counseling;
    - 6. alcohol and drug abuse prevention services.
  - q. URGES that the use of long-term contraception be combined with education on the transmission and prevention of sexually transmitted diseases. (1995)
  - r. OPPOSES policies of federal, state, and local agencies that prohibit the discussion and demonstration of proper contraceptive usage to adolescents through a health or sexual education curriculum. (1997)
9. Regarding education:
- a. SUPPORTS the rights of adolescents with children to have access to educational opportunities equivalent to those available to adolescents without children; (1995)
  - b. URGES educational institutions, including those of higher learning, to make efforts to enroll and support adolescents with children. (1995)
10. Supports the rights of children and adolescents to have access to health and educational services regardless of their country of origin or citizenship status, and opposes any laws that would curtail such access. (1995)
11. In regard to violence: (1996)
- a. BELIEVES that violence is a serious and often overwhelming threat in an adolescent's life;
  - b. SUPPORTS the availability of primary, secondary and tertiary violence prevention services for children and adolescents, including access to mental health services when necessary; (1996)
  - c. ENCOURAGES physicians and health-care professionals to discuss violence with parents, and children and adolescents. (1996)

## **PRINCIPLES REGARDING AGING**

The American Medical Student Association:

1. URGES that medical schools be mandated to establish teaching programs in geriatric medicine as an integral part of the formal curriculum;
2. SUPPORTS the establishment of competency standards in geriatric medicine for the licensing and certification of all physicians;
3. ENCOURAGES the providing of funds to schools of medicine and other organizations for training and research in the field of aging;
4. ENCOURAGES those specialties that treat large numbers of elderly patients to recognize the special needs of the elderly and to include training about these needs in medical school and residency programs. (1985)

## **PRINCIPLES REGARDING PHYSICIAN-SCIENTISTS**

The American Medical Student Association:

1. DEFINES a physician-scientist to be any M.D. or D.O. who is involved in either basic or clinical research;
2. RECOGNIZES that physician-scientists are an integral part of our health-care system, as they provide a much needed link between medical research and medical practice;
3. ENCOURAGES the U.S. government to promote programs that will maintain an adequate number of well-trained physician-scientists for the American health care system (e.g., postdoctoral research fellowships, the Medical Scientist Training Program and sufficient funds for medical research).
4. OPPOSES any efforts to affect student specialty choice that would decrease the production of well-trained physician-scientists. (1994)



## PRINCIPLES REGARDING INTERNATIONAL HEALTH

The American Medical Student Association:

1. SUPPORTS the World Health Organization's (WHO) program of "Health for All in the 21st Century" (2005) established at the International Conference on Primary Health Care held in Alma-Ata, USSR in 1978. In this we recognize the central role of primary health care in attaining this goal of a level of health for all people of the world that will permit them to lead a socially and economically productive life. There is a deeper understanding of international health and medical problems worldwide;
2. SUPPORTS the Program of Action developed at the International Conference on Population and Development held in Cairo in 1994. In this we recognize that population issues are tied to sustainable development and sustaining the environment and must be addressed in conjunction with efforts to reduce poverty and improve public health. We further recognize that successful population stabilization requires empowerment of women to exercise reproductive choice by promoting their economic, social, legal and educational equality. We encourage public and private investment in universal access to reproductive health care and family planning services; (1995)
3. RECOGNIZES the importance of United States policy with regard to the reproductive and sexual health of developing nations and therefore:
  - a. OPPOSES the United States' "gag rule" policies that implicitly or expressly prohibit the inclusion of abortion counseling or services in any family planning clinics or counseling services in developing countries that receive US funds; (2006)
  - b. OPPOSES restriction of funding for HIV/AIDS in developing countries to those programs that deal only with abstinence-based sex education, and BELIEVES education about abstinence, but also protection, to be imperative; (2006)
  - c. ENCOURAGES the United States to take the lead in developing an affordable, widely available microbicide that allows people to discreetly protect themselves from sexually transmitted infections, including HIV. (2006)
4. RECOGNIZES that although the health and medical principles of other countries may be different from those of the United States, many of the principles of AMSA, as stated in the Preamble, Purposes and Principles, are applicable to other countries;
5. CONDEMNS the actions of those multinational corporations that have erected double standards, those in the United States and those abroad; that are engaged in manufacturing practices in impoverished nations so as to escape occupational and environmental safety regulations in other countries; that seek out cheap labor markets where workers are prohibited from organizing, thus imposing harms on people within the United States who lose jobs and health care coverage, and people in poor countries who are offered unsafe, substandard work; (1999)
6. In the interest of maintaining AMSA's effectiveness as a national organization and spokesperson for its members, URGES that resolutions concerning AMSA's Principles and Purposes on international health shall have as their primary goal health care and medical issues; (1985)
7. URGES U.S. physicians and medical students to work for social justice and CONDEMN any medical organization or system that perpetuates or supports oppressive ideologies of any kind, here or abroad.
8. RECOGNIZES the promotion of world health as an important and justifiable humanitarian concern. (1986)
9. RECOGNIZES that research, education of local health care providers and application of appropriate levels of medical technology are important factors in improving health of a community; RECOGNIZES that the United States and other developed countries have both human and technical resources to aid the development of such research, education and technology in developing countries and SUPPORTS the free exchange of medical resources (including information, technology and materials) between all countries regardless of political considerations. (1997)

10. STRONGLY SUPPORTS the notion of Comprehensive Primary Health Care, and URGES the U.S. government and the international aid industry (WHO/UNICEF, World Bank and IMF, Bilateral Aid Agencies and NGOs) to support the efforts of developing nations to strengthen their internal health care systems and educational institutions by opposing structural adjustment programs that defund health and educational infrastructures; and URGES these institutions to push for loan forgiveness and other measures to alleviate the oppressive economic debt which contributes to unacceptably high morbidity and mortality rates in heavily indebted nations. (1986) (1999)
11. BELIEVES that international health programs should be created with the goal of including input from members of the developing country that will be affected by the program, as well as including participation by educational, voluntary and private organizations. (1997)
12. ENCOURAGES medical schools of the United States to commit resources to the development and incorporation of curricula related to problems of international health, especially in the fields of community medicine, primary care medicine, tropical medicine, parasitology, epidemiology, and health information systems, public health, environmental health, health-care organization and management of health policy. (1986)
13. RECOGNIZES that field experience plays a critical role in the education and training of health professionals entering the field of international health, and ENCOURAGES organizations and associations with interests in international health work to commit resources to the development and implementation of international health field experience for physicians-in-training. (1986)
14. SUPPORTS increased involvement of health-care providers, including physicians-in-training, in the field of international health. (1986)
15. OBJECTS TO action by the U.S. Congress which has curtailed assessed payments to the World Health Organization and URGES that the United States maintain its financial support of the WHO at the full assessed level as determined by the WHO Constitution, become current on its financial obligations by paying in full all funding in arrears, and further URGES the U.S. Congress to make additional voluntary contributions to enable the WHO to carry on the work planned by its Executive Board and the World Health Assembly. (1988) (1990)
16. RECOGNIZES the special health-care needs of refugees, (those that have been dislocated from their traditional living environment and dispossessed due to war, famine and economic and/or political instability), such as tropical infectious diseases and post traumatic stress disorder, and strongly urges that federal and state government allocate adequate funds to meet health and relocation needs. (1990)
17. SUPPORTS international experiences that recognize the long-term needs of the communities in which they are serving; this includes but is not limited to:
  - a. Long-term involvement, preferably permanent, but at a minimum annual delivery of aid through services and supplies. (1998)
  - b. Projects that involve members of the local community in health care and, where applicable, work to increase those community members' medical knowledge. (1998)
  - c. Projects with the ultimate goal of independent operation by the local community with minimal or no international support. (1998)
  - d. Projects that work to further public health initiatives within the community which will improve the overall health of the community even when a short-stay, annually visiting medical team is not present. (1998)
18. ENCOURAGES medical projects in developing countries to include in their goals continuing medical education for community members or members of the host country through educational exchange or through delivery of health education directly, including instruction and giving relevant books and supplies which would enhance this education. (1998)
19. SUPPORTS the idea that students can learn in international sites, provided there is appropriate mentorship by trained nurses and physicians, (preferably health care providers who are also local community members), and that there is accountability for the students actions and impact on the local community. (1998)

20. SUPPORTS any international experience that is created as an exchange between peers — a U.S. student exchanging places with a foreign student of similar educational level who can come to the United States to learn clinical medicine. RECOGNIZES that, whenever possible, exchanges are the best way to promote the principles of international health. (1998)
21. OBJECTS to groups, organizations, individual practitioners and students that force a poor community or impoverished individuals to accept beliefs/"traditions" that are not their own in order to receive life saving assistance, economic development or education. (2007)
22. SUPPORTS the Cuban Humanitarian Trade Act as introduced in the House (June 18, 1997) and Senate (November 6, 1997). (1998)
23. URGES the president and Congress to work together to lift the embargo on the sale of food and medicine to Cuba. (1998)
24. SUPPORTS the purchase of "Union Made" apparel. (2001)
25. SUPPORTS cultural, religious and traditional preservation. (2007)
26. OPPOSES proselytization as a condition for medical treatment, medical services and the disbursement of medication. (2007)
27. RECOGNIZES the positive contributions of faith-based humanitarian groups and organizations. (2007)

## PRINCIPLES REGARDING VIVISECTION IN MEDICAL EDUCATION

The American Medical Student Association:

1. AFFIRMS that the use of animals in medicine is justified if such use will save or benefit human lives (1986), while recognizing the fact that advancements in scientific knowledge have been made using nonanimal laboratory methods. (1993)
2. DISTINGUISHES between vivisection in medical research, which is the pursuit of knowledge; and vivisection in medical education, which is the demonstration of already well-known facts and techniques. (1986)
3. URGES the use of non-household pets (e.g., rats and mice) for such classes and labs when it is possible to derive equal educational value from them. (1986)
4. CONDEMNS the use of household pets (e.g., cats and dogs) from pounds, shelters and Class B random source animal dealers. (2007)
5. Regarding mandatory participation in animal laboratories:
  - a. URGES that all medical school classes and laboratories involving the use of live animals be optional for students, who for moral or pedagogical reasons, feel such use is either unjustified or unnecessary. (1993)
  - b. SUPPORTS the practice of giving medical students complete information beforehand on the source, procurement procedure, transportation, kenneling and state of health of animals that would be used for educational purposes, so that medical students can make their own informed ethical decisions. (1986)
  - c. CONDEMNS the practice of faculty intimidation of medical students to force them to attend classes and labs using live animals. (1986)
  - d. URGES the University of Colorado School of Medicine, the Uniformed Services University of Health Sciences, F. Edward Herbert School of Medicine, and the University of Nevada School of Medicine to immediately rescind the requirement for medical students to participate in laboratories using live animals as a requisite for advancement within the school. (1993)
6. Regarding alternatives to animal laboratories:
  - a. Strongly ENCOURAGES the replacement of animal laboratories with non-animal alternatives in undergraduate medical education. (2007)
  - b. URGES a directory of such alternative educational materials be produced. (1986)
  - c. ENCOURAGES the utilization of non-animal teaching materials and methods in Continuing Medical Education. (1993)
7. Regarding animal rights in laboratories:
  - a. CONDEMNS laxity in the administration and maintenance of anesthesia and analgesia for animals during and after procedures. (1986)
  - b. SUPPORTS humane and comfortable transportation, kenneling, feeding and medical care before procedures; and the same, including analgesia, after nonlethal procedures. (1986)
8. OPPOSES any legislation that would necessitate the increased use of bred animals for research and opposes any legislation that would limit the use of animals from shelters for research. (1995)
9. URGES STRONGLY that medical research on the great apes, including bonobo, chimpanzee, gorilla and orangutan, be limited as much as possible to nonlethal, humane and, as much as possible, noninvasive research activities, and that arrangements be made for care and accommodations for great apes that fosters their physical and psychological health before, during and after any research activity. (1999)

## **PRINCIPLES REGARDING PHYSICIAN IMPAIRMENT**

The American Medical Student Association:

1. RECOGNIZES that physician impairment is a serious problem requiring early intervention and prevention; (1986)
2. SUPPORTS efforts by medical schools and residency training programs to develop confidential counseling services outside of the training program; (1986)
3. URGES the establishment of confidential “Aid to Impaired Medical Students” programs in medical schools according to AAMC chemical impairment guidelines, and believes that students have a critical role in their development and subsequent functioning; (1986) (1990)
4. CONDEMNS elements of the medical education system which contribute to and foster impairment, and URGES medical schools and training programs to decrease in-hospital time demands on physicians-in-training, decrease the amount of time spent in activities of little to no educational value, and increase scheduling flexibility; (1986)
5. SUPPORTS efforts undertaken by medical students, residents, medical schools and residency training programs that underscore the importance of physician well-being and develop wellness programs aimed at prevention of impairment and health promotion; (1986)
6. CONDEMNS discrimination by medical schools and residency programs of students or residents who are recovering from impairment, and URGES effective advocacy for their reassimilation into the training process. (1986)

## **PRINCIPLES REGARDING MENTAL HEALTH**

The American Medical Student Association:

1. URGES that mental health-care services not be withheld from individuals in need of such services regardless of ability to pay. (1987)
2. OPPOSES discriminatory practices by insurance companies which either set higher deductibles, provide for a lower level of reimbursement, or both, for mental health care compared to physical health care. (1987)
3. RECOGNIZES that behavior is an essential aspect of mental health and is of fundamental importance to the pathogenesis, severity and recovery from the vast majority of physical illnesses. (1997)
4. RECOGNIZES psychiatry's increased focus on diagnosis and scientifically based treatments and its increased effectiveness in treating patients with behavioral as well as pharmacological modalities. In light of this, AMSA encourages continuing research into the causes of and treatment of mental illness.
5. SUPPORTS and ENCOURAGES efforts to educate the public about the prevalence and treatability of mental illness in order to eliminate the stigma that prevents the diagnosis and successful treatment of the mentally ill.
6. OPPOSES health care policies which determine a psychiatric patient's discharge date based solely upon his/her source of funding and without regard to attainment of any defined treatment goals which would indicate a good prognosis for recovery following discharge. (1987)
7. SUPPORTS the continuing importance of interpersonal skills training that is central to total patient care and should remain an integral part of the psychiatric training. And therefore, strongly SUPPORTS the continuing inclusion of psychodynamic techniques in medical education. (1997)
8. SUPPORTS mental health policies that are scientifically substantive, socially valuable, and place the individual above the disease. (1997)
9. RECOGNIZES the fundamental importance of the community setting for the development and treatment of mental illness and therefore ENCOURAGES the improvement of housing, education, and community health as a means to improve the mental well-being of the community. (1997)

## PRINCIPLES REGARDING MEDICARE AND SOCIAL SECURITY

The American Medical Student Association:

1. SUPPORTS the development of a catastrophic health safety net program that will be incorporated into the present Medicare system. (1987)
2. In regard to accepting Medicare assignment:
  - a. STRONGLY SUPPORTS every physician who practices under the principle that quality health care for all people, including Medicare recipients, is the ultimate concern. (1988)
  - b. OPPOSES the imposition of a mandatory link between medical licensure and the acceptance of Medicare assignment by physicians. (1988)
  - c. URGES local, state and federal government officials and concerned private organizations to find positive incentive programs to encourage voluntary acceptance of Medicare assignment. (1988)
3. SUPPORTS the development of a system that will limit out-of-pocket expenses of the chronically ill. (1987)
4. In regard to undergraduate medical education:
  - a. SUGGESTS that the Medicare Program consider making a lump sum payment for the principle and interest on educational loans taken out by medical students. In return, the medical students would enter residency programs for specialties judged to be in short supply, and heavily involved in care of the elderly. The students would also agree to accept payments by Medicare (perhaps at a discount) when they eventually enter practice.
5. In regard to balance billing:
  - a. SUPPORTS legislation that allows physicians to “opt in” or “opt out” of Medicare on a yearly basis. Those who “opt in” are allowed to balance bill on all services up to a certain percentage of the approved charge. Those who “opt out” could charge as they like, but Medicare would pay nothing for their services. (1989)
  - b. SUPPORTS legislation that caps balance billing at 15 percent of the allowed charge (1989), and STRONGLY URGES all physicians to eliminate the process of balance billing entirely for patients who are financially in need. (1992)
6. URGES the elimination of return on equity payments through Medicare to proprietary hospitals, and, furthermore, (1986)
7. SUPPORTS the maintenance of adequate capital contributions through Medicare to not-for-profit hospitals. (1986)
8. STRONGLY URGES the federal government to maintain Medicare as a national entitlement program and OPPOSES any legislation that would serve to: (1996)
  - a. Transfer control over the allocation of Medicare funds to the state governments;
  - b. Decrease access to any and all health-care services covered by Medicare for those insured by Medicare.
9. STRONGLY URGES Medicare to cover services that are required by long-term care recipients. These include, but are not limited to:
  - a. More extensive coverage of different Home Health Agencies;
  - b. Adult day care services for the chronically ill for those patients with three or more deficits in Activities of Daily Living;
  - c. Physical/Occupational Therapy.
10. STRONGLY URGES the federal government to not discontinue any of the following Medicare services to Medicare recipients:
  - a. Hospital inpatient services, subject to a deductible and coinsurance after day 60;
  - b. Home health services;
  - c. Skilled nursing facility care, limited to 100 days and subject to a coinsurance after day 20;

- d. Hospice care.
  - e. Prescription drug benefit. (2004)
11. STRONGLY URGES the federal government to not raise the monthly premium of Part B by more than 10 percent (not including cost-of-living adjustment) each year.
  12. SUPPORTS in principle the federal Medicare program, but only in the absence of a comprehensive national health program with universal coverage available for all Americans. (1997)
  13. In regard to Social Security, AMSA:
    - a. BELIEVES that the Social Security Program is an essential social program, as it benefits a large segment of the population of the United States;
    - b. OPPOSES reductions in Social Security benefits that would adversely affect the health and well-being of the elderly and others dependent upon the system;
    - c. URGES the U.S. government to consider alternative revenue sources as a means of insuring the solvency of the Social Security system.
  14. In regard to a Medicare Prescription Drug Plan: (2004)
    - a. STRONGLY URGES the Federal government to use volume purchasing of pharmaceutical drugs to negotiate lower prices with drug companies. (2004)
    - b. URGES the Federal government to provide all beneficiaries with an affordable and comprehensive prescription drug benefit, regardless of the availability of private plans in individual regions. (2004)
    - c. OPPOSES assets tests or means testing of Medicare beneficiaries to determine levels of coverage based on income or assets. (2004)
    - d. OPPOSES attempts to privatize Medicare whereby beneficiaries are forced to select private plans in order to receive prescription drug or other benefits. (2004)
    - e. OPPOSES decreasing Medicaid or employer retirement prescription drug benefits in order for Medicare beneficiaries to participate in the Medicare prescription drug plan. (2004)
    - f. SUPPORTS a Medicare prescription drug benefit that is administered as a simple add-on benefit to traditional Medicare; (2006)
    - g. SUPPORTS the elimination of the “doughnut hole,” which refers to the range of levels of prescription drug out-of-pocket expenditures for which the drug benefit offers zero percent coverage in the Medicare prescription drug benefit; (2006)
    - h. URGES the government to lower the drug expenditure threshold for catastrophic coverage eligibility; (2006)
    - i. URGES insurers to provide a generous formulary that covers multiple members of a class of drugs; (2006)
    - j. URGES insurers to set up an effective, rapid mechanism for beneficiaries or their agents to appeal denials of coverage of drugs that are not on the formulary. (2006)
    - k. SUPPORTS the development of user-friendly applications for enrollment in Part D, the development of unbiased, evidence based tools to make informed choices between drug plans, and the promulgation of pertinent information about the benefits offered in different plans; (2006)
    - l. URGES legislatures to eliminate the requirement that forces Medicare prescription drug beneficiaries to enroll with a drug plan for one year; (2006)
    - m. SUPPORTS beneficiary freedom to switch drug plans without barriers; (2006)
    - n. URGES the federal government to allow federal matching funds for state initiated Medicaid wrap-around coverage for dual eligibles. (2006)



## PRINCIPLES REGARDING MEDICAID

The American Medical Student Association:

1. SUPPORTS in principle the aim and implementation of the Medicaid program to provide health coverage for disadvantaged uninsured residents (2005), but in all instances will work toward a comprehensive national medical care program with universal coverage available for all Americans; (1990)
2. In regard to eligibility;
  - a. SUPPORTS legislation that abandons categorical tests for eligibility for Medicaid; (1990)
  - b. SUPPORTS legislation that grants Medicaid benefits on the basis of financial need alone, with eligibility levels of at least 200% Federal Poverty Level (FPL) for children and 133% FPL for adults; (2005)
  - c. SUPPORTS legislation that expands coverage to impoverished individuals with physical disabilities, terminal illnesses, chemical dependency and mental illnesses; (1990)
  - d. ENCOURAGES health care reform to ensure universal coverage but until that time provide Medicaid to all eligible persons and families; (2005)
  - e. STRONGLY ENCOURAGES the federal government to disallow state governments from restricting the eligibility criteria for Medicaid which would exclude any and all recipients of TANF (2005) and low-income pregnant mothers; (1996)
  - f. STRONGLY ENCOURAGES the federal government to disallow state governments from imposing enrollment caps on Medicaid which eliminates Medicaid's guarantee to coverage and is not based on need but rather on a first come first serve basis; (2005)
  - g. SUPPORTS the states' simplification of enrollment and renewal procedures for Medicaid and SCHIP programs; (2005)
3. In regard to women and children;
  - a. SUPPORTS legislation that insures pregnant women eligible for Medicaid to be automatically covered for prenatal care for at least 45 days from the earliest point of contact and maternal and child care for up to two months after delivery; (1990)
  - b. OPPOSES separating the eligibility of a pregnant woman and her fetus for SCHIP or Medicaid benefits. (2005)
4. With regard to Medicaid funding;
  - a. STRONGLY URGES the federal government to maintain the current Medicaid funding structure in which states and the federal government share risk and responsibility for populations covered by Medicaid; (2005)
  - b. OPPOSES any legislation that would serve to: (1996)
    1. Transfer control over the allocation of federal Medicaid funds to the state governments;
    2. Decrease benefits currently received by U.S. citizens insured under Medicaid, including approving Section 1115 Waivers that alter Medicaid's enrollment, benefits and affordability; (2005)
    3. Allow states the option of refusing to match federal funds for Medicaid recipients;
    4. Allow states to use different eligibility criteria for TANF (2005) from Medicaid criteria in order to eliminate or maintain benefit status. (1996)
    5. Remove requirement for federal approval of state waivers for any reduction in eligibility or benefits; (2005)
    6. Place any caps on states' Medicaid spending which would limit states' capacity to provide health coverage and would break the federal-state partnership to share the risk and responsibility of covering this low-income population. (2005)

## **PRINCIPLES REGARDING HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND HIV-RELATED ILLNESSES**

The American Medical Student Association:

1. In regard to patient rights to health care:
  - a. BELIEVES that patients with known or suspected HIV infection or related illness(es) maintain their right to obtain health care at all levels of the health-care system, including, but not limited to: emergency medical services, outpatient and emergency room treatment, inpatient treatment, home nursing care, nursing-home care and hospice care; (1988)
  - b. BELIEVES that patients with known or suspected HIV infection or related illness(es) have a right to the same quality of care as would be provided to a patient not suffering from a known or suspected HIV infection or related illness, at all levels of the health-care system; (1988)
  - c. BELIEVES that patients with known or suspected HIV infection or related illness(es) deserve to be treated with the same degree of compassion as would be afforded to patients not suffering from a known or suspected HIV infection or related illness, at all levels of the health-care system; (1988)
  - d. OPPOSES any policy/policies which would jeopardize a patient with known or suspected HIV infection or related illness(es)'s ability to access the health-care system or to receive quality, compassionate care as outlined above. (1988)
2. In regard to discrimination:
  - a. OPPOSES discrimination based upon known or suspected HIV infection or related illness(es) in the areas of providing: (including, but not limited to) hospital admissions, diagnostic and/or therapeutic procedures (including nonelective surgery), and emergency medical services; (1988)
  - b. OPPOSES discrimination based upon known or suspected HIV infection or related illness(es) in the areas of: (including, but not limited to) housing, employment (including health-care employees seropositive to anti-HIV antibodies), insurance eligibility and coverage, education and travel. (1988)
3. In regard to physician responsibilities:
  - a. BELIEVES that physicians have the following responsibilities regarding HIV and HIV-related illnesses:
    1. to provide quality medical care to patients with known or suspected HIV infection or related illness(es), including but not limited to: diagnosis, treatment, cure and education; (1988)
    2. to refer patients with known or suspected HIV infection or related illness(es) to another medical professional in the event that the primary physician is unable to provide quality medical care to a patient due to lack of expertise or resources on the part of the physician;
    3. to provide society with factual education regarding HIV infection and related illness, including but not limited to: how HIV is and is not transmitted, the signs and symptoms of HIV infection and related illnesses, the use of screening tests for HIV infection (i.e., HIV test or testing), and the methods of preventing HIV transmission; (1988)
    4. to allay undue fears and change misconceptions in society about HIV infection and related illness through education and appropriate medical and psychological referrals, if necessary; (1988)
    5. to provide factual education to medical students, residents, attending physicians, and all other health-care professionals and students regarding HIV infection and related illnesses, treatments and prevention strategies; (1988)

6. to ensure that responsible measures, as outlined in the CDC guidelines, are taken in the workplace to prevent the transmission of HIV; (1988)
  - b. BELIEVES it to be unethical for physicians to refuse to treat or refer patients with known or suspected HIV infection or related illness(es) based solely upon personal attitudes regarding such patients, their illness (actual or perceived), or their lifestyles. (1988)
4. In regard to HIV testing:
- a. SUPPORTS the use of the HIV test to screen donated blood products and donors of sperm, organs and tissues as a precondition for acceptance or use in transfusions, insemination and transplants; (1988)
  - b. SUPPORTS the rights of blood, sperm and organ banks to refuse donations from individuals who refuse to consent to an HIV test; (1988)
  - c. BELIEVES that individuals who are donating blood products, sperm, organs or tissues for use in transfusion, insemination, or transplant should be advised that they will be tested for the presence of anti-HIV antibodies, be required to give informed consent for such testing; (1988)
  - d. OPPOSES mandatory HIV testing for any purpose other than as described above, and specifically OPPOSES mandatory testing of health-care workers as a breach of confidentiality; (1988)
  - e. SUPPORTS the rights of individuals to choose to have the HIV test performed in a voluntary, anonymous and confidential manner free or at minimal cost; (1988)
  - f. BELIEVES that such testing should only be performed when the patient has provided informed consent; (1988)
  - g. OPPOSES any use of an HIV test as a precondition for receiving health-care services; (1988)
  - h. BELIEVES that persons undergoing HIV testing should receive pretest education regarding the nature of the test, the possible interpretations of the results and ways to reduce the risk of HIV transmission through behavioral changes; (1988)
  - i. BELIEVES that persons undergoing HIV testing should receive post-test counseling and education regarding their HIV status, its implications for personal physical and mental health, ways to reduce the risk of transmission through behavioral changes, available help for voluntary follow-up of any sexual and/or I.V. drug use partners who may have been exposed to HIV; (1988)
  - j. SUPPORTS programs to assist anti-HIV antibody seropositive individuals to perform voluntary contact tracing and notification of individuals who may be at risk of HIV exposure; (1988)
  - k. SUPPORTS the reportability of seropositive HIV test results with nonidentifying information such as age, sex, race, city and state of residence, risk factor(s) for infection and current signs/symptoms of HIV-related illness. (1988)
  - l. OPPOSES mandatory reportability of names of persons registering a positive anti-HIV antibody status, or the maintenance of any registry of anti-HIV antibody seropositive individuals; (1988)
  - m. SUPPORTS the inclusion of HIV test results under separate cover in medical records to safeguard the confidentiality of the patient; (1988)
  - n. RECOGNIZES the uncertain meaning of a positive anti-HIV antibody status, and the stigma attached to anti-HIV antibody seropositivity, that mandatory testing is not a viable public health strategy for preventing HIV transmission; (1988)

- o. SUPPORTS the availability of free, confidential and voluntary HIV testing and counseling in the event of a parenteral exposure to HIV in the work place by a health-care worker; (1988)
  - p. OPPOSES mandatory HIV screening of applicants for permanent residency in the United States; (1990)
  - q. OPPOSES the requirement of HIV serologic status documentation of foreign visitors; (1990)
  - r. SUPPORTS the rights of adolescents to choose to have the HIV test performed without consent of a legal guardian. (1995)
  - s. SUPPORTS mandatory legislation surrounding maternal-fetal HIV transmission including:
    - 1. Requiring health-care providers and facilities to counsel and offer all pregnant women HIV testing at least once during pregnancy; (2005)
    - 2. Requiring labor and delivery units to offer rapid HIV testing to women in labor who do not have documentation of HIV results during time of pregnancy; (2005)
    - 3. Requiring labor and delivery and nursery units to have medications available for both mother and child in the case of a positive HIV test result. (2005)
5. In regard to education:
- a. SUPPORTS the recommendations of the Surgeon General contained in the Surgeon General's Report on Acquired Immune Deficiency Syndrome; (1988)
  - b. BELIEVES that education regarding HIV, HIV related illnesses and risk elimination/reduction practices are currently the most promising public health options to control the spread of HIV; (1988)
  - c. SUPPORTS efforts to achieve widespread public education regarding all aspects of HIV, HIV related illnesses and risk elimination/reduction practices; (1988)
  - d. BELIEVES that additional resources should be committed at the federal, state and local levels of government to provide educational resources about HIV, HIV related illnesses and risk elimination/reduction practices to all individuals, with particular emphasis on reaching minorities and individuals at greatest risk of infection with HIV; (1988)
  - e. SUPPORTS the education about HIV and HIV-related illnesses beginning with the grammar school curricula. Such education should address topics appropriate to the ages of the students involved, be factual in nature, and be presented in a professional and nonjudgmental manner, including discussion on sexuality, drug abuse and condoms; (1988)
  - f. URGES the medical community to become actively involved in public education efforts addressing HIV and HIV-related illnesses; (1988)
  - g. OPPOSES guidelines which restrict the content of educational materials, making them ineffective for the intended audience; (1992)
  - h. URGES guidelines to develop educational materials which are sensitive, culturally appropriate and effective as determined by members of the population targeted by the materials. (1992)
6. In regard to support services:
- a. BELIEVES that adequate support services to assist with medical needs, food, shelter and personal care should not be denied to individuals with HIV related illnesses, regardless of ability to pay, a position AMSA takes regarding all debilitating illnesses; (1988)
  - b. URGES the development of a system of coordinated volunteer and government agencies at the local level to assess the support needs and financial resources of individuals with HIV related illnesses, to create and develop such services and to coordinate the disbursement of all support services deemed appropriate; (1988)

- c. BELIEVES that individuals should not be denied admission to nursing homes or hospice care facilities on the basis of either a known or presumed HIV infection or related illness and OPPOSES any policy that would have such an effect; (1988)
- d. URGES the development of alternative living situations for individuals with HIV related illnesses who do not have adequate housing. (1988)

7. In regard to HIV research:

- a. URGES research into the following topics integral to addressing the HIV/AIDS crisis:
  - i. continued research defining the epidemiology of HIV infection in the population and the impact of HIV infection; (1988)
  - ii. continued research into woman-controlled methods of protection against HIV. AMSA in particular strongly supports increased funding and coordination of microbicide research as a prevention tool against HIV; (2005)
  - iii. increased research efforts into the development of pediatric formulations for HIV-positive children; (2005)
  - iv. increased research efforts to develop low-cost methods of rapid HIV testing, CD4 count measurements, and viral load testing that can be easily used in resource-poor settings; (2005)
  - v. increased research efforts to develop treatments for the HIV infection, including:
    - 1. a cure for HIV infection (1988)
    - 2. an HIV vaccine (2005)
  - vi. increased research into the various strains of HIV, and SUPPORTS the development of separate diagnostic tests for each strain discovered such that the principle added be numbered appropriately. (1988)
- b. URGES strict enforcement of confidentiality guarantees provided to individuals participating in research studies of HIV and HIV-related illnesses and that access to identifying information within such files should be limited to those individuals requiring such information for legitimate research purposes (1988)

8. In regard to infection control policies:

- a. SUPPORTS and URGES the following measures to control the spread of infectious diseases in every health-care facility in the United States:
  - i. Mandatory adherence to Hepatitis B infection control guidelines (i.e., universal precautions) by all health-care facilities and personnel for every patient, regardless of known or suspected infection with Hepatitis B and/or HIV; (1988)
  - ii. Employee and patient education programs in every health-care facility regarding HIV, HIV-related illness, risk of HIV transmission and techniques to minimize such risks; (1988)
  - iii. Implementation in every health-care facility of disciplinary procedures for any individual found to be routinely and/or intentionally disregarding standard infection control policies; (1988)
  - iv. Adoption of the Occupational Safety and Health Administration Guidelines for the Control of Blood-Borne Infections within all clinical settings; (1992)
- b. URGES infection control education for all health-care related professionals and pre-professionals. This includes:
  - i. mandatory education concerning infection control guidelines for all health-care workers at the time of employment in a health-care facility, and on a yearly basis (minimally) thereafter; (1988)
  - ii. timely updates regarding changes in recommended CDC and/or local infection control policies at all health-care facilities to all health-care facility employees; (1988)
  - iii. infection control education for all health-care related students as part of their standard curriculum. (2005)
- c. SUPPORTS AND URGES harm reduction principles in the education and treatment of drug users. In these cases, harm reduction would include, but not be limited to, the following measures:

- i. Communities with injection drug users to adopt needle exchange programs in conjunction with substance abuse treatment and prevention and addiction treatment programs. In particular, access to drug treatment programs, methadone maintenance, bleach, and pilot needle exchange programs in prisons should be implemented to ensure the health of prisoners and halt the epidemic of HIV and Hepatitis C in prisons across the US. (2005)
  - ii. The creation of methadone maintenance programs in states that do not currently have these types of drug treatment programs, and urges increased funding to meet the demand of those already in operation. (2005)
  - iii. Educating drug users about safe injecting practices, Hepatitis C and HIV transmission, and overdose treatment. (2005)
- 9. In regard to federal policy:
  - a. ENCOURAGES the development and adoption of a comprehensive national policy setting priorities and goals for confronting and controlling the current HIV epidemic; (1988)
  - b. URGES passage of legislation by Congress making it illegal to discriminate against any individual on the basis of a presumed or known HIV infection or related illness, extending to such individuals full protection of their civil rights; (1988)
  - c. URGES the allocation of increased funding for all aspects of HIV-related programs, including research, education, social services and health-care delivery; (1988)
  - d. URGES that the Presidential Advisory Commission on HIV and AIDS be expanded to include more healthcare workers with direct clinical expertise on AIDS and representatives from the following groups: people infected with AIDS, specifically including women, gay/bisexual men, transgender people, people of color, recovering injection drug users, adolescents and the sexual partners of persons infected with HIV. (2006)
  - e. URGES that current FDA guidelines for testing new drugs/treatments should be reviewed, and that procedures should be developed and implemented to shorten the time required to test, approve and make available any drugs/treatment that are shown to be effective against HIV and HIV-related illnesses. Such new procedures should not sacrifice reasonable evaluations of safety and efficacy; (1988)
  - f. URGES that the CDC and FDA establish research protocol guidelines which maintain scientific autonomy from social-political bias and which are humane and expedite the availability of new treatments; (1991)
  - g. URGES the U.S. federal government to remove HIV and AIDS from the list of diseases which excluded foreigners from traveling to the United States; (1993)
  - h. URGES that the federal government lift the ban on federal funding of needle exchange programs. (1999)
- 10. In regard to HIV infected health-care providers:
  - a. SUPPORTS the right of physicians and health-care workers with known or suspected HIV infection or illness to continue working in their chosen profession and that each seropositive physician or health-care worker should be under competent medical care with a provider who is aware of the changing management of HIV infections. It is suggested that medical care should not be obtained from a provider located in the same workplace; (1988)
  - b. ENCOURAGES physicians and health-care workers with a debilitating illness (including HIV infection or illness) to voluntarily refrain, either temporarily or indefinitely, from providing patient care at any time when their physical and/or mental capacities become impaired. Physicians and other health-care workers with AIDS and opportunistic infections must conform to the same infection control guidelines applicable to those infections that would apply to any practitioner; (1988)

- c. SUPPORTS the creation at each health-care facility of a mechanism to evaluate the ability of physicians and health-care providers to provide competent medical care. Such mechanisms shall maintain the individual's confidentiality and right to due process guaranteed to any potentially disabled employee. Each institution should develop personnel policies concerning HIV testing and diseases, taking into account the above recommendations and circulate these to all employees and staff; (1988)
  - d. SUPPORTS the reassignment to non-patient care duties any physician or health-care provider with known HIV infection or illness when: (1988)
    - 1. such reassignment is requested by the individual, or
    - 2. the individual's continued direct involvement in providing patient care would present an identifiable and real risk to the health of either the patient or the individual. Such determinations should be made in accordance with paragraph c above. (1988)
  - e. BELIEVES that a student with a known infectious disease and/or illness not otherwise covered by legal statute to include HIV/AIDS, should be allowed to complete his or her medical education, including residency program, provided: (1993)
    - 1. his/her health allows his or her active participation in the classroom or clinic and (1993)
    - 2. any student who feels he or she is being discriminated against based on their HIV status must have the opportunity to have the final decision regarding their medical education be determined by a committee at that student's medical school created specifically to make such a determination. This committee will include at least one ethicist and at least one licensed infectious disease specialist, preferably one with clinical experience treating patients with HIV disease. The student maintains the option of appointing advocate(s) to the committee. In order to maintain confidentiality the student also has the option of appointing a representative to speak to the committee on their behalf, thus maintaining anonymity. (1993)
    - 3. URGES any such medical school committee, set up specifically to determine whether an HIV-positive medical student may continue his/her medical education, to allow such students to continue their education unless, and only unless, that individual has active tuberculosis or other contagious opportunistic infection, an open wound, or physical or mental impairment which would adversely affect that student's ability to interact with and care for patients. (1993)
  - f. OPPOSES the actions of federal, state, or local regulatory bodies requiring disclosure of physician HIV status to patients, RECOGNIZING that such actions violate physician's personal rights to privacy without any medical justification. (1988)
- 11. URGES the United States to give increased financial and personnel support and other contributions to small and large, private and public international organization efforts aimed at controlling the spread of AIDS in less developed areas that have limited resources. (1988)
  - 12. RECOGNIZES that human rights abuses are integral to the possible human rights catastrophe surrounding HIV/AIDS and includes but is not limited to violations of the right to be free from discrimination, the right to personal protection, the right to information, the right to health and the right to life. (2002)
  - 13. URGES the United States as a donor country to contribute to the Global Fund to Fight AIDS, Tuberculosis and Malaria at the level recommended by the Secretary General of the United Nations. (2002)
  - 14. SUPPORTS legislation mandating that HIV positive children be informed of their status at an early age. (2006)

## PRINCIPLES REGARDING RESIDENT AND STUDENT WORK HOURS

The American Medical Student Association:

1. BELIEVES that the need to reduce housestaff working schedules are clear and reasonable and deserves attention from residency program directors, specialty residency review committees, state governments and the federal governments.
2. BELIEVES the resident duty hours regulations as adopted by the ACGME are currently insufficient to ensure maximized patient and resident safety and health. (2005)
3. SUPPORTS and will work toward the implementation of regulations, including those at the federal level, which will regulate resident work hours with the intent of providing a better standard of care for all patients and more humane working conditions for residents. These regulations should be based on the most current research on sleep, learning and patient and resident physician safety. They should include or take into account, but not be limited to, the following: (2006)
  - a. The number of hours a resident may work per week should not exceed 80 hours, without averaging hours worked over a period of greater than one week. (2005)
  - b. The number of hours a resident may work per shift should not exceed 16 hours, including time for transfer of patient care and resident education. (2006)
  - c. Residents should have at least 10 hours of time off duty between scheduled shifts. (2003)
  - d. Residents should have at least 1 full continuous 24 hour period off out of every 7 days, without averaging off hours over a period of greater than 7 days, and one full weekend off per month. (2005)
  - e. AMSA urges the ACGME to support and to help to facilitate further research on resident work hours specifically with regard to sleep, learning, patient and resident physician safety. (2006)
4. BELIEVES in order to accommodate needed residency reform, private and governmental health financing bodies must recognize the need of hospitals to hire increased ancillary personnel to perform many tasks which do not require the physician's expertise but are currently performed by residents.
5. BELIEVES resident's salaries or benefits should not be reduced. In addition, there will not be any prolongation of the residency training period due to limitations on working hours.
6. BELIEVES independent review committees should include resident physicians and should monitor residency program compliance. (2003)
7. BELIEVES public hospitals and indigent patients must not bear the brunt of this reform.
8. SUPPORTS continued exploration on the relationship between sleep deprivation and high work hours and how they affect physical and emotional health, learning and retention, and professionalism among residents and students.(2005)
9. BELIEVES that the same limits that apply to resident work hours should be applied towards medical student work hours. (2005)
10. SUPPORTS the action of the Liaison Committee on Medical Education (LCME) in February 2004 to limit medical student work hours to the same maximum level as those worked by residents, BUT BELIEVES that more specific guidelines would be appropriate. (2005)
11. URGES medical schools to swiftly enact the guidelines issued by the LCME limiting student work hours. (2005)
12. URGES the LCME to incorporate a formal standard governing student work hours which applies the same regulations towards medical students that AMSA urges for residents as described above. (2005)
13. BELIEVES that resident fatigue and sleep deprivation increase the risk of harm to residents and the general public, and URGES residency programs to acknowledge that this increased risk may arise as a consequence of residents' conscientious fulfillment of their duties, and URGES residency programs to institute appropriate measures to minimize the risk of harm to residents and the public. (2005)
14. In regard to the need for reduced-schedule residencies, AMSA:
  - a. REALIZES the value of reduced-schedule residencies within graduate medical education. (2006)



- b. BELIEVES that reduced-schedule residencies should be in place for those individuals who would otherwise consider opting out of residency. (2006)
  - c. UNDERSTANDS that there are various reasons why individuals would choose reduced-schedule residencies and not that they are simply “being lazy.” (2006)
15. In regard to establishment of reduced-schedule residencies, AMSA:
- a. BELIEVES that a comprehensive strategy incorporating research, education, policy changes, and communication between and among residency programs and residency candidates is necessary to further acceptance of shared and part-time residencies. (2006)
  - b. CALLS FOR the availability of accurate information about which programs offer reduced-schedule residencies within graduate medical education. (2006)
  - c. URGES more residency programs to consider establishment of reduced-schedule residencies. (2006)
  - d. ENCOURAGES the establishment of reduced-schedule residencies within graduate medical education in a way that is beneficial to both the residency program and its residents. (2006)
  - e. SUPPORTS those organizations that are involved in encouraging the establishment of reduced-schedule residencies within graduate medical education. (2006)

## **PRINCIPLES REGARDING NONPROFIT ORGANIZATIONS**

The American Medical Student Association:

1. BELIEVES that society significantly benefits from the tax-exempt status of nonprofit organizations;
2. OPPOSES changes to the Unrelated Business Income Tax statute that would undermine the favorable tax status of nonprofit organizations;
4. OPPOSES any attempt to tax the investment and other unrelated business income of 501(c)(6) associations. (1999)

## PRINCIPLES REGARDING PHYSICIAN PAYMENT REFORM

The American Medical Student Association:

1. RECOGNIZES that health-care delivery and the provision of physician services do not adhere to economic laws based on supply and demand, but instead to a more monopoly oriented economic model. (1990)
2. In regard to choice of medical field;
  - a. STRONGLY ENCOURAGES physicians and physicians-in-training to look beyond economic concerns to broader moral and ethical obligations when making patient management decisions, and also when making specialty career choices. (1990)
  - b. RECOGNIZES that inequity exists within our current physician compensation system between the provision of primary care and procedures, and further RECOGNIZES that this inequity is represented by lower mean and median salaries for primary care physicians relative to the more procedure oriented specialties. (1990)
3. In regard to the Resource Based Relative Value Scale (RBRVS);
  - a. SUPPORTS the Resource Based Relative Value Scale as a valid instrument, useful for comparing work levels across medical and surgical specialties, and further ENCOURAGES the implementation of this scale, in a budget neutral fashion, by third payers, including federal and state governments, the private insurance industry, health maintenance organizations and employers. (1990)
  - b. SUPPORTS the 1989 Physician Payment Review Commission (PPRC) version of the original RBRVS, but suggests that any other changes or deviations from the original scale be thoroughly researched and verified as scientifically sound, so as not to introduce inequities. (1990)
  - c. SUPPORTS the second phase of the RBRVS research (scheduled for completion in 1990), and ENCOURAGES broadening the scale to include physicians in all specialties. (1990)
  - d. ENCOURAGES the incorporation of the RBRVS, or a version of it, into National Health Program or National Health Insurance Proposals. (1990)
  - e. OPPOSES any changes of Graduate Medical Education Stipends or programs based on, or as a result of, the implementation of the RBRVS. (1990)
  - f. The American Medical Student Association (AMSA) recognizes the existence of the Resource-Based Relative Value Scale and further recognizes the need for equity in Medicare reimbursement between procedures and cognitive services that prompted the development of the RBRVS.
  - g. SUPPORTS the use of a RBRVS as a basis for a Medicare fee schedule, and URGES that all specialties be included under that fee schedule. (1989)
4. In regard to volume controls;
  - a. RECOGNIZES the necessity of volume controls as a regulatory measure to control inflation within Medicare Part B, but DISAGREES with the presumption that the growth of Medicare Part B in the late 1980s was solely due to overutilization by physicians; (1990)
  - b. EMPHASIZES that volume controls, like price controls and freezes, prospective payment systems, and, in fact, the entirety of both the Medicare and Medicaid programs, are inadequate corrective measures for a health-care system that has failed in the free market economy of the United States., and STRONGLY SUPPORTS the concept that physician payment reform must be developed in concert with comprehensive reforms of our health-care system. (1990)
5. In regards to reimbursement:
  - a. URGES providers to take care of patients regardless of insurance status and/or the reimbursement rate of the patient's insurance; (2006)
  - b. RECOGNIZES that providers may have difficulty seeing patients on public insurance programs due to low reimbursement rates; (2006)
  - c. STRONGLY URGES the federal government to maintain sufficient reimbursement rates in public insurance programs. (2006)

## **PRINCIPLES REGARDING PREMEDICAL EDUCATION**

The American Medical Student Association:

1.       RECOGNIZES the special needs of undergraduate premedical students. (1990)
2.       SUPPORTS the pursuit of interests outside the basic sciences for premedical students both within the curriculum and in extracurricular activities. (1990)
3.       ENCOURAGES clinical exposure in premedical curricula. (1990)
4.       SUPPORTS the exposure of premedical students to course work in humanistic and evidence-based studies including, but not limited to, sociology, philosophy, ethics and statistics. (2005)

## PRINCIPLES REGARDING RESEARCH

The American Medical Student Association:

1. SUPPORTS the increased efforts of the National Institutes of Health and the medical research community to address the health issues of women. (1994)
2. ENCOURAGES the National Institutes of Health and the medical research community to increase efforts to address the health issues of minorities. (1994)
3. ENCOURAGES the National Institutes of Health and the medical research community to increase efforts to address the health issues of lesbian, gay, bisexual and transgender persons. (1994)
4. SUPPORTS efforts in the medical research community to increase the amount of prospective, population-based outcomes research. (1994)
5. OPPOSES the systematic exclusion of women from participation as subjects in medical research on the basis of their reproductive potential; (1997)
6. ENCOURAGES the inclusion of women as research subjects in all medical research that could potentially benefit women; (1997)
7. BELIEVES that research about the transmission, progression and presentation of HIV infection and HIV disease in women should include, but not be limited to, possible transmission to her offspring. (1997)
8. ENCOURAGES education of the consequence of diethylstilbestrol exposure (DES) so that medical students and health-care professionals receive satisfactory knowledge of the signs and symptoms of DES exposure in both the mother and her children. Furthermore, AMSA SUPPORTS continued federally funded research on DES exposure and the future health of those affected. (1998)
9. With Regards to Clinical Trial Databases and Open Access Publishing: (2005)
  - a. SUPPORTS the creation of a centralized and comprehensive national registry of all publicly and privately funded clinical trials involving drugs, biological products, or devices regardless of the outcome of the trial. (2005)
  - b. Supports taxpayer-funded research being freely available in PubMed Central or a similar repository immediately upon publication. (2005)
  - c. SUPPORTS the concept of open access publishing, defined by the Bethesda criteria as follows: (2005)

An Open Access Publication[1] is one that meets the following two conditions:

    1. The author(s) and copyright holder(s) grant(s) to all users a free, irrevocable, worldwide, perpetual right of access to, and a license to copy, use, distribute, transmit and display the work publicly and to make and distribute derivative works, in any digital medium for any responsible purpose, subject to proper attribution of authorship[2], as well as the right to make small numbers of printed copies for their personal use. (2005)
    2. A complete version of the work and all supplemental materials, including a copy of the permission as stated above, in a suitable standard electronic format is deposited immediately upon initial publication in at least one online repository that is supported by an academic institution, scholarly society, government agency, or other well-established organization that seeks to enable open access, unrestricted distribution, interoperability, and long-term archiving (for the biomedical sciences, PubMed Central is such a repository). (2005)

[1] Where:

    1. Open access is a property of individual works, not necessarily journals or publishers. (2005)
    2. Community standards, rather than copyright law, will continue to provide the mechanism for enforcement of proper attribution and responsible use of the published work, as they do now. (2005)
  - d. SUPPORTS the Public Library of Science as a model of open access publishing. (2005)

## **PRINCIPLES REGARDING CARE OF THE HOMELESS AND INDIGENT**

The American Medical Student Association:

1. AFFIRMS its commitment that every citizen of the United States have access to health care when needed, regardless of housing status or ability to pay. (1994)
2. SUPPORTS the concept of physicians and physicians-in-training volunteering person-hours for the care of the homeless and indigent. (1994)
3. ENCOURAGES individual physicians and physicians-in-training, hospitals and medical schools to initiate programs to serve the homeless and indigent. (1994)
4. ENCOURAGES medical schools to incorporate principles of care and specific problems of care for the homeless and indigent into their curricula. (1994)
5. URGES all medical schools to provide opportunities to their students to provide care to the homeless and indigent. (1994)
6. URGES all medical students to avail themselves of opportunities to participate in the care of the homeless and indigent during their education. (1994)
7. ENCOURAGES medical schools and academic health centers to undertake research into the nature and extent of health care needed by the homeless and indigent in their communities. (1994)
8. URGES all jurisdictions to provide physicians and physicians-in-training with insurance for liability for pro-bono care for the homeless and indigent. (1994)
9. SUPPORTS legislation providing tax exemptions and financial support for other incentives for health professionals providing pro-bono care. (1994)
10. URGES more primary care services for the homeless and indigent in order to improve quality of life and minimize reliance on emergency departments as sole interface for healthcare access. (2006)
11. REAFFIRMS that universal health care would significantly improve access to primary care for these populations and bolster their human right to health. (2006)
12. ENCOURAGES medical centers to advocate for homeless and indigent patients to obtain Medicaid and other governmental entitlements. (2006)
13. DISCOURAGES criminalization of illicit substance use among the homeless and indigent but rather encourages alternate investment in drug rehabilitation, counseling, vocational training, and education regarding economic sustainability. (2006)

## **PRINCIPLES REGARDING THE ENVIRONMENT**

The American Medical Student Association:

1. SUPPORTS anti-pollution programs, publicity and legislation with its enforcement to reduce industrial and environmental health hazards and to correct pollution problems;
2. In regard to nuclear power:
  - a. BELIEVES that the United States should refrain from issuing permits for the siting, construction or operation of all nuclear power plants until such a time as the present problems these plants pose to the nation's health and safety are resolved;
  - b. URGES the U.S. Government to immediately institute programs to replace functioning nuclear power plants with safer, renewable forms of energy production;
  - c. BELIEVES that the United States should suspend exportation of nuclear power plants to other countries pending resolution of the associated world security questions and the safety of nuclear power;
3. SUPPORTS educational, case-finding and follow-up programs regarding lead poisoning;
4. SUPPORTS efforts directed at the following objectives for asbestos control:
  - a. revisions of Environmental Protection Agency and other federal regulations so as to extend asbestos building monitoring standards beyond elementary and secondary schools and to institute corrective actions where needed;
  - b. studies of asbestos from products and their potential health impact;
  - c. alternatives to the use of asbestos wherever it poses a human health hazard.
5. SUPPORTS the protection of a safe and healthy environment through the development of efficient, effective and safe alternative mass transit systems; and SUPPORTS the limited use of gasoline or diesel driven internal combustion engines in the future. (1985)
6. SUPPORTS legislation to require facilities that produce, store or transport hazardous substances to file with the appropriate Federal, State and local authorities an inventory of all such substances produced or stored on the premises. Documentation of the known risks to human health which are posed by such substances and a description of the appropriate medical treatment in the event of exposure should be provided. This information should be readily accessible to those requesting it. (1986)
7. STRONGLY SUPPORTS the protection of public health and the environment from the contamination of medical waste and urges the following:
  - a. Establishment of federal regulations to prevent medical waste from fouling public areas.
  - b. Promotion and the stricter enforcement of a safe national standard for treatment and disposal of medical waste, including a system of uniform labeling.
  - c. Integration into the medical education curriculum of presentations regarding the issues of medical waste and its control.
  - d. Promotion and stricter enforcement of responsible medical waste management including, but not limited to the following: (1999)
    1. Reduced incineration of PVC plastics and mercury containing items; (1999)

2. Increased procurement of non-PVC and nonmercury containing products; (1999)
  3. Increased recycling of applicable medical products; (1999)
  4. Increased procurement and implementation of reusable medical products; and, (1999)
  5. Ongoing alternative waste management technology research. (1999)
8. URGES the Department of Energy to provide immediate access to scientists, physicians and public health officials to all historical data on releases of radioactive and toxic substances into the environment so the impact of these exposures can be better assessed and analyzed by impartial health professionals. (1990)
9. In regard to disposable diapers:
- a. RECOGNIZES that improper disposal of disposable diapers and similar products used with incontinent adults is occurring and poses a potential health risk from human excreta in the waste stream by contamination of ground water; (1990)
  - b. SUPPORTS greater public education about the environmental risks of diapers, about all the available choices for diapering and about proper disposal of diapers and human excreta; (1990)
  - c. SUPPORTS legislation that requires manufacturers of disposable diapers to provide better instructions on the packaging for proper disposal of excreta; (1990)
  - d. ENCOURAGES institutions to use reusable diapers and manufacturers to develop a recyclable product that generates less solid waste; (1990)
  - e. URGES manufacturers of disposable diapers to act responsibly in marketing their products overseas; (1990)
  - f. SUPPORTS further research on types of diapers so that standards can be developed and researched on the health implications of disposing disposable diapers and their fecal contents into the solid waste stream. (1990)
10. In regard to the responsible use of environmental resources:
- a. SUPPORTS the doctrine of reduce: the amount of toxicity of products that we rely on, reuse: containers and products as much as possible, recycle: everything possible, and reduce: excessive packaging and products whose production, use and disposal is harmful to the environment.
  - b. SUPPORTS the current change of printing *The New Physician* on coated, recycled stock paper.
  - c. SUPPORTS an incremental progression toward the use of environmentally responsible materials (paper and ink) in all AMSA publications. Further, it URGES the use of recycled and recyclable products, while maintaining the traditional high quality of these publications.
  - d. ENCOURAGES reduction of repetitive mailing by AMSA and AMSA-affiliated corporations to decrease paper use.
  - e. ENCOURAGES recycling on a personal and professional level.
  - f. SUPPORTS federal incentives for paper companies producing recycled paper products.
  - g. Urges that hospitals work to reduce the amount of disposable material used and to recycle when possible.
  - h. Condemns the use of non-biodegradable and non-recyclable products at medical functions.
  - i. Urges the Association to use only biodegradable and recyclable products at future conventions and in the National Office. (1989)
11. OPPOSES species and ecosystem extinction, particularly where it would adversely affect human health; (1985)
12. SUPPORTS the development of a U.S. energy policy less dependent upon foreign oil imports and emphasizing development of alternative energy sources and energy conservation efforts. (1991)



## PRINCIPLES REGARDING SEXUALITY

The American Medical Student Association:

1. In regard to sexual orientation and gender identity:
  - a. OPPOSES all public and private discrimination based on sexual orientation or gender identity, including in: medical school admissions, promotion and graduation; postgraduate placement; hospital staff appointments; licensure; availability of health services; and access to social welfare; (2008)
  - b. URGES enactment of civil rights laws at the local, state and federal levels, which would provide, to gay, lesbian, bisexual and transgender people, the same protections now provided to others on the basis of race, religion, national origin, or sex; (2008)
  - c. ENCOURAGES the study of the problems encountered by gay, lesbian, bisexual and transgender people when both receiving and providing health care; (2008)
  - d. BELIEVES the burden and proof of judgment, reliability, integrity, capability, or entitlement to a position for gay, lesbian, bisexual and transgender people should not be greater than, or different from, that placed on other persons. (2008)
  - e. OPPOSES psychiatric diagnosis or treatment policies that discriminate against patients based on their sexual orientation and gender identity or inhibit their access to quality care; (1985)
  - f. OPPOSES the use of reparative therapy, a psychological process, which aims to change the sexual orientation of a patient to heterosexual. (2008)
  - g. ESTABLISHES as a priority the inclusion of sexual orientation and gender identity into medical school's nondiscrimination policy; (1989)
  - h. URGES the American Psychoanalytic Association to encourage applicants to its affiliated psychoanalytic institutes without regard to sexual orientation and gender identity; (1990)
2. In regard to equal civil rights for gay/lesbian/bisexual/transgender people:
  - a. BELIEVES that all persons have equal right to bear and rear children without regard to sexual orientation and gender identity; (1985)
  - b. BELIEVES that lesbians who have conceived have a right to nonjudgmental prenatal care and have the right to involve their parenting partner in all aspects of prenatal care and delivery;
  - c. BELIEVES that contracts between sperm donor and recipient regarding relinquishment of child custody rights should be viewed as legally binding should such disputes later ensue; (1985)
  - d. OPPOSES discrimination based on the sexual orientation and gender identity of either parent in legal child custody disputes; (1985)
  - e. OPPOSES discrimination based on the sexual orientation and gender identity in the determination of fitness of prospective adoptive parents. However, in view of the special needs of adolescents, URGES that agencies seek placement on the basis of mutual respect and support regarding sexual orientation and gender identity; (1985)
  - f. OPPOSES discrimination against lesbians by physicians who perform artificial insemination, and URGES physicians to fully cooperate with lesbians and lesbian couples. (1985)
  - g. BELIEVES that committed same-sex couples be granted the opportunity to form a legally recognized commitment that extends to this couple all legal benefits formerly reserved for marriages between a man and a woman. (2001)

- h. BELIEVES that this legally recognized commitment allow for the equal adoption of children as a couple with parenting rights extended to both members of the couple. (2001)
  - i. DEMANDS all accredited postgraduate residency programs to extend equal benefits to the partners of gay/lesbian/bisexual/transgender residents that are given to the partners of those heterosexual residents in the same program. (2001)
  - j. REQUIRES the Executive Director of AMSA to continue to extend equal benefits to all spouses of gay/lesbian/bisexual/transgender employees working for AMSA. (2001)
  - k. OPPOSES any legislation or any attempt to amend the federal or any state Constitution to restrict marriage to opposite-sex couples. (2004)
  - l. BELIEVES that full marriage rights should be extended to same-sex couples. (2004)
3. RECOGNIZES that Lesbian, Gay, Bisexual and Transgender-focused medical student groups play critical roles in supporting Lesbian, Gay, Bisexual, and Transgender medical student well-being and activism. (2006)
  4. FURTHER RECOGNIZES that Lesbian, Gay, Bisexual and Transgender-focused medical student groups play critical roles in cultivating cultural competency at their medical institutions with respect to the health of and healthcare received by Lesbian, Gay, Bisexual, and Transgender communities. (2006)
  5. EMBRACES its commitment to Lesbian, Gay, Bisexual and Transgender equality through continued support of the efforts of local Lesbian, Gay, Bisexual and Transgender-focused medical student groups. (2006)
  6. URGES medical schools to collaborate with Lesbian, Gay, Bisexual, and Transgender and Straight Allied medical students and medical student groups in developing policies, practices, resources, and curriculum that supports Lesbian, Gay, Bisexual and Transgender equality. (2006)
  7. SUPPORTS individuals who identify as members of minority populations within the Lesbian, Gay, Bisexual and Transgender community and recognizes the unique challenges facing the health of these populations of people. (2006)
  8. SUPPORTS educating the medical community at large of issues that pertain to Lesbian, Gay, Bisexual and Transgender members of minority populations with intention to increase provider competency and reduce the double stigma that these individuals face. (2006)
  9. SUPPORTS advocating reducing the health disparities faced by and enhance the well being of Lesbian, Gay, Bisexual and Transgender members of minority populations. (2006)
  10. URGES Medical Schools to include training in healthcare issues facing minority populations within the Lesbian, Gay, Bisexual and Transgender community as part of its mandatory curriculum. (2006)

## PRINCIPLES REGARDING VIOLENCE AND HATE CRIMES

The American Medical Student Association:

1. URGES the enactment of effective national handgun control legislation which calls for the following:
  - a. a ban on the sale, manufacture, importation, ownership and possession of handguns in the United States, except for the police, military and secured gun clubs; (1988)
  - b. a requirement that handgun owners be responsible and accountable for possession, care, use and ultimate disposition of their guns; (1988)
  - c. an imposition and enforcement of severe penalties, mandatory sentencing and civil liability for crimes involving handguns; (1988)
  - d. a strict federal ban on all plastic handguns; (1988)
  - e. national and all state legislation banning the concealed carry of any handgun, loaded or unloaded, by private citizens in any public place. (2001)
2. SUPPORTS child abuse prevention programs that would require a physician, without fear of criminal or civil liability, to report suspected cases of battered-child syndrome to appropriate agencies and to file such reports so that recurrent offenses can be detected;
3. SUPPORTS additional major research on the causes, prevention and cures of violence. (1993)
4. URGES the education of all Americans about the known facts about violence and encourages further studies on violence as a public health emergency. (1993)
5. In regard to hate crimes:
  - a. CONDEMNS hate crimes which are defined as harassment, violence and crime motivated by prejudice and hate based on actual or perceived sexual orientation and gender identity, race, ethnicity, religion, gender or sex and physical or mental ability whether by groups or individuals; (1988)
  - b. SUPPORTS nationwide legislation calling for the documentation and increased public awareness of hate crimes and bias related violence; (1988)
  - c. URGES health professionals, community leaders, governmental and private agencies to recognize, help reduce and alleviate the effects of hate crimes upon victims to better preserve their human dignity and self worth; (1988)
  - d. SUPPORTS violence prevention by education, research and funding of community service on a national, state and local level; (1988)
  - e. URGES vigorous enforcement and prosecution efforts against individuals and groups perpetrating such crimes. (1988)
6. In regard to sexual abuse:
  - a. SUPPORTS the repeal of laws classifying as criminal conduct consensual sexual activity of any form in private, excepting those laws which protect children, the mentally incompetent and other persons from rape and other forced sexual activity;
  - b. CONDEMNS all advertising that portrays women or men as natural and willing victims of sexual violence;
  - c. URGES state legislatures to institute or expand existing programs for dealing with the physical and psychological trauma of a sexual assault;
  - d. URGES state legislatures to adequately compensate the victim for the cost of medical, surgical and hospital expenses, counseling, emergency funds for housing and pregnancy;
  - e. URGES physicians to inquire sensitively about sexual, physical, or child abuse in an open atmosphere with all patients;
  - f. ENCOURAGES health professionals to address the psychological, legal and safety needs of adult and pediatric patients who are victims of sexual and/or physical abuse. (1997)

7. SUPPORTS domestic abuse prevention programs that would require a physician, without fear of criminal or civil liability, to:
  - a. Note in the medical record suspected cases of child abuse, spouse/partner abuse, infirmed or elder abuse;
  - b. Report child, infirmed and elder abuse to the appropriate agencies as directed by law;
  - c. Comply with mandatory reporting of demographic information in regard to cases of domestic violence. (1996)
8. OPPOSES mandatory reporting by health professionals of spouse or partner abuse that requires identifying individuals to outside agencies. (1996)
9. ENCOURAGES health professionals to discuss with patients the legal and support services available to victims of domestic violence and to discuss safety planning. (1996)
10. ENCOURAGES legislation and public health measures intended to prevent violence, which may include but are not limited to:
  - a. School-based conflict resolution, peer-mediation and mentoring programs; (1996)
  - b. Economic incentives for inner-city businesses; (1996)
  - c. Maintenance of affirmative action; (1996)
  - d. Increased resources for inner-city schools and adult education centers, including bilingual education. (1996)
  - e. School-based programs for violence prevention; (1996)
  - f. School- and community-based parenting education and support programs; (1996)
  - g. Hospital-based tertiary prevention programs, including violence prevention team intervention for trauma patients who have been victims of violence; (1996)
  - h. Population-based early childhood interventions modeled after successful programs such as Headstart. (1996)
11. SUPPORTS measures which will reduce the effects of domestic violence on adults and children by: (1996)
  - a. Supporting programs aimed at reducing domestic violence, such as school-based Domestic Violence Prevention Programs; (1996)
  - b. Supporting federal and state programs that aid a person desiring to leave an abusive relationship, including housing assistance, battered women's shelters, Temporary Assistance to Needy Families (TANF) (2005), Women, Infants and Children and other social support services;
  - c. Supporting the availability of mental health services for children who have witnessed abuse;
  - d. Supporting the availability of mental health services for victims of abuse. (2006)
  - e. Supporting increased education of current and future health professionals concerning domestic violence and its effects on children, including increased funding for such programs; (2006)
  - f. Supporting increased education of current and future health care professionals to screen for and respond appropriately to patients who are victims of domestic violence, including increased funding for such programs; (2006)
  - g. Supporting nonpunitive aide services for households experiencing violence.
12. URGES provision of culturally and linguistically appropriate support services and legal advocacy for all victims of domestic violence, regardless of economic status, legal status, political beliefs, cultural background, geographic position, race, creed, national origin, age, sex, sexual orientation and gender identity, physical handicap, mental handicap, or institutionalization for criminal, medical, or psychiatric reasons, and ENCOURAGES increased funding and programs for special needs and underserved groups. (2006)

## PRINCIPLES REGARDING DISABILITIES AND DISABLED PERSONS

The American Medical Student Association:

1. ENCOURAGES all health-care professionals and facilities to provide for equal access to quality health care and supportive services for disabled individuals.
2. OPPOSES all public and private discrimination against persons with a disability including medical school admissions; promotion and graduation; post graduate placement; hospital staff appointment; licensure; availability of health care; and access to social welfare. The term "disability" is used as defined by the "Americans With Disabilities Act of 1990." (1997)
3. URGES enactment of more civil rights laws at the local, state and federal levels, which would provide to persons with disability the same protections now provided to others on the basis of race, religion, national origin, or sex. (1997)
4. ENCOURAGES the study of the problems encountered by the person with a disability when both receiving and providing health care. (1997)
5. BELIEVES the burden of proof of judgment, reliability, capability, or entitlement to a position for individuals with a disability should not be greater than or different from that placed on other persons.
6. URGES all medical schools and health-care providers to continually assess their physical, environmental and attitudinal surroundings/approach in order to provide and maintain a barrier-free, as well as discrimination-free, environment for their students, faculty, staff, patients and visitors;
  - a. ENCOURAGES that the 'barrier' be defined by the patient/visitor and/or health-care provider as opposed to solely by the health-care provider; (1997)
  - b. URGES the health-care provider to acknowledge the need for auxiliary aids and services, including a sign language interpreter, in communicating with many deaf patients. Therefore, the provider is encouraged to seek out and pay for a qualified and appropriately certified sign language interpreter in such instances that the patient or the physician feels it would improve communication. (1997)
7. ENCOURAGES health-care providers, at minimum, to acknowledge the deaf community's cultural (i.e., non-disability, nonpathological) perspective on deafness. (1997)
8. ENCOURAGES healthcare providers to eliminate the words deaf-mute, deaf and dumb and hearing-impaired from their vocabularies, and instead use the patient's preferred terminology. (1997)
  - a. ENCOURAGES health-care providers to continually check with themselves and their patients, and make necessary modifications, to ensure that patients receive equal treatment and accessible and effective communication, regardless of their degree of deafness. (1997)
9. In regard to treatment of disabled infants:
  - a. SUPPORTS the Principles of Treatment of Disabled Infants developed by the American Academy of Pediatrics; (1985)
  - b. OPPOSES federal and state regulations and/or legislation which would impose a governmental or uninvolved third party role in the decision-making process as it relates to the care of the severely ill infant when the infant's best interest is not clearly defined (as outlined in the President's Commission Report on Deciding to Forego Life-Sustaining Treatment); (1985)
  - c. ENCOURAGES the establishment of hospital multidisciplinary ethics committees to review the decision-making process, to assist in conflicts between physicians and parents and to assist the parents as they

decide about the care of their infant when the infant's best interest is not clearly defined (as outlined in the President's Commission Report on Deciding to Forego Life-Sustaining Treatment); (1985)

- d. ENCOURAGES hospitals to establish explicit policies on decision-making procedures, based on the recommendations of the President's Commission Report on Deciding to Forego Life-Sustaining Treatment, to facilitate decisions regarding the care and best interest of infants requiring life-sustaining treatments. (1985)

10. In regards to treatment of persons with mental retardation:

- a. RECOGNIZES that compared with other populations, adults, adolescents, and children with mental retardation experience poorer health and more difficulty in finding, getting to, and paying for appropriate health care. (2004)
- b. ENCOURAGES that measures be taken by the healthcare community to eliminate the health disparity among individuals with mental retardation. (2004)
- c. ENCOURAGES the integration of didactic and clinical training in the health care of individuals with mental retardation into the basic and specialized education and training of medical students. (2004)

## **PRINCIPLES REGARDING POVERTY AND PUBLIC ASSISTANCE**

The American Medical Student Association:

1. In regard to poverty and public assistance:
  - a. RECOGNIZES that poverty is an important health risk factor, both when defined in absolute terms, as well as in terms of the discrepancy between high and low ends of income distribution within a population, and may be approached as a public health problem; (1999)
  - b. SUPPORTS the reformation of the welfare system to adequately address the effects and causes of poverty and RECOGNIZES that poverty extends beyond the current definition of welfare; (1995)
  - c. EMPHASIZES that prevention must be considered a cornerstone of any welfare reform effort;
  - d. ENCOURAGES federal, state and local governments and private institutions, to assist communities, families and individuals to reduce and prevent poverty; (1995)
  - e. URGES the creation of a single federal agency, in lieu of the current fragmented system, to set general requirements and to distribute funding for all public assistance programs; (1995)
  - f. RECOGNIZES that each individual community has different needs and SUPPORTS the development of customized programs by communities while complying with broad federal requirements. (1995)
2. BELIEVES that unemployment correlates with an increased incidence of mental, physical and social illness, and therefore, URGES the United States Congress to promote full employment at dignified wages for every able and willing American as a high national economic priority; (1995)
3. SUPPORTS the Early Periodic Screening, Diagnosis and Treatment Program which provides for preventive health services and early detection and treatment of diseases in children of low income families; (1995)
4. RECOGNIZES the connection between housing and health status, and therefore strongly URGES federal and state programs to provide safe, affordable, sanitary and appropriately maintained housing to all welfare recipients, at-risk poor and homeless persons by the following, but not limited to: (1995)
  - a. Addressing the needs of the community for low-income housing. (1995)
  - b. Encouraging innovative programs, such as rent to own, to assist with the transition to independence. (1995)
  - c. Renovation of existing housing and the creation of more scattered site, low-rise, mixed-income housing. (1995)
  - d. Improving management of housing programs and enforcement of safety, living and building standards for existing housing. (1995)
  - e. Encouraging innovative programs for decreasing crime in subsidized housing areas. (1995)
  - f. Increasing subsidies so that individuals can afford housing. (1995)
5. In regard to parenting:
  - a. ENCOURAGES the unification and improvement of collection of court-ordered child support. (1995)
6. In regard to the family:

- a. OPPOSES provisions, commonly known as “Child Exclusion” or “Family Cap,” which seek to reduce birthrates among welfare recipients by denying benefits to children conceived by women while receiving public assistance. (1995)
  - b. OPPOSES the illegitimacy bonus, a state bonus for reductions in out-of-wedlock births or abortion.
  - c. OPPOSES the use of welfare assistance to encourage marriage or limit child-bearing decisions, as is explicitly stated in the The Personal Responsibility and Work Opportunity Reconciliation Act.
  - d. SUPPORTS the idea that marital status and reproductive choice are personal matters that should not be linked to or encouraged by welfare assistance. (2001)
7. In regard to data collection and program development:
- a. AMSA SUPPORTS the creation of a national clearinghouse to act as a resource for successful and unsuccessful federal, state and local public and private assistance programs, and to act as a source for data collection regarding such programs. (1995)
  - b. AMSA encourages the further development of research on public assistance programs including, but not limited to, issues on why individuals are unable to maintain work, effects of various types of housing programs and the underlying reasons why teens become parents. (1995)
8. In regard to case managers:
- a. AMSA encourages the streamlining of paperwork and documentation performed by case managers, supports ensuring that case loads are manageable for case workers, and supports incentives to case managers for the progression of their clients to self-sufficiency. Furthermore, AMSA encourages the increased direct interaction between the case worker and recipient. (1995)
9. In regard to immigrants:
- a. RECOGNIZES that the legal immigrant population is not the source of the failures of the U.S. Welfare System. (1995)
  - b. URGES the U.S. government to restore welfare assistance and Medicaid to legal immigrants.
  - c. Strongly OPPOSES any attempt at welfare reform that disproportionately penalizes legal immigrants. (2001)
10. AMSA strongly opposes any attempt at welfare reform that penalizes legal immigrants in an effort to finance the reform. (1995)
11. In regard to income:
- a. AMSA supports raising the minimum wage for working individuals so that if working full time for a full year their income would be at least 100% of the federal poverty level, as defined for a three-person family, single head of household. (1995)
  - b. AMSA recognizes that current wage and income levels for employment can deter an individual from maintaining a job, and encourages a graded expansion of the Earned Income Credit benefit to act as an incentive for individuals to transition to the workforce. (1995)
12. In regard to work, job availability and job training:
- a. AMSA supports job training and education for all individuals and families at high risk for requiring some form of public assistance. (1995)



- b. AMSA supports the expansion of the Temporary Assistance to Needy Families (TANF) (2005) program and further believes the program should continue or expand the provision of support services such as child care, transportation, food, housing and health care. These services should be continued on a graded scale, decreasing as an individual gains stability while transitioning to the work force. (1995)
  - c. AMSA believes that states should be required to provide life skills training, for those transitioning to the work force, such as: budgeting, time and stress management and how to prepare for future job retraining possibilities. (1995)
  - d. AMSA encourages the expansion of job training programs to meet community needs by creating incentives for the private sector to employ individuals transitioning from welfare, expanding and investing in a job corps to support the failing infrastructure, and providing for jobs with upward mobility. (1995)
  - e. AMSA opposes mandatory work outside the home as a condition of receiving Temporary Assistance for Needy Families assistance. (2001)
13. In regard to teen parents:
- a. AMSA believes that secondary school attendance and participation should count as credit in the TANF program for teenagers. (1995)
  - b. AMSA discourages the use of penalties for students, receiving welfare and aid, who do not attend school, but encourages the use of positive benefits for secondary school attendance. (1995)
14. In regard to minor residency requirements:
- a. AMSA DOES NOT SUPPORT a minor residency requirement for receipt of public assistance for pregnant teenagers and teenage mothers, but encourages the creation of incentives for pregnant teenagers and teenage mothers to stay at home with their parents unless remaining at home jeopardizes their physical or emotional health; (1995)
  - b. AMSA BELIEVES that services should be provided by either federal, state, or local communities to find alternate living arrangements for pregnant teenagers and teenage mothers if remaining at home jeopardizes their physical or emotional health. (1995)
15. In regard to time limits:
- a. OPPOSES strict time limits. (1995)
16. RECOGNIZES that socioeconomically deprived persons have a need for transportation for activities of daily living and when seeking employment and ENCOURAGES improving their access to public transportation by: (1995)
- a. Creation of innovative transportation systems or expansion of existing ones by communities to adequately provide transportation for its members. (1995)
  - b. Providing vouchers or other non-cash benefits for transportation and direct benefits such as offering free transportation. (1995)

## PRINCIPLES REGARDING LEGISLATIVE CONCERNS AND POLITICAL ACTION

The American Medical Student Association:

1. Can support national political nominees for nonelected positions that are of direct relevance and importance to the Association. The process for doing so will include:
  - a. a thorough review of the nominees qualifications for the position by the Legislative Affairs Director and the National President.
  - b. upon completion of the review, the Board of Trustees will meet to discuss the nominees qualifications and views and how they reflect the principles and policies of AMSA, and subsequent to which the Board of Trustees will make the ultimate decision regarding support of the nominee in question.
2. BELIEVES the determination of proper technique is out of the realm of expertise of legislators. Whereas certain acts by health professionals may be determined unlawful, AMSA opposes any legislation that outlaws certain techniques for legal medical procedures. It is lawful to regulate medical procedure, but not the techniques used to perform the procedure. (1995)
3. In regard to transportation reimbursement programs:
  - a. will lobby federal and state governments for an efficient program to compensate health centers serving low-income population for the costs of transportation provided by the aforementioned health centers; and (1999)
  - b. ENCOURAGES and SUPPORTS individual chapters to lobby local officials for similar programs. (1999)

## **PRINCIPLES REGARDING AFFIRMATIVE ACTION**

The American Medical Student Association:

1. SUPPORTS the principle of federal and state affirmative action programs for the purpose of increasing diversity in education, government and business settings. (1996)

## **PRINCIPLES REGARDING INTEGRATIVE, COMPLEMENTARY AND ALTERNATIVE MEDICINE (ICAM)**

The American Medical Student Association:

1. RECOGNIZES the potential inherent to non-western systems of medicine and forms of health care and prevention currently available outside of accepted biomedical practice.
  - a. The term “Integrative, Complementary and Alternative Medicine” shall be understood so as to correspond with definitions used by the National Institutes of Health Center for Complementary and Alternative Medicines. “Complementary medicine” shall be understood to mean the use of alternative medicine secondary, or as an adjunct, to unconventional therapies alongside conventional biomedicine with the approval of a licensed physician. The term “alternative medicine” shall be understood to mean the use of unconventional therapies in place of conventional biomedicine. The term “integrative medicine” shall be understood to mean medical practice combining conventional treatments and CAM therapies where there is some quality scientific evidence of safety and effectiveness. The term “Holistic Medicine” shall be understood to correspond with the American Holistic Medical Association’s principles, which refer to a practice of medicine that reaffirms the importance of relationship between practitioner and patient, emphasizes prevention, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches to achieve optimal health and healing. (2006)
  - b. ENCOURAGES research and investigation regarding integrative, alternative and complementary medicines (ICAM) within ethical, legal, professional guidelines. (2005)
  - c. ENCOURAGES medical students and residents to seek and take advantage of educational opportunities in integrative, alternative and complementary medicine. When unavailable, medical students and residents are encouraged to propose the addition of such opportunities to the curricula or practices of their respective institutions. (2005)
  - d. ENCOURAGES medical administrators and faculty to meet the demands of their students and the patient population by developing and implementing appropriate training in integrative, complementary, and alternative medicines. Training should include general information about the variety of treatment alternatives available to the general public, especially those that have been proven to be effective. (2005)
  - e. Conscientious and effective health care shall include the use of integrative, complementary and alternative medicine when such remedies or modalities have been clearly demonstrated to positively affect patient outcomes. In cases where efficacy is undetermined but strongly suspected, ICAM may be used with the same precautions and indications for other experimental therapies. (2005)
  - f. Physicians and physicians-in-training have an obligation to respect the patient’s prerogative to self-treat with over-the-counter alternatives, visit a practitioner in the field of ICAM, and otherwise choose nonbiomedical means of health care and maintenance. (2005)

## **PRINCIPLES REGARDING OSTEOPATHIC MEDICINE**

The American Medical Student Association:

1. AMSA RECOGNIZES the equality of osteopathic and allopathic medical degrees within the organization and the healthcare community as a whole. As such, D.O. students shall be entitled to the same opportunities and membership rights as M.D. students. (2006)
2. AMSA DOES NOT SUPPORT efforts by groups or individuals aimed at combining the doctor of medicine (M.D.) and doctor of osteopathic medicine (D.O.) degrees, as we feel that each of these approaches is important in the advancement of medical care for patients now and in the future. (2006)
3. AMSA SUPPORTS collaborative efforts with the American Osteopathic Association (AOA) and/or the Student Osteopathic Medical Association (SOMA) on issues that are consistent with AMSA strategic priorities and principles. (2006)
4. AMSA strongly urges the international medical community to recognize American Osteopathic Physicians as fully licensed and accredited physicians with residency, practice, and surgical rights equal to that of Allopathic physicians that travel or relocate abroad. (2006)
5. AMSA URGES foreign residency programs to accept American Osteopathic medical students with the same equality as Allopathic medical students. (2006)
6. AMSA SUPPORTS the standardization of Osteopathic medical education in the United States and abroad. Furthermore, we support the education of schools, hospitals, and other related institutions regarding the currently existing differences between American Osteopaths and Osteopaths in other countries. (2006)

To this end, AMSA SUPPORTS the efforts of the AOA in accomplishing these goals. (2006)

## **PRINCIPLES REGARDING DIETARY SUPPLEMENTS**

The American Medical Student Association:

1. ENCOURAGES the Food and Drug Administration (FDA) to develop provisions for enforcement of the following current labeling requirements for dietary supplements. Those labeling requirements include:
  - a. The name and quantity of each dietary ingredient or for proprietary blends, the total quantity of all dietary ingredients in the blend; (2000)
  - b. Identifying the product as a "dietary supplement"; (2000)
  - c. Identifying the part of the plant from which the product is derived. (2000)
2. SUPPORTS authorizing the FDA to apply the same safety standards to dietary supplements as it currently does for food and food additives; specifically, to require dietary supplements to undergo premarket approval. Such premarket approval must require manufacturers to conduct safety studies and submit the results to the FDA for review before the ingredient can be used in marketed products. (2000)
3. SUPPORTS allowing exemption of currently marketed dietary supplements to this premarket approval process if and only if these supplements are generally recognized as safe. (2000)
4. SUPPORTS pulling from the market those dietary supplements which have caused significant or unreasonable harm or death until they pass the above premarket approval process. (2000)
5. SUPPORTS adequate funding for the Federal Trade Commission to maintain adequate surveillance on the advertising of dietary supplements. (2000)
6. SUPPORTS research into the efficacy of dietary supplements by the National Institutes of Health. (2000)

## **PRINCIPLES REGARDING THE FDA'S PROHIBITION ON MEN WHO HAVE SEX WITH MEN FROM DONATING BLOOD AND SPERM**

1. URGES the Food and Drug Administration, Centers for Disease Control and Prevention, state governments, and sperm banks throughout the United States to revise donation screening guidelines, policies, and regulations to reflect the current scientific knowledge about HIV; (2006)
2. STRONGLY URGES the above named bodies to enact policies that create equivalent standards of evaluating transmissible disease risks with regard to sperm donations and that allow HIV-negative persons, regardless of sexual orientation and gender identity, the opportunity to donate blood and to become known or anonymous sperm donors or to store their own sperm without prejudice. (2008)
3. ENCOURAGES groups within AMSA to educate the membership about the discrepancies between current public health standards and the current screening practice that prohibits men who have sex with men from donating blood or sperm or storing sperm at their own expense. (2006)
4. RECOGNIZES that the current policy, regulations and guidelines against blood and sperm donation by men who have sex with men is an instance of institutionalized discrimination that is contrary to current public health standards. (2006)

## **PRINCIPLES REGARDING PHYSICIAN UNIONIZATION**

The American Medical Student Association:

1. SUPPORTS the 1999 decision by the National Labor Relations Board that recognizes interns, residents and clinical fellows as ‘employees’ under the National Labor Relations Act; (2001)
2. RECOGNIZES the unique role of INTERNS, RESIDENTS AND CLINICAL FELLOWS as both caregivers and students. FURTHERMORE, AMSA BELIEVES
  - a. Housestaff unions have an important role to play in advancing patient care by acting as a patient advocate and also advocating for good working conditions for residents. These conditions include, but are not limited to, reasonable work hours, comprehensive benefit packages and the right to take medical, maternity or paternity leave. (2001)
  - b. Housestaff unions should not interfere with academic decisions unless these decisions interfere with the learning environment or good working conditions; (2001)
3. SUPPORTS the creation of those physician unions that advocate for QUALITY patient care FOR ALL PEOPLE, and SUPPORTS the ability of ALL physicians to unionize in this context. (2001)
4. OPPOSES unions that are primarily concerned with improving the economic condition of physicians and SUPPORTS the inclusion of patient and consumer representatives in these unions; (2001)
5. SUPPORTS the right of both housestaff and physician unions to strike as a last resort, if and only if it is based on improving patient care and does not jeopardize patient care. (2001)
6. SUPPORTS the right of physicians to collectively bargain with managed care organizations in the context of improving patient care, and (2001)
7. OPPOSES collective bargaining for the purpose of increasing physician income at the expense of patient care. (2001)



## **PRINCIPLES REGARDING CAMPAIGN FINANCE AND ELECTIONS**

The American Medical Student Association:

1. SUPPORTS the concept of meaningful campaign finance reform. (2001)
2. SUPPORTS full or partial-public funding of elections and strict campaign limits that make it feasible for all Americans to have an equal voice. (2001)
3. CONDEMNS proposals that will raise limits to campaign contributions. (2001)
4. SUPPORTS a ban on soft money contributions. (2001)
5. SUPPORTS public funding on nonpartisan events to help increase voter turnout. (2001)
6. SUPPORTS federal and state election reforms that insure that every eligible American has the opportunity to have their vote counted in elections, including but not limited to: (2005)
  - a. The full investigation into and prosecution of groups and individuals involved in attempts at voter intimidation. (2005)
  - b. A requirement that all electronic voting systems have a voter-verified paper trail to insure the integrity of each vote. (2005)
  - c. The establishment of national standards for voter registration. (2005)
  - d. The full and proper funding of election agencies to insure the thorough training of all election workers regarding election laws and procedures. (2005)
  - e. Attempts to make voting more accessible to citizens by: (2005)
    - i. Encouraging the adoption of no-excuse absentee ballots or mail-in ballots.
    - ii. Expanding the hours of polling places and increasing early voting opportunities such as weekend voting hours.
    - iii. Declaring the day of a Presidential election a national holiday.

## **PRINCIPLES REGARDING ACTIVISM**

The American Medical Student Association:

1. SUPPORTS the use of nonviolent direct action as a strategy for activism within the struggle for social change. (2001)

"Direct Action" is a term that describes a range of actions taken to directly confront or highlight an issue. (2001)

## **PRINCIPLES REGARDING AMSA POLICY MAKING**

The American Medical Student Association:

1. SUPPORTS the consideration of the impact of decisions made today on future generations. (2001)

## **PRINCIPLES REGARDING GENETICS**

The American Medical Student Association:

1. OPPOSES the patenting of the unmodified nucleotide and/or amino acid sequences of human genes and/or proteins. (2002)
2. RECOGNIZES the value of intellectual property rights in general and SUPPORTS the patenting of specific diagnostic and therapeutic products based on human genetic material. (2002)
3. SUPPORTS the mandatory public disclosure of any such similar genetic information that is discovered by an institution within standard, peer-reviewed scientific publishing forums to allow for complete access by all research or other institutions whether public or private. (2002)

## **PRINCIPLES REGARDING CIVIL RIGHTS**

The American Medical Student Association:

1. MOURNS the loss of innocent lives suffered by terrorist acts here and all over the world as well as the loss of innocent lives suffered due to response to those terrorist acts. (2003)
2. URGES respect for the primacy of civil rights even in the heightened need for security, and condemns unjust mass detentions, hate crimes, and suspensions of due process in the name of national security. (2003)
3. IS CONCERNED BY the USA Patriot Act, bill number H.R. 2975 – “Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism” (10/24/01), and any act that may decrease constitutionally guaranteed civil rights in the name of fighting terrorism. (2003)

## **PRINCIPLES REGARDING TERRORISM**

The American Medical Student Association:

1. URGES instruction on the medical consequences of terrorism and identification of likely terrorism agents in the curriculum of all medical schools, including; (2003)
  - a. Biological agents
  - b. Chemical agents
  - c. Nuclear/radiological agents
2. ENCOURAGES communication between medical, public health, emergency management, and law enforcement professionals to organize an effective response to acts of terrorism; (2003)
3. SUPPORTS education of established practitioners in the medical community at-large as to the identification and treatment of patients compromised by biological/chemical/nuclear agents; (2003)
4. OPPOSES any plan to use civilian medical facilities or civilian medical personnel (or coercion of said entities) to create biological, chemical, or nuclear agents to be used in acts of terrorism; (2003)
5. STRONGLY OPPOSES any plans to utilize medical research funding and/or facilities, to the detriment or human disease research, for the purpose of creating more deadly biological/chemical/nuclear agents for the purpose of terrorism. (2003)

## **PRINCIPLES REGARDING INTERNATIONAL TRADE AGREEMENTS**

The American Medical Student Association:

1. SUPPORTS international agreements that place the health of populations above commercial interests.
2. SUPPORTS international trade agreements that secure the right to life-saving medications in resource-poor settings and that encourage investment in public health, (2003) as outlined in the World Trade Organization's Ministerial Declaration on the TRIPS (Trade Related Aspects of International Property) Agreement and Public Health ("Doha Declaration"), that allows for World Trade Organization members to take measure to protect public health. (2004)
  - a. SUPPORTS the need-based use of compulsory licensing as outlined in the Doha Declaration to make life-saving medications accessible on a country-by-country basis. (2008)
  - b. OPPOSES efforts by governments and corporations to circumvent and obstruct the use of compulsory licenses by sovereign nations. (2008)
3. OPPOSES the enactment of more stringent intellectual property provisions from bi- and pluri-lateral free trade agreements, and this would severely limit access to essential medications. (2004)
4. SUPPORTS use the TRIPS agreement as the maximum and not the minimum protection for intellectual property rights. (2004)
5. SUPPORTS trade agreements that deter harmful environment practices and unfair labor laws. (2003)

## PRINCIPLES REGARDING PEDIATRIC OBESITY

The American Medical Student Association:

1. RECOGNIZES obesity of children as a ripple effect for future health disparities. (2004)
2. ENDORSES Surgeon General's report, Healthy People 2010 (2003) and Health and Human Services "Nutrition and Overweight" and SUPPORTS the following general recommendations for families and schools in pursuit of healthy children and health disparities free: (2004)
  - a. Learning the benefits of healthful eating
  - b. Making healthful food choices for meals and snacks
  - c. Preparing healthy meals and snacks
  - d. Adding nutrition labels on food products
  - e. Eating a variety of food
  - f. Balancing food intake and physical activity
  - g. Accepting body size differences
3. SUPPORTS the ABC's of the 2000 Dietary Guidelines for Americans for families in pursuit of healthy children and health disparity free: Aim for fitness, Build a healthy base, Choose sensibly. (2004)
4. SUPPORTS the CDC recommendations that pediatric obesity be classified based on Body Mass Index (BMI)-for-age charts, where individuals 2-20 years old are classified as "at risk of overweight" if they fall into the 85th to 95th percentile and "overweight" if they fall over the 95th percentile, as these cutoffs increase the risk for hyperlipidemia, glucose intolerance, hepatic steatosis, cholelithiasis, early maturation and several other conditions. (2005)
5. In regards of prevention through school:
  - a. STRONGLY SUPPORTS nutrition should be taught as part of a comprehensive school health education program and essential education topics should be integrated into curriculum. (2004)
  - b. SUPPORTS students having healthier food options to enhance the likelihood of adopting healthful dietary practices. (2004)
  - c. SUPPORTS public school education about the long-term health consequences and risks associated with overweight and how to achieve and maintain a healthy weight. (2004)
6. URGES policymakers and program planners at the national and state levels to provide funds to implement programs that facilitate and encourage children making healthier food choices: (2004)
  - a. Promotion of healthy vending machines that provide products with less saturated fat, less trans-fatty acids, more natural fruit juices, and fewer sugar-sweetened beverages (2004) .
  - b. Implement educational programs for parents about nutrition and prevention tactics that will minimize pediatric obesity. (2004)
7. URGES school boards to seek distributors that provide healthier food options for students that eat in the school cafeteria. (2004)
8. In regards to physical education:
  - a. OPPOSES schools canceling physical education courses because evidence has shown physical education provides: (2004)
    1. nutritional education about different fats, carbohydrates, caloric intake, metabolic process of the body.



2. provides students with the recommended 60 minutes of daily activity.
    3. provides students with an opportunity to learn different exercises that will better their body mass index, cardiovascular, and strength.
  - b. SUPPORTS effective physical education classes (2004)
9. Opposes schools canceling recess or other protected free time for elementary school children. (2004)

## **PRINCIPLES REGARDING HEALTH DISPARITIES**

The American Medical Student Association:

1. BELIEVES that a comprehensive strategy incorporating research, education, policy changes, and community partnerships is necessary to eliminate health disparities. (2004)
2. URGES all medical schools to incorporate health disparities and cultural competency education into the curriculum, including but not limited to knowledge of disparities in healthcare access, treatment, outcomes, and health status for racial and ethnic minority patients; the patient-physician relationship; the health care delivery system; limited English proficiency populations; understanding of culture-specific illnesses and culture-specific treatments; patient beliefs; provider biases and stereotyping. (2004)
3. ENCOURAGES federal and state initiatives to eliminate health disparities “by providing” funding to cultural competency curriculum development in medical training, translation services for patients with limited English proficiency, and data collection and analysis to identify disproportionately high and adverse health and environmental effects on minority populations. (2004)
4. STRONGLY OPPOSES any efforts to weaken the office of minority health by opening its jurisdiction to white populations or by removing grant-making authority from the office of minority health. (2004)
5. RECOGNIZES the importance of a universal health care system in eliminating health disparities. (2004)

## **PRINCIPLES REGARDING MEDICAL EDUCATION MISSION STATEMENTS**

The American Medical Student Association:

1. In regard to the content of mission statements of medical schools:
  - a. ENCOURAGES the inclusion of clauses that reflect a:
    1. Primacy of teaching to the mission of academic medical centers. (2005)
    2. Focus on service to the community in which it operates. (2005)
    3. Emphasis on developing scientific discovery within its students through, but not limited to, basic and/or clinical science research. (2005)
    4. Commitment to fostering self-directed, self-motivated excellence in academics. (2005)
    5. Commitment to teaching patient-centered, evidence-based medicine. (2005)
    6. Commitment to fostering professionalism and humanism within students. (2005)
    7. Commitment to increasing diversity and eliminating health disparities. (2005)

## **PRINCIPLES REGARDING TREATMENT OF PRISONERS OF WAR AND ENEMY COMBATANTS**

The American Medical Student Association:

1. CONDEMS the use of torture, cruel, inhuman or degrading treatment or punishment by the United States Armed Forces on prisoners in Iraq, Afghanistan and Guantanamo Bay. (2005)
2. CONDEMS the active or passive involvement of military medical personnel, especially physicians, in designing, planning, covering up, or participating in acts of torture or cruel and inhuman punishment and identifies such complicity as an abhorrent violation of medical ethical codes. (2005)
3. SUPPORTS the Geneva Convention Relative to the Treatment of Prisoners of War 1949, and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. (2005)
4. SUPPORTS valid investigations of governments who might be in violation of these international treaties. (2005)
5. DEMANDS an independent investigation of the functioning of the United States military medical system focusing on obligations towards the Geneva Convention,<sup>24</sup> and the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment,<sup>1</sup> focusing on the following key areas: (2005)
  1. The military medical system and its record keeping, provision of sanitation, food and health care; (2005)
  2. Collaboration of military medical personnel with interrogation plans by evaluating detainees for interrogation, monitoring coercive interrogations, and sharing of medical records with interrogators to develop interrogation approaches; (2005)
  3. Investigation of deaths of prisoners and falsifying death certificates; (2005)
  4. Mechanisms and standards for reporting human rights abuses. (2005)

## **PRINCIPLES REGARDING CPR (BCLS & ACLS PROGRAMS) IN MEDICAL EDUCATION**

The American Medical Student Association:

1. BELIEVES that proper education for medical students is paramount, and specific emphasis on clinical preparation in CPR (BCLS and/or ACLS Programs) should be made. (2005)
2. URGES all medical schools that they should instate a CPR (BCLS and/or ACLS Programs) before medical students are exposed to patients. Also, be it understood that this certification should be kept current as future patient exposure will continue in later training. (2005)
3. RECOGNIZES the need for medical students to be trained in the most basic life saving techniques as future physicians and as hospital personnel and more so citizens. (2005)

## **PRINCIPLES REGARDING VOTING SYSTEMS AND ELECTION REFORM**

The American Medical Student Association:

1. SUPPORTS the development and use of safe, simple, accessible, affordable, and verifiable voting systems with open source software, (2006)
2. SUPPORTS any election recounts undertaken to insure the accuracy of reported vote totals, (2006)
3. SUPPORTS policy that would provide a standardized method of performing recounts, (2006)
4. SUPPORTS any investigations into alleged or possible instances of voting fraud, voting errors, voting miscounts, voter suppression, and SUPPORTS the creation of a federal policy to institute appropriate reversal of any election result found to be incorrect, even if this discovery occurs after an official has been inaugurated to office, (2006)
5. SUPPORTS changing federal election day from the Tuesday following the first Monday of November every year, which is always the Tuesday between November 2 and November 8, inclusively, to the weekend following the first Monday of November every year, and SUPPORTS the establishment of a national holiday to coincide with yearly federal election day, (2006)
6. SUPPORTS employers giving employees ample time off to vote. (2006)

## **PRINCIPLES REGARDING HEARING LOSS**

The American Medical Student Association:

1. URGES manufacturers of portable music players and headphones to display warning labels on packaging indicating that “listening to music above 85 dBs for prolonged periods of time can result in permanent hearing damage” and provide information on safe listening practices. (2006)
2. URGES manufacturers of portable music players to display the volume of sound in terms of decibels. (2006)

## **PRINCIPLES REGARDING PHYSICIAN/INDUSTRY INTERACTION**

The American Medical Student Association:

1. OPPOSES direct provision of pharmaceutical samples to physicians and supports a system of vouchers for low-income patients. (2006)
2. SUPPORTS academic medical centers taking the lead in eliminating the conflicts of interest that characterize the relationship between physicians and the healthcare industry by developing their own guidelines that more stringently regulate those interactions. (2006)
3. BELIEVES that hospital and medical group formulary committees and committees overseeing purchases of medical devices should exclude physicians (and all healthcare professionals) with financial relationships with drug manufacturers, including those who receive any gift, inducement, grant or contract. (2006)
4. SUPPORTS curricula in medical education that includes studies on medical student-drug company interactions. (2006)
5. SUPPORTS curricula in medical education that includes studies on the effects of marketing on prescribing habits. (2006)



## **PRINCIPLES REGARDING PATIENT MEDICATION LISTS**

The American Medical Student Association:

1. ENCOURAGES physicians to educate their patients to the importance of creating and carrying a self-written description of all medications, pills, liquids, OTC agents, drugs, herbs, and other natural products to be used in emergency situations, such as but not limited to, situations of unconsciousness, accidents, inability to communicate verbally or with written words, or changes in mental status. (2006)

## PRINCIPLES REGARDING STEM CELL RESEARCH

The American Medical Student Association

1. BELIEVES that all types of stem cell research, including embryonic stem cell research, umbilical cord blood stem cell research, and adult stem cell research, should be explored to the fullest potential with support from federal and local initiatives, while abiding by appropriate ethical guidelines, for the purposes of advancing treatment and preventing disease. (2006)

In regards to embryonic stem cell acquisition, AMSA:

1. BELIEVES patients should have the right to choose, under the standards of informed consent, whether supernumerary embryos created for infertility treatment should be donated or discarded. (2006)
2. BELIEVES that nuclear transplantation, used for the purpose of creating embryonic stem cells that are an immunologic match for a given patient, and for the purpose of studying genetic defects and congenital anomalies, is an acceptable form of research. (2006)
3. URGES the creation of guidelines that will establish:
  - a. uniform procedures for obtaining consent from all individual(s) providing biological material prior to the acquisition or any manipulation of that material; (2006)
  - b. uniform processes for ascertaining the wishes of the parent(s) with regard to excess embryos in the form of written consent obtained prior to the creation of embryos; (2006)
  - c. strict, uniform processes for retroactively ascertaining the wishes of parent(s) with regard to excess embryos that will be disposed of or indefinitely cryopreserved, giving parent(s) the opportunity to select donation for research. (2006)
4. OPPOSES the use of embryos or ova for stem cell research that have not been expressly donated for research purposes in the form of written consent; (2006)
5. OPPOSES the creation of excess embryos during IVF procedures, without prior consent of patients, solely to provide embryos for research; (2006)

In regards to funding for Stem Cell Research, AMSA:

1. SUPPORTS the use of federal and local funding, including but not limited to the NIH, the CDC, and public and private universities, for all types of stem cell research conducted on legally acquired embryos and biological material; (2006)
2. URGES the federal government to restore permissions for NIH funding for research on new embryonic stem cell lines; and to expand permissions for funding for the creation of new embryonic stem cell lines from excess embryos created during normal *in vitro* fertilization procedures or using nuclear transplantation techniques. (2006)

In regards to oversight and standards of practice, AMSA:

1. SUPPORTS the creation of a Stem Cell Research Advisory Board to:
  - a. ENSURE that all stem cell research meets ethical and moral requirements regarding the use of human tissue for research; (2006)
  - b. EVALUATE successful strategies for ethical research in other countries with regard to stem cell research, nuclear transplantation, and umbilical cord blood research. (2006)
  - c. INCLUDE representatives from medicine, biosciences, and ethics to ensure a comprehensive analysis of procedures and policies. (2006)
2. OPPOSES:
  - a. human reproductive cloning; (2006)
  - b. the buying or selling of embryos via monetary or other exchange; (2006)
  - c. monetary or other gains for donors or handlers of embryos; (2006)
  - d. handling or processing agencies profiting from such transactions beyond reasonable fees for storage, transfer, and transport. (2006)

## **PRINCIPLES REGARDING INTERSEX HEALTH**

The American Medical Student Association:

1. SUPPORTS the Patient-Centered Model in managing the care of patients born with genitalia not standard for male or female. (2006)
2. BELIEVES Intersexuality is primarily a problem of stigma and trauma, not gender. (2006)
3. BELIEVES Surgeries done to standardize the genitals as strictly male or female should be deferred until a child is mature enough to make an informed decision for herself or himself. (2006)
4. BELIEVES maturity in addition to psychological fitness, should be determined by the analysis of psychiatric examinations accepted by the medical community, in addition to clinical evaluations. (2006)
5. URGES Medical Schools to include training in Intersex Health as part of its mandatory curriculum. (2006)

## **PRINCIPLES REGARDING HUNGER STRIKES**

The American Medical Student Association:

1. URGES healthcare professionals to uphold patient autonomy, as recognized by the 1975 Declaration of Tokyo and Declaration of Malta, such that medically informed and competent prisoners may refuse nourishment. Physicians should not be involved in and should actively oppose the force-feeding of prisoners or detainees at any facilities, in the US or on foreign soil. (2006)

## PRINCIPLES REGARDING HEALTH EQUITY

The American Medical Student Association:

1. REGARDING Culturally and Socially Responsible Education
  - a. BELIEVES education needs to be made more affordable and accessible to children born into poverty. (2007)
  - b. RECOGNIZES educational debt deters health students from pursuing careers in primary care and underserved areas. (2007)
  - c. URGES the United States to address debt and the affordability of medical education so that educational debt repayment and management does not constrain the culturally and socially responsible opportunities available to graduates of higher education. (2007)
  - d. BELIEVES that the U.S. educational institutions should reflect our nation's diversity to promote culturally and socially responsible education. (2007)
  - e. RECOGNIZES that the proportion of racial and ethnic minorities in the U.S. population is disproportionate to the number of racial and ethnic minorities in the U.S. physician workforce. (2007)
  - f. SUPPORTS efforts that promote the recruitment, retention, and matriculation of underrepresented persons at all levels of higher education, especially in the health professions to reflect the diversity of our nation. (2007)
2. REGARDING Health Care Workforce Access and Training
  - a. BELIEVES all health care providers should be adequately trained to competently address the needs of diverse and traditionally marginalized communities. (2007)
  - b. SUPPORTS the training of health students and residents to occur in underserved areas and community centered clinical practices by instituting minimum standards and quality measures in health professions curricula and licensure to promote a sense of equity and commitment to medically underserved communities and their expectations of the health workforce. (2007)
  - c. RECOGNIZES that the current health care workforce growth is insufficient to keep pace with the needs of underserved areas and the increasing burden of chronic disease. (2007)
  - d. URGES the expansion of the number of health care workers and training slots available domestically and abroad. (2007)
3. REGARDING Social Determinants of Health
  - a. RECOGNIZES that poverty and socioeconomic inequality are major causes of chronic disease. (2007)
  - b. BELIEVES we must address the social and economic causes of chronic disease, increase emphasis on prevention and primary care, and educate ourselves and our communities on mechanisms of causation and opportunities for prevention. To this end, we must address the impact of poverty and promote the provision of a living wage to individuals as an investment in the health of working families. (2007)
  - c. BELIEVES that environmental hazards lead to adverse health outcomes and disproportionately affect economically disadvantaged and minority communities. (2007)
  - d. BELIEVES we need to promote healthy environments for all people and address environmental health issues as critical to achieving social justice and eliminating health disparities. We must address quality of housing and built environment when attempting to sponsor community-driven initiatives or supporting community-centered interventions. (2007)

4. Regarding Quality of Care
  - a. BELIEVES that investing in the delivery of high quality health care for all is an investment in society and the ability of our nation to respond to national emergencies and threats to our health. (2007)
  - b. RECOGNIZES that the U.S. spends the highest per capita on health care (2007)
  - c. BELIEVES that the U.S. should be among the healthiest nations in the world. (2007)
  - d. SUPPORTS the notion that we can no longer let the current U.S. market based health care system ignore the possible savings of preventive health practices. (2007)
  - e. URGES the United States to strengthen the public health and primary care infrastructure by ensuring that proven models of chronic disease prevention and management such as Community Health Centers are adequately supported. (2007)
  - f. BELIEVES that the increasing burden of disease on our health care delivery system has overwhelmed our current health care system and compromised our nation's ability to deliver the highest quality of care. (2007)
  - g. BELIEVES that health care access, delivery and quality of care are a human right. (2007)
  - h. BELIEVES that current attempts to contain costs and maximize profits of the U.S. health management and insurance industries have left millions of people uninsured and millions of people underinsured nationally, compromising access to care with the greatest burden placed on our most needy communities. (2007)
  - i. URGES efforts to promote equitable access and delivery of high-quality care for medically vulnerable populations among whom systemic bias and stigma continue to compromise public policy, insurance parity, and quality of treatment. (2007)
5. URGES all health professionals and students to advocate for Health Equity as described above. AMSA will accept these principles and the Health Equity Campaign will adopt these principles as a platform and working document based on membership action, community initiation and support. (2007)

## PRINCIPLES REGARDING GENDER IDENTITY

The American Medical Student Association:

1. In regard to treatment of transgender patients:
  - a. OPPOSES the categorization of Gender Identity Disorder as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (2008)
  - b. RECOGNIZES that the financial cost of healthcare for many transgender people is currently covered only under the diagnosis of Gender Identity Disorder; (2008)
  - c. BELIEVES that before the Gender Identity Disorder diagnosis is removed from the DSM, a system should be set up to provide similar or superior care for these patients; (2008)
  - d. SUPPORTS requiring insurance companies to provide healthcare for transgender patients under new diagnostic categories not related to mental disorders; (2008)
  - e. BELIEVES healthcare for transgender people should be comprehensive; this comprehensive care should include, but not be limited to, psychiatric counseling for pre-hormonal and pre-operative patients, endocrinological (hormone) treatment, surgical treatment, and routine care—including (but not limited to) gynecological exams, prostate exams, and pap smears (both anal and vaginal)—directed towards treating patients based on their entire anatomy. (2008)

## **CONSTITUTION AND BYLAWS**

**Adopted:** December 29, 1950

### **Amended:**

December 28, 1951  
December 30, 1952  
June 17, 1953  
May 3, 1954  
May 8, 1955  
May 3, 1957  
May 3, 1959  
May 13, 1962  
May 5, 1963  
May 5, 1965  
May 6, 1967  
May 7, 1970  
May 7, 1971  
April 30, 1972  
May 6, 1973  
March 2, 1974  
March 8, 1975  
March 9, 1976  
April 3, 1977  
March 3, 1978  
March 24, 1979  
March 21, 1980  
March 29, 1981  
April 4, 1982  
March 6, 1983  
March 18, 1984  
March 24, 1985  
March 7, 1986  
March 20, 1987  
March 26, 1988  
March 17, 1989  
March 23, 1990  
April 4, 1991  
May 20, 1992  
March 28, 1993  
March 19, 1994  
March 29, 1995  
May 8, 1996  
March 21, 1997  
March 14, 1998  
March 14, 1999  
March 18, 2000  
March 31, 2001  
March 9, 2002  
March 22, 2003  
March 20, 2004  
March 19, 2005  
April 1, 2006  
March 10, 2007  
March 15, 2008

## **INTERNAL AFFAIRS**

Adopted: April 3, 1977

### Amended:

March 3, 1978  
March 24, 1979  
March 21, 1980  
March 6, 1981  
March 18, 1984  
March 24, 1985  
March 7, 1986  
March 20, 1987  
March 26, 1988  
March 17, 1989  
March 23, 1990  
April 4, 1991  
May 20, 1992  
March 28, 1993  
March 19, 1994  
March 29, 1995  
May 8, 1996  
March 22, 1997  
March 14, 1998  
March 14, 1999  
March 18, 2000  
March 31, 2001  
March 9, 2002  
March 22, 2003  
March 20, 2004  
March 19, 2005  
April 1, 2006  
March 10, 2007  
March 15, 2008

## **PREAMBLE, PURPOSES and PRINCIPLES**

Adopted: March 9, 1977

### Amended:

April 3, 1977  
April 3, 1978  
March 24, 1979  
March 21, 1980  
March 29, 1981  
April 4, 1982  
March 6, 1983  
March 18, 1984  
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March 7, 1986  
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March 26, 1988  
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March 28, 1993  
March 19, 1994  
March 29, 1995  
May 8, 1996  
March 22, 1997  
March 14, 1998  
March 14, 1999  
March 18, 2000  
March 31, 2001  
March 9, 2002  
March 22, 2003  
March 20, 2004  
March 19, 2005  
April 1, 2006  
March 10, 2007  
March 15, 2008



**The Proposed Model Oath for New Physicians**

Graduates: In the light of all I hold sacred, in the presence of my family, friends and teachers, I pledge to fulfill my obligations as a member of the healing profession.

My responsibility is to promote the health of the community and persons I serve. The health of you, my patient, will be my first commitment.

My privileges depend upon your trust: I will not violate that trust. I will respect all that is confided in me. I will not intentionally do harm.

Witnesses: We are your patients and your partners. Honor our dignity.

Graduates: I will honor your dignity. I will be your zealous advocate, guided by your will, sensitive to your feelings, needs and thoughts.

I respect and cherish the lives of all persons. I will not discriminate against any person in my medical decisions.

I recognize the limits of my competence. I will strive to improve the skills and to increase the knowledge I possess. I will seek the guidance of my colleagues whenever indicated.

I am responsible for upholding my profession's integrity. I will strive to counsel those physicians deficient in character or competence and I will not tolerate fraud or deception.

I will serve as both a teacher and a role model for my patients, my successors and the public. I will strive to transform the social and environmental factors which adversely affect our health.

With this oath, I willingly assume these responsibilities of a physician.

Witnesses: We accept and respect your commitment. May you long experience the joy of healing those who seek your help.

**Chairs of the House of Delegates**

1974-75 - Sam W. Cullison  
1974-75 - John P. Trowbridge  
1975-77 - Charlie Clements  
1977-78 - John A. Barrasso  
1978-79 - Kevin B. Kunz  
1979-81 - Nancy Schmitz  
1981-82 - Jeffrey D. Bloss  
1982-83 - Diane Mosbacher  
1983-84 - Jonathan D. Klein  
1984-85 - Sharon S. Burke  
1985-86 - Angela F. Gardner  
1986-87 - Steven Maron  
1987-88 - Jan Frederick  
1988-89 - Brian Zehnder  
1989-90 - Tamara M. Fogarty  
1990-91 - Bret E. Sherman  
1991-92 - Elizabeth H. Morrison  
1992-93 - George Perkins  
1993-94 - Karen Vloedman  
1994-95 - Andrew J. Nowalk  
1995-96 - Tamara Howard  
1996-97 - Glenn A. Tucker  
1997-98 - Ilana B. Addis  
1998-99 - Philip Chang  
1999-00 - Robert W. Chisholm  
2000-01 - Michael D. Mendoza  
2001-02 - Lauren D. Oshman  
2002-03 - Alexa M. Oster  
2003-04 - Michael B. Tomblyn  
2004-05 - Leana S. Wen  
2005-06 - Kara Durand  
2006-07 - Lauren Sachs  
2007-08 - Jennifer Jackson  
2008-09 – Lauren Hughes