

Constitution and Bylaws

and

Structure, Functions and
Internal Policy

and

Preamble, Purposes and Principles

2002-2003

American Medical Student Association
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APPENDIX

Appendix I. Proposed AMSA Model Oath 201

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AMERICAN MEDICAL STUDENT ASSOCIATION

CONSTITUTION AND BYLAWS

Adopted: December 29, 1950

Amended: December 28, 1951
December 30, 1952
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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
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STRUCTURE, FUNCTIONS AND INTERNAL POLICY

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March 23, 1990
April 4, 1991
May 20, 1992
March 28, 1993
March 19, 1994
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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
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CONSTITUTION AND BYLAWS

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, gender and disability.

ARTICLE III. MEMBERSHIP

Membership in the Association shall be classified as follows:

- A. Full Membership
 - 1. Active membership
 - 2. Graduate membership
- B. Affiliate Membership
 - 1. Supporting affiliate membership
 - 2. Professional sustaining membership
 - 3. Corporate sustaining membership
 - 4. Premedical sustaining membership
 - 5. International sustaining membership

Section 1—Full Membership

A. Active Membership

Active 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. Active membership shall be that period from the time of receipt of dues at the national office of the American Medical Student Association until one year following the termination of the student's undergraduate medical education or until the initiation of the student's postgraduate medical education, whichever shall occur first. Active membership shall entitle them to the full privileges of the Association.

The American Medical Student Association defines a medical student 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; and medicine as a profession of an individual from allopathic or osteopathic educational background.

Full active members of the Association shall have the right to become active members of the various committees of the Board of Trustees, as specified in Article IV, Section I of the Constitution and Bylaws.

B. Graduate Membership

Graduate membership in the Association shall be available to any medical school alumnus/a, who has demonstrated a serious interest in the profession of medicine and the objectives of the organization. The American Medical Student Association defines an alumnus/a as any individual who has graduated from an allopathic or osteopathic medical school. Former student members shall become eligible for graduate membership upon graduation from medical school.

Full graduate members shall carry full privileges in the Association, except for voting privileges in the regional meetings, *The New Physician*, and such benefits as shall be deemed legally or fiscally infeasible by the Board of Trustees. Graduate members shall not be eligible for election to national or regional office, except for the positions of Graduate Trustee. Implementation of graduate membership shall be the responsibility of the Board of Trustees.

There shall be a Graduate Caucus, which shall be composed of all full graduate members of the Association and all medical students in the final year of their undergraduate medical training. The Graduate Caucus will convene during each annual meeting under the direction of the Graduate Trustees and the National President. The Graduate Caucus shall elect two Graduate Trustees as specified in Article VIII, Section 7 of the Association's Bylaws. (2002)

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 premedical sustaining dues of the Association.

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 Associate Trustee, as specified in Article IV, Section 11 of the Constitution and Bylaws, and Action Committee Coordinator and Project Coordinator as specified in Section V, Part B of the Structure, Function and Internal Policy. No premedical student may serve as a committee coordinator in the Advocacy Action Committee, and no more than two premedical students may serve as committee coordinators in each of the other Action Committees. (2000)

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 Associate Premedical Trustees as specified in Article VIII, Section 5 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. During Board of Trustee meetings the Board will hold comments and/or suggestions made from the Premedical Trustee as equal to those of a voting member of the Board of Trustees. (2001)

D. International Sustaining Membership

International sustaining membership in the Association shall be available to all American and foreign students 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.

International sustaining members shall carry full privileges of the Association, except for election to offices other than International Trustee, (2002) voting privileges in the House of Delegates and regional meetings and such benefits as shall be deemed legally or fiscally infeasible by the Board of Trustees. International sustaining members shall not be eligible for election to office except for International Trustee. The Board of Trustees may annually renew international membership subject to recommendation. (1991)

Section 3—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.

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 5 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. To remain a chartered premedical chapter of AMSA, a chapter must maintain at least five national members in good standing. (1995)
5. 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.

C. International Chapters

Similarly, any group of at least five medical students studying at a foreign medical school may petition for affiliate 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 executive committee on an annual basis. (1991)

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.

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.

ARTICLE VI. WITHDRAWAL OF A CHAPTER

Section 1—Withdrawal by a Chapter From the National Association

1. If a 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 active 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—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 active members of the Association, except for the Graduate Trustee, Premedical Trustee and Associate Premedical Trustees, and International Trustee, at the time of their election and during their term of office. In addition, each Regional Trustee and Associate Regional Trustee shall be an active member of a chapter located in the established geographical region from which he/she is elected. The At-Large Trustees shall represent all of the regions and shall not be elected on a regional basis. The Action Committee Trustee shall be an active member of the Association and shall represent all of the regions and therefore be elected by the House of Delegates.

Section 2—Term of Office

The term of office for all Officers, Regional Trustees, Associate Regional Trustees, Premedical Trustee, Associate Premedical Trustees, International Trustee, and Action Committee Trustee, shall be for one (1) year, or until their successors are duly elected and qualified. The At-Large Trustees and the Graduate Trustees shall serve alternating two (2) year terms such that one At-Large Trustee and one Graduate Trustee shall be elected a year. (2001) None of the above Officers or Trustees serve more than two (2) consecutive terms in the same position.

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

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 Executive Director, the National President and the At-Large Trustees. (1999)

Section 4—Dismissal of the Officers

The Board of Trustees shall be empowered to dismiss from his/her position any Officer, At-Large Trustee, Regional Trustee, Associate Regional Trustee, Premedical Trustee, Premedical Associate Trustee, Graduate Trustee, International Trustee, or Executive Director 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 a meeting of 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 dismissal.

The Executive Committee of the Board of Trustees shall be empowered to dismiss from his/her position any Officer, At-Large Trustee, Regional Trustee, Associate Regional Trustee, Premedical Trustee, Premedical Associate Trustee, Graduate Trustee, or International Trustee 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 a meeting of the Executive Committee. A two-thirds vote shall be necessary for the dismissal.

With regard to the Regional Trustees, the local AMSA chapters in the region involved shall be empowered to dismiss a Regional Trustee 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 Action Committee Trustee, the Action Committee Chairs and Committee Coordinators 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 Action Committee Chairs and Committee Coordinators. A vote of at least two-thirds (2/3) of the Action Committee Chairs and Committee Coordinators shall be necessary for dismissal.

The Executive Board of the Action Committees shall be empowered, upon recommendation of either the Action Committee Trustee or Director of Student Programming, to dismiss from his/her position any Action Committee Chair, Project Coordinator, or Committee Coordinator who has failed to perform the duties of his/her position. The Officer in question must be given one 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 Committee. A vote of at least two-thirds (2/3) of the Executive Committee shall be necessary for dismissal. The Executive Committee shall fill vacant positions through appointment, with approval from the Board of Trustees.

The Chair of any Action Committee shall be empowered to dismiss from his/her position any officer of an Action Committee, including individuals serving as Associate Coordinators, or other officer, who has failed to perform the duties of his/her position. If the officer in question wishes to appeal the decision, he/she may bring an appeal to the Executive Board. A vote of two-thirds (2/3) against dismissal shall be necessary to reverse the dismissal. The decision of the Executive

Board shall be final. The Action Committee Chair shall fill a vacant position in an Action Committee.

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 shall serve in that position for the remainder of the term; and in the case of a vacancy in the position of Vice President, Treasurer, or At-Large Trustees, the Board of Trustees 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 Trustee, the Associate Regional Trustee shall serve in the Trustee's absence; and in the case of a vacancy in both the positions of Regional Trustee and Associate Regional Trustee, the Board of Trustees, 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 an Associate Regional Trustee, Premedical Trustee, Premedical Associate Trustee, Graduate Trustee, or International Trustee, the Board of Trustees shall designate an individual to serve in that position for the remainder of the term.

In the case of a vacancy of the Action Committee Trustee, the Action Committee Chairs 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 Action Committee Chairs and Action Committee Trustee 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, Vice President, and a Treasurer. 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 and the Executive Committee. 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-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 VICE PRESIDENT—The Vice President shall carry out those duties and responsibilities assigned to him/her by the Board of Trustees or the House of Delegates and shall be responsible for the conduct of the meetings of the Board of Trustees and the Executive Committee in the absence of the President.

Further, he/she will be for communicating the most recent Board of Trustees' plans, actions and deliberations as specified in Article VII, Section 13, Subsection F. (2002)

THE TREASURER—The Treasurer shall have final responsibility for writing the budget of the Association, and, under the direction of the Board of Trustees, shall oversee the expenditures of the Association.

Section 7—The Regional Trustees

Regional Trustees 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 Trustees shall carry out the policy of the House of Delegates as members of the Board of Trustees.

Section 8—The Associate Regional Trustees

An Associate Regional Trustee shall be elected from each of the geographical regions established by the House of Delegates. Each Associate Regional Trustee will organize at least one regional project that will increase awareness or activism in one of the established Strategic Priorities of the Association. The project should include all chapters in that

region and should be agreed upon by the Associate Regional Trustee and the Regional Trustee. Project plans are to be presented to the Board of Trustees at the Pre-Chapter Officers' Conference Board Meeting. The Associate Regional Trustee is expected to attend and help organize activities at the Chapter Officer's Conference in July and the Annual Meeting in March.

In addition, the Associate Regional Trustee will also disseminate information from the Action Committees and Interest Groups to the local chapters. The Associate Regional Trustee may perform any regional duty mutually agreed upon with the Regional Trustee.

Section 9—The At-Large Trustees

Two At-Large Trustees shall be selected to serve on the Board of Trustees. The At-Large Trustees represent the entire membership of the Association and shall carry out the policy of the House of Delegates as members of the Board of Trustees. The At-Large Trustees shall be elected as specified in Article VIII of the Constitution and Bylaws

The At-Large Trustee in the second year of his/her two-year term shall serve as Chairperson of the House of Delegates and shall be responsible for the conduct of all sessions of the House of Delegates. The Vice Chairperson shall assume the duties of the Chairperson in the event of his/her absence or unwillingness to perform his/her duty. (2001)

Section 10—The Graduate Trustees

Two Graduate Trustees shall be elected to serve on the Board of Trustees. The Trustees shall represent all alumni of the Association in all matters relating to participation in Association programs and membership. The Graduate Trustees shall be elected as specified in Article VIII of the Constitution and Bylaws.

The Graduate Trustees shall be responsible for coordinating, with the National Office, the activities of the Association's graduate membership, and shall act as a liaison between the Board of Trustees and the Alumni Network. The Graduate Trustees will organize, with approval of the Board of Trustees, the Graduate Caucus. Together the two Graduate Trustees shall be responsible for ensuring continuity of communication and programming involving resident and physician members of AMSA and the medical community at large. The Graduate Trustee in his or her second year in office shall be responsible for effectively transitioning long-term projects to the Graduate Trustee in his or her first year. (2001)

Section 11—The Premedical Trustee and Associate Premedical Trustees

Representatives of the premedical membership shall be elected to coordinate activities of the premedical membership along with the National President. The Premedical Trustees will organize, with approval of the Board of Trustees, the Premedical Caucus. The Premedical Trustee and the Associate Premedical Trustees shall be elected as specified in Article VIII Section 5 of the Constitution and Bylaws. The Premedical Trustee shall serve as an ex-officio member of the Board of Trustees, and an Associate Premedical Trustee shall serve as an ex-officio member in the Premedical Trustee's absence. (1997)

Section 12—The International Trustee and Associate International Trustee

The International Trustee and the Associate International Trustee shall be elected in a manner set forth in the Bylaws. The International Trustee shall serve as an ex-officio member of the Board of Trustees. (2002)

The International Trustee and the Associate International Trustee shall be elected by the Association's international constituency at a meeting of the International Caucus at the national convention. Each affiliate chapter attending shall be entitled to one (1) vote, and at least five (5) affiliate international chapters must be present at the time of the election or the positions shall be declared vacant. (2002)

In the event that the International Caucus does not elect the International Trustee and Associate International Trustee, the positions will be filled by the Board of Trustees as specified by Article VII, Section 6 of the Association's Bylaws. (2002)

The International Trustee shall be responsible for coordinating, with the other members of the national leadership, the activities of the association's international membership. The Associate International Trustee shall be responsible for assisting the IT in said coordination, specifically by maintaining accurate membership records for international chapters

and by disseminating information from the national leadership, action committees, and other sources to the international chapters and members. (2002)

Section 13—The Board of Trustees

- A. The Board of Trustees of the Association shall be composed of the officers, the At-Large Trustees, the Regional Trustees and the Action Committee Trustee. In addition, the Immediate Past President, the Executive Director, the Premedical Trustee, the Graduate Trustees, the International Trustee and other individuals designated as such by the Board of Trustees shall serve as ex-officio, nonvoting members. The Board of Trustees shall be responsible for carrying out such duties and responsibilities as may be designated in this Constitution and Bylaws of the Association.
- B. One (1) Trustee from Regions I, IV, V, VI, VII and IX, and two (2) Co-Trustees from Regions II, III, VIII and X shall be invited to each of the Board of Trustees meetings. Each Regional Trustee or Co-Trustee will be financed by the national budget, and each Regional Trustee or Co-Trustee will have a single vote on the Board of Trustees.
- C. The Board of Trustees may invite the Associate Regional Trustees to attend one Board of Trustees meeting, with their expenses for the meeting financed by the national budget. Otherwise, if the Associate desires to be present in addition to the Regional Trustee, all expenses incurred by the Associate Regional Trustee, including transportation, per diem, room expense and incidentals, will be paid by the Associate Regional Trustee. At the meeting, only the Regional Trustee will have the right to vote.
- D. The Board of Trustees 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 Board and Action Committee 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 to review the Executive Committee actions. Emergency meetings of the Board of Trustees may be called by a majority of the members of the Board.
- E. The Board of Trustees shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed by law for trustees of corporations and as may be prescribed by this Constitution and Bylaws. It will be the responsibility of the Board of Trustees to see that the policy determined by the House of Delegates is carried out and interpreted correctly, and that the Association is responsive to local chapters.
- F. The Board of Trustees shall bear the responsibility of assuring the House of Delegates 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 House of Delegates. This function will be accomplished by the preparation of a report by the Vice-President within two weeks following each meeting or substantive action of the Board of Trustees or Executive Committee outlining the Board of Trustees' 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. (2002)
- G. The Board of Trustees shall, on an annual basis, review the processing of student memberships by the National Office, and make the changes necessary to insure that memberships are processed within one month after receipt in the National office.

Section 14—The Executive Committee

The Officers, one (1) Regional Trustee, the At-Large Trustee, who shall be in the second year of his/her two-year term, and the Action Committee Trustee shall form the Executive Committee, whose responsibility shall be to conduct the affairs of the Association between meetings of the Board of Trustees. The President-Elect will serve as an ex-officio (nonvoting) member of this committee.

The Executive Committee shall implement the policies established by the House of Delegates and shall carry out such further duties and responsibilities as may be designated in this Constitution and Bylaws of the Association.

Section 15—Action Committees

Action Committees represent the long-term, ongoing and overall priorities of the Association. There shall be six Action Committees of the Association: Medical Education, Health Policy; Community and Public Health; Advocacy; Global Health Action; and Humanistic Medicine. (Effective March 1, 2002) (2001) The Advocacy Action Committee will be composed of subcommittees on Minority Affairs; Women in Medicine; Lesbian, Gay, Bisexual and Transgender People in Medicine; and Disabilities. The Global Health Action Committee will be composed of subcommittees on International Health, Occupational and Environmental Health, and Health and Human Rights.

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 4 of the Constitution and Bylaws and Section IV and V of the Structure, Functions and Internal Policy.

Section 16—Executive Board of the Action Committees

The Action Committee Chairs, Action Committee Trustee 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 17—The Executive Director

The Executive Director 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 executive director shall prepare an annual budget for review by the Board of Trustees. The executive director shall undergo an annual performance review that will be conducted by representatives of the Board of Trustees. The executive director shall attend the annual convention and the meetings of the Board of Trustees and the executive committee 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 18—The Legislative Affairs Director

The Legislative Affairs Director 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. Her/His duties and selection shall be set forth in the Section I, Part N, of the Structure, Functions and Internal Policy.

Section 19—Director of Student Programming

One member shall be chosen to coordinate the Action Committees and initiatives of the membership and shall also represent the Action Committees to the Board of Trustees. This officer shall have responsibility for representing the Advocacy Committee to the Board as well. The DSP shall be chosen as is set forth in the Structure, Functions and Internal Policy.

Section 20—Issue Response Groups

Issue Response Groups represent the interests and projects of a group of active 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 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 III, Part B in the Structure, Functions and Internal Policy.

ARTICLE VIII. ELECTIONS OF THE OFFICERS AND TRUSTEES

Section 1—President-Elect, Vice President, Treasurer, At-Large Trustee, Action Committee Trustee

1. The House of Delegates shall elect the President-Elect, Vice President, Treasurer, one Trustee-at-Large, and one Action Committee Trustee of the Association at its annual meeting. Prior to said meeting, the At-Large Trustees shall appoint a Nominations Committee.
2. 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 and At-Large Trustee position to the House of Delegates. Following the report of the Nominations Committee, additional nominations for each of the offices and At-large Trustee position may be made from the floor of the House of Delegates.
3. Each nominee shall have the opportunity to address the House of Delegates or withdraw his candidacy prior to the elections.
4. 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.
5. 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 Senior Trustee-at-Large before that meeting. The Senior Trustee-at-large will then be responsible for reporting all information on challenges to the Board of Trustees at the post-convention Board of Trustees meeting. (1994)
6. 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 June Board of Trustees meeting following his/her election.

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 X 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 Trustees

Each established geographical region shall be responsible for determining the election of the Regional Trustee(s) from said region. Each chapter in said region shall be entitled to one vote in the election of said Regional Trustee(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. Following the election of the three (3) Officers, one (1) At-Large Trustee, and one (1) Action Committee Trustee of the Association, the House of Delegates shall confirm the choices of the established geographical regions of individuals to serve as Regional Trustees. The House of Delegates shall then install the newly elected Officers and Regional Trustees as the Board of Trustees of the Association.

Section 4—Action Committee Chairs

Action Committee Chairs shall be elected by the members of that Action Committee at the Annual Meeting. Voting shall be by secret ballot, with each person casting one ballot until a majority is received for one candidate.

Section 5—Premedical Trustee and Associate Premedical Trustees

1. The Premedical Trustee and the Associate Premedical Trustees shall be elected by the Association's premedical constituency at a meeting of the Premedical Caucus at the national convention. One (1) Associate Premedical Trustee shall be elected per region. Each premedical chapter attending shall be entitled to one (1) vote, and at least five (5) affiliate premedical chapters must be present at the time of the election or the positions shall be declared vacant. (1997) (2000) Both the Premedical Trustee and Associate Premedical Trustee shall be members of the Premedical Caucus. (1991)
2. In the event that the Premedical Caucus does not elect the Premedical Trustee and Associate Premedical Trustee(s), the positions will be filled by the Board of Trustees as specified by Article VII, Section 5 of the Association's Bylaws. (1991)

Section 6—Graduate Trustees

The Graduate Caucus shall elect the Graduate Trustees at the Annual Meeting. Any candidate for Graduate Trustee must have already earned an M.D. or D.O. degree. (2002) The Graduate Trustee shall be elected by a simple majority of those present at the Graduate Caucus meeting. In the event that the Graduate Caucus fails to elect the Graduate Trustee, the position shall be filled by the Board of Trustees as specified in Article VII, Section 5 of the Association's Constitution and Bylaws.

Section 7—National Leadership Code of Election Conduct

Members of the AMSA national leadership, including Board of Trustees members, Associate Trustees, 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)

Allegations of misconduct shall be reported to the Trustees-at-Large, who shall determine the appropriate course of action. (2002)

Section 8—Code of Election Conduct (2001)

1. No distribution of campaign materials. The Nominations Committee chair, with the assistance of the Trustees-at-Large, 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 post-

marked 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 Trustees-at-Large 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. If this occurs, the candidate is obligated to notify the nominations committee immediately. Any allegation of misconduct regarding a candidate shall be submitted in writing to the nominations committee for review 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.
6. The rising STAL and the STAL (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 9—Selection of Action Committee Chairs and Committee Coordinators (2002)

- A. Candidate profiles: Each Action Committee Chair, with assistance from the Action Committee Trustee 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 active members shall be eligible to run for Committee Chair. Only full active members of the Association and premedical affiliate members shall be eligible to run for Committee Coordinator positions, but no Action Committee shall have more than two premed Committee Coordinators.
- C. Elections: Elections for Action Committees shall take place during organizational time during the Annual Meeting. The Action Committee Chair will create and chair an election committee made up of the Action Committee Chair and at least current two Committee Coordinators or other AMSA members that are not running for a position. If the 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.

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 Action Committee Trustee 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 Action Committee Trustee and the Director of Student Programming 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 Action Committee Trustee and the Director of Student Programming 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, one At-Large Trustee, one Action Committee Trustee, establish and amend the policy of the Association, and conduct such other business as may be necessary.

Section 1—Representation of Full Medical and Graduate 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 (200) active members, or 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.

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.

B. Graduate Members

Full graduate members of the Association shall be entitled to representation in the House of Delegates on the basis of one (1) vote per region per 500 graduate members, or a fraction thereof. Each such delegate shall be a full graduate member of the Association. In the absence of the delegate, an alternate delegate may be seated. Graduate members may serve as delegates or alternate delegates only in the region in which they are employed in an internship, residency or fellowship program.

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, as described by Section VIII of the Structure, Functions, and Internal Policy, shall be entitled to one (1) ex-officio delegate to the House of Delegates.

B. Affiliate International Sustaining Members

Each Foreign Affiliate Chapter, as described by Article IV, Section I, Part C of the Constitution and Bylaws, shall be entitled to one ex-officio member in the House of Delegates of the Association as well as three alternate delegates.

Section 3—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 4—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. 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 and amendment, make a motion or vote.
3. The guidelines for Official Observer status are as follows:
 - a. The student organization and AMSA should already have an informal relationship established and have worked for the mutual benefit of both.
 - b. The student organization should be national in scope and have similar goals and concerns about health issues.
 - c. The student organization is expected to add a unique perspective and bring expertise to deliberations in the House.
 - d. In order to maintain official observer status, a representative of the student organization cannot miss two consecutive meetings of the House.
 - e. The student organization must submit their application for observer status at least two weeks before the AMSA November Board Meeting so that all applications can be reviewed at the November 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 5—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 6—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 7—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 8—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, nor more than sixty (60) days, after notice has been sent to the chapter.

Section 9—Selection of the Chairperson and Vice Chairs

The At-Large Trustee 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 At-Large Trustee 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 At-Large Trustee 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 10—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)

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 and associate trustees regarding their performance and responsiveness to the membership. Via the feedback given at the conference, the trustee and associate trustee can direct future action to meet the needs of the region.
3. Regions I, II and III shall hold a joint conference to be hosted on a rotating schedule beginning with Region I in 1998, Region II in 1999, and Region III in 2000, and thereafter continuing to rotate through Regions I, II and III in that order. The AMSA funds for the three regions will be pooled and rotated to the hosting region. If one of the regions chooses to hold an additional convention out-of-turn, they shall not automatically receive funds from the pool. (1998)

ARTICLE XI. DISCRIMINATION

Neither the Association, nor its chapters, may refuse membership on the basis of race, religion, color, gender (1993), sexual orientation, 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, 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 medical students enrolled in standard MD/DO programs in the United States or Canada, as well as international students with U.S. addresses shall be:

1. U.S. \$65.00 when joining AMSA as a first- or second-year medical student, good for up to five and four years of medical school, respectively. (2002)
2. U.S. \$45.00 when joining AMSA as a third or fourth year medical student, good for up to three and two years, respectively. (2002)
3. Dues for students enrolled in joint programs lasting longer than five years shall be a one-time fee of U.S. \$10.00 for each additional year (U.S. \$75.00 for six years, U.S. \$95.00 for eight years, etc.). The student may, if she/he chooses, pay U.S. \$65.00 upon entering the program and the remainder upon entering the fifth year of the program. (2002)

Graduate membership shall be free of dues.

Dues for Premedical members shall be \$25.00 per year with the option of a onetime payment of \$70.00 for a four year premedical membership. (2002)

Dues for international members with mailing addresses outside of the United States shall be U.S. \$45.00 per year. (2002)

Dues for non-physician providers in the U.S. shall be \$30.00 per year, the cost of a domestic subscription to *The New Physician*. (2002)

Sole authority to raise the amount of dues shall be vested in the House of Delegates.

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 Executive Director, 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. 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 Executive Committee 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 Trustee, Fall Workshop 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 13, Subsection F. (2002)

In addition, each Regional Trustee 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 Trustees, Associate Regional Trustees, Premedical Trustee, Associate Premedical Trustees, Graduate Trustee, Action Committee Trustee, Action Committee Chairs, BOT Committee Chairs, Director of Student Programming and Legislative Affairs Director 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.

ARTICLE XVII. AMENDMENTS OF 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 active members or affiliate members of the Association may propose amendments to this Constitution and Bylaws by submitting such proposals in writing to the Executive Director 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.

ARTICLE XVIII. CLOSURE OF MEDICAL SCHOOLS AND 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 Trustee from the region of the affected medical school, the Advocacy Action Committee Chair and one other coordinator from a subcommittee under Advocacy, the National President, the Director of Student Programming, the Legislative Affairs Director and the Action Committee Trustee will be created. (2000)

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)

**STRUCTURE,
FUNCTIONS AND
INTERNAL POLICY**

STRUCTURE, FUNCTIONS AND INTERNAL POLICY
OF THE
AMERICAN MEDICAL STUDENT ASSOCIATION

Section I. Structure of the Board of Trustees

The Board of Trustees consists of one or two Regional Trustees for each designated region, (as outlined in the Constitution and Bylaws, Article VII, Section 13, Subsection B), the President, the Vice President, the Treasurer, two At-Large Trustees, the Action Committee Trustee, and the Immediate Past President. The President-elect, Immediate Past President, Premed Trustee, International Trustee and the Graduate Trustees shall be nonvoting members of the Board of Trustees. The Board of Trustees meets a minimum of four times per year (Constitution and Bylaws—Article VII, Section 13, Subsection D) to review organizational activities and to act on pertinent issues of concern to the Association. The first meeting of the Board of Trustees is immediately following the Annual Meeting and serves as an orientation for new members of the Board.

- A. Selection of National Officers. The House of Delegates elects the President-Elect, Vice President, Treasurer and one At-Large Trustee at the Annual Meeting. The President-Elect will have a two-week in-person transition period during the early weeks of May following his/her election. The President-Elect will assume responsibilities as President approximately 30 days prior to the June meeting of the Board of Trustees following his/her election. (Constitution and Bylaws—Article VIII, Section 1.6). Applications for national office are distributed to chapter officers and chapter liaisons with the “Official Call” prior to the Annual Meeting. All active members of the Association are eligible for national office, as designated in the Constitution and Bylaws of the American Medical Student Association.
1. 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.
 2. Voting procedures (Constitution and Bylaws, Article VIII, Section 2.2) for the election of national officers are contained in the Rules Committee report, which is annually received and approved by the House of Delegates.
- B. President. The President serves as the identified Spokesperson for all activities and policy positions of the Association. The functions of the President exceed any specific description and encompass input into all affairs of the Association. However, general functions of the President include:
1. representing the Association as an ex-officio member of all committees, except for the nominations committee, task forces and other such groups established by the Board of Trustees or as mandated by the Constitution and Bylaws;
 2. serving as the primary liaison between the Board of Trustees, Coordinators, regions and chapters and the staff of the Association;
 3. representation before all other associations, institutions and organizations, regions and chapters relative to the policy, programs and activities 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 the sum received by a first-year postgraduate resident in the Washington, D.C., area.

- C. President-Elect. The President-Elect serves as an officer in training to learn the duties and responsibilities of the senior elected officers of the Association. He/she will serve as a nonvoting member of the Board of Trustees and an ex-officio (nonvoting) member of the Executive Committee.

- D. Vice President. The Vice President serves in a capacity defined by the Board of Trustees, and in the event of resignation of the President, assumes that office (Constitution and Bylaws—Article VII, Section 5). The function and role of the Vice President 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 Board of Trustees; (2000)
 4. Act as a resource for the fall workshop coordinators in collaboration with the respective regional and associate trustees; (2000)
 5. Provide a report following each meeting or substantive action of the Board of Trustees or Executive Committee to the membership-at-large. (2000)
- E. Treasurer. The Treasurer functions in overseeing all fiscal affairs of the Association and in other capacities defined by the Board of Trustees. Generally, the following areas are of concern to the Treasurer:
1. serving as the primary liaison between the Board of Trustees, regions and the chapters and the Controller of the Association with regard to financial affairs;
 2. assisting in the preparation of the annual budget of the Association for presentation and approval to the Board of Trustees; and,
 3. preparation of a financial report for consideration by the House of Delegates at the Annual Meeting.
- F. Trustees-at-Large. Each of the two Trustees-at-Large serves on the Board of Trustees for a period of two years, one elected each year at the Annual Meeting. The roles and responsibilities of the Trustees-at-Large shall include the following: (2001)
1. The Trustees-at-Large shall represent all AMSA members, affiliate members and chapters to the Board of Trustees.
 2. The Trustees-at-Large shall assist the President in communicating with Regional Trustees on areas of concern to medical students and on activities of the Association.
 3. The Trustees-at-Large shall coordinate fall workshop programming concerning AMSA's Strategic Initiatives.
 4. The Trustees-at-Large shall be responsible for preserving the PPP by proposing through resolutions, deletions of out-of-date language, and by ensuring consistency among different sections of the PPP. Corrections of grammar can be done with approval of the board, as long as the changes to the PPP that do not change the intent of the PPP.
 5. The Senior Trustee-at-Large (STAL) shall serve as the Chairperson and the Junior Trustee-at-Large (JTAL) shall serve as the Vice-Chairperson of the House of Delegates.
 6. The STAL shall, with the assistance of the JTAL and the approval of the President, select the Reference Committees, Nominations Committee and Credentials Committee of the House of Delegates.
 7. The STAL shall serve on any committee of the Board of Trustees dealing with membership issues.
 8. The JTAL shall represent the Action Committees during the June and November meetings of the Board

in the absence of a Action Committee Trustee.

9. The JTAL shall represent the Interest Groups on the Board of Trustees.
- G. Regional Trustee. The Regional Trustee serves as the official representative of a region to the Board of Trustees. The functions of the Regional Trustee 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 fall workshops;
 3. coordination of the annual membership drive on the regional level with the chapter officers;
 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 Trustees;
 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 Trustee, National Officers, Graduate Trustee, Premed Trustee and Action Committee Trustee, the outgoing Board members will assist and orient the new trustee to their responsibilities.
- H. Associate Regional Trustee. In addition to the Regional Trustee, each region elects an Associate Regional Trustee. The responsibilities of that individual are determined jointly by the Regional Trustee and the Associate Trustee. In the event of resignation by the Regional Trustee, the Associate Regional Trustee automatically assumes the responsibilities of the Trustee (Constitution and Bylaws—Article VII, Section 5).
- I. Premed Trustee. The Premedical Trustee and Associate Premedical Trustees have the following functions:
1. development and maintenance of the premed chapters at the local level;
 2. representation of concerns of the premedical student membership to the Board of Trustees;
 3. service as a resource to premedical student members of the Association for information about or contact with levels of the organization;
 4. facilitation of meetings of premedical members of the organization at the annual meeting;
- J. Selection of the Regional Trustees and Associates.
- In regions with one Regional Trustee 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 Trustee, 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)

Associate Trustee elections in regions shall be conducted in the same manner as Regional Trustee elections.

All ballots for Regional Trustee or Associate Trustee elections shall be turned in by the Regional or Associate Trustee(s) to the Trustees-at-Large immediately following elections.

Disputes of election procedure or challenges of election results shall be made to the Trustees-at-Large prior to the start of the post-convention meeting of the Board of Trustees. (2002)

K. Selection of the Action Committee Trustee. Applications for the position of Action Committee Trustee will be solicited in the spring of the year. Candidates for the position of Action Committee Trustee must be active members of AMSA. The applications will be distributed as part of the Official Call. The elections will be held at the Annual Meeting as specified in the Bylaws. (1999)

L. Selection and Evaluation of the Director of Student Programming. Applications for the position of Director of Student Programming will be solicited in the fall and winter of the year. Candidates for the Director of Student Programming must be active members of AMSA. Applications will be distributed as part of the Official Call. The position will be filled by a committee composed of the Executive Director, the National President, the outgoing Director of Student Programming, the outgoing Action Committee Trustee and the outgoing Action Committee Chairs. (1997)(1999)

The Director of Student Programming's performance will be evaluated by the Executive Director and Board of Trustees at the November Board meeting.

M. Reports of the Board of Trustees. In addition to the reports to be written and published in an official publication of the Association (Constitution and Bylaws—Article XVII), each member of the Board of Trustees shall compose an Annual Activities Report that summarizes his/her activities, and details his/her financial expenditures.

In the case of the National Officers, this report shall be included in the Delegates Handbook.

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

In the case of the Associate Regional Trustee, their year-end report will be submitted in January and included in the Delegates Handbook. In addition, the Associate Regional Trustees will submit an interim report to the Board of Trustees before the November Board meeting.

In the case of the Action Committee Trustee 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.

N. Legislative Affairs Director. The Legislative Affairs Director 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 Legislative Affairs Director include, but are not limited to:

1. serve as the primary Association contact for all health policy and legislative issues;
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,
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.

The Legislative Affairs Director 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 Legislative Affairs Director, commensurate with 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:

1. developing, with the input and cooperation of the National President, the Executive Director and the outgoing Legislative Affairs Director, a Legislative Agenda to present to the Board of Trustees at the June Board meeting; and,
2. reporting to the Board of Trustees at each Board meeting by presenting a detailed report on the state of the Legislative Agenda.

The Legislative Affairs Director's performance will be evaluated by the Executive Director and Board of Trustees at the November Board meeting.

The American Medical Student Association will develop a Political Leadership Institute (PLI), administered and executed by the LAD. The PLI will consist of 15 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 participants' school and housing will be provided in the AMSA townhouse.

O. Graduate Trustees. The Graduate Trustees have the following functions:

1. coordinating the activities of the Association's graduate membership;
2. acting as liaison between the Board of Trustees and the Alumni Network of the Association;
3. facilitation of meetings of graduate members and organization of the graduate caucus at the Annual Meeting; and, (1997)
4. attending the Board of Trustees meetings and the Annual Meeting.

P. International Trustee. The International Trustee has the following functions:

1. development and maintenance of the international chapters at the local level;
2. representation of concerns of the international student membership to the Board of Trustees;
3. serve as a resource to international affiliate members of the Association for information about, or contact with, levels of the organization; and,
4. facilitation of meetings of international members of the organization at the annual meeting.

Section II. Committees of the Board of Trustees

- A. Executive Committee. The Executive Committee consists of the President, Vice President, Senior Trustee-At-Large, Treasurer, one Regional Trustee and the Action Committee Trustee. The President-Elect serves as an ex-officio (nonvoting) member. The functions of the Executive Committee include the following areas:
1. coordination of the activities of the Association and presentation of recommendations to the Board of Trustees on such activities;
 2. assistance in implementing all policies established by the Board of Trustees and/or House of Delegates;
 3. service as members of any other committees and/or task forces which the Board of Trustees deems appropriate;
 4. supervision of all fiscal affairs of the Association;
 5. approval and justification of all income solicited for the Association;
 6. supervision of all expenditures;
 7. preparation of recommendations for the Board of Trustees and/or Executive Committee on budgetary priorities;
 8. compilation of reimbursement guidelines for expenses incurred in activities related to the Association;
 9. resolution of disputes which may arise in reimbursements of staff and students; and,
 10. 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 Trustees, Fall Workshop and Action Committee budgets. This financial statement shall be reviewed by the Board of Trustees and 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.
- B. Other Committees. The Board of Trustees may establish committees to review a particular area of concern, based upon priorities, goals and objectives, or because of specific problems in need of in depth consideration. The Board of Trustees appoints Coordinators for a specific area of concern to work with the Board in formulating policy and programs.

Section III. 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 active 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 Action Committee Trustee and DSP to maintain quality assurance of the Action Committees. As such, the DSP and Action Committee Trustee 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. **Advocacy Action Committee:** The Advocacy Action Committee shall function under the same rules and regulations maintained for the other Action Committees, but its composition shall be regulated by the House of Delegates. The Advocacy Committee shall be composed of four (4) Committees: Women in Medicine, Minorities in Medicine, Lesbian/Gay/Bisexual/Transgender People in Medicine, and Disabilities. Each of these Committees shall have two (2) Coordinators which function in all other aspects as Project Coordinators within other Action Committees. These Committees shall assume the tasks assigned to a Action Committee, including project development, newsletter distribution, and Convention programming. The Coordinators of each Committee shall be elected from the members of that Committee at the Annual Meeting, with one Coordinator elected each year to serve a two year term of office. Both coordinators will attend the two (2) general meetings of the Action Committees in conjunction with meetings of the Board of Trustees. Each Advocacy Committee shall be allotted an appropriate amount of programming time at the Annual Meeting in order to hold a student caucus. (1998)
4. **Advocacy Action Committee Formation:** Advocacy committees represent long-term, broad, ongoing, important groups of students which are underrepresented, disempowered or otherwise in need of advocacy and a voice. Advocacy Committees may be created through a constitutional amendment submitted to the House of Delegates by five (5) or more active members of the Association. Creation of a new Advocacy Committee must be accompanied by a Statement of Purpose, Goals and Means, as well as justification to the House of Delegates of the institutional need for and fiscal impact of a new Advocacy Committee. The constitutional amendment must receive an affirmative vote of at least two thirds of the delegates present and voting. Membership is open to all members of the Association. (1998)

B. Issue Response Groups

1. **Issue Response Group Formation:** Issue Response Groups represent the short-term priorities of active 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, 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 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 a Action Committee. Lastly, the Executive Board 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. provision to the membership of newsletters each year, noting the projects and activities of the Action Committee, as well as articles for *AMSA Focus*;
 - 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;
 - 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;
 - h. provision of a forum for networking at organizational meetings at Annual Meetings and Spring/Fall workshops;

- 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 Advocacy Action Committee shall be to coordinate an Advocacy Board. This Board, made up of representatives from each Committee of the Advocacy Committee, the Advocacy Committee Chair, 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 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 Action Committee Trustee 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. The Action Committee Trustee 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 IV. 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 Bylaws.
- 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. Attendance at two (2) general meetings of the Action Committees and Issue Response Groups, in conjunction with meetings of the Board of Trustees;
 - 2. Providing for the budgeting and resource allocation for all Projects within each Action Committee, and assuring that such guidelines are adhered to;
 - 3. Solicitation and editing of materials for newsletters and *The New Physician*;
 - 4. Reporting to the Board of Trustees both orally and in writing at each general meeting the status of all Action Committee Projects;
 - 5. Submission of a final report to the House of Delegates, detailing the accomplishments of the Action Committee throughout the year;
 - 6. Communication with Project Coordinators in a timely fashion;
 - 7. Coordinating all activities of the Action Committee for the Annual Meeting, including speakers and programming time;
 - 8. Bringing forward all views of members to the Board of Trustees through the Action Committee Trustee.
 - 9. Attendance at Strategic Planning meetings of the Board of Trustees. (1998)
 - 10. Sitting on committees of the Board of Trustees, as deemed appropriate by the Executive Committee of the Board of Trustees. (1998)

Section V. Administration, Projects and Interest Groups of the Action Committees

A. Action Committee Administration. Each Action Committee (other than Advocacy) 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.

B. Selection of Committee Coordinators and Projects.

1. The Global Health Action Committee will be composed of three focus groups which will continue to work in these areas—international health, occupational and environmental health, and health and human rights. These focus groups will consist of: (2000)

- a. Two committee coordinators for the International Health Focus Group. (2000)
- b. Two committee coordinators for the Occupational and Environmental Health Focus Group. (2000)
- c. One committee coordinator for the Health and Human Rights Focus Group. (2000)

The Action Committee chair will not need to have a particular focus. 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 focus group oversees and making sure that there will be a vote for the unfilled position the following election year. (2000)

2. Committee Coordinators (other than Advocacy): Applications for the Committee Coordinator shall be solicited as part of the Official Call, with the selection process occurring at the Annual Meeting during Standing Committee organizational time. The members of the Action Committee shall choose the Committee Coordinators by majority vote. No greater than five Committee Coordinators shall be chosen by each Action Committee.

3. Projects and Project Coordinators: Applications for projects shall be advertised and solicited as part of the Official Call. Each project must have an individual who will serve as the Project Coordinator for the coming year. The board of each Action Committee will then review the projects and present them at the Annual Meeting during individual Action Committee organizational time. A majority vote on each project shall then accept or reject the project as one of the Committee's projects for the coming year.

C. Responsibilities of Committee Coordinators and Project Coordinators.

1. Committee Coordinators: Committee Coordinators responsibilities shall include, but shall not be limited to, the following:

- a. communicate via newsletters, telephone, e-mail, listserv and letters with the members active in the Action Committee.
- b. communicate with other Coordinators, Action Committee Chairs and National Officers regarding AMSA projects, policy and related matters.
- c. Oversee and assist projects of the Action Committee, as directed by the Action Committee Chair.
- d. promote Action Committee policies, themes, programs and projects to the AMSA membership.
- e. attend two (2) general meetings of the Action Committee leadership in conjunction with the meetings of the Board of Trustees.
- f. coordinate Action Committee activities at the fall workshops and the Annual Meeting.

- g. publish Action Committee resources and information via the Internet and in AMSA newsletters/publications.
 - h. 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.
2. Project Coordinators: Project Coordinator responsibilities shall include, but shall not be limited to, the following:
- a. develop a plan and budget for their project within thirty (30) days of the Annual Meeting that will be approved and modified by the administrative board of the Action Committee as deemed appropriate.
 - b. promote their project to the AMSA general membership.
 - c. submit articles regarding their project at least twice for publication on the Web site or in AMSA publications.
 - d. communicate with the board of the Action Committee regularly and in a timely fashion regarding the progress of the project.
 - e. submit an annual report to the House of Delegates for consideration on a “For Information Only” basis concerning the progress and accomplishments of their project.
- D. 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 programming and one hour of organizational time at the Annual Meeting. (2002)
 3. The Specialty Forum serves as the home for all relevant Specialty Interest Groups, which shall be sub-groups of this Forum. Specialty Interest Groups shall have the same access to webspace and a listserv as other interest groups, but convention programming is structured differently. All Specialty Interest Groups will have their one-hour of convention programming, and no money will be allotted for travel for speakers for Specialty Interest Groups, which shall have local speakers. 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 committee 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 during organizational time at the Annual Meeting. 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.
 - b. The duties of the Interest Group Coordinator include, but are not limited to, periodically updating the AMSA web page, planning the convention speaker, making any necessary announcements within the AMSA listserves and publications, and reporting to the DSP.
 - 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)

Section VI. Executive Board of the Action Committees

- A. Purpose: The Action Committee Chairs, Action Committee Trustees 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 Action Committee Trustee, 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, and in addition shall meet two (2) times yearly in conjunction with the Executive Committee of the Board of Trustees, in order to monitor the function and effectiveness of the Action Committees and Issue Response Groups.
 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.
 - 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 workshops.

3. Allocate funds for programming and activities at the Annual Meeting.
4. Advertise and oversee elections of new Chairs and Project Coordinators at the Annual Meeting.

c. Communications

1. Establish and maintain a Action Committee/Issue Response Group network for use in quick dissemination of information.
2. Contact with each Project Coordinator and Committee Chair before meetings to identify urgent needs or complaints.
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.

C. Responsibilities of the Director of Student Programming. 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 Junior Trustee-at-Large 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 Trustees 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 and initiatives (Strategic Priorities) that are being coordinated by the DSP. (2001)

11. To work with AMSA Regional Workshop 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 Action Committee Trustee, 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)
- D. Evaluation of the Director of Student Programming (DSP): The DSP position shall be evaluated after the completion of the second DSP's term by a group consisting of the following: the current Executive Board, Past Action Committee Trustees and the Past Director of Student Programming. The DSP position will be evaluated for further enhancement as well as to analyze the benefit of the additional student position in office.

Section VII. 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; and
3. to facilitate the development of inter-organization programs and activities of mutual benefit.

B. Fundamental Liaison Positions

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:

AAFP—American Academy of Family Physicians
 AAMC—Association of American Medical Colleges
 AAP—American Academy of Pediatrics
 ACOG—American College of Obstetricians and Gynecologists
 ACP—American College of Physicians
 ACS—American College of Surgeons
 AMA—American Medical Association
 AMWA—American Medical Women's Association
 AOA—American Osteopathic Association
 APHA—American Public Health Association
 GLMA—Gay and Lesbian Medical Association
 LCME—Liaison Committee on Medical Education
 NBME—National Board of Medical Examiners
 NMA—National Medical Association
 SNMA—Student National Medical Association
 SOMA—Student Osteopathic Medical Association

C. Creation of Liaison Positions

1. The above-mentioned liaison positions will exist as the core of AMSA's liaisons, and, as such, will continue to exist from year to year. (1998)
2. Any member of the Association may submit a proposal to develop a liaison position with another organization. These proposals should be submitted by April 30. The proposal must include a statement of

goals for the year's contact with the outside organization as well as a statement of the reason for the establishment of the liaison. The member must also complete an application for liaison as below. The proposal will be reviewed by the Communications and Liaisons Committee and approved or rejected by the Board of Trustees in conjunction with the Director of Student Programming (DSP) at the June board meeting. (1998)

3. Any outside organization may solicit AMSA for possible establishment of a liaison position with their organization. Such proposal will be reviewed by the Communications and Liaisons Committee and approved or rejected by the Board of Trustees in conjunction with the DSP. Until such time as the position is approved and filled, communication with the outside organization will be maintained through the office of the DSP and the National President. (1998)
4. The House of Delegates will make recommendations to the Board of Trustees at its discretion concerning the creation and maintenance of certain liaison positions. (1998)

D. Selection of Liaisons

1. Any member of the Association is encouraged to apply for a liaison position. (1998)
2. The liaison positions mentioned in Part B require a detailed working knowledge of the Association and its policies. They will therefore be appointed by the Board of Trustees in conjunction with the DSP at the June board meeting. The AMSA liaison to any external organization shall be a Coordinator of the related Action Committee or Interest Group. If no related Action Committee or Interest Group exists, or its Coordinator does not wish to serve as liaison, the liaison shall be selected as indicated below. If there is uncertainty regarding the most appropriate Coordinator, the Director of Student Programming and Board of Trustees shall select whichever eligible Coordinator they consider to be most qualified. (2002)
3. Liaison positions not filled by an Interest Group or Action Committee Coordinator will be filled by an application process. Candidates will be solicited during and after the National Convention. Each candidate must submit a liaison application, obtainable from the national office, which will include a statement of goals for the year. Applications should be postmarked or received in the national office no later than April 30 for the one-year term beginning in June. Applications will be reviewed by the Communications and Liaisons Committee and approved or rejected by the Board of Trustees in conjunction with the DSP at the June board meeting. (2002)
4. In the event that there are no applicants for a liaison position which the Association and the Board of Trustees have determined is a vital contact for the Association, candidates will be solicited for that position by the DSP, the Communications and Liaisons Committee, and the Board of Trustees. If no candidate is found, communication with that organization will be maintained by the DSP and/or the National President for that year. (1998)
5. In the event that there are no applicants for a liaison position which the Association feels is not a vital contact for the Association, that position will be terminated. (1998)
6. In the interest of fairness and inclusion, it is permissible for a member to serve in more than one liaison position at a time only if there are more liaison positions available than interested members, or with the approval of the Board of Trustees. (1998)
7. Liaisons will be notified of their new positions and will receive a congratulatory letter and a liaison handbook as soon as possible after the June board meeting. (1998)

E. Term of Liaison Positions

All liaison positions will be for a one-year term from June of one year to June of the following year. (1998)

F. Administration of Liaisons

1. The Communications and Liaisons (C&L) Committee of the Board of Trustees will be responsible for the administration of all liaisons with outside organizations. (1998)
2. C&L, the DSP and the National President will bear the responsibility for communicating with the liaisons throughout the year, with the co-chairs of the committee serving as coordinators. The committee will notify the new liaisons as soon as possible after the June board meeting with a congratulatory letter and a liaison handbook, detailing the responsibilities of a liaison as below. The committee will also divide up the various liaisons and notify each of them as to who their contact person is for the year. (1998)
3. C&L will update the liaison handbook as required by changes in the Constitution and Bylaws; Structure, Function and Internal Policy; and Preamble, Purposes and Principles of the Association. (1998)
4. C&L will review every liaison position each year with respect to its function with the other organization, the necessity of the relationship with the other organization, and its adherence to the purposes of liaisons as stated in part A. (1998)
5. The House of Delegates will make recommendations at its discretion to the Board of Trustees concerning the administration of the liaison positions. (1998)

G. Responsibilities of Liaison Positions

1. Liaisons will serve a one-year term from their appointment at the June board meeting until the following board meeting. (1998)
2. In order to adequately represent the Association, liaisons will need to be conversant with the PPP, especially those portions which pertain particularly to the organization with which they are the liaison. (1998)
3. Liaisons are responsible for providing both the national office and their contact on the Communications and Liaisons Committee with current contact information, including address, telephone, and e-mail addresses where applicable. They will be responsible for notifying these parties of any changes in this information. (1998)
4. Liaisons will be responsible for providing at least two reports to the Association during the course of their term.
 - a. The first will be to the House of Delegates, to be delivered to the national office or postmarked no later than January 10 of the year, and will detail the activities of the other organization and of the liaison until that point in the year, including a summary of what the liaison has learned about the host organization and a report on the annual meeting of the other organization if it has occurred between June of the previous year and the time the report is due. (1998)
 - b. The second report will be an end-of-term report to the Board of Trustees to be delivered to the national office or postmarked no later than April 30 of the year. This report should detail, among other things, the activities of the other organization and the activities of the liaison throughout the course of the year, as well as a report on the annual meeting of the other organization if it has occurred between the January report and the year-end report. The year-end report should also include recommendations for continuation or discontinuation of the liaison relationship. Other topics may be included at the discretion of the liaison. (1998)
5. Liaisons who fail to fulfill their responsibilities may be removed at the discretion of the Communications and Liaisons Committee and the Board of Trustees. (1998)

H. Termination of Liaison Positions

1. Termination of liaison positions will be at the request of either organization with which the liaison is involved. (1998)
2. When a liaison position not mentioned in part B and not determined to be of any value to the Association is not filled by the application process, that position may be terminated by C&L.
3. The House of Delegates may recommend termination of liaison positions to the Board of Trustees at its discretion. (1998)

I. Funding of Liaisons

Funding of liaisons will be encouraged from the other organizations to which the liaisons are appointed. This funding will be contingent on the submission of the two reports as detailed above in part G. Failure to discharge the responsibilities of a liaison, including submission of reports, will be grounds for withholding of funding. (1998)

J. AMSA Representatives to the boards of the National Board of Medical Examiners (NBME) and the National Resident Matching Program (NRMP). (2000)

1. The purpose of the above listed board representatives will be similar to that of our fundamental liaison positions. (2000)
2. The board positions to the NBME and NRMP require a detailed working knowledge of the Association and its policies. Given the importance of these positions, it will be filled by the National President during his/her term in office. (2000)
3. In the event that the National President is unable to fill the above board positions, the replacement will be selected and approved by the Executive Committee of the Board of Trustees. (2000)
4. The AMSA board representative to the NBME and NRMP must adhere to all policies relating to fundamental liaison positions. (2000)
5. Termination of the AMSA Representative to the NBME and NRMP will be at the request of either organization with which the liaison is involved. Specifically, the AMSA Executive Committee maintains the authority to review the performance of the AMSA Representative and take any necessary action to ensure that the Association is being appropriately represented. (2000)
6. Funding of the AMSA Representative will be encouraged from the organizations to which they are appointed. (2000)

Section VIII. 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
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Tufts University
University of Vermont
Yale University
Memorial University of Newfoundland

Region II

Albany Medical College
Albert Einstein College of Medicine
Columbia University
Cornell University
Mount Sinai School of Medicine
UMDNJ—Newark
New York Medical School
New York University
University of Puerto Rico
University of Rochester
Robert Wood Johnson Medical School—Piscataway
Robert Wood Johnson Medical School—Camden
State University of New York—Buffalo
State University of New York—Brooklyn
State University of New York—Stony Brook
State University of New York—Syracuse
Sophie Davis/CUNY Medical School
Ponce
Universidad Central Del Caribe
New York COM
New Jersey SOM

Region III

George Washington University
Georgetown University
Howard University
Jefferson Medical College
Johns Hopkins University
University of Maryland
University of Pennsylvania
MCP Hahnemann School of Medicine
University of Pittsburgh
Pennsylvania State University
Temple University
Uniformed Services University
Philadelphia COM
Eastern Virginia Medical School
University of Virginia
Medical College of Virginia
Marshall University
West Virginia University
West Virginia COM

Region IV

Case Western Reserve University
University of Cincinnati
Northeastern Ohio Universities
Medical College of Ohio
Ohio State University
Wright State University
Ohio University COM
University of Michigan
Michigan State University
Wayne State University
Michigan State COM

- Region V
- Wake Forest University School of Medicine (formerly Bowman Gray Univ.)
 - Duke University
 - East Carolina University
 - Emory University
 - University of Florida
 - Medical College of Georgia
 - Mercer University
 - University of Miami
 - Morehouse School of Medicine
 - University of North Carolina
 - Medical University of South Carolina—Charleston
 - University of South Carolina—Columbia
 - University of South Florida—Tampa
 - Florida State University (Branch of University of Florida)
 - NOVA Southeastern Miami SOM (1994)
- Region VI
- Chicago Medical School
 - University of Chicago
 - University of Illinois—Champaign
 - University of Illinois—Chicago
 - University of Illinois—Peoria
 - University of Illinois—Rockford
 - Indiana University—Indianapolis
 - Indiana University—Bloomington
 - Loyola Stritch School of Medicine
 - Northwestern University
 - Rush Medical College
 - Southern Illinois University—Carbondale
 - Southern Illinois University—Springfield
 - University of Wisconsin
 - Medical College of Wisconsin
 - Chicago COM
- Region VII
- University of Alabama
 - University of Arkansas
 - Louisiana State University—New Orleans
 - Louisiana State University—Shreveport
 - Meharry Medical College
 - University of Mississippi
 - University of South Alabama
 - University of Tennessee
 - Tulane University
 - Vanderbilt University
 - East Tennessee State University
 - University of Kentucky
 - University of Louisville
 - Pikeville College—School of Osteopathic Medicine
- Region VIII
- Creighton University
 - University of Iowa
 - University of Kansas—Kansas City
 - University of Kansas—Wichita
 - Mayo Medical School
 - University of Minnesota—Duluth
 - University of Minnesota—Minneapolis
 - University of Missouri—Columbia

University of Missouri—Kansas City
University of Nebraska
University of North Dakota
University of South Dakota
Saint Louis University
Washington University—St. Louis
Des Moines University College of Osteopathic Medicine
Kirksville COM
Kansas City COM

Region IX
Baylor College of Medicine
University of Oklahoma
University of Oklahoma—Tulsa
University of Texas—Galveston
University of Texas—Houston
University of Texas—San Antonio
University of Texas—Southwestern
Texas A&M University College of Medicine
Texas Tech University
Oklahoma COM
Texas COM

Region X
University of Arizona
University of California, Davis
University of California, Irvine
University of California, Los Angeles
University of California, San Diego
University of California, San Francisco
University of Colorado
University of Hawaii
Loma Linda University
University of Nevada
University of New Mexico
University of Oregon
University of Southern California
Stanford University
University of Washington—Seattle
WAMI—Bozeman (Branch of Washington—Seattle)
WAMI—Fairbanks (Branch of Washington—Seattle)
WAMI—Pullman (Branch of Washington—Seattle)
WAMI—Moscow (Branch of Washington—Seattle)
University of Utah
Western University of Health Sciences
University of California, Berkeley
Touro University College of Osteopathic Medicine

Premedical Chapters

Region I
University of New England (1995)
Harvard University (1996)
Radcliffe College (1996)
Boston University (1998)
University of Connecticut (1998)
University of Massachusetts (1999)
Massachusetts Institute of Technology (2000)
Brandeis University (2000)
University of New Hampshire (2001)

Trinity College @ Connecticut (2001)
Tufts University (2001)
Northeastern University (2001)

Region II

Princeton University
State University of New York—Binghamton
Brooklyn College (1993)
College of Natural Sciences, University of Puerto Rico (1994)
Columbia University (New York, NY) (1994)
New York Institute of Technology (1995)
Rutgers University (1995)
University of Puerto Rico (1996)
Cayey University College (1996)
Hunter College—CUNY (1996)
New York University (1997)
Interamerican University of Puerto Rico (1998)
Fordham University (1999)
Rider University (1999)
St. Joseph's College (2000)
University of Puerto Rico—Bayamon University College (2000)
Cornell University (2001)
Syracuse University (2001)
State University of New York @ Stony Brook (2001)
Rutgers @ Newark (2001)
Rutgers @ Camden (2002)
Ithaca College (2002)
Polytechnic University (2002)

Region III

University of Pittsburgh
George Washington University (1994)
University of Pennsylvania (1994)
Haverford College (1995)
Dickinson College (1997)
Johns Hopkins University (1999)
MCP Hahnemann (2000)
University of Virginia (2000)
College Misericordia (2000)
Eastern College (2000)
Indiana University of Pennsylvania (2001)
Temple University (2001)
American University (2002)
Bucknell University (2002)

Region IV

University of Michigan
Case Western Reserve University (1993)
Miami University (Ohio) (1993)
Ohio State University (1995)
Ohio University, College of Osteopathic Medicine (1996)
Cleveland State University (1997)
Columbus State University (2001)
Wilmington College (2001)
Wayne State University (2001)
Calvin College (2001)

Region V

Georgia Institute of Technology
University of Florida—Gainesville
University of Central Florida (Orlando) (1993)

Albany State College (Albany, GA) (1994)
Pembroke State University (1994)
Stetson University (1994)
Barry University (1994)
Savannah State College (1995)
Florida International University (1995)
Nova Southeastern University (1995)
University of South Florida (1995)
Augusta College (1995)
Johnson C. Smith University (1997)
Valencia Community College (1998)
Oxford College of Emory University (1999)
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)
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)

Region VI

Northwestern University
University of Wisconsin—Milwaukee
Illinois Benedictine College (1995)
Michigan State University (1995)
Marquette University (1997)
Rose-Hulman Institute of Technology (1997)
Tri-State University (1997)
Anderson University (1999)
University of Wisconsin—La Crosse (1999)
Loyola University of Chicago (1999)
Butler University (1999)
Indiana University/Purdue University @ Indianapolis (2000)
Western Michigan University (2000)
Southern Illinois University—Carbondale (2000)
McKendree College (2000)
North Central College (2000)
Northeastern Illinois University (2001)
University of Illinois @ Urbana/Champaign (2001)
Indiana University/Purdue University @ Fort Wayne (2001)
Knox College (2002)

Region VII

Vanderbilt University
University of Kentucky (1997)
Mississippi State University (1999)
University of Louisiana—Lafayette (2000)
Auburn University (2000)
Centre College (2001)
Tennessee State University (2001)
Our Lady of Holy Cross College (2002)

Region VIII

University of Missouri—Kansas City (1995)
University of Missouri—Columbia (1997)

Creighton University (1996)
Black Hills State University (1996)
Kansas State University (1998)
University of Iowa (1998)
University of Minnesota (1998)
Truman State University (1999)
Carleton College (2000)
University of Nebraska @ Lincoln (2001)
Washington University (2002)
Fort Hays State University (2002)

Region IX
Texas A&M University (1996)
University of Texas—Austin (1997)
University of Oklahoma—Norman (1997)
McMurry University (1999)
Abilene Christian University (1999)
Texas Tech University (1999)
Hardin-Simmons University (1999)
Oklahoma State University (2000)
Lamar University (2000)
Texas A&M University @ Kingsville (2001)

Region X
University of California, Berkeley
University of California, Davis
University of California, Fresno
University of California, Los Angeles (1995)
University of California, San Diego (1997)
University of Colorado at Denver (1995)
California State University—Fullerton
California State University—Sacramento (1995)
California State University—Bakersfield (1998)
Sacramento City College (1996)
University of Puget Sound (1997)
Oregon Health Sciences University (1997)
California Polytechnic State University (1997)
Mesa State College (1997)
San Diego State University (1998)
University of Southern California (1998)
Western Oregon University (1999)
Evergreen State College (2000)
California State University—Los Angeles (2000)
California State University—Northridge (2000)
Brigham Young University (2000)
Oregon State University (2000)
Boise State University (2001)
California State University @ San Bernardino (2001)
Arizona State University (2001)
University of California @ Riverside (2001)
University of Washington @ Seattle (2002)
Ohlone College (2002)
University of Utah (2002)

Foreign Affiliate

San Juan Bautista School of Medicine—Puerto Rico
Ross University School of Medicine—Dominica, West Indies (1993)
St. George's University School of Medicine—Grenada, West Indies (1993)

American University of the Caribbean (1995)
 Universidad Autonoma de Guadalajara, School of Medicine, C/O N.A.S.A. (1997)
 Saba University School of Medicine (1998)
 Universidad Central del Este (1998)
 Flinders University of South Australia (1998)
 University of the West Indies (1998)
 Sackler School of Medicine (1999)
 Ben Gurion University (1999)
 Spartan Health Science University (2000)
 University College of Dublin (2000)
 Kigezi International SOM (2000)
 Universidad IberoAmericana (UNIBE) (2000)
 St. Matthew's University (2000)
 Central America Health Sciences University (2000)
 University of Health Sciences Medical School—Antigua (2000)
 Universidad de Monterrey (2000)
 University of Ankara Faculty of Medicine (2000)
 Istanbul University Cerrahpasa Medical Faculty (2000)
 Hacettepe University Faculty of Medicine (2000)
 American International School of Medicine (2001)
 Medical University of the Americas (2001)
 Trinity College @ Dublin, Ireland (2001)
 Royal College of Surgeons (2001)
 International University of the Health Sciences (2001)
 Medical University of Silesia (2002)
 St. Christopher's College of Medicine (2002)

Section IX. 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 an accredited allopathic or osteopathic United States 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 Chapter Legislative Representative and a Chapter Action Committee Representative. The creation of other offices and positions is at the discretion of the local chapter.
- 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 Trustee 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 Trustee;
 3. coordinate programs and activities at the chapter level;
 4. coordinate the annual membership drive; and
 5. facilitate activity within the chapter and communicate through periodic chapter meetings to discuss and review issues of concern to medical students.

6. be active 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 Liaison. The primary functions of the Chapter Liaison are as follows:

To serve as the 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.

D. Responsibilities of the Chapter Legislative Representative. The Chapter Legislative Representative serves as the primary contact for the Coordinators of National and State Legislative Affairs. 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 Action Committee Representative

The Chapter Action Committee Representative serves as the primary distributor of information concerning the activities and projects of the Action Committees, Issue Response Groups and Interest Groups. The functions of the Chapter Action Committee Representative include:

1. subscribing to the Chapter Action Committee Representative listserv to receive all updates concerning the activities of the Action Committees, Issue Response Groups 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, Issue Response Groups 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. Chapter Action Committee Representatives will be strongly encouraged to attend the Annual Meeting and become familiar with the activities, projects and policies of the Action Committees, Issue Response Groups and Interest Groups.

F. 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.

G. Chapter Legislative Representative Selection. The Chapter Legislative Representative shall be the coordinator of the Legislative Affairs Committee (LAC) at each chapter as outlined in Section VII, Article D. At chapters where such a member is not available, the Chapter Officer shall become an honorary member of LAC and serve as the LACNET Contact her/himself.

Section X. 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 8). 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 Trustees and National Officers.

Section XI. Structure and Functions of the House of Delegates

The House of Delegates serves as the official policy-formulating body of the Association. The House elects the national officers and considers and takes action on any proposed amendments to the Constitution and Bylaws; the Preamble, Purposes and Principles; and the Structure, Functions and Internal Policy of the American Medical Student Association. The House of Delegates meets once per year during the Annual Meeting, unless a "special" meeting is called (Constitution and Bylaws—Article IX, Section 8).

- A. Composition of the House of Delegates. Each chapter of the Association is authorized to send one (1) Delegate to the House of Delegates for every two hundred (200) active members of the chapter or fraction thereof (Constitution and Bylaws—Article IX, Section 1, Subsection A). The number of active 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. Full graduate members are entitled to delegates in the House of Delegates on the basis of one (1) vote per region per 500 graduate members, (Constitution and Bylaws, Article IX, Section 1, Subsection B).

All AMSA members studying at foreign medical schools who are in attendance at the Annual Meeting are encouraged to form a caucus to select a nonvoting member of the House of Delegates. Such a nonvoting member would have a right as specified in Constitution and Bylaws—Article IX, Section 2, Subsection B. Graduate delegates will be chosen at the beginning of the Annual Meeting by general caucus of all graduate members present at the Meeting. Voting will take place on a regional basis, with the delegate being selected by a majority vote. Graduate members may serve as delegates only in the region in which they are employed in a residency or fellowship program. If no members are present from a given region, no delegate will be seated in the House of Delegates from that region.

Each region of the Association is authorized to send one premedical ex-officio delegate to the House of Delegates.

- B. **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. Graduate 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. Graduate Delegates and Alternate Delegates will complete Delegate registration forms and be credentialed at the first opening session of the House of Delegates.

Each Foreign Affiliate 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 foreign medical schools will certify their selection of nonvoting members and alternates to the Credentials Committee Chairperson.

- C. **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.

Section XII. 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. 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.
- C. The Structure, Functions and Internal Policy. 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.

Section XIII. 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 stressed. 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 the regularly scheduled regional meeting immediately prior to the Opening Session of the House of Delegates, each region reviews all submitted amendments, resolutions and reports. Regions usually assign their members to attend specific Reference Committees in order to optimally provide input into the deliberations on the issues under consideration. The regions also receive the final reports of the Reference Committees before they are officially presented to the House of Delegates. The regions usually review the reports and discuss the actions Delegates may take in the actual meetings of the House of Delegates.
- 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, Treasurer, Board of Trustees, Coordinators and/or Committees and the Executive Director, 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 with the responsibility for

implementation of all policies established by the House of Delegates. 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 permanent, persistent issues which are most pertinent to medical students: (1997)
 - a. Student Loan Issues: AMSA will address the cost of medical education and the availability of adequate student loans for medical students. Other aspects of this issue include, but are not limited to, tax credits for student loan interest, improved methods of loan repayment, and innovative student and school-based financing strategies. (1997)
 - b. Undergraduate Medical Education: AMSA will address the undergraduate medical education process, structure, and curriculum. This effort will include, but are 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, and encouraging a public health and community-based curricula. (1997)
 - c. Graduate Medical Education: AMSA will address the graduate medical education process, structure, and curriculum. This effort will include, but are 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, and encouraging a public health and community-based curricula. (1997)
 - d. Residency Work Hours: AMSA will address the particular issue of residency work hours. This effort will include, but are not limited to, acting to implement, where appropriate, such regulations as the New York State Bell Commission Laws. (1997)
 - e. National Health System: 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 plan, working for improved Medicare regulations, and advocating for greater access for insured individuals. (1997)
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. Individuals who seek to change established association policy are encouraged to write resolutions to the contrary.

Section XIV. 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, 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. AMSA bans all pharmaceutical ads in its publications and events.
4. Support documentation verifying claims must be submitted to publisher upon request before an advertisement will be accepted for publication.

5. Nutritional advertisements should not conflict with the U.S. Dietary Guidelines.
6. 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.
7. The implementation of the above guidelines will be the responsibility of the BOT.

Section XV. 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 Trustees-At-Large to periodically reformat the Principles of the Association in order to make the organization of them more relevant to the membership.

Section XVI. 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 XVII. Reference Committees of the House of Delegates

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.

- A. Reference Committee Structure. Each Reference Committee consists of five to seven 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. 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.
- B. 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. No smoking is allowed during Reference Committee sessions.

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.

Section XVIII. Committees of the House of Delegates

In order to enable to 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. Credentials Committee. The Credentials Committee consists of active 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 Trustees-at-Large. (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.
- B. Nominations Committee. The Nominations Committee consists of active 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 Trustees-at-Large. (2002) The functions of the Committee are to ensure that all candidates for national office are active members, to present all identified candidates to the House of Delegates during the Open Session and to oversee the electoral process.
- C. 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.

Section XIX. Candidacy for National and Regional Office in the Association

During the Annual Meeting, the House of Delegates elects the President-Elect, Vice President, Treasurer and one At-Large Trustee. The individual regions elect a Regional Trustee and an Associate Regional Trustee. Applications for National and Regional office are distributed to Chapter Officers and Chapter Liaisons with the "Official Call."

- A. Application for National Office. Active members of the Association may declare their candidacy for national office until the Opening Session of the House of Delegates at the Annual Meeting. However, the House requests that all eligible members seeking national office make their intentions known at the earliest possible date in order to allow the Delegates adequate time to review the qualifications of the candidate.
- B. Application for Regional Office. Candidates for Regional Trustee and Associate Regional Trustee must declare their candidacy by the time designated in the election procedures adopted by their region. Regions must specify their election procedures at the first regional meeting at the Annual Meeting.

Section XX. 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.

Section XXI. Smoking at AMSA Meetings

No smoking is allowed during meetings of AMSA House of Delegates and Reference Committees, and smoking is strongly discouraged during regional meetings, chapter meetings, fall workshops and other meetings and programs.

Section XXII. 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.

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, 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, gender sexual orientation, 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, 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.

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PRINCIPLES

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PRINCIPLES REGARDING MEDICAL EDUCATION— CURRICULUM DESIGN AND CONTENT

The American Medical Student Association:

1. In regard to Active and Technical Education
 - a. 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)
 - b. 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)
 - c. RECOGNIZES that supervision appropriate to the individual medical student's level of proficiency is integral to maximizing the learning process and at the same time minimizing the possibility of morbidity and mortality. (1988)
 - d. ENCOURAGES credentialing to document proficiency in technical skills during undergraduate medical training. Any medical student who has repeatedly demonstrated proficiency in a particular procedure should be allowed to perform that procedure without in-person supervision. (1988)
2. 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;
 - 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)
3. SUPPORTS a medical school curriculum that:
 - a. In regard to educational experience:
 1. 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;
 2. provides, as part of the curriculum, information and statistics on relative specialty and geographical needs for physicians;
 3. allows, but does not require, individuals to pursue areas of special interest including nontraditional educational experiences that demonstrate definite educational value;
 4. incorporates formal and effective interpersonal skills training as an integral part of the pre-clinical and clinical instruction of medical students and residents;
 - b. 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;
- c. incorporates training in the special health-care needs of the terminally ill, including concerns for psychosocial issues and symptom control;
- d. 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)
- e. 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;
- f. 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)
- g. 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)
- 4. Regarding curriculum design:
 - a. 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;
 - b. 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;
 - c. SUPPORTS development of clinical rotations that devote a fair portion of time to teaching patient communication and health promotion skills. (1992)
 - d. While recognizing the value of optional three-year programs to certain students, OPPOSES rigid and inflexible three-year curricula which merely compress the traditional curriculum into 36 consecutive months, thus depriving students of free choice electives, needed vacation periods, and the opportunity for experiences away from the medical school setting;
 - e. 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;

5. 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;
6. 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;
7. 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;
8. 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. In response to the February, 1999, NBME field test, a 350-item full-length computer-based examination administered to exam registrants prior to the live exam, AMSA BELIEVES that NBME must take the following actions: (1999)
 1. guarantee future student representation in decisions regarding present and future USMLE exams and future proposed licensing exams. (1999)
 2. offer a free full-length, computer-based practice test to all 1999 USMLE exam registrants prior to the live test. (1999)

If the NBME and AMSA conclude that the full-length, computer-based practice tests for all registrants are cost prohibitive and/or create excessive strain on the USMLE system, AMSA STRONGLY URGES NBME to take the following actions: (1999)

1. withhold all score reports from the field test participants; (1999)
 2. track student scores to evaluate for statistical differences between the students who participated in the field test with those who did not; (1999)
 3. publicly disclose the results of the above tracking; and, (1999)
 4. collaborate with AMSA prior to 1999 testing to develop a plan in the event that statistical differences are noted in examination results. (1999)
- e. OPPOSES the addition of a Standardized Patient Test (SPT) to the United States Medical Licensing Exam (USMLE). In the event that the SPT becomes an USMLE requirement AMSA: (2000)
1. strongly SUPPORTS pass/fail grading of the SPT; (2000)
 2. strongly SUPPORTS making the SPT available free or at a nominal cost to all medical students at U.S. medical schools; (2000)
 3. strongly SUPPORTS making SPT testing locations available in every U.S. city with a medical school; (2000)
 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)
9. 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)
10. SUPPORTS requiring every medical school to include rotational exposure to community service and practice in an underserved community in their curriculum. (1994)
11. 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)
12. SUPPORTS the development of interdisciplinary education programs in the undergraduate, graduate and continuing education training of health-care professionals where appropriate. (1995)

13. SUPPORTS and PROMOTES the inclusion of medicolegal topics such as medical malpractice and tort processes in medical school and continuing education curricula. (1996)
14. 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)
15. 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)
16. 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)
17. In regard to grading:
 - a. SUPPORTS the use of pass/fail grading in the preclinical years of medical school. (2001)
18. 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 in Section 13 of the Principles Regarding Graduate Medical Education and Specialty Distribution. (2002)

PRINCIPLES REGARDING ADMISSION TO MEDICAL SCHOOL

The American Medical Student Association:

1. **SUPPORTS** the broadening of qualifications for admission to include differences in social class, race and social experience;
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." (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." (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)

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., 17 percent according to the 1980 census);
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 Liaison Committee on Medical Education (LCME) 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. 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, as practiced by the Student Loan Marketing Association (Sallie Mae);
 - d. CONDEMNS student loan recipients who are greater than 90 days delinquent or default on their student loan obligations;
 - e. URGES that strict financial penalties be imposed against medical school graduates who default or are greater than 90 days delinquent on repayment of their student loans;
 - f. URGES that medical schools cooperate with the federal government to improve collection practices on student loans;
 - g. ENDORSES the release of information about the repayment records of student loan recipients who default or are delinquent to private credit agencies and lending institutions;
 - h. BELIEVES that federal law should discourage physicians from discharging their loan obligations through bankruptcy proceedings;
2. 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, in principle, the AMA-Education and Research Foundation Student Loan Program and URGES the AMA and the private banking institutions participating in the AMA-ERF Student Loan Program to seek ways to reduce the present loan interest rates and to increase the size of the program;
 - e. SUPPORTS federal direct lending programs for students enrolled in medical schools, and for medical students pursuing other advanced degrees. (1997)
3. In regard to the Armed Services:
 - a. CONDEMNS any use of a student's military draft registration status as a criterion in the eligibility for, or awarding of, financial aid.
 - b. SUPPORTS the continuation of the Department of Defense's Armed Forces Health Professions Scholarship Program;

4. In regard to taxation:
 - a. CONDEMNS the tax on human potential represented by the nondeductibility of interest on student loans and URGES Congress to reinstate the tax deduction for such interest. (1987)
 - 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;
5. URGES that child care expenses be included in the assessment of financial aid needs for all medical students;
6. SUPPORTS the funding, by state governments, of a substantial portion of the costs of private medical schools within their jurisdiction;
7. 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;
8. 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)
9. 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)
10. SUPPORTS the interest exemption on subsidized loans during the time period a student is attending either undergraduate or graduate medical school. (1995)
11. 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)

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)

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 implementors 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. RECOGNIZES the need to support current legislation which would address the health-care needs of the working uninsured. (1989)
 - b. SUPPORTS legislation to require employers to provide health benefits. Such legislation should address the affordability of health insurance for small businesses; minimum benefits should include mental health, prenatal, obstetrical and well-child care coverage. Such benefits should be extended to all non-dependent employees and their families wherein the employee works full time, and dependent employees who are not covered by other health insurance. (1989)
 - c. SUPPORTS provisions which require that any individual or group health plan not impose treatment limitations or financial requirements on the coverage of mental health services in excess of those limitations or requirements imposed on coverage for other health services. (1997)
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 Medical Savings Accounts (MSAs) in the nonelderly private insurance market:
- a. RECOGNIZES that the medical savings account can be a counterproductive health-care financing instrument due to adverse selection, income tax unfairness and the introduction of preventive care disincentives, and therefore;
 - b. OPPOSES MSA policy that does not include measures to address these hazards. Examples of these measures may include:
 1. with respect to adverse selection, placing restrictions on deductibles and maximum out-of-pocket payment on MSA-associated insurance policies.
 2. with respect to tax fairness,
 - a. capping total annual deposits to MSAs
 - b. limiting MSA fund investments to low-risk ventures.
 3. with respect to preventive care disincentives, requiring MSA/catastrophic insurance policies to provide first-dollar coverage for preventive care services.
24. STRONGLY URGES that all insurers fully cover rehabilitation for the purpose of optimizing adaptation to and improvement of cognitive deficits. (1999)

PRINCIPLES REGARDING UNIVERSAL HEALTH CARE

The American Medical Student Association:

1. SUPPORTS the establishment of a national health insurance or health-care plan that will provide quality, affordable health care for all regardless of a person's socioeconomic status, geographic location, race/ethnicity, employment status, age, sexual orientation, gender, or occupation. Furthermore, a person residing in the United States should not be discriminated against based upon the legality or documentation of their citizenship/residency status; this specifically excludes persons who enter the United States for the sole purpose of obtaining medical care. Such a program should include: (1994)
 - a. In regard to financing:
 1. SUPPORTS single-payer health insurance with one method of billing; (1992)
 2. multisource, progressive financing, including income and payroll taxes; (1994)
 3. the elimination of tax deduction for the purchase of additional, supplemental health insurance;
 4. provisions to protect consumers from the financial repercussions of catastrophic illness;
 5. SUPPORTS the use of revenue from the sale of tobacco products, alcohol, firearms and firearm ammunition to finance a national health plan. (1994)
 - b. 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. prescriptions and medically necessary supplies and devices; (1994)
 - i. ophthalmic care; (1994)
 - j. supportive services for the disabled. (1994)
 2. an emphasis on ambulatory and preventive care services as opposed to the often emphasized concept of hospital inpatient care;
 - c. In regard to portability and preexisting conditions:
 1. guaranteed annual renewal of coverage regardless of change in health status;
 2. OPPOSES denying or limiting coverage for any individual based upon medical history or current medical status, and further OPPOSES increasing payments or premiums based upon medical history or current medical status. (1994)
 3. SUPPORTS a national health program that ensures portability of coverage, including but not limited to travel, changes in residence and changes in employment. (1994)

- d. In regard to the consumer:
 - 1. a delivery system that is responsive to the individual consumer needs with regards to accessibility, availability and cultural suitability;
 - 2. 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;
 - 3. an opportunity for each individual to access the primary care provider of his/her choice; (1994)
- e. 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;
- f. In regard to quality assurance:
 - 1. mechanisms to guarantee quality, cost-consciousness and cost-efficiency through adequate peer review and the participation of consumers and financers;
- g. sufficient flexibility and innovation so as to allow for the investigation of alternative forms of health-care delivery;
- h. In regard to work-force issues:
 - 1. provisions for maintaining and training an adequate supply of health professions;
- i. optional means of provider reimbursement allowing physicians to choose fee-for-service, capitation or salary;
- j. expansion of clinical research protocols, such as the work at the Agency for Health Care Policy and Research, to determine appropriate utilization and usage of new and existing technology to counter increases in medical costs associated with the use of technology. (1992)
- 2. In regard to establishment, administration and regulation of a national health insurance plan AMSA:
 - a. consumer participation in the planning and implementation;
 - b. 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 consumer.
- 3. SUPPORTS the Physicians for National Health Program proposal as a framework for public debate on fundamental health policy reform. (1989)

PRINCIPLES REGARDING PRIMARY CARE AND FAMILY PRACTICE

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 practice 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 practice interest groups to maintain and stimulate interest in family practice;
 - 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 practice 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 practice programs;
 - c. BELIEVES that federal money for the development of primary care residency programs should give priority to programs in family practice and also fund those programs in internal medicine, pediatrics and ob/gyn that are specifically oriented toward primary care training;
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 Practice 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 Practice to include questions on abortion procedures in written and oral exams. (1995)
 - d. ASKS the Residency Review Committee for Family Practice 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 analysis of student-optimal versus hospital-optimal Match algorithms, and URGES the NRMP to implement the algorithm which best suits student preferences; (1996)

Until the incorporation of a student-optimal algorithm, SUPPORTS the rewording of NRMP "Match" literature to clarify the hospital-optimal nature of the current algorithm; (1996)
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. URGES that the Liaison Committee on Graduate Medical Education require, for certification of graduate medical education programs, either a maximum on-call schedule of every third night or a maximum of 80 on-duty hours per week;
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.” (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.” (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. ENCOURAGES local legislatures to consider reducing the enrollment of their medical schools and discourage opening new medical schools in light of the projected physician surplus. (1997)

Any action to reduce the projected oversupply of physicians in the United States should begin with the allocation of U.S. residency positions to U.S. citizens and legal, permanent residents graduating from LCME or AOA accredited medical schools. (1997)
33. ENCOURAGES the federal government, via Medicare GME funding, to reduce the number of graduate medical training positions to the number of U.S. medical school graduates plus 10 percent. (1997)
34. 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)
35. 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)
36. 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)
37. 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)

PRINCIPLES REGARDING FOREIGN MEDICAL SCHOOLS AND GRADUATES

The American Medical Student Association:

1. In regard to foreign medical schools:
 - a. OPPOSES the certification of foreign 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 foreign medical schools;
 - b. URGES the federal government to initiate a comprehensive evaluation and accreditation process for all foreign 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 foreign medical graduates and residencies:
 - a. 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;
 - b. URGES that all FMGs, including U.S. FMGs, pass an examination equivalent to Parts I and II of the National Board examinations before entry into a U.S. postgraduate program. To be eligible to take this examination, only non-U.S. FMGs must pass an English proficiency examination;
3. SUPPORTS continued graduate medical education funding through Medicare for those graduates of foreign medical schools who have passed both parts of the Foreign Medical Graduate Examination in the Medical Sciences; (1986)
4. URGES that any phase out of graduate medical education funding through Medicare for graduates of foreign 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 foreign medical graduates at the discretion of the residency program. Foreign 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. OPPOSES the Clinical Skill Assessment examination for U.S. citizens who attend medical schools outside of the U.S. because of the financial and logistical difficulties imposed on these students. (1999)
7. 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)
8. 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. Regarding Medical Malpractice Reform:
 - a. BELIEVES the reduction of preventable medical injury and the fair and timely compensation of injured persons to be the most important goals of a medical malpractice system; (1992)
 - b. BELIEVES that if the current tort system remains, efforts must be made to implement alternative dispute resolution systems and accelerated compensation events to decide questions of medical malpractice; (1994)
 - c. SUPPORTS a comprehensive, multifaceted approach to medical liability tort law reform; (1997)
 - d. BELIEVES that any acceptable alternative to the current tort law system should provide for the following 10 criteria: (1996)
 1. Accessibility for the injured;
 2. Compensation which is fair and equitable to the injured;
 3. A screening mechanism for the validity of filed cases;
 4. Ability to contain medical costs;
 5. Quality control/improvement;
 6. Deterrence of negligent acts;
 7. Speed of claim resolution;
 8. Predictability of outcome;
 9. Limit to excessive punitive damages;
 10. Guidelines/Case Precedents for establishing punitive damage award amounts.
 - e. SUPPORTS the continued examination of clinical practice guidelines within the context of medical malpractice. AMSA particularly supports the use of guidelines that are targeted to highly specific medical situations, such as CPR or ACLS; (1996)
2. 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)
3. 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)
4. OPPOSES sexual contact between physicians and patients under any circumstances;
5. 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)
6. 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.

7. 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)
8. SUPPORTS an excise tax on vaccines, proportional to their incidence of adverse outcomes, as a mechanism for funding childhood vaccine injury compensation. (1987)
9. 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)
10. OPPOSES the ranking of hospitals that is not based upon fully disclosed criteria which are both objective and comprehensive. (1996)

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. OPPOSES the AMA proposed creation of the profession destined to be named Registered Care Technologists in the health care setting, and URGES the strengthening of cooperative efforts between Medicine and Nursing to collaborate on a joint solution to hospitals' nursing shortages; (1989)
6. SUPPORTS the creation of national standards for and regulation of nurse practitioner, nurse midwife and midwife education, licensure and continuing education and upon doing so further supports the independent practice for nurse practitioners, nurse midwives and state certified midwives. (1997)

PRINCIPLES REGARDING PHARMACEUTICALS AND MEDICAL DEVICES

The American Medical Student Association:

1. Regarding Government Policy:
 - a. URGES increased funding for the Food and Drug Administration (FDA) to enable it to ensure that pharmaceutical, diagnostic and other medical products are of the highest quality;
 - b. SUPPORTS legislation that provides for the classification, testing and pre-market clearance of medical devices and encourages the development and use of new devices;
 - c. SUPPORTS the incorporation of the National Drug Code into various drug compendia, and SUPPORTS the mandatory utilization of the National Drug Code and its imprintation on all drug containers and solid dosage forms;
 - d. URGES adequate funding of a federal agency to be charged with:
 1. coordinating evaluative testing of bio-equivalence and requiring it where indicated;
 2. reviewing testing results for protocol/performance/conclusion;
 3. publishing lists of products it judges to be bio-equivalent or not bio-equivalent;
 4. receiving and evaluating challenges to previous bio-equivalency decisions.
 - e. URGES the FDA and pharmaceutical manufacturers to make widely available to physicians and pharmacists definitive reports on bio-availability and therapeutic equivalence and bulletins indicating current trends where studies are not yet conclusive;
 - f. SUPPORTS the laws requiring FDA to certify drugs as safe and effective before the drugs can enter interstate commerce;
 - g. OPPOSES judicial and state legislative efforts to allow the use of uncertified drugs on an intrastate basis in treatment of a medical condition;
2. Regarding physician/industry interaction:
 - a. SUPPORTS the concept that the physician's role in pharmaceutical product selection remain primary;
 - b. ENDORSES the "Medical Letter of Drugs and Therapeutics," "Facts and Comparisons," "The American Medical Association Drug Evaluations," "The American Hospital and Formulary," and other objective sources of therapeutic information on pharmaceuticals, and ENCOURAGES all institutions to provide independent sources such as these, rather than relying solely 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-a-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)
3. Regarding costs of pharmaceuticals:
- a. SUPPORTS, in principle, the Maximum Allowable Cost (MAC) program as a cost-saving program, only if all the following provisions are met:
 - 1. 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;
 - 2. that the pharmacist be reimbursed for a prescribed brand name-drug if he/she cannot reach the physician for permission to substitute;
 - 3. that stringent quality controls be instituted regarding all substituted products to ensure they are, indeed, as safe and efficacious as the standard product.
 - b. 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;
 - c. ENCOURAGES physicians to consider and make students aware of cost-effectiveness when recommending or prescribing commonly used drugs;
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, 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 a medicine, consult your pharmacist or doctor before using our product," should be included in all OTC drug advertisements.
- b. SUPPORTS required labeling of all cosmetic ingredients;
5. Regarding pharmaceuticals and international health:
- a. CONDEMNS the pharmaceutical companies that produce and export dangerous and controlled drugs to foreign countries in quantities much greater than is used in those countries, thus greatly contributing to the quantity of illicit smuggling and sale of these drugs in the United States.
 - 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. Essential drugs are those satisfying the health-care needs of a majority of the population: Selection of essential drugs is based on the most common diseases and conditions within a country as well as the capability and training of the majority of health-care workers who will be using the drugs and vaccinations. (1986)
 - c. SUPPORTS the Action Program on Essential Drugs and Vaccines as a means to assure that essential drugs and vaccines of good quality are available and affordable in a primary care setting. (1986)
 - d. URGES the pharmaceutical industry to adopt policies of research, development, manufacture and pricing that would support developing countries in their drive to make essential drugs and vaccines available to their peoples, and would not exploit developing countries by promoting use of drugs and vaccines not included on the WHO List of Essential Drugs. (1986)
6. Regarding Direct to Consumer (DTC) pharmaceutical advertising,
- a. ACKNOWLEDGES the value of well-informed patients with regards to pharmaceutical agents, (2001)
 - b. SUPPORTS unbiased evidence-based patient education efforts, (2001)
 - c. CONDEMNS the practice of using misleading information in DTC advertising (2001)
 - d. SUPPORTS measures that will remove the bias in patient education efforts and DTC advertising by the pharmaceutical industry. (2001)
 - e. RECOGNIZES that the marketing of prescription pharmaceuticals increases their cost to patients, (2001)
 - f. ENCOURAGES the pharmaceutical industry to consider the additional costs patients will pay as a result of DTC advertising when planning marketing campaigns. (2001)

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 abuse:
 1. SUPPORTS efforts to educate the public—especially school-aged persons—regarding drug abuse and addiction and alternatives to drug abuse;
 2. ENCOURAGES continued efforts in health education which would inform children, adolescents and adults of the dangers involved in alcohol abuse, including its effects on decision-making and judgment. (1995)
 3. SUPPORTS educational programs for medical students, physicians and other health professionals concerning drug abuse and addiction.
 4. 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;
 5. 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)
3. Regarding health and treatment:
 - a. BELIEVES that drug abuse and addiction are not primarily criminal problems, but are socioeconomic health problems with 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 treatment programs to meet the special needs of women;
 - c. RECOGNIZES that the health needs of alcoholics merit the same degree of attention and concern as the needs of any other segment of society; (1985)
 - d. 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. SUPPORTS a shift of emphasis of federal drug policy from expensive and ineffective international interdiction policies to innovative, community-based approaches. (1993)
 - b. SUPPORTS community-based approaches to drug control, including community policing and other sustained coalitions between communities, policy makers, law enforcement and other constituencies concerned with the public welfare. (1993)
 - c. OPPOSES the overrepresentation of first-time drug offenders, especially those from communities of color, among prison populations and SUPPORTS the exploration of innovative alternatives to traditional incarceration, including rehabilitation and house arrest. (1993)
 - d. SUPPORTS all appropriate measures to control alcoholism. (1985)
 - e. SUPPORTS all efforts directed toward the detection and prosecution of intoxicated drivers.
 - f. SUPPORTS legislation that would establish a minimum legal drinking age on a national basis.
 - g. As it relates to the legalization of therapeutic/medicinal cannabis:
 - 1. SUPPORTS the legislation of cannabis as a Schedule II drug for empirically validated medicinal use in the most effective form for the individual; (1999)
 - 2. SUPPORTS the legalization of cannabis for medicinal use in the most effective form for the individual. (1999)

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 Surgeon General's goal of a Smoke-Free Society by the year 2000, and furthermore, **PLEDGES** its support toward developing an effective program to realize this goal; (1985)

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)

1. 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, 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 multicomponent 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)

PRINCIPLES REGARDING SEX AND REPRODUCTIVE RIGHTS

The American Medical Student Association:

1. In regard to sex education:
 - a. 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)
 - b. BELIEVES that such a comprehensive program should be based on, though not limited to, the following principles:
 1. enhancing the self concept, such that young people feel good about themselves and are not available for exploitation and do not exploit others;
 2. understanding that parenthood requires responsibilities and interpersonal skills that strengthen family life, such as communication, compromise and a good sense of humor;
 3. understanding love as the basic component of a person's sexuality;
 4. preparation for making responsible decisions in critical areas of sexuality, based on a universal value of not hurting or exploiting others;
 5. helping young people understand the need for equal opportunities for males and females;
 6. contributing to knowledge and understanding of the sexual dimension of our lives, focusing on feelings, communication and values;
 7. helping young people develop tolerance and appreciation for nontraditional lifestyles;
 8. involve peer counseling for all ages; (1995)
 9. education should be age appropriate, nondirective, and start at a young age; (1995)
 10. emphasize situational and life skills; (1995)
 11. incorporate a full and appropriate education on family planning for youths and adults. (1995)
 - c. SUPPORTS the establishment and the administration of comprehensive sexual education programs that include the qualities listed above as well as adequate information on abstinence, contraception, barrier methods and other evidence-based safer sexual practices. (2002)
 - d. 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;
 - e. URGES that physicians and medical students play a more integral role in teaching children about sexuality. (1992)
 - f. SUPPORTS the use of randomized controlled trials to determine the effectiveness of sexual education programs 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)
 - g. URGES the federal government and local school boards to provide funding for comprehensive sexual education programs in which discussions of on abstinence, contraception, barrier methods, and other evidence-based safer sexual practices are included as important components. (2002)
 - h. 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)

2. In regard to contraception:
 - a. BELIEVES that excessive population growth can be a serious threat to the health and welfare of the American People, and BELIEVES birth control to be a form of preventive medicine;
 - b. 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)
 2. as a secondary means, abortion, with totally informed consent, be fully accessible to all.
 - c. BELIEVES that the display and sale of contraceptive devices and the distribution of contraceptive information to all persons should be legal;
 - d. SUPPORTS the proposal that cost be no barrier in the availability of birth control information, devices and medications;
 - e. 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;
 - f. TAKES THE POSITION and STATES publicly that a convenient, effective, and safe form of contraception for either males or females has not yet been produced and should become the goal of government and industry co-sponsored development programs;
3. In regard to abortion:
 - a. BELIEVES that all women, regardless of age, social status, or marital status should be able to obtain a voluntary abortion. Federal, state and local funds should be provided to women unable to afford an abortion, as it is provided for other medical services to indigent people;
 - b. BELIEVES that voluntary induced abortions should be available from all public hospitals on the same basis as any other medical or surgical procedure;
 - c. OPPOSES abortion performed on the basis of the fetus' sex;
 - d. URGES a repeal of all legislation which restricts the availability of federal, state or local funds to women who cannot afford abortions; (1988)
 - e. OPPOSES any policy by the Department of Health and Human Services that causes delay and increased medical risk in the delivery of abortion services, including but not limited to prohibiting abortion counseling and referral in health care settings which receive federal funds. (1992)
 - f. OPPOSES and lobbies against all legislation that would require explicit visual and/or verbal representation of the products of abortion that tend to produce emotional trauma rather than provide useful information to the candidate of abortion;
 - g. 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;
 - h. 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)
 - i. BELIEVES that voluntary, induced abortion by sound medical and surgical procedure should be legal and that abortion should be a matter to be decided between patient and physician, without the interference of any third party;
 - j. OPPOSES the prohibition of intact dilation and extraction abortion. (1999)
4. In regard to medical abortifacients:
- a. SUPPORTS the continued research and clinical use of all pharmaceutical abortifacients. (1998)
 - b. RECOGNIZES that pharmaceutical abortifacients, although effective, do not replace the need for surgical abortion. (1998)
5. In regard to fertility and sterility:
- a. BELIEVES that every person has the right to control his/her own fertility;
 - b. SUPPORTS, in principle, legislation designed to encourage smaller families, without regard to race, creed, national origin, or socioeconomic status; (1995)
 - c. SUPPORTS sterilization as an acceptable form of birth control when totally informed consent has been given by the individual involved;
 - d. SUPPORTS the availability of sterilization of adults without requirements concerning parity and marital state;
 - e. BELIEVES that it is preferable, but not required, that a marital partner give informed consent for his/her spouse's sterilization;
 - f. OPPOSES sterilization by other than free, uncoerced choice or as a genocidal or discriminatory device;
6. In regard to venereal disease:
- a. SUPPORTS the reporting to proper authorities of each case of venereal disease in accordance with the laws of each state, and URGES the medical community to recognize its contribution to the incidence of venereal disease as a consequence of laxity in such required reportings.
7. 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 court ordered medical interventions, irrespective of the indications for such procedures, where the woman is legally competent of informed consent; (1987)
- e. 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)
- f. 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.
- g. The care mentioned in 1 and 2 above should be provided through a uniform nationwide system, financed through a combination of public and private funds.

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 2000 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 fat overall, saturated fat, hydrogenated oils and cholesterol; (1995)
 - 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 complex carbohydrates and sugars occurring naturally in foods; (1995)
 - 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, including beef, pork, poultry and fish, to no more than two to three servings per week, and increase the consumption of vegetable proteins. (1995)
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 labeling of calories, protein, fats, sodium and fiber content in all processed foods, food supplements and over-the-counter drugs; (1995)
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 U.S. Dietary Guidelines and reducing the percentage of saturated fat and the total fat content to less than 30 percent of total calories, for all school meals. (1995)
 - 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 in all schools. (2001)
 - 13. ENCOURAGES local communities to urge the prevention and termination of such marketing efforts. (2001)
 - 14. 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)

PRINCIPLES REGARDING THE FOOD INDUSTRY

The American Medical Student Association:

1. In dealing with companies from the food industry
 - a. AMSA 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)

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 CONDEMNNS 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 allows for the individual's participation in choosing a program that responds to the nation's need;
5. SUPPORTS the Department of Defense's Armed Forces Health Professions Scholarship Program as a means of providing volunteer armed forces physicians;
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; (1985)
7. 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. (1985)
8. 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.
9. SUPPORTS the efforts of LGBPM to increase awareness of discrimination in the military through fall workshops, convention planning and *The New Physician*.

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, 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, gender, ethnicity, socioeconomic status and sexual orientation.
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 which 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, GENDER IDENTITY, ETHNICITY, SOCIOECONOMIC STATUS AND SEXUAL ORIENTATION.

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, religion, disability, or gender;
 - 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 uninjured 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)

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 and that students should not take call more often than every third night;
 3. the total amount of hours worked should not be required to exceed 72 hours per week;
 4. students should have at least one scheduled day per week free of clinical responsibilities;
 5. students should not be expected to work late evenings in the hospitals except when on call.
 6. student working hours should not be greater than those worked by the housestaff in their supervision. (1990)
 - 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 benefits of such counseling so as to dispel the myth that recourse to counseling is an indication of weakness in the student;
 - 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;

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 name tag, 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 cadaveric 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 cadaveric, 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 which 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 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.
5. 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)
6. 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)

PRINCIPLES REGARDING PHYSICIAN-ASSISTED SUICIDE

The American Medical Student Association:

1. Should the practice of physician-assisted suicide become legalized, SUPPORTS this practice only as a last resort option in patient care if the following criteria are met. The criteria include, but may not be limited to: (1998)
 - 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 competent, based on current standards of competency. (1998)
 - 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 and exhausted or rejected by the patient:
 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)

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/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 disease, especially the leading causes of mortality and morbidity;
 - 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, 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)
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 which 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 which 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 child care 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 JOBS program and train individuals in the JOBS 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. SUPPORTS the Public Health Service goal of immunizing 90 percent of children under age 2 against preventable diseases including measles, mumps, polio, rubella and diphtheria by the year 2000. As this prevention does not require large fiscal reserves, we urge that federal, state other programs aimed at increasing vaccination rates be made top priority and be sufficiently funded until such goals are reached. (1995)
13. SUPPORTS coverage of routine childhood vaccinations; pregnancy prevention; smoking cessation; stress, nutrition, sexually transmitted disease and exercise counseling; Pap smears and mammograms as aspects of preventive care in all types of health insurance policies and prepaid health plans. (1995)

PRINCIPLES REGARDING WAR AND MILITARY ACTION

The American Medical Student Association:

1. In regard to Central and South America:
 - a. OPPOSES all war-related aid, whether military, advisory or personnel, to El Salvador, Guatemala, Honduras, and the Nicaraguan contras; (1990)
 - b. BELIEVES the United States can play a reconstructive role in post-war El Salvador, and SUPPORTS congressional initiatives that shift committed U.S. military aid to economic development projects in health, education, and agriculture through nongovernmental organizations; (1992)
 - c. URGES the U.S. government to pressure the government of El Salvador to follow the agreements made at the U.N.-mediated peace accords in January 1992; (1992)
 - d. URGES the United States to redirect foreign policy initiatives in Central and South American, Africa and Asia to address contemporary geopolitical realities, in light of developments within the former Soviet Union and the eastern European nations; (1992)
 - e. CALLS on the United States to respect self-determination for the people of Central America; (1990)
2. 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)
3. 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)
4. 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)
5. 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 20th 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, specifically the Intermediate-Range Nuclear Forces (INF) Treaty in its present, unamended form, and strongly urges all medical students and health-care personnel to actively lobby their senators to such ends. (1988)
 - 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 and thus supports bilateral efforts to achieve parity through reduction in conventional weapons in Europe; (1988)
 - 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. URGES the U.S. government to respond to Russian and Ukrainian initiatives in regard to No First Use of Nuclear Weapons and to continue serious negotiations with these countries, working toward a ban, on all nuclear weapons and all nuclear weapons today, and further 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)
6. Regarding armament and the arms race:
- a. CONDEMNS the development of nuclear weapons that subserve a first strike capability such as the MX, the Trident II, the Pershing II and cruise missiles;
 - 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 respond to Soviet initiatives in regard to No First Use of Nuclear Weapons and a ban on space weapons and to enter serious negotiations with the government of the Soviet Union immediately;
 - 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, both between the United States and the Soviet Union, and among all other nations with nuclear capability.
 - 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.
7. URGENTLY CALLS FOR a renewed long-range United Nations-sponsored diplomatic effort to solve the difficult problems of the Gulf region; (1991)
8. SUPPORTS a complete ban on the production, use, trade and export of antipersonnel landmines. (1996)

PRINCIPLES REGARDING HUMAN RIGHTS

The American Medical Student Association:

1. BELIEVES in the following general principles regarding human rights:
 - a. that the best interests of all people are served when individuals, groups and nations respect and protect human rights and fundamental freedoms, including the freedom of thought, conscience, religion or belief, for all, without distinction as to race, sex, gender, sexual orientation, language, religion, or health status, including but not limited to HIV status;
 - b. that any act of torture or other cruel, inhumane or degrading treatment or punishment is an offense to human dignity and shall be condemned as a violation of human rights and fundamental freedoms;
 - c. that equality of rights shall not be denied or abridged on account of sex;
 - d. any other statements regarding human rights located in other sections of the Preamble, Purposes and Principles;
 - e. that freedom from confinement should not be denied or abridged based on account of HIV status.
2. RECOGNIZES that the above general principles are incorporated in:
 - a. the 1975 Helsinki Agreement;
 - b. the 1975 Declaration on the Protection of All Persons from Torture and Other Cruel, Inhumane, or Degrading Treatment or Punishment;
 - c. the Equal Rights Amendment;
 - d. the United Nations' Universal Declaration of Human Rights which, in part, states that "the best interests of all people are served when individuals, groups and nations respect and protect human rights and fundamental freedoms...without distinction as to race, sex, sexual orientation, language, or religion (and) that any act of torture or other cruel, inhumane or degrading treatment or punishment is an offense to human dignity and shall be condemned as a violation of human rights and fundamental freedoms." (1996)
3. DENOUNCES all nations in which dissent is crushed and the rule of a single party is forced upon the people of that nation;
4. OPPOSES any violation of the above principles regarding human rights, and specifically:
 - a. DENOUNCES the activities of fascist groups, including the Klu Klux Klan, the United Racist Front, all Nazi groups and other racist organizations, because of their discrimination on the basis of race and religion, and BELIEVES that participation in such organizations is incompatible with ethical medical practice;
 - b. BELIEVES that public funds should be available to foster freedom of expression under the First Amendment even when the views expressed are not in the majority; (1992)
 - c. OPPOSES any government restrictions on protected First Amendment speech based on content and specifically OPPOSES such content restrictions on artistic, scientific, medical, or other projects that use public grants; (1992)
 - d. RECOGNIZES that violent shaking is a form of torture that can result in death and CONDEMNS the use of shaking and all other forms of torture under any circumstances. (1996)

5. CONDEMNS military support of governments engaging in torture, terrorism and other willful violations of human rights and medical neutrality, and CONDEMNS the participation in torture by an M.D., D.O., health-care worker, or medical student .
6. DENOUNCES governments engaging in the forced resettlement of refugees or ethnic and racial minorities. (1990)
7. CONDEMNS the human rights abuses by the government and military of El Salvador that has left many doctors, nurses, labor union activists, church leaders, teachers, students and peasants tortured, dismembered, or dead; (1992)
8. URGES the U.S. government to demand of the government of El Salvador fast, effective, and impartial trials of major human rights cases; (1992)
9. In regard to genetic discrimination: (1996)
 - 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)
10. 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)

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 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 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 homosexuality;
 - 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 by the Year 2000" 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 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;
4. CONDEMNNS 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)
5. 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)
6. 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.
7. RECOGNIZES the promotion of world health as an important and justifiable humanitarian concern. (1986)
8. 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)
9. 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)
10. 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)
11. 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)

12. 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)
13. SUPPORTS increased involvement of health-care providers, including physicians-in-training, in the field of international health. (1986)
14. 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)
15. 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)
16. SUPPORTS international experiences which 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 which 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)
17. 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)
18. 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)
19. 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)
20. OBJECTS to groups or 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. (1998)
21. SUPPORTS the Cuban Humanitarian Trade Act as introduced in the House (June 18, 1997) and Senate (November 6, 1997). (1998)
22. URGES the president and Congress to work together to lift the embargo on the sale of food and medicine to Cuba. (1998)
23. SUPPORTS the purchase of "Union Made" apparel. (2001)

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 nonhousehold pets (e.g., rats and mice) for such classes and labs when it is possible to derive equal educational value from them. (1986)
4. URGES obtaining household type animals (e.g., cats and dogs) from local pounds when the use of these types of animals is necessary, and provided a system is devised to select animals least likely to be claimed for ownership. (1986)
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 who 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. URGES that alternative educational materials, such as films, videotapes and computer simulations be provided for students who do not choose to attend these classes and labs. (1986)
 - b. URGES a directory of such alternative educational materials be produced. (1986)
 - c. ENCOURAGES the utilization of nonanimal 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 breded 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.
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.

PRINCIPLES REGARDING MEDICAID

The American Medical Student Association:

1. SUPPORTS in principle the aim and implementation of the Medicaid program, 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, mandating a federal ceiling of eligibility at 185 percent of the federal poverty standard; (1990)
 - 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 Aid to Families with Dependent Children (ADSC) recipients and provide transitional Medicaid coverage based on a sliding scale as the welfare recipient becomes gainfully employed. (1995)
 - e. STRONGLY ENCOURAGES the federal government to disallow state governments from restricting the eligibility criteria for Medicaid which would exclude any and all recipients to AFDC and low-income pregnant mothers. (1996)
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)
4. With regard to Medicaid funding;
 - a. STRONGLY URGES the federal government to maintain the Medicaid program, (1996)
 - 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;
 3. Allow states the option of refusing to match federal funds for Medicaid recipients;
 4. Allow states to use different eligibility criteria for AFDC from Medicaid criteria in order to eliminate or maintain benefit status. (1996)

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., anti-HIV antibody test), 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 anti-HIV antibody testing:
- a. SUPPORTS the use of the anti-HIV antibody 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 anti-HIV antibody 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 anti-HIV antibody 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 anti-HIV antibody 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 anti-HIV antibody test as a precondition for receiving health-care services; (1988)
 - h. BELIEVES that persons undergoing anti-HIV antibody 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 anti-HIV antibody testing should receive post-test counseling and education regarding their anti-HIV antibody 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 anti-HIV antibody 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 anti-HIV antibody 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 anti-HIV antibody test performed without consent of a legal guardian. (1995)
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. SUPPORTS distribution of the Surgeon General's Report on Acquired Immune Deficiency Syndrome to each home in the United States; (1988)
 - c. 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)
 - d. SUPPORTS efforts to achieve widespread public education regarding all aspects of HIV, HIV related illnesses and risk elimination/reduction practices; (1988)
 - e. 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)
 - f. 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)
 - g. URGES the medical community to become actively involved in public education efforts addressing HIV and HIV-related illnesses; (1988)
 - h. OPPOSES guidelines which restrict the content of educational materials, making them ineffective for the intended audience; (1992)
 - i. 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. RECOGNIZES the tremendous advances which have been made in the search for the cause, treatment, cure and prevention of HIV related illnesses; (1988)
 - b. URGES continued research to define the epidemiology of HIV infection in the population, the impact of HIV infection and methods to stop the spread of HIV; (1988)

- c. URGES continued research to develop a more specific serologic test to detect and quantify the presence of HIV, with thorough evaluation of sensitivity, specificity and predictive value of developing and HIV related illness; (1988)
 - d. URGES that when a more specific test to detect and quantify the presence of HIV is developed, it be made available free or at minimal cost to individuals at high risk of infection with HIV;
 - e. URGES increased research efforts to develop effective treatments for HIV related illnesses;
 - f. URGES increased research efforts to develop a cure for HIV infection; (1988)
 - g. URGES increased research efforts to develop strategies to prevent HIV transmission; (1988)
 - h. URGES increased research efforts to define the mechanism(s) by which HIV infection produces AIDS and other HIV-related illnesses; (1988)
 - i. BELIEVES that the medical records related to an individual's participation in research studies of HIV and HIV-related illnesses should be considered strictly confidential, and that access to identifying information within such files should be limited to those individuals requiring such information for legitimate research purposes; (1988)
 - j. URGES strict enforcement of confidentiality guarantees provided to individuals participating in research studies of HIV and HIV-related illnesses; (1988)
 - k. SUPPORTS further research into the various strains of HIV, and SUPPORTS the development of separate diagnostic tests for each strain discovered and that the principle added be numbered appropriately; (1988)
8. In regard to infection control policies:
- a. URGES 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)
 - b. URGES policies for controlling the spread of infectious diseases in every health-care facility in the United States; (1988)
 - c. URGES infection control education for all health-care related students as part of their standard curriculum; (1988)
 - d. SUPPORTS and ENCOURAGES 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)
 - e. URGES 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)
 - f. URGES providing total health-care facility employees timely updates regarding changes in recommended CDC and/or local infection control policies at all health-care facilities; (1988)
 - g. SUPPORTS 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)
 - h. SUPPORTS adoption of the Occupational Safety and Health Administration Guidelines for the Control of Blood-Borne Infections within all clinical settings; (1992)
 - i. SUPPORTS the use of needle exchange programs as one method to prevent the spread of HIV and other blood-borne pathogens; (1999)
 - j. SUPPORTS existing efforts by private and public agencies to use needle exchange programs to combat the spread of HIV and other blood-borne pathogens and URGES communities with injection drug users

to adopt such programs in conjunction with substance abuse treatment and prevention and addiction treatment programs. (1999)

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 Commission on AIDS be expanded to include more health-care workers with direct clinical expertise on AIDS and representatives from the following groups: women infected with HIV, gay/bisexual men, people of color, recovering injection drug users, adolescents and the sexual partners of persons infected with HIV; (1995)
 - 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 nonpatient care duties any physician or health-care provider with known HIV infection or illness when:
 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)

PRINCIPLES REGARDING RESIDENCY 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. 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 include or take into account, but not be limited to, the following:
 - a. The number of hours a resident may work per week should be limited to 72, averaged over a four-week period.
 - b. There should be a daily limit of 12 consecutive hours in the emergency room and other similarly intensive settings or 16 consecutive hours per a 24-hour period in other areas of the hospital.
 - c. Call should be limited to no more than one night in three.
 - d. Resident physicians shall not work more than 12 days straight without two 24 hour periods off-time.
 1. Residents may work beyond the above daily limits if they are treating an acutely ill patient whose care may be compromised by the resident physician's departure. These exceptions are for emergency and extreme situations. No program shall allow residents to partake or participate in these exceptions on a regular or recurrent basis. This will reduce chronic fatigue but allow residency programs flexibility to meet their own scheduling needs while providing good learning experience for their residents.
3. 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.
4. 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.
5. BELIEVES residency program compliance should be monitored by establishing review committees which should include resident physicians.
6. BELIEVES public hospitals and indigent patients must not hear the brunt of this reform.

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;
3. DIRECTS the Legislative Affairs Director to include Unrelated Business Income Tax as a high priority issue on AMSA's annual legislative agenda, and to actively lobby on its behalf.
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)

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 sociology, philosophy and/or ethics. (1990)

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 and bisexual 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)

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)

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 form 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 nonbiodegradable and nonrecyclable 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:
 - a. OPPOSES all public and private discrimination against persons with a homosexual orientation, including: medical school admissions, promotion and graduation; postgraduate placement; hospital staff appointments; licensure; availability of health services; and access to social welfare;
 - b. URGES enactment of civil rights laws at the local, state and federal levels, which would provide, to persons with a homosexual orientation, the same protections now provided to others on the basis of race, religion, national origin, or sex;
 - c. ENCOURAGES the study of the problems encountered by the homosexually oriented person when both receiving and providing health care;
 - d. BELIEVES the burden and proof of judgment, reliability, ethicality, capability, or entitlement to a position for individuals with a homosexual orientation should not be greater than, or different from, that placed on other persons.
 - e. OPPOSES psychiatric diagnosis or treatment policies that discriminate against patients based on their sexual orientation or inhibit their access to quality care; (1985)
 - f. RECOGNIZES that mental disorders related to sexual orientation occur in all types of sexual orientation; (1985)
 - g. ESTABLISHES as a priority the inclusion of sexual orientation 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; (1990)
 - i. ESTABLISHES as a priority to urge the American Medical Association to include sexual orientation into their nondiscrimination clause. (1992)
2. In regard to equal civil rights for gay/lesbian/bisexual people:
 - a. BELIEVES that all persons have equal right to bear and rear children without regard to sexual orientation; (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 of either parent in legal child custody disputes; (1985)
 - e. OPPOSES discrimination based on the sexual orientation 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; (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 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 employees working for AMSA. (2001)

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, 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 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, Aid to Families with Dependent Children , 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 increased education of health professionals concerning domestic violence and its effects on children; (1996)
 - e. Supporting stronger penalties for the perpetrators of abuse; (1996)
 - f. Supporting nonpunitive aide services for households experiencing violence.
12. ENCOURAGES culturally and linguistically appropriate support services and legal advocacy for all victims of domestic violence, including undocumented immigrants. (1996)
13. ENCOURAGES support services and legal advocacy that is easily accessible to victims of domestic violence with disabilities. (1996)
14. ENCOURAGES support services and legal advocacy appropriate to the needs of battered lesbians and gay men. (1996)

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)

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 JOBS 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 workforce, 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 JOBS 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 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.
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."
12. The magazine shall routinely carry timely and important news concerning the American Medical Student Association 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 Board of Trustees 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, Association 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.

PRINCIPLES REGARDING COMPLEMENTARY AND ALTERNATIVE MEDICINE

The American Medical Student Association:

1. RECOGNIZES the potential inherent to forms of health care and prevention currently available outside of accepted biomedical practice.
 - a. The term “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 biomedicine with the approval of a licensed physician. “Integrative medicine” may be used to indicate the combined use of alternative medicine and biomedicine when either one or the other is considered the primary mode of therapy.
 - b. ENCOURAGES research and investigation regarding alternative and complementary medicines within ethical, legal, professional guidelines.
 - c. ENCOURAGES medical students and residents to seek and take advantage of educational opportunities in 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.
 - d. ENCOURAGES medical administrators and faculty to meet the demands of their students and the patient population by developing and implementing appropriate training in 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.
 - e. Conscientious and effective health care shall include the use of 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, alternative medicines may be used with the same precautions and indications for other experimental therapies.
 - 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 of alternative medicine, and otherwise choose nonbiomedical means of health care and maintenance.

PRINCIPLES REGARDING OSTEOPATHIC MEDICINE

The American Medical Student Association:

1. 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. However, we do stress that each of these degrees should be viewed equally by the medical community. (1999)

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 PRODUCTS

1. AMSA calls upon the FDA's Blood Products Advisory Committee to immediately revise the blood donation screening guidelines in order to reflect equivalent standards of evaluating homosexual and heterosexual sex risks with regards to safety of blood donations; and allow HIV negative persons with low risk behaviors—regardless of sexual orientation—the opportunity to fully exercise the civic responsibility of donating blood. (2001)
2. URGES 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. (2001)
3. RECOGNIZES that the current policy against blood donation by men who have sex with men is an instance of institutionalized discrimination that is contrary to current public health standards. (2001)

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)

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)

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.