2026
HOUSE OF DELEGATES

THE ONE HUNDRED SIXTY-FIRST
ANNUAL SESSION

April 18, 2026

2026 House of Delegates
Order of Business

Reference Committee Meetings – 6:00 pm
Zoom Link:
https://us02web.zoom.us/j/85681480400?pwd=991BFkXaCwJ2QhfgjLPA9foHUEpdpu.1
Passcode:118350

- Ways and Means and Officer Speeches – Thursday, March 19, 2026
- Reference Committee on Internal Affairs, Bylaws, and Rules (C) – Wednesday, March 25, 2026
- Reference Committee on Payer and Legislative Advocacy (A and B) – Tuesday, March 31, 2026
- Reference Committee on Public Health and Education (D and E) – Monday, April 6, 2026

General Session - Saturday, April 18, 2026, 8:00 am

- Opening Remarks
- Report of the Committee on Credentials and Tellers
- Ways and Means
- A/B – Payer and Legislative Advocacy
- D/E – Public Health and Education
- C – Internal Affairs, Bylaws, and Rules

Second General Session – Saturday, April 18, 2026

Per Bylaws 12.70, the MSMS Board of Directors has called a second session of the House of Delegates for the changes to the bylaws associated with the Reorganization Report immediately following the first general session.

Parliamentary Procedures

MSMS Speakers' Principles of Rules of Order

(Based on Sturgis)

1. Only one main motion

2. A motion may be amended only to second order

3. Motion stated affirmatively

4. Precedence of motion must be honored

5. A motion, once reiterated by Chair, belongs to assembly

6. Member may speak/vote against own motion

7. Any member may move for reconsideration

8. Unless otherwise stated, vote immediately applies only to immediately-pending issue

9. More than majority vote required when rights are limited

10. Requests are rights of member/assembly which may be asked for

11. On appeal, vote always on sustaining speaker or vice speaker

12. Nominations require no second

13. Presiding officer may vote

14. Presiding officer may not adjourn meeting

PRINCIPAL RULES GOVERNING MOTIONS

Order of precedence [1]	Can interrupt?	Requires second?	Debatable?	Amendable?	Vote required?	Applies to what other motions?	Can have what other motions applied to it?[4]
PRIVILEGED MOTIONS							
1. Adjourn	No	Yes	No[3]	Yes[3]	Majority	None	Amend
2. Recess	No	Yes	Yes[3]	Yes[3]	Majority	None	Amend[3]
SUBSIDIARY MOTIONS							
3. Postpone temporarily (Table)	No	Yes	No	No	Majority[2]	Main motion	None
4. Close debate	No	Yes	No	No	2/3	Debatable motions	None
5. Limit debate	No	Yes	Yes[3]	Yes[3]	2/3	Debatable motions	Amend[3]
6. Postpone to a certain time	No	Yes	Yes[3]	Yes[3]	Majority	Main motion	Amend[3], close debate, limit debate
7. Refer to committee	No	Yes	Yes[3]	Yes[3]	Majority	Main motion	Amend[3], close debate, limit debate
8. Amend	No	Yes	Yes	Yes	Majority	Rewordable motions	Close debate, limit debate, amend
MAIN MOTIONS							
9. a. The main motion	No	Yes	Yes	Yes	Majority	None	Restorative, subsidiary
b. Restorative main motions							
Amend a previous action	No	Yes	Yes	Yes	Majority	Main motion	Subsidiary, restorative
Ratify	No	Yes	Yes	Yes	Majority	Previous action	Subsidiary
Reconsider	Yes	Yes	Yes[3]	No	Majority	Main motion	Close debate, limit debate
Rescind	No	Yes	Yes	No	Majority	Main motion	Close debate, limit debate
Resume consideration	No	Yes	No	No	Majority	Main motion	None

INCIDENTAL MOTIONS

No order of precedence	Can interrupt?	Requires second?	Debatable?	Amendable?	Vote required?	Applies to what other motions?	Can have what other motions applied to it?
MOTIONS							
Appeal	Yes	Yes	Yes	No	Majority	Decision of chair	Close debate, limit debate
Suspend rules	No	Yes	No	No	2/3	None	None
Consider informally	No	Yes	No	No	Majority	Main	None
REQUESTS							
Question of privilege	Yes	No	No	No	None	None	None
Point of order	Yes	No	No	No	None	Any error	None
Parliamentary inquiry	Yes	No	No	No	None	All motions	None
Withdraw a motion	Yes	No	No	No	None	All motions	None
Division of question	No	No	No	No	None	Main motion	None
Division of assembly	Yes	No	No	No	None	Indecisive vote	None

[1] Motions are in order only if no motion higher on the list is pending.

[2] Requires two-thirds vote when it would suppress a motion without debate.

[3] Debatable if no other motion is pending.

[4] Withdraw may be applied to all motions.

PRINCIPAL PARLIAMENTARY MOTIONS GUIDE

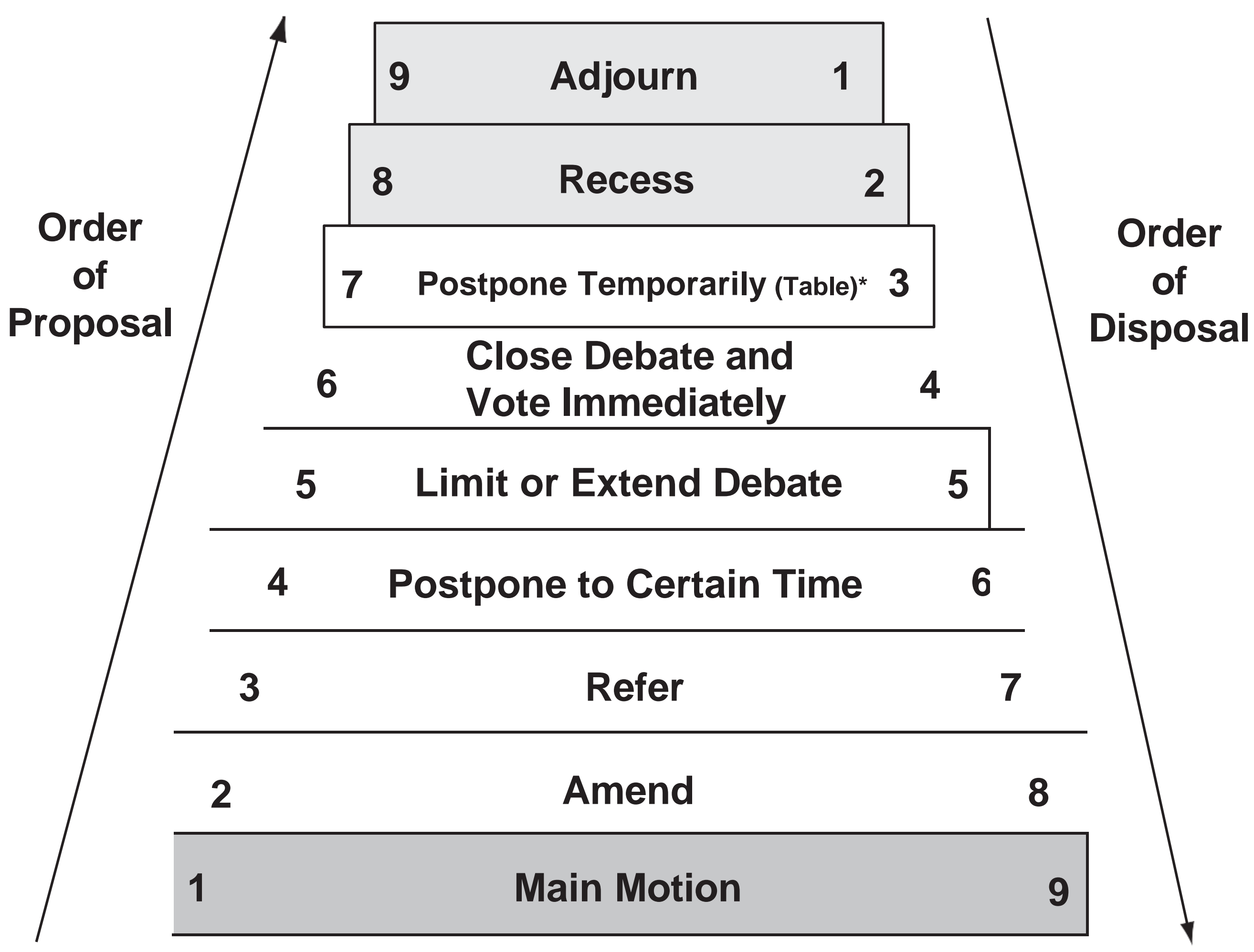
The Standard Code of Parliamentary Procedure, Sturgis, 4th ed.

What You Want To Accomplish, in order of precedence[1]	**What You Need To Say**
Close/adjourn the meeting	"I move that we adjourn"
Take a break/recess	"I move to recess until..."
Register a complaint/raise a question of privilege	"I rise to a question of privilege"
Postpone an item temporarily/Table[2]	"I move that we postpone/table the item temporarily"
Close debate and vote immediately[3]	"I move to close debate"
Limit or extend debate	"I move to limit debate of each speaker to..."
Postpone to a certain time	"I move to postpone the item until..."
Refer an item	"I move to refer this item to the Board"
Amend (by substitution, insertion, deletion)	"I would like to amend the resolution by..."
Bring business before assembly, i.e. main motion[4]	"I move that..."
Restorative Main Motions, no order of precedence. Introduce when nothing else is pending.	**What You Need to Say**
Amend a previous action	"I move to amend the motion that was..."
Reconsider an item previously votes upon	"I move to reconsider..."
Rescind a previously considered item	"I move to rescind..."
Resume consideration/take from the table	"I move to resume consideration of..."
Incidental Motions, no order of precedence	**What You Need to Say**
Disagree with the ruling of the Speaker	"I appeal the ruling of the chair"
Suspend rules	"I move to suspend the rules requiring..."
Enforce rules	"Point of order." State your point when recognized
Ask about parliamentary procedure	"Point of parliamentary inquiry"
Request to withdraw a motion	"I wish to withdraw the motion"
Divide an issue into individual resolved clauses	"I would like to divide the question"
Ask for a hand count of the assembly	"I call for a division of the assembly"

[1] Motions are in order only if no motion higher on the list is pending, e.g. if a motion to close debate is pending, a motion to amend would be out of order, but a motion to recess would be in order, since it outranks the pending motion.
[2] Tabling an item effectively results in killing the item and no action being taken unless the item is moved for reconsideration.
[3] Unless specifically stated, vote will be taken only on the pending item.
[4] Main motions are the resolutions submitted to the HOD.

STURGIS RULES OF ORDER

MOTIONS WITH PRECEDENCE AND THEIR RANK



Precedented Motions

Privileged Motions

Subsidiary Motions

Main Motion

***Postponing temporarily or tabling a motion means no action is taken & the motion dies.**

Candidates for Office

OFFICERS, 2025-2026

President	Amit Ghose, MD	Ingham
President-Elect	Phillip G. Wise, MD	Kent
Immediate Past President	Mark C. Komorowski, MD	Bay
Secretary	Jayne E. Courts, MD	Kent
Treasurer	John A. Waters, MD	Genesee
Speaker	Bryan W. Huffman, MD	Ottawa
Vice Speaker	Mildred J. Willy, MD	Saginaw
Chair	Paul D. Bozyk, MD	Oakland
Vice Chair	Bradley J. Uren, MD	Livingston
Ex-Officio	Dennis M. Ramus, MD	Macomb
Ex-Officio	F. Remington Sprague, MD	Muskegon

REGIONAL DIRECTORS

Latonya A. Riddle-Jones, MD, MPH	1	Wayne	2026
Herbert C. Smitherman, Jr., MD, MPH	1	Wayne	2026
Paul D. Bozyk, MD	2	Oakland	2028
Daniel M. Ryan, MD	2	Macomb	2026
Larry Junck, MD	3	Washtenaw	2028
Bradley J. Uren, MD	3	Livingston	2026
Robert M. Doane, MD	4	Jackson	2026
David T. Walsworth, MD	4	Ingham	2027
Edward P. Fody, MD	5	Allegan	2027
Daniel J. Johnston, MD	5	Kalamazoo	2027
Nita M. Kulkarni, MD	6	Genesee	2028
Annette S. Gilmer, MD, MPH	6	St. Clair	2027
Michael A. Kremer, MD	7	Bay	2026
Christopher J. Allen, MD	7	Saginaw	2028
Eric L. Larson, MD	8	Kent	2027
Brian R. Stork, MD	8	Muskegon	2027
Ryan J. Brang, MD	9	Marquette-Alger	2026

DESIGNATED DIRECTORS

Academic Physician	Louito C. Edje, MD, MHPE, FAAFP	Washtenaw	2027
Independent Small Practice Physician	Leah C. Davis, DO	Grand Traverse	2026
Physician Serving as DIO/Representing GME Training	Robert F. Flora, MD, MBA, MPH	Genesee	2026
Physician Serving in Government/Public Health Role	Jennifer E. Morse, MD, MPH, FAAFP	Isabella-Clare	2026

SECTION DIRECTORS

Young Physicians Section	Katherine J. Mills, MD	Kalamazoo
Medical Students Section	Sebastian P. Loonen	Ingham

DELEGATION TO THE AMA

Delegates	**Term Expires**
Paul D. Bozyk, MD, Oakland	2026
T. Jann Caison-Sorey, MD, MSA, MBA, Wayne	2027
Michael D. Chafty, MD, JD, Kalamazoo	2026
Betty S. Chu, MD, MBA, Oakland	2027
Pino D. Colone, MD, Genesee	2027
Amit Ghose, MD, Ingham	2026
Theodore B. Jones, MD, Wayne	2026
Mark C. Komorowski, MD, Bay	2027
Christie L. Morgan, MD, Oakland	2026
Rose M. Ramirez, MD, Kent	2026
Krishna K. Sawhney, MD, Wayne	2027
David T. Walsworth, MD, Ingham	2027
John A. Waters, MD, Genesee	2026

Alternates (in order of seniority)	**Term Expires**
Patricia A. Kolowich, MD, Wayne	2027
M. Salim U. Siddiqui, MD, PhD, Wayne	2027
Edward C. Bush, MD, Wayne	2027
Courtland Keteyian, MD, Jackson	2026
Brooke M. Buckley, MD, Wayne	2027
David W. Whalen, MD, Kent	2027
Louito C. Edje, MD, MHPE, FAAFP, Washtenaw	2026
Aliya C. Hines, MD, PhD, Wayne	2026
Mohammad Ibrahim, DO, Jackson	2027
Nicklas Bara, Medical Student	

Notification of Slate of Offices – 2026 House of Delegates

BOARD OF DIRECTORS (Three-year term)

Region 1 – LaTonya Riddle Jones, MD, MPH, Wayne (first term)

Region 2 – Daniel M. Ryan, MD, Macomb (second term)

Region 3 – Bradley J. Uren, MD, Livingston (third term)

Small Practice – Leah C. Davis, DO, Grand Traverse (second term)

DIO/GME Training – Robert F. Flora, MD, MBA, MPH, Genesee (third term)

Government/Public Health – Jennifer E. Morse, MD, MPH, FAAFP, Clare (second term)

OFFICERS (One-year term)

Speaker: Bryan W. Huffman, MD, Ottawa

Vice Speaker: Mildred J. Willy, MD, Saginaw

President Elect: Paul D. Bozyk, MD, Oakland

MICHIGAN DELEGATION TO THE AMA (Two-year terms)

Delegates

Paul D. Bozyk, MD, Oakland

Michael D. Chafty, MD, JD, Kalamazoo

Amit Ghose, MD, Ingham

Theodore B. Jones, MD, Wayne

Christie L. Morgan, MD, Oakland

John Waters, MD, Genesee

Alternate Delegates

Louito C. Edje, MD, MHPE, FAAFP, Washtenaw

Aliya C. Hines, MD, PhD, Wayne

Courtland Keteyian, MD, Jackson

In Memoriam

In Memory

The members of the Michigan State Medical Society remember with respect their colleagues who have passed away since our last annual meeting.

Edmund Barbour, MD
Robert Bartlett, MD
Deloris Berrien-Jones, MD
Wayne Breece, MD
Thomas Burkey, MD
Mark Campbell, MD
Pyara Chauhan, MD
John Colwill, MD
Frederick Deane, MD
Joseph DeCook, MD
David Deitrick, MD
Wallace Duffin, MD
Jerry Evans, MD
E Field, MD
Frank Gould, MD
Duane Harrison, MD
Herman Hoeksema, MD
Richard Horvitz, MD
Marvin Jewell, MD
James Kraatz, MD
Donna Kushner, MD
Brian Lane, MD, PhD
Peter Luea, MD
Douglas Mack, MD
Gene Maddock, MD
Daniel Mankoff, MD
Gary Maynard, MD
Myrtle McLain, MD
John Mulder, MD
Peter Muller, MD
Carl Ogas, MD
Leon Oostendorp, MD
Sanjay Pathak, MD
Gladstone Payton, DO
Daisy Ramos, MD
Sudhir Rao, MD
Emilio Rusciano, MD
George Shade, MD
James Shetlar, MD
Norman Silas, MD
Harold Stinson, MD
Emmanuel Tendero, MD
Gregory Trowbridge, MD
Dennis VanAlst, MD
Lester Webb, MD
Daniel Wechter, MD

Roster of Delegates and Alternates

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES
April 18, 2026
Roster of Delegates

OFFICERS:

Bryan	Huffman	MD	Speaker
Mildred	Willy	MD	Vice-Speaker

County: Allegan

Thomas	Collins	MD	Delegate

County: Calhoun

John	Bizon	MD, FACS	Delegate

County: Genesee

Edward	Christy	MD	Delegate
Michael	Danic	DO	Delegate
Omar	Khorfan	DO	Delegate
Paul	Kocheril	MD	Delegate
Macksood	Aftab	DO	Alternate Delegate
John	Hebert III	MD	Alternate Delegate
Rama	Rao	MD	Alternate Delegate

County: Grand Traverse - Leelanau - Benzie

Yelena	Kier	DO	Delegate
Edward	Rutkowski	MD	Delegate
Richard	Schultz	MD	Delegate

County: Ingham

Kenneth	Elmassian	DO	Delegate

County: Jackson

Courtland	Keteyian	MD, MBA, MPH	Delegate

County: Kalamazoo

Brad	Berndt	MD	Delegate
Charita	Roque	MD, MPH	Delegate
Erlyn	Rudico	DO	Delegate

County: Kent

Patrick	Droste	MD	Delegate
Megan	Edison	MD	Delegate
Androni	Henry	MD	Delegate
Warren	Lanphear	MD, FACEP	Delegate
Karen	Leavitt	MD	Delegate
Gerald	Lee	MD	Delegate
Sonia	Samant	MD	Delegate
David	Whalen	MD	Delegate

County: Livingston

Rupinder	Sekhon	MD	Delegate

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES
April 18, 2026
Roster of Delegates

County: Macomb

Terrence	Brennan	MD	Delegate
Narendra	Gohel	MD	Delegate
Lawrence	Handler	MD	Delegate
Khaled	Ismail	MD	Delegate
Carolann	Kinner	DO	Delegate
Akash	Sheth	MD	Delegate
Jareer	Hmoud	MD	Alternate Delegate
Cheryl	Lerchin	MD	Alternate Delegate

County: Oakland

Jaime	Aragones	MD	Delegate
Barry	Auster	MD	Delegate
Stephanie	Clemens	MD	Delegate
Rubin	Gappy	MD	Delegate
Ashok	Gupta	MD	Delegate
Sherwin	Imlay	MD	Delegate
Robert	Levine	MD	Delegate
Theodore	Roumell	MD	Delegate
Justin	Skrzynski	MD	Delegate
Catherine	Stark	MD	Delegate
Karol	Zakalik	MD	Delegate
Donald	Peven	MD	Alternate Delegate

County: Ottawa

Bryan	Huffman	MD	Delegate

County: Saginaw

Kai	Anderson	MD	Delegate
Abishek	Bala	MD	Delegate
Taylor	Gaudard	MD	Delegate
Anushree	Jagtap	MD	Delegate
Cecilia	Kraus-Horbal	DO	Delegate
Jennifer	Romeu	MD	Delegate
Miriam	Schteingart	MD	Delegate
Mildred	Willy	MD	Delegate
Elvira	Dawis	MD	Alternate Delegate
Brittany	Garza	DO	Alternate Delegate
Furhut	Janssen	DO	Alternate Delegate
Mohammad	Khan	MD	Alternate Delegate
Tiffany	Kim	MD	Alternate Delegate
Jisselly	Sanchez Salcedo	MD	Alternate Delegate
Caroline	Scott	MD	Alternate Delegate
Thomas	Veverka	MD, FACS	Alternate Delegate
Claudia	Zacharek	MD	Alternate Delegate

County: St. Clair

Brian	Favero	MD	Delegate
Dawn	Lambrecht	MD	Delegate
Sara	Liter-Kuester	DO	Delegate

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES
April 18, 2026
Roster of Delegates

County: Washtenaw

Richard	Burney	MD, FACS	Delegate
James	Mitchiner	MD, MPH	Delegate

County: Wayne

Susan	Adelman	MD, FACS	Delegate
E. Chris	Bush	MD	Delegate
Thelma	Caison-Sorey	MD, MSA, MBA	Delegate
Denise	Collins	MD	Delegate
Aliya	Hines	MD, PhD	Delegate
Robert	Jackson	MD	Delegate
Federico	Mariona	MD, MHSA, FACS, FACOG	Delegate
Gaurav	Sharma	MD	Delegate
M. Salim	Siddiqui	MD, PhD	Delegate
Marwan	Abouljoud	MD	Alternate Delegate
Brooke	Buckley	MD	Alternate Delegate
Zahia	Esber	MD	Alternate Delegate
Nicolas	Fletcher	MD, MHSA	Alternate Delegate
Cheryl	Gibson Fountain	MD	Alternate Delegate
Theodore	Jones	MD, FACOG	Alternate Delegate
Shunji	Nagai	MD, PhD	Alternate Delegate
Krishna	Sawhney	MD	Alternate Delegate
Theresa	Toledo	MD	Alternate Delegate

County: Wexford-Missaukee

Martin	Dubravec	MD	Delegate

Delegate-At-Large: Immediate Past President

Mark	Komorowski	MD	Delegate

Delegate-At-Large: Medical School Dean, Central Michigan University

Tina	Thompson	PhD	Delegate

Delegate-At-Large: Medical School Dean, Michigan State University

Joyce	DeJong	DO	Delegate
Supratik	Rayamajhi	MD, FACP	Delegate

Delegate-At-Large: Medical School Dean, University of Michigan

Thomas	Wang	MD	Delegate

Delegate-At-Large: Medical School Dean, Oakland University

Christopher	Carpenter	MD, MHSA	Delegate

Delegate-At-Large: Medical School Dean, Wayne State University

Wael	Sakr	MD	Delegate

Delegate-At-Large: Medical School Dean, Western Michigan University

Robert	Sawyer	MD	Delegate

Members-At-Large: MDHHS Chief Medical Officer

Natasha	Bagdasarian	MD	Delegate

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES
April 18, 2026
Roster of Delegates

Medical Student Section

Natalie	Aguilar		Student Delegate
Nick	Bara		Student Delegate
Michael	Fernandes		Student Delegate
Jeren	Ghoujeghi		Student Delegate
Sara	Kazyak		Student Delegate
Connor	Plagens		Student Delegate
Kristina	Avakumov		Student Alternate Delegate
Manas	Peddiboyina		Student Alternate Delegate
Audrey	Pham		Student Alternate Delegate
Jack	Xin		Student Alternate Delegate

Resident and Fellow Section

Katherine	Neff	MD, MPH	Delegate
Janki	Vaghasia	MD	Alternate Delegate

Young Physician Section

Halley	Crissman	MD, MPH	Delegate

Specialty Society: MI Society of Addiction Medicine

Colleen	Lane	MD	Specialty Society Delegate

Specialty Society: MI Allergy & Asthma Society

Nonie	Arora	MD	Specialty Society Delegate

Specialty Society: MI Society of Anesthesiologists

Mousab	Eteer	MD	Specialty Society Delegate
Goodarz	Golmirzaie	MD	Specialty Society Alternate

Specialty Society: MI Chapter, American College of Cardiology

Sunilkumar	Rao	DO	Specialty Society Delegate

Specialty Society: MI College of Emergency Physicians

Sara	Chakel	MD, FACEP	Specialty Society Delegate
Luke	Saski	MD, FACEP, FAAEM	Specialty Society Alternate

Specialty Society: MI Society of Eye Physicians and Surgeons

Theresa	Cooney	MD	Specialty Society Delegate
Shahzad	Mian	MD	Specialty Society Alternate

Specialty Society: MI Academy of Family Physicians

Mary	Marshall	MD, RN, FAAFP	Specialty Society Delegate

Specialty Society: MI Society of Hematology & Oncology

Jerome	Seid	MD	Specialty Society Delegate

Specialty Society: MI Association of Medical Examiners

Carl	Hawkins	MD	Specialty Society Delegate
John	Maino	MD	Specialty Society Alternate

Specialty Society: MI Section, American College of OB/GYN

Thomas	Klein	MD	Specialty Society Delegate
Charisse	Loder	MD	Specialty Society Alternate

Specialty Society: MI Orthopaedic Society

Manuel	Schubert	MD, MS	Specialty Society Delegate

Specialty Society: MI Otolaryngological Society

Christie	Morgan	MD	Specialty Society Delegate

Specialty Society: American College of Physicians, MI Chapter

Martha	Gray	MD	Specialty Society Delegate

Specialty Society: MI Academy of Plastic Surgeons

Anthony	Zacharek	MD	Specialty Society Delegate

Specialty Society: MI Association of Public Health and Preventive Medicine Physicians

Catherine	Bodnar	MD, MPH	Specialty Society Delegate
William	Nettleton	MD, MPH	Specialty Society Alternate

Specialty Society: MI Radiological Society

Mark	Weiss	MD	Specialty Society Delegate

Specialty Society: MI Rheumatism Society

Joshua	June	DO	Specialty Society Delegate

Specialty Society: MI Academy of Sleep Medicine

Maria	Tovar Torres	MD	Specialty Society Delegate

Specialty Society: American College of Surgeons, MI Chapter

Tasha	Hughes	MD, MPH	Specialty Society Delegate

Specialty Society: MI Urological Society

Aron	Liaw	MD	Specialty Society Delegate

Specialty Society: MI Vascular Society

Nicholas	Osborne	MD	Specialty Society Delegate

Reference Committees

MICHIGAN STATE MEDICAL SOCIETY
2026
HOUSE OF DELEGATES

Reference Committee A/B – Payer and Legislative Advocacy
Barry I. Auster, MD, Oakland, Chair
Kai Anderson, MD, Saginaw
Lawrence Handler, MD, Macomb
Yelena E. Kier, DO, Grand Traverse
Sara Liter-Kuester, DO, St. Clair
Warren Lanphear, MD, Kent
Kristina Avakumov, Wayne State University

Board Advisors:
Leah C. Davis, DO
Robert F. Flora, MD, MBA, MPH
Daniel M. Ryan, MD

AMA Advisors:
Brooke Buckley, MD
E. Chris Bush, MD
Michael D. Chafty, MD, JD
Betty S. Chu, MD, MBA
Mohammad Ibrahim, DO
Courtland Keteyian, MD, MBA, MPH
Patricia Kolowich, MD
Rose Ramirez, MD

Staff: Kate Dorsey and Stacey P. Hettiger

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Reference Committee C – Internal Affairs, Bylaws, and Rules
M. Salim Siddiqui, MD, PhD, Wayne, Chair
Brooke M. Buckley, MD, Wayne
Sara S. Chakel, MD, FACEP, MI College of Emergency Physicians
Kenneth Elmassian, DO, Ingham
Cheryl Gibson Fountain, MD, Wayne
Martha L. Gray, MD, MI Chapter, American College of Physicians
Thomas J. Klein, MD, MI Section, American College of OB/GYN
Richard C. Schultz, MD, Grand Traverse
Nick Bara, Michigan State University

Board Advisors:
Paul D. Bozyk, MD
Mark C. Komorowski, MD
Bradley J. Uren, MD
John A. Waters, MD

AMA Advisors:
Pino D. Colone, MD
Mark C. Komorowski, MD
Christie L. Morgan, MD
Brian R. Stork, MD
David W. Whalen, MD

Staff:
Rebecca J. Blake

MICHIGAN STATE MEDICAL SOCIETY
2026
HOUSE OF DELEGATES

Reference Committee D/E – Public Health and Education
Aliya C. Hines, MD, PhD, MS, FAAD, Wayne, Chair
Catherine M. Bodnar, MD, MI Assoc of Preventive Medicine and Public Health Physicians
Stephanie G. Clemens, MD, Oakland
Zahia Y. Esber, MD, MI Thoracic Society
Sherwin P. T. Imlay, MD, Oakland
Colleen K. Lane, MD, MI Society of Addiction Medicine
Mary C. Marshall, MD, RN, FAAFP, Genesee
Natalie Aguilar, Central Michigan University

Board Advisors:
Louito C. Edje, MD, MHPE, FAAFP
Annette S. Gilmer, MD, MPH
Jennifer E. Morse, MD, MPH, FAAFP

AMA Advisors:
Nick Bara
T. Jann Caison-Sorey, MD, MSA, MBA
Louito C. Edje, MD, MHPE, FAAFP
Amit Ghose, MD
Aliya C. Hines, MD, PhD, MS, FAAD
Theodore B. Jones, MD
Krishna K. Sawhney, MD
David T. Walsworth, MD

Staff: Dara J. Barrera and Trisha L. Keast

* * * * * * * * * *

Reference Committee on Ways and Means
Edward J. Rutkowski, MD, Grand Traverse, Chair
Richard C. Schultz, MD, Grand Traverse, Vice-Chair
Anita R. Avery, MD, Kent
E. Chris Bush, MD, Wayne
T. Jann Caison-Sorey, MD, MSA, MBA, Wayne
Denise D. Collins, MD, Wayne
Bryan W. Huffman, MD, Ottawa
Robert J. Jackson, MD, Wayne
M. Salim U. Siddiqui, MD, PhD, Wayne

Board Advisors:
Paul D. Bozyk, MD
Brian R. Stork, MD
Bradley J. Uren, MD
John A. Waters, MD

Staff: Lauchlin W. S. MacGregor

Miscellaneous Information

PO Box 950 | East Lansing, Michigan 48826
517-337-1351 | msms@msms.org | www.msms.org

Fiscal Note Formula/Narrative

Resolutions are submitted each year requiring various levels of staff time and outsourced activities to accomplish. Historically, fiscal notes would be assigned only to those resolutions requiring unbudgeted outsourced expenses. The 2018 Ways and Means Committee requested that both staff time and outsourced costs be reported for each resolution to better measure the costs associated with accomplishing each resolution. The estimated costs include outsourced costs, staff time and related overhead costs. These amounts represent the estimated costs to accomplish the resolution.

The process to develop estimated fiscal note costs includes all staff expected to be involved in each type of resolution and the estimated amount of time it will take to accomplish the resolution from beginning to end. The time required to accomplish a resolution includes direct activities, various levels of prep/review/approvals/follow up, committee structures, department meetings, staff meetings, CEO meetings, board reference committees, board meetings, website updates, database updates, etc.

The staff costs are projected based on salaries, benefits, taxes and overhead allocated and the number of estimated hours needed to accomplish the resolution. Overhead is applied based on the same IRS approved methodology as used on the MSMS annual tax return. Overhead includes a portion of all costs associated with an employee performing their duties including but not limited to: desks, chairs, office supplies, office space, computers, printers, IT infrastructure, phone system, heating, cooling, electric, HR, accounting, office maintenance/repairs, cleaning, etc. The final component is any outsourced costs, if needed.

Below is a table of resolution activity types and the related estimated fiscal note costs:

Resolution Activity Types and Estimated Costs

Activity Type	Activity Name	Estimated Staff Cost Range	Estimated Outsourced Cost Range	Total Estimated Cost Range
Advocacy	Messaging Campaign	4,500 - 9,000	-	4,500 - 9,000
Advocacy	Legislative	16,000 - 32,000	-	16,000 - 32,000
Advocacy	Ask AMA to Advocate	1,000 - 2,000	-	1,000 - 2,000
Advocacy	Regulatory/Industry	12,000 - 24,000	-	12,000 - 24,000
Education/Outreach	Collaborative Outreach Efforts	2,000 - 4,000	-	2,000 - 4,000
Education/Outreach	Physician Outreach Efforts	2,000 - 4,000	-	2,000 - 4,000
Education/Outreach	Public Education Campaign	2,000 - 4,000	50,000 - 100,000	52,000 - 104,000
Education/Outreach	Basic Reporting/Communication	1,000 - 2,000	-	1,000 - 2,000
Education/Outreach	Extensive Reporting/Communication	12,000 - 24,000	-	12,000 - 24,000
Governance	Board Study	2,500 - 5,000	-	2,500 - 5,000
Governance	Bylaws Amendments	2,000 - 4,000	-	2,000 - 4,000
Governance	Bylaws Changes With Study	4,000 - 8,000	-	4,000 - 8,000
Governance	New/Revised MSMS/AMA Policy	1,000 - 2,000	-	1,000 - 2,000
Other	External Consultants to Study Issue	2,000 - 4,000	25,000 - 50,000	27,000 - 54,000
Other	Request Cost Increase to Budget	1,000 - 2,000	-	specific amount

House of Delegates Conflict of Interest Policy

All members of the Michigan State Medical Society House of Delegates should declare any conflict of interest, including regulatory capture*, to the House of Delegates and its Reference Committees prior to testimony. The MSMS House of Delegates considers a potential conflict of interest to exist when a Delegate, Alternate Delegate, other physician member or a non-member testifying on the floor of the House of Delegates or in Reference Committee has a relationship, or engages in any activity, or has any personal financial or commercial interest that might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters.

- Board Action Report #4, 2000 HOD, Res 10-HOD99A and Res 13-HOD99A -Edited 2017

*Regulatory capture refers to the corruption of the regulatory process such that public good is sacrificed in favor of the commercial interests of the regulated entity.

HOD Resolution 33-25, Penalties and Reporting of Inappropriate Prior Authorization and Claim Denials

Resolution 33-25 was approved as amended to create an ad hoc committee to look into various approaches to the multifactorial problem of prior authorization and inappropriate denials of claims. This committee was directed to provide a report back to the 2026 MSMS House of Delegates.

The MSMS Committee on State Legislation and Regulations met the criteria specified in the resolution to serve as the ad hoc committee. A meeting to discuss the resolution was held on November 19, 2025. This approach enabled a full review of options and development of a strategic plan.

Based on the research and white paper on this issue by MSMS's Spring 2025 Health Policy Advocacy Fellow, Patrick Fakhoury, and the discussions and approval of the MSMS Committee on Legislation and Regulations at their January 28, 2026, the following report is presented to the 2026 MSMS House of Delegates.

Report on Strategies to Improve Prior Authorization Processes and Reduce Inappropriate Denial of Services

Background & Michigan Baseline

The Michigan Legislature most recently addressed prior authorization (PA) with the passage of Public Act 60 of 2022. The law requires a standardized electronic prior authorization (ePA) process that accepts clinical information and is aligned to nationally accepted standards. This provision was operationalized by the Michigan Department of Insurance and Financial Services (DIFS) via Bulletin 2023-05-INS. For medical benefits, a process using CAQH CORE (Council for Affordable Quality Healthcare—Operating Rules for information exchange) satisfies the requirement. For pharmacy benefits, a process using NCPDP (National Council for Prescription Drug Programs) standards satisfies the requirement. Insurers were required to file details in SERFF by May 1, 2023, and attest the process would be fully operational no later than June 1, 2023.

Public Act 60 also built transparency and measurement into Michigan's PA requirements. By June 1 of each year, insurers must report aggregated trend data about their PA activity to DIFS (e.g., total requests, denials, appeals, reversals of adverse determinations, top services and reasons), and DIFS must post an annual public report by October 1. DIFS' 2023 Section 2212e report shows how the department aggregates and publishes those metrics. This reporting baseline is important because it lets the state and stakeholders track whether reforms are reducing friction without guessing.

At the federal level, there is a clear set of guardrails with which Michigan can harmonize, especially on PA timelines and data exchange. On January 17, 2024, the Centers for Medicare & Medicaid Services (CMS) finalized the Interoperability & Prior Authorization Final Rule CMS-0057-F. For impacted payers, such as Medicare Advantage, Medicaid/CHIP fee-for-service and managed care, and QHP issuers on the federally facilitated Exchanges, the rule requires HL7® FHIR® (Fast Healthcare Interoperability Resources) Application Programming Interfaces (APIs) for patient access, provider access, payer-to-payer exchange, and prior authorization. Most API requirements come due January 1, 2027. The rule also sets PA decision timeframes with 72 hours for expedited (urgent) requests and 7 calendar days for standard (non-urgent) requests. This is applicable to most

impacted programs and it requires a specific reason with any PA denial. Adopting these timelines and API expectations in state-regulated commercial markets would let Michigan "build once" with the national standard rather than creating bespoke state-only technology.

Finally, the National Association of Insurance Commissioners (NAIC) adopted a Model Bulletin on the Use of Artificial Intelligence Systems by Insurers in December 2023, setting expectations for insurers' AI governance, documentation, and regulator access to testing/audit trails to prevent errors or unfair discrimination. Several states have referenced or adopted the bulletin, making it a credible floor Michigan can incorporate for claims and PA decisions that use automation.

Prior Authorization Modernization and Responsible Use of Automation
Michigan law already requires a standardized electronic prior authorization process that accepts clinical information and tracks to nationally accepted standards. The Department of Insurance and Financial Services (DIFS) implemented this through Bulletin 2023-05-INS, which treats CAQH CORE operating rules as compliant for medical benefits and NCPDP standards as compliant for pharmacy benefits, and it required plans to attest in 2023 that the electronic process was live.

Michigan also set firm decision clocks. Urgent requests must be acted upon within 72 hours. Non-urgent requests were nine calendar days beginning June 1, 2023 and moved to seven calendar days after May 31, 2024. Multiple official and industry notices reflect these timelines, including a state summary of Public Act 60 of 2022, a Blue Cross provider alert that implemented the statutory clocks, and an NAIC document that describes Michigan's seven-day standard for non-urgent decisions.

DIFS now publishes annual Section 2212e reports that aggregate statewide prior authorization volumes, denials, appeals, reversals, and other metrics. These reports provide the measurement baseline for any new reforms to Michigan's PA law.

Create a Targeted Gold-Card Program for High-Approval Clinicians
Michigan can reduce administrative churn by exempting clinicians from prior authorization for specific services when their historical approvals meet a clear threshold. Texas House Bill 3459 established a national reference point. A physician who achieves at least a 90 percent approval rate for a given service during the prior six months receives an exemption from prior authorization for that service for the next six months, with audit authority preserved and with scope limited to state-regulated plans. The enrolled bill text and the Texas Department of Insurance guidance describe the threshold, look-back window, and exemptions that keep safeguards in place.

Although Michigan's 2022 prior authorization statute included provisions related to "gold carding," the language lacked specificity regarding program requirements and operational standards. The statute merely requires insurers to "adopt a program … that promotes the modification of prior authorization requirements" based on factors such as provider adherence to nationally recognized evidence-based medical guidelines, appropriateness, efficiency, and other quality criteria. While this represented an important initial step, the absence of clear statutory direction has resulted in significant variation in interpretation and implementation.

As a result, Michigan's health plans and insurers have developed disparate, uncoordinated protocols, leading to a lack of consistency and standardization across programs. Many of these

programs are narrowly constructed and, in practice, exclude a substantial number of otherwise high-performing physicians.

If Michigan were to follow Texas' model by adopting a defined standard—such as a 90 percent approval rate over a six-month period—the statute should also incorporate additional safeguards and clarity. These should include same-service auditing requirements, clearly defined revocation criteria when approval thresholds are no longer met, and mandatory transparency provisions requiring insurers to publish gold-card eligibility standards on plan portals so physicians can readily assess their status.

Strengthen Clinical Integrity and Notice Requirements for any Denials

Denials should be reviewed by a clinician with training and experience in the same or a similar specialty as the ordering professional. Texas codified a same-specialty peer review requirement inside HB 3459 and within its utilization review chapter, which offers a workable model. Michigan's statute already requires public posting of criteria and annual reporting. The package adds explicit same-specialty review for any adverse determination and requires that the denial notice cites the exact clinical policy used.

At the federal level, CMS's 2024 Interoperability and Prior Authorization Final Rule requires impacted payers to include a specific reason with any denial. Aligning our commercial market with that expectation will improve clarity for patients and physicians.

Measure Results and Publish What Matters

DIFS should continue the Section 2212e reporting but add public dashboards that show time to decision for urgent and non-urgent prior authorization, overturn rates on appeal, and the effect of any gold-card program by service category. Using the existing annual report foundation means Michigan can expand transparency without building a new system from scratch.

AI Guardrails for Claims and Utilization Review

Plans increasingly use automated tools to triage or recommend prior authorization outcomes. Michigan can set clear guardrails that match national insurance standards. The National Association of Insurance Commissioners (NAIC) adopted a Model Bulletin on December 4, 2023 that sets expectations for board accountability, documented inventories of AI systems, risk controls, testing, and the ability to furnish policies and technical evidence during examinations. The bulletin makes clear that AI use must comply with unfair trade practice and anti-discrimination laws and that regulators may request documentation that shows how models are designed, validated, monitored, and corrected. Insurers that use automated tools in claims handling or utilization review should operate under a written Artificial Intelligence Systems governance program. Michigan can incorporate these expectations into statute and direct the Department of Insurance and Financial Services to ensure compliance. Several states have already adopted this bulletin, which makes it a credible floor for Michigan.

When an automated tool contributes to an adverse determination for a claim or a prior authorization request, a clinician with relevant training should review and confirm the decision. The denial notice should say that automation was used and should identify the clinical policy applied in plain language. This approach aligns with insurance oversight trends that emphasize transparency and explainability and it is consistent with the federal move to require a specific reason with any prior authorization denial. New York's 2024 circular letter instructs all insurers it regulates,

including health maintenance organizations and Article 43 corporations, to manage Artificial Intelligence Systems and external data under governance that prevents unfair results and to maintain documentation that explains how models affect decisions. CMS's Interoperability and Prior Authorization Final Rule requires impacted federal payers to provide a specific reason with every denial, which gives Michigan a ready model for commercial lines.

Test for Unfair Discrimination and Accuracy

Using a framework adopted in Colorado as a template, Michigan could require periodic testing for both accuracy and unfair discrimination, with written test plans, controlled datasets, and remediation timelines. Colorado's Senate Bill 21-169 prohibits unfair discrimination from the use of external consumer data, algorithms, and predictive models and directs the Division of Insurance to set governance and testing expectations. Colorado's first implementing regulation focuses on life insurers and requires a governance and risk management framework for the use of external consumer data and algorithms. The structure is transferable to health claims and utilization review. Michigan can adopt the same core features for health carriers, while tailoring the scope to claims and prior authorization.

Hold Vendors to the Same Standard and Preserve Full Regulator Access

Many plans use third-party vendors for claims editing, utilization management, or fraud analytics. The NAIC Model Bulletin expects insurers to oversee third parties, keep documentation about model provenance and changes, and be ready to provide that information to regulators during investigations or exams. Connecticut's 2024 bulletin adopts the NAIC framework and confirms that the department may ask for the documentation it needs to evaluate the insurer's AI use, which includes vendor systems. Michigan can codify that any carrier using a vendor remains responsible for compliance, that model and data documentation must be retained, and that DIFS may obtain those materials from the carrier.

Conclusion

Physicians and patients benefit when clean claims are paid on time with interest and when prior authorization is electronic, predictable, and targeted. National administrative cost studies estimate meaningful time savings for electronic prior authorization when compared with manual workflows, which is especially important for small practices. Michigan can capture those gains by aligning commercial plans to the federal API suite and by adopting gold-card relief for high-approval services. Prior authorization becomes electronic, time certain, and transparent, with a human reviewing any adverse decision that relied on automation. Interoperability is aligned to the federal FHIR API suite so carriers build once and patients and clinicians see faster decisions across coverage types.

Ultimately, the recommended actions identified in this Report result in faster care for patients, less administrative waste and denials for physicians and other clinicians, and a single build standard for plans. Michigan can harness the momentum of other states by adopting policies, procedures, and compliance vocabulary that are already tested and thereby, reducing guesswork for plans that operate in many states.

TASK FORCE ON REORGANIZATION

FINAL REPORT
JANUARY 7, 2026

Task Force on Reorganization Final Report
January 7, 2026

Executive Summary

The Michigan State Medical Society (MSMS) faces significant structural, financial, and membership challenges that threaten its long-term viability. The Reorganization Task Force, appointed by the MSMS Board of Directors following resolutions adopted by the 2025 House of Delegates, was charged with developing recommendations to modernize governance, improve efficiency, and strengthen engagement across the organization.

After extensive review and deliberation, the Task Force unanimously recommends a series of comprehensive structural changes designed to position MSMS for the next decade of success. These recommendations are interdependent and intended to be adopted as a unified reform plan rather than individually.

1. Context and Financial Overview

Over the last 25 years, MSMS has experienced:

- 60% decrease in dues revenue
- 51% drop in active members
- 87% reduction in staff (from 154 to 20 employees)

While the 2025 budget was temporarily balanced by one-time grants, ongoing declines in membership and revenue continue. Without reform, MSMS faces an unsustainable future that could result in severe downsizing—potentially to an organization of just three staff members within a few years. The Task Force concluded that structural change is essential to preserve MSMS's financial integrity, mission, and relevance.

2. Key Recommendations

   A. House of Delegates
      Recommendation: Replace the House of Delegates with an all MSMS member, online policy-making process.
      - Expands participation to all members, rather than the 2% currently represented in the House of Delegates.
      - Reduces direct costs (~$60,000 for in-person meeting) and indirect staff time.
      - Modernizes governance through continuous, year-round policy engagement using digital platforms.
      - Retains democratic decision-making while improving efficiency and inclusivity.

   B. Organizational Partnerships

Recommendation: Eliminate mandatory dual membership between MSMS and county medical societies (CMS).

- Aligns with legal counsel's findings that the dual membership model poses significant liability risks for MSMS and the CMS.
- Addresses inequitable dues structures (CMS dues range from $0 to $415) and the resulting barriers to state membership.
- Reduces administrative complexity (over 2,300 dues combinations) and costs.
- Empowers counties to operate independently while continuing advocacy and collaboration with MSMS.
- Modernizes membership to reflect the realities of modern medical practice, supporting flexibility and affordability.

C. Leadership – Board of Directors

Recommendation: Reduce the size of the MSMS Board of Directors from 36 to 13 members, focusing on skill-based rather than representational governance.

- Reflects nonprofit best practices for associations under $3 million in revenue.
- Promotes strategic decision-making grounded in financial, organizational, and physician leadership expertise.

D. Judicial Commission

Recommendation: Eliminate the Judicial Commission and peer review committees and transfer disciplinary authority to the Board of Directors.

- Reflects common practice among other state medical societies.
- Streamlines governance by referring complaints to appropriate professional licensing boards while retaining MSMS authority over membership status.

3. Alternate Outcomes

If the recommendations are not adopted and trends continue, MSMS will need to take immediate cost-cutting actions, including:

- Further staff reductions, including potential downsizing to a minimal staff of three employees.
- Elimination of education programs.
- Selling or closing subsidiary businesses - Physicians Insurance Agency (PIA), Professional Credentials and Verification Service (PCVS), Physicians Service Inc (PSI) and Physicians Holding Company (PHC).

Without structural reform, MSMS risks losing its operational capacity, advocacy influence, and long-term sustainability.

4. Conclusion

The Task Force urges the MSMS Board of Directors and House of Delegates to adopt this report in full. The proposed reforms—modern governance, flexible membership, financial

stabilization, and enhanced engagement—represent a realistic, forward-looking approach to rebuilding MSMS into a more efficient, inclusive, and resilient organization prepared for the next era of organized medicine in Michigan.

1. Task Force Charge

Based on three resolutions approved by the House of Delegates in May 2025, the Board of Directors appointed a Task Force on Reorganization to review the structure of the organization with precedence to membership engagement, financial impact and administration simplification. The Task Force was specifically asked to provide recommendations on three major structural areas within MSMS:

- House of Delegates
- Organizational Partnerships (County, Specialty and Physician Organization)
- Leadership (Board of Directors and Judicial Commission)

The Task Force met four times (August, September, October and January) with ambitious agendas, ideas, and recommendations for action. These discussion areas and recommendations were deliberately crafted in tandem to create a cohesive restructuring of MSMS leadership and governance, ensuring the organization is well-positioned for future financial stability and policy effectiveness. While this report contains several recommendations, the Task Force asks the Board of Directors and the House of Delegates to consider this document as a whole. Structural change, while difficult and complex, crosses many areas of the infrastructure. Reforming one without the other creates confusion and inconsistency. Consider the last reorganization efforts which changed the Board of Directors regions but not the House of Delegates. Of note, all recommendations in this report received full consensus from the entire Task Force.

House of Delegate Resolutions Under Review

47-25 - Study Medical Society Structures – APPROVED

RESOLVED: That MSMS study the organizational structures, Constitution and Bylaws, and business model of other state medical societies as potential options for improving the efficiency and productivity of our organization.

16-25 - County and State Medical Society Alliance – APPROVED

RESOLVED: That MSMS create a task force of physicians across the state, in both county and state society leadership, to do the following:

- Examine the history, finances, and bylaws of our county and state societies;
- Be bold and creative in offering a unified solution to solve this historical issue, and future-proof our organizations so we can focus on our mission together;
- Utilize MSMS legal counsel to aid in this effort by examining county medical society and state medical society bylaws and offering a clear plan on how to update county and state medical society bylaws to achieve the mutual goals; and

- Present recommendations to county and state medical societies prior to the 2026 House of Delegates, with any MSMS bylaws changes presented for a first vote at that time.

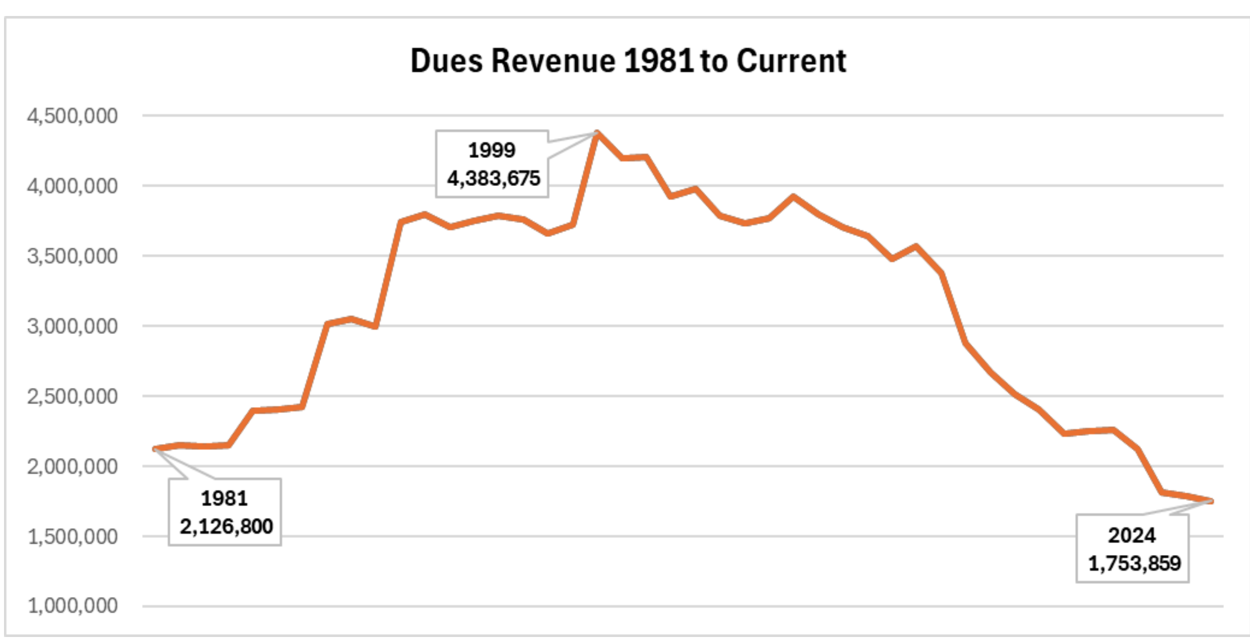
14-25 - Rotation of MSMS House of Delegates Meeting Location – REFERRED

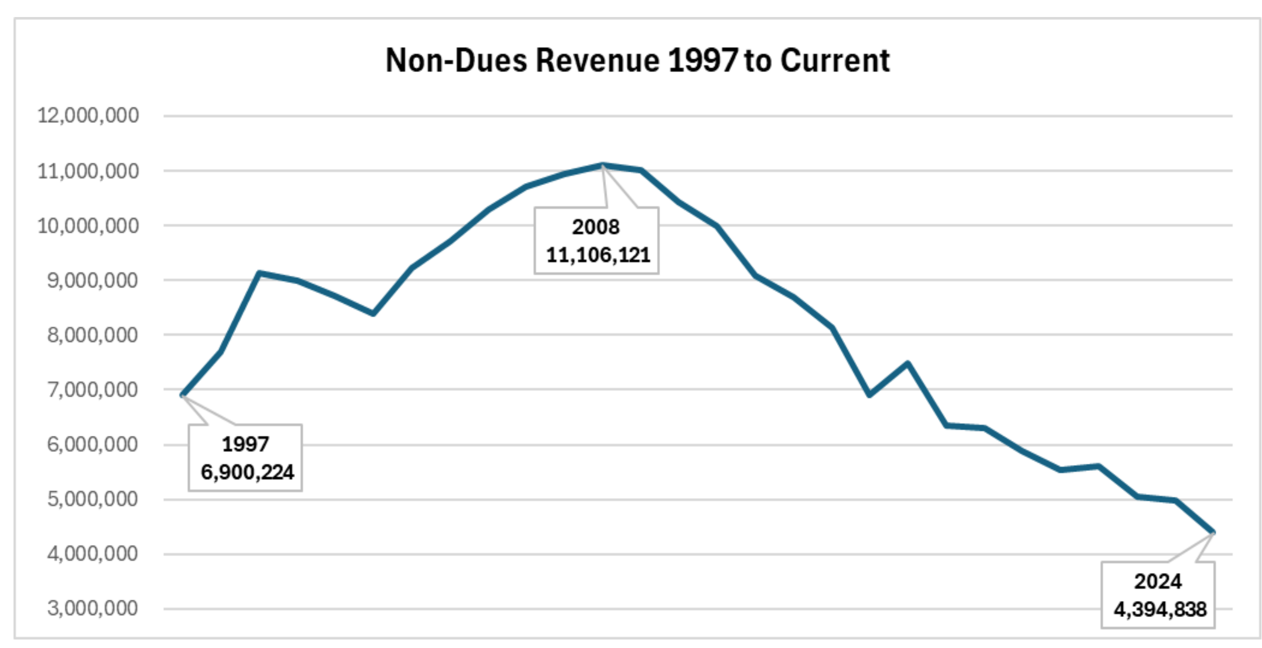
RESOLVED: That the MSMS House of Delegates shall return to the rotation of alternating meetings between an outstate venue and a southeast Michigan venue with the 2026 meeting to be held in the Detroit area.

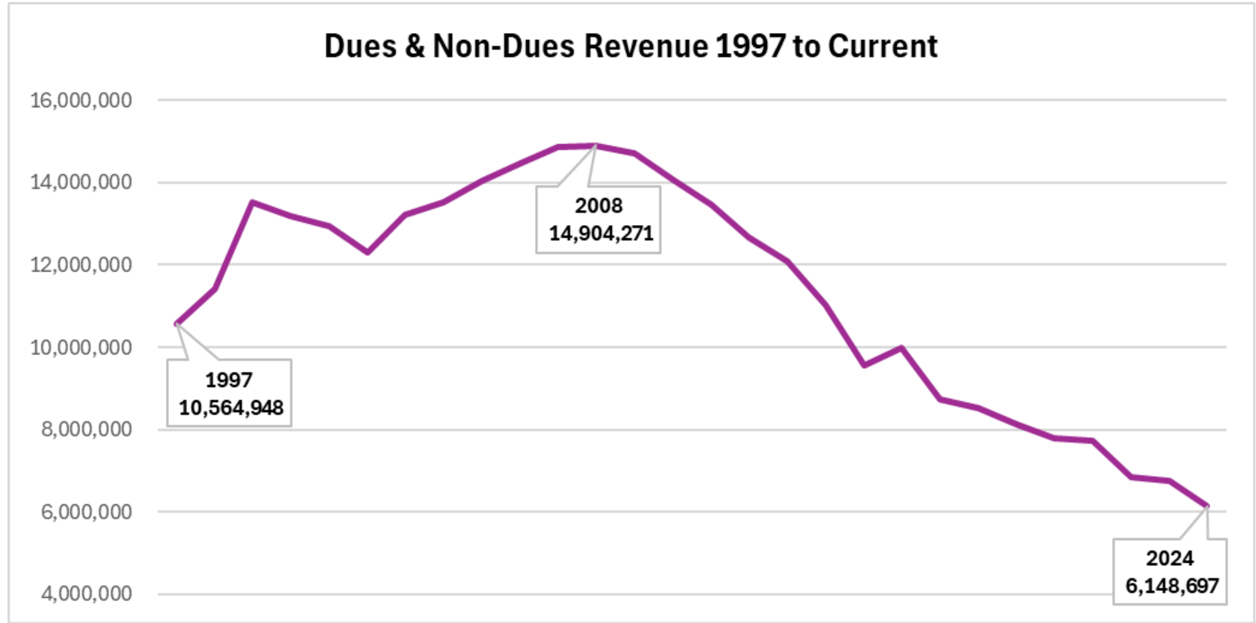
2. Historical Analysis, Current Status, Projections of Financials

The 2025 budget includes $600,000 of one-time grants. MSMS will exceed budget this year due to these grants, resulting in a year-over-year increase in revenue. However, MSMS experienced a 15 percent decline in dues revenue in 2025, the third largest year-over-year decrease in the past 25 years. An operating loss was likely if not for the one-time grants.

MSMS has experienced 25 years of declining dues revenue since 1999, which is a 60 percent reduction. Active members have dropped by 51 percent or 4,070 members since 1999; 7,967 in 1999; and 3,950 in 2025. MSMS has also experienced 16 years of declining non-dues revenue beginning in 2010 when the Affordable Care Act (ACA) was passed. Non-dues revenue declined by 60 percent since 2008 going from $11.1 million to $4.4 million. The ACA regulations eliminated MSMS's unique insurance offerings and created health insurance marketplaces resulting in diminishing traditional commission-based insurance sales, which comprised 75 percent of non-dues revenue.







During these 25 years of declining revenue, MSMS had different four CEO's, all who needed to reduce expenses to maintain profitability. Many expenses were reduced including selling the building, closing unprofitable businesses, eliminating/reducing staff benefits and implementing other operational cost efficiencies. However, the single largest expense reduction was staff deductions. Since 1999, MSMS staff has been reduced from 154 to 20 (87% reduction). Of those 20, only nine are dedicated MSMS staff. Others work for a subsidiary company. There have been minimal impacts on services due to the staff restructurings (i.e. fewer staff doing more). For 2026, if not for the conversion of the House

of Delegates to virtual and reducing the American Medical Association Delegation travel reimbursements, MSMS would have budgeted a deficit.

MSMS is budgeting dues revenue to be reduced by another 7 percent in 2026, so membership and revenue are still trending down. This means additional expenses will need to be reduced to remain profitable moving forward. In addition, the staff reductions over the years (including the 45% reduction over the past 3 years) with little change to services has left current staff exhausted. Further staff reductions will necessitate the elimination or reduction of essential services including advocacy, as well as the sale of businesses, eventually leading to a state medical society staffed by three to five people. Since most other expense reductions and restructuring have been directed toward the internal operations of the organization, the next area of focus has been governance and pricing. Also, with a smaller staff, these new restructuring efforts will need to reduce both actual costs and staff administrative time.

In summary, MSMS has experienced 25 years of declining membership dues revenue, 16 years of declining active members, and 25 years of declining staff levels. MSMS must reduce costs to help balance the budget and reduce staff administration time to allow more time for membership and revenue growth. The next steps for MSMS must include real structural reforms. The Officers and the Board of Directors have a fiduciary duty to protect the financial integrity of MSMS. Structural reforms may be uncomfortable for Board members, but they are crucial to fulfilling that responsibility. By possessing the ability to amend the MSMS Constitution and Bylaws, the House of Delegates plays a vital role in enabling the Board of Directors to effectuate what it has determined is necessary to protect the financial integrity of MSMS, position it for continued existence and otherwise make changes that are in the best interest of MSMS.

3. House of Delegates

For any association, an engaged and active member is a member for life. The Task Force considered how MSMS can engage more members in our policy and advocacy efforts with the goals of creating policy with broader physician input and expanding advocacy reach, retaining current members and recruiting new members, and increasing dues revenue.

Through the current process, the House averages 100 delegates in-person for the general session. Over the years, delegates and members expressed several concerns about barriers to participation including the time and travel commitment, the often-tedious process of testimony and voting, and occasionally the unprofessional tone or conduct of delegates. This has created a system whereas mostly the same 100 delegate members determine policy and priorities for thousands of members. In terms of improved representation and structural sustainability, the Task Force was interested in other models of governance that would include more physicians, more members and more engagement.

When MSMS had 16,000 members it was necessary to have a "representative structure" like the House of Delegates due to the sheer size of the organization and need for designated delegates to stay informed about what was happening at the state level. Physicians serving as delegates usually in private practices or retired. Taking time off from private practice, for any reason, was a loss of income in addition to the inconvenience of travel. Now, we have significantly less members and at the same time advances in virtual communication have made it possible to communicate from virtually anywhere instantaneously. As a result, MSMS has the opportunity to move from a cumbersome representative model to a more engaging democratic model where each member's voice is equally represented.

Another factor that deserves further research and dialogue is the direct and in-direct costs of the meeting. A one-day, in-person, centrally located House of Delegates costs MSMS approximately $60,000. This does not include in-direct staff costs. In the last few years, MSMS has not had enough employees to cover all the required areas of the meeting. Out of necessity, the work of the House is mostly completed after hours by MSMS staff who shoulder many other responsibilities including revenue. Historically, there were dedicated staff whose entire jobs were preparing for and managing the House of Delegates. However, due to the many budget cuts over the years, those positions were eliminated, and the House was assigned and reassigned to the few remaining staff.

For these critical financial reasons, the Board of Directors voted to transition the House to a virtual format for 2026. This would keep the same Reference Committee process online with live testimony but also move the general session online with live testimony and voting. While this option addresses issues with the direct expenses, it does not fully litigate expanding involvement. In investigating other options, further opportunities exist for process efficiencies, in-direct staff costs and engagement with all members.

While many states have eliminated their House of Delegates completely, about a dozen have moved to an all-member online policy system. They report equal if not greater success in terms of member engagement and policy outcomes. Resolutions are collected year-round. A Policy Review Committee evaluates resolutions two to three times per year. Testimony is collected via an online written forum, like the one currently used. Then the Policy Committee's recommendations are sent to all members for a vote. The Policy Committee would have authority to evaluate resolutions for purview per bylaws (medical policy vs financial/business decisions), prioritizing practice sustainability and practice of medicine, MSMS scope, and fiscal notes. As many of our state medical societies have already experienced, this system allows all members to have the opportunity to introduce and engage with policy initiatives, allows MSMS to make more timely policy decisions, eliminates all direct costs, creates efficiency and redistributes work throughout the year for the limited staff.

The inaugural Chair and Vice-Chair of the Policy Committee would be the current Speaker and Vice-Speaker of the House of Delegates. The Board of Directors would appoint 10 to

12 other Committee members with recommendations from counties, specialties, sections, physician organizations and individual members. This option allows for more immediate decisions, engages all members, and decreases direct and indirect costs.

With the shift away from an in-person House, the Task Force also conferred the importance of making delegates and members more aware of additional opportunities for engagement. As an example, MSMS meets with:

- County Presidents Meetings – 3/year, 30 attendees
- Special Society Presidents Meetings – 3/year, 40 attendees
- Physician Organization Council Meetings – 6/year, 100 attendees
- MSMS Committees and Boards (10) – at least 2/year, 20-30 attendees
- In-Person Education Conferences – 4/year, 200-250 attendees
- Live Virtual Education Programs – 24/year, 50 attendees
- State of MSMS Open Member Forums – 4/year, 100-150 attendees

House of Delegates Recommendation

The MSMS Task Force on Reorganization recommends replacing the House of Delegates with an all MSMS member, online policy making process.

House of Delegates Resources

A. State Medical Society Data
   There is not one resource that tracks this information. Based on states voluntarily responding to an MSMS survey.
   - Online option – Colorado, Minnesota, Iowa, Wisconsin, Wyoming
   - Some type of hybrid – Illinois
   - In-person – California, Indiana, Ohio

B. Recent Attendance Numbers

Delegate Attendance	
2025	105
2024	117
2023	126
2022	115
2021	virtual
2020	virtual
2019	125
2017	125

C. Membership Survey, May 2025 – 350 responses

QUESTION 1: What are the most important reasons you choose to be an MSMS member?

Reason	Count	Percent
Educational opportunities (CME, webinars, etc.)	203	63%
Advocacy at the state level	200	62%
Legal and regulatory updates	132	41%
Staying connected to organized medicine	120	37%
Professional networking	91	28%
Discounts or member-only benefits	51	16%
Practice management support	46	14%
AMA advocacy	44	14%
Physician wellness resources	41	13%
MSMS House of Delegates	38	12%
Other	9	3%

4. Organizational Partnerships

MSMS and the County Medical Societies have many long-term, successful partnerships with groups within the physician and health care community including Specialty Societies, Physician Organizations, Medical Schools, Primary Care, and Other Health Care Associations. Reasons vary but all involve common advocacy or activities with set goals or outcomes. These relationships are strictly voluntary and usually works on a per "topic" basis meaning they may be partners on some issues, and not on others. These are productive, collegial, beneficial relationships that work for all parties. MSMS and CMS have a unique partnership as it is as an additional connection via bylaws with joint membership and a financial relationship. This requirement does not exist for any other collaborations.

Throughout this reorganization process, the Task Force reviewed numerous issues surrounding the joint membership requirements. The first, and perhaps the most pressing matter is legal counsel's concerns that MSMS is at legal risk for mandating members to also hold membership in a separate entity (that MSMS does not control and has no ability to exercise oversight of) – this also applies to the county with requiring MSMS membership. MSMS and the CMS have no oversight of each other's expenses, financial controls, dues, or tax filings.

MSMS chartering a CMS and maintaining that charter in and of itself often creates the misconception that the CMS is a division of MSMS rather than a separate entity. The requirement of membership in both MSMS and a component society adds to this misconception. For example, members may claim that the MSMS requirement of dual membership constitutes a representation by MSMS that component society dues are being collected, safeguarded and used for proper purposes with MSMS oversight, verification,

and management. A court may view this as a reasonable expectation of members, creditors and others claiming that the component society's relationship to MSMS was misrepresented to them. And further, they were fraudulently induced to pay dues to a defunct or failing component society.

In reviewing the 2025 dues data, MSMS charters 59 component societies. Thirteen are active and collect dues ranging from $50 to $415. Eleven are inactive with no discernible activities but still charge dues. According to the state of Michigan and IRS business filings, 2 counties have been dissolved by law and nine have no record. Thirty-five counties are mostly inactive and do not charge dues. With the decreases in membership, this has led to smaller county organizations, fewer physicians engaged in the leadership and overall less oversight. Based on requirements for CPA firms to perform independent financial audits, most of the counties would not qualify for as they do not have adequate staffing to meet standards for internal controls, segregation of duties or approval processes.

The only way to eliminate the risk of claims is to amend the Constitution and Bylaws to eliminate the chartering of component societies by MSMS and the requirement of dual membership in MSMS and a component society. This legal advice protects MSMS, which the MSMS Board has a fiduciary duty to act exclusively in the best interest of MSMS. But also protects County Medical Societies, as County Boards have the fiduciary duty to protect themselves.

Other equally meaningful barriers involve the cost of membership. Selling membership priced at $495, plus the county dues ranging from $100 to $415 has become increasingly difficult. Current membership trends demonstrate this. The price of the dual membership has exceeded the perceived value. This extends from individual membership to groups, even with the quantity discounts. Joint membership requirements also create financial barriers, particularly for younger physicians or those in lower-paying specialties. Options for membership lower the cost of participation, making it easier for more physicians to engage in organized medicine. Additionally, there is significant variability in member benefits and cost across counties, which blurs return of investment for prospective members, individuals and groups. Even MSMS's initiation of free Continuing Medical Education has not made inroads because the dual costs of membership are still greater than the cost of the education. Staff have tracked several non-members a week choosing to purchase education rather than membership for these reasons. Over the past several years, the State and Counties have attempted to partner together to increase their respective memberships via the Membership Committee. This did not result in a significant increase in membership for either party, which again suggests underlying organizational structural problems.

MSMS and CMS create complex dues pricing with more than 2,300 different membership combinations. Group bills take weeks to produce because they cross counties and require a roster. Group practices that span multiple counties often question the value of CMS membership. The task of assigning members to the appropriate county and calculating an

invoice considering the counties varying dues levels is cumbersome at best, and at worst a deterrent to membership. There are real costs associated with billing dues and managing county relationships. The customized membership database with state and county information is complex and expensive. Although MSMS would no longer receive county billing fees ($47,000 in 2025), costs would decrease overall due to software costs and significant staff time.

The practice of medicine in Michigan has changed dramatically over the past decades, and our membership structure should reflect that reality. Many physicians now work as contracted employees, often practicing in multiple locations or across state lines. Mandatory county membership is impractical for these mobile physicians. Michigan is also increasingly an outlier in requiring joint membership. Many states allow physicians to choose county, state, or both independently. Options for dues modernizes MSMS's structure and makes membership more competitive and attractive to physicians relocating from other states.

The Task Force believes CMS are best positioned to understand and address local needs. Independent dues restore the county medical society's flexibility to establish membership policies that reflect individual community priorities, making those societies more responsive and attractive to local physicians. For example, a county could focus on a local health system or medical school. A special project or initiative could be developed that local physicians would like to participate in without the dual dues of the state. MSMS has heard for years that conservative or liberal policies have turned off local physicians from joining. Under this scenario, local physicians could join the county without the conflict of a state position. This encourages both county societies and MSMS to deliver tangible value to their members, enhancing the strength and relevance of organized medicine in Michigan. This change ensures our societies remain inclusive, relevant, and responsive to all physicians. Done well, the counties and the state could all have increases in membership by better meeting the needs of their communities.

As MSMS has lost members, the same is true for the counties. As previously mentioned, MSMS does not have access to CMS financials. MSMS does have county member numbers and membership revenue. See the 5-year report below. Some counties have remained consistent like Macomb (+9), Lapeer (+13), Kalamazoo (+2), St. Clair (-17) and Muskegon (-15). Other counties have experienced more severe declines in members and revenue like Grand Traverse (-74 and -$2,110), Kent (-80 and -$35,389), Ingham (-139 and -$59,690), Oakland (-161 and -$54,803), Washtenaw (-361 and -$89,093), Wayne (-1,620 and $-222,135). Many of these more significant declines can be attributed to the losses of large groups. Revenue for Saginaw and Jackson counties is not included as they bill for themselves.

MSMS and County Societies have had relationship challenges for decades – this spans dozens of physician leaders, staff and external consultants. Most recently, in 2018, MSMS hired an experienced medical society consultant to facilitate a process for better

communication and understanding between the state and the counties. After a full year and cost of $21,975 to MSMS, the consultant concluded for many reasons an effective relationship is not impossible, but it remains a challenge in the current environment. Moreover, an incorrect interpretation of the MSMS bylaws caused some counties to believe they had oversight of MSMS business, financial and operations decisions. This is clearly not the case, the MSMS Board has "the custody and entire control of all funds and property of the Society" (Article IX, Section 2). This misunderstanding of the organizational structure continues to distract from the mission of MSMS and its ability to advocate on behalf of physicians and patients. The Task Force discussed that removing the joint membership could reset the relationship to function more like other successful partnerships, to the benefit of all organizations.

Mandatory joint membership can discourage participation. Removing this barrier opens the door for more physicians to join either or both organizations, ultimately strengthening county and state organizations. Separating county and state society dues is practical, forward-looking reform that reflects the realities of modern medical practice, welcomes a broader range of physicians, decreases legals risks, and strengthens organized medicine in Michigan.

MSMS and the County Medical Societies are stronger together. The financial requirement does not change our relationship or partnership to represent physicians in Michigan. This is not being proposed and will not change. All organizations will continue to work on policy and advocacy together.

Organizational Partnership Recommendation

The Task Force recommends the bylaws be amended to allow MSMS and CMS to function independently, therefore adhering to legal recommendations of risk to MSMS; allows counties to focus locally and MSMS at the state level; and applies the same opportunities to MSMS and CMS to be responsible for their own membership and revenue. Partnership and collaboration would remain.

Transition Options for Counties

Strong county medical societies and a strong state society are in the best interest of physicians and organized medicine in Michigan. To assist in the transition to independence, the Task Force also asks the Board of Directors to consider offering county societies the following:

- MSMS will bill 2027 dues at no cost to allow time for counties to research billing and marketing options
- The MSMS Foundation will provide grant opportunities to assist with transition costs identified by county leadership, examples might be to purchase billing software or developing county specific marketing
- Access to membership reporting portal (excel reports) through 2027

- MSMS CEO, CFO and COO are available as a resource in reviewing revenue and expenditures
- Provide insurance and benefit consultation
- Continued assistance with legislative meetings, alerts, etc.
- Continuation of one CME application per year at no cost
- Continued assistance with internal and external speakers

Organizational Partnership Resources

A. County Dues Data

County	Active Dues
Allegan	$0
Alpena (Alpena/Alcona/Presque Isle)	$0
Barry	$0
Bay	$150
Berrien	$25
Branch	$200
Calhoun	$0
Cass	$0
Chippewa (Chippewa/Mackinac)	$0
Clinton	$0
Delta	$0
Dickinson (Dickinson/ Iron)	$0
Eaton	$0
Genesee	$415
Gogebic	$0
Grand Traverse (Grand Traverse/Benzie/Leelanau)	$50
Gratiot	$50
Hillsdale	$0
Houghton (Houghton/Baraga/Keweenaw)	$200
Huron	$0
Ingham	$350
Ionia (Ionia/Montcalm)	$0
Iosco (Iosco/Arenac)	$0
Isabella (Isabella/Clare)	$200
Jackson	$200
Kalamazoo	$250
Kent	$295
Lapeer	$100
Lenawee	$150
Livingston	$0
Luce	$0
Macomb	$260
Manistee	$0
Marquette (Marquette/Alger)	$150
Mason	$0
Mecosta (Mecosta/Lake/Osceola)	$0
Medical (Crawford/Gladwin/Kalkaska/Montmorency/Otsego/Roscommon)	$0
Menominee	$0

Midland	$0
Monroe	$100
Muskegon	$275
Newaygo	$0
Northern (Antrim/Charlevoix/Cheboygan/Emmet)	$0
Oakland	$295
Oceana	$0
Ogemaw (Ogemaw/Oscoda)	$0
Ontonagon	$0
Ottawa	$125
Saginaw	$300
Sanilac	$0
Schoolcraft	$0
Shiawassee	$0
St Clair	$225
St Joseph	$0
Tuscola	$0
Van Buren	$0
Washtenaw	$300
Wayne	$325
Wexford (Wexford/ Missaukee)	$0

B. County Member and Revenue

	Bay County Medical Society	Berrien County Medical Society	Branch County Medical Society	Gennesee County Medical Society	Grand Traverse County Medical Society	Gratiot County Medical Society	Houghton-Baraga County Medical Society	Ingham County Medical Society	Isabella-Clare County Medical Society
2020									
Members	114	14	6	231	325	6	3	342	7
Revenue	9,135	$1,350	$1,200	$83,949.25	$9,202.50	$250.00	$600	$99,522.50	$1,210.00
2021									
Members	121	16	4	205	330	24	3	124	36
Revenue	$9,960	$400	$800	$74,764.75	$10,232.50	$885.00	$600	$40,197.50	$5,240.00
2022									
Members	109	11	4	201	314	28	2	120	41
Revenue	$8,650	$275	$800	$74,728.50	$9,635.00	$1,010.00	$400.00	$38,990.00	$6,020.00
2023									
Members	110	11	3	215	290	30	2	105	38
Revenue	$8,750	$275.00	$600	$77,551.85	$8,950.00	$1,110.00	$400.00	$34,422.50	$5,680.00
2024									
Members	103	11	3	223	281	62	2	372	41
Revenue	11,047.50	$224.19	$540	$75,759.72	$7,870.50	$1,863.00	$360.00	$40,955	$5,490.00
2025									
Members	85	10	1	165	251	8	4	203	16
Revenue	$9,351.00	$225.00	$200.00	$63,546.93	$7,083.00	$360	$630.00	$39,832	$2,358.00

	Jackson County Medical Society	Kalamazoo Academy of Medicine	Kent County Medical Society	Lapeer County Medical Society	Macomb County Medical Society	Marquette-Alger County Medical Society	Monroe County Medical Society	Muskegon County Medical Society
2020								
Members	136	118	468	3	285	34	15	86
Revenue	$18,200.00	$34,175.00	$135,478.75	$300	$47,054.00	$10,125.00	$1,300	$23,225.00
2021								
Members	145	115	453	4	279	33	16	92
Revenue	$18,250.00	$28,300.00	$129,438.75	$400.00	$49,730.00	$4,950.00	$1,450	$23,900.00
2022								
Members	152	111	460	8	258	34	12	89
Revenue	$18,826.44	$26,875.00	$132,278.00	$753.92	$50,778.00	$5,025.00	$1,150	$22,812.50
2023								
Members	150	106	452	7	273	38	12	83
Revenue	$18,580.00	$25,450.00	$128,988.75	$700.00	$52,845.00	$5,700	$1,150	$21,462.50
2024								
Members	189	121	426	17	408	40	14	74
Revenue	No Info Bill on Ow	$22,761.00	$110,962.12	$1,188.00	$51,508.00	$4,500.00	$1,125.00	$17,640.00
2025								
Members	193	120	388	16	294	45	14	71
Revenue	No Info Bill on Ow	$23,627.25	$100,089.10	$1,098.00	52,594.00	5,906.25	$1,125.00	$17,235.00

	Muskegon County Medical Society	Oakland County Medical Society	Ottawa County Medical Society	Saginaw County Medical Society	St. Clair County Medical Society	Washtenaw County Medical Society	Wayne County Medical Society Southeast MI	MSMS
2020								
Members	86	843	52	245	135	475	2,010	6,768
Revenue	$23,225.00	$184,812.50	$5,100	$72,165.00	$19,416.25	$111,840.00	$302,455.20	$2,162,417.19
2021								
Members	92	667	57	281	133	377	3,539	7519
Revenue	$23,900.00	$130,657.75	$5,600.00	$80,880.00	$19,215.00	$83,972.50	$244,704.00	$2,053,266.75
2022								
Members	89	573	41	280	131	277	1,111	5,123
Revenue	$22,812.50	$112,435.39	$4,937.50	$81,180.00	$18,533.00	$43,693.41	$150,932.00	$1,701,949.64
2023								
Members	83	615	28	270	123	207	2321	5790
Revenue	$21,462.50	$124,236.54	$3,437.50	$78,780.00	$17,379.00	$51,015.00	$157,457.49	$1,767,766.47
2024								
Members	74	714	31	350	125	137	1527	5054
Revenue	$17,640.00	$125,804.63	$3,425.63	No Info Bill on Ow	$16,181.88	$29,325.80	$104,541.55	$1,713,817.25
2025								
Members	71	682	27	313	118	114	390	3960
Revenue	$17,235.00	$130,009.11	$2,981.25	No Info Bill on Ow	$19,807.60	$22,747.00	$80,320.60	$1,417,049.00

C. Services By County

Benefits	MSMS	Genesee	Ingham	Kalamazoo	Kent	Macomb	Muskegon	Oakland	Ottawa	Saginaw	Washtenaw	Wayne	Jackson
	Active		Active	Active	Active		Active	Active	Active	Active	Active	Active	Active
Legislative Advocacy (state)	X	X	X	X	X	X			X	X	X		X
Legislative Advocacy (local)		X	X	X	X	X		X	X	X	X	X	X
CME/Education	X	X	X	X	X			X	X	X	X	X	X
Human Resources Support	X			X	X			X					
Contract Review (legal)	X				X			X					
Payer Advocacy	X												
Legal Consulting	X							X					
Reimbursement Advocacy	X												X
Medical Alerts	X	X	X	X	X				X		X		X
Legal & Regulatory Compliance	X			X	X								X
Legal Alerts	X	X	x					X			X		X
Guides	X	X		X	X				X		X		
Health & Law Library	X												
Practice Management	X	X	X	X	X			X	X	X	X		
Billing & Coding Assistance	X		X					X	X	X			
Insurance	X												
Journal/Magazine	X	X		X	X	X		X	X	X	X	X	
Newsletter	X		X	X	X			X	X		X	X	
Website	X	X	X		X	X	X	X		X	X	X	
Confidential Assistance (Physician Wellness)	X			X	X				X	X		X	X
County Delegation at MSMS HOD		X	X	X	X	X		X	X	X	X	X	X
Marketing Consultation					X			X	X				
Outreach in Health & Fitness		X			X					X			
Finding resources to serve uninsured patients					X	X				X			X
Outreach in charity care and advocacy		X			X						X		X
Community Outreach & Service		X	X		X	X				X	X	X	X
Health Care Publications		X						X				X	
Member Only Social Events				X	X	X			X			X	X
Membership Meetings		X	X		X	X			X	X	X	X	X
Physician Directory	X			X	X				X	X	X		
Referrals		X		X	X	X			X	X			
Loans & Scholarships										X		X	
Peer Review Mediation Committee	X		X		X	X				X	X	X	
Peer Review Ethics Committee	X		X			X				X	X	X	
Email Alerts	X	X	X	X	X	X			X	X	X	X	X
County & City Health Department presentations		X	X		X				X	X	X	X	

D. Other State Medical Societies Data

Other State Medical Societies Data – Arizona, Arkansas, Connecticut, Hawaii, Illinois, Iowa, Massachusetts, Ohio, Texas, Vermont, and Virginia do not require dual membership

AMA, Michigan Academy of Family Practice and Michigan Osteopathic Association do not require joint membership

**There is not one resource that tracks this information. Based on states voluntarily responding to our requests.*

5. Leadership - Board of Directors

As reported above, MSMS is a significantly smaller organization than it was 25 years ago, but the governance size has not adjusted accordingly. Currently the MSMS Board of Directors has 36 members, 18 Regional Directors, six Designated Directors, seven Officers, three Sections and two ex-officio from the BCBSM Board.

Non-profit sector data shows a median board size of around nine, with an average of 13, and a trend towards smaller boards (BoardSource; Urban Institute). The American Society

of Association Executives (ASAE) Foundation adds that right-sizing boards improves strategic performance. Their study of 1,583 associations found that effectiveness depends on aligning board size with mission scope, emphasizing strategy and skills over representation. Smaller, skills-based boards are recommended for profit-oriented governance models. Non-profits under $3 million in revenue, like MSMS, typically have seven to 13 board members. Larger boards with 25 – 40+ are usually reserved for national, multi-division organizations. For example, the Texas Medical Association has 18 Board members, 50 percent less than MSMS with 10 times the revenue and 15 times the members. The American Medical Association has 21 Board members with 150 times the revenue.

With declining membership and revenue there is a need to modernize not just the size, but the composition of the board to reflect these financial challenges. This would include a change from representational governance to skill-based governance. All board members are physicians, but with distinct leadership, finance, and strategic skills. Intent would also include diversity of geography, specialty and practice. Examples of a diverse composition:

- Employed Physician Leaders: System-level insight and strategic connections
- Private Practice Physicians: Independent practice and entrepreneurial discipline
- Academic Medicine: Training, research, and early-career engagement
- Public Health/Community Physician: Population, urban and rural health perspective
- Physician with Finance/Business Background: Financial expertise
- At-Large/Emerging Leader: Innovation and digital insight

The officer structure would have a Chair to lead the board and set strategic direction, Vice-Chair to oversee initiatives and succession, Treasurer/Secretary to direct financial strategy and act as the recording officer and President and President-Elect to represent MSMS internally and externally.

The current board term is three, three-year terms (nine years) plus three more years if holding an officer position (maximum of 12 years). MSMS has annual elections for President, President Elect, Immediate Past President, Treasurer and Secretary (maximum 12 years).

President-Elect and Board members would be elected by members. Officers/Nominating Committee will administer the application process. Chair and Vice Chair would be elected by the Board annually with two-year limits. The Treasurer/Secretary would also be elected by the Board with a six-year limit. Terms would be staggered.

Current Board members not chosen for the new Board would be given priorities for leadership positions in the new Ad Hoc Board Advisory Committee, MSMS Committees, Task Forces and other Boards.

In summary a smaller, more skill-based board with diversity of geography, specialty and practice type of 13 will strengthen efficient decision-making, align governance with current resources and allow a focus on strategic renewal and membership recovery. These changes further position the society for long-term sustainability.

Board of Directors Recommendation

The Task Force on Reorganization recommends the MSMS Board of Directors be comprised of 13 skill-based board members.

6. Judicial Commission

The current MSMS bylaws require CMS to maintain a standing Peer Review and Ethics Committee and for MSMS to maintain a standing Judicial Commission. Most CMS are in non-compliance with this bylaw. The Judicial Commission would be activated by a referral from a CMS Peer Review and Ethics Committee that has recommended an action against one of its members. These processes predate the development of modern boards of medicine and osteopathy.

Most state and specialty medical societies have eliminated these committees or commissions and instead direct complainants to the appropriate licensing body. With the dissolution of Peer Review and Ethics Committees and Judicial Commissions, state medical societies have deferred to their boards to handle disciplinary matters.
If a member's professional license is suspended, their membership is automatically suspended.

Eliminating the Judicial Commission and Peer Review Committees reflects common practice among other state medical societies and streamlines governance by referring complaints to appropriate professional licensing boards while retaining MSMS authority over membership status.

Judicial Commission Recommendation

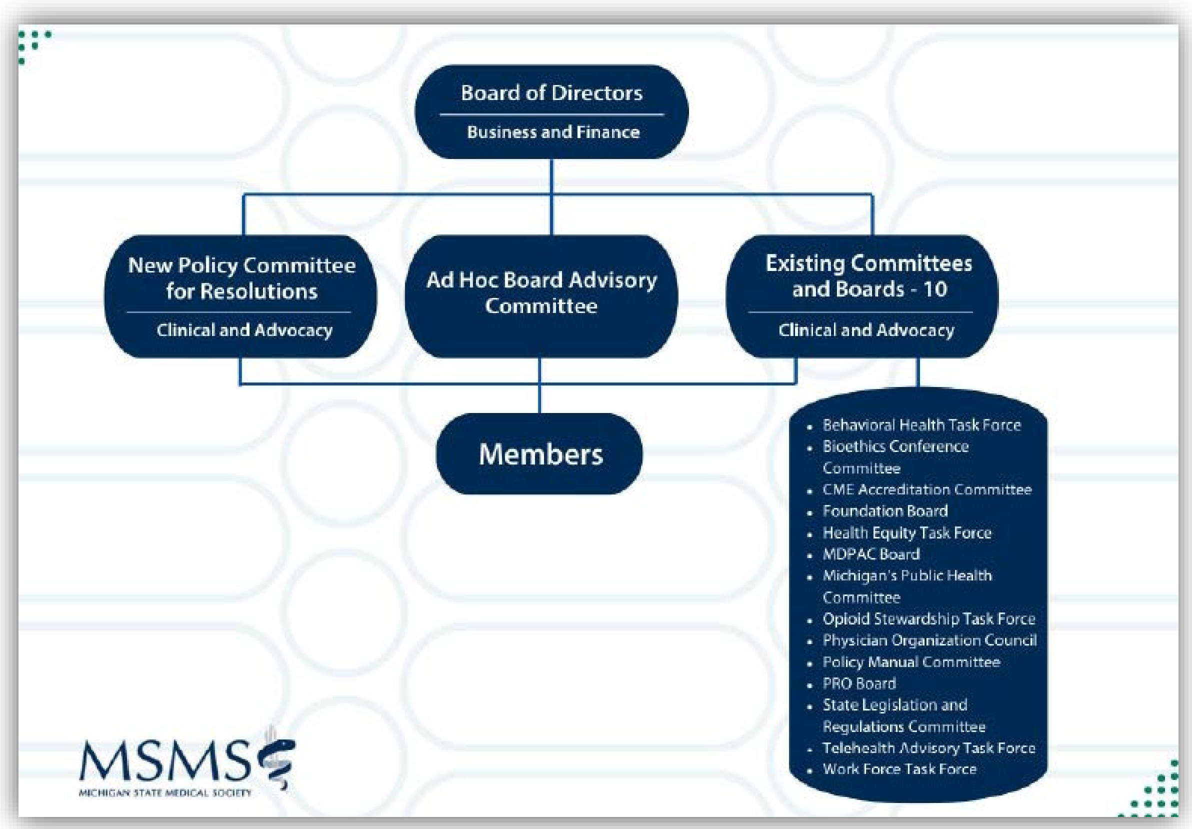
The Task Force on Reorganization recommends eliminating the Judicial Commission and Peer Review Committees and transfer disciplinary authority to the Board of Directors.

7. New Organization Model

After reviewing these financial challenges and decline in membership, the Task Force on Reorganization have recommended replacing the House of Delegates with a Policy Committee process, eliminating the joint membership requirement and reducing the size of the board and changing composition. These changes improve governance efficiencies by reducing costs, improving staff efficiencies, modernizing policy and decision making

and lowering membership prices resulting in increasing the probabilities of maintaining current service levels and reversing declining membership/revenue.

As mentioned previously, each of these recommendations were developed with a new financial and policy structure and reorganization of MSMS. While there are several parts to this report, the Task Force asks the Board of Directors and the House of Delegates to consider this as a comprehensive plan in creating a new path forward and a revisioning of organized medicine in Michigan. An organization chart can be found below to better represent the Board, Policy Committee, the 10 existing Committees and Boards and members.



8. Reorganization Report Distribution and Approval Plan

Approval Process

- Final Meeting of the Task Force to Review and Approve Report – January 7, 2026
- Presentation to the MSMS Board via zoom – January 21, 2026
- MSMS Board Meeting to Further Discuss and Vote – January 28, 2026, and February 26, 2026
- Reference Committee C – March 25, 2026

- House of Delegates - April 18, 2026

Forums – February and March
- Request to speak at County Medical Society Meetings – February 15, 2026
- County President Meeting – February 3, 2026
- County Executive Meeting – February 4, 2026
- Specialty President Meetings – February 10, 2026
- Live Delegate and Member Forums – February 10, 2026, and March 3, 2026, 5:30 pm
- Recorded Video Presentation – Released February 14, 2026

Written Communications
- Delegate Emails – February 6, February 20, March 6 and March 20
- Medigram - February 6, February 14, February 20, February 27, March 6 and March 20

9. Other Options to Reorganization

Should the Board of Directors or the House of Delegates reject the Task Force's recommendations and trends continue, MSMS will need to implement another plan to reduce more costs to maintain profitability immediately. Much of this would mirror MSMS's current working relationship with specialty societies. Some parts of that plan could include:
- The House could be converted to online system like 2020 with no live meeting or testimony. Policy making would be simplified and streamlined.
- Eliminate dues billing for county medical societies. This will simplify the billing process to allow MSMS to downsize the membership CRM system to save costs. Cost savings would be greater than the loss of CMS dues billing revenue. This will also reduce staff administration time.
- Transition monthly staff and legislative meetings to as needed and available.
- Create efficiencies with the Board of Directors. This could include reducing meeting times, eliminating one or more meetings, eliminating Board Committees, transition to virtual meetings and utilizing a consent calendar.
- Eliminate MSMS Committees and Task Forces.
- Eliminate external coalition work like Coalition for Auto No Fault, Vaccine Advocacy Groups, MIDOCs, BCBSM Tri-Staff.

Leadership will explore all ideas to operate governance more efficiently without requiring bylaw changes. These changes will not be as efficient as the Task Force recommendations so the probability of MSMS downsizing its operations in the near future will remain high.

Downsizing Sequence, Process and Options (Could Start as Early as 2026)

For more than two decades, MSMS has been quietly weathering the storm of declining revenue. At first, it was manageable, closing unprofitable businesses, cutting non-

essential services and restructuring staff (i.e. fewer staff doing more work). This was all done in hope the tide would turn. However, 25 years later, MSMS is not just in a rough patch, it is the new reality. In fact, 2026 has started with membership revenue projected to decline by over seven percent which is greater than the five and 10-year average year over year loss of just over five percent. If revenue continues to decline, MSMS will no longer be able to maintain the same level of staffing or services once offered and remain profitable. Additional staff consolidations are not possible. There is little left to cut that would not significantly change the organization. Without governance changes, MSMS is close to either using reserves to fund operating deficits or capitulating and downsize the organization to approximately three staff. The three remaining staff would be the CEO, one advocacy staff and one membership staff. In this context, MSMS is essentially surrendering to the financial pressures it's been facing. After decades of declining membership and revenue, the organization acknowledges that it can no longer sustain its current operations, services or staffing levels. The timing would be determined by the Board of Directors based on revenue trends and deficit budgets.

Given this context, it is important for the Board and the House of Delegates to understand the optimal sequence in which operations should be reduced or discontinued. An orderly sequence protects the organization's financial position, maintains legal and regulatory compliance and preserves the value of business assets that will be sold or closed. The downsizing process should begin with the areas that are the least essential to the organization's final stage of operations and that can be eliminated quickly without complex transition requirements.

- **Advocacy (Reduce Staff from three to one) -** Advocacy should be reduced first. Although valued by many members, it does not generate revenue directly and is entirely discretionary from a financial standpoint. Substantially reducing advocacy operations provides immediate expense relief and reduces staff workload without requiring significant lead time. The loss of advocacy effectiveness is a meaningful impact, but in the context of a multi-decade membership and revenue decline, it does not affect the viability of the wind-down.

- **Education (Close Down) -** Education should follow as the next area to downsize. Educational programs are time-intensive, require marketing and administrative support and consume staff resources that the society can no longer afford. While education is visible to members and some join for the free CME, it can be discontinued almost immediately and the financial risk of doing so is minimal. Reducing education programs helps realign operations with the society's reduced capacity and shifting future structure.

- **Membership (Reduce Staff from three to one) -** The membership/marketing department should not be eliminated outright but should be scaled down to a minimal administrative function. Even during a downsizing or wind-down scenario, the society still requires basic membership administrative support including

maintaining member records, processing dues that are still received and distributing any legally required notices related to organizational changes or governance votes. Active membership recruitment or retention strategies are no longer practical, but administrative continuity remains essential.

- **MSMS Subsidiaries (PIA, PCVS, PSI, PHC - Sell or Close Down) -** While MSMS departments can be reduced quickly, subsidiary businesses require a different approach. These businesses cannot be shut down abruptly without significant financial and regulatory consequences. The winddown of these business units requires early planning but later execution.
  - **PIA** – As the for-profit insurance agency, PIA is a department of PSI (see PSI below). Due to its financial importance, PIA should remain operational in the near term while the organization prepares it for sale. This preparation includes improving financial reporting, cleaning customer and policy data, engaging valuation experts, meeting regulatory requirements and positioning the business for maximum market value. Prematurely cutting staff or limiting operations in the agency could reduce its valuation and eliminate one of MSMS's few remaining revenue streams.
  - **PCVS -** The non-profit credential verification company is smaller with a break-even budget. It also requires proper planning to unwind any contracts with hospitals and other customers. It has little value due to its operating net, but selling should be explored. If a buyer cannot be found, it should be closed down. It cannot be closed abruptly, but its transition can occur earlier than PIA once formal notice periods and transition support plans are established.
  - **PSI –** PSI, the for-profit management company, holds a contract with Physicians Review Organization (PRO). PSI would need to work with PRO to cancel this contract in a reasonable time frame. Since PIA is the largest business segment, PSI will not be closed until PIA is sold off.
  - **PHC –** PHC, the for-profit holding company, has no business activities but does hold the stock in PSI and PCVS. PHC can be closed after PSI and PCVS have been sold or closed.

- **COO, CFO, Finance -** The organization's operational leadership, the Chief Operating Officer (COO), should remain in place through the final-stage of downsizing. The COO will be critical in overseeing program closures, staff reductions, transitions involving business units and operational realignment. Only once all operational functions have been completed should the COO role be eliminated. The finance department or an equivalent outsourced finance function must be preserved until the final stage of the organization's operations. Finance is essential for audit work, tax compliance, reserve management, business sale transactions, payroll processing, severance calculations, contract terminations and final dissolution filings. Eliminating finance too early would create serious fiduciary, legal, and regulatory risks for the board and the organization. For this reason, the Chief Financial Officer (CFO) is expected to remain until the end, ensuring accurate

financial reporting and compliant closure of all financial and legal obligations. Once completed, the CFO role will be eliminated.

The appropriate sequence of downsizing begins with the rapid elimination or reduction of advocacy and education, followed by a reduction of membership activities to administrative support only. At the same time, MSMS should begin preparing its businesses for transition, recognizing that PCVS can likely be closed earlier, while PIA must be maintained until it can be sold or transitioned without loss of value. Operational and financial management can be reduced once the work is complete and the MSMS reaches its final stage of wind-down and business closures.

In summary, if membership and revenue continue to decline without recommended structural changes, MSMS will need to use reserves to fund operating deficits and eventually downsize the organization by selling businesses, eliminating services and reducing staff from 20 to three.

The Board of Directors has a fiduciary duty to operate the organization in fiscally responsible ways. Making structural changes to improve governance efficiencies is one way the Board and the House can fulfill this duty. Improving efficiencies are best practice and needed in times of financial distress.

10. Task Force Members

- Brian Stork, MD, Chair - Muskegon
- Paul Bozyk, MD - Oakland
- Nick Fletcher, MD - Wayne
- Mark Komorowski, MD - Bay
- Eric Larson, MD - Kent
- Gary Sarafa, MD - Oakland
- Richard Schultz, MD – Grand Traverse
- Salim Siddiqui, MD - Wayne
- Brad Uren, MD - Livingston
- John Waters, MD - Genesee
- David Whalen, MD - Kent
- Claudia Zacharek, MD - Saginaw
- Romy Shubitowski, County Executive - Oakland

3/19/26

MSMS
MICHIGAN STATE MEDICAL SOCIETY

MSMS Task Force on Reorganization
Frequently Asked Questions

Task Force Composition

Can you provide additional background information on the Task Force members?

Resolution 16-25 asks that "MSMS create a Task Force of physicians across the state, in both county and state society leadership." No other criteria are included. The MSMS Board of Directors appointed six current Board members who have previously served in county leadership and as county delegates (Stork, Bozyk, Komorowski, Larson, Uren and Waters). Two are former Board members who served as county delegates prior to and after serving on the Board (Schultz and Siddiqui). They are currently seated delegates for their respective counties. Four have no current affiliation with the MSMS Board, are active in county leadership and are also seated delegates (Sarafa, Whalen, Zacharek and Fletcher).

Overall Plan Questions

What is the Task Force's Vision for MSMS and County Medical Societies?

The proposed reforms—modern governance, flexible membership, financial stabilization, and enhanced engagement—represent a realistic, forward-looking approach to rebuilding MSMS into a more efficient, inclusive, and resilient organization prepared for the next era of organized medicine in Michigan.

What will be the value of joining MSMS once these changes are implemented?

These changes put MSMS in a position to decrease expenses, increase membership and increase revenue. Meaning no major cuts to advocacy or services, or the reasons physicians have told us why they join MSMS (see survey below). If these structural changes are not made and trends continue as they have, then additional cuts to advocacy and services would need to begin.

QUESTION 1: What are the most important reasons you choose to be an MSMS member?

Reason	Count	Percent
Educational opportunities (CME, webinars, etc.)	203	63%
Advocacy at the state level	200	62%
Legal and regulatory updates	132	41%
Staying connected to organized medicine	120	37%
Professional networking	91	28%
Discounts or member-only benefits	51	16%
Practice management support	46	14%
AMA advocacy	44	14%
Physician wellness resources	41	13%
MSMS House of Delegates	38	12%
Other	9	3%

Do we know the MSMS staff is working in the physicians' best interest?

In response to the financial challenges of the organization, MSMS has reduced in size from 154 staff members to 20. Only 11 are dedicated to the business of MSMS, while nine are employed by the subsidiaries. Current staff are life-long proponents of advocating for our mission to advocate for physicians in Michigan, so they can provide the best care possible for the people of Michigan. If delegates do not pass these essential updates to bylaws, MSMS will need to reduce this expert group of staff which will result in a reduction of essential membership benefits. The MSMS Board has heard a plan from staff leadership to decrease remaining staff sequentially, to reduce membership benefits, and reduce subsidiaries, over the next several years. With current trends and if no action is taken, MSMS will drop to 1,000 members in the next 4-5 years. The MSMS Board and physician leadership know that our dedicated staff do not want this, and we trust their expertise in assisting to manage the Society.

General Financial Questions

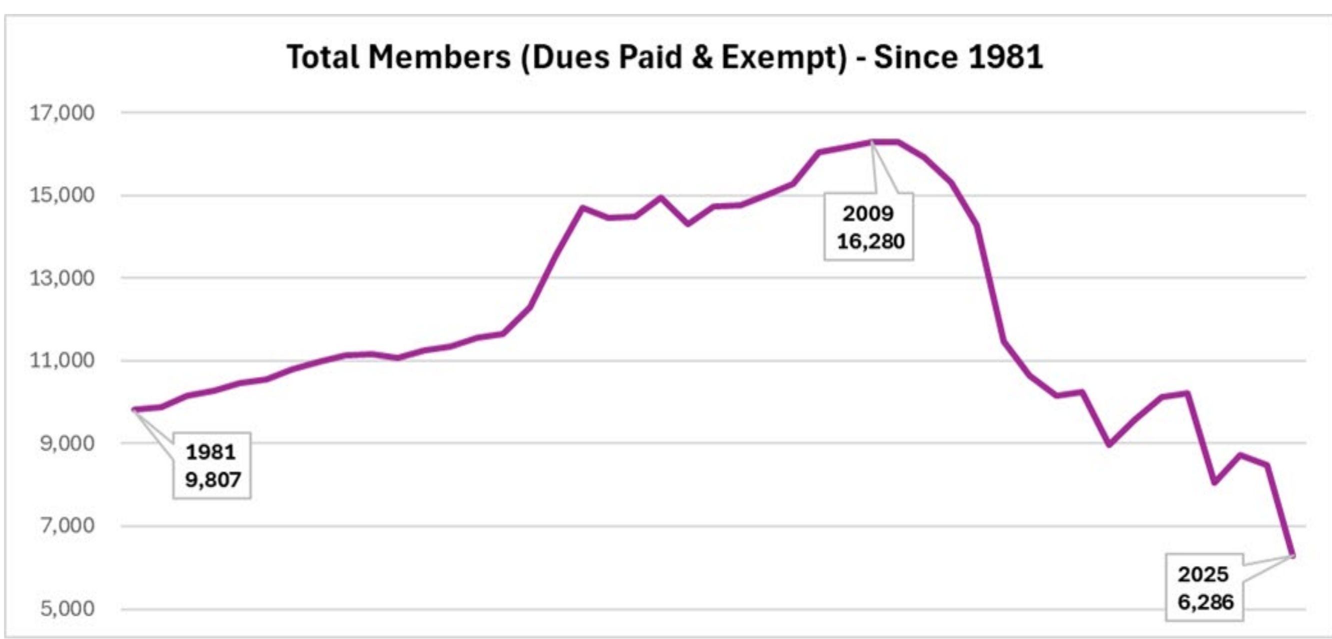
How does the MSMS Board of Directors assure MSMS has appropriate financial management?

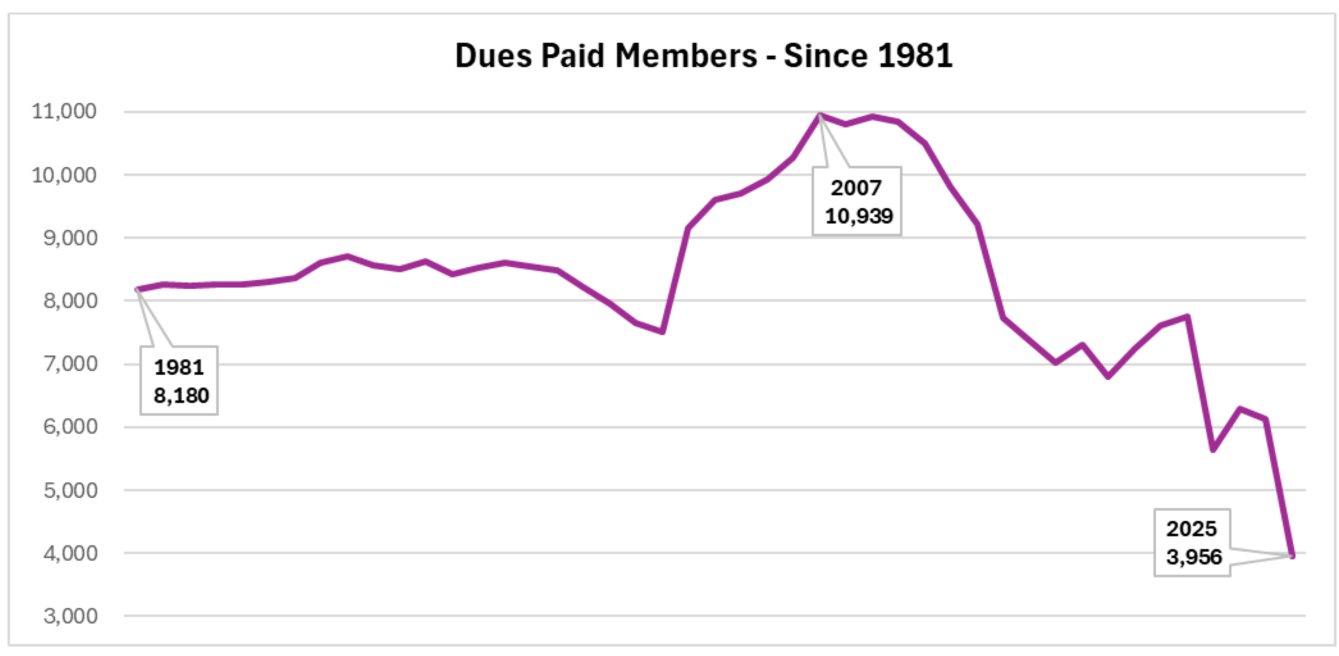
MSMS receives a financial statement audit each year. The audit is conducted by an independent auditing firm. An audit is only possible because MSMS meets rigorous accounting infrastructure, internal control and financial documentation requirements. MSMS has passed every audit for at least the past 3 decades. The MSMS Treasurer speaks directly with the audit partner before every audit. The Finance Committee meets privately with the auditors after the audit concludes. The full audited financials are shared with the Board and are included in the Annual Financial Report to the House of Delegates every year. Regarding the operating budget, the MSMS Budget Development Committee reviews

the draft budget. The budget is then reviewed by the Finance Committee. Finally, the Board receives the budget and votes on approval. Regarding reserve investments, MSMS contracts with an independent registered investment advisor who oversees the management of the investment funds per the investment policy statement. The Finance Committee reviews the investment policy statement with the advisor and recommends any changes to the Board for approval. The investment advisor presents to the Finance Committee each year.

There is some confusion about historical membership numbers with specific reference to the Annual Financial Report included in the House of Delegates handbook. Can this be clarified?

In 2009, total membership (dues paid and exempt) was 16,280 and is the highest total membership MSMS has had since at least 1981 (see chart below). The membership numbers in the prior Annual Financial Reports were total membership approximately every 20 years from 1936 to current. It is trend data, not a statement of highest membership. Regarding dues paying members, 2007 was the highest year at 10,939 (see chart below).





How will these changes together impact the finances?

Direct Cost Savings

Summary of Direct Cost Savings	
Eliminate mandatory dual membership between MSMS and CMS'	20,000
Eliminate HOD, replace with policy committee/membership at large	18,000
Reduce board size to 13	7,000
Total direct cost savings	45,000

Direct Cost Savings Summary. It should be noted that staff have been asked to find cost savings anywhere they can regardless of amount. After 25 years of declining membership, any cost savings are critically important, even if it is just $500 or $1,000. Eliminating mandatory dual membership between MSMS and the CMS' will allow MSMS to downsize the current Association Management System (AMS). Billing CMS dues requires a more advanced and costly AMS. Therefore, the savings on downsizing the AMS more than offsets the elimination of the CMS dues billing fees. The net cost savings are $20,000. Moving the HOD to a virtual live meeting in 2026 saved $42,000 in costs related to meeting space, food/beverage, hotel, mileage, AV, audience response system, moving costs and presidential reception. However, eliminating the HOD altogether and moving policy making to year-round via a policy committee and membership at large will negate the need for additional IT and legal counsel support saving an additional $18,000. Reducing the Board size to 13 directors saves $7,000 on food/beverages and travel reimbursements for the board meetings. While these are identified direct cost savings, they do not account for indirect and in-kind costs such as staff time which is addressed below.

Staff Time Savings (Administrative Simplification)

Summary of Staff Time Savings (Measured in FTE's)	
Eliminate mandatory dual membership between MSMS and CMS'	1.5
Eliminate HOD, replace with policy committee/membership at large	0.7
Reduce board size to 13	0.8
Total staff time savings measured in FTE's	3.0
% of total FTE's (20 staff currently)	15%

Staff Time Savings (Administrative Simplification) Summary. MSMS has historically had staff who were dedicated to the CMS', HOD and the Board. Those dedicated positions have been eliminated due to the 25 years of declining membership revenue. With staff being reduced by 43% over the past 3 years (going from 35 to 20) without a reduction in services, staff are exhausted and in need of administrative simplification. All administrative work, including governance, needs to be simplified and reduced. The total staff time savings above represent many staff working in these areas. As measured in FTE's, it is estimated that MSMS will save staff time that equates to around 3.0 FTE's or 15% of total staff time. This time will be allocated to focus on growing membership and revenue. With 25 years of declining membership, freeing up this administrative time to focus on revenue is fiscally responsible.

How could these changes drive an increase in revenue?

The price of the dual membership has exceeded the perceived value. Delinking automatically provides a lower price for counties and the state providing options of one or both.

- MSMS lost 53 groups in the last 5 years, 17 in 2025, and 3 already this year. The most common reason is cost.
- In the last 3 years, MSMS has met with 70 groups representing 13,000 physicians, they are clear the cost of dual membership price is a barrier to joining.

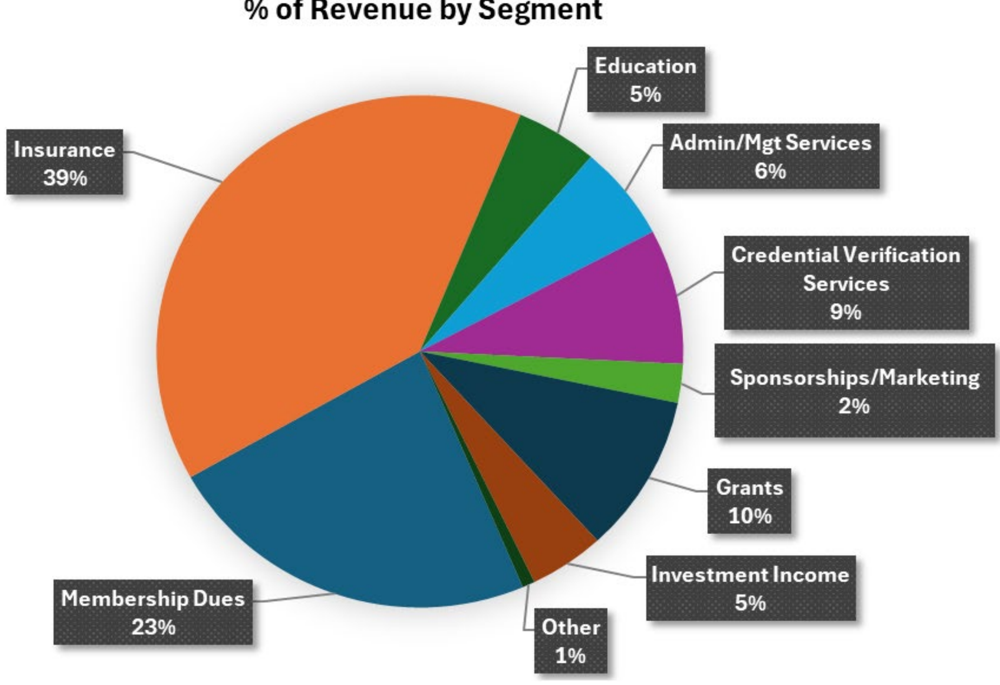
MSMS believes it could conservatively close five percent of these leads, which would add more than $650,000 of new revenue.

Additionally, MSMS has tracked 150 non-members in 2025, when presented the option of free CME with membership, chose to purchase education rather than membership. In these cases, the physician was willing to pay $495 but not the additional cost of county dues. The cost of dual membership exceeds the value of even free unlimited CME. This is $74,000 in lost member revenue.

Eliminating the county dues also allows MSMS the flexibility to research, pilot and implement other dues models outside of individual membership. Options might include pricing for health systems, groups, practice type, limited services.

What are the sources of non-dues revenue to MSMS?

The subsidiaries fund half of MSMS's annual revenue. These include: Physicians Insurance Agency, Professional Credentialing and Verification Service, Physician Services Inc and MSMS Education. See chart below (also see Annual Financial Report).



Have the subsidiaries also experienced budget and staff cuts?

Yes, both. MSMS and its subsidiaries have reduced both staff and non-staff costs over the years to balance the budget. As MSMS has eliminated association staff, the same is true for subsidiary staff. In the last 3 years, MSMS reduced staff by 15 and more than half of that was subsidiary staff. At this point, any additional subsidiary staff cuts would significantly affect subsidiary revenue and in turn MSMS revenue. For example, MSMS Physicians Insurance Agency employs 2 FTEs. Together they are responsible for 28 million in insurance premiums. Close to 1 million is returned annually to the MSMS operating budget in the form of revenue and expense sharing. If MSMS eliminates one of these positions, the agency could not function and would begin losing customers and revenue resulting in the need to start downsizing MSMS. The subsidiaries fund half of MSMS's annual revenue. Please see the Annual Financial Report for more information on the potential future downsizing of MSMS and its subsidiaries.

Why not close subsidiary companies?

The subsidiaries fund half of MSMS's annual revenue. Closing the subsidiaries would require MSMS to eliminate half of their staff and half of their services to members. MSMS would be dependent on just membership revenue which currently is just over 1 million. In

the Task Force report, the section titled "Other Options to Reorganization" outlines this scenario whereas the association consists of 3 staff funded solely by dues. Please also see the Annual Finance Report for more information on the potential future downsizing of MSMS and its subsidiaries.

Counties

What happens to the future of county medical societies?

Experience from other states suggests that counties with a clear value proposition and active physician engagement tend to remain viable. Those with limited benefits and higher dues have struggled to sustain membership. Some counties have already taken steps to reassess their offerings and dues structures. Moving forward, strong physician leadership and thoughtful, and at times difficult, decision-making at the county level will be key to determining each organization's path.

Will there still be collaboration between the State and County Medical Societies?

Yes! Ongoing communication between state and counties remains essential to the mission, vision, and values of the organizations supporting Michigan physicians. MSMS and the County Medical Societies are stronger together. Ending mandatory dual membership does not change our relationship or partnership. This is not being proposed and will not change. All organizations will continue to work on policy and advocacy together.

Does this mean CMS can do whatever they want with advocacy?

Counties already manage their own advocacy. As separate organizations, they can choose to be active or not in MSMS policy initiatives. MSMS values coalition work and has been successful in legislative and payer advocacy efforts with the partnership of other physician associations. As MSMS has government relations experts and lobbyists, we would encourage the counties to continue to participate in these activities with MSMS, specialty societies, physician organizations and other physician groups.

Why didn't the Task Force recommend other potential actions other than eliminating the charter and removing the dual dues?

MSMS has no authority to recommend or enforce CMS to change any aspect of their business. Only County leadership can decide to decrease dues, change or add member benefits, or regionalize for cost and efficiency. As a separate company, MSMS's only option in regard to CMS is delinking. Over the years, many suggestions have been made at the House of Delegates and Membership Committees to encourage counties to consider efficiencies and modernization. Ultimately, it is the county leadership that needs to make those decisions.

MSMS has had the same law firm for years, what has changed that there are now concerns with the State and County relationship?

In recent years, MSMS leadership and legal counsel have become aware of a growing number of operational and compliance concerns within some counties. These include issues related to financial oversight, tax filings, and governance practices. While counties are independent organizations, these challenges have prompted a closer evaluation of risk and the relationship between state and county entities.

MSMS was previously informed of county medical societies not obtaining or maintaining state or federal tax status and did nothing. Why do they care now?

MSMS and County Medical Societies are separate organizations, each with their own tax identification and governance structures, led by local executive directors and physician leadership. As independent entities, counties are responsible for their own compliance requirements, including tax filings. MSMS does not have the authority to enforce those activities.

As awareness of administrative and compliance challenges has grown across multiple counties, there has been an increased focus on risk mitigation and organizational clarity. This broader perspective has contributed to ongoing discussions about structure, including the proposal to eliminate the dual membership requirement as a way to better define roles and responsibilities moving forward. Delinking is a way to clarify organizational boundaries and responsibilities.

It has been reported that MSMS has experienced several incidents involving financial operations. Can MSMS explain?

Delinking mitigates risks for CMS and MSMS. Several years ago, a phishing incident occurred at MSMS in which MSMS and CMS dues were redirected to a scam account. The scammer deceived the group into transferring the dues payment to the scammer's account rather than MSMS' account. This was a revenue diversion attack, not an attack on MSMS' financial infrastructure. The auditors were made aware of this attack, investigated and concluded that the attack was outside of MSMS' financial infrastructure resulting in a clean audit opinion. MSMS followed internal IT standard operating procedures which identified the issue, informed the group to contact their bank to try to get the funds reversed and filed a claim with our cyber insurance policy. The insurance pay-out was not the full amount of dues loss resulting in MSMS and several counties recovering approximately 70 percent. The MSMS Board of Directors provided oversight and approval of this situation. This phishing incident reinformed the importance of clear financial separation and risk management.

If MSMS and CMS break up, what happens to MSMS's assets? Will the counties receive a share of assets?

The counties do not own MSMS and therefore do not have any claim to MSMS assets. MSMS' assets are used to fund MSMS operations. County assets are used to fund the county operations. There will be no change if dues are separated. .

Do you have examples of other state medical societies' experiences after delinking?
There is no centralized source that compiles data on state medical societies. Although no single model exists, a common pattern is that delinking tends to shift the focus toward value-driven membership at both the state and county levels.

- **Arkansas -** We delinked from the counties a long time ago because their processes for enrolling members was burdensome and many of the counties were becoming inactive. Our numbers increased as a result.

- **Arizona -** Does not require joint membership.

- **Iowa -** There are very few county medical societies remaining in Iowa, none of which are unified.

- **Ohio -** We delinked about 15 years ago. It certainly makes things easier to sell and market. All but a handful of our counties have ceased operations. We just have Cincinnati, Columbus, Cleveland, Dayton and a few other smaller ones. In terms of our group sales, we have added one large independent group due to a discount in our 2026 recruitment and have made presentations to six large systems with two more scheduled. None have signed a check yet but nobody has told us no yet either. Our hope is to add two in 2026. In my opinion delinking is a natural progression and should happen but I realize these things are hard.

- **Vermont -** We delinked when I came on board several years ago. Our county societies were largely defunct and no longer even had leadership or bylaws that could be identified.

- **Virginia -** We do not have unified counties.

- **Requested Anonymity -** We delinked from the counties. We still offer the option to bill for them but only a handful take us up on it. Since delinking we have seen several counties cease operations. There are 5-7 counties that remain active, but a couple struggle with their purpose. What is interesting is delinkage was attempted a few times before and it was a third rail. We engaged an outside consultant to build a medical group membership sales program. They did some surveys and interviews, and their findings said that if we do not delink, do not bother trying to recruit groups because they perceive no value in county membership. We have a few large groups operating across multiple counties, so achieving agreement when we were linked was impossible. Since delinking we have had positive year-over-year growth, with the exception of the second year of COVID. We now have a dedicated staff person

recruiting groups. We have brought in one state specialty as a group, an ER group that operates statewide, and a very large multispecialty operating throughout the suburbs. None of these would have been feasible when we were unified with the counties.

Is MOA also running into this situation?

MOA does not link dues with their county medical associations.

Does MSMS have recommendations for counties without staff to bill dues?

MSMS will assist counties by connecting them with association management and billing service providers. Several organizations offer these services and provide options tailored to smaller the counties' needs.

<u>Board of Directors</u>

Please provide more details about the structure of the proposed smaller Board.

The recommendation is 13 skill-based board members.

- Board members will be chosen by skill set and qualifications, there are no slated seats for section, geographic or group representation.
- Candidates would complete an application. Board Officers/Nominating Committee would administer the application process.
- Board Officers/Nominating Committee would recommend a slate to be **approved by members** via electronic vote.

There are five officers.

- Chair, Vice-Chair, and Treasurer/Secretary are elected by the Board.
- President and President-Elect are elected by membership.

What would be the timeline for new Board?

With approval in April, the proposed timeline is as follows:

- April 20 - May 15: Nominating Committee develop application and review process
- May 15 - June 15: Open call for applications
- June 16 – June 30: Nominating Committee Review and Recommend Slate
- June 30 – July 15: Member Vote
- Late July: First Board meeting

What about concern for geographic diversity?

A Board of Directors of 36 members is inefficient for a membership advocacy organization. The intent is to have a Board with all types of diversity including specialty, practice type and geography. Most importantly, the MSMS Board needs competencies related to

financial and strategic expertise. The Nominating Committee will attempt their best to create a Board with all the necessary competencies and experiences.

Are there other options for involvement for current Board members not interested or not chosen for the new Board of Directors?

Current Board members not interested or chosen for the new Board would be given priorities for serving on the new *Ad Hoc Board Advisory Committee* and any of the existing MSMS Committees, Task Forces and other Boards.

Would the Speaker and/or Vice speaker still automatically be part of the board as the heads of the new committee, or would this be two separate elections?

The current Speaker and Vice Speaker will be appointed Chair and Vice-Chair of the inaugural policy committee by the Board of Directors. Moving forward, these positions as well as Policy Committee members will be appointed by the Board, like all other MSMS Committees. These positions will not be slotted positions on the Board of Directors. If interested, Policy Committee Chairs would need to apply for the Board.

Judicial Commission

Would MSMS still have the ability to revoke membership for legitimate cause?

The current MSMS bylaws require CMSs to maintain a standing Peer Review and Ethics Committee and for MSMS to maintain a standing Judicial Commission. Most if not all, CMSs are in non-compliance with this bylaw. The Judicial Commission would be activated by a referral from a CMS Peer Review and Ethics Committee that has recommended an action against one of its members. These processes predate the development of modern boards of medicine and osteopathy.

Many state and specialty medical societies have eliminated these committees or commissions and instead direct complainants to the appropriate licensing body. If a member's professional license is suspended, their membership is automatically suspended.

With the dissolution of Peer Review and Ethics Committees and Judicial Commissions, state medical societies have deferred to their boards to handle disciplinary matters with language such as, "The Board of Directors shall have full power and authority to refer to a committee or task force or hear and decide all questions of discipline affecting the conduct of members of this association. Its decisions in all cases, including questions regarding the right of membership in this association, shall be final."

House of Delegates

Who would have voting rights? Are all votes equal - including students?

All MSMS members of any membership category would have one vote.

Provide an outline for the new policy review process.

The new Policy Committee would function like a larger Reference Committee.

- Resolutions are collected year-round.
- MSMS processes these two to three times per year.
- Testimony is collected via an online written forum, like the one currently used.
- Policy Committee meets to review and develop recommendations
- Recommendations are sent to all members for an electronic vote.

How does MSMS intend to engage all members when participation in the current House of Delegates is already limited and how will this lead to member recruitment and retention?

This policy program is based on other states' successes with the same model. The all-online model, rather than an in-person meeting is the reason for increased engagement. All types of associations know if an individual contributes to an organization through policy, committee, education, etc., they are more likely to remain a member. Member engagement directly correlates to member recruitment and retainment.

MSMS has shared "Policy Link" as an example of an online policy forum. What is the cost to implement?

Policy Link is one option some states have utilized. MSMS already has and used the technology in place to accept resolutions, host an online forum and facilitate a member vote. So, there would be no additional cost for the new policy forum.

General Process Questions

How will this be presented and voted on at the House of Delegates?

While these recommendations are interdependent and intended to be adopted as a unified reform plan rather than individually. For purposes of an organized deliberation and vote at the House, each recommendation will be its own resolved statement and will be taken one at a time. This will be the process for the Reference Committee and the general session of the House.

Bylaws require a second reading. How will that work if the House supports these changes?

As allowed in bylaws, the MSMS Board of Directors called a second session of the House of Delegates for the bylaws changes associated with the Reorganization Report on April 18, 2026.

What is the timeline for implementing these major structural changes?

- Board of Directors – This would need to happen first, from April through July 2026.
- Organization Partnerships – MSMS committed to billing for counties through the 2027 dues cycle. The turnover would take place in August 2027 for 2028 dues.
- House of Delegates – The Policy Committee would be created in the fall 2026 and be ready to accept resolutions January 2027. First cycle of review would begin March 2027.

Ed 3/19/26, 4:00 pm

Resolution Index

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES
RESOLUTION INDEX

RESOLUTION	TITLE	REFERENCE COMMITTEE
01-26	Universal Access to Patient Advocacy Services in Michigan Hospitals	A/B
02-26	Increasing Financial Access to In Vitro Fertilization (IVF) Treatment	A/B
03-26	Medication Safety at Home Post-Discharge	D/E
04-26	Access to Clothing for Patients in Inpatient Psychiatric Facilities	D/E
05-26	Standards for Physician-Directed Medical Spa Care and Public Disclosure	A/B
06-26	Supervision of Children and Public Education to Mitigate the Dangers of Dog Bites	D/E
07-26	Pregnancy-Related Health Coverage for Uninsured Individuals	A/B
08-26	Moral Duty to Patients and Ensuring Healthcare Facilities Remain Protected Spaces	C
09-26	Safe Clinical Learning and Practice Environments	D/E
10-26	Adopt Evidence-Based Child, Adolescent, and Adult Immunization Schedules	D/E
11-26	Additional Nurse Practitioner Certification to Protect Patients	A/B
12-26	Eliminate Prior Authorization for Low-Cost Medications and Procedures	A/B
13-26	Enhance Physician Value Based Care Literacy	A/B
14-26	Gender Affirming Care Education for Elected Officials	D/E
15-26	Preserving Michigan’s Independent Primary Care Physician Workforce Through Strategic Sustainability Initiatives	C
16-26	Modernizing Organ Acquisition Reimbursement to Support Normothermic Machine Perfusion and Ensure Equitable Patient Access	A/B
17-26	Confidentiality of Peer Support Programs within Michigan	A/B
18-26	Nondiscrimination and Advocacy for Patients with Opioid Use Disorder in Post-Acute Care Settings	A/B
19-26	Medicare Coverage for In-Office Vaccines	Reaffirmation
20-26	Revise Michigan's Universal Lead Testing Law	D/E
21-26	Delay Gender-Related Surgeries in Minors	D/E
22-26	Rescind MSMS Policy Opposing the Interstate Medical Licensing Compact	A/B

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES
RESOLUTION INDEX

23-26	Restoring the Prerogatives of the Michigan Board of Medicine	A/B
24-26	Endorsement of AAP and AAFP Vaccine Recommendations	D/E
25-26	Dissolution of the House of Delegates	C
26-26	Oppose Work Requirements for Medicaid Beneficiaries	Reaffirmation
27-26	Amend CME Rules to Align with American Board of Medical Specialties Standards	Reaffirmation
28-26	Shared Mission and Vision for MSMS and Component Societies	C
29-26	Support for HB 5313	Reaffirmation
30-26	Access to Stock Albuterol in Schools	D/E
31-26	Expand Michigan Medicaid Coverage for Continuous Glucose Monitors	A/B
32-26	Support for Equity-Focused Scoliosis Screening in Michigan Public Schools	A/B
33-26	Expand Medicaid Coverage for GLP-1	A/B
34-26	Hemorrhage Control Kits and Bleeding-Control Training in Schools	D/E
35-26	Making Transportation Accessible, Reliable, and Patient-Centered	D/E
36-26	Self-Collected HPV Screening for Cervical Cancer Prevention	D/E
37-26	Decriminalization of Harm Reduction Strategies	A/B
38-26	Gradual Return-to-Learn Protocol for Youth After Concussion	D/E
39-26	Physician Competency and Clinical Care for Patients with ASD	A/B
40-26	Ethical Engagement with Private Equity	D/E
41-26	Incentive Programs for Adherence	A/B
42-26	Financial Incentive Programs for Smoking Cessation	D/E
43-26	Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs	A/B
44-26	2026 MSMS House of Delegates Meet in Person	C
BOARD ACTION REPORT	**TITLE**	**REFERENCE COMMITTEE**
#01-26	Resolution 02-25: Imposition of Penalties by Disciplinary Subcommittee	A/B

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES
RESOLUTION INDEX

#02-26	Resolution 05-25: Immediate Authorization for HIV Post-Exposure Prophylaxis Medication	A/B
#03-26	Resolution 11-25: Resolutions Are Not Publications or Presentations	D/E
#04-26	Resolution 46-25: Physician Union	C
#05-26	Resolution 25-25: Regulation of Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions	D/E
#06-26	Chartering Component/County Medical Societies- - Resolution 14-25 - Rotation of MSMS House of Delegates Meeting Location; Resolution 16-25 - County and State Medical Society Alliance; Resolution 47-25 - Study Medical Society Structures	C
#07-26	House of Delegates- Resolution 14-25 - Rotation of MSMS House of Delegates Meeting Location; Resolution 16-25 - County and State Medical Society Alliance; Resolution 47-25 - Study Medical Society Structures	C
#08-26	Judicial Commission- Resolution 14-25 - Rotation of MSMS House of Delegates Meeting Location; Resolution 16-25 - County and State Medical Society Alliance; Resolution 47-25 - Study Medical Society Structures	C
#09-26	Board of Directors- Resolution 14-25 - Rotation of MSMS House of Delegates Meeting Location; Resolution 16-25 - County and State Medical Society Alliance; Resolution 47-25 - Study Medical Society Structures	C
#10-26	Revisions to the MSMS Policy Manual and the 2026 Sunset Report	C
2nd READING	**TITLE**	**REFERENCE COMMITTEE**
27-25	Remove Separate County Requirement for Regional Directors	C
49-25	Membership Categories	C
50-25	Revisions to Constitution and Bylaws	C

Reaffirmation Calendar

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES

REAFFIRMATION CALENDAR

RESOLUTION	DESCRIPTION
19-26	Medicare Coverage for In-Office Vaccines
26-26	Oppose Work Requirements for Medicaid Beneficiaries
27-26	Amend CME Rules to Align with American Board of Medical Specialties Standards
29-26	Support for HB 5313

Resolution: 19-26

Title: Medicare Coverage for In-Office Vaccines

Introduced by: Megan Edison, MD, for the Kent County Delegation

Author(s): Gerald Lee, MD

Referred to: Reaffirmation Calendar

House Action:

Whereas, Medicare is for elderly and handicapped individuals who struggle often to get into facilities; and

Whereas, these individuals are often most susceptible to vaccine-preventable illness; and

Whereas, currently vaccines are included in Medicare Part D so for most vaccines patients have to go to a pharmacy to get their vaccines; and

Whereas, many patients forget or struggle to get into a second facility, and therefore never get vaccines; and

Whereas, patients want to get advice from their physician and feel more comfortable at their physician's office; and

Whereas, physicians are then accountable for vaccine rates and preventative health; and

Whereas, vaccines should be available in the office or pharmacy through Medicare Part B or Part D; and

Whereas, this would result in improved vaccine rates and preventable illness would decline; and

Whereas, vaccine costs are cheaper than hospitalizations; therefore be it

RESOLVED, that the Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate that Medicare patients receive coverage for vaccines administered in the office or pharmacy.

Fiscal Note: $1,000-$2,000

RELEVANT MSMS POLICY

Adequate Vaccine Funding and Reimbursement
MSMS supports:
1). Efforts to immunize children and adults consistent with recommendations by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices;
2). Increased federal funding for vaccines; and,
3). Collaboration with local payers and other stakeholders to ensure the availability of CDC recommended vaccines and full reimbursement for physician practices if unable to find a supplier charging lower than the reimbursement fee.

RELEVANT AMA POLICY

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981

1. Our American Medical Association will continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services.
2. Our AMA will continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers, including federal funds to reimburse for administration of the COVID-19 vaccine to uninsured patients.

3. Our AMA will encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine.
4. Our AMA will seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices through May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies, or clearly state in large bold font in their notices to patients and businesses that they do not follow evidence-based vaccine recommendations.
5. Our AMA will advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.

Reimbursement for Influenza Vaccine H-440.848

1. Our American Medical Association will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine.
2. Our AMA encourages the manufacturers of influenza vaccine to publish the purchase price by June 1st each year.
3. Our AMA shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations.

Covering Vaccinations Through Medicare D-330.896

Our American Medical Association will advocate that Medicare cover the full cost of all vaccinations administered to Medicare patients at the point of care and outside of budget neutrality requirements, that are recommended by the Advisory Committee on Immunization Practices (ACIP) as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies.

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. All persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, or national medical specialty society recommended vaccines as soon as possible following publication of these recommendations.
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of recommended vaccines, and the timely distribution of recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines, including those from national medical specialty societies.

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our American Medical Association supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National **Vaccine** Advisory Committee's 2008 white paper on pediatric **vaccine** financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States: Provider-related
    a. Develop a data-driven rationale for improved **vaccine** administration fees.
    b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, **vaccine** company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
    c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
    d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a **vaccine** is not given.

Federal-related

a. Increase federal resources for adult immunization to:
    i. Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations.
    ii. Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered.
    iii. Fund an adequate universal reimbursement rate for all federal and state immunization programs.
b. Optimize use of existing federal resources by, for example:
    i. Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding.
    ii. Capitalizing on public health preparedness funding.
c. Ease federally imposed immunization burdens by, for example:
    i. Providing coverage for **Medicare**-eligible individuals for all vaccines, including new vaccines, under **Medicare** Part B.
    ii. Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient.
    iii. Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
d. The Centers for **Medicare** & Medicaid Services should raise **vaccine** administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

a. State Medicaid programs should increase state resources for funding vaccines by, for example:
    i. Raising and funding the maximum Medicaid reimbursement rate for **vaccine** administration fees.
    ii. Establishing and requiring payment of a minimum reimbursement rate for administration fees.
    iii. Increasing state contributions to vaccination costs.
    iv. Exploring the possibility of mandating immunization coverage by third party payers.
b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in **vaccine** management by:
    i. Providing model **vaccine** coverage contracts for purchasers of health insurance.
    ii. Creating simplified rules for eligibility verification, billing, and reimbursement.
    iii. Providing vouchers to patients to clarify eligibility and coverage for patients and providers.
    iv. Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, and national medical specialty society recommended vaccines.
        a. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
        b. Improve accountability by adopting performance measurements.
        c. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as of May 1, 2025, and national medical specialty society recommended vaccines as part of the health plan.
        d. Provide incentives to encourage providers to begin immunizing by, for example:

i. Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations.
ii. Simplifying payment to and encouraging immunization by nontraditional providers.
iii. Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related
Market stability for adult vaccines is essential. Thus:

i. Solutions to the adult **vaccine** financing problem should not deter research and development of new vaccines.
ii. Solutions should consider the maintenance of vibrant public and private sector adult **vaccine** markets.
iii. Liability protection for manufacturers should be assured by including **Vaccine** Injury Compensation Program coverage for all ACIP recommend adult vaccines as of May 1, 2025, and national medical specialty society recommended adult vaccines.
iv. Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult **vaccine** supply (including influenza **vaccine**) that results from the large contracts between **vaccine** manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

AMA MEMBERSHIP ATTESTATION

Pursuant to approved HOD Resolution 65-14, any resolutions "submitted to the MSMS House of Delegates that require action by the AMA may only be submitted by MSMS members that are also members of the AMA."

I am a current member of the American Medical Association.
☒ Yes
☐ No

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY

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☒ The author(s) have no conflict(s) of interest to disclose
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DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS

Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires authors to disclose any current, very similar, or pending resolutions at other state medical societies of which they are aware.

☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Title: Oppose Work Requirements for Medicaid Beneficiaries

Introduced by: James C. Mitchiner, MD, MPH, for the Washtenaw County Delegation

Author(s): James C. Mitchiner, MD, MPH

Referred to: Reaffirmation Calendar

House Action:

Whereas, Public Law 119-21 will require states with expanded Medicaid coverage, including Michigan, to initiate work requirements for their Medicaid beneficiaries as of January 1, 2027; and

Whereas, expanded Medicaid coverage has increased overall access to healthcare, expanded preventive services, improved prescription drug coverage and boosted employment, while creating less financial stress for beneficiaries, increasing reimbursement for hospitals, and improving state tax revenues; and

Whereas, there is no evidence to date that Medicaid work requirements have a significant impact on employment or poverty for Medicaid beneficiaries; and

Whereas, evidence from Arkansas, the first state to initiate a mandatory Medicaid work requirement in 2018, suggests that this policy has adversely affected healthcare coverage due to confusion about eligibility and logistical difficulties in reporting requirements; and

Whereas, Michigan's attempt to initiate a Medicaid work requirement in 2020 caused the state to expend $30 million in administrative costs before the requirement was invalidated by court order, without any effect on Medicaid costs or Medicaid beneficiary employment; and

Whereas, any policy that denies or disrupts insurance coverage, and thus creates a barrier to healthcare access, could lead to poor health outcomes for affected individuals and increased uncompensated care burdens imposed on hospital Emergency Departments; therefore be it

RESOLVED, that our MSMS opposes mandatory work requirements that require Medicaid beneficiaries to prove employment or seek employment in order to receive or maintain health insurance.

Fiscal Note: $1,000 - $2,000

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3. Ayanian JZ, Ehrlich GM, Grimes DR, Levy H. Economic effects of Medicaid expansion in Michigan. *N Engl J Med* 2017; 376:407-410. (https://www.nejm.org/doi/full/10.1056/NEJMp161398).
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6. Pavetti L. Work requirements don't cut poverty, evidence shows. Center on Budget and Policy Priorities, Updated June 7, 2016. ("*The large majority of individuals subject to work requirements remained poor, and some became poorer.*") (https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows)
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9. Wells, K. He built Michigan's Medicaid work requirement system. Now he's warning other states. *KFF Health News*. September 5, 2025. https://kffhealthnews.org/news/article/michigan-medicaid-work-requirement-verification-implementation-lessons/ ("*Michigan's experience illustrates how challenging it can be to stop large numbers of people from inadvertently losing coverage, even when leaders try their best to prevent that.*")
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11. Haught R, Dobson A, Luu P-H. How will Medicaid work requirements affect hospitals' finances? Commonwealth Fund Issue Brief, March 2019. ("*In states that impose work requirements, fewer covered Medicaid beneficiaries means hospitals will see reduced revenues, increased uncompensated care costs, and smaller operating margins.*") (https://www.commonwealthfund.org/sites/default/files/2019-03/Haught_medicaid_work_requirements_hosp_finances_ib_v2.pdf)

RELEVANT MSMS POLICY

Opposition to Medicaid Work Requirements
MSMS opposes work requirements as a criterion for Medicaid eligibility.

RELEVANT AMA POLICY

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility.

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Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires authors to disclose any current, very similar, or pending resolutions at other state medical societies of which they are aware.

☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 27-26

Title: Amend CME Rules to Align with American Board of Medical Specialties Standards

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Author(s): Richard E. Burney, MD

Referred to: Reaffirmation Calendar

House Action:

Whereas, in 2022, the MSMS House of Delegates passed Resolution 31-22, which reads:

> That MSMS work with the Michigan Boards of Medicine and Osteopathic Medicine and Surgery to amend the Michigan Administrative Code, Rules 338.2443 and 88 338.143, or to seek legislative remedy, to align with the new American Board of Medical Specialties' Standards for Continuing Certification such that active participation in specialty continuing certification constitutes evidence of substantial compliance with continuing medical education (CME) requirements and an acceptable means of meeting CME requirements for license renewal.

Whereas, active participation in specialty board certification still does not fulfill CME licensing requirements; therefore be it

RESOLVED, that the Michigan State Medical Society reaffirms its commitment to work with the Michigan Boards of Medicine and Osteopathic Medicine and Surgery to amend the Michigan Administrative Code, Rules 338.2443 and 88 338.143, or to seek legislative remedy, to align with the new American Board of Medical Specialties' Standards for Continuing Certification such that active participation in specialty continuing certification constitutes evidence of substantial compliance with continuing medical education (CME) requirements and an acceptable means of meeting CME requirements for license renewal.

Fiscal Note: $1,000 - $2,000

RELEVANT MSMS POLICY

CME Credit for Continuing Board Certification

MSMS believes that active participation in specialty continuing certification, which is aligned with the American Board of Medical Specialties' Standards for Continuing Certification, constitutes evidence of substantial compliance with continuing medical education (CME) requirements and an acceptable means of meeting CME requirements for license renewal. (Res31-22)

RELEVANT AMA POLICY

1. Our American Medical Association will continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Our AMA will continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Our AMA will continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Our AMA will encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.

5. Our AMA will work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Our AMA will work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Our AMA will recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Our AMA will work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Our AMA will encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Our AMA will encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Our AMA will work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Our AMA will work with key stakeholders to
    a. support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC.
    b. support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement.
    c. encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards.
    d. work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Our AMA will work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Our AMA will work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Our AMA will encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Our AMA will encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Our AMA will continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Our AMA will encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Our AMA will continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Our AMA will encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Our AMA will recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Our AMA will continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Our AMA will encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Our AMA will continue to assist physicians in practice performance improvement.
25. Our AMA encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Our AMA will support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.

27. Our AMA will oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Our AMA will ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Our AMA will call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Our AMA will support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Our AMA will continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Our AMA will continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Our AMA , through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for:
    a. medical staff membership, privileging, credentialing, or recredentialing.
    b. insurance panel participation.
    c. state medical licensure.
34. Our AMA will increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Our AMA will advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Our AMA will continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.
40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

AMA MEMBERSHIP ATTESTATION

Pursuant to approved HOD Resolution 65-14, any resolutions "submitted to the MSMS House of Delegates that require action by the AMA may only be submitted by MSMS members that are also members of the AMA."

I am a current member of the American Medical Association.
☒ Yes
☐ No

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies: Click or tap here to enter text.

Title: Support for HB 5313

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Author(s): Richard E. Burney, MD

Referred to: Reaffirmation Calendar

House Action:

Whereas, physicians in Michigan have been unduly burdened by excessive requirements for continuing medical education and other mandatory education requirements as part of medical license renewal; and

Whereas, penalties for not meeting these requirements are also excessive and lead to reporting to National Practitioner Data Bank as permanent disciplinary actions; and

Whereas, HB 5313 introduced into the current Michigan legislative session seeks to modify these requirements in ways that would relieve these burdens while preserving appropriate oversight of licensing requirements; therefore be it

RESOLVED, that our MSMS supports passage of HB 5313 which decreases CME from 150 hours to 75, would require review of mandated topics, sunsets administrative errors after seven years, and creates transparency and fairness in the investigative process.

Fiscal Note: $1,000 - $2,000

RELEVANT MSMS POLICY

Pain Management Education and CME Credit
MSMS supports the concept of requiring physicians to be educated in pain management techniques but opposes mandating this type of education through CME credit.

Opposition to Compulsory Content of Mandated Continuing Medical Education
MSMS opposes any attempt to introduce compulsory content of mandated Continuing Medical Education (CME) in the state of Michigan.

RELEVANT AMA POLICY

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
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Reference Committee A/B

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES

RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE A/B – PAYER AND LEGISLATIVE ADVOCACY

RESOLUTION	DESCRIPTION
01-26	Universal Access to Patient Advocacy Services in Michigan Hospitals
02-26	Increasing Financial Access to In Vitro Fertilization (IVF) Treatment
05-26	Standards for Physician-Directed Medical Spa Care and Public Disclosure
07-26	Pregnancy-Related Health Coverage for Uninsured Individuals
11-26	Additional Nurse Practitioner Certification to Protect Patients
12-26	Eliminate Prior Authorization for Low-Cost Medications and Procedures
13-26	Enhance Physician Value Based Care Literacy
16-26	Modernizing Organ Acquisition Reimbursement to Support Normothermic Machine Perfusion and Ensure Equitable Patient Access
17-26	Confidentiality of Peer Support Programs within Michigan
18-26	Nondiscrimination and Advocacy for Patients with Opioid Use Disorder in Post-Acute Care Settings
22-26	Rescind MSMS Policy Opposing the Interstate Medical Licensing Compact
23-26	Restoring the Prerogatives of the Michigan Board of Medicine
31-26	Expand Michigan Medicaid Coverage for Continuous Glucose Monitors
32-26	Support for Equity-Focused Scoliosis Screening in Michigan Public Schools
33-26	Expand Medicaid Coverage for GLP-1
37-26	Decriminalization of Harm Reduction Strategies
39-26	Physician Competency and Clinical Care for Patients with ASD
41-26	Incentive Programs for Adherence
43-26	Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs
BOARD ACTION REPORT	**DESCRIPTION**
#1-26	Resolution 02-25: Imposition of Penalties by Disciplinary Subcommittee
#2-26	Resolution 05-25: Immediate Authorization for HIV Post-Exposure Prophylaxis Medication

Resolution: 01-26

Title: Universal Access to Patient Advocacy Services in Michigan Hospitals

Introduced by: Brittany M. Garza, DO, for the Saginaw County Delegation

Author(s): Brittany M. Garza, DO

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, patients navigating the healthcare system often face complex medical, financial, and administrative challenges that can hinder their understanding of treatment options and compromise informed decision-making; and

Whereas, patient advocates play a critical role in assisting patients and families by facilitating communication between healthcare teams, clarifying medical information, supporting shared decision-making, and ensuring patient rights and preferences are respected; and

Whereas, the presence of trained patient advocates has been shown to improve patient satisfaction, reduce preventable errors related to miscommunication, and enhance care coordination; and

Whereas, lack of access to patient advocacy can be especially detrimental for vulnerable populations—including those with language barriers, limited health literacy, cognitive impairment, or complex medical conditions—who are at higher risk of misunderstanding treatment plans or experiencing adverse events; and

Whereas, ensuring the reliable availability of patient advocates aligns with the core mission of physicians to promote patient safety, autonomy, and equitable care; and

Whereas, there is currently no existing standardized protocol to address this issue, resulting in inconsistent practices and potential gaps in implementation; therefore be it

RESOLVED, that the MSMS advocates for all licensed hospitals in Michigan to maintain readily accessible patient advocacy services for all patients and all families throughout the entirety of their medical care, including during hospitalization, at discharge, following outpatient visits, and throughout any subsequent care-related or medico-legal processes; and be it further

RESOLVED, that the MSMS supports the development of standardized guidelines for patient advocacy services in Michigan hospitals, including minimum availability, training expectations, and transparency in how patients may access advocacy resources.

Fiscal Note: $4,500-$9,000

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY
Patient Navigation Programs H-373.994
1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs:
a. The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities.
b. Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.
c. Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team.
d. Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide.
e. Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.

2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care.

3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers.

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Resolution: 02-26

Title: Increasing Financial Access to In Vitro Fertilization (IVF) Treatment

Introduced by: Brittany M. Garza, DO, for the Saginaw County Delegation

Author(s): Brittany M. Garza, DO

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, infertility is a recognized disease by the World Health Organization and affects approximately one in six individuals during their reproductive lifetime, with many requiring assisted reproductive technologies (ART), including in vitro fertilization (IVF), to achieve pregnancy; and

Whereas, IVF represents the most effective treatment for numerous causes of infertility, including diminished ovarian reserve, tubal factor infertility, endometriosis, male-factor infertility, and unexplained infertility; and

Whereas, the cost of IVF in Michigan typically ranges from $15,000–$25,000 per cycle including medications, placing significant financial strain on affected individuals and couples, and often making medically necessary care inaccessible; and

Whereas, lack of insurance coverage forces many patients to delay or forgo treatment, which can worsen outcomes, particularly for individuals with advancing maternal age, diminished ovarian reserve, or medical diagnoses requiring timely intervention; and

Whereas, at least 21 states have enacted laws requiring some level of insurance coverage for infertility diagnosis and/or IVF treatment, yet Michigan currently provides no such mandate, resulting in inequitable access to fertility care across the state; and

Whereas, increased financial access to IVF has been associated with decreased rates of high-order multiple gestations, improved prenatal care utilization, and greater overall maternal-fetal safety due to reduced reliance on less-effective, higher-risk treatments; and

Whereas, expanding access to IVF supports family building for a diverse range of patients, including individuals with medical infertility, cancer survivors facing gonadotoxic therapy, LGBTQ+ families, and single intended parents; and

Whereas, there is currently no existing standardized protocol to address this issue, resulting in inconsistent practices and potential gaps in implementation; therefore be it

RESOLVED, that the MSMS advocates for legislation requiring Michigan-based insurers to provide comprehensive and equitable coverage for infertility diagnosis and medically necessary infertility treatments, including in vitro fertilization (IVF); and be it further

RESOLVED, that the MSMS advocates for coverage parity ensuring that infertility care, including in vitro fertilization (IVF), is not subject to more restrictive deductibles, annual caps, exclusions, or lifetime limits than other medical or surgical treatments; and be it further

RESOLVED, that the MSMS supports efforts to expand fertility preservation coverage, including oocyte and sperm cryopreservation, for patients undergoing medical treatments that may impair fertility; and be it further

RESOLVED, that the MSMS supports exploration of additional financial pathways to increase access to in vitro fertilization (IVF) in Michigan, such as tax credits, state-funded grants, Medicaid coverage for medically indicated infertility treatment, and employer incentives.

Fiscal Note: $16,000-$32,000

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY
Safeguarding Access to IVF Amid Restorative Reproductive Medicine Legislation H-425.962

1. Our American Medical Association opposes any efforts to limit patient access to the full scope of evidence-based fertility treatments, including but not limited to: In Vitro Fertilization (IVF).
2. Our AMA should advocate for NIH funding for women's health, including reproductive health, so that we can expand research on the potential underlying causes of infertility.
3. Our AMA acknowledges that practices considered “restorative reproductive medicine” constitute part of what Reproductive Endocrinology and Infertility physicians, Urologists, and other fertility specialists provide in their daily practice through patient-centered evaluation and individualized treatment of underlying conditions.
4. Our AMA acknowledges that IVF is an important part of the comprehensive, evidence-based infertility treatment options that should be offered to patients and is often the most successful option for many patients looking to grow or start their families.

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Resolution: 05-26

Title: Standards for Physician-Directed Medical Spa Care and Public Disclosure

Introduced by: Anthony M. Zacharek, MD, for the Michigan Academy of Plastic Surgeons and the Saginaw County Delegation

Author(s): Natalie Aguilar and Anthony M. Zacharek, MD

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, "medical spa" services consist of procedures that carry medical risk, such as injectables, laser treatments, and other office-based aesthetic interventions, and patients may reasonably assume these services are supervised by a physician; and

Whereas, the term "medical spa" is used inconsistently across settings and may create confusion about who is providing care, the credentials of the supervising clinician, and what safety protocols are in place; and

Whereas, office-based aesthetic procedures can involve complications, including but not limited to vascular occlusion, infection, burns, nerve injury, anaphylaxis, and adverse drug reactions, that require timely medical evaluation and possible intervention; and

Whereas, physician offices that incorporate medical spa services may improve continuity of care and safety when services are delivered under clear physician-led care following appropriate training; and

Whereas, the Michigan State Medical Society (MSMS) is actively advocating against legislation that would expand the scope of practice for nurse practitioners, including House Bill 4399 and Senate Bill 268, which may further increase confusion among the public understanding of provider roles; therefore be it

RESOLVED, that the MSMS advocates for and supports that medical spas operating in Michigan be physician-owned and physician-led, with a licensed physician serving as the provider responsible for clinical protocols, delegation of duties, and complication management, ideally with specialties with established training and expertise in aesthetic medicine such as dermatology and plastic surgery; and be it further

RESOLVED, that the MSMS advocates against ownership and/or operation of medical spas that are independent of physician ownership/physician-directed clinical oversight, with ownership or oversight by non-physicians, such as nurse practitioners, physician assistants, and certified registered nurse anesthetists, which may lead to public confusion regarding physician supervision, undermine accountability for medical decision-making, or compromise patient safety; and be it further

RESOLVED, that the MSMS educates the public on differences in education, clinical training, and scope of practice among providers offering office-based aesthetic and "medical spa" services and promote clear disclosure of the credentials and role of each person providing services.

Fiscal Note: $16,000-$32,000

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY

Addressing Safety and Regulation in Medical Spas D-35.983

1. Our American Medical Association will advocate for state regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as "medically necessary" procedures, including those which require appropriate training, supervision and oversight.
2. Our AMA will advocate that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine.
3. Our AMA will take steps to increase the public awareness about the dangers of those medical spas which do not adhere to patient safety standards by encouraging the creation of formal complaint procedures and accountability measures in order to increase transparency.
4. Our AMA will continue to evaluate the evolving issues related to medical spas, in conjunction with interested state and medical specialty societies.

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Resolution: 07-26

Title: Pregnancy-Related Health Coverage for Uninsured Individuals

Introduced by: Kai Anderson, MD, for the Saginaw County Delegation

Author(s): Kai Anderson, MD, and Anushree Jagtap, MD

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, timely prenatal, delivery, and postpartum care are clinical necessities that reduce preventable maternal morbidity and adverse neonatal outcomes; and

Whereas, Michigan has demonstrated a commitment to maternal health by providing 12 months of continuous postpartum Medicaid coverage and enacting the Reproductive Health Act (PA 286 of 2023); and

Whereas, significant coverage gaps remain for residents who are ineligible for Medicaid yet cannot afford private insurance, leading to increased uncompensated care and threatening the sustainability of rural hospitals; and

Whereas, ongoing state legislative and regulatory initiatives prioritize expanded access to essential services, such as group prenatal care and mental health screenings, establishing a clear policy framework for advancing maternal health equity; and

Whereas, clinical and administrative staff often lack standardized protocols or resources to identify these "gap" patients and facilitate their transition to alternative coverage options; therefore be it

RESOLVED, that the MSMS supports policies ensuring comprehensive pregnancy-related health coverage for individuals who are ineligible for Medicaid and unable to afford private insurance; and be it further

RESOLVED, that the MSMS supports closing health care insurance coverage gaps through eligibility expansion, state-funded options, or public-private bridge programs that ensure continuous care from pregnancy confirmation through 12 months postpartum; and be it further

RESOLVED, that the MSMS supports the development of clinical and administrative best practices to assist healthcare facilities in identifying pregnant patients at risk of being uninsured and connecting them with appropriate coverage resources; and be it further

RESOLVED, that the MSMS promotes expanded pregnancy coverage as a vital strategy for workforce stability, rural hospital sustainability, and the reduction of high-cost emergency utilization.

Fiscal Note: $4,500-$9,000

REFERENCES

1. MCL 333.26103 (Reproductive Health Act / Act 286 of 2023): This statute establishes a fundamental right to reproductive freedom in Michigan, explicitly defining it to include "prenatal care, childbirth, [and] postpartum care" within the scope of pregnancy-related decisions.
2. MDHHS: Healthy Moms Healthy Babies: Michigan officially implemented 12 months of continuous postpartum Medicaid coverage following federal approval on April 14, 2022, ensuring continuity of care for roughly 45,000 postpartum mothers annually.
3. SB 414 and SB 415 (2025–2026): These bills would require commercial insurers and Michigan Medicaid to cover evidence-based group prenatal care services, including peer-to-peer interaction and family-centered education. Both bills passed the Michigan Senate on July 1, 2025, and are pending in the House.
4. Public Act 246 of 2024 (HB 5169): This act requires health professionals to offer mental health screenings and resources to postpartum individuals during follow-up or well-child visits. It is effective April 2, 2025, with Medicaid coverage for these screenings required to begin by January 1, 2026.

5. HR 59 and SR 24 (2025): These resolutions declared April 11–17, 2025, as Black Maternal Health Week in Michigan to acknowledge significant racial disparities in maternal mortality and the critical need for equitable healthcare access.
6. SR 50 (2025): Adopted on May 20, 2025, this resolution urges the federal government to fully fund Medicaid and reject any proposals that would shift costs onto states, health care providers, or vulnerable individuals.

RELEVANT MSMS POLICY

Automatic and Affordable Health Insurance Coverage for All

MSMS supports affordable health insurance coverage for Americans.

Insurance Coverage of Perinatal Mental Health Services

MSMS supports inclusive private and public insurance coverage of, and sufficient payment for, all mental health services during pregnancy and the postpartum period.

RELEVANT AMA POLICY

Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917

1. Our American Medical Association acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:
    a. Informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
    b. Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
    c. Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.
6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.

11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.
12. Our AMA supports research to reduce disparities in maternal health outcomes, including research on the long-term health sequelae and treatment of pregnancy-related diseases and diseases diagnosed or identified during pregnancy.
13. Our AMA supports further insurance coverage for conditions related to long-term sequelae of pregnancy.
14. Our AMA supports appropriate organizations working to improve awareness and education among patients, families, and clinicians of the risks of long-term sequelae of pregnancy.

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Resolution: 11-26

Title: Additional Nurse Practitioner Certification to Protect Patients

Introduced by: E. Chris Bush, MD, for the Wayne County Delegation

Author(s): E. Chris Bush, MD

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, the professional often encountered by a patient is a nurse practitioner or physician assistant; and

Whereas, these professionals are found in diverse practice settings; and

Whereas, the degree of physician supervision of these non-physician practitioners is not always clear to the patient; and

Whereas, a nurse practitioner may practice in many different specialties during his/her career; and

Whereas, only the following certifications are recognized by the Michigan Department of Licensing and Regulatory Affairs (LARA): Pediatric Nursing, Women's Health Nursing, Neonatal Nursing, Emergency Nursing, Family Nursing, Adult-Gerontology Nursing, Oncology Nursing, and Acute Critical Care Nursing; and

Whereas, LARA does not stipulate a certification for the specialties including but not limited to cardiology, pulmonary medicine, urology, nephrology, general surgery, and neurosurgery; and

Whereas, many nurse practitioners frequently change jobs and one day they may be practicing orthopedics and the next day neurosurgery; and

Whereas, the public may be at risk when being seen by an incompletely trained or inexperienced nurse practitioner; therefore be it

RESOLVED, that the MSMS will work with the Legislature to draft a bill directing the Michigan Department of Licensing and Regulatory Affairs to formulate language that stipulates that nurse practitioners obtain certification in those fields in which they practice; and be it further

RESOLVED, that the MSMS works with the Michigan Department of Licensing and Regulatory Affairs to require certification for commonly used specialty fields; and be it further

RESOLVED, that the MSMS works with the Michigan Department of Licensing and Regulatory Affairs to develop guidelines requiring maintenance of certification for all nurse practitioners.

Fiscal Note: $16,000-$32,000

REFERENCES

1. Regulations from the Michigan Department of Licensing and Regulation

RELEVANT MSMS POLICY

Oppose Scope of Practice Expansion for Allied Health Care Professionals

MSMS opposes scope of practice changes for non-physician health care professionals that are not supported by their level of education and training.

RELEVANT AMA POLICY

None

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Resolution: 12-26

Title: Eliminate Prior Authorization for Low-Cost Medications and Procedures

Introduced by: E. Chris Bush, MD, for the Wayne County Delegation

Author(s): E. Chris Bush, MD

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, the Michigan State Medical Society has advocated and successfully achieved passage of legislation to reform prior authorization; and

Whereas, despite the enactment of these laws, most clinicians are faced with more prior authorization requests than ever; and

Whereas, these impediments to patient care are time-consuming, frustrating, and certainly contribute to physician and staff burnout; and

Whereas, many simple, inexpensive drugs and procedures are now being delayed or denied by prior authorization requirements; and

Whereas, at the national level the American Medical Association passed Resolution 808 at the November 2025 Interim House of Delegates meeting; and

Whereas, the resolution stated that "Resolved that our AMA advocate that low-cost medications and procedures shall not require a Prior Authorization"; therefore be it

RESOLVED, that the MSMS advocates and engages with the executive and legislative branches of the government of the State of Michigan to eliminate prior authorization requirements for low-cost medications and procedures; and be it further

RESOLVED, that the MSMS works with the appropriate State of Michigan leaders and departments to further delineate the medications and procedures to be exempted from prior authorization requirements.

Fiscal Note: $16,000-$32,000

RELEVANT MSMS POLICY

Prior Authorization Reform

MSMS supports the American Medical Association's 21 guiding principles to reform prior authorization requirements and will utilize the principles as a guide for prior authorization reform.

Compensation for Prior Authorization Efforts

MSMS supports working with Michigan insurance companies to study the effectiveness, efficiency, and outcomes of prior authorization processes with the goal of minimizing the burden of prior authorization activities and eliminating non-value added processes including, but not limited to, such issues as value, efficiency, and compensation.

Prior Authorization for Delivery

MSMS opposes the current practice/rule requiring prior authorization for elective delivery of any patient.

Prior Authorization for Surgical Procedures
MSMS supports requiring Michigan health plans to finalize their decisions on "prior authorization" at least one calendar week before the scheduled procedure.

RELEVANT AMA POLICY
No Prior Authorization for Inexpensive Medications D-320.968
Our American Medical Association advocates that low-cost medications and procedures should not require prior authorization.

Prior Authorization Reform D-320.982
Our American Medical Association will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Utilization Review, Medical Necessity Determination, Prior Authorization Decisions D-320.977
a. Our American Medical Association will advocate for implementation of a federal version of a prior authorization "gold card" law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations.
b. Our AMA will advocate that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a "gold-card" or "preferred provider program."

Advocating Against Prior Authorization for In-Person Visits with Physicians D-320.970
Our AMA advocates against health insurance plan policies that require prior authorization for in-person visits with a physician.

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 13-26

Title: Enhance Physician Value Based Care Literacy

Introduced by: Gaurav Sharma, MD, for the Wayne County Delegation

Author(s): Courtland Keteyian, MD, and Gaurav Sharma, MD

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, physicians across Michigan increasingly participate in value-based care (VBC) models such as shared savings arrangements, bundled payments, and accountable care organizations; and

Whereas, these models rely on specialized terms—including risk adjustment, attribution, benchmarking, quality measurement, and total cost of care—that may not be part of traditional medical education; and

Whereas, strengthening VBC literacy supports physicians in contributing effectively to quality improvement efforts, clinical operations, and organizational decision making that affect patient care; and

Whereas, a clear, accessible glossary of VBC terms would provide physicians with a practical resource to improve understanding, promote shared language, and support informed participation in discussions about care delivery and performance; therefore be it

RESOLVED, that the MSMS supports efforts to enhance physician understanding of value-based care concepts, including through educational programming and the development of a voluntary, physician focused glossary designed to promote shared and consistent terminology across Michigan; and be it further

RESOLVED, that the MSMS, as appropriate, collaborates with interested specialty societies and subject matter experts to review, develop, and disseminate information to support the creation of an accurate, accessible glossary aligned with current value-based care terminology, standards, and practices in Michigan.

Fiscal Note: $2,000-$4,000

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RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY
None

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Resolution: 16-26

Title: Modernizing Organ Acquisition Reimbursement to Support Normothermic Machine Perfusion and Ensure Equitable Patient Access

Introduced by: M. Salim Siddiqui, MD, PhD, for the Wayne County Delegation

Author(s): Marwan Abouljoud, MD, Shunji Nagai, MD, PhD, and M. Salim Siddiqui, MD, PhD

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, normothermic machine perfusion (NMP), including portable perfusion systems used during procurement and transport, has become an important component of contemporary liver transplantation practice by enabling greater utilization of extended-criteria organs, reducing organ discard, and improving timely access to lifesaving transplantation; and

Whereas, high-volume programs in Michigan, such as Henry Ford Hospital, have utilized NMP to increase transplant volume significantly (e.g., from 120 cases in 2024 to 175 cases in 2025), positioning Michigan adult liver transplant centers among the top 10 nationally; and

Whereas, from a reimbursement and accounting perspective, the costs of organ preservation and perfusion services (including NMP-related technology, specialized personnel, and associated procurement logistics) are incorporated within the Organ Acquisition Charge (OAC), and the policy issue is therefore not solely one of separate device reimbursement rather of adequate modernization of organ acquisition reimbursement methodologies and rates; and

Whereas, evolving federal oversight and organ allocation practices, including Health Resources & Services Administration/Organ Procurement and Transplantation Network (HRSA/OPTN)-driven expectations to increase organ utilization, broader geographic sharing, and increased procurement travel and ischemic time challenges, have increased reliance on modern organ preservation strategies to safely utilize extended-criteria organs and maintain high-quality transplant outcomes; and

Whereas, there exists a profound disparity in the commercial insurance landscape, where major regional payers, such as Blue Cross Blue Shield of Michigan (BCBSM), consistently fail to adequately update organ acquisition reimbursement methodologies and rates to reflect the changing landscape in organ preservation, including increased procurement travel and operational complexity driven by evolving allocation practices and national expectations to maximize utilization of extended-criteria organs; and

Whereas, the lack of adequate reimbursement by dominant regional payers often also results in NMP coverage being used as a “bargaining chip” in broader health system contract negotiations rather than being evaluated on its independent clinical and economic merits; and

Whereas, this regional market failure creates a two-tiered system of care where Michigan patients may face reduced access to life-saving technology compared to patients in other regions (e.g., Mayo Scottsdale) where commercial reimbursement is already established; therefore be it

RESOLVED, that our MSMS advocates with Michigan commercial payers, and as appropriate engage the Michigan Department of Insurance and Financial Services (DIFS), to modernize organ acquisition reimbursement methodologies and rates to ensure that acquisition payments appropriately reflect contemporary organ

preservation practices (including NMP) and procurement travel/logistical realities, thereby preventing financial barriers from restricting equitable access to liver transplantation for Michigan patients; and be it further

RESOLVED, that the Michigan Delegation to the American Medical Association (AMA) asks our AMA to support national efforts to reduce state-by-state variability in organ acquisition reimbursement adequacy by promoting best-practice payer frameworks aligned with contemporary organ allocation and utilization realities; and be it further

RESOLVED, that the Michigan Delegation to the American Medical Association (AMA) asks our AMA to support appropriate recognition and valuation through relevant coding and payment (i.e., CPT and RUC) processes, of the evolving physician work and technical specialty services involved in ex vivo organ management and contemporary organ recovery/preservation practices, so that physicians and transplant programs are not penalized for delivering evidence-based modern transplant care.

Fiscal Note: $12,000-$24,000

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6. Centers for Medicare & Medicaid Services. Organ acquisition costs. Accessed February 12, 2026. https://www.govinfo.gov/content/pkg/CFR-2024-title42-vol2/pdf/CFR-2024-title42-vol2-sec413-402.pdf
7. OPTN Strategic Plan — Explicit Goals Targeting Organ Use - This plan (approved by the OPTN Board) includes Goal 2: Optimize organ use, with objectives and metrics directly aimed at reducing non-use (organ discard) rates: "Collaborate with stakeholders to identify and reduce key barriers influencing organ non-use and non-utilization" and Metrics include decreasing non-use rates for kidney and liver organs. This constitutes a formal, strategic mandate for reducing "discard" or organs recovered but not transplanted. Reference: Organ Procurement and Transplantation Network. OPTN Strategic Plan 2025–2028 (with organ non-use reduction objectives). HRSA; 2025. Available from HRSA OPTN website https://www.hrsa.gov/optn/about/strategic-plan?utm_source=chatgpt.com
8. OPTN/UNOS White Paper — Focus on Increased Organ Usage - A UNOS/HRSA-linked paper discussing strategies to improve organ acceptance and reduce unused organs shows: HRSA directed OPTN to remove Donor Service Area (DSA) boundaries from allocation, a reform intended to increase fairness and opportunities for organ placement and OPTN/UNOS acknowledge organ non-use as a key metric and list initiatives (offer filters, predictive tools, acceptance collaboratives) aimed at increasing utilization and reducing non-use. Reference: United Network for Organ Sharing. Saving More Lives Through Increased Organ Usage. UNOS/HRSA; 2024. PDF on organ non-use and utilization improvement strategies. https://unos.org/wp-content/uploads/Saving-More-Lives-Through-Increased-Organ-Usage.pdf?utm_source=chatgpt.com

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY

Increasing Organ Donation H-370.971
Our American Medical Association recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care.

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.

AMA MEMBERSHIP ATTESTATION
Pursuant to approved HOD Resolution 65-14, any resolutions "submitted to the MSMS House of Delegates that require action by the AMA may only be submitted by MSMS members that are also members of the AMA."

Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool H-370.958

1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation.
2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.
3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation.

I am a current member of the American Medical Association.
☒ Yes
☐ No

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Resolution: 17-26

Title: Confidentiality of Peer Support Programs within Michigan

Introduced by: Thomas Klein, MD, MPH, for the American College of Obstetricians & Gynecologists, Michigan Section

Author(s): Thomas Klein, MD, MPH

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, physicians often face challenging, stressful, and difficult situations throughout their professional careers, including but not limited to adverse events and medical errors, which can lead to mental and emotional distress, as well as burnout; and

Whereas, the American Medical Association has placed a strong emphasis on physician wellbeing, with support of and passage of acts such as the Dr. Lorna Breen Healthcare Provider Protection Act; and

Whereas, the American Psychiatric Association recommends peer support as a way to address such significant professional events and stressors for physicians; and

Whereas, peer support through supportive discussions with peers who share one's professional background is often preferred by physicians; and

Whereas, principles for peer support include confidentiality, empathetic listening, voluntary participation, and reinforcement of coping skills; and

Whereas, peer support programs have been developed both within health care systems and within many specialty medical societies throughout the country; and

Whereas, peer support programs often provide trained peer-support physicians but are not considered professional counseling or therapy, and physicians are encouraged to seek out further professional and/or medical help as required; and

Whereas, peer support programs strive to maintain strict confidentiality with the exception of cases in which the peer may cause harm to others or themselves; and

Whereas, peer support is not peer review, root cause analysis, or a legal discussion; and

Whereas, other states, such as Arizona and Washington, have enacted confidentiality protections for participants of peer support and health professional wellness programs such that a physician's participation in and conversations within such a program are "confidential and not subject to discovery, subpoena, or a reporting requirement to the applicable health profession regulatory board," unless to report criminal conduct, unprofessional conduct, concern for safety to practice, or concern for imminent harm to self or others; and

Whereas, peer support programs within the state of Michigan are not currently protected from discovery, subpoena, or reporting; and

Whereas, there are no Michigan state legislative measures protecting the confidentiality of peer support discussions or physician wellness groups acting with the intent to promote physician wellness and reduce burnout; therefore be it

RESOLVED, that the MSMS advocates for confidential physician support and wellness programs to support the physical, mental, and emotional wellbeing of physicians; and be it further

RESOLVED, that the MSMS will advocate for the creation and passage of legislation that would provide that communications among participants of physician peer support or wellness programs within the state of Michigan be confidential, not to be used for administrative or judicial processes, and not subject to discovery, subpoena, or admissible as evidence except in cases that a peer supporter has a duty to report.

Fiscal Note: $16,000-$32,000

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RELEVANT MSMS POLICY

Homicidal Ideation Risk Assessment
MSMS supports the identification and dissemination of practical remedies to help all Michigan primary care physicians and their colleagues learn how to assess for homicidal ideation in order to identify persons poised to commit homicide.

Suicide Awareness and Intervention Training Programs
MSMS supports training programs in the use of integrated multidisciplinary approaches to suicide awareness and intervention for health care professionals including physicians, advanced practice nurses, physician assistants, registered nurses, and mental health professionals.

Suicide Prevention Awareness and Education
MSMS supports efforts to raise awareness about the rising rate and devastating toll of suicide; to increase suicide prevention education for all physicians, residents, medical students, and allied health professionals; to encourage active engagement in suicide prevention awareness with their patients and colleagues; to increase research associated with suicides; and to reduce liability for those who provide suicide prevention care.

Support for Mental Health Reform in Michigan
MSMS supports efforts to improve mental health services in Michigan, including those that address mental health disparities, promote interdepartmental coordination and shared accountability, and provide greater access to timely outpatient

treatment, crisis intervention, specialty behavioral health services, inpatient psychiatric hospitalizations and other medically necessary related therapies.

RELEVANT AMA POLICY

Peer Support Groups for Second Victims (D-405.980)
Our AMA: (1) encourages institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the “second victim phenomenon”; and (2) will work with other interested organizations to encourage that any future surveys of physician burnout should incorporate questions about the prevalence and potential impact of the “second victim phenomenon” on our physician workforce.

Access to Confidential Health Services for Medical Students and Physicians (H-295.858)

1. Our American Medical Association will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
    a. provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that:
        i. include appropriate follow-up;
        ii. are outside the trainees' grading and evaluation pathways; and
        iii. are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
    b. ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
    c. encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
    d. remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages undergraduate and graduate medical education programs to create mental health substance use awareness and suicide prevention screening programs that would:
    a. be available to all medical students, residents, and fellows on an opt-out basis;
    b. ensure anonymity, confidentiality, and protection from administrative action;
    c. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
    d. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA:
    a. encourages state medical boards to consider physical and mental conditions similarly;

    b. encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and
    c. encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA:
    a. encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide;
    b. encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and
    c. will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as:
    a. introduction to the concepts of physician impairment at orientation;
    b. ongoing support groups, consisting of students and house staff in various stages of their education;
    c. journal clubs;
    d. fraternities;
    e. support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or
    f. the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

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Resolution: 18-26

Title: Nondiscrimination and Advocacy for Patients with Opioid Use Disorder in Post-Acute Care Settings

Introduced by: Thomas Klein, MD, MPH, for the Michigan Section of the American College of Obstetricians and Gynecologists

Author(s): Thomas Klein, MD, MPH, and Amanda Wewer

Referred to: Reference Committee on Payer and Legislative Advocacy

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Whereas, there is a growing population of adults diagnosed with opioid use disorder (OUD) requiring post-acute care facility placements; and

Whereas, methadone maintenance treatment (MMT) is an evidence-based treatment for OUD to reduce illicit opioid use, improve treatment retention, and decrease mortality; and

Whereas, post-acute care facilities have been documented to deny patients based on prescribed medications for opioid use disorder (MOUD) or impose arbitrary limitations on methadone dosage, resulting in prolonged hospitalizations, suboptimal discharge, and reduced access to high-quality post-acute care; and

Whereas, opioid use disorder is recognized as a disability and discrimination against patients with OUD or MOUD violates the Americans with Disabilities Act; and

Whereas, post-acute care facilities face logistical, regulatory, staffing, and financial barriers to providing methadone to patients; therefore be it

RESOLVED, that the MSMS affirms and advocates for legislation that patients with opioid use disorder, including those receiving medications for opioid use disorder, must not be denied admission to post-acute care facilities on the basis of this diagnosis or treatment; and be it further

RESOLVED, that the MSMS advocates for state-level funding mechanisms to support post-acute care facilities in providing care for patients receiving medications for opioid use disorder, including incentives for partnerships between post-acute care facilities and opioid treatment programs; and be it further

RESOLVED, that the MSMS collaborates with state agencies, health systems, and community organizations to develop guidance and best practices for integrating medications for opioid use disorder into post-acute care facilities; and be it further

RESOLVED, that the MSMS advocates for modernization of federal methadone regulations that would increase access to medications for opioid use disorder, such as waivers for post-acute care facilities or pharmacist-dispensing models.

Fiscal Note: $16,000-$32,000

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RELEVANT MSMS POLICY

Addiction a Disease
MSMS recognizes drug addiction as a disease.

Addiction Treatment, Facilities, and Services
MSMS supports enhanced availability of and access to addiction treatment, facilities, and services within the State of Michigan.

Expand Access to Medication for the Treatment of Opioid Use Disorder
MSMS recommends the removal of legislative, regulatory, and other barriers to the use of medications for opioid use disorder.

RELEVANT AMA POLICY

Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD) D-95.955
Our American Medical Association advocates to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder.
Our AMA advocates that our federal, state, and local governments remove barriers to evidence-based treatment for substance use disorders, including medications for opioid use disorder, at skilled nursing facilities.
Our AMA advocates that Medicare and Medicaid, including managed care organizations, remove barriers to coverage and treatment for substance use and opioid use disorder, including medications for opioid use disorder, in skilled nursing facilities.

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985

1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.
3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.

Support the Elimination of Barriers to Evidence-Based Treatment for Substance Use Disorders D-95.968

1. Our American Medical Association will:
    a. advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities.
    b. develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medications for opioid use disorder (MOUD) and other evidence-based options as first-line treatments for this chronic medical disease.
2. Our AMA will support further research into how primary care practices can implement MOUD into their practices and disseminate such research in coordination with primary care specialties.
3. Our AMA Substance Use and Pain Care Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
4. Our AMA will support increased access to affordable, accessible transportation for individuals to obtain evidence-based treatment for substance use disorders.

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 22-26

Title: Rescind MSMS Policy Opposing the Interstate Medical Licensing Compact

Introduced by: Richard Burney, MD, for the Washtenaw County Delegation

Author(s): Richard Burney, MD

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, the MSMS House of Delegates adopted policy, "Opposing the Federation of State Medical Boards Interstate Medical Licensure Compact," in 2015 to oppose the Interstate Medical Licensing Compact (IMLC) via the approval of Resolution 48-15, and

Whereas, at the time there was concern about the inability to modify terms of the compact and whether certain provisions could result in an effort to advance mandatory maintenance of certification (MOC) as a condition of licensure in Michigan, and

Whereas, this policy remains in effect despite the fact that Michigan joined the IMLC in 2019 following the passage of authorizing legislation (Public Acts 524 and 563 of 2018) and that Michigan also passed legislation (Public Act 486 of 2018) prohibiting the Michigan Department of Licensing and Regulatory Affairs or the Boards of Medicine or Osteopathic Medicine and Surgery requiring MOC as a condition of licensure, and

Whereas, Michigan's IMLC statute included a three-year sunset provision which was extended in 2022 from March 28, 2022 to March 28, 2025 by Public Act 38 of 2022; and

Whereas, the Legislature's failure to extend or eliminate the sunset clause last year has resulted in the repeal of Michigan's statute authorizing participation in the IMLC, and

Whereas, Michigan has begun the process of withdrawing from the IMLC, and

Whereas, physician participation in the IMLC has not been proven to negatively impact quality of care, but instead is viewed to be beneficial to both patients and physicians, and

Whereas, obtaining a license through the IMLC takes three to five business days in most states, while primary verification may take up to three months, and

Whereas, it is estimated that thousands of physicians currently licensed in Michigan utilized the IMLC including physicians seeking locum tenens employment in- and out-of-state, and

Whereas, Michigan's exit from the IMLC would result in hardships to physicians utilizing this pathway, as well as to timely access to care delivered by physicians, and

Whereas, Michigan's statute needs to be reinstated so that Michigan's participation in the IMLC can continue beyond the final withdrawal date of March 28, 2026, and

Whereas, the current MSMS policy does not permit MSMS to advocate for continuation of the IMLC in Michigan, therefore be it

RESOLVED, that our MSMS policy, "Opposing the Federation of State Medical Boards Interstate Medical Licensure Compact," be rescinded, and be it further

RESOLVED, that our MSMS actively supports legislation to renew Michigan's membership in the Interstate Medical Licensure Compact.

Fiscal Note: $16,000 - $32,000

RELEVANT MSMS POLICY

Opposing the Federation of State Medical Boards Interstate Medical Licensure Compact
MSMS opposes participation with the Federation of State Medical Boards' Interstate Medical Licensure Compact.

RELEVANT AMA POLICY

Facilitating Credentialing for State Licensure D-275.994

1. Our American Medical Association encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible.
2. Our AMA will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions.
3. Our AMA encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license.
4. Our AMA supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 23-26

Title: Restoring the Prerogatives of the Michigan Board of Medicine

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Author(s): Richard E. Burney, MD

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, the Michigan Board of Medicine is one of the weakest state medical boards in the country, unable to function even quasi-independently by virtue of it being only “advisory” to the Michigan Department of Licensing and Regulatory Affairs (LARA) and other restrictions; and

Whereas, the Michigan Board of Medicine is not a co-equal member, with the Attorney General’s office and the Department of Licensing and Regulatory Affairs, in overseeing professional medical practice of doctors of medicine in the state, and is unnecessarily subservient to the Department and subject to unrealistic requirements, such as those as stipulated in MCL 333.16231; and

Whereas, the Michigan Board of Medicine has no dedicated administrative support or budget that would enable it to function as a true Board, despite the state collecting over $1 million per year in medical licensing fees; and

Whereas, because appointments to the Board of Medicine are made by the Governor, it is considered to be a part of the executive branch of state government and as such is prohibited from contacting or communicating with legislators or offering opinions on any legislative proposals, such as current House Bill 5313, even when they directly affect how the Board functions; therefore be it

RESOLVED, that our MSMS seeks opportunities to strengthen the Michigan Board of Medicine by restoring prerogatives that have been stripped away over the years.

Fiscal Note: $2,000 - $4,000

REFERENCES

1. Public Health Code 333.16231 Allegation; review; investigation; compliance conference; duties of department following investigation; confidentiality of identity; complaint; failure to respond;
   conditions applicable to subsection (2)(a); "conflict of interest" defined.
   Sec. 16231. (1) A person or governmental entity that believes that a violation of this article, article 7, or
   article 8 or a rule promulgated under this article, article 7, or article 8 exists may submit an allegation of that fact to the department in writing.
   (2) Subject to subsection (3) and section 16221b, if the department determines after reviewing an
   application or an allegation or a licensee's or registrant's file under section 16211(4) that there is a reasonable basis to believe that a violation of this article, article 7, or article 8 or a rule promulgated under this article, article 7, or article 8 exists, 1 of the following applies:
   Unless subdivision (b) applies, subject to subsection (10), with the authorization of a panel of at least 3 board members that includes the chair and at least 2 other members of the appropriate board or task force designated by the chair, the department shall investigate the alleged violation. Subject to subsection (10), if the panel fails to grant or deny authorization within 7 days after the board or task force receives a request for authorization, the department shall investigate. If the department believes that immediate jeopardy exists, the director or his or her designee shall authorize an investigation and notify the board chair of that investigation within 2 business days.
   From Board Member Orientation materials:
   The Department and the AG's office strive to work with the board conferee to propose appropriate sanction to resolve, but the Department and AG are not required to agree to conferee's proposed resolution. Conversely, conferee does not have to agree to support Department or AG proposed resolution. Department or AG can submit proposed Consent Order & Stipulation without board member support.
   333.16216.amended Disciplinary subcommittee for board or task force; members; voting;
   chairperson; final decision of disciplinary subcommittee; set aside by department; issuance of different final action; inclusion of final decision on website.
   Sec. 16216.
   (1) The chair of each board or task force shall appoint 1 or more disciplinary subcommittees
   for that board or task force. A disciplinary subcommittee for a board or task force shall consist of 2 public members and 3 professional members from the

board or task force. The chair of a board or task force shall not serve as a member of a disciplinary subcommittee.
(2) A final decision of the disciplinary subcommittee finding a violation of this article, article 7, or article 8 shall be by a majority vote of the members appointed and serving on the disciplinary subcommittee.
(3) A final decision of the disciplinary subcommittee imposing a sanction under this article, article 7, or article 8 or a final decision of the disciplinary subcommittee other than a final decision described in subsection (2) requires a majority vote of the members appointed and serving on the disciplinary subcommittee with an affirmative vote by at least 1 public member.
(4) The chairperson of each disciplinary subcommittee shall be a public member and shall be appointed by the chair of the board or task force.
(5) The department may review a final decision of the disciplinary subcommittee within 30 days after the date of the disciplinary subcommittee's decision. If the department determines that the action taken by the disciplinary subcommittee does not protect the health, safety, and welfare of the public, the department, with the approval of the board chair, may set aside the decision of the disciplinary subcommittee and issue a different final action. The final action of the department shall serve as the final action on the matter and is subject to judicial review in the same manner as the final decision of the disciplinary subcommittee.
(6) Beginning January 1, 2015, the department shall include on its public licensing and registration website each final decision where disciplinary action is taken against a licensee, including the reason for and description of that disciplinary action.
History: Add. 1993, Act 87, Eff. Apr. 1, 1994;.Am. 2013, Act 268, Imd. Eff. Dec. 30, 2013;.Am. 2014, Act 98, Eff. July 1, 2014.
Compiler's note: Former MCL 333.16216, which pertained to disciplinary subcommittee for board or task force, was repealed by Act 87 of 1993, Eff. Apr. 1, 1994

RELEVANT MSMS POLICY

Fees to be Returned
All medical licensing fees should be returned to the Michigan Board of Medicine.

Transparency Within the Board of Medicine
MSMS support efforts to protect the citizens of Michigan by assuring transparency within the Michigan Board of Medicine by strengthening policies against conflicts of interest by requiring attestation of the lack of any conflict on a case by case basis, and other efforts to assure that conflicts of interest of this nature do not occur.

RELEVANT AMA POLICY

Protecting State Medical Licensing Boards from External Political Influence D-270.984
Our American Medical Association will work with the Federation of State Medical Boards and other interested parties to minimize external interference with the independent functioning of state medical disciplinary and licensing boards.

Principles of Due Process for Medical License Complaints D-275.964

1. Our American Medical Association will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians' rights.
2. Our AMA takes the position that:
   a. when a state medical board conducts an investigation or inquiry of a licensee applicant's quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant.
   b. when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given:
      i. A minimum of 30 days to respond to inquiries or requests from a state medical board.
      ii. Prompt board decisions on all pending matters.
      iii. Sworn expert review by a physician of the same specialty
      iv. A list of witnesses providing expert review.
      v. Exculpatory expert reports, should they exist.

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relationship, or engages in any activity, or has any personal financial or commercial interest that might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters. (Board Action Report #4, 2000 HOD, re Res10-99A & Res13-99A)

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Title: Expand Michigan Medicaid Coverage for Continuous Glucose Monitors

Introduced By: Nick Bara for the Medical Student Section

Author(s): Sandra Messiha, Grace Nolan, Rohit Ray, and Nevin Zia

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, continuous glucose monitors (CGMs) are an integral tool that improves treatment adherence and outcomes for patients with type I or type II diabetes; and

Whereas, insurance coverage of CGMs has traditionally been limited to conditions of type-I, insulin-dependent type-II, and gestational diabetes; and

Whereas, Michigan Medicaid coverage of CGMs is currently limited to persons with type-I diabetes or gestational diabetes without prior authorization, or type-II diabetes with at least once daily insulin injection with required prior authorization that introduces administrative delays and access barriers; and

Whereas, CGMs support more efficacious glycemic control as evidenced by reduced glycemic index, reduced glycemic variability, and decreased occurrence of hypoglycemic events among insulin-dependent and insulin-independent diabetics; and

Whereas, non-insulin dependent persons with type-II diabetes benefit clinically from using CGMs as evidenced by improved HbA1c and time-in-range, as well as improved lifestyle and behavior modifications, strengthened self-efficacy, and lower levels of diabetes-related distress; and

Whereas, persons with type-II diabetes and using CGMs that were treated with insulin but achieve improved glycemic control to the extent that they can transition to alternative therapies, lose Medicaid coverage for CGMs; and

Whereas, persons with type-II diabetes and using CGMs that were historically treated with insulin but are candidates for newer GLP-1 drugs that may better manage their condition, lose Medicaid coverage for CGMs; and

Whereas, Medicaid programs in states including Delaware, Indiana, Kentucky, New York, and Minnesota have removed prior authorization requirements for CGMs as a pharmacy benefit for type I and type II diabetes, decreasing the paperwork burden on healthcare providers and improving timely access of CGMs for patients; and

Whereas, approximately 13 percent of adults in Michigan have diagnosed diabetes, with type II diabetes accounting for the majority of cases, and Medicaid beneficiaries are disproportionately affected; and

Whereas, poorly controlled type II diabetes contributes to preventable hospitalizations, emergency department visits, and long-term complications including nephropathy, neuropathy, and cardiovascular disease which increase Medicaid expenditures; therefore be it

RESOLVED, that our MSMS supports Michigan Medicaid covering continuous glucose monitors (CGM) for individuals whose improved glycemic control allows transition from insulin therapy to alternative regimens and persons with type-II diabetes who are not treated with insulin.

Fiscal Note: $1,000 - $2,000

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RELEVANT MSMS POLICY

None

RELEVANT AMA POLICY

Coverage for Continuous or Flash Glucose Monitoring Devices D-480.959
Our American Medical Association will advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective continuous or flash glucose monitoring devices.

Coverage of Continuous Glucose Monitoring Devices H-330.885
Our American Medical Association supports efforts to achieve coverage of continuous and flash glucose monitoring devices for patients when it is evidence-based and determined appropriate by physicians.

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Resolution: 32-26

Title: Support for Equity-Focused Scoliosis Screening in Michigan Public Schools

Introduced by: Nick Bara for the Medical Student Section

Author(s): Connor Plagens

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, adolescent idiopathic scoliosis (AIS) is the most common spinal deformity in children, affecting 2-4 percent of adolescents; and

Whereas, if left untreated, AIS can commonly lead to cosmetic changes and physiological distress, and more severe cases resulting in rib deformities and respiratory compromise; and

Whereas, early identification is crucial because non-surgical management such as bracing can greatly reduce AIS progression, which greatly improves patient quality of life[3]; and

Whereas, Michigan has widespread primary care access barriers, many counties such as Wayne, Clare, Gladwin, Cass, Presque Isle, and Oscoda are listed as Health Professional Shortage Areas, indicating a shortage of clinicians providing preventative services based on geographic or population-based limitations; and

Whereas, Massachusetts, Texas, and New York all have adopted policies that mandate integrated scoliosis screening into their existing public school structure; and

Whereas, national pediatric and orthopedic organizations (American Academy of Orthopedic Surgeons, Pediatric Orthopedic Society of North America, American Academy of Pediatrics) jointly support scoliosis screening to implement effective non-operative treatment and prevent the gravity of AIS progression[9]; and

Whereas, preventing the progression of AIS can reduce patient and systemic-level economic burden, with scoliosis surgery reported to cost roughly $120,000; and

Whereas, preventing severe AIS can reduce disturbances in body image and the accompanying psychological impacts for adolescent patients; and

Whereas, Michigan law currently permits school districts to employ registered nurses who can provide simple AIS screening methods in the most at-risk populations[2]; therefore be it

RESOLVED, that our MSMS supports targeted adolescent idiopathic scoliosis screening initiatives in school districts where routine childhood wellness screenings are not reliably accessible; and be it further

RESOLVED, that our MSMS encourages collaboration amongst school districts, local health departments, pediatric primary care and orthopedic departments in prioritizing efficient referral pathways for adolescent idiopathic scoliosis treatment in Michigan.

Fiscal Note: $1,000 - $2,000

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RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY
None

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
Excerpt from the MSMS Policy Manual:

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☑ The author(s) have no conflict(s) of interest to disclose
☐ The author(s) has/have the following conflict(s) of interest to disclose:

DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS

Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires authors to disclose any current, very similar, or pending resolutions at other state medical societies of which they are aware.

☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 33-26

Title: Expand Medicaid Coverage for GLP-1

Introduced by: Nick Bara for the Medical Student Section

Author(s): Sooin Choi, Mahnoor Khan, and Sirapa Vichaikul

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, Michigan has one of the highest rates of obesity in the country, with prevalence greater than 50 percent for both male and female, and is projected to continue to rise; and

Whereas, obesity is associated with a relative risk of 4.56 for type 2 diabetes compared with normal weight, and severe obesity increases this risk to 22.97; and high BMI accounted for approximately 66 percent of type 2 diabetes–related disability-adjusted life-years (DALYs) defined by the World Health Organization in 2019; thus, the American Diabetes Association recognizes obesity as a key driver of diabetes and its complications; and

Whereas, individuals with prediabetes have a 12.5 percent probability of developing diabetes in 10 years and 36.1 percent reverse to normoglycemia; however being obese conferred 34 percent lower likelihood of reverting from prediabetes to normoglycemia; and

Whereas, those with lower socioeconomic status (SES) experience substantially higher prevalence of diabetes, obesity, and prediabetes, with over 60 percent greater odds of progressing from prediabetes to diabetes and elevated complication rates; and

Whereas, lifestyle intervention mediates less than 20 percent of the association between unfavorable social determinants and progression from prediabetes and has limited effectiveness in preventing early-onset type 2 diabetes in low SES; and

Whereas, given the worsened comorbidity burden and mortality among patients with obesity and prediabetes, pharmacology such as Glucagon-like peptide-1 receptor agonists (GLP-1RAs) offers a great potential interventional target to help prevent progression to diabetes and reduce its associated morbidity and mortality; and

Whereas, a meta-analysis of eight random control trials found that GLP-1 RAs increased the odds of restoring normoglycemia by 4.62-fold and reduced diabetes incidence by 69 percent; and

Whereas, SCALE Obesity and Prediabetes trial demonstrated that 66 percent of participants on GLP-1RAs reverted from prediabetes to normoglycemia compared to 36 percent on placebo over three-year period, with a three-year cumulative of two percent of diabetes in the GLP-1 group compared to six percent in the placebo group, highlighting the disease reversal capacity of GLP-1 treatment; and

Whereas, GLP-1 RAs is an optimal treatment option for this high risk group given its substantially greater cardiovascular and renal benefits, including a 14 percent reduction in major adverse cardiovascular events, cardiovascular death, and heart failure hospitalizations, as well as a 17 percent reduction in composite kidney outcomes, translating into lower long-term healthcare costs related to hospitalizations, treatment, and management of these complications; and

Whereas, Medicaid currently does not cover GLP-1 RAs for the treatment of pre-diabetes, and coverage for obesity remains highly repatientsve; and updated Michigan Department of Health and Human Services Fiscal Year 2026

budget policies further limit GLP-1 RAs coverage for obesity by restricting eligibility to patients classified as morbidly obese, patient with obesity who failed trials of Preferred Drug List anti-obesity medications and a patient whose only next treatment option is bariatric surgery; and

Whereas, University of Michigan Health Care Policy and Innovation projected that up to one million people in Michigan who are overweight or obese could lose coverage with the updated Fiscal Year 2026 budget policies on GLP-1 RAs, putting them at continuous risk for obesity and related complications; and

Whereas, as of November 2025, the federal government announced the drug manufactures will substantially reduce the cost for both the injectable and oral formulations of GLP-1 with Medicare cost of $245 per month for injectable GLP-1 and the oral form will be available at $150 per month; and the State Medicaid programs can voluntarily participate in CMS GENEROUS model which can offer these medication at a lower than current Medicaid prices.

Whereas the growing evidence supporting the benefits of GLP-1 receptor agonists, combined with ongoing efforts to reduce medication costs and the long-term savings from preventing complications in individuals with obesity and prediabetes, suggests that GLP-1 therapy can be a long-term cost-effective strategy in reducing morbidity and mortality associated with obesity and prediabetes; therefore be it.

RESOLVED, that our MSMS advocates for Medicaid coverage for GLP-1 receptor agonists for pre-diabetics and individuals with obesity.

Fiscal Note: $12,000-$24,000

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RELEVANT MSMS POLICY

Evidence-based Treatment for Obesity as a Covered Benefit

MSMS supports evidence-based, medically necessary treatments for obesity as a benefit covered by health insurance plans without undue prerequisites on the part of the patient.

RELEVANT AMA POLICY

Advocacy Against Obesity-Related Bias by Insurance Providers H-440.801

1. Our American Medical Association will urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to:
   a. Revise their policies to ensure that bariatric surgery are covered for patients who meet the appropriate medical criteria.
   b. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider.
   c. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
   d. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes.
   e. Reduce the prior authorization burden for the coverage of anti-obesity medications, to include not requiring a new prior authorization for every dose change.
   f. Allow a patient's physician to prescribe anti-obesity medication and have it covered by insurance, without a requirement that patients must receive the prescription only from contracted disease management companies.
2. Our AMA will support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed

Restoring High Quality Care to the Medicare Part D Prescription Drug Program D-330.933

Our AMA will:

   a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;
   b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;
   c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;
   d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and
   e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial.

Recognizing and Taking Action in Response to the Obesity Crisis D-440.980

1. Our American Medical Association will advocate for the creation of a multidisciplinary federal task force, including representation from the medical profession, to review the public health impact of obesity and recommend measures to:
   a. Better recognize and treat obesity as a chronic disease.
   b. Confront the epidemic of obesity and its root causes, particularly among populations with disproportionally high incidence.
2. Our AMA will actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month".

3. Our AMA will strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention.
4. Our AMA will promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula.
5. Our AMA will make Council on Medical Education Report 3, A-17, Obesity Education, available on the AMA website for use by medical students, residents, teaching faculty, and practicing physicians.
6. Our AMA elevates obesity to be one of its public health priorities

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Resolution 37-26

Title: Decriminalization of Harm Reduction Strategies

Introduced by: Nick Bara for the Medical Student Section

Author(s): Tylar Dickson, MA, Cristen Enge, Mary Finedore, and Jasmine Jeffers, MS

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, drug paraphernalia (DP) is legally defined as "any equipment, product, material, or combination of equipment, products, or materials, which is specifically designed for use in planting; propagating; cultivating; growing; harvesting; manufacturing; compounding; converting; producing; processing; preparing; testing; analyzing; packaging; repackaging; storing; containing; concealing; injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance;" and

Whereas, under MCL Section 333.7451 of the Michigan Public Health Code, the legal definition of drug paraphernalia includes harm reduction supplies, such as syringes, distributed by Syringe Service Programs (SSPs); and

Whereas, possession of DP is currently a misdemeanor criminal offense; and

Whereas, House Bill 5178 from legislative session 2023-2024, which proposed similar criminal exemptions for DP in the state of Michigan passed through both the state Senate and House but ultimately was not signed into law prior; and

Whereas, successful decriminalization has occurred at the state level in Minnesota with the repeal of criminal penalties for possession and use of DP, amendment of a law that previously prohibited the manufacture or sale of syringes and needles, permitted delivery of syringes, and excluded residual amounts of drugs found in syringes from being classified as possession of controlled substances; and

Whereas, access to Syringe Service Programs and harm reduction supplies has successfully decreased the transmission of HIV, hepatitis B, and C; and

Whereas, harm reduction strategies have been proven to decrease overall morbidity and mortality for those with substance use disorder; and

Whereas, a study done by Avalere Health found that the economic burden for opioid use disorder for the state of Michigan in 2024 was $40 billion; and

Whereas, one study found that the "total annual Opioid Use Disorders related costs to the United States in 2018 were $786.8 billion to society, $93 billion to taxpayers, and $89.1 billion to the healthcare sector;" and

Whereas, AMA policy H-95.900 "supports decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking;" and

Whereas, successful decriminalization has occurred at the local level in Lansing, Michigan with the repeal of ordinance 1213 by enacting ordinance 1281 which repealed misdemeanor charges and penalties relating to the possession and/or use of DP; and

Whereas, ordinances for the legality of DP are dependent on the level of government with incongruencies between cities and counties leading to fear of legal repercussions, increased stigma, and barriers to access that include the following criminal penalties: “possession of drug paraphernalia is currently punishable by up to 90 days in prison or a fine of up to $5,000” per MCL- Section 333.7455 of the Michigan Public Health Code; and

Whereas, Senate Bill 629, in the 2025-2026 legislative session, authorizes, establishes, and regulates needle and hypodermic syringe access programs to decrease the spread of communicable diseases and aims to eliminate the discrepancies between state and local laws that have impeded operation of SSP programs in Michigan; therefore be it

RESOLVED, that our MSMS supports decriminalization of harm reduction strategies such as needle and hypodermic syringe access programs to decrease the spread of communicable diseases.

RESOLVED, that our MSMS supports the statewide decriminalization of drug paraphernalia.

Fiscal Note: $1,000 - $2,000

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RELEVANT MSMS POLICY

Safe Consumption Sites for Opioids

MSMS supports the use of government funding in Michigan by clean syringe access programs for the purchase of syringes, needles and other equipment needed for safe consumption of opioids. (Res25-19)

RELEVANT AMA POLICY

Supporting Harm Reduction H-95.900

1. Our American Medical Association supports efforts to decriminalize the possession of non-prescribed buprenorphine for personal use by individuals who lack access to a physician for the treatment of opioid use disorder.
2. Our AMA supports decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking.
3. Our AMA encourages additional study whether "safer smoking supplies" may be a potential harm reduction measure to reduce harms from the nation's overdose and death epidemic.

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Resolution 39-26

Title: Physician Competency and Clinical Care for Patients with ASD

Introduced by: Nick Bara for the Medical Student Section

Author(s): Ahmad Abu-Mahfouz, Aryan Arora, Sandra Messiha, and Vereena Salib

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, Autism Spectrum Disorder (ASD) affects approximately 1 in 36 children in the United States and a growing population of autistic adults are requiring ongoing medical care across the lifespan; and

Whereas, individuals with ASD experience significantly higher rates of unmet healthcare needs, delayed diagnoses, and reduced access to preventive services compared to the general population; and

Whereas, communication differences, sensory sensitivities, and difficulties with standard clinical environments contribute to barriers in physical examinations, procedures, and routine medical visits for autistic patients; and

Whereas, many practicing physicians report limited formal training in caring for autistic patients, particularly regarding communication approaches, sensory accommodations, and behavioral de-escalation strategies; and

Whereas, targeted physician education, including Continuing Medical Education (CME), environmental accommodations, and clinical toolkits, has been shown to improve patient cooperation, reduce distress, and improve health outcomes for autistic patients; and

Whereas, practical interventions such as modified waiting procedures, sensory-friendly examination techniques, caregiver-guided communication, and structured visit preparation can significantly improve patient experience and safety in clinical settings; therefore be it

RESOLVED, that our MSMS supports the development and dissemination of educational resources and clinical toolkits for Michigan physicians addressing communication strategies, sensory accommodations, and examination modifications for patients with Autism Spectrum Disorder; and be it further

RESOLVED, that our MSMS encourages Autism Spectrum Disorder continuing medical education programming that includes outpatient, inpatient, emergency, and procedural care settings; and be it further

RESOLVED, that our MSMS collaborates with Michigan healthcare systems, specialty societies, and patient advocacy organizations to promote adoption of sensory-friendly clinical practices and physician training opportunities for the care of autistic patients.

Fiscal Note: $2,000 - $4,000

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RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY

Standardizing Coverage of Evidence-Based Treatments for Neurodivergent Individuals H-185.921
Our American Medical Association supports coverage and reimbursement for evidence-based treatments and services for neurodivergent individuals, including Autism Spectrum Disorder.

Caring for Neurodivergent Patients H-90.962
1. Our American Medical Association supports research toward the evaluation and the development of interventions and programs for autistic individuals.
2. Our AMA will work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism.
3. Our AMA advocates for peer reviewed, evidence-based guidance for states on innovative health systems solutions to reduce specific barriers to the diagnosis and treatment of autism, including complex care coordination in the medical home by primary care team members trained in the diagnosis and treatment of autism.

AMA MEMBERSHIP ATTESTATION
Pursuant to approved HOD Resolution 65-14, any resolutions "submitted to the MSMS House of Delegates that require action by the AMA may only be submitted by MSMS members that are also members of the AMA."

I am a current member of the American Medical Association.
☑ Yes
☐ No

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Title: Incentive Programs for Adherence

Introduced by: Nick Bara for the Medical Student Section

Author(s): Mahnoor Khan

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, missed follow-up appointments and gaps in continuity of care contribute significantly to worsening chronic disease outcomes, preventable hospitalizations, and increased healthcare costs; and

Whereas, in Michigan, preventable hospital readmissions cost an estimated $1.2 billion annually, with missed follow-up appointments identified as a leading contributing factor; and

Whereas, Michigan Medicaid beneficiaries of approximately 2.8 million residents experience no-show rates for outpatient appointments ranging from 23 percent to 42 percent, significantly higher than commercially insured populations; and

Whereas, structural barriers such as transportation limitations, financial constraints, and competing social needs are major contributors to poor follow-up adherence, particularly among Medicaid beneficiaries and underserved populations[1]; a Michigan-based study found that transportation barriers alone account for approximately 3.6 million missed or delayed medical appointments annually in the United States, with disproportionate impact on rural and low-income populations; and

Whereas, evidence demonstrates that targeted incentive-based interventions, including transportation assistance, reduced cost-sharing, and modest financial incentives, can improve appointment adherence by 15–30 percent, patient engagement, and participation in preventive and chronic disease care; and

Whereas, multiple states have demonstrated the cost-effectiveness and positive outcomes of Medicaid transportation programs: Georgia and Kentucky demonstrated $18/month per-person cost savings for adults with diabetes and children with asthma through transportation services; Nevada and New Jersey data show adults using Non-Emergency Medical Transportation (NEMT) for preventive care at greater rates compared to traditional Medicaid populations; and State spending for Medicaid NEMT services can be reimbursed as administrative or medical service expense; and

Whereas, improving follow-up adherence is associated with earlier detection of complications, improved disease control, reduced emergency department utilization, and better long-term health outcomes; and

Whereas, economic analyses demonstrate that reducing missed appointments and improving continuity of care generate net cost savings for healthcare systems by preventing downstream complications and avoidable acute care utilization, with estimated returns on investment ranging from $2.50 to $4.00 saved per dollar invested in adherence-support interventions; and

Whereas, several Michigan healthcare systems, including Hurley Medical Center in Flint and federally qualified health centers (FQHCs) across the state, have successfully piloted transportation assistance and appointment reminder programs, demonstrating feasibility and acceptability within Michigan's healthcare landscape; therefore be it

RESOLVED, that our MSMS supports the use of evidence-based incentive and access-enabling programs, such as transportation assistance, cost-sharing reduction, and other targeted supports, to improve patient follow-up adherence and continuity of care; and be it further

RESOLVED, that our MSMS encourages Michigan healthcare systems, FQHCs, local health departments, and Medicaid-supported organizations to explore and evaluate pilot programs that address structural barriers to follow-up care, particularly in high-risk and underserved populations; and be it further

RESOLVED, that our MSMS supports providing physicians with practical tools and resources to improve patient adherence to medically necessary follow-up care, including strategies that reduce non-medical barriers to access; and be it further

RESOLVED, that our MSMS encourages ongoing evaluation of follow-up adherence programs to assess clinical outcomes, healthcare utilization, cost-effectiveness, and impact on health disparities.

Fiscal Note: $1,000 - $2,000

REFERENCES

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12. Hurley Medical Center. *Community Health Needs Assessment: Transportation Barriers and Pilot Interventions.* Hurley Medical Center; 2024.

RELEVANT MSMS POLICY

Conditions for Mandatory Vision Screening
MSMS supports the current state of Michigan Vision Screening Program (VSP) for infants and children which ensures follow-up and collaboration with local health departments, primary care physicians, schools, and the Michigan Department of Health and Human Services and opposes any changes to the current VSP process that do not demonstrate added value.

Barriers to Connectivity
MSMS supports governmental authorities and purchasers of care to compel health systems to cooperate by developing electronic interfaces with physician offices and supports the Centers for Medicare and Medicaid Services to compel and/or incentivize health systems to work with physician practices to achieve interconnectivity through interfaces.

Physical Fitness and Nutrition Incentives for Regular Physical Exercise
MSMS encourages initiatives that positively incentivize regular physical exercise as a means of improving health.

RELEVANT AMA POLICY

AMA Policy H-160.919 — Removing Barriers to Care for the Underserved
The AMA supports efforts to identify and eliminate barriers—including transportation, cost, and structural factors—that prevent patients from accessing medically necessary care.

AMA Policy H-185.927 — Social Determinants of Health
The AMA recognizes that social determinants of health, including access to transportation and economic stability, significantly influence health outcomes and supports policies that address these determinants as part of comprehensive patient care.

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
Excerpt from the MSMS Policy Manual:
All members of the Michigan State Medical Society House of Delegates should declare any conflict of interest to the House of Delegates and its Reference Committees prior to testimony.

The MSMS House of Delegates considers a potential conflict of interest to exist when a Delegate, Alternate Delegate, other physician member or non-member testifying on the floor of the House of Delegate or in Reference Committee has a relationship, or engages in any activity, or has any personal financial or commercial interest that might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters. (Board Action Report #4, 2000 HOD, re Res10-99A & Res13-99A)

Additionally, Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires author conflicts of interest to be disclosed and printed on the resolution.

☑ The author(s) have no conflict(s) of interest to disclose
☐ The author(s) has/have the following conflict(s) of interest to disclose:

DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS
Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires authors to disclose any current, very similar, or pending resolutions at other state medical societies of which they are aware.

☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 43-26

Title: Ensuring Proportional Accountability for Hospital Expenditures Attributed to Medicare ACOs

Introduced by: Courtland Keteyian, MD, MBA, MPH, for the Jackson County Delegation

Author(s): Courtland Keteyian, MD, MBA, MPH

Referred to: Reference Committee on Payer and Legislative Advocacy

House Action:

Whereas, in traditional Medicare fee-for-service, hospital care accounts for approximately 41–43 percent of total Medicare spending, while physician and clinical services account for approximately 22–24 percent; and

Whereas, inpatient and outpatient hospital facility expenditures represent the largest single driver of total cost performance within the Medicare Shared Savings Program (MSSP) and materially affect shared savings and downside risk reconciliation; and

Whereas, hospital outpatient services have been among the fastest-growing components of Medicare spending over the past decade, in part due to site-of-service payment differentials that allow hospital outpatient departments to bill higher rates than independent physician offices for comparable services; and

Whereas, under the Medicare Shard Savings Program (MSSP), total cost of care calculations for an Accountable Care Organization (ACO) include all Medicare expenditures incurred by ACO-assigned beneficiaries, including hospital inpatient and outpatient facility spending, regardless of whether the hospital maintains a participation or financial accountability agreement with the ACO contracting entity; and

Whereas, physicians participating in ACO contracting entities may be exposed to shared savings reductions or downside financial risk based on hospital expenditures over which they do not have direct operational or financial control; and

Whereas, hospitals that receive substantial volumes of ACO-attributed Medicare beneficiaries benefit from patient flow generated through ACO care coordination efforts yet are not uniformly required to assume proportionate financial accountability for total cost performance; therefore be it

RESOLVED, that our Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate that the Centers for Medicare & Medicaid Services (CMS) establish policies requiring hospitals that receive substantial expenditures attributable to ACO-assigned beneficiaries to enter defined participation and financial accountability agreements with the relevant ACO contracting entity; and be it further

RESOLVED, that our Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate that, absent such defined participation and accountability agreements, hospital expenditures for ACO-assigned beneficiaries not be included in total cost of care reconciliation calculations under the Medicare Shared Savings Program or other advanced alternative payment models; and be it further

RESOLVED, that our Michigan Delegation to the American Medical Association (AMA) ask our AMA to advocate for enhanced transparency of hospital facility spending attributable to ACO-assigned beneficiaries within benchmarking and reconciliation methodologies; and be it further

RESOLVED, that our Michigan Delegation to the American Medical Association (AMA) ask our AMA to study and report on policy mechanisms to ensure equitable financial accountability for hospital expenditures attributed to Medicare ACOs, including mechanisms addressing site-of-service payment differentials and facility fee impacts.

Fiscal Note: $1,000 - $2,000

REFERENCES

1. Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare Payment Policy. March 13, 2025.
2. Centers for Medicare & Medicaid Services (CMS). Medicare Shared Savings Program Fast Facts and Performance Year Financial Results. 2024.

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY
None

AMA MEMBERSHIP ATTESTATION
Pursuant to approved HOD Resolution 65-14, any resolutions "submitted to the MSMS House of Delegates that require action by the AMA may only be submitted by MSMS members that are also members of the AMA."

I am a current member of the American Medical Association.
☒ Yes
☐ No

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
Excerpt from the MSMS Policy Manual:
All members of the Michigan State Medical Society House of Delegates should declare any conflict of interest to the House of Delegates and its Reference Committees prior to testimony.

The MSMS House of Delegates considers a potential conflict of interest to exist when a Delegate, Alternate Delegate, other physician member or non-member testifying on the floor of the House of Delegate or in Reference Committee has a relationship, or engages in any activity, or has any personal financial or commercial interest that might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters. (Board Action Report #4, 2000 HOD, re Res10-99A & Res13-99A)

Additionally, Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires author conflicts of interest to be disclosed and printed on the resolution.

☒ The author(s) have no conflict(s) of interest to disclose
☐ The author(s) has/have the following conflict(s) of interest to disclose:

DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS
Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires authors to disclose any current, very similar, or pending resolutions at other state medical societies of which they are aware.

☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

ACTION REPORT #01-26 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 02-25
Imposition of Penalties by Disciplinary Subcommittee

REFERRED TO: Reference Committee B

HOUSE ACTION:

The current and immediate past Chairs of the MSMS Committee on State Legislation and Regulations, Michael Redinger, MD, and Jayne Courts, MD, met with Eleanor Kue, MD, author of Resolution 02-25, to discuss her concerns regarding Michigan's physician disciplinary process. Doctor Kue described her experience with a prolonged disciplinary matter beginning in 2019, including multiple dismissals by Administrative Law Judges, and expressed concerns about due process following disciplinary action imposed in 2023. She emphasized that her intent was to raise broader issues of fairness, transparency, and due process, rather than to relitigate her case.

MSMS Legal Counsel, Kathleen Westfall, advised that the first Resolved statement was problematic, as it would require advocacy for statutory changes limiting the discretion of Disciplinary Subcommittee members under MCL 333.16237, though she noted that other process improvements could be considered. After discussion of Doctor Kue's comments, Reference Committee concerns, and Legal Counsel's guidance, Doctor Redinger and Doctor Courts proposed amendments to the Resolved statements to allow MSMS to identify best practices for potential future regulatory, internal, and/or legislative changes.

During discussion of the Resolution by the Legislative Policy Committee, Doctor Courts provided further perspective on the rationale for the changes and support for the recommendation. The Committee members present believed the amended resolution properly prioritized due process protections for physicians while not limiting the decision-making ability of the licensing board. The five members present voted unanimously to recommend approval as amended.

RECOMMENDATION: THAT THE 2026 MSMS HOUSE OF DELEGATES APPROVE RESOLUTION 02-25, "IMPOSITION OF PENALTIES BY DISCIPLINARY SUBCOMMITTEE," AS AMENDED TO READ AS FOLLOWS:

RESOLVED: That MSMS develop actionable recommendations to ensure that physicians are afforded a transparent and fair due process mechanism that provides meaningful procedural safeguards in situations where a licensing board or the Disciplinary Subcommittee (DSC) of a licensing board disagrees in whole or part with the Findings of Fact and Conclusions of Law in an Administrative Law Judge's (ALJ) Proposal for Decision in a manner that would adversely affect a licensee's license or registration. MSMS shall explore best practices recommended by the Federation of State Medical Boards as well as those adopted by other states when developing recommendations that protect licensees' rights while preserving public trust and patient safety; and be it further

RESOLVED: That MSMS believes a licensing board or the Disciplinary Subcommittee (DSC) of a licensing board should be allowed to hear from the licensee at a regularly scheduled meeting of the licensing board or DSC before rejecting in whole or in part the Findings of Facts and Conclusions of Law in an Administrative Law Judge's Proposal for Decision in a manner that would adversely affect a licensee's license or registration.

Attachment
Resolution 02-25

RESOLUTION 02-25

Title: Imposition of Penalties by Disciplinary Subcommittee

Introduced by: Eleanore Kue, MD, for the Ingham County Delegation

Original Author: Eleanore Kue, MD

Referred To: Reference Committee B

House Action: **REFERRED TO MSMS BOARD OF DIRECTORS**

Whereas, it is the responsibility of each state to regulate the practice of medicine, as well as outline the responsibility of state medical boards to regulate that practice within their borders, and

Whereas, the Michigan Department of Licensing and Regulatory Affairs (LARA) is the agency with regulatory oversight of health professionals in Michigan, and

Whereas, the Michigan Board of Medicine and the Michigan Board of Osteopathic Medicine and Surgery are housed within LARA's Bureau of Professional Licensing, and

Whereas, the authority provided to both Boards resides in the Michigan Public Health Code, which also governs the practice of medicine and osteopathic medicine and surgery in Michigan, and

Whereas, Administrative Complaints, Consent Orders and Stipulations, and Recommended Findings of Fact and Conclusions of Law issued by an Administrative Law Judge (ALJ) are presented to the Boards' Disciplinary Subcommittees for review and action, and

Whereas, when an ALJ's Recommended Findings of Fact and Conclusions of Law is given to the Disciplinary Subcommittee (DSC), it is the DSC's responsibility to decide whether the licensee will be sanctioned and, if so, what the sanction will be, and

Whereas, Michigan Compiled Law (MCL) 333.16237(1) requires the DSC, when imposing a penalty, to review the Recommended Findings of Fact and Conclusions of Law of the ALJ, and

Whereas, MCL 333.16237(4) supports that If a DSC finds that a preponderance of the evidence supports the recommended findings of fact and conclusions of law of the hearing's examiner indicating that grounds exist for disciplinary action, the DSC shall impose an appropriate sanction as permitted by statute, and

Whereas, if the DSC finds that a preponderance of the evidence does not support the findings of fact and conclusions of law of the hearing's examiner indicating that grounds exist for disciplinary action, the DSC shall dismiss the complaint, and

Whereas, the DSC must report final action taken by it in writing to the appropriate board or task force, and

Whereas, the DSC is not permitted to be present at the hearing held by the ALJ, to do its own investigation, or to seek information that is not included in the certified record, and

Whereas, there are situations in which the DSC did not give any effect to the Proposal for Decision when deciding to accept in part and reject in part the ALJ's Findings of Facts and Conclusion of

54 Law; therefore be it
55
56 RESOLVED: That MSMS advocate that a Disciplinary Subcommittee (DSC) of a licensing board is
57 required to give effect to an Administrative Law Judge's (ALJ) Proposal for Decision if the DSC does
58 not support fully or in part or the Findings of Fact and Conclusions of Law of the ALJ; and be it
59 further
60
61 RESOLVED: That MSMS believes a Disciplinary Subcommittee (DSC) of a licensing board should be
62 allowed to hear from the licensee at a regularly scheduled meeting of the DSC before rejecting in
63 part or the entire Findings of Facts and Conclusions of Law of the Administrative Law Judge.
64

65
66 WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy
None

Relevant AMA Policy
None

ACTION REPORT #02-26 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 05-25
Immediate Authorization for HIV Post-Exposure Prophylaxis Medication

REFERRED TO: Reference Committee A

HOUSE ACTION:

This Resolution seeks to ensure individuals who are exposed to bloodborne pathogens are able to receive post-exposure prophylaxis (PEP) within the recommended 72-hour timeframe following exposure. In order to achieve this, it directs MSMS to advocate for legislation that guarantees immediate authorization of a full 28-day supply of HIV PEP medications.

This resolution was originally referred to the Board because the members of Reference Committee A had questions about whether there was an issue that actually needed to be resolved. When MSMS staff queried the commercial health plans and insurers, those that replied indicated they were already covering without a prior authorization. The Board of Directors sent Resolution 05-25 to the MSMS Liaison Committee on Public Health.

Unfortunately, the author was not able to attend the Reference Committee to share that the main impetus behind the Resolution are the policies of worker's compensation carriers. He was, however, able to meet with the Public Health Committee and present his rationale. The author practices occupational medicine and frequently treats people who are exposed to bloodborne pathogens during the course of performing their jobs. He explained that it is labor intensive to work through the carriers' approval processes and often takes days to even get the case assigned. Given that the Centers for Disease Control and Prevention recommends PEP be started as soon as possible or at least within 72 hours of exposure to HIV, this is problematic. The author and members of the Public Health Committee worked together to amend the Resolved statement to highlight occupational exposure and recommended the Board to approve as amended.

Following a discussion by the Health Care Delivery Committee, members agreed that this issue should be addressed. The Committee supported the Public Health Committee's recommendation unanimously.

RECOMMENDATION: THAT THE 2026 MSMS HOUSE OF DELEGATES APPROVE RESOLUTION 05-25, IMMEDIATE AUTHORIZATION FOR HIV POST-EXPOSURE PROPHYLAXIS MEDICATION, AS AMENDED TO READ AS FOLLOWS:

RESOLVED: That MSMS advocate for legislation that guarantees immediate authorization of a full 28-day supply of HIV PEP medications, including for those with occupational exposures, when prescribed according to the Centers for Disease Control and Prevention guidelines.

Attachment
Resolution 05-25

RESOLUTION 05-25

Title: Immediate Authorization for HIV Post-Exposure Prophylaxis Medication

Introduced by: Courtland Keteyian, MD

Original Author: Courtland Keteyian, MD

Referred To: Reference Committee A

House Action:

Whereas, the World Health Organization estimates that about three million healthcare workers are exposed to occupational bloodborne pathogens each year, and

Whereas, in the United States, there are an estimated 400,000 sharps injuries per year in the hospital setting, and

Whereas, in 2023, there were 481,017 victims of sexual assault in the United States, and

Whereas, PEP (post-exposure prophylaxis) is more than 80 percent effective in reducing the risk of contracting HIV following exposure, and

Whereas, to be effective, the Centers for Disease Control and Prevention recommends PEP be started at soon as possible or at least within 72 hours of a recent possible exposure to HIV and continued for 28 days, and

Whereas, PEP typically includes Tenofovir plus Emtricitabine with either Raltegravir or Dolutegravir, and

Whereas, these medications are prohibitively expensive for most individuals without insurance coverage, and

Whereas, many pharmacies require authorization of payment before dispensing PEP medications given the cost of treatment, and

Whereas, worker's compensation insurance companies and traditional payors do not routinely provide timely authorization for PEP medications within the 72 hours window; therefore be it

RESOLVED: That MSMS advocate for legislation that guarantees immediate authorization of a full 28-day supply of HIV PEP medications when prescribed according to the Centers for Disease Control and Prevention guidelines.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy
None

Relevant AMA Policy

HIV, Sexual Assault, and Violence H-20.900

Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.

Improving PrEP & PEP Access H-20.894

1. Our American Medical Association supports efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements between pharmacists and physicians, based on AMA's model legislation related to collaborative drug therapy management.
2. Our AMA supports a requirement that any pharmacy-associated prescription of PREP/PEP needs to be in accordance with the current CDC PREP/PEP clinical practice guidelines within the physician-led team.

Sources:

1. World Health Organization. World health statistics 2010. 2010. https://www.who.int/publications/i/item/9789241563987. Accessed 28 Feb 2025.
2. Phillips EK, Conaway MR, Jagger JC. Percutaneous injuries before and after the Needlestick Safety and Prevention Act. N Engl J Med. 2012 Feb 16;366(7):670-1.
3. RAINN. Victims of Sexual Violence: Statistics. https://rainn.org/statistics/victims-sexual-violence#:~:text=On%20average%2C%20there%20are%20463%2C634,year%20in%20the%20United%20States. Accessed 28 Feb 2025.
4. National Institutes of Health. HIV Prevention: Post-Exposure Prophylaxis (PEP). https://hivinfo.nih.gov/understanding-hiv/fact-sheets/post-exposure-prophylaxis-pep#:~:text=does%20PEP%20work?-,PEP%20is%20effective%20in%20preventing%20HIV%20when%20it%20is%20taken,consistently%20and%20correctly%2C%20as%20prescribed. Access 28 Feb 2025.
5. Centers for Disease Control and Prevention. Preventing HIV with PEP. https://www.cdc.gov/hiv/prevention/pep.html. Accessed 28 Feb 2025.

PEP 101

If you may have been exposed to HIV* in the last 72 hours, talk to your health care provider, an emergency room doctor, or an urgent care provider about PEP right away.

PEP can reduce your chance of getting HIV after a possible exposure.

WHAT IS PEP?

- PEP, or post-exposure prophylaxis, means taking medicine to prevent HIV after a possible exposure.
- **PEP must be started within 72 hours (3 days) after you may have been exposed to HIV.** The sooner you start PEP, the better. Every hour counts!
- If your health care provider prescribes PEP, you'll need to take it daily for 28 days.
- PEP is effective in preventing HIV, but not 100%. Always use condoms with sex partners and use safe injection practices.

IS PEP RIGHT FOR YOU?

If you don't have HIV or don't know your HIV status, and in the last 72 hours you

- May have been exposed to HIV during sex (for example, if the condom broke),
- Shared needles, syringes, or other equipment to inject drugs, or
- Were sexually assaulted,

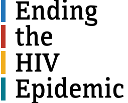
Talk to your health care provider, an emergency room doctor, or an urgent care provider about PEP right away.

CAN I TAKE PEP EVERY TIME I HAVE SEX WITHOUT A CONDOM?

- No. You should only use PEP in **emergency situations.**
- If you engage in behaviors that may increase your chances of getting HIV, talk to your health care provider about PrEP (pre-exposure prophylaxis).

* *People are exposed to HIV by coming into contact with certain body fluids of a person with HIV, including blood, semen, and vaginal fluids. This usually happens through vaginal or anal sex or by sharing needles.*

Scan to learn more!



For more information, please visit **www.cdc.gov/hiv.**

INFORMACIÓN BÁSICA SOBRE LA PEP

Si es posible que haya estado expuesto al VIH* en las últimas 72 horas, hable inmediatamente con su proveedor de atención médica, un médico de la sala de emergencias o un proveedor de atención médica urgente acerca de la profilaxis posexposición (PEP).

¿QUÉ ES LA PEP?

- PEP, o profilaxis posexposición, significa tomar medicamentos después de una posible exposición al VIH para prevenir infectarse.
- **La PEP se debe comenzar dentro de las 72 horas (3 días) después de la posible exposición al VIH.** Cuanto antes comience la PEP, mejor. ¡Cada hora cuenta!
- Si su proveedor de atención médica le receta la PEP, deberá tomar estos medicamentos a diario por 28 días.
- La PEP es eficaz para la prevención del VIH, pero no en un 100 %. Siempre use condones con sus parejas sexuales y practique hábitos de inyección seguros.

¿ES LA PEP ADECUADA PARA USTED?

Si usted no tiene el VIH o no sabe si lo tiene, y en las últimas 72 horas:

- estuvo posiblemente expuesto al VIH a través de una relación sexual (por ejemplo, si se rompió el condón),
- compartió con otras personas las agujas, jeringas, u otros equipos para inyectarse drogas, o
- ha sido víctima de una agresión sexual,

Hable inmediatamente con su proveedor de atención médica, un médico de la sala de emergencias o un proveedor de atención médica de urgencia acerca de la PEP.

¿PUEDO TOMAR LA PEP CADA VEZ QUE TENGA RELACIONES SEXUALES SIN CONDÓN?

- No. Solo debe usar la PEP en **situaciones de emergencia.**
- Si usted tiene comportamientos que podrían aumentar sus probabilidades de contraer el VIH, hable con su proveedor de atención médica sobre la PrEP (profilaxis prexposición).

** Las personas se exponen al VIH cuando tienen contacto con determinados líquidos corporales de una persona que tenga el VIH; estos líquidos incluyen la sangre, el semen y el flujo vaginal. Esto generalmente ocurre a través del sexo vaginal o anal, o al compartir agujas.*

¡Escanea para obtener más información!

Para obtener más información, visite la página **www.cdc.gov/hiv/spanish.**

MLS-280327_r

Reference Committee C

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES

RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE C – INTERNAL AFFAIRS, BYLAWS, AND RULES

RESOLUTION	DESCRIPTION
08-26	Moral Duty to Patients and Ensuring Healthcare Facilities Remain Protected Spaces
15-26	Preserving Michigan's Independent Primary Care Physician Workforce Through Strategic Sustainability Initiatives
25-26	Dissolution of the House of Delegates
28-26	Shared Mission and Vision for MSMS and Component Societies
44-26	2026 MSMS House of Delegates Meet in Person
BOARD ACTION REPORTS	**DESCRIPTION**
#4-26	Resolution 46-25: Physician Union
#6-26	Chartering Component/County Medical Societies- Resolution 14-25 - Rotation of MSMS House of Delegates Meeting Location; Resolution 16-25 - County and State Medical Society Alliance; Resolution 47-25 - Study Medical Society Structures
#7-26	House of Delegates- Resolution 14-25 - Rotation of MSMS House of Delegates Meeting Location; Resolution 16-25 - County and State Medical Society Alliance; Resolution 47-25 - Study Medical Society Structures
#8-26	Judicial Commission- Resolution 14-25 - Rotation of MSMS House of Delegates Meeting Location; Resolution 16-25 - County and State Medical Society Alliance; Resolution 47-25 - Study Medical Society Structures
#9-26	Board of Directors- Resolution 14-25 - Rotation of MSMS House of Delegates Meeting Location; Resolution 16-25 - County and State Medical Society Alliance; Resolution 47-25 - Study Medical Society Structures
#10-26	Revisions to the MSMS Policy Manual and the 2025 Sunset Report
2nd Reading	**DESCRIPTION**
27-25	Remove Separate County Requirement for Regional Directors
49-25	Membership Categories
50-25	Revisions to Constitution and Bylaws

Resolution: 08-26

Title: Moral Duty to Patients and Ensuring Healthcare Facilities Remain Protected Spaces

Introduced by: Anushree Jagtap, MD, for the Saginaw County Delegation

Author(s): Kai Anderson, MD, Abishek Bala, MD, MPH, and Anushree Jagtap, MD

Referred to: Reference Committee on Internal Affairs, Bylaws, and Rules

House Action:

Whereas, the Hippocratic Oath mandates that physicians use treatment to help the sick according to their ability and judgment, but never with a view to injury and wrongdoing; and

Whereas, as societal role models, physicians have a sacred duty to protect the vulnerable and ensure that no external fear including that of federal immigration enforcement obstructs access to life-saving care; and

Whereas, any failure to provide medical assistance due to discrimination, including immigration status, goes against the moral duty of the physician and undermines the essential mission of our profession; and

Whereas, current immigration enforcement activities create a "chilling effect" that discourages the utilization of public healthcare services, violating the ethical principle of non-maleficence; therefore, therefore be it

RESOLVED, that the MSMS reaffirms that the professional and moral duty of every physician is to provide care to all human beings regardless of immigration status, honoring the timeless values of the Hippocratic Oath; and be it further

RESOLVED, that the MSMS takes a firm stance that medical facilities must remain protected clinical spaces where patients can seek care without fear of immigration enforcement; and be it further

RESOLVED, that the MSMS actively advocates for policies that recognize healthcare institutions as sensitive locations, ensuring that the patient-physician relationship remains a safe space for healing.

Fiscal Note: $12,000-$24,000

REFERENCES

1. AMA Code of Medical Ethics Opinion 1.1.1
2. Michigan Public Health Code Section 333.20201
3. Michigan Senate Bill 508 (2026): Immigration Enforcement; Sensitive Locations

RELEVANT MSMS POLICY

AMA Principles of Medical Ethics

MSMS supports the AMA Principles of Medical Ethics:

"PREAMBLE: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, but also as well as to society, to other health professionals, and to self.

"The following Principles adopted by the American Medical Association are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care with compassion and respect for human dignity and rights.
II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements
IV. which are contrary to the best interests of the patient.

V. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
VI. A physician shall continue to study, apply and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.
VII. A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
VIII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
IX. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
X. A Physician Shall Support Access To Medical Care For All People."

Integrity and the Values and Principles Embedded in the Tradition of Medicine
MSMS supports the 1996 House of Delegates resolution on "Statement on Integrity and the Values and Principles Embedded in the Tradition of Medicine."

RELEVANT AMA POLICY
Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our American Medical Association will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

Support of Health Care to Legal Immigrants H-290.983
Our American Medical Association opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.

Patient and Physician Rights Regarding Immigration Status H-315.966
1. Our American Medical Association supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records, Medicaid, Children's Health Insurance Program (CHIP), or other health program data, including but not limited to Emergency Medicaid and related immigrant-specific programs, for immigration enforcement purposes.
2. Our AMA supports efforts by interested parties to educate physicians, medical students, and patients about existing privacy protections to safeguard confidential health information, and to help ensure that this information reaches immigrant and mixed-status families.

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA opposes;
   a. any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants;
   b. any policies, regulations, or legislation requiring physicians, other health care providers, and healthcare entities to collect and report data regarding an individual patient's legal resident status;
   c. proof of citizenship as a condition of providing health care; and
   d. withholding federal funds if health care institutions fail to comply with policies which mandate collection of a patient's immigration status.
2. Our AMA opposes any legislative proposals that would criminalize the provision of health care to undocumented residents.

Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
1. Our American Medical Association will take immediate action by releasing an official statement that acknowledges that the health of unaccompanied immigrant children without proper documentation is a humanitarian issue.
2. Our AMA urges special consideration of the physical, mental, and psychological health in determination of the legal status of unaccompanied minor children without proper documentation.
3. Our AMA will immediately meet and work with other physician specialty societies to identify the main obstacles to the physical health, mental health, and psychological well-being of unaccompanied children without proper documentation.

4. Our AMA will participate in activities and consider legislation and regulations to address the unmet medical needs of unaccompanied minor children without proper documentation status, with issues to be discussed to include the identification of:
   a. The health needs of this unique population, including standard pediatric care as well as mental health needs.
   b. Health care professionals to address these needs, to potentially include but not be limited to non-governmental organizations, federal, state, and local governments, the US military and National Guard, and local and community health professionals.
   c. The resources required to address these needs, including but not limited to monetary resources, medical care facilities and equipment, and pharmaceuticals.
   d. Avenues for continuity of care for these children during the potentially extended multi-year legal process to determine their final disposition.

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
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Additionally, Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires author conflicts of interest to be disclosed and printed on the resolution.

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DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS
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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 15-26

Title: Preserving Michigan's Independent Primary Care Physician Workforce Through Strategic Sustainability Initiatives

Introduced by: Robert J. Jackson, MD, for the Wayne County Delegation

Author(s): Robert J. Jackson, MD

Referred to: Reference Committee on Internal Affairs, Bylaws, and Rules

House Action:

Whereas, Michigan is experiencing accelerating primary care workforce instability driven by physician retirements, consolidation pressures, reimbursement challenges, recruitment barriers, and increasing administrative burden; and

Whereas, independent private practice physicians—both primary care and specialty—play a critical and interdependent role in sustaining patient access, continuity of care, referral networks, competition, and community-based healthcare delivery; and

Whereas, independent private practice physicians have historically delivered high-value, cost-effective care within their communities; and

Whereas, a significant proportion of independent private practice primary care physicians are approaching retirement age, and many are experiencing physician burnout, further straining workforce stability and threatening patient access and continuity of care; and

Whereas, successful succession planning, physician recruitment pathways, and operational stabilization strategies are essential to preserving independent practice models; and

Whereas, Michigan lacks sufficient structured operational and financial support infrastructure specifically tailored to assist independent private practice physicians with recruitment, succession planning, and long-term practice sustainability; and

Whereas, Carebridge of Michigan is a Michigan-based, physician-led, federally recognized 501(c)(3) nonprofit organization established to support the sustainability of independent private practice primary care through structured succession planning, physician recruitment pathways, onboarding assistance, and practice stabilization services; and

Whereas, Carebridge of Michigan does not acquire, employ, or financially control medical practices, but instead seeks to provide operational and financial support designed to reduce barriers to physician recruitment and retention, prevent unnecessary practice closures or acquisition by health systems, and preserve independent community-based care; and

Whereas, the Michigan State Medical Society has a longstanding role in physician advocacy, education, and leadership, including protecting physician autonomy, advancing high-quality patient care, strengthening Michigan's physician workforce, and supporting practicing physicians and medical residents with resources that promote practice sustainability, operational efficiency, and professional well-being; therefore be it

RESOLVED, that the MSMS affirms its commitment to preserving and strengthening independent private practice medicine, including primary care and specialty practices, as a critical component of Michigan's healthcare infrastructure; and be it further

RESOLVED, that MSMS leadership be authorized to review and engage with relevant nonprofit organizations focused on private practice primary care workforce stabilization and practice sustainability; identifying potential areas of alignment and collaboration that facilitate the addition of primary care physicians into existing independent private practices through succession planning resources, recruitment pathways, educational programming, and policy coordination; and be it further

RESOLVED, that the MSMS explores supporting collaborative funding opportunities or grant applications submitted by nonprofit organizations that aim to strengthen the sustainability of independent private practice primary care with the acknowledgment that MSMS shall not expend significant monetary resources and that any such involvement be consistent with the Society's standard review and approval processes.

Fiscal Note: $2,000-$4,000

RELEVANT MSMS POLICY
NONE

RELEVANT AMA POLICY
NONE

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 25-26

Title:	Dissolution of the House of Delegates
Introduced by:	Richard E. Burney, MD, for Washtenaw County Delegation
Author(s):	Richard E. Burney, MD
Referred to:	Reference Committee on Internal Affairs, Bylaws, and Rules
House Action:	

Whereas, MSMS and its component societies have experienced continuing declines in membership and revenue; and

Whereas, MSMS as well as component societies have made major budget and staff reductions to reduce expenses; and

Whereas, MSMS cannot continue to reduce staff without essential programs being sacrificed; and

Whereas, additional structural changes and expense reductions will be needed if revenue continues to decline; and

Whereas, the annual House of Delegates represents one of MSMS's largest expenses; and

Whereas, other states societies no longer maintain a House of Delegates and have developed alternative mechanisms for soliciting member input to formulate policy; therefore be it

RESOLVED, that our MSMS dissolves the House of Delegates as its chief policy-making body and adopt an executive form of governance and policy development; and be it further

RESOLVED, that our MSMS maintains democratic representation at local and state levels, while reducing the size of the MSMS Board of Directors; and be it further

RESOLVED, that our MSMS recognize that component societies, while remaining semi-independent, may beneficially collaborate in providing forums and services that align with the mission and goals of MSMS.

Fiscal Note: $2,000 - $4,000

RELEVANT MSMS POLICY
MSMS Reorganization Report and Recommendations – Reference Committee on Internal Affairs, Bylaws and Rules

RELEVANT AMA POLICY
None

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 28-26

Title: Shared Mission and Vision for MSMS and Component Societies

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Author(s): Richard E. Burney, MD

Referred to: Reference Committee on Internal Affairs, Bylaws, and Rules

House Action:

Whereas, MSMS is comprised of a central, statewide organization and component medical societies; and

Whereas, MSMS and its component societies may have different, complementary roles in service of their memberships; and

Whereas, at present the stated mission of MSMS is to improve the lives of physicians so they may best care for the people they serve, and (for example) the Washtenaw County Medical Society works in tandem with MSMS and in affiliation with the American Medical Association to advocate, educate, and lead; and

Whereas, a common mission and vision for all parties would be in the best interest of all parties; therefore be it

RESOLVED, that our MSMS and component medical societies agree to the following shared mission:

- To advocate on behalf of physicians and their patients
- To educate the profession and public in matters related to health and medical care
- To communicate to members, government agencies, political leaders, and health care providers regarding health and medical care issues of importance to the public
- To convene as necessary to address emergency threats (e.g., COVID, drastic cuts to Medicaid)
- To provide services to its membership that facilitate sound, ethical medical practices
- To work in affiliation with the AMA to advocate, educate, and lead in matters related to health and medical care, and be it further

RESOLVED, that our MSMS and component societies agree to the following shared vision: that MSMS and its component societies will work collaboratively to pursue their shared mission and convene as necessary to effect changes needed to enable all parties to carry out their shared mission.

Fiscal Note: $1,000 - $2,000

RELEVANT MSMS POLICY

MSMS Mission
The MSMS mission is to improve the lives of physicians so they may best care for the people they serve

RELEVANT AMA POLICY

AMA Mission
The AMA mission is to promote the art and science of medicine and the betterment of public health.

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 44-26

Title: 2026 MSMS House of Delegates Meet in Person

Introduced by: Megan Edison, MD, for the Kent County Delegation

Author(s): Warren Lanphear, MD, and Gerald Lee, MD Reference

Referred to: Committee on Internal Affairs, Bylaws, and Rules

House Action:

Whereas, the delegates to the House of Delegates feel that the 2025 decision to go to a virtual online format for the 2026 meeting of the House of Delegates was made by the MSMS Board of Directors without adequate debate and discussion by delegates and other members of MSMS; and

Whereas, the MSMS Board of Directors and its leadership have stated that due to financial concerns holding any future House of Delegates meetings including 2026 live and in-person is not a wise use of MSMS funds; and

Whereas, many members of MSMS believe holding a fiscally-responsible live meeting is best for our consideration of making bylaws changes of this importance; and

Whereas, the MSMS Board Task Force proposes dissolving the House of Delegates permanently and this decision will be made at a virtual online House of Delegates meeting in 2026; and

Whereas, many delegates and members of MSMS do not feel the virtual online format allows for the proper discussion and debate of a decision of this magnitude and significance; and

Whereas, two other proposals by the MSMS Board of Directors and the MSMS Task Force on Reorganization are of similar importance - one being to reconfigure the composition of the Board of Directors, and two being to dissolve the relationship of the county medical societies to the state medical society are to also be discussed and debated during a virtual online meeting; and

Whereas, the MSMS bylaws require two readings of these changes and two separate votes to approve them; and

Whereas, there has been informal discussion of a possible move to hold both readings and votes of approval at the same virtual online meeting; therefore be it

RESOLVED, that our MSMS requires at least one of the meetings of the House of Delegates in 2026 to be live and in-person to discuss, debate, and vote to approve any bylaws changes.

Fiscal Note: $45,000

RELEVANT MSMS POLICY

MSMS Bylaws
14.00 THE BOARD OF DIRECTORS, 4.70 CONTROL OF FUNDS—The funds of this Society hall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.

RELEVANT AMA POLICY
None

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

ACTION REPORT #04-26 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 46-25
Physician Union

REFERRED TO: Reference Committee C

HOUSE ACTION:

The MSMS Board of Directors appointed an Executive Committee to review the resolution for a recommendation. Executive Committee members were supportive of an initiative to research a state organized medicine led physician union. However, the Committee acknowledged a project of this size was not possible this year as Board and staff leadership have been occupied with the reorganization work. The author was consulted and supportive of revisiting this request at a later date.

RECOMMENDATION: THAT THE 2026 MSMS HOUSE OF DELEGATES DISAPPROVE RESOLUTION 46-25, "PHYSICIAN UNION."

Attachment
Resolution 46-25

1 **RESOLUTION 46-25**
2
3 **Title:** Physician Union
4
5 **Introduced by:** Paul Kocheril, MD
6
7 **Original Author:** Paul Kocheril, MD
8
9 **Referred To:** Reference Committee C
10
11 **House Action:**
12

13
14 Whereas, the number and percentage of physicians employed in Michigan and throughout the
15 country has grown, reports range from 50 – 70 percent of physicians are employed, and
16
17 Whereas, employed physicians usually do not have adequate representation in regards to their
18 employment issues, and
19
20 Whereas, as for-profit, private equity firms have more influence in determining patient care, and
21
22 Whereas, MSMS and the American Medical Association (AMA) are always looking for creative and
23 productive ways to represent the best interest of physicians, and
24
25 Whereas, as an association, MSMS is legally limited in their representation of members in regards
26 to contracting and reimbursement, and
27
28 Whereas, discussions within MSMS and the AMA evaluating the potential of a physicians union has
29 not been completed in at least a decade, therefore be it
30
31 RESOLVED: That MSMS evaluate the feasibility of a state-based physician union.
32

33
34 WAYS AND MEANS COMMITTEE FISCAL NOTE: $27,000-$54,000

Relevant MSMS Policy

Limited Antitrust Exemption for Physicians
MSMS supports a limited physician antitrust exemption to balance the bargaining position between health care insurance companies and physicians and therefore enable fair negotiations. (Res51-07A) – Amended (Sunset Report 2021)

Relevant AMA Policy

Collective Bargaining for Physicians H-385.946
The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

Physician Collective Bargaining H-385.976
Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education

and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians. (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature. (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively. (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients. (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Support for Physicians Pursuing Collective Bargaining and Unionization D-385.943
Our American Medical Association will study opportunities for the AMA or physician associations to support physicians initiating and navigating a collective bargaining process, including but not limited to unionization.

ACTION REPORT #6-26 OF THE BOARD OF DIRECTORS

SUBJECT: Chartering Component/County Medical Societies
14-25 - Rotation of MSMS House of Delegates Meeting Location
16-25 - County and State Medical Society Alliance
47-25 - Study Medical Society Structures

REFERRED TO: Reference Committee on Internal Affairs, Bylaws, and Rules

HOUSE ACTION:

RECOMMENDATION: THAT THE 2026 HOUSE OF DELEGATES ELIMINATE MANDATORY DUAL MEMBERSHIP AND CHARTERING OF COUNTY MEDICAL SOCIETIES.

The Michigan State Medical Society (MSMS) faces significant structural, financial, and membership challenges that threaten its long-term viability. The Reorganization Task Force, appointed by the MSMS Board of Directors following resolutions adopted by the 2025 House of Delegates, was charged with developing recommendations to modernize governance, improve efficiency, and strengthen engagement across the organization.

After extensive review and deliberation, the Task Force unanimously recommends a series of comprehensive structural changes designed to position MSMS for the next decade of success.

MSMS and the County Medical Societies have many long-term, successful partnerships with groups within the physician and health care community including Specialty Societies, Physician Organizations, Medical Schools, Primary Care, and Other Health Care Associations. Reasons vary but all involve common advocacy or activities with set goals or outcomes. These relationships are strictly voluntary and usually work on a per "topic" basis meaning they may be partners on some issues, and not on others. These are productive, collegial, beneficial relationships that work for all parties. MSMS and CMS have a unique partnership as it is as an additional connection via bylaws with joint membership and a financial relationship. This requirement does not exist for any other collaborations.

Throughout this reorganization process, the Task Force reviewed numerous issues surrounding the joint membership requirements. The first, and perhaps the most pressing matter is legal counsel's concerns that MSMS is at legal risk for mandating members to also hold membership in a separate entity (that MSMS does not control and has no ability to exercise oversight of) – this also applies to the county with requiring MSMS membership. MSMS and the CMS have no oversight of each other's expenses, financial controls, dues, or tax filings.

MSMS chartering a CMS and maintaining that charter in and of itself often creates the misconception that the CMS is a division of MSMS rather than a separate entity. The requirement of membership in both MSMS and a component society adds to this misconception. For example, members may claim that the MSMS requirement of dual membership constitutes a representation

by MSMS that component society dues are being collected, safeguarded, and used for proper purposes with MSMS oversight, verification, and management. A court may view this as a reasonable expectation of members, creditors, and others claiming that the component society's relationship to MSMS was misrepresented to them. And further, they were fraudulently induced to pay dues to a defunct or failing component society.

In reviewing the 2025 dues data, MSMS charters 59 component societies. Thirteen are active and collect dues ranging from $50 to $415. Eleven are inactive with no discernible activities but still charge dues. According to the state of Michigan and IRS business filings, two counties have been dissolved by law and nine have no record. Thirty-five counties are mostly inactive and do not charge dues. With the decreases in membership, this has led to smaller county organizations, fewer physicians engaged in the leadership, and overall less oversight. Based on requirements for CPA firms to perform independent financial audits, most of the counties would not qualify as they do not have adequate staffing to meet standards for internal controls, segregation of duties, or approval processes.

The only way to eliminate the risk of claims is to amend the Constitution and Bylaws to eliminate the chartering of component societies by MSMS and the requirement of dual membership in MSMS and a component society. This legal advice protects MSMS, which the MSMS Board has a fiduciary duty to act exclusively in the best interest of MSMS. But also protects County Medical Societies, as County Boards have the fiduciary duty to protect themselves.

Other equally meaningful barriers involve the cost of membership. Selling membership priced at $495, plus the county dues ranging from $100 to $415 has become increasingly difficult. Current membership trends demonstrate this. The price of the dual membership has exceeded the perceived value. This extends from individual membership to groups, even with the quantity discounts. Joint membership requirements also create financial barriers, particularly for younger physicians or those in lower-paying specialties. Options for membership lower the cost of participation, making it easier for more physicians to engage in organized medicine. Additionally, there is significant variability in member benefits and cost across counties, which blurs return of investment for prospective members, individuals, and groups. Even MSMS's initiation of free Continuing Medical Education has not made inroads because the dual costs of membership are still greater than the cost of the education. Staff have tracked several non-members a week choosing to purchase education rather than membership for these reasons. Over the past several years, the State and Counties have attempted to partner together to increase their respective memberships via the Membership Committee. This did not result in a significant increase in membership for either party, which again suggests underlying organizational structural problems.

MSMS and CMS create complex dues pricing with more than 2,300 different membership combinations. Group bills take weeks to produce because they cross counties and require a roster. Group practices that span multiple counties often question the value of CMS membership. The task of assigning members to the appropriate county and calculating an invoice considering the counties varying dues levels is cumbersome at best, and at worst a deterrent to membership. There are real costs associated with billing dues and managing county relationships. The customized membership database with state and county information is complex and expensive. Although MSMS would no longer receive county billing fees ($47,000 in 2025), costs would decrease overall due to software costs and significant staff time.

The practice of medicine in Michigan has changed dramatically over the past decades, and our membership structure should reflect that reality. Many physicians now work as contracted employees, often practicing in multiple locations or across state lines. Mandatory county membership is impractical for these mobile physicians. Michigan is also increasingly an outlier in requiring joint membership. Many states allow physicians to choose county, state, or both independently. Options for dues modernizes MSMS's structure and makes membership more competitive and attractive to physicians relocating from other states.

The Task Force believes CMS are best positioned to understand and address local needs. Independent dues restore the county medical society's flexibility to establish membership policies that reflect individual community priorities, making those societies more responsive and attractive to local physicians. For example, a county could focus on a local health system or medical school. A special project or initiative could be developed that local physicians would like to participate in without the dual dues of the state. MSMS has heard for years that conservative or liberal policies have turned off local physicians from joining. Under this scenario, local physicians could join the county without the conflict of a state position. This encourages both county societies and MSMS to deliver tangible value to their members, enhancing the strength and relevance of organized medicine in Michigan. This change ensures our societies remain inclusive, relevant, and responsive to all physicians. Done well, the counties and the state could all have increases in membership by better meeting the needs of their communities.

As MSMS has lost members, the same is true for the counties. As previously mentioned, MSMS does not have access to CMS financials. MSMS does have county member numbers and membership revenue. See the 5-year report below. Some counties have remained consistent like Macomb (+9), Lapeer (+13), Kalamazoo (+2), St. Clair (-17) and Muskegon (-15). Other counties have experienced more severe declines in members and revenue like Grand Traverse (-74 and -$2,110), Kent (-80 and -$35,389), Ingham (-139 and -$59,690), Oakland (-161 and -$54,803), Washtenaw (-361 and -$89,093), Wayne (-1,620 and $-222,135). Many of these more significant declines can be attributed to the losses of large groups. Revenue for Saginaw and Jackson counties is not included as they bill for themselves.

Mandatory joint membership can discourage participation. Removing this barrier opens the door for more physicians to join either or both organizations, ultimately strengthening county and state organizations. Separating county and state society dues is practical, forward-looking reform that reflects the realities of modern medical practice, welcomes a broader range of physicians, decreases legals risks, and strengthens organized medicine in Michigan.

MSMS and the County Medical Societies are stronger together. The financial requirement does not change our relationship or partnership to represent physicians in Michigan. This is not being proposed and will not change. All organizations will continue to work on policy and advocacy together.

The Task Force recommends the bylaws be amended to allow MSMS and CMS to function independently, therefore adhering to legal recommendations of risk to MSMS; allows counties to focus locally and MSMS at the state level; and applies the same opportunities to MSMS and CMS to be responsible for their own membership and revenue. Partnership and collaboration would remain.

Strong county medical societies and a strong state society are in the best interest of physicians and organized medicine in Michigan. To assist in the transition to independence, the Task Force and Board of Directors will offer the county societies the following:

- MSMS will bill 2027 dues at no cost to allow time for counties to research billing and marketing options
- The MSMS Foundation will provide grant opportunities to assist with transition costs identified by county leadership, examples might be to purchase billing software or developing county specific marketing
- Access to membership reporting portal (excel reports) through 2027
- MSMS CEO, CFO, and COO are available as a resource in reviewing revenue and expenditures
- Provide insurance and benefit consultation
- Continued assistance with legislative meetings, alerts, etc.
- Continuation of one CME application per year at no cost
- Continued assistance with internal and external speakers

Attachment

Task Force on Reorganization's Report (see Miscellaneous Tab)

Resolution 14-25

Resolution 16-25

Resolution 47-25

Proposed Changes to Bylaws

1 **RESOLUTION 14-25**
2
3 **Title:** Rotation of MSMS House of Delegates Meeting Location
4
5 **Introduced by:** E. Chris Bush, MD, for the Wayne County Delegation
6
7 **Original Author:** E. Chris Bush, MD
8
9 **Referred To:** Reference Committee C
10
11 **House Action:**
12

13
14 Whereas, the MSMS House of Delegates (HOD) is an annual meeting for all the Delegates from
15 across the state, and
16
17 Whereas, the MSMS HOD location has traditionally rotated to various locations across the state to
18 be more equitable for the attendees, and
19
20 Whereas, the majority of the Delegates attending the MSMS HOD each year are from the counties in
21 southeast Michigan, and
22
23 Whereas, the MSMS HOD approved Resolution 03-22 which states that the MSMS will continue to
24 rotate the annual HOD meeting between the east and west side of the state, but at least once every
25 12 years, the western meeting shall take place in a northern county, and
26
27 Whereas, moving to a one-day meeting in Lansing, that starts at 10:00 a.m., was done as a cost-
28 reduction measure for MSMS, the costs have been shifted to the Delegates who should have a say
29 in where the annual meeting is held, and
30
31 Whereas, the overall costs of a one-day meeting would be expected to be similar regardless of the
32 geographical location; therefore be it
33
34 RESOLVED: That the MSMS House of Delegates shall return to the rotation of alternating meetings
35 between an outstate venue and a southeast Michigan venue with the 2026 meeting to be held in the
36 Detroit area.
37

38
39 WAYS AND MEANS COMMITTEE FISCAL NOTE: $50,000

	2024/2025 Lansing Actual from Hotel Bill	**2026 Dearborn Actual Proposal – The Henry**
Delegate Beverage and Lunches	$10,400	$13,000
Presidents Reception	$5,400	$7,700
Conference Rooms Rental	$7,800	$29,000
Overnights Students, Staff and Board	$5,300	$22,500
Staff Meals	$2,000	$4,400
Staff Mileage	$0	$3,500
	$30,900	$80,100

Fiscal notes are estimates and should be used as one reference point in determining support or opposition of any resolution.

Of note:

- This comparison does not include the AV contractor, Audience Response System, Signs, Awards, Online Forum, Election Ballot or other meeting costs that do not differ based on location. This cost is approximately $20,000.
- The Henry was used as one comparison for purposes of developing a fiscal note because they are one of few locations in the Detroit area that can accommodate our dates, the combination of number of overnight rooms, number of conference rooms and the House set-up all at one-time. MSMS has received prior proposals from other hotels including the Motor City Casino and the Suburban Showcase which were both significantly more expensive than the Henry. And the Somerset, Novi Sheraton, Southfield Weston, all being either more expensive or lacking enough space for the general session. As regular practice, MSMS always requests multiple proposals for off-site events and would work with individual facilities and the CVB to do so if a Detroit location is needed.
- The Henry proposal includes room rental of $58,000. Only half was used in the fiscal note as staff expects some ability to negotiate contract. Similarly, the food and beverage minimum is $30,000 but only $25,000 is reference in the fiscal note as that is also an area of potential negotiation. That proposal is attached.
- Event documentation involved 3 different pieces. The contract locks in the date, space, pricing for the room rental and overnight rooms, food and beverage minimums, and cancelation clause. The Banquet Event Orders details room set-up, AV, and quantity and selections for food and drink. This will contain some pricing for those items. The final bill will itemize room set-up, AV, and quantity and selections for food and drink. The amounts will differ from the Banquet Event Order as onsite changes occur like additional easels were needed, extra lunches were ordered and typically some food and beverages are charged on consumption. These will be reflected in the final bill.
- Events are also subject to several taxes. As indicated in the Henry proposal, overnight rooms are subject to 6 percent state tax and 8 percent occupancy tax. Food, beverages and rental costs are subject to 24 percent taxable service charge and 6 percent state sales.
- Set up for the House begins at 12:00 noon the day before the meeting. Tear down is completed around 9:00 pm that evening. Staff are allowed to stay the night Friday and Saturday if they wish for the completion of the event and safety of our employees.
- MSMS manages the House of Delegates costs as frugally as possible. Many state associations utilize event management companies which range from $20,000 - $50,000 to assist in preparing for the meeting and staffing onsite. This includes work like loading, unloading, setting up, testing and tearing down the general session room for 300, registration, meeting rooms, event spaces, exhibits. MSMS staff balances this while maintaining their normal day-to-day workloads. Much of the preparation for the House is completed after work hours including the weekends.
- Room calculations

  $250 (includes all tax)
  25 staff/contractors x 2 nights = $12,500
  10 students = $2,500
  10 board x 2 nights = $5,000
  10 board x 1 night = $2,500

The information contained in the fiscal note was prepared by Rebecca Blake, Certified Meeting Planner (CMP) with 25 years of meeting planning experience with the House of Delegates, Annual Scientific Meeting, Board meetings, and thousands of other MSMS events.

Relevant MSMS Policy

Annual Financial Report
Please refer to the Annual Financial Report to the House of Delegates for more information on the organization's finances.

House of Delegates
MSMS continue to rotate the HOD meeting between the east and west 36 side of the state, but at least once every 12 years, the western meeting shall take place in a 37 northern county.

Relevant AMA Policy
None

Sources:

1. Past MSMS HOD Locations: 2010 - Dearborn, Michigan; 2011 - Kalamazoo, Michigan; 2012 - Dearborn, Michigan; 2013 - Grand Rapids, Michigan; 2014 - Dearborn, Michigan; 2015 - Grand Rapids, Michigan; 2016 - Dearborn, Michigan; 2017 - Grand Rapids, Michigan; 2018 - Dearborn, Michigan; 2019 - Kalamazoo, Michigan; 2020 - Dearborn, Michigan; 2021 – Virtual Meeting during COVID; 2022 - Kalamazoo, Michigan; 2023 - Dearborn, Michigan 2024 - Lansing, Michigan; 2025 - Lansing, Michigan
2. Approved MSMS Resolution 03-22 introduced by Ottawa County https://www.msms.org/hodresolutions/2022/3.pdf

RESOLUTION 16-25

Title: County and State Medical Society Alliance

Introduced by: Megan Edison, MD, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee C

House Action:

Whereas, MSMS has had declining membership and revenues, and

Whereas, this loss of membership revenue impacts all physicians across the state as our legislative impact and outreach is limited, and

Whereas, MSMS has significantly restructured itself into a relevant, physician-led, financially viable organization focused on the core mission, and

Whereas, MSMS is aggressively working to regain large group membership to increase membership revenue, diverse physician voices, and our political footprint, and

Whereas, MSMS bylaws and county medical society bylaws require joint membership of physicians in counties with an active medical society, and

Whereas, the number of active county medical societies has diminished significantly over the years so that some counties no longer charge dues while others charge dues, and

Whereas, MSMS has failed to secure large group memberships reportedly due to the cost of required county membership dues, and

Whereas, county medical societies have lost county members reportedly due to cost and/or value of the required MSMS membership, and

Whereas, creative efforts by MSMS to avoid county membership and membership "deals" recommended to and by county medical societies have created undue stress on this relationship as well as test the bylaws of both organizations, and

Whereas, the 10 percent billing fee charged to county medical societies for the required dual membership has proved financially challenging to county societies, and

Whereas, the historical financial binding of county and state medical societies may now be a hinderance to our mutual survival, and

Whereas, the survival and revival of all county medical societies benefits MSMS and Michigan physicians, as county medical societies are the voice to local politicians in a way lobbyists cannot achieve, and

Whereas, the survival and growth of MSMS is crucial to all Michigan physicians and our patients, as the only physician voice in Lansing representing all physicians, allopathic and osteopathic, of all specialties, and inclusive of all stages of their career and place of practice, and

54
55 Whereas, restructuring our state and county medical societies towards mutual growth and
56 purposes will only strengthen organized medicine; therefore be it
57
58 RESOLVED: That MSMS create a task force of physicians across the state, in both county and state
59 society leadership, to do the following:
60
61 1. Examine the history, finances, and bylaws of our county and state societies;
62 2. Be bold and creative in offering a unified solution to solve this historical issue, and future-proof
63 our organizations so we can focus on our mission together;
64 3. Utilize MSMS legal counsel to aid in this effort by examining county medical society and state
65 medical society bylaws and offering a clear plan on how to update county and state medical
66 society bylaws to achieve the mutual goals; and
67 4. Present recommendations to county and state medical societies prior to the 2026 House of
68 Delegates, with any MSMS bylaws changes presented for a first vote at that time.
69

70
71 WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy
None

Relevant AMA Policy
None

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RESOLUTION 47-25

Title: Study Medical Society Structures

Introduced by: Paul Kocheril, MD

Original Author: Paul Kocheril, MD

Referred To: Reference Committee C

House Action:

Whereas, the MSMS Bylaws state the Board "shall have the custody and entire control of all funds and property of the Society" and the House "shall transact all of the business of this Society not otherwise specifically provided for," and

Whereas, in the past, occasional resolutions have lapsed into the financial responsibilities assigned to the Board, and

Whereas, other state societies have clarified and streamlined their organizational structure regarding medical policy and business/financial decisions, and

Whereas, the functioning of MSMS is critical to the future of MSMS and medicine in Michigan; therefore be it

RESOLVED: That MSMS study the organizational structures, Constitution and Bylaws, and business model of other state medical societies as potential options for improving the efficiency and productivity of our organization.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy

ARTICLE IX—THE BOARD OF DIRECTORS

Section 2. - POWERS AND DUTIES—The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions.

14.00 THE BOARD OF DIRECTORS

14.60 DUTIES OF THE BOARD OF DIRECTORS—It shall be the duty of the Board of Directors:

14.61 To make careful inquiry into the condition of the profession in each county in the State. It shall have authority to adopt such methods as may be deemed most efficient for increasing interest in all existing component societies. It shall especially and systematically endeavor to promote friendly intercourse between doctors of medicine in the same locality. It shall make every effort to bring each reputable doctor of medicine in the State under the Society's influence;

14.62 To direct and control the publication of the Journal of the Michigan State Medical Society;

14.63 To provide and maintain such headquarters for this Society as may be required to conduct its business properly;

14.64 To render an Annual Report to the House of Delegates; and

14.65 At least every three years, review the composition of the Board of Directors including the geographical boundaries of the Regions making any recommendations in its discretion it deems necessary.

14.70 CONTROL OF FUNDS—The funds of this Society shall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.

14.71 The Board of Directors shall have the authority to borrow money upon the general credit of the Society. The Board of Directors shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Board of Directors shall authorize and empower the President or the Chair of the Board of Directors, and the Secretary or the Treasurer to execute such instruments as may be required.

12.00 HOUSE OF DELEGATES

12.90 POWERS AND DUTIES—As the legislative body of this Society, the House of Delegates shall have the power arid authority to adopt, institute, and carry out such methods and measures as it may deem to be in the best interests of the medical profession in Michigan. In the exercise of such powers and duties, but without limitation thereof:

12.91 It shall transact all of the business of this Society not otherwise specifically provided for.

12.92 It shall adopt rules and regulations for its own government and for the administration of the affairs of the Society.

12.93 It shall provide for the organization of Regions which shall be depicted on Exhibit A.

12.94 It shall concern itself with and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws, and the health of the public.

12.95 It shall be active in the education of the public in regard to medical research and scientific medicine.

12.96 It shall have the power to identify areas of concern and to instruct the Board of Directors to appoint committees or task forces to study or act on those areas. These committees or task forces shall report to the Board of Directors, which in turn shall report in the annual report of the Board of Directors to the House of Delegates. The House of Delegates shall itself have necessary internal committees, such as I) Credentials, 2) Rules of Orders of Business, 3) Constitution and Bylaws, and 4) Ways and Means. The seated House, by majority vote, reserves the right to instruct the Board of Directors to discharge a specific standing committee, liaison committee, or task force, and to require the Board of Directors to appoint an ad hoc committee with appointees nominated by the seated House. This ad hoc committee shall report through the Board of Directors to the House at the next session, and be discharged.

12.97 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.

12.98 It shall publish its minutes or a summary of its proceedings in the Journal of the Society.

12.99 It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge of hypothecation. It shall have the authority specifically to authorize the Board of Directors and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid.

Relevant AMA Policy

None

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Michigan State Medical Society

Constitution and Bylaws

2023 Edition

CONSTITUTION

~~Regional Map (Exhibit A) 3~~
Article I - Name ~~4~~1
Article II - Purposes ~~4~~1
Article III - Component Societies ~~4~~1
Article IV - Divisions ~~4~~1
Article V - The Society as a Whole ~~4~~1
Article VI - Scientific Assembly ~~4~~1
Article VII - House of Delegates ~~4~~1
Article VIII – Officers and AMA Delegates ~~4~~1
Section 1 - Officers ~~5~~1
Section 2 - AMA Delegates ~~5~~1
Article IX - The Board of Directors ~~5~~2
Section 1 - Composition ~~5~~2
Section 2 - Powers and Duties ~~5~~2
Section 3 - Executive Committee ~~5~~2
Article X - Judicial Commission ~~5~~2
Article XI - Finances ~~5~~2
Section 1 - Method of Financing ~~5~~2
Section 2 - Power to Fix ~~5~~2
Article XII - Amendments ~~5~~2
Section 1 - Method of Amendments ~~5~~2
Section 2 - Effective Date ~~5~~2

BYLAWS

~~**1.00 Component Societies** 6~~
~~1.10~~**1.00** ~~Charter~~**Reserved** ~~6~~**3**
~~1.20 Revocation of Charter 6~~
2.00 Membership—Classification—Election ~~6~~**3**
2.10 Definition ~~6~~3
2.20 ~~Membership Prerequisite~~ ~~6~~Reserved 3
2.30 Active Members ~~6~~3
2.31 Suspended Member ~~6~~3
2.40 Active Members—Dues Exempt ~~7~~3
2.41 Hardship ~~7~~3
2.42 Postgraduate Study ~~7~~3
2.43 Voluntary Service ~~7~~3
2.50 Physicians-In-Training ~~7~~3
2.60 Students ~~7~~3
2.70 Emeritus Members ~~7~~3
2.71 Active Emeritus ~~7~~3
2.72 Emeritus ~~7~~3
2.80 Life Members ~~7~~3
3.10 Service Members ~~8~~4
3.11 Military ~~8~~4
3.12 Commissioned Medical Officers ~~8~~4
3.20 Honorary Members ~~8~~4
3.30 ~~Non-Resident Members~~ ~~8~~Reserved 4
3.40 ~~Affiliate Members~~ ~~8~~Reserved 4
3.50 Resolutions Concerning Membership Changes ~~8~~4
4.00 Membership—Regulation ~~8~~**4**
4.10 Membership as Privilege–Not Right ~~8~~4
4.20 ~~Duties of County Society~~ ~~8~~Reserved 4
4.30 Rosters ~~8~~4
5.00 ~~**Membership—Transfers**~~ ~~**8**~~**Reserved 4**
~~5.10 Change of Location—Procedure 8~~
~~5.20 Refund of Dues 9~~
~~5.30 Removal from State 9~~
6.00 Dues and Assessments ~~9~~**4**
6.10 How Fixed ~~9~~4
6.20 Collection ~~9~~4
6.30 New Members ~~9~~4
6.40 First Year of Practice ~~9~~5
6.50 Arrears—Suspension ~~9~~5
6.60 Deferment ~~9~~5
6.70 Reinstatement ~~9~~5
6.80 Dues—Resident Physicians and Students ~~10~~5
6.90 Active Status—Part-Time Dues ~~10~~5
7.00 Conduct and Discipline of Members ~~10~~**5**
7.10 Standards of Conduct-Grounds for Discipline ~~10~~5
7.20 Discipline-What Constitutes ~~10~~5
7.30 Discipline-What Procedure to Govern ~~10~~5
7.40 ~~Society of More than 150 Members~~ ~~10~~Reserved5
7.50 Peer Review/Ethics Committee ~~10~~5
7.60 Request for Investigation ~~10~~5
7.70 Informal Investigation-Procedure ~~10~~6
7.80 Informal Investigation-Dismissal ~~10~~6
7.90 Informal Investigation-Reprimand ~~11~~6
8.10 Formal Complaint-Notice of Hearing ~~11~~6
8.20 Answer to Formal Complaint ~~11~~6
8.30 Formal Hearing-How Conducted, Right to Counsel ~~11~~6
8.40 Findings and Report ~~11~~6
8.50 Action on Report-Additional Testimony ~~11~~6
8.60 Action by Society ~~11~~7
8.70 Finality and Effectiveness of Order ~~12~~7
8.80 Appeal Procedure ~~12~~7
8.90 Appeal to Judicial Council of the American Medical Association ~~12~~7
9.10 Exception to Procedures ~~12~~7
9.20 ~~Effect of Suspension or Expulsion~~ ~~12~~Reserved7
9.30 Construction ~~12~~7
10.00 Grievances of Non-Members-Peer Review/Mediation Committee ~~12~~**7**
10.10 Peer Review/Mediation Committee ~~12~~7
10.20 Purposes ~~12~~7
10.30 Powers and Duties-Limitation ~~13~~8
10.40 Procedure to Govern ~~13~~8
11.00 General Meetings ~~13~~**8**
11.10 Determination of Time and Place ~~13~~8
11.20 Right to Participate ~~13~~8
11.30 Actions ~~13~~8

[Different first page setting changed from off in original to on in modified.].

12.00 House of Delegates ~~13~~8
12.10 Composition ~~13~~8
12.20 Delegates-At-Large, Ex Officio Members ~~13~~8
12.30 Election—Certification ~~14~~9
12.40 Seating—Tenure ~~14~~9
12.50 Seating of Alternate Delegates ~~14~~9
12.60 Officers ~~14~~9
12.70 Meetings—Annual Session ~~14~~9
12.80 Quorum ~~14~~9
12.90 Powers and Duties ~~14~~9
13.10 Reference Committees ~~15~~10
13.20 Election of Regional Directors ~~15~~10
13.30 Election of Delegates to American Medical Association ~~15~~10
13.40 Election of Officers ~~16~~11
13.50 Resolutions ~~16~~11
13.60 New Business ~~16~~11
13.70 Rules of Order ~~16~~11
13.80 Nominating Committee ~~16~~11
14.00 The Board of Directors ~~16~~11
14.10 Organization ~~16~~11
14.20 Executive Committee ~~16~~11
14.30 Reference Committees ~~16~~11
14.40 Regional Director Duties ~~17~~12
14.50 Removal of Regional Director ~~17~~12
14.60 Duties of the Board of Directors ~~17~~12
14.70 Control of Funds ~~17~~12
14.80 Regions ~~17~~12
15.00 The Judicial Commission ~~17~~12
15.10 Composition—Qualifications ~~17~~12
15.20 Judicial Districts ~~17~~12
15.30 Nominations ~~17~~12
15.40 Ballot—Election ~~18~~13
15.50 Terms of Office ~~18~~13
15.60 Vacancies ~~18~~13
15.70 Organization of the Commission ~~18~~13
15.80 Powers and Duties ~~18~~13
16.00 Committees/Task Forces of the Society ~~19~~14
16.10 Standing Committees ~~19~~14
16.20 Liaison Committees ~~19~~14
16.30 Task Forces ~~19~~14
17.00 Officers ~~19~~14
17.10 Term of Office ~~19~~14
17.20 Induction of President ~~19~~14
17.30 President ~~19~~14
17.40 President-Elect—Duties—Succession ~~20~~15
17.50 Chair of the Board ~~20~~15
17.60 Vice-Chair ~~20~~15
17.70 Treasurer ~~20~~15
17.80 Secretary ~~20~~15
17.90 Chief Executive Officer ~~20~~15
18.10 Speaker of the House of Delegates ~~20~~15
18.20 Vice-Speaker of the House of Delegates ~~20~~15
18.30 Remuneration ~~20~~15
19.00 Indemnification ~~20~~16
20.00 Specialty and Ethnic Medical Societies ~~21~~16
20.10 Recognized Specialty and Ethnic Medical Societies ~~21~~16
20.20 Criteria ~~21~~16
20.30 Resident and Fellow Section ~~21~~16
20.40 Medical Student Section ~~21~~16
20.50 Organized Medical Staff Section ~~21~~16
20.60 Young Physicians Section ~~22~~17
20.70 International Medical Graduates Section ~~22~~17
21.00 Referendum ~~22~~17
21.10 Referendum at Society Meeting ~~22~~17
21.20 Referendum by House of Delegates ~~22~~17
22.00 Seal ~~22~~17
22.10 Seal ~~22~~17
23.00 Emergency ~~22~~17
23.10 Emergency Action by Board of Directors ~~22~~17
24.00 Definition of Session and Meeting ~~22~~17
24.10 Session ~~22~~17
24.20 Meeting ~~22~~17
25.00 Amendments ~~22~~17
25.10 Amendments—Procedure ~~22~~17
OFFICIAL PROCEDURES FOR THE JUDICIAL COMMISSION ~~23~~18
Judicial Commission Districts Map ~~25~~20

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MSMS Constitution

2023 Edition

ARTICLE I—NAME

Section I. - NAME—The name of this organization shall be the Michigan State Medical Society ("MSMS").

ARTICLE II—PURPOSES

Section I. - PURPOSES—The purposes of this Society shall be: To bring into one viable, effective organization the ethical physicians licensed to practice in Michigan in order that their contribution to human welfare will be enhanced.

In order to accomplish this effectively, the Society also will work to accomplish the following sub purposes:

a) To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.

b) To ~~charter and organize~~affiliate with component medical societies for the purpose of electing delegates to the House of Delegates in accordance with section 12 of the bylaws and electing Regional Directors in accordance with Article IX of this Constitution.

c) To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

d) To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his or her patients and the public health generally.

e) To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

f) To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals.

g) To preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care.

h) To promote quality medical and health care by development and support of activities appropriate to this goal.

i) To advocate fair remuneration for services rendered.

j) To ensure adequacy of the medical workforce by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.

k) To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians.

1) To support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession.

m) To institute and provide specific services to meet the needs of the members.

n) To foster and support continuing medical education.

ARTICLE III—COMPONENT SOCIETIES

Section 1. - DEFINITION—Component societies shall consist of those county medical societies which ~~hold charters from this Society~~elect and send delegates to the House of Delegates in accordance with Section 12 of the bylaws and who participate in the election of Regional Directors in accordance with Article IX of this Constitution.

Section 2. - GEOGRAPHICAL SCOPE—Not more than one component society shall be chartered in any county of the State. The House of Delegates may, however, in its discretion, grant a charter to a component society comprising two or more counties.

ARTICLE IV—DIVISIONS

Section 1. - DIVISIONS—The Society shall have three major divisions, namely:

1) The Society as a whole.

2) The Scientific Assembly with its subordinate or related bodies.

3) The House of Delegates with its subordinate or related bodies.

ARTICLE V—THE SOCIETY AS A WHOLE

Section 1. - SESSIONS—The Society as a whole shall hold such sessions at such times and places of such duration as the House of Delegates may determine. The power to so determine may be delegated to the Board of Directors or to the Executive Committee of the Board of Directors by the House of Delegates.

ARTICLE VI—SCIENTIFIC ASSEMBLY

Section I. - DEFINITION—The Scientific Assembly of this Society is the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine and to the conservation of the health of the public.

ARTICLE VII—HOUSE OF DELEGATES

Section 1. - COMPOSITION—The House of Delegates shall be the legislative body of the Society and shall consist of delegates elected by component societies, recognized specialty societies, delegates from the Residents and Fellows, Students, Young Physicians, Organized Medical Staff and International Medical Graduates Sections, and other sections as shall from time to time be approved by the House of Delegates, delegates-at-large and ex officio members, as prescribed by the Bylaws.

ARTICLE VIII—OFFICERS AND AMA DELEGATES

Section 1. - OFFICERS—The officers of this Society shall be a President; a President-Elect; the Immediate Past President; a

Treasurer; a Secretary; a Speaker and a Vice-Speaker of the House of Delegates and shall be elected as provided in the Bylaws.

Section 2. - AMA DELEGATES—The Society's delegates and alternate delegates to the House of Delegates of the American Medical Association shall be elected as provided in the Bylaws. *(See Bylaws, Section 13.30)*

ARTICLE IX—THE BOARD OF DIRECTORS

Section 1. - COMPOSITION—The Board of Directors shall be the executive body of the Society. Effective at the first meeting of the Board of Directors immediately following the final meeting of the House of Delegates held at its 2020 Annual Session, the Board of Directors shall consist of:

a) Two Directors (the "Regional Directors") from each of the nine regions depicted on Exhibit A to the Bylaws (each a "Region" and collectively the "Regions"). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula.

b) The President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker and Vice Speaker of the House of Delegates.

c) One Director elected by those members in each of the membership classifications defined in Sections 2.50 and 2.60 of the Bylaws, and one Director elected by those members in the Young Physicians Section as defined in Section 20.60 of the Bylaws. These seats will be for one-year renewable terms, and the directors elected must remain in the category elected for the entire term.

d) The following ex officio Directors: (i) the Chair of the delegates to the AMA or another member of the delegation, designated as a substitute; and (ii) the two members serving as the physician representatives on the Blue Cross Blue Shield of Michigan Board of Directors.

e) Up to six Directors elected by the House of Delegates representing those constituencies deemed from time to time the most relevant to the current health care marketplace to be designated by the nominating committee of the House of Delegates with input from the Board of Directors and the House of Delegates (the "Designated Directors"). The Designated Directors shall serve three-year terms. Designated Directors may not serve more than three consecutive terms; the same individual may serve additional terms after an absence of at least one year.

Section 2. - POWERS AND DUTIES—The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions.

Section 3. - EXECUTIVE COMMITTEE—The Board of Directors may have an Executive Committee with power to act between meetings of the Board. The composition, powers and duties thereof shall be such as are prescribed by the Bylaws.

ARTICLE X—JUDICIAL COMMISSION

Section 1. - COMPOSITION - POWERS AND DUTIES—The Judicial Commission shall be the body having general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members and professional conduct generally. It shall consist of members to be elected by the voting members of the Society. The number of members, their terms of office, the time and manner of their election and the specific powers and duties of the Commission shall be as prescribed by the Bylaws.

ARTICLE XI—FINANCES

Section 1. - METHOD OF FINANCING—Funds for meeting the expenses of the Society shall be raised by annual dues and may be augmented by other methods including special assessments and voluntary contributions.

Section 2. - POWER TO FIX—Annual membership dues and assessments shall be fixed by the House of Delegates.

ARTICLE XII—AMENDMENTS

Section 1. - METHOD OF AMENDMENTS—The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates seated at any regular session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been published at least once during the interval in the Journal of the Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

Section 2. - EFFECTIVE DATE—Unless otherwise provided herein, this Constitution and all amendments hereto shall become effective immediately upon adoption by the House of Delegates.

MSMS Bylaws

2023 Edition

1.0 RESERVED

~~1.00 COMPONENT SOCIETIES~~

~~1.10 CHARTER - The charter of each component society shall be authorized by the House of Delegates and signed by the President and Secretary. Such charter shall require that the constitution and bylaws of such component society be at all times consistent with the provisions of the Constitution and Bylaws of this Society and with all amendments thereto hereafter adopted. Each component society shall file with the State Society headquarters a current copy of its constitution and bylaws.~~

~~1.20 REVOCATION OF CHARTER - The House of Delegates is empowered to revoke the charter of any component society whenever it finds that such society has materially breached any of the provisions of the Constitution or Bylaws of this Society or has failed to function within the expressed spirit and purpose of this Society to such an extent that revocation of charter is compatible with the best interests of this Society.~~

~~Petition for the revocation of charter of any component society may be filed with the Board of Directors by a Director of the Region within which such society is located, or by any three members of the Board of Directors of this Society or by the President of this Society. Such petition shall be in writing and set forth with reasonable particularity the matters complained of and upon which the petition is founded. A copy of such a petition together with written notice of the time and place of hearing on the petition shall be served on the affected component society by registered mail, return receipt requested, not less than 60 days before the date of such hearing.~~

~~The affected component society may, within 30 days after service upon it of copy of the petition, file with the Board of Directors by registered mail, return receipt requested, a written answer thereto. The Board of Directors shall afford the affected component society a fair hearing of the matters complained of and a suitable opportunity to present its defense. The component society may be represented by legal counsel. Written arguments may be filed on behalf of the affected component society and by the petitioner. Stenographic notes shall be made of the entire proceedings on such hearing and a complete record shall be prepared, which record shall consist of the petition, answer, testimony, exhibits, written arguments and other pertinent matter.~~

~~The Board of Directors shall make its decision based on the records, setting forth in writing the finding of facts, conclusions and reasons therefore. If two-thirds of the members of the Board of Directors do not concur in the conclusion that the charter of the affected component society should be revoked, the petition shall be deemed dismissed and the proceedings ended. If two-thirds of the members of the Board of Directors concur in the conclusion that the charter of the affected component society should be revoked, the Chair of the Board of Directors shall transmit to the House of Delegates a report, consisting of the decision of the Board of Directors with all records annexed, and shall serve a copy thereof on the affected component society. The House of Delegates shall at the next regular or special session thereof following the transmittal of such report, consider and take such action on the report as it may deem proper. In case the House of Delegates desires further proofs in relation to the issues involved, it may remand the matter to the Board of Directors for further hearing and report. The action of the House of Delegates on the report of the Board of Directors shall be the final decision with reference to the revocation of the charter of a component society; provided, that the component society, if it feels aggrieved by the decision of the House of Delegates, may, within six months, appeal to the Council on Judicial and Ethical Affairs of the American Medical Association, whose opinion shall be final.~~

2.00 MEMBERSHIP—CLASSIFICATION—ELECTION

2.10 DEFINITION - As used in these Bylaws, except as otherwise herein expressly qualified, whenever the terms “doctor of medicine” or “practice of medicine” or “medical profession” are used, these terms shall be deemed to include the terms “doctor of medicine and doctor of osteopathy,” “practice of medicine and practice of osteopathy,” and “medical profession and osteopathic profession.”

~~2.20 MEMBERSHIP PREREQUISITE All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society where they reside or primary location of practice or direct members through the Resident and Fellow Section or the Medical Student Section.~~

2.20 RESERVED

2.30 ACTIVE MEMBERS - To be eligible for active

membership in ~~any component society~~MSMS, doctors of medicine must hold an unrevoked, permanent license that is not currently under suspension in Michigan, or if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership~~ in any component society~~, doctors of medicine must ~~maintain active membership in this Society and~~ comply with all the provisions of the Bylaws~~ of this Society and the component society~~.

2.31 Suspended Member - If an Active Member's license is suspended, ~~his/her component society~~MSMS may change his/her membership classification to "Suspended Member." Those in the Suspended Member classification shall be so recognized by this Society, will not be responsible for dues payments, nor be eligible for holding any office or serve on any committee. ~~The component society~~MSMS shall reinstate anyone in the Suspended Member classification immediately upon notice of reinstatement of his/her license.~~ The Society shall recognize such a reinstatement upon notice from a component society and the member shall again be obligated to pay dues, eligible to hold office and serve on committees.~~

2.40 ACTIVE MEMBERS - DUES EXEMPT - Members in any of the following three categories shall be classified "Active-Dues Exempt" and shall have all the privileges of active membership.

2.41 Hardship - Members for whom the payment of dues would be a financial hardship by reason of physician disability or illness may be excused, fully or partially, from payment of dues by the Board of Directors provided the member is fully or partially exempted from the payment of component society dues. Members may also be excused from payment of dues because of financial hardship, or for other reason, but these must be set forth by the secretary of the member's component society.

2.42 Postgraduate Study - Active membership may be maintained by those members who are out of practice on account of postgraduate medical studies, by payment of dues of PHYSICIANS-IN-TRAINING covered in Section 2.50.

2.43 Voluntary Service - Members who serve as missionaries or who participate, for nominal or no compensation in a government-sponsored volunteer medical program, either in the United States or abroad.

2.50 PHYSICIANS-IN-TRAINING - Physicians-in-training in AMA-approved programs who have licenses to practice in Michigan or fellowships, members serving as their primary occupation in a structured educational program begun immediately upon completion of medical school, residency, or fellowship training, may become active members of ~~the State Medical Society through a component society or directly where no provision for reduced dues active membership exists at the component level. State Society dues for resident members~~MSMS. Dues for physicians-in-training shall be set by the Board of Directors of MSMS.~~ Component dues, if any, shall be determined locally.~~

2.60 STUDENTS (MEDICAL STUDENT SECTION) - Medical students may become members of ~~the State Medical Society through a component society or directly through the MSMS Medical Students Section.~~

MSMS.

Except as provided in Section 12.10 of these Bylaws, they may not vote or hold office. They may be appointed to MSMS committees as student members. ~~State Society dues~~ Dues shall be set by the Board of Directors to cover administrative costs of membership except in the first year of membership.~~ Component dues for students shall be determined at the local level.~~

2.70 EMERITUS MEMBERS—Members who have maintained active membership in any one or more component societies in Michigan for a period of five or more years, and who have retired from practice, may be transferred to the emeritus members roster of ~~such component society and this society~~MSMS, provided the member's dues have been paid to the end of the preceding calendar year

2.71 ACTIVE EMERITUS—A member who has been elected an active emeritus member, who pays an annual fee set by the Board of Directors, shall be classified as an active emeritus member. Active emeritus members will receive Society publications; may serve on committees; may vote in elections and hold officer positions; may serve as delegate or alternate delegate to House of Delegates; will be included in the Society membership count; will be included in the count for Delegates to the House of Delegates; will be eligible for Society insurance and member rate for Society sponsored continuing education.

2.72 EMERITUS—A member who has been elected an emeritus member, who does not pay the annual fee set by the Board of Directors, shall be classified as an emeritus member. Emeritus members will not receive Society publications by mail but will be able to have member access to the MSMS website and to participate in MSMS online activities; may not serve on committees; may not vote in elections and hold officer positions; may not serve as delegate or alternate delegate to House of Delegates; will be included in the Society membership count; will not be included in the count for Delegates to the House of Delegates; will be eligible for Society insurance and member rate for Society sponsored continuing education.

2.80 LIFE MEMBERS

2.81 Doctors of medicine who have maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues paid for the previous calendar year and who 1) have attained the age of 70 years or 2) have been in practice for 50 years, may be transferred to the life membership roster of ~~the component society and this Society~~MSMS.

2.82 Each President, Chair of the Board of Directors and Speaker of the House of Delegates of this Society shall, upon retiring from office, become a life member of this Society without further action.

2.83 Life members shall pay no dues or assessments but shall have the right to vote and hold office and shall be entitled to receive publications at such rates as the Board of Directors may determine.

2.84 No members shall be transferred to the former life member classification following the 149th session of the House of Delegates held on Sunday, April 27, 2014.

3.10 SERVICE MEMBERS

Service members shall pay no dues and are not entitled to vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.

3.11 Military - Members in good standing who serve on active duty in the military forces of the United States may be transferred by the component society to service member status for the period of time such service continues.

3.12 Commissioned Medical Officers - Commissioned medical officers of the United States Army, Navy, Public Health Service, or physicians employed by the Veterans Administration, on duty in this State, who are not engaged in the private practice of medicine, may be granted service members status by the component society in the area where the medical officer is located.

3.20 HONORARY MEMBERS - A component society may elect as an honorary member any person distinguished for service or attainments in medicine or the allied sciences, or who have rendered other services of unusual value to organized medicine or the medical profession. Upon recommendation of a component society, the House of Delegates may elect such persons honorary members of the Society. Honorary members shall pay no dues and shall be without the right to vote or hold office in ~~either this or the component society~~MSMS.

3.30 RESERVED.

3.40 RESERVED.

~~3.30 NON-RESIDENT MEMBERS - A component society may elect as non-resident members any doctors of medicine residing and practicing outside of the county who are members in good standing of their Michigan component societies. Non-resident members shall not have the right to vote or hold office.~~

~~3.40 AFFILIATE MEMBERS - Component societies may~~

~~elect to affiliate membership lay persons in areas of endeavor which are related to medicine and medical practice. Affiliate members shall pay no dues and may not vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.~~

3.50 RESOLUTIONS CONCERNING MEMBERSHIP CHANGES - Any change in membership status which requires action by the House of Delegates shall be effected by resolution presented at an Annual Session of the House of Delegates after such secretarial certification as is required by these Bylaws.

4.00 MEMBERSHIP—REGULATION

4.10 MEMBERSHIP AS PRIVILEGE - NOT RIGHT—Anyone eligible may apply for ~~component~~MSMS membership~~ within the county where they reside or primary location of practice. Any exception would require written, mutual agreement between the physician and/or physician group, MSMS, and the respective county(ies)~~. Admission to membership in ~~any component society~~MSMS is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of ~~such society. Each component society may~~MSMS. MSMS shall determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation.

~~4.20 DUTIES OF COUNTY SOCIETY—Each component society shall have general direction of the affairs of the profession in its county or counties and shall be under the continuing duty to exert its influence for the betterment of the scientific, moral, and material conditions of the doctors of medicine therein. It shall also be its duty to make systematic effort to bring every eligible doctor of medicine into membership therein.~~

4.20 RESERVED.

4.30 ROSTERS—The secretary of ~~each component society~~MSMS shall keep a roster of its members and, if practicable, a list of non-affiliated doctors of medicine in ~~the county~~Michigan, and other doctors of medicine, such as commissioned officers of the Navy, Army, and Public Health Service, in which shall be shown the full name, the address, the college and date of graduation, the date of license to practice in this State, and such other information as may be deemed necessary, or desirable.

5.00 ~~MEMBERSHIP—TRANSFERS~~RESERVED

~~5.10 CHANGE OF LOCATION - PROCEDURE—When a member of a component society, by reason of change of residence or primary location of practice, desires to transfer membership to another component society, such member shall make application thereto accompanied by tender of dues for the remaining half of the current year (any major fraction of a half being regarded as a full half and any minor fraction being disregarded). Thereupon, the secretary of the society to which application is made shall request certification of standing from the Society from which the member desires to transfer and upon receipt of such request the secretary of the latter Society shall supply certification of good standing, provided the following requirements have been met:~~

~~5.11 All component society dues and assessments shall have been paid for the calendar year previous to the year in which application for transfer is made.~~

~~5.12 The member shall not be delinquent in the payment of dues and assessments to this Society.~~

~~5.13 Component society dues and assessments shall have been paid to cover that portion of the year in which application for transfer is made (any major fraction of a half year being regarded as a full half and any minor fraction being disregarded).~~

~~Upon favorable action by the component society to which application has been made, following compliance with the foregoing, the transfer of membership shall be in effect.~~

~~5.20 REFUND OF DUES A member who has transferred to another component society in accordance with the provisions of paragraph 5.10 above, shall be entitled to a refund from the Society from which such member has transferred, of prepaid dues to such Society (any major fraction of a half year being regarded as a full half and any minor fraction being disregarded).~~

~~5.30 REMOVAL FROM STATE A member of this Society who, by reason of removal from the State, desires to resign from membership in the component society and in this Society and make application for membership in a society of another state, may submit his or her resignation to the secretary of the component society and the Secretary of this Society and request certification of good standing. The resignation from each shall be effective at the end of the half year in which submitted. If, at the time of resignation, the member is in good standing, is not facing charges of unethical conduct and is not in arrears in the payment of dues and assessments to this or to the component society, the secretary of each Society shall furnish him or her certification of good standing.~~

~~If the resigning member shall have prepaid dues to this Society or to the component society for any period beyond the half year in which resignation becomes effective, such excess shall be refunded by the respective Societies.~~

6.00 DUES AND ASSESSMENTS

6.10 HOW FIXED—Members of this ~~Society~~MSMS shall pay such dues and assessments as shall, from time to time, be fixed and determined by the House of Delegates.

6.11 Notwithstanding Section 6.10, the Board of Directors shall have the authority to implement pilot membership incentive programs within the standard dues structure.

~~Prior to implementing a pilot membership incentive program full consideration shall be given to the impact upon component society dues.~~

6.20 COLLECTION—All dues are to be collected on or before April 1 of each year in a manner set by ~~this society in consultation with the component society~~MSMS.

6.30 NEW MEMBERS—For the purpose of determining the dues for new members only, the fiscal year of this Society shall be divided into two six-month periods. New members shall pay adjusted annual dues and assessments for the unexpired semiannual periods of that year. Such new members shall not be entitled to membership benefits until their election to membership has been duly reported to the Secretary of this Society and they shall not be entitled to membership benefits for any period prior to becoming members in good standing.

6.40 FIRST YEAR OF PRACTICE—The annual dues payable to this Society by a doctor of medicine who is elected to membership during the first year of practice, shall be 25 percent of the amount fixed and determined pursuant to Section 6.10 during the first year of practice, 50 percent of such amount during the second year of practice, 75 percent of such amount during the third year of practice and the full amount during the fourth year of practice. This reduction in annual dues shall not exempt such member from the payment of any regularly levied assessment.

6.50 ARREARS - SUSPENSION—Any member in arrears in the payment of dues assessments to this Society on the date in any year which coincides with the suspension date of the American Medical Association (currently March 1), if no extension of time for payment has been granted under the provisions of Section 6.60 of this Chapter, or upon the expiration of such extension as may have been granted there-under, shall stand suspended until all sums in arrears have been paid. However, if the ~~secretary of the component society~~Member shall certify to the Secretary of this Society ~~that the name of the member in arrears is to be submitted to~~he/she will submit to the House of Delegates at its next Annual Session for election to a different classification of membership under the provisions of Chapter 2.00 hereof, such member shall not be suspended pending action by the House of Delegates upon such requested change of classification.

6.60 DEFERMENT—Upon written request of ~~the governing body of a component society~~a Member to the Board of Directors of this Society, a member shall be granted an extension of time for the payment of dues to this Society, provided, such extension shall not be beyond the close of the current fiscal year of this Society.

6.70 REINSTATEMENT—A member who is in arrears in the payment of dues or assessments ~~to this or the~~

~~component society~~ for not more than one year may be reinstated to good standing upon payment of all arrearages. If in arrears for more than one year, such member shall be deemed to have forfeited membership. ~~In such case the component society may reinstate such member to membership in good standing upon the payment of all arrearages or may, at its option, require reapplication for election to membership.~~

6.80 DUES - RESIDENTS, FELLOWS AND STUDENTS—Dues for these membership categories shall be set by the Board of Directors as defined in Sections 2.50 and 2.60.

6.90 ACTIVE STATUS - PART-TIME DUES—Dues for the following categories will be one-half the annual active membership dues rate. Members in these categories will have all the privileges of active membership. Eligibility for these categories will be determined prior to the due date for the payment of dues each year and thereafter verified on a yearly basis.

6.91 A member who works less than 20 hours per week.

6.92 Members sharing one full-time position, each working 50 percent within a practice.

6.93 A physician spouse of a full dues paying active member.

7.00 CONDUCT AND DISCIPLINE OF MEMBERS

7.10 STANDARDS OF CONDUCT - GROUNDS FOR DISCIPLINE—Any conduct of a member of this ~~or any component~~ society, whether or not occurring in the course of a physician-patient relationship, which

7.11 is in violation of the Principles of Medical Ethics of the American Medical Association, or

7.12 constitutes unprofessional and dishonest conduct as defined by Act 368 or the Public Acts of Michigan of 1978, as amended, or

7.13 results in conviction of a felony under the laws of any state or of the United States of America, or

7.14 is in violation or disregard of the constitution, bylaws, principles, rules, regulations or orders of this Society or of its Judicial Commission or of the American Medical Association, or

7.15 constitutes defamation or otherwise unjust reflection on the integrity, character or professional performance or reputation of a fellow member of the profession, or

7.16 is prejudicial to or tends to expose the medical profession of this ~~or a component~~ society to contempt or reproach, or which is in anywise contrary to ethics, honesty or good morals, shall be grounds for discipline. The willful failure or refusal of a member whose conduct has been called into question to appear before any disciplinary body upon request or to cooperate with such disciplinary body or the Judicial Commission in any authorized investigation shall also, in and of itself, be grounds for discipline.

7.20 DISCIPLINE - WHAT CONSTITUTES— Discipline as used in this chapter shall include reprimand, suspension and expulsion, and for grievous offense, recommendation to the State licensing authority for revocation of license.

7.30 DISCIPLINE - WHAT PROCEDURE TO GOVERN—All disciplinary proceedings conducted by this Society ~~or by any component society~~, shall be governed by the provisions of this chapter and the current Official Procedures of the Judicial Commission~~, any provisions of the constitution or bylaws of any component society to the contrary notwithstanding~~. Any provisions of this chapter in conflict with the Official Procedures of the Judicial Commission shall be of no effect.

~~7.40 SOCIETY OF MORE THAN 150 MEMBERS— Any component society having more than one hundred fifty active members may, by appropriate provisions in its Constitution or Bylaws, delegate its authority and power to discipline its members to the governing board of such Society, in which event, all of the functions, powers and duties of a component society as set forth in this Chapter shall be exercised and carried out by such governing board. Unless otherwise provided by the Constitution or Bylaws of such component society, any order of expulsion or suspension made by such governing board shall be subject to the approval of the component society in the same manner as may be provided for the approval of any other report of such governing board.~~

7.40 RESERVED.

7.50 PEER REVIEW/ETHICS COMMITTEE—~~Every component society~~MSMS shall have a standing committee designated the Peer Review/Ethics Committee, charged with duties and powers concerning the maintenance of standards of conduct and discipline of members, including the duties and powers specifically set forth in this chapter.

7.60 REQUEST FOR INVESTIGATION—Upon the receipt by ~~a component society~~MSMS of a written request for investigation of the conduct of one of its members, signed by an active member or committee of ~~such component society~~MSMS and setting forth briefly the alleged facts of such claimed misconduct, such request for investigation shall be referred to the Peer Review/Ethics Committees.

7.70 INFORMAL INVESTIGATION PROCEDURE—The Peer Review/Ethics Committee shall thereupon make such informal investigations as the circumstances and nature of the matter require. The procedure to be followed shall be determined by the

Peer Review/Ethics Committee but shall be such as to insure that the member whose conduct is questioned has full opportunity to be heard and to offer any defense or explanation available to him or her.

7.80 INFORMAL INVESTIGATION - DISMISSAL—Upon conclusion of its informal investigation the Peer Review/Ethics Committee if it decides that there is no ground for discipline shall dismiss the matter and so report to the ~~Society~~Board of Directors.

7.90 INFORMAL INVESTIGATION REPRIMAND—If, upon the conclusion of its informal investigation, the Peer Review/Ethics Committee decides that the member whose conduct is questioned is guilty of conduct warranting only a reprimand it shall forthwith administer such reprimand and so report to the ~~Society~~Board of Directors unless a formal hearing is demanded by the member.

8.10 FORMAL COMPLAINT-NOTICE OF HEARING—If the Peer Review/Ethics Committee finds there is reasonable cause to believe that the respondent is guilty of misconduct warranting suspension or expulsion from membership, or if the respondent demands a formal hearing, a formal complaint setting forth the facts of the alleged misconduct shall be prepared by the Peer Review/Ethics Committee and subscribed by the Chair or Vice-Chair thereof. ~~A copy of such complaint shall be filed with the component society.~~ Thereupon, it shall be the duty of the Peer Review/Ethics Committee or its Chair to fix the time and place for a formal hearing thereon. A written notice of such hearing, together with a copy of the formal complaint, shall be served on the respondent by registered or certified mail, ~~or other appropriate means as approved by the MSMS Judicial Commission,~~ not less than thirty days before the date of such hearing.

8.20 ANSWER TO FORMAL COMPLAINT—It shall be the duty of the respondent to file an answer to the formal complaint. Such answer shall be in writing, signed by the respondent, and filed with the Peer Review/Ethics Committee within fifteen days after service of the copy of the formal complaint. The answer shall admit or deny each material allegation contained in the complaint, and shall set forth any special defenses which the respondent claims to have. If the answer is not filed within the time hereby limited, the complaint may be taken as confessed.

8.30 FORMAL HEARING - HOW CONDUCTED - RIGHT TO COUNSEL—It shall be the duty of the respondent to appear before the Peer Review/Ethics Committee in person at the time and place specified in such notice. Both the respondent and the Peer Review/Ethics Committee shall be entitled to be represented by counsel at such hearing. At such formal hearing, it shall be the duty of the respondent to answer fully and fairly all questions pertaining to conduct which may be asked by any member of the Peer Review/Ethics Committee of the component society or its counsel. Formal hearings shall be conducted fairly, but not necessarily in accordance with all rules governing court trials. A stenographic record shall be made of the proceedings at such hearings.

8.40 FINDINGS AND REPORT—If upon formal hearing the Peer Review/Ethics Committee finds that the charges of misconduct are not established by a preponderance of the evidence, the Committee shall dismiss the complaint. If the Committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant discipline by way of reprimand, the Committee shall administer such reprimand, and shall make a written report thereof, together with its findings of fact, to the ~~component society~~Board of Directors. If the Committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant suspension or expulsion from membership by action of the component society, the Committee shall make a written report of the proceedings held before the Committee, and shall include in such report a certified transcript of the evidence, including copies of all documents taken in proof, a summary statement of all previous misconduct for which the respondent has been disciplined, and the Committee's findings of fact and recommendations for discipline. Every such report shall be signed by not fewer than a majority of the members of the Peer Review/Ethics Committee, and shall be filed with the ~~component society~~Board of Directors.

8.50 ACTION ON REPORT - ADDITIONAL TESTIMONY—Whenever a Peer Review/Ethics Committee files a report with ~~its component society~~the Board of Directors recommending suspension or expulsion as herein provided, the respondent shall be served with a copy of the Committee's findings of fact and recommendations so filed, not less than twenty days before the meeting of the ~~component society~~Board of Directors at which such recommendations are to be considered and acted on, together with a notice of the time and place of such meeting. The respondent may thereupon file with the Society not less than ten days before such meeting reasons in writing why the recommendations of the Peer Review/Ethics Committee should not be adopted. The respondent may also at such meeting appear in person and offer any further reasons why such respondent should not be suspended or expelled from membership; provided, however, that at such meeting no testimony as to any matter of misconduct shall be taken. If it is decided at such meeting that the interests of justice require additional testimony to be taken, the matter shall be referred to the Peer Review/Ethics Committee for such purpose. In such event the Peer Review/Ethics Committee shall cause such additional testimony to be taken promptly, and shall make a supplemental report thereon, including findings of fact and recommendations based thereon, and shall file the same, together with a certified

transcript of such additional testimony with the ~~component society~~Board of Directors. A copy of the findings of fact and recommendations contained in the supplemental report shall be served on the respondent as required in the case of an original report, and thereafter the same procedures shall be followed as in this section provided in relation to an original report.

8.60 ACTION BY SOCIETY—Following the filing of any such report of a Peer Review/Ethics Committee recommending suspension or expulsion, the ~~component society~~Board of Directors shall, at a regular meeting thereof, or at a special meeting called for such purpose, consider and act upon the report and recommendation of the Peer Review/Ethics Committee. Suspension or expulsion from membership shall require the affirmative vote of not less than two-thirds of members present at any such meeting and entitled to vote thereat, but not including the respondent, who shall have no right to vote on the question. If any measure for discipline is adopted by ~~a component society~~the Board of Directors, an appropriate order in accordance therewith shall be signed by the President and Secretary of ~~such Society~~MSMS and a copy thereof served on the respondent~~ and on the Michigan State Medical Society~~.

8.70 FINALITY AND EFFECTIVENESS OF ORDER—No order of suspension or expulsion from membership shall be final or effective until the respondent shall have been given the opportunity to exhaust remedies of appeal and review in accordance with the provisions of this Chapter.

8.80 APPEAL PROCEDURE—Any member feeling aggrieved by an order of suspension or expulsion may appeal to the Judicial Commission of the Michigan State Medical Society. Notice of such appeal shall be in writing, signed by the appellant and shall set forth specific reasons for the appeal. The notice shall be served on the Judicial Commission ~~and on the appellant's component society~~ by registered or certified mail~~, addressed to the respective secretaries thereof~~. Unless notice of appeal is so served within 30 days following the service on the member of a copy of the order of the suspension or expulsion as herein above provided, such member's right of appeal and review shall be conclusively treated as having been waived and the order of suspension or expulsion shall thereupon become final and effective. On receiving notice of appeal, the ~~component society~~MSMS Peer Review/Ethics Committee shall forward to the Judicial Commission the complete record of the matter, including copies of the order appealed from, all reports of the Peer Review/Ethics Committee, formal complaint, answer, transcript of testimony, exhibits and all other pertinent writings and data on which the order of suspension or expulsion was based. The Judicial Commission may request the ~~component society~~MSMS Peer Review/Ethics Committee or the appellant to furnish such further information in writing as the commission deems necessary for the proper and full review of the matter. Written arguments may be filed with the Judicial Commission by the ~~component society and the~~MSMS Peer Review/Ethics Committee and the appellant within 45 days following notice of appeal. The Judicial Commission shall, within 90 days after receiving the full records in the case, review the record on appeal and the written arguments, make such findings as it deems appropriate and, by majority vote of the participating members of the Commission, affirm, modify or reverse the order of expulsion or suspension appealed from, or remand the matter for further action by the ~~component society~~Board of Directors. In the consideration of any appeal, not less than six members of the Judicial Commission shall participate, and in the event that the participating members of the Judicial Commission are equally divided, so that no majority prevails, the order or finding appealed from shall stand affirmed.

A copy of such decision shall be promptly served on the ~~appropriate component society~~Board of Directors and on the appellant by registered or certified mail. Unless within twenty days after service on ~~them~~the Board of Directors of a copy of such decision the ~~component society or the~~ appellant shall take an appeal to the Judicial Council of the American Medical Association, the right to such further appeal and review will be conclusively treated as having been waived, and the decision of the Judicial Commission shall be final and effective.

8.90 APPEAL TO JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION—The appellant, if a member in good standing of the American Medical Association at the date of the alleged misconduct, ~~or the component society,~~ may, within twenty days after service of a copy of the final decision of the Judicial Commission, take an appeal there from to the Council on Ethical and Judicial Affairs of the American Medical Association.

9.10 EXCEPTION TO PROCEDURES—Any member ~~of a component society~~ whose license to practice medicine shall have been revoked, or who shall have been convicted of a felony in any state or federal court, shall be expelled from the ~~component and State~~ Society without benefit of, or resort to, the procedures prescribed in this Chapter.

~~9.20 EFFECT OF SUSPENSION OR EXPULSION—Whenever a member of any component society is suspended or expelled from such society, he or she shall thereby also stand automatically suspended or expelled from the Michigan State Medical Society.~~

9.20 RESERVED.

9.30 CONSTRUCTION—Procedures under this Chapter of the Bylaws shall be as summary as may be reasonable. No investigation or proceeding hereunder shall be held invalid by reason of any non-prejudicial irregularity or for any error not resulting in a

miscarriage of justice. The provisions of this Chapter shall be liberally construed for the maintenance of the dignity, integrity, purposes and high principles of this Society and its component societies.

10.00 GRIEVANCES OF NON-MEMBERS—PEER REVIEW/MEDIATION COMMITTEE

10.10 PEER REVIEW/MEDIATION COMMITTEE—~~Every component society~~MSMS shall have a standing committee designated the Peer Review/Mediation Committee. ~~Directors holding membership in a component society~~All Members are eligible for membership on ~~that component society's~~the Peer Review/Mediation Committee.

10.20 PURPOSES—The purposes of such committee shall be:

10.21 to afford the public an informal means of making known to the profession any alleged grievance arising from a physician-patient relationship;

10.22 to resolve misunderstanding between physician and patient ~~or between the component society~~ and the public;

10.23 to reconcile differences between physician and patient by means of persuasion and explanation; and

10.24 to assist ~~the Peer Review/Ethics Committee of its component society~~ in maintaining among members high levels of professional deportment.

It shall not be the purpose of this committee to establish fees, but serve to resolve disputes. Each case should be considered on its own merits and it shall not be the intent of the committee to establish precedents.

10.30 POWERS AND DUTIES—LIMITATION—The specific powers and duties to be exercised by such committee in furthering the purposes above set forth, shall be as fixed and determined by the ~~component~~committee society, provided, however, that such committee shall function in the area of mediation or conciliation only and shall not have power to act as a trial body or to render decisions or awards, nor shall such committee have power to impose discipline or in any wise encroach upon the function of the Peer Review/Ethics Committee.

10.40 PROCEDURE TO GOVERN—The provisions of this chapter shall be governed by the current Official Procedures of the Judicial Commission regarding mediation committees and procedures. Any provisions of this chapter in conflict therewith shall be of no effect.

11.00 GENERAL MEETINGS

11.10 DETERMINATION OF TIME AND PLACE—During each Annual Session the Society may hold one or more General Meetings. The number and times of these General Meetings shall be determined by the Board of Directors. Such General Meetings shall be presided over by the President or in his/her absence the President-Elect or the Chair of the Board of Directors.

11.20 RIGHT TO PARTICIPATE—Each registered member at an Annual Session shall have an equal right to participate in the deliberations of a General Meeting and each active member, active emeritus member, and life member so registered shall have the right to vote on pending questions before the General Meeting.

11.30 ACTIONS—At any General Meeting or at any section meeting of this Society, there may be recommended to the House of Delegates or to the Board of Directors the appointment of committees or commissions for scientific investigations of special interest and importance to the profession and the public. Such investigations and reports shall not become official actions or expressions of this Society until approved by the House of Delegates or the Board of Directors.

12.00 HOUSE OF DELEGATES

12.10 COMPOSITION—The House of Delegates shall be composed of members elected by the component societies, a delegate from each recognized specialty society, a delegate from the Resident and Fellow Section, one delegate from the Organized Medical Staff Section, a delegate from the Young Physicians Section, a delegate from the International Medical Graduates Section and one voting at-large delegate for every 50 MSMS student members to be selected by the MSMS Medical Student Section. These student delegates and alternate delegates must be members of the MSMS Medical Student Section. All other delegates and alternate delegates must be voting members of MSMS.

Each component society shall be entitled to send to the House of Delegates each year one delegate for each fifty voting members (active, life, and active emeritus) and one delegate for each additional major fraction thereof. Any component society having less than fifty members shall be entitled to send one delegate.

The president of a component medical society that all or part of which is located more than 400 miles by road from the site of the House of Delegates may designate a Regional Director of its region to serve as a delegate to the House of Delegates, provided that no member of the component medical society will otherwise be present in person serving as a delegate in any capacity. In the case of such designation of a single Regional Director by two or more component societies, said Regional Director shall have only one vote on all matters before the House of Delegates.

12.20 DELEGATES-AT-LARGE - EX OFFICIO

MEMBERS—Except as provided by Section 12.10, the officers of this Society, members of the Board of Directors, and the Chair, Vice Chair, and Secretary of the MSMS Sections recognized by these Bylaws, shall be ex officio members of the House of Delegates, but with the exception of the Speaker and Vice Speaker of the House of Delegates, shall be without power to vote therein. The Past President shall be a member-at-large of the House of Delegates during the first year of past- presidency with right to vote and hold office. All other Past Presidents shall have the privilege of the floor, without the right to vote.

Except for the Speaker, Vice Speaker, Immediate Past President, and as otherwise provided in Section 12.10, members of the Board of Directors are not eligible for election as delegates by their component societies.

The dean of each accredited medical school in Michigan, if an active member of MSMS, shall be a delegate-at-large to the House of Delegates, with voting privileges. An alternate may not be seated for any dean, and any provisions of these Bylaws regarding the seating of an alternate shall not apply.

The Chief Medical Officer of the Michigan Department of Community Health, if an active MSMS member, shall be an ex officio member of the House of Delegates, but without power to vote therein. No alternate may be seated in place of that officer and any provision of these Bylaws regarding the seating of an alternate shall not apply.

12.30 ELECTION - CERTIFICATION—Each component society shall elect the number of delegates to which it is entitled. The number of delegates shall be determined by the State Society as of December 1, preceding the House of Delegates meeting. The component society shall also elect an equal number of alternate delegates and shall designate the order or seniority thereof. Promptly after election the secretary of the component society, recognized specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section shall certify the names of its delegates and alternate delegates to the Secretary of this Society.

12.40 SEATING - TENURE—A delegate becomes a member of the House of Delegates when the Speaker is notified in writing of the delegates election by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section. Such certification shall be submitted by February 1 of each year. The delegate shall remain a member of the House of Delegates until the Speaker is notified, in writing, by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section that the delegate has been replaced. The delegate shall remain a member of the House of Delegates regardless of whether or not an alternate substitutes for him/her at any meeting of the House.

12.50 SEATING OF ALTERNATE DELEGATES—An alternate delegate may substitute for a duly certified delegate at any regular or special meeting of the House of Delegates provided that such substitution is authorized in writing by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section.

12.60 OFFICERS—The officers of the House of Delegates shall be the Speaker and Vice Speaker. The Secretary of the Society shall be the Secretary of the House of Delegates. The Speaker and Vice Speaker shall be elected by the House of Delegates at the Annual Session from the members of the then-constituted House of Delegates for a one-year term. The Speaker and Vice Speaker of the House of Delegates shall be limited to no more than four one-year terms in each position.

12.70 MEETINGS - ANNUAL SESSION—The House of Delegates shall meet at least annually at the time and place of the Annual Session of this Society and may hold such number of meetings as the House may determine or its business require, recessing from day to day as may be necessary to complete its business and specifying its own time for the holding of its meeting. The House of Delegates may also be called into session at any time by the Speaker upon a two-thirds vote of the Board of Directors, or on petition of twenty-five percent of the Delegates. The purposes of such special session shall be stated in the notice of call and no other business shall be transacted.

12.80 QUORUM—A quorum of the House of Delegates shall consist of not less than 40 percent of the accredited delegates, provided that a majority of such quorum shall not come from any one component society, and the presence of a quorum established at the beginning of the business portion of a meeting shall be sufficient to conduct official business for the duration of the meeting.

12.90 POWERS AND DUTIES—As the legislative body of this Society, the House of Delegates shall have the power arid authority to adopt, institute, and carry out such methods and measures as it may deem to be in the best interests of the medical profession in Michigan. In the exercise of such powers and duties, but without limitation thereof:

12.91 It shall transact all of the business of this

Society not otherwise specifically provided for.

12.92 It shall adopt rules and regulations for its own government and for the administration of the affairs of the Society.

12.93 It shall provide for the organization of Regions which shall be depicted on Exhibit A.

12.94 It shall concern itself with and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws, and the health of the public.

12.95 It shall be active in the education of the public in regard to medical research and scientific medicine.

12.96 It shall have the power to identify areas of concern and to instruct the Board of Directors to appoint committees or task forces to study or act on those areas. These committees or task forces shall report to the Board of Directors, which in turn shall report in the annual report of the Board of Directors to the House of Delegates. The House of Delegates shall itself have necessary internal committees, such as I) Credentials, 2) Rules of Orders of Business, 3) Constitution and Bylaws, and 4) Ways and Means.

The seated House, by majority vote, reserves the right to instruct the Board of Directors to discharge a specific standing committee, liaison committee, or task force, and to require the Board of Directors to appoint an ad hoc committee with appointees nominated by the seated House. This ad hoc committee shall report through the Board of Directors to the House at the next session, and be discharged.

12.97 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.

12.98 It shall publish its minutes or a summary of its proceedings in the Journal of the Society.

12.99 It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge of hypothecation. It shall have the authority specifically to authorize the Board of Directors and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid.

13.10 REFERENCE COMMITTEES—The House of Delegates shall have the following reference committees, together with tellers and sergeants-at-arms, appointed by the Speaker of the House and approved by the House of Delegates, and such other reference committees as may be deemed necessary to conduct the business of the House:

1. Credentials
2. Rules and Order of Business
3. Constitution and Bylaws (which shall serve also as the standing Committee on Constitution and Bylaws)
4. Ways and Means

13.20 ELECTION OF REGIONAL DIRECTORS—Regional Directors shall be elected as provided in Article IX, Section 1(a) of the Constitution. Each component society in a Region shall be notified in writing by the Secretary of the Society at least sixty days in advance of the Annual Session when a Regional Director is to be elected from that Region.

If, by reason of death or resignation, a vacancy in the office of Regional Director occurs at any time other than during an Annual Session, each component society in that Region shall be promptly notified in writing by the Secretary of the Society. Thereupon the seated delegates of such Region may caucus, and if a majority of the seated delegates from such Region shall submit a nomination to the Board of Directors to fill such vacancy, the Board of Directors shall appoint such nominee to serve as interim Regional Director of such Region until a successor is elected in accordance with Article IX, Section 1(e) of the Constitution.

If a vacancy in the office of Regional Director occurs during an Annual Session of the Society, the delegates of the component societies in the Region affected shall be given notice thereof and afforded time to caucus and consider nominations to fill such vacancy.

13.30 ELECTION OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION—The House of Delegates shall elect delegates and alternate delegates to the American Medical Association in accordance with the regulations of that parent organization and as hereinafter provided.

Delegates and alternate delegates to the American Medical Association shall be elected for two-year terms.

Any physician filling the position of delegate or alternate delegate to the American Medical Association must spend the majority of his/her professional time in active clinical practice; teaching; research; and/or administrative practice and be a full-time Michigan resident, unless they hold an elected or appointed AMA Council position for which they are still eligible.

At each Annual Session, candidates for delegates to the House of Delegates of the American Medical Association shall be nominated in number equal to or

greater than the number to be elected that year. Election shall be by ballot. The required number of candidates receiving the greater number of votes shall be declared elected.

In case of a tie vote the winner or winners shall be decided by drawing lots under the supervision of the Speaker of the House of Delegates; provided, however, that any candidate thus tied shall have the right to a decision by ballot on request.

The number of alternate delegates shall equal the number of delegates. They shall be elected in the same manner after all delegates have been elected.

Alternate delegates shall have seniority according to the greatest length of service as an alternate delegate. When it occurs that two or more alternate delegates have equal lengths of service, seniority shall be determined by the respective number of votes received by each when first elected, and such seniority shall be designated at the time of the first election.

When a delegate shall be unable to attend a meeting of the House of Delegates of the American Medical Association that seat shall be filled by an alternate delegate chosen in order of seniority as defined in this Section.

Should the Society become entitled to one or more additional delegates subsequent to the Annual Session of the House of Delegate in any year, such additional delegate or delegates shall be designated and accredited by the Board of Directors until the next Annual Session. In filling such offices alternate delegates shall be designated in order of their seniority as defined in this section.

13.40 ELECTION OF OFFICERS—Election of officers of the Society shall take place at the House of Delegates at each Annual Session. All nominations shall be made from the floor of the House with the exception of the Secretary and Treasurer who are elected by the Board of Directors. If there is only one nomination for any office, the candidate so nominated may be elected viva voce.

13.50 RESOLUTIONS—Each resolution introduced in the House of Delegates shall be introduced by a delegate. It shall be presented in writing to the Secretary. It shall be referred by the Speaker to the proper reference committee before action is taken thereon.

13.60 NEW BUSINESS—No new business shall be introduced in the last meeting of a session of the House of Delegates without unanimous consent of the delegates present except when presented by the Board of Directors. All new business so introduced shall require the affirmative vote of three-fourths of the delegates present for adoption.

13.70 RULES OF ORDER—When not in conflict the Constitution or Bylaws of this Society, the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* shall govern the parliamentary procedure of the House of Delegates.

13.80 NOMINATING COMMITTEE - The House of Delegates shall form a Nominating Committee consisting of ten members. The Society's Immediate Past President shall be a member and serve as the chairperson and there shall be one member from each Region who shall be elected by the members holding membership in a county located in that Region. The elected members of the Nominating Committee must be a delegate with the right to vote in the House of Delegates and not be a member of the Board of Directors. It shall be the duty of the Nominating Committee to provide the Speaker of the House of Delegates at least thirty days prior to each annual session of the House of Delegates with at least one nomination for each of the Designated Director positions. The members of the Nominating Committee shall carefully review the credentials of each potential candidate, seek out the most qualified candidates for these positions and when possible insure that the candidates nominated reflect the diversity of the Society's membership.

14.00 THE BOARD OF DIRECTORS

14.10 ORGANIZATION—The Board of Directors is the executive body of the Society. Subject only to the following, it shall determine the times and places of its meetings. At its first meeting immediately following the Annual Session of the House of Delegates, the Board of Directors shall elect a Secretary and Treasurer, who shall serve for a term of office of one year or until a successor is elected and takes office. At the same meeting, the Board of Directors shall elect a Chair, a Vice-Chair, a Chair of the Finance Committee, a Chair of the Health Care Delivery Committee, a Chair of the Legislative Policy Committee, and a Chair of the Scientific and Educational Affairs Committee, who shall be duly elected Regional Directors or Designated Directors, each to take office immediately and to serve for a term of one year or until a successor is elected and takes office.

14.20 EXECUTIVE COMMITTEE—The Executive Committee of the Board shall consist of the President, President-Elect, Immediate Past President, Chair, Vice-Chair, Speaker, Secretary and Treasurer. The Chair of the Board shall serve as Chair of the Executive Committee.

14.30 REFERENCE COMMITTEES—The Reference Committees of the Board of Directors and their composition and duties shall be as follows:

14.31 The Scientific and Educational Affairs Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Scientific and Educational Affairs Committee shall advise the Board of Directors on matters

of scientific and educational activity and relationships with component medical societies, and consider other matters referred to it by the Board of Directors.

14.32 The Finance Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members, of which one shall be the Treasurer, ex officio, with power to vote, and the remainder appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Finance Committee shall advise the Board of Directors on administration of the Society's finances, and consider other matters referred to it by the Board of Directors.

14.33 The Legislative Policy Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Legislative Policy Committee shall advise the Board of Directors on matters of legislation and liaison with governmental agencies and shall consider other matters referred to it by the Board of Directors.

14.34 The Health Care Delivery Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Health Care Delivery Committee shall advise the Board of Directors on matters concerning the financing and delivery of health care and shall consider other matters referred to it by the Board of Directors.

14.40 REGIONAL DIRECTOR DUTIES—Each Regional Director shall be the organizer, peacemaker and censor for the Region. The Regional Director shall visit each component society in the Region at least once a year and shall keep in touch with the activities of the component societies constituting the Region. The Regional Director shall make such reports as the Chair of the Board of Directors shall request concerning the condition of the profession in the Region.

14.50 REMOVAL OF REGIONAL DIRECTOR—Upon written complaint signed by not less than one-half of the Delegates from a Region presented to the House of Delegates in Annual or Special Session charging that the Regional Director for such Region has been remiss in the duties prescribed above, and that at least one month's notice of such proposed action has been given, the Speaker shall bring the matter before the House of Delegates for consideration. By the vote of not less than two-thirds of the House of Delegates present at the meeting at which such matter is considered, such Regional Director may be removed from office and a successor elected.

14.60 DUTIES OF THE BOARD OF DIRECTORS—It shall be the duty of the Board of Directors:

14.61 To make careful inquiry into the condition of the profession in each county in the State. It shall have authority to adopt such methods as may be deemed most efficient for increasing interest in all existing component societies. It shall especially and systematically endeavor to promote friendly intercourse between doctors of medicine in the same locality. It shall make every effort to bring each reputable doctor of medicine in the State under the Society's influence;

14.62 To direct and control the publication of the Journal of the Michigan State Medical Society;

14.63 To provide and maintain such headquarters for this Society as may be required to conduct its business properly;

14.64 To render an Annual Report to the House of Delegates; and

14.65 At least every three years, review the composition of the Board of Directors including the geographical boundaries of the Regions making any recommendations in its discretion it deems necessary.

14.70 CONTROL OF FUNDS—The funds of this Society shall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.

14.71 The Board of Directors shall have the authority to borrow money upon the general credit of the Society. The Board of Directors shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Board of Directors shall authorize and empower the President or the Chair of the Board of Directors, and the Secretary or the Treasurer to execute such instruments as may be required.

14.80 REGIONS – For the purpose of electing Regional Directors and any other purposes described in these bylaws, there shall be those regions depicted on Exhibit A.

15.00 THE JUDICIAL COMMISSION

15.10 COMPOSITION - QUALIFICATIONS—The Judicial Commission shall be composed of ten members, each of whom shall be a voting member of the Society in good standing. No member of the Judicial Commission shall, during tenure of office, hold any of the following offices or positions: Speaker or Vice-Speaker of the House of Delegates of

this Society, or District Director of this Society. Any member of the governing board of a component society which serves in these capacities, shall not, as a Commissioner, participate in deliberations pertaining to a grievance involving a member of that component society or cast a vote in respect thereto.

15.20 JUDICIAL DISTRICTS—There shall be seven Judicial Districts formed by grouping component societies as follows:

District 1—Wayne
District 2—Macomb, Oakland. St. Clair
District 3—Ingham, Livingston, Monroe, Shiawassee, Washtenaw
District 4—Bay, Iosco-Arenac, Genesee, Gratiot, Huron, lsabella-Clare, Lapeer, Midland, Saginaw, Sanilac, Tuscola
District 5—Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Jackson, Kalamazoo, Lenawee, St. Joseph, Van Buren
District 6—Barry, Clinton, Ionia-Montcalm, Kent, Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana, Ottawa
District 7—Alpena-Alcona-Presque Isle, Chippewa-Mackinac, Delta, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central Counties (Crawford, Gladwin, Kalkaska, Montmorency, Otsego, Roscommon), Northern Michigan (Antrim, Charlevoix, Cheboygan, Emmett), Ogemaw- Oscoda, Ontonagon, Schoolcraft, Wexford- Missaukee

15.30 NOMINATIONS—On or before July 15 each year, the Chair of the Board of Directors shall, with the advice and consent of the Board of Directors, appoint a Nominating Committee composed of seven members of the Board of Directors. Such Nominating Committee shall select from the voting members in good standing of the Society in each Judicial District at least twice as many nominees for the office of Judicial Commissioner as are to be elected in such year from such District. After obtaining the consent of such nominees to become candidates, the Nominating Committee shall submit its list of nominations to the Secretary of the Society on or before September 1st each year. Within ten days thereafter, the Secretary of the Society shall post a list of such nominations in a conspicuous place in the headquarters building of the Society and shall mail a list of such nominations to the secretary of each component society and shall give notice to the secretary of each said component society that the voting members of this Society within the several Judicial Districts have the right to make additional nominations by petition as hereinafter set forth. Promptly upon receipt of such notice and list of nominations, the secretary of each component society shall make such nominations known to the voting members thereof in such manner as shall be determined by the component society. Additional nominations may be made by petition signed by not less than twenty-five voting members in good standing in any Judicial District. Such nominating petitions shall be filed with the Secretary of this Society not later than October 15.

15.40 BALLOT - ELECTION—Under the direction of the Secretary of the Society, ballots shall be prepared for each Judicial District from which a member of the Commission is to be elected. On or before November 10 each year in which a member of the Commission is to be elected from such district, the Secretary of the Society shall send a ballot containing the names of all nominees, arranged in alphabetical order, to each voting member in good standing of the Society in such Judicial District. Ballots shall be marked and returned to the office of the Society no later than December 1 and any ballot bearing a return date later than such date shall not be counted. Each ballot, to be valid, must be voted for neither a greater nor a smaller number of nominees than are to be elected from such district at such election. The ballot furnished to voting members shall have printed upon it a copy of the preceding sentence.

The valid ballots so cast shall be tabulated and the results certified by the Secretary of the Society. In case of a tie vote, the winning candidate shall be determined by lot under the supervision of the Secretary. Those elected shall be notified by the Secretary and the names of those elected shall be made known to the members of the Society through publication in the Journal of the Society or by such other means as shall be directed by the Board of Directors.

15.50 TERMS OF OFFICE—At the election held in the year 1965, four members of the Commission shall be elected from District 1, and one each from District 2, 3, 4, 5, 6 and 7. At the first meeting of the Commission following the election in 1965, it shall be determined by lot that two of the members elected from District 1 shall serve for a term of three years each, one for a term of two years, and one for a term of one year. Thereafter, one member of the Commission shall be elected annually from District 1 to serve for a three-year term, provided, however, that in the year 1968 and each third year thereafter, two members shall be elected from District 1 to serve for terms of three years each. It shall also be determined by lot at such meetings that two of the members elected from Districts 2, 3 ,4, 5, 6, and 7 shall serve for terms of three years each, two for terms of two years each and two for terms of one year each. Thereafter, one member of the Commission shall be elected annually from each of Districts 2, 3, 4, 5, 6, and 7 in which an elective term expires, such election to be for a term of three years.

15.60 VACANCIES—Whenever a vacancy occurs as the result of the death or resignation of a Commissioner or from any other cause, the President of the Society shall have the authority, acting with the advice of the Regional Directors of the Judicial District affected, to appoint a Commissioner from the district affected, such appointee to serve until the next election of

Commissioners at which time a Commissioner shall be elected to serve for a remainder of the unexpired term.

15.70 ORGANIZATION OF THE COMMISSION—The Commission shall meet as soon as feasible after each annual election and at such meeting select a Chair, a Vice-Chair, and such other officers as may be deemed desirable. The terms of such officers and their duties and responsibilities shall be as determined by the Commission.

15.80 POWERS AND DUTIES—The Judicial Commission shall have:

15.81 Authority to make binding interpretations of the Constitution and Bylaws of this Society and of the several component societies as they pertain to matters of ethics, mediation, grievance and discipline.

15.82 Authority to make ethical interpretations and decisions in accordance with the standards of the American Medical Association.

15.83 Sole appellate powers at the state level in all matters relating to ethics, professional conduct, mediation and discipline of members of component societies.

15.84 The power to entertain and exercise original jurisdiction in matters pertaining to ethics, mediation, conduct of members or discipline of members when requested to do so by any component society or by any member in good standing of this Society.

15.85 The power and authority to make and promulgate from time to time, rules and regulations governing all procedures pertaining to ethics, grievances, mediation, professional conduct and discipline of members, which rules and regulations shall be binding upon all component societies.

15.86 The power and authority to appoint such committees and to adopt such rules, regulations and procedures as, in the sole judgment of the Commission, are deemed desirable in carrying out the functions and purposes of the Commission.

16.00 COMMITTEES/TASK FORCES OF THE SOCIETY

16.10 STANDING COMMITTEES—The Board of Directors shall designate standing committees of the Society to deal with ongoing subjects. The chair and members shall be appointed by the Board of Directors upon recommendation of the Chair of the Board of Directors. Committee chairs shall be appointed to serve for a term of two years. Members shall be appointed to serve two-year staggered terms, and be eligible for re-appointment.

The Chair of the Board of Directors shall appoint at least one Board member to each standing committee. The Board member shall be a voting member of the committee. The Board member shall be expected to attend committee meetings, participate in committee activities, and interpret to the Board of Directors the committee's recommendations that come before it via special reports.

If necessary, a standing committee may appoint one or more of its members to research a subject. The subgroup shall report its findings to the standing committee.

Standing committees shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. Each standing committee shall submit an annual summary of its activities, without recommendations, to the House of Delegates.

16.20 LIAISON COMMITTEES—The Board of Directors shall designate liaison committees to carry out MSMS liaison relationships with selected organizations and agencies. The chair and members shall be appointed by the Board of Directors upon recommendation of the Board Chair. Committee chairs shall be appointed to serve for a term of two years. Members shall be appointed to serve two- year staggered terms, and be eligible for reappointment.

The Chair of the Board of Directors may appoint a District Director to selected liaison committees. The District Director shall be a voting member of the committee, and shall be expected to attend committee meetings, participate in committee activities, and interpret to the Board of Directors the committee's recommendations that come before it via special reports.

If necessary, a liaison committee may appoint one or more of its members to research a subject. This subgroup shall report its findings to the liaison committee.

Liaison committees shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. Each liaison committee shall submit an annual summary of its activities, without recommendations, to the House of Delegates.

16.30 TASK FORCES—The Board of Directors shall create task forces as needed for specific assignments. Each task force shall be charged to study certain problems and to recommend courses of action to the Board of Directors. The chair shall be appointed to serve for a term of two years. The members shall be appointed by the Board of Directors upon recommendation of the Board Chair.

Task forces shall submit action reports to the Board of Directors on matters concerning MSMS policy or

requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. The action of the task forces may be included in the Board of Directors Annual Report to the House of Delegates, if the Board Chair deems it appropriate.

17.00 OFFICERS

17.10 TERM OF OFFICE—Except as herein otherwise provided, officers shall take office immediately after the election and shall serve until the next Annual Session and until their respective successors shall have been elected. Regional Directors shall serve for three years and may not serve more than three consecutive terms, provided, however that a Regional Director may serve additional terms after an absence of at least one year.

A physician may not serve on the Board of Directors for more than 12 years in any capacity. The slotted, one-year positions for the Student Section, the Resident and Fellow Section, and the Young Physician Section will not be counted in the lifetime aggregate of 12 years.

17.20 INDUCTION OF PRESIDENT—At the Annual Session of this Society, next following election, the President-Elect shall be installed into and assume the office of the President, and shall serve until a successor takes office. The assumption of office shall take place in a General Meeting of the Society as a whole or in a meeting of the Annual Session of the House of Delegates.

17.30 PRESIDENT—The President shall be the principal spokesperson for the Society, communicating to the membership and the public the official action and policies of the organization. The President shall be the principal officer to liaison with component societies, and to report on the conditions and concerns of the membership. The President shall preside over the General Meeting of the Society and shall deliver the President's Address to the House of Delegates and participate in its deliberations but without vote.

The President shall be an ex officio member of the Board of Directors and its Executive Committee with power to vote therein.

The President shall perform such other duties as are imposed by the Constitution and Bylaws of this Society.

17.40 PRESIDENT-ELECT-DUTIES-SUCCESSION—
The President-Elect shall act for the President in the President's absence or disability. Should the office of President become vacant, the President-Elect shall succeed to the presidency for the unexpired term. Should the office of President thereafter again become vacant, the Board of Directors at a regular or special meeting, shall elect a President to serve until the next Annual Session of the Society.

The President-Elect shall be an ex officio member of the Board of Directors with the right to vote therein.

17.50 CHAIR OF THE BOARD—The Chair shall preside at all meetings of the Board of Directors and its Executive Committee and direct and supervise the preparation of the agenda for the meetings of the Board and the Executive Committee. The Chair shall consult with the Presidents and Chief Executive Officer as necessary and appropriate on behalf of the Society.

The Chair of the MSMS Board shall be familiar with the day-to-day operations of the Society and its executive staff, to provide advice and guidance regarding the implementation of policy.

17.60 VICE-CHAIR—The Vice-Chair of the Board shall preside at meetings of the Board in the absence of the Chair or at the Chair's request, and shall perform such other duties as custom and parliamentary usage require.

In the event the office of Chair is vacated through death or resignation, the Vice-Chair shall become Chair Pro Term until the next meeting of the Board when a new Chair shall be elected.

17.70 TREASURER—The Treasurer, under the direction and control of the Board of Directors, shall be the custodian of all the invested funds and the securities of the Society. The Treasurer shall be accountable through the Board of Directors to the Society. The Board of Directors shall cause an annual audit of the accounts to be made. The Treasurer shall be bonded in amount considered sufficient by the Board of Directors, the cost of such bond to be paid from the funds of the Society. The Treasurer shall perform such other duties as are imposed by the Constitution and Bylaws of the Society.

17.80 SECRETARY—The Secretary shall be a member of the Society and shall serve as the recording officer of the House of Delegates and the Board of Directors.

The Secretary, in addition to having the rights and duties ordinarily devolving on the secretary of a corporation by law, custom of parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, shall perform the following specific duties unless otherwise directed or assigned by the Board of Directors.

17.81 Perform ceremonial duties, including the administering of the oath of office to the incoming President.

17.82 Serve as official contact with the component medical societies concerning memberships and dues transfers.

17.83 Review requests for the use of the MSMS mailing list and authorize its use.

17.84 Serve as an official MSMS signatory for official regulatory and governmental documents.

17.85 Be available to the Chief Executive Officer and staff for consultation and advice on day-to-day staff problems.

17.90 CHIEF EXECUTIVE OFFICER—There shall be Chief Executive Officer, not necessarily a doctor of medicine or a member of the Society, who shall be designated by contract approved by the Board of Directors on an annual basis and who shall be remunerated in an amount which shall be fixed by the Board of Directors. The Chief Executive Officer shall be bonded in an amount considered sufficient by the Board of Directors, the cost of which shall be paid from the funds of the Society.

18.10 SPEAKER OF THE HOUSE OF DELEGATES—The Speaker of the House of Delegates shall preside at sessions of the House of Delegates. The Speaker shall perform such duties as custom and parliamentary usage require, and shall be a member of the Board of Directors and of its Executive Committee with the power to vote.

18.20 VICE-SPEAKER OF THE HOUSE OF DELEGATES—The Vice-Speaker of the House of Delegates shall assume the duties of the Speaker when the Speaker is absent at a meeting of the House of Delegates and at such other times as the House of Delegates or the Board of Directors (between Sessions of the House) shall determine. The Vice-Speaker shall be a member of the Board of Directors with the power to vote.

18.30 REMUNERATION—Each of the following officers, namely, the President, the Chair of the Board of Directors, the Secretary, the Treasurer, the Speaker of the House of Delegates, the President-Elect, and the Immediate Past President shall be entitled to draw from the funds of the Society a special expenses allowance in each year of incumbency of the office. The annual amount will be recommended by the Finance Committee to the Ways and Means Committee and approved or amended by the House of Delegates. These officers shall not be required to account to the Society for the expenditure of such funds, which shall be in addition to ordinary reimbursable expenses.

19.00 INDEMNIFICATION

19.10 The Board of Directors may indemnify any person for any liability, claim or expenses incurred or to be incurred, by reason of the fact that such person was or is a director, officer, employee, agent, or committee member of the Society, or was or is serving at the request of the Society as a director, officer, employee, agent, or committee member of a corporation, partnership, joint venture, trust, or other entity owned, in whole or in part, by the Society, or established by the Board of Directors of the Society. The extent and terms of such indemnifications shall be determined by the Board of Directors of the Society, either in advance or on a case by case basis; provided, however, such indemnification shall not be broader or more inclusive than permitted by law either at the time of the act or omission to be indemnified against or at the time of carrying out such indemnification.

20.00 SPECIALTY AND ETHNIC MEDICAL SOCIETIES

20.10 RECOGNIZED SPECIALTY AND ETHNIC MEDICAL SOCIETIES—To provide representation for the interests of medical specialty and ethnic medical societies within the structure of the Michigan State Medical Society, Michigan specialty and ethnic medical societies can be recognized and eligible for a delegate and alternate delegate to the MSMS House of Delegates provided the criteria as set forth in Section 20.20 has been met. A list of recognized specialty and ethnic medical societies will reside in the MSMS Chief Executive Officer's Office.

20.20 CRITERIA—Specialty and ethnic medical societies that wish to be included as a recognized specialty or ethnic medical society must meet the following criteria: a) be statewide in scope, with a minimum of one meeting per year; b) be a statewide specialty or ethnic medical society at least five years old; c) have 25 or more active physician members of whom 50 or 50 percent or more maintain their membership in MSMS; and d) be approved by the House of Delegates.

The governing body of the specialty and ethnic medical society must take formal action requesting delegate representation by sending a letter to the MSMS Board of Directors. The Board would then determine if the society meets the criteria and, if so, make a recommendation to the House of Delegates.

The method of determining whether the specialty or ethnic medical society meets the membership criterion outlined in this section shall be the responsibility of the MSMS Board of Directors.

20.30 RESIDENT AND FELLOW SECTION—To provide representation for the interests of residents and fellows within the structure of the Michigan State Medical Society, there shall be a Section on Residents and Fellows, composed of resident physicians (physicians-in-training) who are residents in an AMA-recognized residency program in Michigan, fellows serving as their primary occupation in a structured educational program begun immediately upon completion of medical school, residency or fellowship training, and who are active members of MSMS, and of medical students after March 15 of their senior year.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to residents and fellows in Michigan.

At its annual meeting the Section shall elect a chair, a

vice-chair, a secretary, a delegate and an alternate delegate to the MSMS House of Delegates, each of whom shall serve for a term of one year.

At its annual meeting, the Section shall elect a representative to fill the residents' seat on the Board of Directors for a one-year renewable term to begin at the first Board of Directors meeting after the House of Delegates. If a vacancy in the residents' seat should occur during a term, the vacancy shall remain unfilled until the next term.

20.40 MEDICAL STUDENT SECTION—To provide representation for the interests of medical students within the structure of the Michigan State Medical Society, there shall be a Section on Medical Students, composed of students of each established medical school in Michigan who are student members of MSMS.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to medical students in Michigan.

At its annual meeting, the Section shall elect a Governing Council consisting of a chair, a vice-chair, a secretary, a member of the Michigan Delegation to the AMA, and a representative to the MSMS Board of Directors. These officers shall all serve for one year-renewable terms to begin after the House of Delegates.

The Section shall also elect delegates to the MSMS House of Delegates, each of whom shall serve for one year. There shall be one delegate for every 50 MSMS student members.

If a vacancy in any of the officers' positions should occur during the term, that seat shall be immediately filled by election as provided in the Student Section Bylaws, with approval of the Board of Directors.

20.50 ORGANIZED MEDICAL STAFF SECTION—To provide representation for the interests of hospital medical staffs and of other delivery systems within the structure of the Michigan State Medical Society, there shall be an Organized Medical Staff Section composed of MSMS members, one to be elected by and from the active voting physician members with clinical privileges of each JCAHO-accredited hospital in Michigan, and each other delivery system accepted by the Governing Council.

The purpose of this Section is to provide a direct means to address the relationship between MSMS members and organized medical staffs.

At its annual meeting, the Section shall elect a chair, a vice-chair, a secretary and two at-large members. It shall also elect one delegate and one alternate delegate to the MSMS House of Delegates, each of whom shall serve for a term of two years.

20.60 YOUNG PHYSICIANS SECTION—To provide representation for the interests of young physicians within the structure of the Michigan State Medical Society, there shall be a section on young physicians, composed of physicians under 40 years of age and/or professionally employed through eight (8) years after residency and fellowship training programs, who are active members of MSMS.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to young physicians in Michigan.

At its annual meeting the Section shall elect officers in accordance with the Bylaws of the MSMS Young Physicians Section and a representative to fill the young physicians' seat on the Board of Directors for a two-year renewable term to begin at the first Board of Directors meeting after the House of Delegates. If a vacancy in the young physicians' seat should occur during a term, a representative chosen by the Young Physicians Governing Council may be appointed to fill the term, with approval by the Board of Directors.

20.70 INTERNATIONAL MEDICAL GRADUATES SECTION—To provide representation of the interests of international medical graduates within the structure of the Michigan State Medical Society, there shall be a section for international medical graduates composed of international medical graduates who are members of MSMS.

The purpose of this Section will be to provide a forum within the organizational structure of this Society for the study and consideration of matters of special interest and significance to international medical graduate in Michigan.

At its annual meeting the Section shall elect a delegate and alternate delegate to the MSMS House of Delegates.

21.00 REFERENDUM

21.10 REFERENDUM AT SOCIETY MEETING—Any General or Special Meeting of this Society as a whole, may, by a two-thirds vote of the voting members present, order a general referendum upon any question pertinent to the purposes and objects of the Society, organized medicine, or health of the public; provided, however, that a quorum at such General or Special Meeting shall consist of not less than 300 voting members of the Society who are in good standing.

21.20 REFERENDUM BY HOUSE OF DELEGATES—The House of Delegates by a majority vote may submit any question pertinent to the community and organized medicine to the membership of the Society for its vote, such vote to be taken by county societies and certified by their respective secretaries to the Secretary of this Society.

Two-thirds of the vote cast shall be required to carry

the question.

22.00 SEAL

22.10 SEAL—The Society shall have a common seal. The power to change or renew the seal shall rest with the Board of Directors.

23.00 EMERGENCY

23.10 EMERGENCY ACTION BY BOARD OF DIRECTORS—When prompt speech or action is imperative, authority to speak or act in the name of this Society is vested in the Board of Directors or the Executive Committee of the Board of Directors.

24.00 DEFINITION OF SESSION AND MEETING

24.10 SESSION—A session shall mean all meetings at any one call.

24.20 MEETING—A meeting shall mean each separate convention at any one session.

25.00 AMENDMENTS

25.10 AMENDMENTS-PROCEDURE—These Bylaws may be amended by a majority vote of the delegates seated, after the proposed amendment is laid on the table until the next session, unless by consent of 75 percent of the delegates present and voting, such time requirement is waived, in which event the said amendment may be voted upon at the next meeting of the House of Delegates. The amendment or amendments to these Bylaws become effective immediately upon adoption.

Official Procedures for the Judicial Commission

of the Michigan State Medical Society

(ADOPTED APRIL 14, 1971, AND AMENDED JANUARY 31, 1973)

In accordance with Paragraphs 15.80 through 15.86 of the Bylaws of the Michigan State Medical Society, the Judicial Commission of the Michigan State Medical Society does hereby declare the following rules, regulations and procedures to govern all matters pertaining to ethics, grievances, mediation, professional conduct, and discipline binding on the Michigan State Medical Society and each of its component medical societies.

I. Disciplinary Procedure for Component Medical Societies

The procedure to be followed by each component society on its complaints of original jurisdiction with respect to the censure, suspension or expulsion of a member shall be in accordance with Paragraphs 7.00 through 9.30 of the Bylaws of MSMS. The procedure to be followed by each component society in cases referred to it by the Judicial Commission shall be expressly subject to the procedural rules hereinafter set forth.

II. Mediation Committees for Component Medical Societies

The procedure to be followed by each component medical society on its complaints of original jurisdiction regarding grievances of non-members shall follow the procedural outline in Paragraphs 10.00 through 10.40 of the Bylaws of MSMS. The procedure to be followed by each component society in cases referred to it by the Judicial Commission shall be expressly subject to the procedural rules hereinafter set forth.

III. Procedural Rules for the Judicial Commission involving ethics, grievances, mediation, professional conduct, and discipline of members of the Michigan State Medical Society

1. All questions of ethics referred to the Judicial Commission must be in writing. No matter under active litigation will be accepted for processing. Matters involving alleged infractions of civil and criminal law are generally outside the scope of the Judicial Commission.

2. When a proper complaint is received, it shall be recorded and forwarded when appropriate to the component medical society of which the physician named is a member.

3. The component medical society shall process the complaint, review the case, determine its merits, and report its conclusions in writing to the complainant with copies to the physician involved and to the Judicial Commission.

4. The Judicial Commission requires that a complainant and the physician involved be informed of the right of appeal to the Judicial Commission from the final ruling of a component society.

5. All properly entered complaints shall be processed by the component medical society within 60 days. Each complaint and its investigation shall be kept confidential except to members of the Judicial Commission or its agents and the members of the committees of the component medical societies investigating the complaint.

6. Jurisdiction over complaints received by the Judicial Commission and forwarded to a component medical society rests with the component medical society designated by and at the discretion of the Judicial Commission. Apart from supervisory function of the judicial mechanism, the Judicial Commission serves as an appellate tribunal except under circumstances deemed by the Judicial Commission such that regional jurisdiction by a component medical society would not properly serve the purposes of the complainant, the physician involved, or the public or profession in general. Such discretionary powers are set forth hereafter under the section of this document—V. "Jurisdiction of the Judicial Commission."

7. Complaints from a component medical society directed to the Judicial Commission which concern matters about another component society shall be processed by the Judicial Commission in a manner similar to a complaint from a member individual but shall remain the proper business of the Judicial Commission itself without reference.

IV. Procedure for Appeal to the Judicial Commission

1. A member of a component society censured, suspended, or expelled by his or her county society may appeal from the action of such component society to the Judicial Commission of MSMS within a period of 60 days succeeding the date of such censure, suspension or expulsion. Appeals shall be in writing and be filed within said period of 60 days with the Chair of the Judicial Commission at the Michigan State Medical Society headquarters office. Said appeal shall be accompanied by a record of the entire proceedings before the component society duly certified by its secretary, provided the Chair of the Judicial Commission may, in his or her discretion, extend the time of the appellant to file such record. Upon the filing of such an appeal, the Chair shall present it to the next subsequent meeting of the Judicial Commission.

Written notice of not less than 10 days of the time and place of the hearing shall be given to the appellant member and the president and secretary of the component society involved.

2. In hearing appeals, the Judicial Commission shall review all questions of procedure, and may, in its discretion, review the evidence contained in the record of the original proceedings held before the proper committee of the component society. The Judicial Commission may make findings of fact contrary to, or in addition to, those made by the committee of the component society. Such findings may be based on the evidence adduced by the committee of the component medical society, either with or without the taking of evidence by the Judicial Commission. The Judicial Commission may, for the purpose of making such findings or for other purposes in the interest of justice, take additional evidence of or concerning facts material to the questions involved, or may, for such purpose, appoint a committee of its members to act as referees for the taking of such evidence.

   (a) Such referees shall render a report in writing to the Judicial Commission, which report shall contain a clear statement of the facts found by the referees from the testimony or evidence adduced.

3. The Judicial Commission may affirm, reverse, or modify the decision of the proper committee of the component society so reviewed or make such other disposition of the proceedings as it may deem proper.

4. The Judicial Commission may exert, through a committee thereof, prior to the hearing being held on the appeal, all proper efforts at conciliation and compromise.

5. The MSMS may be represented by its attorney to advise the Judicial Commission. The appellant may likewise be represented by his or her attorney.

6. The decision of the Judicial Commission shall be final and bind the appellant member and the component society unless further appealed to the American Medical Association as set forth hereunder.

V. Jurisdiction of the Judicial Commission in respect to all matters relating to discipline of members of MSMS

1. The Judicial Commission, within its sound discretion, may take original jurisdiction of any question appropriately referred to it and conduct hearings thereon without referral to a component society.

2. The procedure in original jurisdiction hearings shall follow rules set forth in the MSMS Bylaws, paragraphs 8.40 through 8.70.

3. In cases of original jurisdiction, the Judicial Commission will report its recommendations to the governing body of the component society for implementation.

4. Any decision of the Judicial Commission affirming a decision of a component medical society which disciplines a member or a component medical society itself so disciplined may be appealed to the appropriate agency of the American Medical Association upon such terms, conditions and in accordance with such procedure as may be set forth in the Constitution and Bylaws of the American Medical Association. Any decision of such agency of the AMA shall be final and binding upon all parties of the appeal.

5. The decision of the component medical society if not appealed or of the Judicial Commission if original or appealed for the settlement of a complaint, although binding upon a member physician, cannot be made binding upon a non-physician. Since, however, the submission of a complaint by a lay person to the judicial mechanism or settlement is an act of good faith, it can be assumed that the recommendation of the Judicial Commission or the proper committee of a component medical society will be accepted by non-physicians.

VI. Grievances Against Non-Member Physicians

The Judicial Commission is without jurisdiction over physicians who are not members of MSMS but recognizes the obligation of organized medicine to act in the best interests of those doctors and of the public. The Commission and the component medical societies will undertake to mediate grievances and matters of ethics and professional conduct when requested by the person or persons in controversy with the non-member M.D. physician, providing the latter agrees to accept the services of the Society in this aspect and agrees to abide by its procedural rules, and to the condition that the Society reserves the right at its discretion, when appropriate, to disclose pertinent information to the Michigan Board of Medicine. Lacking this agreement or such approval from the non-member, the Society may at its discretion forward the complaint as received to the Michigan Board of Medicine.

The procedures to be followed shall, to the extent relevant, be those set forth in the Official Procedures promulgated April 14, 1971, including the underlying MSMS Bylaws section recited therein. The original jurisdiction for component societies noted in the Official Procedures shall be emphasized in these mediations. If the non-member and the complaining party reside in different counties, the component society jurisdiction within which the non-member physician has his or her principal practice shall be the venue of the hearing unless the Judicial Commission exercises its power to take original jurisdiction. The procedural rules set forth in Article II of said Official Procedures shall be adhered to as literally as possible. The appeal procedures of Article IV, save for those sections which are patently irrelevant, shall likewise be controlling.

VII. The Judicial Commission expressly reserves to itself the

jurisdiction to amend these rules from time to time as it deems appropriate, and to publish same.

These rules of procedure accepted and promulgated by the Judicial Commission of the MSMS on this date hereby govern the Michigan State Medical Society in all such matters and any provisions of the Constitution and Bylaws of MSMS in conflict therewith shall have no effect.

[Link-to-previous setting changed from on in original to off in modified.].

ACTION REPORT #7-26 OF THE BOARD OF DIRECTORS

SUBJECT:	House of Delegates 14-25 - Rotation of MSMS House of Delegates Meeting Location 16-25 - County and State Medical Society Alliance 47-25 - Study Medical Society Structures
REFERRED TO:	Reference Committee on Internal Affairs, Bylaws, and Rules
HOUSE ACTION:	

RECOMMENDATION: THAT THE 2026 MSMS HOUSE OF DELEGATES REPLACE THE HOUSE OF DELEGATES WITH AN ALL MSMS MEMBER, ONLINE POLICY-MAKING PROCESS.

The Michigan State Medical Society (MSMS) faces significant structural, financial, and membership challenges that threaten its long-term viability. The Reorganization Task Force, appointed by the MSMS Board of Directors following resolutions adopted by the 2025 House of Delegates, was charged with developing recommendations to modernize governance, improve efficiency, and strengthen engagement across the organization.

After extensive review and deliberation, the Task Force unanimously recommends a series of comprehensive structural changes designed to position MSMS for the next decade of success.

For any association, an engaged and active member is a member for life. The Task Force considered how MSMS can engage more members in our policy and advocacy efforts with the goals of creating policy with broader physician input and expanding advocacy reach, retaining current members and recruiting new members, and increasing dues revenue.

Through the current process, the House averages 100 delegates in-person for the general session. Over the years, delegates and members expressed several concerns about barriers to participation including the time and travel commitment, the often-tedious process of testimony and voting, and occasionally the unprofessional tone or conduct of delegates. This has created a system whereas mostly the same 100 delegate members determine policy and priorities for thousands of members. In terms of improved representation and structural sustainability, the Task Force was interested in other models of governance that would include more physicians, more members, and more engagement.

When MSMS had 16,000 members it was necessary to have a “representative structure” like the House of Delegates due to the sheer size of the organization and need for designated delegates to stay informed about what was happening at the state level. Physicians serving as delegates were usually in private practices or retired. Taking time off from private practice, for any reason, was a loss of income in addition to the inconvenience of travel. Now, MSMS has significantly less

members and at the same time advances in virtual communication have made it possible to communicate from virtually anywhere instantaneously. As a result, MSMS has the opportunity to move from a cumbersome representative model to a more engaging democratic model where each member's voice is equally represented.

Another factor that deserves further research and dialogue is the direct and in-direct costs of the meeting. A one-day, in-person, centrally located House of Delegates costs MSMS approximately $60,000. This does not include in-direct staff costs. In the last few years, MSMS has not had enough employees to cover all the required areas of the meeting. Out of necessity, the work of the House is mostly completed after hours by MSMS staff who shoulder many other responsibilities including revenue. Historically, there were dedicated staff whose entire jobs were preparing for and managing the House of Delegates. However, due to the many budget cuts over the years, those positions were eliminated, and the House was assigned and reassigned to the few remaining staff.

For these critical financial reasons, the Board of Directors voted to transition the House to a virtual format for 2026. This would keep the same Reference Committee process online with live testimony but also move the general session online with live testimony and voting. While this option addresses issues with the direct expenses, it does not fully litigate expanding involvement. In investigating other options, further opportunities exist for process efficiencies, in-direct staff costs, and engagement with all members.

While many states have eliminated their House of Delegates completely, about a dozen have moved to an all-member online policy system. They report equal if not greater success in terms of member engagement and policy outcomes. Resolutions are collected year-round. A Policy Review Committee evaluates resolutions two to three times per year. Testimony is collected via an online written forum, like the one currently used. Then the Policy Committee's recommendations are sent to all members for a vote. The Policy Committee would have authority to evaluate resolutions for purview per bylaws (medical policy vs financial/business decisions), prioritizing practice sustainability and practice of medicine, MSMS scope, and fiscal notes. As many of our state medical societies have already experienced, this system allows all members to have the opportunity to introduce and engage with policy initiatives, allows MSMS to make more timely policy decisions, eliminates all direct costs, creates efficiency and redistributes work throughout the year for the limited staff.

The inaugural Chair and Vice-Chair of the Policy Committee would be the current Speaker and Vice-Speaker of the House of Delegates. The Board of Directors would appoint 10 to 12 other Committee members with recommendations from counties, specialties, sections, physician organizations and individual members. This option allows for more immediate decisions, engages all members, and decreases direct and indirect costs.

Attachment

- Task Force on Reorganization's Report (see Miscellaneous Tab)
- Resolution 14-25
- Resolution 16-25
- Resolution 47-25
- Proposed Changes to Bylaws

1 **RESOLUTION 14-25**
2
3 **Title:** Rotation of MSMS House of Delegates Meeting Location
4
5 **Introduced by:** E. Chris Bush, MD, for the Wayne County Delegation
6
7 **Original Author:** E. Chris Bush, MD
8
9 **Referred To:** Reference Committee C
10
11 **House Action:**
12

13
14 Whereas, the MSMS House of Delegates (HOD) is an annual meeting for all the Delegates from
15 across the state, and
16
17 Whereas, the MSMS HOD location has traditionally rotated to various locations across the state to
18 be more equitable for the attendees, and
19
20 Whereas, the majority of the Delegates attending the MSMS HOD each year are from the counties in
21 southeast Michigan, and
22
23 Whereas, the MSMS HOD approved Resolution 03-22 which states that the MSMS will continue to
24 rotate the annual HOD meeting between the east and west side of the state, but at least once every
25 12 years, the western meeting shall take place in a northern county, and
26
27 Whereas, moving to a one-day meeting in Lansing, that starts at 10:00 a.m., was done as a cost-
28 reduction measure for MSMS, the costs have been shifted to the Delegates who should have a say
29 in where the annual meeting is held, and
30
31 Whereas, the overall costs of a one-day meeting would be expected to be similar regardless of the
32 geographical location; therefore be it
33
34 RESOLVED: That the MSMS House of Delegates shall return to the rotation of alternating meetings
35 between an outstate venue and a southeast Michigan venue with the 2026 meeting to be held in the
36 Detroit area.
37

38
39 WAYS AND MEANS COMMITTEE FISCAL NOTE: $50,000

	2024/2025 Lansing Actual from Hotel Bill	**2026 Dearborn Actual Proposal – The Henry**
Delegate Beverage and Lunches	$10,400	$13,000
Presidents Reception	$5,400	$7,700
Conference Rooms Rental	$7,800	$29,000
Overnights Students, Staff and Board	$5,300	$22,500
Staff Meals	$2,000	$4,400
Staff Mileage	$0	$3,500
	$30,900	$80,100

Fiscal notes are estimates and should be used as one reference point in determining support or opposition of any resolution.

Of note:

- This comparison does not include the AV contractor, Audience Response System, Signs, Awards, Online Forum, Election Ballot or other meeting costs that do not differ based on location. This cost is approximately $20,000.
- The Henry was used as one comparison for purposes of developing a fiscal note because they are one of few locations in the Detroit area that can accommodate our dates, the combination of number of overnight rooms, number of conference rooms and the House set-up all at one-time. MSMS has received prior proposals from other hotels including the Motor City Casino and the Suburban Showcase which were both significantly more expensive than the Henry. And the Somerset, Novi Sheraton, Southfield Weston, all being either more expensive or lacking enough space for the general session. As regular practice, MSMS always requests multiple proposals for off-site events and would work with individual facilities and the CVB to do so if a Detroit location is needed.
- The Henry proposal includes room rental of $58,000. Only half was used in the fiscal note as staff expects some ability to negotiate contract. Similarly, the food and beverage minimum is $30,000 but only $25,000 is reference in the fiscal note as that is also an area of potential negotiation. That proposal is attached.
- Event documentation involved 3 different pieces. The contract locks in the date, space, pricing for the room rental and overnight rooms, food and beverage minimums, and cancelation clause. The Banquet Event Orders details room set-up, AV, and quantity and selections for food and drink. This will contain some pricing for those items. The final bill will itemize room set-up, AV, and quantity and selections for food and drink. The amounts will differ from the Banquet Event Order as onsite changes occur like additional easels were needed, extra lunches were ordered and typically some food and beverages are charged on consumption. These will be reflected in the final bill.
- Events are also subject to several taxes. As indicated in the Henry proposal, overnight rooms are subject to 6 percent state tax and 8 percent occupancy tax. Food, beverages and rental costs are subject to 24 percent taxable service charge and 6 percent state sales.
- Set up for the House begins at 12:00 noon the day before the meeting. Tear down is completed around 9:00 pm that evening. Staff are allowed to stay the night Friday and Saturday if they wish for the completion of the event and safety of our employees.
- MSMS manages the House of Delegates costs as frugally as possible. Many state associations utilize event management companies which range from $20,000 - $50,000 to assist in preparing for the meeting and staffing onsite. This includes work like loading, unloading, setting up, testing and tearing down the general session room for 300, registration, meeting rooms, event spaces, exhibits. MSMS staff balances this while maintaining their normal day-to-day workloads. Much of the preparation for the House is completed after work hours including the weekends.
- Room calculations

  $250 (includes all tax)
  25 staff/contractors x 2 nights = $12,500
  10 students = $2,500
  10 board x 2 nights = $5,000
  10 board x 1 night = $2,500

The information contained in the fiscal note was prepared by Rebecca Blake, Certified Meeting Planner (CMP) with 25 years of meeting planning experience with the House of Delegates, Annual Scientific Meeting, Board meetings, and thousands of other MSMS events.

Relevant MSMS Policy

Annual Financial Report
Please refer to the Annual Financial Report to the House of Delegates for more information on the organization's finances.

House of Delegates
MSMS continue to rotate the HOD meeting between the east and west 36 side of the state, but at least once every 12 years, the western meeting shall take place in a 37 northern county.

Relevant AMA Policy
None

Sources:

1. Past MSMS HOD Locations: 2010 - Dearborn, Michigan; 2011 - Kalamazoo, Michigan; 2012 - Dearborn, Michigan; 2013 - Grand Rapids, Michigan; 2014 - Dearborn, Michigan; 2015 - Grand Rapids, Michigan; 2016 - Dearborn, Michigan; 2017 - Grand Rapids, Michigan; 2018 - Dearborn, Michigan; 2019 - Kalamazoo, Michigan; 2020 - Dearborn, Michigan; 2021 – Virtual Meeting during COVID; 2022 - Kalamazoo, Michigan; 2023 - Dearborn, Michigan 2024 - Lansing, Michigan; 2025 - Lansing, Michigan
2. Approved MSMS Resolution 03-22 introduced by Ottawa County https://www.msms.org/hodresolutions/2022/3.pdf

RESOLUTION 16-25

Title: County and State Medical Society Alliance

Introduced by: Megan Edison, MD, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee C

House Action:

Whereas, MSMS has had declining membership and revenues, and

Whereas, this loss of membership revenue impacts all physicians across the state as our legislative impact and outreach is limited, and

Whereas, MSMS has significantly restructured itself into a relevant, physician-led, financially viable organization focused on the core mission, and

Whereas, MSMS is aggressively working to regain large group membership to increase membership revenue, diverse physician voices, and our political footprint, and

Whereas, MSMS bylaws and county medical society bylaws require joint membership of physicians in counties with an active medical society, and

Whereas, the number of active county medical societies has diminished significantly over the years so that some counties no longer charge dues while others charge dues, and

Whereas, MSMS has failed to secure large group memberships reportedly due to the cost of required county membership dues, and

Whereas, county medical societies have lost county members reportedly due to cost and/or value of the required MSMS membership, and

Whereas, creative efforts by MSMS to avoid county membership and membership "deals" recommended to and by county medical societies have created undue stress on this relationship as well as test the bylaws of both organizations, and

Whereas, the 10 percent billing fee charged to county medical societies for the required dual membership has proved financially challenging to county societies, and

Whereas, the historical financial binding of county and state medical societies may now be a hinderance to our mutual survival, and

Whereas, the survival and revival of all county medical societies benefits MSMS and Michigan physicians, as county medical societies are the voice to local politicians in a way lobbyists cannot achieve, and

Whereas, the survival and growth of MSMS is crucial to all Michigan physicians and our patients, as the only physician voice in Lansing representing all physicians, allopathic and osteopathic, of all specialties, and inclusive of all stages of their career and place of practice, and

54
55 Whereas, restructuring our state and county medical societies towards mutual growth and
56 purposes will only strengthen organized medicine; therefore be it
57
58 RESOLVED: That MSMS create a task force of physicians across the state, in both county and state
59 society leadership, to do the following:
60
61 1. Examine the history, finances, and bylaws of our county and state societies;
62 2. Be bold and creative in offering a unified solution to solve this historical issue, and future-proof
63 our organizations so we can focus on our mission together;
64 3. Utilize MSMS legal counsel to aid in this effort by examining county medical society and state
65 medical society bylaws and offering a clear plan on how to update county and state medical
66 society bylaws to achieve the mutual goals; and
67 4. Present recommendations to county and state medical societies prior to the 2026 House of
68 Delegates, with any MSMS bylaws changes presented for a first vote at that time.
69

70
71 WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy
None

Relevant AMA Policy
None

RESOLUTION 47-25

Title: Study Medical Society Structures

Introduced by: Paul Kocheril, MD

Original Author: Paul Kocheril, MD

Referred To: Reference Committee C

House Action:

Whereas, the MSMS Bylaws state the Board "shall have the custody and entire control of all funds and property of the Society" and the House "shall transact all of the business of this Society not otherwise specifically provided for," and

Whereas, in the past, occasional resolutions have lapsed into the financial responsibilities assigned to the Board, and

Whereas, other state societies have clarified and streamlined their organizational structure regarding medical policy and business/financial decisions, and

Whereas, the functioning of MSMS is critical to the future of MSMS and medicine in Michigan; therefore be it

RESOLVED: That MSMS study the organizational structures, Constitution and Bylaws, and business model of other state medical societies as potential options for improving the efficiency and productivity of our organization.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy

ARTICLE IX—THE BOARD OF DIRECTORS

Section 2. - POWERS AND DUTIES—The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions.

14.00 THE BOARD OF DIRECTORS

14.60 DUTIES OF THE BOARD OF DIRECTORS—It shall be the duty of the Board of Directors:

14.61 To make careful inquiry into the condition of the profession in each county in the State. It shall have authority to adopt such methods as may be deemed most efficient for increasing interest in all existing component societies. It shall especially and systematically endeavor to promote friendly intercourse between doctors of medicine in the same locality. It shall make every effort to bring each reputable doctor of medicine in the State under the Society's influence;

14.62 To direct and control the publication of the Journal of the Michigan State Medical Society;

14.63 To provide and maintain such headquarters for this Society as may be required to conduct its business properly;

14.64 To render an Annual Report to the House of Delegates; and

14.65 At least every three years, review the composition of the Board of Directors including the geographical boundaries of the Regions making any recommendations in its discretion it deems necessary.

14.70 CONTROL OF FUNDS—The funds of this Society shall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.

14.71 The Board of Directors shall have the authority to borrow money upon the general credit of the Society. The Board of Directors shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Board of Directors shall authorize and empower the President or the Chair of the Board of Directors, and the Secretary or the Treasurer to execute such instruments as may be required.

12.00 HOUSE OF DELEGATES

12.90 POWERS AND DUTIES—As the legislative body of this Society, the House of Delegates shall have the power arid authority to adopt, institute, and carry out such methods and measures as it may deem to be in the best interests of the medical profession in Michigan. In the exercise of such powers and duties, but without limitation thereof:

12.91 It shall transact all of the business of this Society not otherwise specifically provided for.

12.92 It shall adopt rules and regulations for its own government and for the administration of the affairs of the Society.

12.93 It shall provide for the organization of Regions which shall be depicted on Exhibit A.

12.94 It shall concern itself with and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws, and the health of the public.

12.95 It shall be active in the education of the public in regard to medical research and scientific medicine.

12.96 It shall have the power to identify areas of concern and to instruct the Board of Directors to appoint committees or task forces to study or act on those areas. These committees or task forces shall report to the Board of Directors, which in turn shall report in the annual report of the Board of Directors to the House of Delegates. The House of Delegates shall itself have necessary internal committees, such as I) Credentials, 2) Rules of Orders of Business, 3) Constitution and Bylaws, and 4) Ways and Means. The seated House, by majority vote, reserves the right to instruct the Board of Directors to discharge a specific standing committee, liaison committee, or task force, and to require the Board of Directors to appoint an ad hoc committee with appointees nominated by the seated House. This ad hoc committee shall report through the Board of Directors to the House at the next session, and be discharged.

12.97 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.

12.98 It shall publish its minutes or a summary of its proceedings in the Journal of the Society.

12.99 It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge of hypothecation. It shall have the authority specifically to authorize the Board of Directors and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid.

Relevant AMA Policy

None

Michigan State Medical Society

Constitution and Bylaws

2023 Edition

CONSTITUTION

~~Regional Map (Exhibit A)~~ ~~3~~
Article I - Name ~~4~~3
Article II - Purposes ~~4~~3
Article III - Component Societies ~~4~~3
Article IV - ~~Divisions~~Reserved ~~4~~3
Article V - The Society as a Whole ~~4~~3
Article VI - Scientific Assembly ~~4~~3
~~Article VII - House of Delegates~~ 4
Article VI - Reserved 3
Article VIII – Officers and AMA Delegates ~~4~~3
Section 1 - Officers ~~5~~3
Section 2 - AMA Delegates ~~5~~3
Article IX - The Board of Directors ~~5~~3
Section 1 - Composition ~~5~~4
Section 2 - Powers and Duties ~~5~~4
Section 3 - Executive Committee ~~5~~4
Article X - Judicial Commission ~~5~~4
Article XI - Finances ~~5~~4
Section 1 - Method of Financing ~~5~~4
Section 2 - Power to Fix ~~5~~4
Article XII - Amendments ~~5~~4
Section 1 - Method of Amendments ~~5~~4
Section 2 - Effective Date ~~5~~4

BYLAWS

1.00 Component Societies ~~6~~5
1.10 Charter ~~6~~5
1.20 Revocation of Charter ~~6~~5
2.00 Membership—Classification—Election ~~6~~5
2.10 Definition ~~6~~5
2.20 Membership Prerequisite ~~6~~5
2.30 Active Members ~~6~~5
2.31 Suspended Member ~~6~~5
2.40 Active Members—Dues Exempt ~~7~~6
2.41 Hardship ~~7~~6
2.42 Postgraduate Study ~~7~~6
2.43 Voluntary Service ~~7~~6
2.50 Physicians-In-Training ~~7~~6
2.60 Students ~~7~~6
2.70 Emeritus Members ~~7~~6
2.71 Active Emeritus ~~7~~6
2.72 Emeritus ~~7~~6
2.80 Life Members ~~7~~6
3.10 Service Members ~~8~~7
3.11 Military ~~8~~7
3.12 Commissioned Medical Officers ~~8~~7
3.20 Honorary Members ~~8~~7
3.30 Non-Resident Members ~~8~~7
3.40 Affiliate Members ~~8~~7
3.50 Resolutions Concerning Membership Changes ~~8~~7
4.00 Membership—Regulation ~~8~~7
4.10 Membership as Privilege–Not Right ~~8~~7
4.20 Duties of County Society ~~8~~7
4.30 Rosters ~~8~~7
5.00 Membership—Transfers ~~8~~7
5.10 Change of Location – Procedure ~~8~~7
5.20 Refund of Dues ~~9~~8
5.30 Removal from State ~~9~~8
6.00 Dues and Assessments ~~9~~8
6.10 How Fixed ~~9~~8
6.20 Collection ~~9~~8
6.30 New Members ~~9~~8
6.40 First Year of Practice ~~9~~8
6.50 Arrears—Suspension ~~9~~8
6.60 Deferment ~~9~~8
6.70 Reinstatement ~~9~~8
6.80 Dues—Resident Physicians and Students ~~10~~9
6.90 Active Status—Part-Time Dues ~~10~~9
7.00 Conduct and Discipline of Members ~~10~~9
7.10 Standards of Conduct-Grounds for Discipline ~~10~~9
7.20 Discipline-What Constitutes ~~10~~9
7.30 Discipline-What Procedure to Govern ~~10~~9
7.40 Society of More than 150 Members ~~10~~9
7.50 Peer Review/Ethics Committee ~~10~~9
7.60 Request for Investigation ~~10~~9
7.70 Informal Investigation-Procedure ~~10~~9
7.80 Informal Investigation-Dismissal ~~10~~9
7.90 Informal Investigation-Reprimand ~~11~~10
8.10 Formal Complaint-Notice of Hearing ~~11~~10
8.20 Answer to Formal Complaint ~~11~~10
8.30 Formal Hearing-How Conducted, Right to Counsel ~~11~~10
8.40 Findings and Report ~~11~~10
8.50 Action on Report-Additional Testimony ~~11~~10
8.60 Action by Society ~~11~~10
8.70 Finality and Effectiveness of Order ~~12~~11
8.80 Appeal Procedure ~~12~~11
8.90 Appeal to Judicial Council of the American Medical Association ~~12~~11
9.10 Exception to Procedures ~~12~~11
9.20 Effect of Suspension or Expulsion ~~12~~11
9.30 Construction ~~12~~11
10.00 Grievances of Non-Members-Peer Review/Mediation Committee ~~12~~11
10.10 Peer Review/Mediation Committee ~~12~~11
10.20 Purposes ~~12~~11
10.30 Powers and Duties-Limitation ~~13~~12
10.40 Procedure to Govern ~~13~~12
11.00 General Meetings ~~13~~12
11.10 Determination of Time and Place ~~13~~12
11.20 Right to Participate ~~13~~12
11.30 Actions ~~13~~12

12.00 ~~House of Delegates~~ ~~13~~Policy Review Committee 12
12.10 Composition ~~13~~12
~~12.20 Delegates-At-Large, Ex Officio Members 13~~
~~12.30 Election—Certification 14~~
~~12.40 Seating—Tenure 14~~
~~12.50 Seating of Alternate Delegates 14~~
~~12.60 Officers 14~~
~~12.70 Meetings—Annual Session 14~~
~~12.80 Quorum 14~~
~~12.90~~12.20 Powers and Duties ~~14~~12
~~13.10 Reference Committees 15~~
12.30 Resolution Approval 12
~~13.20~~13.10 Election of Regional Directors ~~15~~12
~~13.30~~13.20 Election of Delegates to American Medical Association ~~15~~12
13.30 Reserved 13
13.40 ~~Election of Officers~~ ~~16~~Reserved 13
13.50 ~~Resolutions~~Reserved ~~16~~13
~~13.60 New Business 16~~
~~13.70~~13.60 Rules of Order ~~16~~13
~~13.80 Nominating Committee 16~~
13.70 Reserved 13
14.00 The Board of Directors ~~16~~13
14.10 Organization ~~16~~13
14.20 Executive Committee ~~16~~13
14.30 Reference Committees ~~16~~13
14.40 Regional Director Duties ~~17~~13
14.50 Removal of Regional Director ~~17~~14
14.60 Duties of the Board of Directors ~~17~~14
14.70 Control of Funds ~~17~~14
~~14.80 Regions 17~~
15.00 The Judicial Commission ~~17~~14
15.10 Composition—Qualifications ~~17~~14
15.20 Judicial Districts ~~17~~14
15.30 Nominations ~~17~~14
15.40 Ballot—Election ~~18~~15
15.50 Terms of Office ~~18~~15
15.60 Vacancies ~~18~~15
15.70 Organization of the Commission ~~18~~15
15.80 Powers and Duties ~~18~~15
16.00 Committees/Task Forces of the Society ~~19~~16
16.10 Standing Committees ~~19~~16
16.20 Liaison Committees ~~19~~16
16.30 Task Forces ~~19~~16
17.00 Officers ~~19~~16
17.10 Term of Office ~~19~~16
17.20 Induction of President ~~19~~16
17.30 President ~~19~~16
17.40 President-Elect—Duties—Succession ~~20~~16
17.50 Chair of the Board ~~20~~17
17.60 Vice-Chair ~~20~~17
17.70 Treasurer ~~20~~17
17.80 Secretary ~~20~~17
17.90 Chief Executive Officer ~~20~~17
18.10 ~~Speaker of the House of Delegates~~ ~~20~~Reserved 17
18.20 ~~Vice-Speaker of the House of Delegates~~ ~~20~~Reserved 17
18.30 Remuneration ~~20~~17
19.00 Indemnification ~~20~~17
20.00 Specialty and Ethnic Medical Societies ~~21~~17
20.10 Recognized Specialty and Ethnic Medical Societies ~~21~~17
20.20 Criteria ~~21~~17
20.30 Resident and Fellow Section ~~21~~18
20.40 Medical Student Section ~~21~~18
20.50 Organized Medical Staff Section ~~21~~18
20.60 Young Physicians Section ~~22~~18
20.70 International Medical Graduates Section ~~22~~18
21.00 Referendum ~~22~~19
21.10 Referendum at Society Meeting ~~22~~19
21.20 ~~Referendum by House of Delegates~~ ~~22~~Reserved 19
22.00 Seal ~~22~~19
22.10 Seal ~~22~~19
23.00 Emergency ~~22~~19
23.10 Emergency Action by Board of Directors ~~22~~19
24.00 Definition of Session and Meeting ~~22~~19
24.10 Session ~~22~~19
24.20 Meeting ~~22~~19
25.00 Amendments ~~22~~19
25.10 Amendments—Procedure ~~22~~19
OFFICIAL PROCEDURES FOR THE JUDICIAL COMMISSION ~~23~~20
Judicial Commission Districts Map ~~25~~22
Directors Region Map (Exhibit A) 25

MSMS Constitution

2023 Edition

ARTICLE I—NAME

Section I. - NAME—The name of this organization shall be the Michigan State Medical Society.

ARTICLE II—PURPOSES

Section I. - PURPOSES—The purposes of this Society shall be: To bring into one viable, effective organization the ethical physicians licensed to practice in Michigan in order that their contribution to human welfare will be enhanced.

In order to accomplish this effectively, the Society also will work to accomplish the following sub purposes:

a) To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.
b) To charter and organize component medical societies.
c) To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.
d) To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his or her patients and the public health generally.
e) To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.
f) To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals.
g) To preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care.
h) To promote quality medical and health care by development and support of activities appropriate to this goal.
i) To advocate fair remuneration for services rendered.
j) To ensure adequacy of the medical workforce by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.
k) To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians.
l) To support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession.
m) To institute and provide specific services to meet the needs of the members.
n) To foster and support continuing medical education.

ARTICLE III—COMPONENT SOCIETIES

Section 1. - DEFINITION—Component societies shall consist of those county medical societies which hold charters from this Society.

Section 2. - GEOGRAPHICAL SCOPE—Not more than one component society shall be chartered in any county of the State. The House of Delegates may, however, in its discretion, grant a charter to a component society comprising two or more counties.

ARTICLE IV—~~DIVISIONS~~RESERVED

~~Section 1. - DIVISIONS—The Society shall have three major divisions, namely:~~

~~1) The Society as a whole.~~

~~2) The Scientific Assembly with its subordinate or related bodies.~~

~~3) The House of Delegates with its subordinate or related bodies.~~

ARTICLE V—THE SOCIETY AS A WHOLE

Section 1. - SESSIONS—The Society as a whole shall hold such sessions at such times and places of such duration as the House of Delegates may determine. The power to so determine may be delegated to the Board of Directors or to the Executive Committee of the Board of Directors by the House of Delegates.

ARTICLE VI—SCIENTIFIC ASSEMBLY

Section I. - DEFINITION—The Scientific Assembly of this Society is the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine and to the conservation of the health of the public.

ARTICLE VII—~~HOUSE OF DELEGATES~~RESERVED

~~Section 1. - COMPOSITION—The House of Delegates shall be the legislative body of the Society and shall consist of delegates elected by component societies, recognized specialty societies, delegates from the Residents and Fellows, Students, Young Physicians, Organized Medical Staff and International Medical Graduates Sections, and other sections as shall from time to time be approved by the House of Delegates, delegates-at-large and ex officio members, as prescribed by the Bylaws.~~

ARTICLE VIII—OFFICERS AND AMA DELEGATES

Section 1. - OFFICERS—The officers of this Society shall be a President; a President-Elect; the Immediate Past President; a Treasurer; and a Secretary~~; a Speaker and a Vice-Speaker of the House of Delegates and shall be elected as provided in the Bylaws~~.

Section 2. - AMA DELEGATES—The Society's delegates and alternate delegates to the House of Delegates of the American Medical Association shall be elected as provided in the Bylaws. *(See*

Bylaws, Section 13.30)

ARTICLE IX—THE BOARD OF DIRECTORS

Section 1. - COMPOSITION—The Board of Directors shall be the executive body of the Society. Effective at the first meeting of the Board of Directors immediately following the final meeting of the House of Delegates held at its 2020 Annual Session, the Board of Directors shall consist of:

a) Two Directors (the "Regional Directors") from each of the nine regions depicted on Exhibit A to the Bylaws (each a "Region" and collectively the "Regions"). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula.

b) The President, President-Elect, Immediate Past President, Secretary, and Treasurer~~, Speaker and Vice Speaker of the House of Delegates~~.

c) One Director elected by those members in each of the membership classifications defined in Sections 2.50 and 2.60 of the Bylaws, and one Director elected by those members in the Young Physicians Section as defined in Section 20.60 of the Bylaws. These seats will be for one-year renewable terms, and the directors elected must remain in the category elected for the entire term.

d) The following ex officio Directors: (i) the Chair of the delegates to the AMA or another member of the delegation, designated as a substitute; and (ii) the two members serving as the physician representatives on the Blue Cross Blue Shield of Michigan Board of Directors.

e) Up to six Directors elected by the ~~House of Delegates~~Board of Directors representing those constituencies deemed from time to time the most relevant to the current health care marketplace ~~to be designated by the nominating committee of the House of Delegates with input from the Board of Directors and the House of Delegates~~ (the "Designated Directors"). The Designated Directors shall serve three-year terms. Designated Directors may not serve more than three consecutive terms; the same individual may serve additional terms after an absence of at least one year.

Section 2. - POWERS AND DUTIES—The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole ~~and for the House of Delegates between sessions~~.

Section 3. - EXECUTIVE COMMITTEE—The Board of Directors may have an Executive Committee with power to act between meetings of the Board. The composition, powers and duties thereof shall be such as are prescribed by the Bylaws.

ARTICLE X—JUDICIAL COMMISSION

Section 1. - COMPOSITION - POWERS AND DUTIES—The Judicial Commission shall be the body having general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members and professional conduct generally. It shall consist of members to be elected by the voting members of the Society. The number of members, their terms of office, the time and manner of their election and the specific powers and duties of the Commission shall be as prescribed by the Bylaws.

ARTICLE XI—FINANCES

Section 1. - METHOD OF FINANCING—Funds for meeting the expenses of the Society shall be raised by annual dues and may be augmented by other methods including special assessments and voluntary contributions.

Section 2. - POWER TO FIX—Annual membership dues and assessments shall be fixed by the ~~House~~Board of ~~Delegates~~Directors.

ARTICLE XII—AMENDMENTS

Section 1. - METHOD OF AMENDMENTS—The ~~House of Delegates~~members may amend any article of this Constitution by a two-thirds vote of the ~~Delegates~~members seated at any ~~regular session~~General Meeting, provided that such amendment shall have been presented in open meeting at ~~the~~a previous ~~regular session~~General Meeting, and that it shall have been published at least once during the interval in the Journal of the Society, or sent officially to each component society at least two months before the ~~meeting~~General Meeting at which final action is to be taken.

Section 2. - EFFECTIVE DATE—Unless otherwise provided herein, this Constitution and all amendments hereto shall become effective immediately upon adoption ~~by the House of Delegates~~.

MSMS Bylaws

2023 Edition

1.00 COMPONENT SOCIETIES

1.10 CHARTER - The charter of each component society shall be authorized by the ~~House of Delegates~~Board of Directors and signed by the President and Secretary. Such charter shall require that the constitution and bylaws of such component society be at all times consistent with the provisions of the Constitution and Bylaws of this Society and with all amendments thereto hereafter adopted. Each component society shall file with the State Society headquarters a current copy of its constitution and bylaws.

1.20 REVOCATION OF CHARTER - The ~~House of Delegates~~Board of Directors is empowered to revoke the charter of any component society whenever it finds that such society has materially breached any of the provisions of the Constitution or Bylaws of this Society or has failed to function within the expressed spirit and purpose of this Society to such an extent that revocation of charter is compatible with the best interests of this Society.

Petition for the revocation of charter of any component society may be filed with the Board of Directors by a Director of the Region within which such society is located, or by any three members of the Board of Directors of this Society or by the President of this Society. Such petition shall be in writing and set forth with reasonable particularity the matters complained of and upon which the petition is founded. A copy of such a petition together with written notice of the time and place of hearing on the petition shall be served on the affected component society by registered mail, return receipt requested, not less than 60 days before the date of such hearing.

The affected component society may, within 30 days after service upon it of copy of the petition, file with the Board of Directors by registered mail, return receipt requested, a written answer thereto. The Board of Directors shall afford the affected component society a fair hearing of the matters complained of and a suitable opportunity to present its defense. The component society may be represented by legal counsel. Written arguments may be filed on behalf of the affected component society and by the petitioner. Stenographic notes shall be made of the entire proceedings on such hearing and a complete record shall be prepared, which record shall consist of the petition, answer, testimony, exhibits, written arguments and other pertinent matter.

The Board of Directors shall make its decision based on the records, setting forth in writing the finding of facts, conclusions and reasons therefore. If two-thirds of the members of the Board of Directors do not concur in the conclusion that the charter of the affected component society should be revoked, the petition shall be deemed dismissed and the proceedings ended. If two-thirds of the members of the Board of Directors concur in the conclusion that the charter of the affected component society should be revoked, the ~~Chair of the~~charter shall be revoked. The Board of Directors shall ~~transmit to the House of Delegates a report, consisting of the decision of the Board of Directors with all records annexed, and shall~~ serve a copy ~~thereof~~of its decision on the affected component society. The ~~House of Delegates shall at the next regular or special session thereof following the transmittal of such report, consider and take such action on the report as it may deem proper. In case the House of Delegates desires further proofs in relation to the issues involved, it may remand the matter to the Board of Directors for further hearing and report. The action of the House of Delegates on the report~~action of the Board of Directors shall be the final decision with reference to the revocation of the charter of a component society; provided, that the component society, if it feels aggrieved by the decision~~ of the House of Delegates~~, may, within six months, appeal to the Council on Judicial and Ethical Affairs of the American Medical Association, whose opinion shall be final.

2.00 MEMBERSHIP—CLASSIFICATION—ELECTION

2.10 DEFINITION - As used in these Bylaws, except as otherwise herein expressly qualified, whenever the terms "doctor of medicine" or "practice of medicine" or "medical profession" are used, these terms shall be deemed to include the terms "doctor of medicine and doctor of osteopathy," "practice of medicine and practice of osteopathy," and "medical profession and osteopathic profession."

2.20 MEMBERSHIP PREREQUISITE-All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society where they reside or primary location of practice or direct members through the Resident and Fellow Section or the Medical Student Section.

2.30 ACTIVE MEMBERS - To be eligible for active membership in any component society, doctors of medicine must hold an unrevoked, permanent license that is not currently under suspension in Michigan, or if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, doctors of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society.

2.31 Suspended Member - If an Active Member's license is suspended, his/her component society may change his/her membership classification to "Suspended Member." Those in the Suspended Member classification shall be so recognized by this Society, will not be responsible for dues payments, nor be eligible for holding any office or serve on any committee. The component society shall reinstate anyone in the Suspended Member classification immediately upon notice of reinstatement of his/her license. The Society shall recognize such a reinstatement upon notice from a component society and the member shall again be obligated to pay dues, eligible to hold office and serve on committees.

2.40 ACTIVE MEMBERS - DUES EXEMPT - Members in any of the following three categories shall be classified "Active-Dues Exempt" and shall have all the privileges of active membership.

2.41 Hardship - Members for whom the payment of dues would be a financial hardship by reason

of physician disability or illness may be excused, fully or partially, from payment of dues by the Board of Directors provided the member is fully or partially exempted from the payment of component society dues. Members may also be excused from payment of dues because of financial hardship, or for other reason, but these must be set forth by the secretary of the member's component society.

2.42 Postgraduate Study - Active membership may be maintained by those members who are out of practice on account of postgraduate medical studies, by payment of dues of PHYSICIANS-IN-TRAINING covered in Section 2.50.

2.43 Voluntary Service - Members who serve as missionaries or who participate, for nominal or no compensation in a government- sponsored volunteer medical program, either in the United States or abroad.

2.50 PHYSICIANS-IN-TRAINING - Physicians-in-training in AMA-approved programs who have licenses to practice in Michigan or fellowships, members serving as their primary occupation in a structured educational program begun immediately upon completion of medical school, residency, or fellowship training, may become active members of the State Medical Society through a component society or directly where no provision for reduced dues active membership exists at the component level. State Society dues for resident members shall be set by the Board of Directors of MSMS. Component dues, if any, shall be determined locally.

2.60 STUDENTS (MEDICAL STUDENT SECTION) - Medical students may become members of the State Medical Society through a component society or directly through the MSMS Medical Students Section. Except as provided in Section 12.10 of these Bylaws, they may not vote or hold office. They may be appointed to MSMS committees as student members. State Society dues shall be set by the Board of Directors to cover administrative costs of membership except in the first year of membership. Component dues for students shall be determined at the local level.

2.70 EMERITUS MEMBERS—Members who have maintained active membership in any one or more component societies in Michigan for a period of five or more years, and who have retired from practice, may be transferred to the emeritus members roster of such component society and this society, provided the member's dues have been paid to the end of the preceding calendar year

2.71 ACTIVE EMERITUS—A member who has been elected an active emeritus member, who pays an annual fee set by the Board of Directors, shall be classified as an active emeritus member. Active emeritus members will receive Society publications; may serve on committees; may vote in elections and hold officer positions; ~~may serve as delegate or alternate delegate to House of Delegates;~~ will be included in the Society membership count~~; will be included in the count for Delegates to the House of Delegates~~; will be eligible for Society insurance and member rate for Society sponsored continuing education.

2.72 EMERITUS—A member who has been elected an emeritus member, who does not pay the annual fee set by the Board of Directors, shall be classified as an emeritus member. Emeritus members will not receive Society publications by mail but will be able to have member access to the MSMS website and to participate in MSMS online activities; may not serve on committees; may not vote in elections and hold officer positions; ~~may not serve as delegate or alternate delegate to House of Delegates;~~ will be included in the Society membership count~~; will not be included in the count for Delegates to the House of Delegates~~; will be eligible for Society insurance and member rate for Society sponsored continuing education.

2.80 LIFE MEMBERS

2.81 Doctors of medicine who have maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues paid for the previous calendar year and who 1) have attained the age of 70 years or 2) have been in practice for 50 years, may be transferred to the life membership roster of the component society and this Society.

2.82 Each President, and Chair of the Board of Directors ~~and Speaker of the House of Delegates~~ of this Society shall, upon retiring from office, become a life member of this Society without further action.

2.83 Life members shall pay no dues or assessments but shall have the right to vote and hold office and shall be entitled to receive publications at such rates as the Board of Directors may determine.

2.84 No members shall be transferred to the former life member classification following the 149th session of the House of Delegates held on Sunday, April 27, 2014.

3.10 SERVICE MEMBERS

Service members shall pay no dues and are not entitled to vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.

3.11 Military - Members in good standing who serve on active duty in the military forces of the United States may be transferred by the component society to service member status for the period of time such service continues.

3.12 Commissioned Medical Officers - Commissioned medical officers of the United States Army, Navy, Public Health Service, or physicians employed by the Veterans Administration, on duty in this State, who are not engaged in the private practice of medicine, may be granted service members status by the component society in the area where the medical officer is located.

3.20 HONORARY MEMBERS - A component society may elect as an honorary member any person distinguished for service or attainments in medicine or the allied sciences, or who have rendered other services of unusual value to organized medicine or the medical profession. Upon recommendation of a component society, the ~~House of Delegates may elect~~Board of Directors may designate such persons honorary members of the Society. Honorary members shall pay no dues and shall be without the right to vote or hold office in either this or the component society.

3.30 NON-RESIDENT MEMBERS - A component society may elect as non-resident members any doctors of medicine residing and practicing outside of the county who are members in good standing of their Michigan component societies. Non-resident members shall not have the right to vote or hold office.

3.40 AFFILIATE MEMBERS - Component societies may elect to affiliate membership lay persons in areas of endeavor which are related to medicine and medical practice. Affiliate members shall pay no dues and may not vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.

3.50 RESOLUTIONS CONCERNING MEMBERSHIP CHANGES - Any change in membership status which requires action by the ~~House of Delegates~~Board of Directors shall be effected by a resolution ~~presented at an Annual Session of the House of Delegates after such secretarial certification as is required by these Bylaws~~of the Board of Directors.

4.00 MEMBERSHIP—REGULATION

4.10 MEMBERSHIP AS PRIVILEGE - NOT RIGHT—Anyone eligible may apply for component membership within the county where they reside or primary location of practice. Any exception would require written, mutual agreement between the physician and/or physician group, MSMS, and the respective county(ies). Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. Each component society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation.

4.20 DUTIES OF COUNTY SOCIETY—Each component society shall have general direction of the affairs of the profession in its county or counties and shall be under the continuing duty to exert its influence for the betterment of the scientific, moral, and material conditions of the doctors of medicine therein. It shall also be its duty to make systematic effort to bring every eligible doctor of medicine into membership therein.

4.30 ROSTERS—The secretary of each component society shall keep a roster of its members and, if practicable, a list of non-affiliated doctors of medicine in the county, and other doctors of medicine, such as commissioned officers of the Navy, Army, and Public Health Service, in which shall be shown the full name, the address, the college and date of graduation, the date of license to practice in this State, and such other information as may be deemed necessary, or desirable.

5.00 MEMBERSHIP—TRANSFERS

5.10 CHANGE OF LOCATION - PROCEDURE—When a member of a component society, by reason of change of residence or primary location of practice, desires to transfer membership to another component society, such member shall make application thereto accompanied by tender of dues for the remaining half of the current year (any major fraction of a half being regarded as a full half and any minor fraction being disregarded). Thereupon, the secretary of the society

to which application is made shall request certification of standing from the Society from which the member desires to transfer and upon receipt of such request the secretary of the latter Society shall supply certification of good standing, provided the following requirements have been met:

5.11 All component society dues and assessments shall have been paid for the calendar year previous to the year in which application for transfer is made.

5.12 The member shall not be delinquent in the payment of dues and assessments to this Society.

5.13 Component society dues and assessments shall have been paid to cover that portion of the year in which application for transfer is made (any major fraction of a half year being regarded as a full half and any minor fraction being disregarded).

Upon favorable action by the component society to which application has been made, following compliance with the foregoing, the transfer of membership shall be in effect.

5.20 REFUND OF DUES—A member who has transferred to another component society in accordance with the provisions of paragraph 5.10 above, shall be entitled to a refund from the Society from which such member has transferred, of prepaid dues to such Society (any major fraction of a half year being regarded as a full half and any minor fraction being disregarded).

5.30 REMOVAL FROM STATE—A member of this Society who, by reason of removal from the State, desires to resign from membership in the component society and in this Society and make application for membership in a society of another state, may submit his or her resignation to the secretary of the component society and the Secretary of this Society and request certification of good standing. The resignation from each shall be effective at the end of the half year in which submitted. If, at the time of resignation, the member is in good standing, is not facing charges of unethical conduct and is not in arrears in the payment of dues and assessments to this or to the component society, the secretary of each Society shall furnish him or her certification of good standing.

If the resigning member shall have prepaid dues to this Society or to the component society for any period beyond the half year in which resignation becomes effective, such excess shall be refunded by the respective Societies.

6.00 DUES AND ASSESSMENTS

6.10 HOW FIXED—Members of this Society shall pay such dues and assessments as shall, from time to time, be fixed and determined by the House of Delegates.

6.11 Notwithstanding Section 6.10, the Board of Directors shall have the authority to implement pilot membership incentive programs within the standard dues structure.

Prior to implementing a pilot membership incentive program full consideration shall be given to the impact upon component society dues.

6.20 COLLECTION—All dues are to be collected on or before April 1 of each year in a manner set by this society in consultation with the component society.

6.30 NEW MEMBERS—For the purpose of determining the dues for new members only, the fiscal year of this Society shall be divided into two six-month periods. New members shall pay adjusted annual dues and assessments for the unexpired semiannual periods of that year. Such new members shall not be entitled to membership benefits until their election to membership has been duly reported to the Secretary of this Society and they shall not be entitled to membership benefits for any period prior to becoming members in good standing.

6.40 FIRST YEAR OF PRACTICE—The annual dues payable to this Society by a doctor of medicine who is elected to membership during the first year of practice, shall be 25 percent of the amount fixed and determined pursuant to Section 6.10 during the first year of practice, 50 percent of such amount during the second year of practice, 75 percent of such amount during the third year of practice and the full amount during the fourth year of practice. This reduction in annual dues shall not exempt such member from the payment of any regularly levied assessment.

6.50 ARREARS - SUSPENSION—Any member in arrears in the payment of dues assessments to this Society on the date in any year which coincides with the suspension date of the American Medical Association (currently March 1), if no extension of time for payment has been granted under the provisions of Section 6.60 of this Chapter, or upon the expiration of such extension as may have been granted there-under, shall stand suspended until all sums in arrears have been paid. However, if the secretary of the component society shall certify to the Secretary of this Society that the name of the member in arrears is to be submitted to the ~~House of Delegates at its next Annual Session for election to a different classification~~Board of Directors for reclassification of membership under the provisions of Chapter 2.00 hereof, such member shall not be suspended pending action by the ~~House of Delegates~~Board of Directors upon such requested change of classification.

6.60 DEFERMENT—Upon written request of the governing body of a component society to the Board of Directors of this Society, a member shall be granted an extension of time for the payment of dues to this Society, provided, such extension shall not be beyond the close of the current fiscal year of this Society.

6.70 REINSTATEMENT—A member who is in arrears in the payment of dues or assessments to this or the

component society for not more than one year may be reinstated to good standing upon payment of all arrearages. If in arrears for more than one year, such member shall be deemed to have forfeited membership. In such case the component society may reinstate such member to membership in good standing upon the payment of all arrearages or may, at its option, require reapplication for election to membership.

6.80 DUES - RESIDENTS, FELLOWS AND STUDENTS—Dues for these membership categories shall be set by the Board of Directors as defined in Sections 2.50 and 2.60.

6.90 ACTIVE STATUS - PART-TIME DUES—Dues for the following categories will be one-half the annual active membership dues rate. Members in these categories will have all the privileges of active membership. Eligibility for these categories will be determined prior to the due date for the payment of dues each year and thereafter verified on a yearly basis.

6.91 A member who works less than 20 hours per week.

6.92 Members sharing one full-time position, each working 50 percent within a practice.

6.93 A physician spouse of a full dues paying active member.

7.00 CONDUCT AND DISCIPLINE OF MEMBERS

7.10 STANDARDS OF CONDUCT - GROUNDS FOR DISCIPLINE—Any conduct of a member of this or any component society, whether or not occurring in the course of a physician-patient relationship, which

7.11 is in violation of the Principles of Medical Ethics of the American Medical Association, or

7.12 constitutes unprofessional and dishonest conduct as defined by Act 368 or the Public Acts of Michigan of 1978, as amended, or

7.13 results in conviction of a felony under the laws of any state or of the United States of America, or

7.14 is in violation or disregard of the constitution, bylaws, principles, rules, regulations or orders of this Society or of its Judicial Commission or of the American Medical Association, or

7.15 constitutes defamation or otherwise unjust reflection on the integrity, character or professional performance or reputation of a fellow member of the profession, or

7.16 is prejudicial to or tends to expose the medical profession of this or a component society to contempt or reproach, or which is in anywise contrary to ethics, honesty or good morals,

shall be grounds for discipline. The willful failure or refusal of a member whose conduct has been called into question to appear before any disciplinary body upon request or to cooperate with such disciplinary body or the Judicial Commission in any authorized investigation shall also, in and of itself, be grounds for discipline.

7.20 DISCIPLINE - WHAT CONSTITUTES— Discipline as used in this chapter shall include reprimand, suspension and expulsion, and for grievous offense, recommendation to the State licensing authority for revocation of license.

7.30 DISCIPLINE - WHAT PROCEDURE TO GOVERN—All disciplinary proceedings conducted by this Society or by any component society, shall be governed by the provisions of this chapter and the current Official Procedures of the Judicial Commission, any provisions of the constitution or bylaws of any component society to the contrary notwithstanding. Any provisions of this chapter in conflict with the Official Procedures of the Judicial Commission shall be of no effect.

7.40 SOCIETY OF MORE THAN 150 MEMBERS— Any component society having more than one hundred fifty active members may, by appropriate provisions in its Constitution or Bylaws, delegate its authority and power to discipline its members to the governing board of such Society, in which event, all of the functions, powers and duties of a component society as set forth in this Chapter shall be exercised and carried out by such governing board. Unless otherwise provided by the Constitution or Bylaws of such component society, any order of expulsion or suspension made by such governing board shall be subject to the approval of the component society in the same manner as may be provided for the approval of any other report of such governing board.

7.50 PEER REVIEW/ETHICS COMMITTEE—Every component society shall have a standing committee designated the Peer Review/Ethics Committee, charged with duties and powers concerning the maintenance of standards of conduct and discipline of members, including the duties and powers specifically set forth in this chapter.

7.60 REQUEST FOR INVESTIGATION—Upon the receipt by a component society of a written request for investigation of the conduct of one of its members, signed by an active member or committee of such component society and setting forth briefly the alleged facts of such claimed misconduct, such request for investigation shall be referred to the Peer Review/Ethics Committees.

7.70 INFORMAL INVESTIGATION PROCEDURE—

The Peer Review/Ethics Committee shall thereupon make such informal investigations as the circumstances and nature of the matter require. The procedure to be followed shall be determined by the Peer Review/Ethics Committee but shall be such as to insure that the member whose conduct is questioned has full opportunity to be heard and to offer any defense or explanation available to him or her.

7.80 INFORMAL INVESTIGATION - DISMISSAL—Upon conclusion of its informal investigation the Peer Review/Ethics Committee if it decides that there is no ground for discipline shall dismiss the matter and so report to the Society.

7.90 INFORMAL INVESTIGATION REPRIMAND—If, upon the conclusion of its informal investigation, the Peer Review/Ethics Committee decides that the member whose conduct is questioned is guilty of conduct warranting only a reprimand it shall forthwith administer such reprimand and so report to the Society unless a formal hearing is demanded by the member.

8.10 FORMAL COMPLAINT-NOTICE OF HEARING—If the Peer Review/Ethics Committee finds there is reasonable cause to believe that the respondent is guilty of misconduct warranting suspension or expulsion from membership, or if the respondent demands a formal hearing, a formal complaint setting forth the facts of the alleged misconduct shall be prepared by the Peer Review/Ethics Committee and subscribed by the Chair or Vice-Chair thereof. A copy of such complaint shall be filed with the component society. Thereupon, it shall be the duty of the Peer Review/Ethics Committee or its Chair to fix the time and place for a formal hearing thereon. A written notice of such hearing, together with a copy of the formal complaint, shall be served on the respondent by registered or certified mail, or other appropriate means as approved by the MSMS Judicial Commission, not less than thirty days before the date of such hearing.

8.20 ANSWER TO FORMAL COMPLAINT—It shall be the duty of the respondent to file an answer to the formal complaint. Such answer shall be in writing, signed by the respondent, and filed with the Peer Review/Ethics Committee within fifteen days after service of the copy of the formal complaint. The answer shall admit or deny each material allegation contained in the complaint, and shall set forth any special defenses which the respondent claims to have. If the answer is not filed within the time hereby limited, the complaint may be taken as confessed.

8.30 FORMAL HEARING - HOW CONDUCTED - RIGHT TO COUNSEL—It shall be the duty of the respondent to appear before the Peer Review/Ethics Committee in person at the time and place specified in such notice. Both the respondent and the Peer Review/Ethics Committee shall be entitled to be represented by counsel at such hearing. At such formal hearing, it shall be the duty of the respondent to answer fully and fairly all questions pertaining to conduct which may be asked by any member of the Peer Review/Ethics Committee of the component society or its counsel. Formal hearings shall be conducted fairly, but not necessarily in accordance with all rules governing court trials. A stenographic record shall be made of the proceedings at such hearings.

8.40 FINDINGS AND REPORT—If upon formal hearing the Peer Review/Ethics Committee finds that the charges of misconduct are not established by a preponderance of the evidence, the Committee shall dismiss the complaint. If the Committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant discipline by way of reprimand, the Committee shall administer such reprimand, and shall make a written report thereof, together with its findings of fact, to the component society. If the Committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant suspension or expulsion from membership by action of the component society, the Committee shall make a written report of the proceedings held before the Committee, and shall include in such report a certified transcript of the evidence, including copies of all documents taken in proof, a summary statement of all previous misconduct for which the respondent has been disciplined, and the Committee's findings of fact and recommendations for discipline. Every such report shall be signed by not fewer than a majority of the members of the Peer Review/Ethics Committee, and shall be filed with the component society.

8.50 ACTION ON REPORT - ADDITIONAL TESTIMONY—Whenever a Peer Review/Ethics Committee files a report with its component society recommending suspension or expulsion as herein provided, the respondent shall be served with a copy of the Committee's findings of fact and recommendations so filed, not less than twenty days before the meeting of the component society at which such recommendations are to be considered and acted on, together with a notice of the time and place of such meeting. The respondent may thereupon file with the Society not less than ten days before such meeting reasons in writing why the recommendations of the Peer Review/Ethics Committee should not be adopted. The respondent may also at such meeting appear in person and offer any further reasons why such respondent should not be suspended or expelled from membership; provided, however, that at such meeting no testimony as to any matter of misconduct shall be taken. If it is decided at such meeting that the interests of justice require additional testimony to be taken, the matter shall be referred to the Peer Review/Ethics Committee for such purpose. In such event the Peer Review/Ethics Committee shall cause such additional testimony to be taken promptly, and shall make a supplemental report thereon, including findings of fact and recommendations based thereon,

and shall file the same, together with a certified transcript of such additional testimony with the component society. A copy of the findings of fact and recommendations contained in the supplemental report shall be served on the respondent as required in the case of an original report, and thereafter the same procedures shall be followed as in this section provided in relation to an original report.

8.60 ACTION BY SOCIETY—Following the filing of any such report of a Peer Review/Ethics Committee recommending suspension or expulsion, the component society shall, at a regular meeting thereof, or at a special meeting called for such purpose, consider and act upon the report and recommendation of the Peer Review/Ethics Committee. Suspension or expulsion from membership shall require the affirmative vote of not less than two-thirds of members present at any such meeting and entitled to vote thereat, but not including the respondent, who shall have no right to vote on the question. If any measure for discipline is adopted by a component society, an appropriate order in accordance therewith shall be signed by the President and Secretary of such Society and a copy thereof served on the respondent and on the Michigan State Medical Society.

8.70 FINALITY AND EFFECTIVENESS OF ORDER—No order of suspension or expulsion from membership shall be final or effective until the respondent shall have been given the opportunity to exhaust remedies of appeal and review in accordance with the provisions of this Chapter.

8.80 APPEAL PROCEDURE—Any member feeling aggrieved by an order of suspension or expulsion may appeal to the Judicial Commission of the Michigan State Medical Society. Notice of such appeal shall be in writing, signed by the appellant and shall set forth specific reasons for the appeal. The notice shall be served on the Judicial Commission and on the appellant's component society by registered or certified mail, addressed to the respective secretaries thereof. Unless notice of appeal is so served within 30 days following the service on the member of a copy of the order of the suspension or expulsion as herein above provided, such member's right of appeal and review shall be conclusively treated as having been waived and the order of suspension or expulsion shall thereupon become final and effective. On receiving notice of appeal, the component society shall forward to the Judicial Commission the complete record of the matter, including copies of the order appealed from, all reports of the Peer Review/Ethics Committee, formal complaint, answer, transcript of testimony, exhibits and all other pertinent writings and data on which the order of suspension or expulsion was based. The Judicial Commission may request the component society or the appellant to furnish such further information in writing as the commission deems necessary for the proper and full review of the matter. Written arguments may be filed with the Judicial Commission by the component society and the appellant within 45 days following notice of appeal. The Judicial Commission shall, within 90 days after receiving the full records in the case, review the record on appeal and the written arguments, make such findings as it deems appropriate and, by majority vote of the participating members of the Commission, affirm, modify or reverse the order of expulsion or suspension appealed from, or remand the matter for further action by the component society. In the consideration of any appeal, not less than six members of the Commission shall participate, and in the event that the participating members of the Commission are equally divided, so that no majority prevails, the order or finding appealed from shall stand affirmed.

A copy of such decision shall be promptly served on the appropriate component society and on the appellant by registered or certified mail. Unless within twenty days after service on them of a copy of such decision the component society or the appellant shall take an appeal to the Judicial Council of the American Medical Association, the right to such further appeal and review will be conclusively treated as having been waived, and the decision of the Judicial Commission shall be final and effective.

8.90 APPEAL TO JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION—The appellant, if a member in good standing of the American Medical Association at the date of the alleged misconduct, or the component society, may, within twenty days after service of a copy of the final decision of the Judicial Commission, take an appeal there from to the Council on Ethical and Judicial Affairs of the American Medical Association.

9.10 EXCEPTION TO PROCEDURES—Any member of a component society whose license to practice medicine shall have been revoked, or who shall have been convicted of a felony in any state or federal court, shall be expelled from the component and State Society without benefit of, or resort to, the procedures prescribed in this Chapter.

9.20 EFFECT OF SUSPENSION OR EXPULSION—Whenever a member of any component society is suspended or expelled from such society, he or she shall thereby also stand automatically suspended or expelled from the Michigan State Medical Society.

9.30 CONSTRUCTION—Procedures under this Chapter of the Bylaws shall be as summary as may be reasonable. No investigation or proceeding hereunder shall be held invalid by reason of any non-prejudicial irregularity or for any error not resulting in a miscarriage of justice. The provisions of this Chapter shall be liberally construed for the maintenance of the dignity, integrity, purposes and high principles of this Society and its component societies.

10.00 GRIEVANCES OF NON-MEMBERS—PEER REVIEW/MEDIATION COMMITTEE

10.10 PEER REVIEW/MEDIATION COMMITTEE—Every component society shall have a standing

committee designated the Peer Review/Mediation Committee. Directors holding membership in a component society are eligible for membership on that component society's Peer Review/Mediation Committee.

10.20 PURPOSES—The purposes of such committee shall be:

10.21 to afford the public an informal means of making known to the profession any alleged grievance arising from a physician-patient relationship;

10.22 to resolve misunderstanding between physician and patient or between the component society and the public;

10.23 to reconcile differences between physician and patient by means of persuasion and explanation; and

10.24 to assist the Peer Review/Ethics Committee of its component society in maintaining among members high levels of professional deportment.

It shall not be the purpose of this committee to establish fees, but serve to resolve disputes. Each case should be considered on its own merits and it shall not be the intent of the committee to establish precedents.

10.30 POWERS AND DUTIES—LIMITATION—The specific powers and duties to be exercised by such committee in furthering the purposes above set forth, shall be as fixed and determined by the component society, provided, however, that such committee shall function in the area of mediation or conciliation only and shall not have power to act as a trial body or to render decisions or awards, nor shall such committee have power to impose discipline or in any wise encroach upon the function of the Peer Review/Ethics Committee.

10.40 PROCEDURE TO GOVERN—The provisions of this chapter shall be governed by the current Official Procedures of the Judicial Commission regarding mediation committees and procedures. Any provisions of this chapter in conflict therewith shall be of no effect.

11.00 GENERAL MEETINGS

11.10 DETERMINATION OF TIME AND PLACE—During each Annual Session the Society may hold one or more General Meetings. The number and times of these General Meetings shall be determined by the Board of Directors. Such General Meetings shall be presided over by the President or in his/her absence the President-Elect or the Chair of the Board of Directors.

11.20 RIGHT TO PARTICIPATE—Each registered member at an Annual Session shall have an equal right to participate in the deliberations of a General Meeting and each active member, active emeritus member, and life member so registered shall have the right to vote on pending questions before the General Meeting.

11.30 ACTIONS—At any General Meeting or at any section meeting of this Society, there may be recommended ~~to the House of Delegates or~~ to the Board of Directors the appointment of committees or commissions for scientific investigations of special interest and importance to the profession and the public. Such investigations and reports shall not become official actions or expressions of this Society until approved by the ~~House of Delegates or the~~ Board of Directors.

12.00 ~~HOUSE OF DELEGATES~~POLICY REVIEW COMMITTEE

12.10 COMPOSITION—The ~~House of Delegates shall be composed of members elected by the component societies, a delegate from each recognized specialty society, a delegate from the Resident and Fellow Section, one delegate from the Organized Medical Staff Section, a delegate from the Young Physicians Section, a delegate from the International Medical Graduates Section and one voting at-large delegate for every 50 MSMS student members to be selected by the MSMS Medical Student Section. These student delegates and alternate delegates must be members of the MSMS Medical Student Section. All other delegates and alternate delegates must be voting members of MSMS.~~Society shall have a Policy Review Committee composed of ten to twelve members. The members of the Policy Review Committee shall be appointed by the Board of Directors following its receipt of recommendations from component societies, specialty societies, sections, physician organizations, and individual members.

~~Each component society shall be entitled to send to the House of Delegates each year one delegate for each fifty voting members (active, life, and active emeritus) and one delegate for each additional major fraction thereof. Any component society having less than fifty members shall be entitled to send one delegate.~~

~~The president of a component medical society that all or part of which is located more than 400 miles by road from the site of the House of Delegates may designate a Regional Director of its region to serve as a delegate to the House of Delegates, provided that no member of the component medical society will otherwise be present in person serving as a delegate in any capacity. In the case of such designation of a single Regional Director by two or more component societies, said Regional Director shall have only one vote on all matters before the House of Delegates.~~

~~12.20 DELEGATES-AT-LARGE – EX OFFICIO MEMBERS—Except as provided by Section 12.10,~~

~~the officers of this Society, members of the Board of Directors, and the Chair, Vice Chair, and Secretary of the MSMS Sections recognized by these Bylaws, shall be ex officio members of the House of Delegates, but with the exception of the Speaker and Vice Speaker of the House of Delegates, shall be without power to vote therein. The Past President shall be a member-at-large of the House of Delegates during the first year of past presidency with right to vote and hold office. All other Past Presidents shall have the privilege of the floor, without the right to vote.~~

~~Except for the Speaker, Vice Speaker, Immediate Past President, and as otherwise provided in Section 12.10, members of the Board of Directors are not eligible for election as delegates by their component societies.~~

~~The dean of each accredited medical school in Michigan, if an active member of MSMS, shall be a delegate-at-large to the House of Delegates, with voting privileges. An alternate may not be seated for any dean, and any provisions of these Bylaws regarding the seating of an alternate shall not apply.~~

~~The Chief Medical Officer of the Michigan Department of Community Health, if an active MSMS member, shall be an ex officio member of the House of Delegates, but without power to vote therein. No alternate may be seated in place of that officer and any provision of these Bylaws regarding the seating of an alternate shall not apply.~~

~~12.30 ELECTION - CERTIFICATION Each component society shall elect the number of delegates to which it is entitled. The number of delegates shall be determined by the State Society as of December 1, preceding the House of Delegates meeting. The component society shall also elect an equal number of alternate delegates and shall designate the order or seniority thereof. Promptly after election the secretary of the component society, recognized specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section shall certify the names of its delegates and alternate delegates to the Secretary of this Society.~~

~~12.40 SEATING — TENURE A delegate becomes a member of the House of Delegates when the Speaker is notified in writing of the delegates election by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section. Such certification shall be submitted by February 1 of each year. The delegate shall remain a member of the House of Delegates until the Speaker is notified, in writing, by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section that the delegate has been replaced. The delegate shall remain a member of the House of Delegates regardless of whether or not an alternate substitutes for him/her at any meeting of the House.~~

~~12.50 SEATING OF ALTERNATE DELEGATES An alternate delegate may substitute for a duly certified delegate at any regular or special meeting of the House of Delegates provided that such substitution is authorized in writing by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section.~~

~~12.60 OFFICERS The officers of the House of Delegates shall be the Speaker and Vice Speaker. The Secretary of the Society shall be the Secretary of the House of Delegates. The Speaker and Vice Speaker shall be elected by the House of Delegates at the Annual Session from the members of the then constituted House of Delegates for a one-year term. The Speaker and Vice Speaker of the House of Delegates shall be limited to no more than four one-year terms in each position.~~

~~12.70 MEETINGS - ANNUAL SESSION The House of Delegates shall meet at least annually at the time and place of the Annual Session of this Society and may hold such number of meetings as the House may determine or its business require, recessing from day to day as may be necessary to complete its business and specifying its own time for the holding of its meeting. The House of Delegates may also be called into session at any time by the Speaker upon a two-thirds vote of the Board of Directors, or on petition of twenty-five percent of the Delegates. The purposes of such special session shall be stated in the notice of call and no other business shall be transacted.~~

~~12.80 QUORUM A quorum of the House of Delegates shall consist of not less than 40 percent of the accredited delegates, provided that a majority of such quorum shall not come from any one component society, and the presence of a quorum established at the beginning of the business portion of a meeting shall be sufficient to conduct official business for the duration of the meeting.~~

~~12.90~~12.20 POWERS AND DUTIES—As the ~~legislative~~policy making body of this Society, the ~~House of Delegates shall have the power arid authority to adopt, institute, and carry out such methods and measures as it may deem to be in the best interests of the medical profession in Michigan. In the exercise of such powers and duties, but without limitation thereof:~~Policy Making Committee shall facilitate the collection of resolutions of members, publisize those resolutions and gather testimony on the resolutions using an online format available to all members. The Policy Making Committee shall meet at least once each calendar year. At its meetings, the

Policy Making Committee shall evaluate all resolutions and testimony received from members. The Policy Making Committee shall determine if a resolution concerns a power or duty reserved by these bylaws to the Board of Directors or another body and, if so, rule the resolution ineligible for a member vote.

~~12.91 It shall transact all of the business of this Society not otherwise specifically provided for.~~

~~12.92 It shall adopt rules and regulations for its own government and for the administration of the affairs of the Society.~~

~~12.93 It shall provide for the organization of Regions which shall be depicted on Exhibit A.~~

~~12.94 It shall concern itself with and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws, and the health of the public.~~

~~12.95 It shall be active in the education of the public in regard to medical research and scientific medicine.~~

~~12.96 It shall have the power to identify areas of concern and to instruct the Board of Directors to appoint committees or task forces to study or act on those areas. These committees or task forces shall report to the Board of Directors, which in turn shall report in the annual report of the Board of Directors to the House of Delegates. The House of Delegates shall itself have necessary internal committees, such as I) Credentials, 2) Rules of Orders of Business, 3) Constitution and Bylaws, and 4) Ways and Means.~~

12.30 RESOLUTION APPROVAL—All resolutions that have been evaluated by the Policy Making Committee and not been determined to be ineligible, shall be presented to all the members for a vote along with the Policy Making Committee's recommendations for approval or disapproval within thirty days following the meeting of the Policy Making Committee at which the resolution was evaluated. To be approved by the members, a resolution must receive the approval of a majority of the members voting for or against the resolution.

~~The seated House, by majority vote, reserves the right to instruct the Board of Directors to discharge a specific standing committee, liaison committee, or task force, and to require the Board of Directors to appoint an ad hoc committee with appointees nominated by the seated House. This ad hoc committee shall report through the Board of Directors to the House at the next session, and be discharged.~~

~~12.97 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.~~

~~12.98 It shall publish its minutes or a summary of its proceedings in the Journal of the Society.~~

~~12.99 It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge of hypothecation. It shall have the authority specifically to authorize the Board of Directors and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid.~~

~~13.10 REFERENCE COMMITTEES—The House of Delegates shall have the following reference committees, together with tellers and sergeants-at-arms, appointed by the Speaker of the House and approved by the House of Delegates, and such other reference committees as may be deemed necessary to conduct the business of the House:~~

~~1. Credentials~~
~~2. Rules and Order of Business~~
~~3. Constitution and Bylaws (which shall serve also as the standing Committee on Constitution and Bylaws)~~
~~4. Ways and Means~~

~~13.20~~13.10 ELECTION OF REGIONAL DIRECTORS—Regional Directors shall be elected as provided in Article IX, Section 1(a) of the Constitution. Each component society in a Region shall be notified in writing by the Secretary of the Society at least sixty days in advance of the Annual Session when a Regional Director is to be elected from that Region.

If, by reason of death or resignation, a vacancy in the office of Regional Director occurs at any time other than during an Annual Session, each component society in that Region shall be promptly notified in writing by the Secretary of the Society. Thereupon the seated delegates of such Region may caucus, and if a majority of the seated delegates from such Region shall submit a nomination to the Board of Directors to fill such vacancy, the Board of Directors shall appoint such nominee to serve as interim Regional Director of such Region until a successor is elected in accordance with Article IX, Section 1(e) of the Constitution.

If a vacancy in the office of Regional Director occurs during an Annual Session of the Society, the delegates of the component societies in the Region affected shall be given notice thereof and afforded time to caucus and consider nominations to fill such vacancy.

~~13.30~~13.20 ELECTION OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION—The ~~House of Delegates~~members shall elect delegates and alternate

delegates to the American Medical Association in accordance with the regulations of that parent organization and as ~~hereinafter provided~~in accordance with those procedures established for the election by the Board of Directors.

Delegates and alternate delegates to the American Medical Association shall be elected for two-year terms.

Any physician filling the position of delegate or alternate delegate to the American Medical Association must spend the majority of his/her professional time in active clinical practice; teaching; research; and/or administrative practice and be a full-time Michigan resident, unless they hold an elected or appointed AMA Council position for which they are still eligible.

~~At each Annual Session, candidates for delegates to the House of Delegates of the American Medical Association shall be nominated in number equal to or greater than the number to be elected that year. Election shall be by ballot. The required number of candidates receiving the greater number of votes shall be declared elected.~~

~~In case of a tie vote the winner or winners shall be decided by drawing lots under the supervision of the Speaker of the House of Delegates; provided, however, that any candidate thus tied shall have the right to a decision by ballot on request.~~

The number of alternate delegates shall equal the number of delegates. They shall be elected in the same manner after all delegates have been elected.

Alternate delegates shall have seniority according to the greatest length of service as an alternate delegate. When it occurs that two or more alternate delegates have equal lengths of service, seniority shall be determined by the respective number of votes received by each when first elected, and such seniority shall be designated at the time of the first election.

When a delegate shall be unable to attend a meeting of the House of Delegates of the American Medical Association that seat shall be filled by an alternate delegate chosen in order of seniority as defined in this Section.

Should the Society become entitled to one or more additional delegates subsequent to the Annual Session of the House of Delegate in any year, such additional delegate or delegates shall be designated and accredited by the Board of Directors until the next Annual Session. In filling such offices alternate delegates shall be designated in order of their seniority as defined in this section.

13.30 RESERVED

13.40 RESERVED

13.50 RESERVED

~~13.40 ELECTION OF OFFICERS—Election of officers of the Society shall take place at the House of Delegates at each Annual Session. All nominations shall be made from the floor of the House with the exception of the Secretary and Treasurer who are elected by the Board of Directors. If there is only one nomination for any office, the candidate so nominated may be elected viva voce.~~

~~13.50 RESOLUTIONS—Each resolution introduced in the House of Delegates shall be introduced by a delegate. It shall be presented in writing to the Secretary. It shall be referred by the Speaker to the proper reference committee before action is taken thereon.~~

~~13.60 NEW BUSINESS—No new business shall be introduced in the last meeting of a session of the House of Delegates without unanimous consent of the delegates present except when presented by the Board of Directors. All new business so introduced shall require the affirmative vote of three-fourths of the delegates present for adoption.~~

~~13.70~~13.60 RULES OF ORDER—When not in conflict the Constitution or Bylaws of this Society, the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* shall govern the parliamentary procedure of the ~~House of Delegates~~Board of Directors and each committee and other body of the Society.

~~13.80 NOMINATING COMMITTEE – The House of Delegates shall form a Nominating Committee consisting of ten members. The Society's Immediate Past President shall be a member and serve as the chairperson and there shall be one member from each Region who shall be elected by the members holding membership in a county located in that Region. The elected members of the Nominating Committee must be a delegate with the right to vote in the House of Delegates and not be a member of the Board of Directors. It shall be the duty of the Nominating Committee to provide the Speaker of the House of Delegates at least thirty days prior to each annual session of the House of Delegates with at least one nomination for each of the Designated Director positions. The members of the Nominating Committee shall carefully review the credentials of each potential candidate, seek out the most qualified candidates for these positions and when possible insure that the candidates nominated reflect the diversity of the Society's membership.~~

13.70 RESERVED

14.00 THE BOARD OF DIRECTORS

14.10 ORGANIZATION—The Board of Directors is the executive body of the Society. Subject only to the following, it shall determine the times and places of its meetings. ~~At its first meeting immediately following the Annual Session of the House of Delegates, the Board of Directors shall elect a Secretary and Treasurer, who shall serve for a term of~~

~~office of one year or until a successor is elected and takes office. At the same meeting, the Board of~~ The Board of Directors shall elect a Chair, a Vice-Chair, a Chair of the Finance Committee, a Chair of the Health Care Delivery Committee, a Chair of the Legislative Policy Committee, and a Chair of the Scientific and Educational Affairs Committee, who shall be duly elected Regional Directors or Designated Directors, each to take office immediately and to serve for a term of one year or until a successor is elected and takes office.

14.20 EXECUTIVE COMMITTEE—The Executive Committee of the Board shall consist of the President, President-Elect, Immediate Past President, Chair, Vice-Chair, Speaker, Secretary and Treasurer. The Chair of the Board shall serve as Chair of the Executive Committee.

14.30 REFERENCE COMMITTEES—The Reference Committees of the Board of Directors and their composition and duties shall be as follows:

14.31 The Scientific and Educational Affairs Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Scientific and Educational Affairs Committee shall advise the Board of Directors on matters of scientific and educational activity and relationships with component medical societies, and consider other matters referred to it by the Board of Directors.

14.32 The Finance Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members, of which one shall be the Treasurer, ex officio, with power to vote, and the remainder appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Finance Committee shall advise the Board of Directors on administration of the Society's finances, and consider other matters referred to it by the Board of Directors.

14.33 The Legislative Policy Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Legislative Policy Committee shall advise the Board of Directors on matters of legislation and liaison with governmental agencies and shall consider other matters referred to it by the Board of Directors.

14.34 The Health Care Delivery Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Health Care Delivery Committee shall advise the Board of Directors on matters concerning the financing and delivery of health care and shall consider other matters referred to it by the Board of Directors.

14.40 REGIONAL DIRECTOR DUTIES—Each Regional Director shall be the organizer, peacemaker and censor for the Region. The Regional Director shall visit each component society in the Region at least once a year and shall keep in touch with the activities of the component societies constituting the Region. The Regional Director shall make such reports as the Chair of the Board of Directors shall request concerning the condition of the profession in the Region.

14.50 REMOVAL OF REGIONAL DIRECTOR—Upon written complaint signed by ~~not less than one-half of the Delegates~~a member from a Region presented to the ~~House of Delegates in Annual or Special Session~~Board of Directors charging that the Regional Director for such Region has been remiss in the duties prescribed above, and that at least one month's notice of such proposed action has been given, the ~~Speaker~~Board of Directors shall ~~bring~~consider the matter ~~before the House of Delegates for consideration~~at a meeting. By the vote of not less than two-thirds of the ~~House of Delegates~~Board of Directors present at the meeting at which such matter is considered, such Regional Director may be removed from office and a successor elected.

14.60 DUTIES OF THE BOARD OF DIRECTORS—It shall be the duty of the Board of Directors:

14.61 To make careful inquiry into the condition of the profession in each county in the State. It shall have authority to adopt such methods as may be deemed most efficient for increasing interest in all existing component societies. It shall especially and systematically endeavor to promote friendly intercourse between doctors of medicine in the same locality. It shall make every effort to bring each reputable doctor of medicine in the State under the Society's influence;

14.62 To direct and control the publication of the Journal of the Michigan State Medical Society;

14.63 To provide and maintain such headquarters for this Society as may be required to conduct its business properly;

14.64 To render an Annual Report to the House of Delegates; and

14.65 At least every three years, review the composition of the Board of Directors including the geographical boundaries of the Regions making any recommendations in its

discretion it deems necessary.

14.66 To provide for the organization of regions which shall be depicted on Exhibit A.

14.67 To elect the Secretary and Treasurer of this Society who shall serve a term of office of one year or until a successor is elected and takes office.

14.68 To provide for the election of the President-Elect of the Society annually by the members.

14.70 CONTROL OF FUNDS—The funds of this Society shall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.

14.71 The Board of Directors shall have the authority to borrow money upon the general credit of the Society. The Board of Directors shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Board of Directors shall authorize and empower the President or the Chair of the Board of Directors, and the Secretary or the Treasurer to execute such instruments as may be required.

~~14.80 REGIONS—For the purpose of electing Regional Directors and any other purposes described in these bylaws, there shall be those regions depicted on Exhibit A.~~

15.00 THE JUDICIAL COMMISSION

15.10 COMPOSITION - QUALIFICATIONS—The Judicial Commission shall be composed of ten members, each of whom shall be a voting member of the Society in good standing. No member of the Judicial Commission shall, during tenure of office~~, hold any of the following offices or positions: Speaker or Vice-Speaker of the House of Delegates of this Society, or District~~ be a Regional Director of this Society. Any member of the governing board of a component society which serves in these capacities, shall not, as a Commissioner, participate in deliberations pertaining to a grievance involving a member of that component society or cast a vote in respect thereto.

15.20 JUDICIAL DISTRICTS—There shall be seven Judicial Districts formed by grouping component societies as follows:

District 1—Wayne
District 2—Macomb, Oakland. St. Clair
District 3—Ingham, Livingston, Monroe, Shiawassee, Washtenaw
District 4—Bay, Iosco-Arenac, Genesee, Gratiot, Huron, lsabella-Clare, Lapeer, Midland, Saginaw, Sanilac, Tuscola
District 5—Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Jackson, Kalamazoo, Lenawee, St. Joseph, Van Buren
District 6—Barry, Clinton, Ionia-Montcalm, Kent, Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana, Ottawa
District 7—Alpena-Alcona-Presque Isle, Chippewa-Mackinac, Delta, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central Counties (Crawford, Gladwin, Kalkaska, Montmorency, Otsego, Roscommon), Northern Michigan (Antrim, Charlevoix, Cheboygan, Emmett), Ogemaw- Oscoda, Ontonagon, Schoolcraft, Wexford- Missaukee

15.30 NOMINATIONS—On or before July 15 each year, the Chair of the Board of Directors shall, with the advice and consent of the Board of Directors, appoint a Nominating Committee composed of seven members of the Board of Directors. Such Nominating Committee shall select from the voting members in good standing of the Society in each Judicial District at least twice as many nominees for the office of Judicial Commissioner as are to be elected in such year from such District. After obtaining the consent of such nominees to become candidates, the Nominating Committee shall submit its list of nominations to the Secretary of the Society on or before September 1st each year. Within ten days thereafter, the Secretary of the Society shall post a list of such nominations in a conspicuous place in the headquarters building of the Society and shall mail a list of such nominations to the secretary of each component society and shall give notice to the secretary of each said component society that the voting members of this Society within the several Judicial Districts have the right to make additional nominations by petition as hereinafter set forth. Promptly upon receipt of such notice and list of nominations, the secretary of each component society shall make such nominations known to the voting members thereof in such manner as shall be determined by the component society. Additional nominations may be made by petition signed by not less than twenty-five voting members in good standing in any Judicial District. Such nominating petitions shall be filed with the Secretary of this Society not later than October 15.

15.40 BALLOT - ELECTION—Under the direction of the Secretary of the Society, ballots shall be prepared for each Judicial District from which a member of the Commission is to be elected. On or before November 10 each year in which a member of the Commission is to be elected from such district, the Secretary of the Society shall send a ballot containing the names of all nominees, arranged in alphabetical order, to each voting member in good standing of the Society in such Judicial District. Ballots shall be marked and returned to the office of the Society no later than December 1 and any ballot bearing a return date later than such date shall not be counted. Each ballot, to be valid, must be voted for neither a greater nor a smaller number of nominees than are to be elected from such district at such election. The ballot furnished to voting members shall have printed upon it a copy of the

preceding sentence.

The valid ballots so cast shall be tabulated and the results certified by the Secretary of the Society. In case of a tie vote, the winning candidate shall be determined by lot under the supervision of the Secretary. Those elected shall be notified by the Secretary and the names of those elected shall be made known to the members of the Society through publication in the Journal of the Society or by such other means as shall be directed by the Board of Directors.

15.50 TERMS OF OFFICE—At the election held in the year 1965, four members of the Commission shall be elected from District 1, and one each from District 2, 3, 4, 5, 6 and 7. At the first meeting of the Commission following the election in 1965, it shall be determined by lot that two of the members elected from District 1 shall serve for a term of three years each, one for a term of two years, and one for a term of one year. Thereafter, one member of the Commission shall be elected annually from District 1 to serve for a three-year term, provided, however, that in the year 1968 and each third year thereafter, two members shall be elected from District 1 to serve for terms of three years each. It shall also be determined by lot at such meetings that two of the members elected from Districts 2, 3 ,4, 5, 6, and 7 shall serve for terms of three years each, two for terms of two years each and two for terms of one year each. Thereafter, one member of the Commission shall be elected annually from each of Districts 2, 3, 4, 5, 6, and 7 in which an elective term expires, such election to be for a term of three years.

15.60 VACANCIES—Whenever a vacancy occurs as the result of the death or resignation of a Commissioner or from any other cause, the President of the Society shall have the authority, acting with the advice of the Regional Directors of the Judicial District affected, to appoint a Commissioner from the district affected, such appointee to serve until the next election of Commissioners at which time a Commissioner shall be elected to serve for a remainder of the unexpired term.

15.70 ORGANIZATION OF THE COMMISSION—The Commission shall meet as soon as feasible after each annual election and at such meeting select a Chair, a Vice-Chair, and such other officers as may be deemed desirable. The terms of such officers and their duties and responsibilities shall be as determined by the Commission.

15.80 POWERS AND DUTIES—The Judicial Commission shall have:

15.81 Authority to make binding interpretations of the Constitution and Bylaws of this Society and of the several component societies as they pertain to matters of ethics, mediation, grievance and discipline.

15.82 Authority to make ethical interpretations and decisions in accordance with the standards of the American Medical Association.

15.83 Sole appellate powers at the state level in all matters relating to ethics, professional conduct, mediation and discipline of members of component societies.

15.84 The power to entertain and exercise original jurisdiction in matters pertaining to ethics, mediation, conduct of members or discipline of members when requested to do so by any component society or by any member in good standing of this Society.

15.85 The power and authority to make and promulgate from time to time, rules and regulations governing all procedures pertaining to ethics, grievances, mediation, professional conduct and discipline of members, which rules and regulations shall be binding upon all component societies.

15.86 The power and authority to appoint such committees and to adopt such rules, regulations and procedures as, in the sole judgment of the Commission, are deemed desirable in carrying out the functions and purposes of the Commission.

16.00 COMMITTEES/TASK FORCES OF THE SOCIETY

16.10 STANDING COMMITTEES—The Board of Directors shall designate standing committees of the Society to deal with ongoing subjects. The chair and members shall be appointed by the Board of Directors upon recommendation of the Chair of the Board of Directors. Committee chairs shall be appointed to serve for a term of two years. Members shall be appointed to serve two-year staggered terms, and be eligible for re-appointment.

The Chair of the Board of Directors shall appoint at least one Board member to each standing committee. The Board member shall be a voting member of the committee. The Board member shall be expected to attend committee meetings, participate in committee activities, and interpret to the Board of Directors the committee's recommendations that come before it via special reports.

If necessary, a standing committee may appoint one or more of its members to research a subject. The subgroup shall report its findings to the standing committee.

Standing committees shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. ~~Each standing committee shall submit an annual summary of its activities, without recommendations, to the House of Delegates.~~

16.20 LIAISON COMMITTEES—The Board of Directors shall designate liaison committees to carry out MSMS liaison relationships with selected organizations and agencies. The chair and members shall be appointed by the Board of Directors upon recommendation of the Board Chair. Committee chairs shall be appointed to serve for a term of two years. Members shall be appointed to serve two- year staggered terms, and be eligible for reappointment.

The Chair of the Board of Directors may appoint a ~~District~~Regional Director to selected liaison committees. The ~~District~~Regional Director shall be a voting member of the committee, and shall be expected to attend committee meetings, participate in committee activities, and interpret to the Board of Directors the committee's recommendations that come before it via special reports.

If necessary, a liaison committee may appoint one or more of its members to research a subject. This subgroup shall report its findings to the liaison committee.

Liaison committees shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. ~~Each liaison committee shall submit an annual summary of its activities, without recommendations, to the House of Delegates.~~

16.30 TASK FORCES—The Board of Directors shall create task forces as needed for specific assignments. Each task force shall be charged to study certain problems and to recommend courses of action to the Board of Directors. The chair shall be appointed to serve for a term of two years. The members shall be appointed by the Board of Directors upon recommendation of the Board Chair.

Task forces shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. ~~The action of the task forces may be included in the Board of Directors Annual Report to the House of Delegates, if the Board Chair deems it appropriate.~~

17.00 OFFICERS

17.10 TERM OF OFFICE—Except as herein otherwise provided, officers shall take office immediately after the election and shall serve until the next Annual Session and until their respective successors shall have been elected. Regional Directors shall serve for three years and may not serve more than three consecutive terms, provided, however that a Regional Director may serve additional terms after an absence of at least one year.

A physician may not serve on the Board of Directors for more than 12 years in any capacity. The slotted, one-year positions for the Student Section, the Resident and Fellow Section, and the Young Physician Section will not be counted in the lifetime aggregate of 12 years.

17.20 INDUCTION OF PRESIDENT—At ~~the Annual Session~~a General Meeting of this Society, next following election, the President-Elect shall be installed into and assume the office of the President, and shall serve until a successor takes office. The assumption of office shall take place in a General Meeting of the Society as a whole~~ or in a meeting of the Annual Session of the House of Delegates~~.

17.30 PRESIDENT—The President shall be the principal spokesperson for the Society, communicating to the membership and the public the official action and policies of the organization. The President shall be the principal officer to liaison with component societies, and to report on the conditions and concerns of the membership. The President shall preside over the General Meeting of the Society~~ and shall deliver the President's Address to the House of Delegates and participate in its deliberations but without vote~~.

The President shall be an ex officio member of the Board of Directors and its Executive Committee with power to vote therein.

The President shall perform such other duties as are imposed by the Constitution and Bylaws of this Society.

17.40 PRESIDENT-ELECT-DUTIES-SUCCESSION—The President-Elect shall act for the President in the President's absence or disability. Should the office of President become vacant, the President-Elect shall succeed to the presidency for the unexpired term. Should the office of President thereafter again become vacant, the Board of Directors at a regular or special meeting, shall elect a President to serve until the next Annual Session of the Society.

The President-Elect shall be an ex officio member of the Board of Directors with the right to vote therein.

17.50 CHAIR OF THE BOARD—The Chair shall preside at all meetings of the Board of Directors and its Executive Committee and direct and supervise the preparation of the agenda for the meetings of the Board and the Executive Committee. The Chair shall consult with the Presidents and Chief Executive Officer as necessary and appropriate on behalf of the Society.

The Chair of the MSMS Board shall be familiar with the day-to-day operations of the Society and its executive staff, to provide advice and guidance regarding the implementation of policy.

17.60 VICE-CHAIR—The Vice-Chair of the Board shall preside at meetings of the Board in the absence of the Chair or at the Chair's request, and shall perform such other duties as custom and parliamentary usage require.

In the event the office of Chair is vacated through death or resignation, the Vice-Chair shall become Chair Pro Term until the next meeting of the Board when a new Chair shall be elected.

17.70 TREASURER—The Treasurer, under the direction and control of the Board of Directors, shall be the custodian of all the invested funds and the securities of the Society. The Treasurer shall be accountable through the Board of Directors to the Society. The Board of Directors shall cause an annual audit of the accounts to be made. The Treasurer shall be bonded in amount considered sufficient by the Board of Directors, the cost of such bond to be paid from the funds of the Society. The Treasurer shall perform such other duties as are imposed by the Constitution and Bylaws of the Society.

17.80 SECRETARY—The Secretary shall be a member of the Society and shall serve as the recording officer of the House of Delegates and the Board of Directors.

The Secretary, in addition to having the rights and duties ordinarily devolving on the secretary of a corporation by law, custom of parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, shall perform the following specific duties unless otherwise directed or assigned by the Board of Directors.

17.81 Perform ceremonial duties, including the administering of the oath of office to the incoming President.

17.82 Serve as official contact with the component medical societies concerning memberships and dues transfers.

17.83 Review requests for the use of the MSMS mailing list and authorize its use.

17.84 Serve as an official MSMS signatory for official regulatory and governmental documents.

17.85 Be available to the Chief Executive Officer and staff for consultation and advice on day-to-day staff problems.

17.90 CHIEF EXECUTIVE OFFICER—There shall be Chief Executive Officer, not necessarily a doctor of medicine or a member of the Society, who shall be designated by contract approved by the Board of Directors on an annual basis and who shall be remunerated in an amount which shall be fixed by the Board of Directors. The Chief Executive Officer shall be bonded in an amount considered sufficient by the Board of Directors, the cost of which shall be paid from the funds of the Society.

18.10 RESERVED

18.20 RESERVED

~~18.10 SPEAKER OF THE HOUSE OF DELEGATES—The Speaker of the House of Delegates shall preside at sessions of the House of Delegates. The Speaker shall perform such duties as custom and parliamentary usage require, and shall be a member of the Board of Directors and of its Executive Committee with the power to vote.~~

~~18.20 VICE-SPEAKER OF THE HOUSE OF DELEGATES—The Vice-Speaker of the House of Delegates shall assume the duties of the Speaker when the Speaker is absent at a meeting of the House of Delegates and at such other times as the House of Delegates or the Board of Directors (between Sessions of the House) shall determine. The Vice-Speaker shall be a member of the Board of Directors with the power to vote.~~

18.30 REMUNERATION—Each of the following officers, namely, the President, the Chair of the Board of Directors, the Secretary, the Treasurer, the ~~Speaker of the House of Delegates, the~~ President-Elect, and the Immediate Past President shall be entitled to draw from the funds of the Society a special expenses allowance in each year of incumbency of the office. The annual amount will be recommended by the Finance Committee to the Ways and Means Committee and approved or amended by the ~~House~~Board of ~~Delegates~~Directors. These officers shall not be required to account to the Society for the expenditure of such funds, which shall be in addition to ordinary reimbursable expenses.

19.00 INDEMNIFICATION

19.10 The Board of Directors may indemnify any person for any liability, claim or expenses incurred or to be incurred, by reason of the fact that such person was or is a director, officer, employee, agent, or committee member of the Society, or was or is serving at the request of the Society as a director, officer, employee, agent, or committee member of a corporation, partnership, joint venture, trust, or other entity owned, in whole or in part, by the Society, or established by the Board of Directors of the Society. The extent and terms of such indemnifications shall be determined by the Board of Directors of the Society, either in advance or on a case by case basis; provided, however, such indemnification shall not be broader or more inclusive than permitted by law either at the time of the act or omission to be indemnified against or at the time of carrying out such indemnification.

20.00 SPECIALTY AND ETHNIC MEDICAL SOCIETIES

20.10 RECOGNIZED SPECIALTY AND ETHNIC MEDICAL SOCIETIES—To provide representation for the interests of medical specialty and ethnic medical societies within the structure of the Michigan State Medical Society, Michigan specialty and ethnic medical societies ~~can~~shall be recognized ~~and eligible for a delegate and alternate delegate to the MSMS House of Delegates provided the criteria as set forth in Section 20.20 has been met~~. A list of recognized specialty and ethnic medical societies will reside in

the MSMS Chief Executive Officer's Office.

20.20 CRITERIA—Specialty and ethnic medical societies that wish to be included as a recognized specialty or ethnic medical society must meet the following criteria: a) be statewide in scope, with a minimum of one meeting per year; b) be a statewide specialty or ethnic medical society at least five years old; and c) have 25 or more active physician members of whom 50 or 50 percent or more maintain their membership in MSMS~~; and d) be approved by the House of Delegates~~.

The governing body of the specialty and ethnic medical society must take formal action requesting delegate representation by sending a letter to the MSMS Board of Directors. The Board would then determine if the society meets the criteria and, if so, make a recommendation to the House of Delegates.

The method of determining whether the specialty or ethnic medical society meets the membership criterion outlined in this section shall be the responsibility of the MSMS Board of Directors.

20.30 RESIDENT AND FELLOW SECTION—To provide representation for the interests of residents and fellows within the structure of the Michigan State Medical Society, there shall be a Section on Residents and Fellows, composed of resident physicians (physicians-in-training) who are residents in an AMA-recognized residency program in Michigan, fellows serving as their primary occupation in a structured educational program begun immediately upon completion of medical school, residency or fellowship training, and who are active members of MSMS, and of medical students after March 15 of their senior year.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to residents and fellows in Michigan.

At its annual meeting the Section shall elect a chair, a vice-chair, a secretary, a delegate and an alternate delegate to the MSMS House of Delegates, each of whom shall serve for a term of one year.

At its annual meeting, the Section shall elect a representative to fill the residents' seat on the Board of Directors for a one-year renewable term~~ to begin at the first Board of Directors meeting after the House of Delegates~~. If a vacancy in the residents' seat should occur during a term, the vacancy shall remain unfilled until the next term.

20.40 MEDICAL STUDENT SECTION—To provide representation for the interests of medical students within the structure of the Michigan State Medical Society, there shall be a Section on Medical Students, composed of students of each established medical school in Michigan who are student members of MSMS.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to medical students in Michigan.

At its annual meeting, the Section shall elect a Governing Council consisting of a chair, a vice-chair, a secretary, a member of the Michigan Delegation to the AMA, and a representative to the MSMS Board of Directors. These officers shall all serve for one year-renewable terms~~ to begin after the House of Delegates~~.

The Section shall also elect delegates to the MSMS House of Delegates, each of whom shall serve for one year. There shall be one delegate for every 50 MSMS student members.

If a vacancy in any of the officers' positions should occur during the term, that seat shall be immediately filled by election as provided in the Student Section Bylaws, with approval of the Board of Directors.

20.50 ORGANIZED MEDICAL STAFF SECTION—To provide representation for the interests of hospital medical staffs and of other delivery systems within the structure of the Michigan State Medical Society, there shall be an Organized Medical Staff Section composed of MSMS members, one to be elected by and from the active voting physician members with clinical privileges of each JCAHO-accredited hospital in Michigan, and each other delivery system accepted by the Governing Council.

The purpose of this Section is to provide a direct means to address the relationship between MSMS members and organized medical staffs.

At its annual meeting, the Section shall elect a chair, a vice-chair, a secretary and two at-large members.~~ It shall also elect one delegate and one alternate delegate to the MSMS House of Delegates, each of whom shall serve for a term of two years.~~

20.60 YOUNG PHYSICIANS SECTION—To provide representation for the interests of young physicians within the structure of the Michigan State Medical Society, there shall be a section on young physicians, composed of physicians under 40 years of age and/or professionally employed through eight (8) years after residency and fellowship training programs, who are active members of MSMS.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to young physicians in Michigan.

At its annual meeting the Section shall elect officers in accordance with the Bylaws of the MSMS Young Physicians Section and a representative to fill the young physicians' seat on the Board of Directors for a two-year renewable term~~ to begin at the first Board of Directors meeting after the House of Delegates~~. If

a vacancy in the young physicians' seat should occur during a term, a representative chosen by the Young Physicians Governing Council may be appointed to fill the term, with approval by the Board of Directors.

20.70 INTERNATIONAL MEDICAL GRADUATES SECTION—To provide representation of the interests of international medical graduates within the structure of the Michigan State Medical Society, there shall be a section for international medical graduates composed of international medical graduates who are members of MSMS.

The purpose of this Section will be to provide a forum within the organizational structure of this Society for the study and consideration of matters of special interest and significance to international medical graduate in Michigan.

~~At its annual meeting the Section shall elect a delegate and alternate delegate to the MSMS House of Delegates.~~

21.00 REFERENDUM

21.10 REFERENDUM AT SOCIETY MEETING—Any General or Special Meeting of this Society as a whole, may, by a two-thirds vote of the voting members present, order a general referendum upon any question pertinent to the purposes and objects of the Society, organized medicine, or health of the public; provided, however, that a quorum at such General or Special Meeting shall consist of not less than 300 voting members of the Society who are in good standing.

21.20 RESERVED

~~21.20 REFERENDUM BY HOUSE OF DELEGATES—The House of Delegates by a majority vote may submit any question pertinent to the community and organized medicine to the membership of the Society for its vote, such vote to be taken by county societies and certified by their respective secretaries to the Secretary of this Society.~~

~~Two-thirds of the vote cast shall be required to carry the question.~~

22.00 SEAL

22.10 SEAL—The Society shall have a common seal. The power to change or renew the seal shall rest with the Board of Directors.

23.00 EMERGENCY

23.10 EMERGENCY ACTION BY BOARD OF DIRECTORS—When prompt speech or action is imperative, authority to speak or act in the name of this Society is vested in the Board of Directors or the Executive Committee of the Board of Directors.

24.00 DEFINITION OF SESSION AND MEETING

24.10 SESSION—A session shall mean all meetings at any one call.

24.20 MEETING—A meeting shall mean each separate convention at any one session.

25.00 AMENDMENTS

25.10 AMENDMENTS-PROCEDURE—These Bylaws may be amended by a majority vote of the ~~delegates seated~~members present and voting at a General Meeting, after the proposed amendment is laid on the table until the next session, unless by consent of 75 percent of the ~~delegates~~members present and voting, such time requirement is waived, in which event the said amendment may be voted upon at the next ~~meeting~~General Meeting of the ~~House of Delegates~~Society. The amendment or amendments to these Bylaws become effective immediately upon adoption.

Official Procedures for the Judicial Commission

of the Michigan State Medical Society

(ADOPTED APRIL 14, 1971, AND AMENDED JANUARY 31, 1973)

In accordance with Paragraphs 15.80 through 15.86 of the Bylaws of the Michigan State Medical Society, the Judicial Commission of the Michigan State Medical Society does hereby declare the following rules, regulations and procedures to govern all matters pertaining to ethics, grievances, mediation, professional conduct, and discipline binding on the Michigan State Medical Society and each of its component medical societies.

I. Disciplinary Procedure for Component Medical Societies

The procedure to be followed by each component society on its complaints of original jurisdiction with respect to the censure, suspension or expulsion of a member shall be in accordance with Paragraphs 7.00 through 9.30 of the Bylaws of MSMS. The procedure to be followed by each component society in cases referred to it by the Judicial Commission shall be expressly subject to the procedural rules hereinafter set forth.

II. Mediation Committees for Component Medical Societies

The procedure to be followed by each component medical society on its complaints of original jurisdiction regarding grievances of non-members shall follow the procedural outline in Paragraphs 10.00 through 10.40 of the Bylaws of MSMS. The procedure to be followed by each component society in cases referred to it by the Judicial Commission shall be expressly subject to the procedural rules hereinafter set forth.

III. Procedural Rules for the Judicial Commission involving ethics, grievances, mediation, professional conduct, and discipline of members of the Michigan State Medical Society

1. All questions of ethics referred to the Judicial Commission must be in writing. No matter under active litigation will be accepted for processing. Matters involving alleged infractions of civil and criminal law are generally outside the scope of the Judicial Commission.

2. When a proper complaint is received, it shall be recorded and forwarded when appropriate to the component medical society of which the physician named is a member.

3. The component medical society shall process the complaint, review the case, determine its merits, and report its conclusions in writing to the complainant with copies to the physician involved and to the Judicial Commission.

4. The Judicial Commission requires that a complainant and the physician involved be informed of the right of appeal to the Judicial Commission from the final ruling of a component society.

5. All properly entered complaints shall be processed by the component medical society within 60 days. Each complaint and its investigation shall be kept confidential except to members of the Judicial Commission or its agents and the members of the committees of the component medical societies investigating the complaint.

6. Jurisdiction over complaints received by the Judicial Commission and forwarded to a component medical society rests with the component medical society designated by and at the discretion of the Judicial Commission. Apart from supervisory function of the judicial mechanism, the Judicial Commission serves as an appellate tribunal except under circumstances deemed by the Judicial Commission such that regional jurisdiction by a component medical society would not properly serve the purposes of the complainant, the physician involved, or the public or profession in general. Such discretionary powers are set forth hereafter under the section of this document—V. "Jurisdiction of the Judicial Commission."

7. Complaints from a component medical society directed to the Judicial Commission which concern matters about another component society shall be processed by the Judicial Commission in a manner similar to a complaint from a member individual but shall remain the proper business of the Judicial Commission itself without reference.

IV. Procedure for Appeal to the Judicial Commission

1. A member of a component society censured, suspended, or expelled by his or her county society may appeal from the action of such component society to the Judicial Commission of MSMS within a period of 60 days succeeding the date of such censure, suspension or expulsion. Appeals shall be in writing and be filed within said period of 60 days with the Chair of the Judicial Commission at the Michigan State Medical Society headquarters office. Said appeal shall be accompanied by a record of the entire proceedings before the component society duly certified by its secretary, provided the Chair of the Judicial Commission may, in his or her discretion, extend the time of the appellant to file such record. Upon the filing of such an appeal, the Chair shall present it to the next subsequent meeting of the Judicial Commission. Written notice of not less than 10 days of the time and place of the hearing shall be given to the appellant member and the president and secretary of

the component society involved.

2. In hearing appeals, the Judicial Commission shall review all questions of procedure, and may, in its discretion, review the evidence contained in the record of the original proceedings held before the proper committee of the component society. The Judicial Commission may make findings of fact contrary to, or in addition to, those made by the committee of the component society. Such findings may be based on the evidence adduced by the committee of the component medical society, either with or without the taking of evidence by the Judicial Commission. The Judicial Commission may, for the purpose of making such findings or for other purposes in the interest of justice, take additional evidence of or concerning facts material to the questions involved, or may, for such purpose, appoint a committee of its members to act as referees for the taking of such evidence.

   (a) Such referees shall render a report in writing to the Judicial Commission, which report shall contain a clear statement of the facts found by the referees from the testimony or evidence adduced.

3. The Judicial Commission may affirm, reverse, or modify the decision of the proper committee of the component society so reviewed or make such other disposition of the proceedings as it may deem proper.

4. The Judicial Commission may exert, through a committee thereof, prior to the hearing being held on the appeal, all proper efforts at conciliation and compromise.

5. The MSMS may be represented by its attorney to advise the Judicial Commission. The appellant may likewise be represented by his or her attorney.

6. The decision of the Judicial Commission shall be final and bind the appellant member and the component society unless further appealed to the American Medical Association as set forth hereunder.

V. Jurisdiction of the Judicial Commission in respect to all matters relating to discipline of members of MSMS

1. The Judicial Commission, within its sound discretion, may take original jurisdiction of any question appropriately referred to it and conduct hearings thereon without referral to a component society.

2. The procedure in original jurisdiction hearings shall follow rules set forth in the MSMS Bylaws, paragraphs 8.40 through 8.70.

3. In cases of original jurisdiction, the Judicial Commission will report its recommendations to the governing body of the component society for implementation.

4. Any decision of the Judicial Commission affirming a decision of a component medical society which disciplines a member or a component medical society itself so disciplined may be appealed to the appropriate agency of the American Medical Association upon such terms, conditions and in accordance with such procedure as may be set forth in the Constitution and Bylaws of the American Medical Association. Any decision of such agency of the AMA shall be final and binding upon all parties of the appeal.

5. The decision of the component medical society if not appealed or of the Judicial Commission if original or appealed for the settlement of a complaint, although binding upon a member physician, cannot be made binding upon a non-physician. Since, however, the submission of a complaint by a lay person to the judicial mechanism or settlement is an act of good faith, it can be assumed that the recommendation of the Judicial Commission or the proper committee of a component medical society will be accepted by non-physicians.

VI. Grievances Against Non-Member Physicians

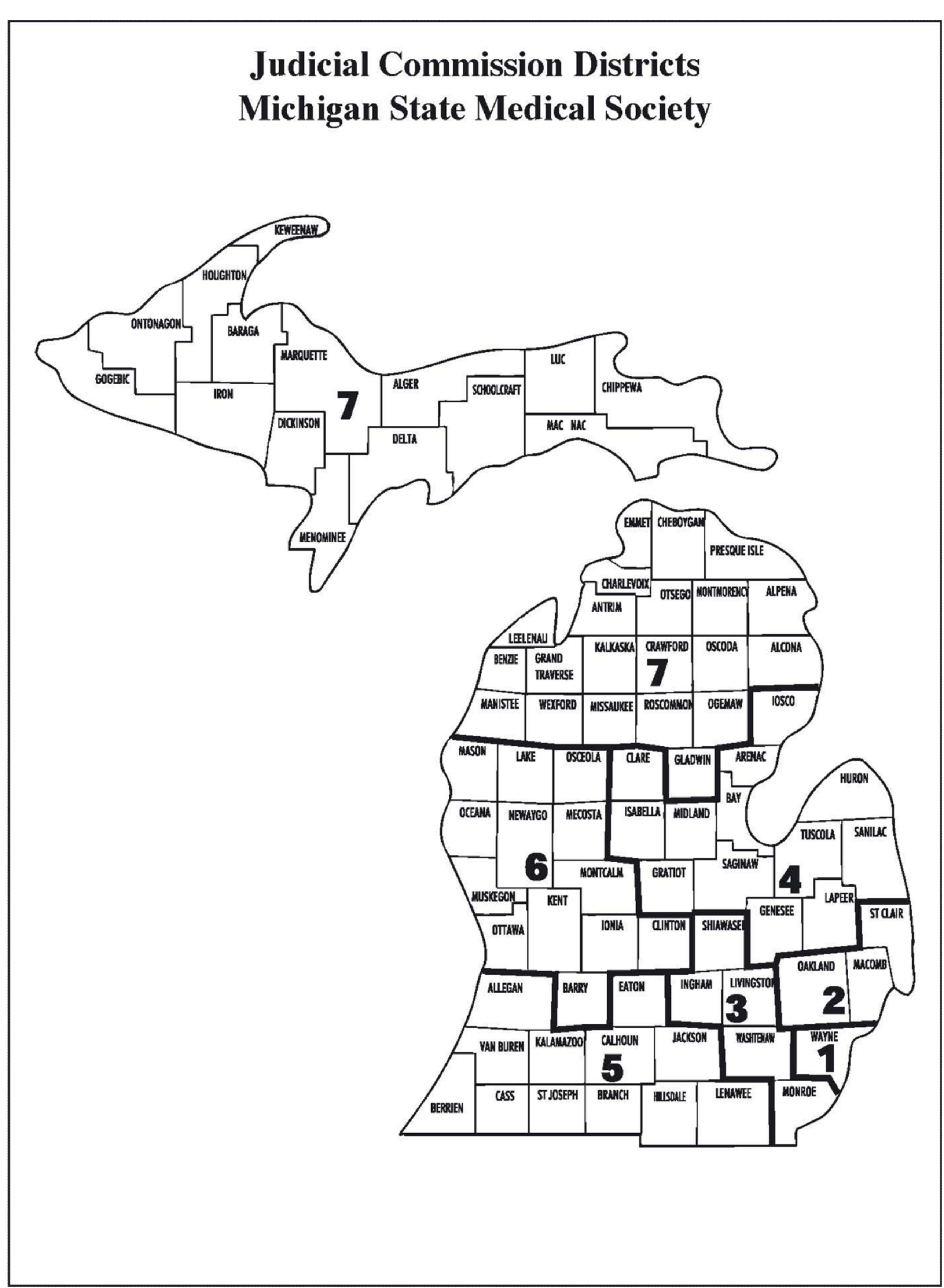
The Judicial Commission is without jurisdiction over physicians who are not members of MSMS but recognizes the obligation of organized medicine to act in the best interests of those doctors and of the public. The Commission and the component medical societies will undertake to mediate grievances and matters of ethics and professional conduct when requested by the person or persons in controversy with the non-member M.D. physician, providing the latter agrees to accept the services of the Society in this aspect and agrees to abide by its procedural rules, and to the condition that the Society reserves the right at its discretion, when appropriate, to disclose pertinent information to the Michigan Board of Medicine. Lacking this agreement or such approval from the non-member, the Society may at its discretion forward the complaint as received to the Michigan Board of Medicine.

The procedures to be followed shall, to the extent relevant, be those set forth in the Official Procedures promulgated April 14, 1971, including the underlying MSMS Bylaws section recited therein. The original jurisdiction for component societies noted in the Official Procedures shall be emphasized in these mediations. If the non-member and the complaining party reside in different counties, the component society jurisdiction within which the non-member physician has his or her principal practice shall be the venue of the hearing unless the Judicial Commission exercises its power to take original jurisdiction. The procedural rules set forth in Article II of said Official Procedures shall be adhered to as literally as possible. The appeal procedures of Article IV, save for those sections which are patently irrelevant, shall likewise be controlling.

VII. The Judicial Commission expressly reserves to itself the jurisdiction to amend these rules from time to time as it deems appropriate, and to publish same.

These rules of procedure accepted and promulgated by the Judicial Commission of the MSMS on this date

hereby govern the Michigan State Medical Society in all such matters and any provisions of the Constitution and Bylaws of MSMS in conflict therewith shall have no effect.

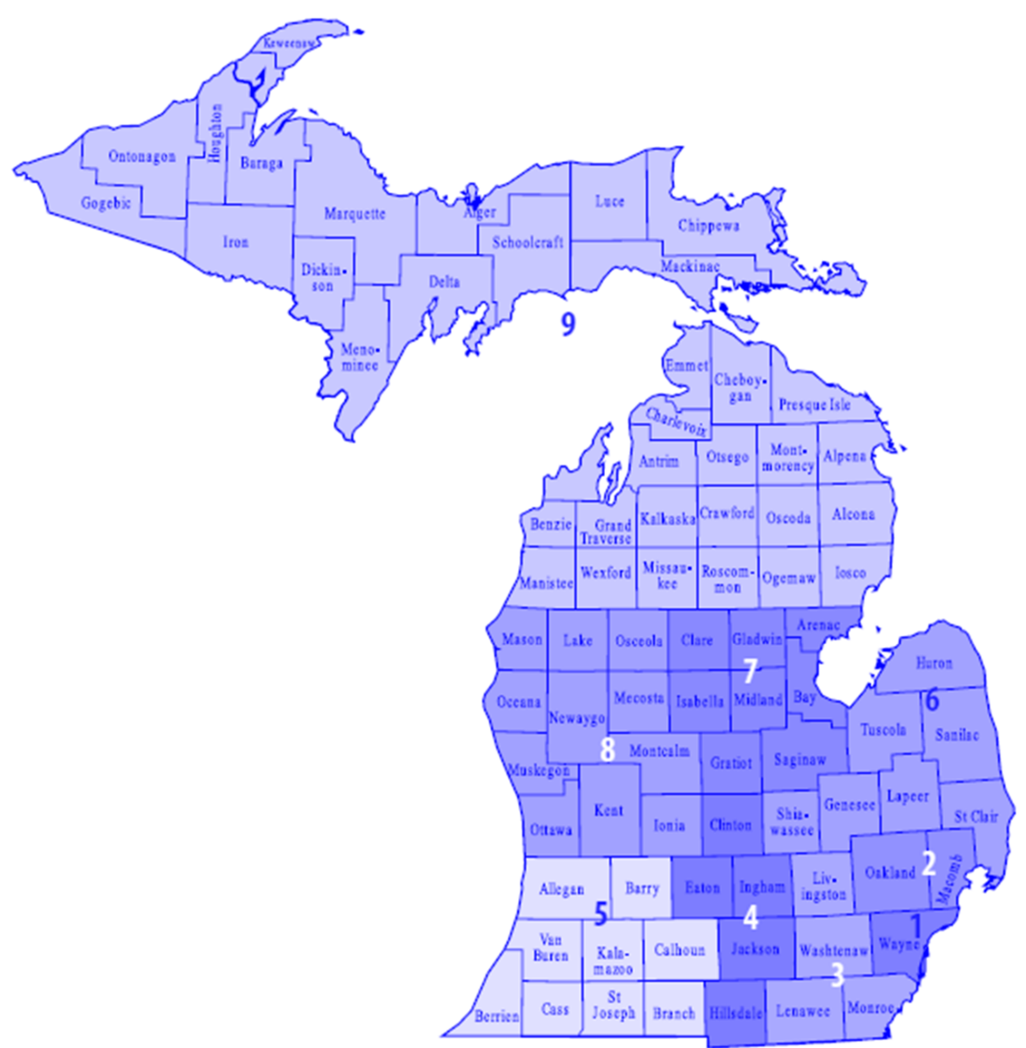

Judicial Commission Districts
Michigan State Medical Society
KEWEENAW
HOUGHTON
ONTONAGON
BARAGA
MARQUETTE
GOGEBIC
IRON
7
ALGER
SCHOOLCRAFT
LUC
CHIPPEWA
DICKINSON
DELTA
MAC NAC
MENOMINEE
EMMET
CHEBOYGAN
PRESQUE ISLE
CHARLEVOIX
OTSEGO
MONTMORENCY
ALPENA
ANTRIM
LEELENAU
BENZIE
GRAND TRAVERSE
KALKASKA
CRAWFORD
OSCODA
ALCONA
MANISTEE
WEXFORD
MISSAUKEE
ROSCOMMON
OGEMAW
IOSCO
MASON
LAKE
OSCEOLA
CLARE
GLADWIN
ARENAC
HURON
BAY
OCEANA
NEWAYGO
MECOSTA
ISABELLA
MIDLAND
TUSCOLA
SANILAC
6
MONTCALM
GRATIOT
SAGINAW
4
MUSKEGON
KENT
LAPEER
GENESEE
ST CLAIR
OTTAWA
IONIA
CLINTON
SHIAWASEE
OAKLAND
MACOMB
ALLEGAN
BARRY
EATON
INGHAM
LIVINGSTON
3
2
VAN BUREN
KALAMAZOO
CALHOUN
JACKSON
WASHTENAW
WAYNE
1
5
CASS
ST JOSEPH
BRANCH
HILLSDALE
LENAWEE
MONROE
BERRIEN

<u>**EXHIBIT A**</u>

<u>**DIRECTOR REGIONS**</u>

(Added graphics)

120 West Saginaw Street
East Lansing, Michigan 48823
(517) 337-1351
msms@msms.org
msms.org



MICHIGAN STATE MEDICAL SOCIETY

ACTION REPORT #08-26 OF THE BOARD OF DIRECTORS

SUBJECT:	Judicial Commission 14-25 - Rotation of MSMS House of Delegates Meeting Location 16-25 - County and State Medical Society Alliance 47-25 - Study Medical Society Structures
REFERRED TO:	Reference Committee on Internal Affairs, Bylaws, and Rules
HOUSE ACTION:	

RECOMMENDATION: THAT THE 2026 HOUSE OF DELEGATES ELIMINATE THE JUDICIAL COMMISSION AND REQUIREMENT FOR COUNTY MEDICAL SOCIETIES TO MAINTAIN A PEER REVIEW AND ETHICS COMMITTEE.

The Michigan State Medical Society (MSMS) faces significant structural, financial, and membership challenges that threaten its long-term viability. The Reorganization Task Force, appointed by the MSMS Board of Directors following resolutions adopted by the 2025 House of Delegates, was charged with developing recommendations to modernize governance, improve efficiency, and strengthen engagement across the organization.

After extensive review and deliberation, the Task Force unanimously recommends a series of comprehensive structural changes designed to position MSMS for the next decade of success.

The current MSMS bylaws require county medical societies (CMS) to maintain a standing Peer Review and Ethics Committee and for MSMS to maintain a standing Judicial Commission. Most CMS are in non-compliance with this bylaw. The Judicial Commission would be activated by a referral from a CMS Peer Review and Ethics Committee that has recommended an action against one of its members. These processes predate the development of modern boards of medicine and osteopathy.

Most state and specialty medical societies have eliminated these committees or commissions and instead direct complainants to the appropriate licensing body. With the dissolution of Peer Review and Ethics Committees and Judicial Commissions, state medical societies have deferred to their Board of Directors to handle disciplinary matters. If a member’s professional license is suspended, their membership is automatically suspended.

In summary, eliminating the Judicial Commission and Peer Review Committees reflects common practice among other state medical societies and streamlines governance by referring complaints to appropriate professional licensing boards while retaining MSMS authority over membership status.

Attachments

Task Force on Reorganization’s Report (see Miscellaneous Tab)

Resolution 14-25
Resolution 16-25
Resolution 47-25
Proposed Changes to Bylaws

1 **RESOLUTION 14-25**
2
3 **Title:** Rotation of MSMS House of Delegates Meeting Location
4
5 **Introduced by:** E. Chris Bush, MD, for the Wayne County Delegation
6
7 **Original Author:** E. Chris Bush, MD
8
9 **Referred To:** Reference Committee C
10
11 **House Action:**
12

13
14 Whereas, the MSMS House of Delegates (HOD) is an annual meeting for all the Delegates from
15 across the state, and
16
17 Whereas, the MSMS HOD location has traditionally rotated to various locations across the state to
18 be more equitable for the attendees, and
19
20 Whereas, the majority of the Delegates attending the MSMS HOD each year are from the counties in
21 southeast Michigan, and
22
23 Whereas, the MSMS HOD approved Resolution 03-22 which states that the MSMS will continue to
24 rotate the annual HOD meeting between the east and west side of the state, but at least once every
25 12 years, the western meeting shall take place in a northern county, and
26
27 Whereas, moving to a one-day meeting in Lansing, that starts at 10:00 a.m., was done as a cost-
28 reduction measure for MSMS, the costs have been shifted to the Delegates who should have a say
29 in where the annual meeting is held, and
30
31 Whereas, the overall costs of a one-day meeting would be expected to be similar regardless of the
32 geographical location; therefore be it
33
34 RESOLVED: That the MSMS House of Delegates shall return to the rotation of alternating meetings
35 between an outstate venue and a southeast Michigan venue with the 2026 meeting to be held in the
36 Detroit area.
37

38
39 WAYS AND MEANS COMMITTEE FISCAL NOTE: $50,000

	2024/2025 Lansing **Actual from Hotel Bill**	**2026 Dearborn** **Actual Proposal – The Henry**
Delegate Beverage and Lunches	$10,400	$13,000
Presidents Reception	$5,400	$7,700
Conference Rooms Rental	$7,800	$29,000
Overnights Students, Staff and Board	$5,300	$22,500
Staff Meals	$2,000	$4,400
Staff Mileage	$0	$3,500
	$30,900	$80,100

Fiscal notes are estimates and should be used as one reference point in determining support or opposition of any resolution.

Of note:

- This comparison does not include the AV contractor, Audience Response System, Signs, Awards, Online Forum, Election Ballot or other meeting costs that do not differ based on location. This cost is approximately $20,000.
- The Henry was used as one comparison for purposes of developing a fiscal note because they are one of few locations in the Detroit area that can accommodate our dates, the combination of number of overnight rooms, number of conference rooms and the House set-up all at one-time. MSMS has received prior proposals from other hotels including the Motor City Casino and the Suburban Showcase which were both significantly more expensive than the Henry. And the Somerset, Novi Sheraton, Southfield Weston, all being either more expensive or lacking enough space for the general session. As regular practice, MSMS always requests multiple proposals for off-site events and would work with individual facilities and the CVB to do so if a Detroit location is needed.
- The Henry proposal includes room rental of $58,000. Only half was used in the fiscal note as staff expects some ability to negotiate contract. Similarly, the food and beverage minimum is $30,000 but only $25,000 is reference in the fiscal note as that is also an area of potential negotiation. That proposal is attached.
- Event documentation involved 3 different pieces. The contract locks in the date, space, pricing for the room rental and overnight rooms, food and beverage minimums, and cancelation clause. The Banquet Event Orders details room set-up, AV, and quantity and selections for food and drink. This will contain some pricing for those items. The final bill will itemize room set-up, AV, and quantity and selections for food and drink. The amounts will differ from the Banquet Event Order as onsite changes occur like additional easels were needed, extra lunches were ordered and typically some food and beverages are charged on consumption. These will be reflected in the final bill.
- Events are also subject to several taxes. As indicated in the Henry proposal, overnight rooms are subject to 6 percent state tax and 8 percent occupancy tax. Food, beverages and rental costs are subject to 24 percent taxable service charge and 6 percent state sales.
- Set up for the House begins at 12:00 noon the day before the meeting. Tear down is completed around 9:00 pm that evening. Staff are allowed to stay the night Friday and Saturday if they wish for the completion of the event and safety of our employees.
- MSMS manages the House of Delegates costs as frugally as possible. Many state associations utilize event management companies which range from $20,000 - $50,000 to assist in preparing for the meeting and staffing onsite. This includes work like loading, unloading, setting up, testing and tearing down the general session room for 300, registration, meeting rooms, event spaces, exhibits. MSMS staff balances this while maintaining their normal day-to-day workloads. Much of the preparation for the House is completed after work hours including the weekends.
- Room calculations

  $250 (includes all tax)
  25 staff/contractors x 2 nights = $12,500
  10 students = $2,500
  10 board x 2 nights = $5,000
  10 board x 1 night = $2,500

The information contained in the fiscal note was prepared by Rebecca Blake, Certified Meeting Planner (CMP) with 25 years of meeting planning experience with the House of Delegates, Annual Scientific Meeting, Board meetings, and thousands of other MSMS events.

Relevant MSMS Policy

Annual Financial Report
Please refer to the Annual Financial Report to the House of Delegates for more information on the organization's finances.

House of Delegates
MSMS continue to rotate the HOD meeting between the east and west 36 side of the state, but at least once every 12 years, the western meeting shall take place in a 37 northern county.

Relevant AMA Policy
None

Sources:

1. Past MSMS HOD Locations: 2010 - Dearborn, Michigan; 2011 - Kalamazoo, Michigan; 2012 - Dearborn, Michigan; 2013 - Grand Rapids, Michigan; 2014 - Dearborn, Michigan; 2015 - Grand Rapids, Michigan; 2016 - Dearborn, Michigan; 2017 - Grand Rapids, Michigan; 2018 - Dearborn, Michigan; 2019 - Kalamazoo, Michigan; 2020 - Dearborn, Michigan; 2021 – Virtual Meeting during COVID; 2022 - Kalamazoo, Michigan; 2023 - Dearborn, Michigan 2024 - Lansing, Michigan; 2025 - Lansing, Michigan
2. Approved MSMS Resolution 03-22 introduced by Ottawa County https://www.msms.org/hodresolutions/2022/3.pdf

RESOLUTION 16-25

Title: County and State Medical Society Alliance

Introduced by: Megan Edison, MD, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee C

House Action:

Whereas, MSMS has had declining membership and revenues, and

Whereas, this loss of membership revenue impacts all physicians across the state as our legislative impact and outreach is limited, and

Whereas, MSMS has significantly restructured itself into a relevant, physician-led, financially viable organization focused on the core mission, and

Whereas, MSMS is aggressively working to regain large group membership to increase membership revenue, diverse physician voices, and our political footprint, and

Whereas, MSMS bylaws and county medical society bylaws require joint membership of physicians in counties with an active medical society, and

Whereas, the number of active county medical societies has diminished significantly over the years so that some counties no longer charge dues while others charge dues, and

Whereas, MSMS has failed to secure large group memberships reportedly due to the cost of required county membership dues, and

Whereas, county medical societies have lost county members reportedly due to cost and/or value of the required MSMS membership, and

Whereas, creative efforts by MSMS to avoid county membership and membership "deals" recommended to and by county medical societies have created undue stress on this relationship as well as test the bylaws of both organizations, and

Whereas, the 10 percent billing fee charged to county medical societies for the required dual membership has proved financially challenging to county societies, and

Whereas, the historical financial binding of county and state medical societies may now be a hinderance to our mutual survival, and

Whereas, the survival and revival of all county medical societies benefits MSMS and Michigan physicians, as county medical societies are the voice to local politicians in a way lobbyists cannot achieve, and

Whereas, the survival and growth of MSMS is crucial to all Michigan physicians and our patients, as the only physician voice in Lansing representing all physicians, allopathic and osteopathic, of all specialties, and inclusive of all stages of their career and place of practice, and

54
55 Whereas, restructuring our state and county medical societies towards mutual growth and
56 purposes will only strengthen organized medicine; therefore be it
57
58 RESOLVED: That MSMS create a task force of physicians across the state, in both county and state
59 society leadership, to do the following:
60
61 1. Examine the history, finances, and bylaws of our county and state societies;
62 2. Be bold and creative in offering a unified solution to solve this historical issue, and future-proof
63 our organizations so we can focus on our mission together;
64 3. Utilize MSMS legal counsel to aid in this effort by examining county medical society and state
65 medical society bylaws and offering a clear plan on how to update county and state medical
66 society bylaws to achieve the mutual goals; and
67 4. Present recommendations to county and state medical societies prior to the 2026 House of
68 Delegates, with any MSMS bylaws changes presented for a first vote at that time.
69

70
71 WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy
None

Relevant AMA Policy
None

RESOLUTION 47-25

Title: Study Medical Society Structures

Introduced by: Paul Kocheril, MD

Original Author: Paul Kocheril, MD

Referred To: Reference Committee C

House Action:

Whereas, the MSMS Bylaws state the Board "shall have the custody and entire control of all funds and property of the Society" and the House "shall transact all of the business of this Society not otherwise specifically provided for," and

Whereas, in the past, occasional resolutions have lapsed into the financial responsibilities assigned to the Board, and

Whereas, other state societies have clarified and streamlined their organizational structure regarding medical policy and business/financial decisions, and

Whereas, the functioning of MSMS is critical to the future of MSMS and medicine in Michigan; therefore be it

RESOLVED: That MSMS study the organizational structures, Constitution and Bylaws, and business model of other state medical societies as potential options for improving the efficiency and productivity of our organization.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy

ARTICLE IX—THE BOARD OF DIRECTORS

Section 2. - POWERS AND DUTIES—The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions.

14.00 THE BOARD OF DIRECTORS

14.60 DUTIES OF THE BOARD OF DIRECTORS—It shall be the duty of the Board of Directors:

14.61 To make careful inquiry into the condition of the profession in each county in the State. It shall have authority to adopt such methods as may be deemed most efficient for increasing interest in all existing component societies. It shall especially and systematically endeavor to promote friendly intercourse between doctors of medicine in the same locality. It shall make every effort to bring each reputable doctor of medicine in the State under the Society's influence;

14.62 To direct and control the publication of the Journal of the Michigan State Medical Society;

14.63 To provide and maintain such headquarters for this Society as may be required to conduct its business properly;

14.64 To render an Annual Report to the House of Delegates; and

14.65 At least every three years, review the composition of the Board of Directors including the geographical boundaries of the Regions making any recommendations in its discretion it deems necessary.

14.70 CONTROL OF FUNDS—The funds of this Society shall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.

14.71 The Board of Directors shall have the authority to borrow money upon the general credit of the Society. The Board of Directors shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Board of Directors shall authorize and empower the President or the Chair of the Board of Directors, and the Secretary or the Treasurer to execute such instruments as may be required.

12.00 HOUSE OF DELEGATES

12.90 POWERS AND DUTIES—As the legislative body of this Society, the House of Delegates shall have the power arid authority to adopt, institute, and carry out such methods and measures as it may deem to be in the best interests of the medical profession in Michigan. In the exercise of such powers and duties, but without limitation thereof:

12.91 It shall transact all of the business of this Society not otherwise specifically provided for.

12.92 It shall adopt rules and regulations for its own government and for the administration of the affairs of the Society.

12.93 It shall provide for the organization of Regions which shall be depicted on Exhibit A.

12.94 It shall concern itself with and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws, and the health of the public.

12.95 It shall be active in the education of the public in regard to medical research and scientific medicine.

12.96 It shall have the power to identify areas of concern and to instruct the Board of Directors to appoint committees or task forces to study or act on those areas. These committees or task forces shall report to the Board of Directors, which in turn shall report in the annual report of the Board of Directors to the House of Delegates. The House of Delegates shall itself have necessary internal committees, such as I) Credentials, 2) Rules of Orders of Business, 3) Constitution and Bylaws, and 4) Ways and Means. The seated House, by majority vote, reserves the right to instruct the Board of Directors to discharge a specific standing committee, liaison committee, or task force, and to require the Board of Directors to appoint an ad hoc committee with appointees nominated by the seated House. This ad hoc committee shall report through the Board of Directors to the House at the next session, and be discharged.

12.97 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.

12.98 It shall publish its minutes or a summary of its proceedings in the Journal of the Society.

12.99 It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge of hypothecation. It shall have the authority specifically to authorize the Board of Directors and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid.

Relevant AMA Policy

None

Michigan State Medical Society

Constitution and Bylaws

2023 Edition

CONSTITUTION

Regional Map (Exhibit A) 3
Article I - Name 4
Article II - Purposes 4
Article III - Component Societies 4
Article IV - Divisions 4
Article V - The Society as a Whole 4
Article VI - Scientific Assembly 4
Article VII - House of Delegates 4
Article VIII – Officers and AMA Delegates 4
Section 1 - Officers 5
Section 2 - AMA Delegates 5
Article IX - The Board of Directors 5
Section 1 - Composition 5
Section 2 - Powers and Duties 5
Section 3 - Executive Committee 5
Article X - ~~Judicial Commission~~Reserved 5
Article XI - Finances 5
Section 1 - Method of Financing 5
Section 2 - Power to Fix 5
Article XII - Amendments 5
Section 1 - Method of Amendments 5
Section 2 - Effective Date 5

BYLAWS

1.00 Component Societies 6
1.10 Charter 6
1.20 Revocation of Charter 6
2.00 Membership—Classification—Election 6
2.10 Definition 6
2.20 Membership Prerequisite 6
2.30 Active Members 6
2.31 Suspended Member 6
2.40 Active Members—Dues Exempt 7
2.41 Hardship 7
2.42 Postgraduate Study 7
2.43 Voluntary Service 7
2.50 Physicians-In-Training 7
2.60 Students 7
2.70 Emeritus Members 7
2.71 Active Emeritus 7
2.72 Emeritus 7
2.80 Life Members 7
3.10 Service Members 8
3.11 Military 8
3.12 Commissioned Medical Officers 8
3.20 Honorary Members 8
3.30 Non-Resident Members 8
3.40 Affiliate Members 8
3.50 Resolutions Concerning Membership Changes 8
4.00 Membership—Regulation 8
4.10 Membership as Privilege–Not Right 8
4.20 Duties of County Society 8
4.30 Rosters 8
5.00 Membership—Transfers 8
5.10 Change of Location – Procedure 8
5.20 Refund of Dues 9
5.30 Removal from State 9
6.00 Dues and Assessments 9
6.10 How Fixed 9
6.20 Collection 9
6.30 New Members 9
6.40 First Year of Practice 9
6.50 Arrears—Suspension 9
6.60 Deferment 9
6.70 Reinstatement 9
6.80 Dues—Resident Physicians and Students 10
6.90 Active Status—Part-Time Dues 10
7.00 Conduct and Discipline of Members 10
7.10 Standards of Conduct-Grounds for Discipline 10
7.20 Discipline-What Constitutes 10
7.30 Discipline-What Procedure to Govern 10
7.40 ~~Society of More than 150 Members~~Reserved 10
7.50 Peer Review/Ethics Committee 10
7.60 Request for Investigation 10
7.70 Informal Investigation-Procedure 10
7.80 Informal Investigation-Dismissal 10
7.90 Informal Investigation-Reprimand ~~11~~10
8.10 Formal Complaint-Notice of Hearing ~~11~~10
8.20 Answer to Formal Complaint 11
8.30 Formal Hearing-How Conducted, Right to Counsel 11
8.40 Findings and Report 11
8.50 Action on Report-Additional Testimony 11
8.60 Action by Society 11
8.70 Finality and Effectiveness of Order ~~12~~11
8.80 ~~Appeal Procedure~~ ~~12~~Reserved 11
8.90 Appeal to Judicial Council of the American Medical Association ~~12~~11
9.10 Exception to Procedures 12
9.20 ~~Effect of Suspension or Expulsion~~Reserved 12
9.30 Construction 12
10.00 ~~Grievances of Non-Members-Peer Review/Mediation Committee~~Reserved 12
~~10.10 Peer Review/Mediation Committee 12~~
~~10.20 Purposes 12~~
~~10.30 Powers and Duties-Limitation 13~~
~~10.40 Procedure to Govern 13~~
11.00 General Meetings ~~13~~12
11.10 Determination of Time and Place ~~13~~12
11.20 Right to Participate ~~13~~12
11.30 Actions ~~13~~12

~~4899-3936-5517, v. 1~~4933-5445-9277, v. 2

12.00 House of Delegates ~~13~~12
12.10 Composition ~~13~~12
12.20 Delegates-At-Large, Ex Officio Members ~~13~~12
12.30 Election—Certification ~~14~~12
12.40 Seating—Tenure ~~14~~13
12.50 Seating of Alternate Delegates ~~14~~13
12.60 Officers ~~14~~13
12.70 Meetings—Annual Session ~~14~~13
12.80 Quorum ~~14~~13
12.90 Powers and Duties ~~14~~13
13.10 Reference Committees ~~15~~14
13.20 Election of Regional Directors ~~15~~14
13.30 Election of Delegates to American Medical Association ~~15~~14
13.40 Election of Officers ~~16~~14
13.50 Resolutions ~~16~~14
13.60 New Business ~~16~~15
13.70 Rules of Order ~~16~~15
13.80 Nominating Committee ~~16~~15
14.00 The Board of Directors ~~16~~15
14.10 Organization ~~16~~15
14.20 Executive Committee ~~16~~15
14.30 Reference Committees ~~16~~15
14.40 Regional Director Duties ~~17~~15
14.50 Removal of Regional Director ~~17~~15
14.60 Duties of the Board of Directors ~~17~~16
14.70 Control of Funds ~~17~~16
14.80 Regions ~~17~~16
~~**15.00 The Judicial Commission** 17~~
~~15.10 Composition—Qualifications 17~~
~~15.20 Judicial Districts 17~~
~~15.30 Nominations 17~~
~~15.40 Ballot—Election 18~~
~~15.50 Terms of Office 18~~
~~15.60~~**15.00** ~~Vacancies~~**Reserved** ~~18~~ **16**
~~15.70 Organization of the Commission 18~~
~~15.80 Powers and Duties 18~~
16.00 Committees/Task Forces of the Society ~~19~~16
16.10 Standing Committees ~~19~~16
16.20 Liaison Committees ~~19~~16
16.30 Task Forces ~~19~~17
17.00 Officers ~~19~~17
17.10 Term of Office ~~19~~17
17.20 Induction of President ~~19~~17
17.30 President ~~19~~17
17.40 President-Elect—Duties—Succession ~~20~~17
17.50 Chair of the Board ~~20~~17
17.60 Vice-Chair ~~20~~17
17.70 Treasurer ~~20~~17
17.80 Secretary ~~20~~17
17.90 Chief Executive Officer ~~20~~18
18.10 Speaker of the House of Delegates ~~20~~18
18.20 Vice-Speaker of the House of Delegates ~~20~~18
18.30 Remuneration ~~20~~18
19.00 Indemnification ~~20~~18
20.00 Specialty and Ethnic Medical Societies ~~21~~18
20.10 Recognized Specialty and Ethnic Medical Societies ~~21~~18
20.20 Criteria ~~21~~18
20.30 Resident and Fellow Section ~~21~~18
20.40 Medical Student Section ~~21~~19
20.50 Organized Medical Staff Section ~~21~~19
20.60 Young Physicians Section ~~22~~19
20.70 International Medical Graduates Section ~~22~~19
21.00 Referendum ~~22~~19
21.10 Referendum at Society Meeting ~~22~~19
21.20 Referendum by House of Delegates ~~22~~19
22.00 Seal ~~22~~20
22.10 Seal ~~22~~20
23.00 Emergency ~~22~~20
23.10 Emergency Action by Board of Directors ~~22~~20
24.00 Definition of Session and Meeting ~~22~~20
24.10 Session ~~22~~20
24.20 Meeting ~~22~~20
25.00 Amendments ~~22~~20
25.10 Amendments—Procedure ~~22~~20
~~**OFFICIAL PROCEDURES FOR THE JUDICIAL COMMISSION** 23~~
~~Judicial Commission Districts Map 25~~

MSMS Constitution

2023 Edition

ARTICLE I—NAME

Section I. - NAME—The name of this organization shall be the Michigan State Medical Society.

ARTICLE II—PURPOSES

Section I. - PURPOSES—The purposes of this Society shall be: To bring into one viable, effective organization the ethical physicians licensed to practice in Michigan in order that their contribution to human welfare will be enhanced.

In order to accomplish this effectively, the Society also will work to accomplish the following sub purposes:

a) To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.

b) To charter and organize component medical societies.

c) To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

d) To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his or her patients and the public health generally.

e) To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

f) To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals.

g) To preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care.

h) To promote quality medical and health care by development and support of activities appropriate to this goal.

i) To advocate fair remuneration for services rendered.

j) To ensure adequacy of the medical workforce by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.

k) To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians.

l) To support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession.

m) To institute and provide specific services to meet the needs of the members.

n) To foster and support continuing medical education.

ARTICLE III—COMPONENT SOCIETIES

Section 1. - DEFINITION—Component societies shall consist of those county medical societies which hold charters from this Society.

Section 2. - GEOGRAPHICAL SCOPE—Not more than one component society shall be chartered in any county of the State. The House of Delegates may, however, in its discretion, grant a charter to a component society comprising two or more counties.

ARTICLE IV—DIVISIONS

Section 1. - DIVISIONS—The Society shall have three major divisions, namely:

1) The Society as a whole.

2) The Scientific Assembly with its subordinate or related bodies.

3) The House of Delegates with its subordinate or related bodies.

ARTICLE V—THE SOCIETY AS A WHOLE

Section 1. - SESSIONS—The Society as a whole shall hold such sessions at such times and places of such duration as the House of Delegates may determine. The power to so determine may be delegated to the Board of Directors or to the Executive Committee of the Board of Directors by the House of Delegates.

ARTICLE VI—SCIENTIFIC ASSEMBLY

Section I. - DEFINITION—The Scientific Assembly of this Society is the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine and to the conservation of the health of the public.

ARTICLE VII—HOUSE OF DELEGATES

Section 1. - COMPOSITION—The House of Delegates shall be the legislative body of the Society and shall consist of delegates elected by component societies, recognized specialty societies, delegates from the Residents and Fellows, Students, Young Physicians, Organized Medical Staff and International Medical Graduates Sections, and other sections as shall from time to time be approved by the House of Delegates, delegates-at-large and ex officio members, as prescribed by the Bylaws.

ARTICLE VIII—OFFICERS AND AMA DELEGATES

Section 1. - OFFICERS—The officers of this Society shall be a President; a President-Elect; the Immediate Past President; a Treasurer; a Secretary; a Speaker and a Vice-Speaker of the House of Delegates and shall be elected as provided in the Bylaws.

Section 2. - AMA DELEGATES—The Society's delegates and alternate delegates to the House of Delegates of the American Medical Association shall be elected as provided in the Bylaws. *(See*

Bylaws, Section 13.30)

ARTICLE IX—THE BOARD OF DIRECTORS

Section 1. - COMPOSITION—The Board of Directors shall be the executive body of the Society. Effective at the first meeting of the Board of Directors immediately following the final meeting of the House of Delegates held at its 2020 Annual Session, the Board of Directors shall consist of:

a) Two Directors (the "Regional Directors") from each of the nine regions depicted on Exhibit A to the Bylaws (each a "Region" and collectively the "Regions"). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula.

b) The President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker and Vice Speaker of the House of Delegates.

c) One Director elected by those members in each of the membership classifications defined in Sections 2.50 and 2.60 of the Bylaws, and one Director elected by those members in the Young Physicians Section as defined in Section 20.60 of the Bylaws. These seats will be for one-year renewable terms, and the directors elected must remain in the category elected for the entire term.

d) The following ex officio Directors: (i) the Chair of the delegates to the AMA or another member of the delegation, designated as a substitute; and (ii) the two members serving as the physician representatives on the Blue Cross Blue Shield of Michigan Board of Directors.

e) Up to six Directors elected by the House of Delegates representing those constituencies deemed from time to time the most relevant to the current health care marketplace to be designated by the nominating committee of the House of Delegates with input from the Board of Directors and the House of Delegates (the "Designated Directors"). The Designated Directors shall serve three-year terms. Designated Directors may not serve more than three consecutive terms; the same individual may serve additional terms after an absence of at least one year.

Section 2. - POWERS AND DUTIES—The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions.

Section 3. - EXECUTIVE COMMITTEE—The Board of Directors may have an Executive Committee with power to act between meetings of the Board. The composition, powers and duties thereof shall be such as are prescribed by the Bylaws.

ARTICLE X—~~JUDICIAL COMMISSION~~RESERVED

~~Section 1. - COMPOSITION - POWERS AND DUTIES—The Judicial Commission shall be the body having general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members and professional conduct generally. It shall consist of members to be elected by the voting members of the Society. The number of members, their terms of office, the time and manner of their election and the specific powers and duties of the Commission shall be as prescribed by the Bylaws.~~

ARTICLE XI—FINANCES

Section 1. - METHOD OF FINANCING—Funds for meeting the expenses of the Society shall be raised by annual dues and may be augmented by other methods including special assessments and voluntary contributions.

Section 2. - POWER TO FIX—Annual membership dues and assessments shall be fixed by the House of Delegates.

ARTICLE XII—AMENDMENTS

Section 1. - METHOD OF AMENDMENTS—The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates seated at any regular session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been published at least once during the interval in the Journal of the Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

Section 2. - EFFECTIVE DATE—Unless otherwise provided herein, this Constitution and all amendments hereto shall become effective immediately upon adoption by the House of Delegates.

MSMS Bylaws

2023 Edition

1.00 COMPONENT SOCIETIES

1.10 CHARTER - The charter of each component society shall be authorized by the House of Delegates and signed by the President and Secretary. Such charter shall require that the constitution and bylaws of such component society be at all times consistent with the provisions of the Constitution and Bylaws of this Society and with all amendments thereto hereafter adopted. Each component society shall file with the State Society headquarters a current copy of its constitution and bylaws.

1.20 REVOCATION OF CHARTER - The House of Delegates is empowered to revoke the charter of any component society whenever it finds that such society has materially breached any of the provisions of the Constitution or Bylaws of this Society or has failed to function within the expressed spirit and purpose of this Society to such an extent that revocation of charter is compatible with the best interests of this Society.

Petition for the revocation of charter of any component society may be filed with the Board of Directors by a Director of the Region within which such society is located, or by any three members of the Board of Directors of this Society or by the President of this Society. Such petition shall be in writing and set forth with reasonable particularity the matters complained of and upon which the petition is founded. A copy of such a petition together with written notice of the time and place of hearing on the petition shall be served on the affected component society by registered mail, return receipt requested, not less than 60 days before the date of such hearing.

The affected component society may, within 30 days after service upon it of copy of the petition, file with the Board of Directors by registered mail, return receipt requested, a written answer thereto. The Board of Directors shall afford the affected component society a fair hearing of the matters complained of and a suitable opportunity to present its defense. The component society may be represented by legal counsel. Written arguments may be filed on behalf of the affected component society and by the petitioner. Stenographic notes shall be made of the entire proceedings on such hearing and a complete record shall be prepared, which record shall consist of the petition, answer, testimony, exhibits, written arguments and other pertinent matter.

The Board of Directors shall make its decision based on the records, setting forth in writing the finding of facts, conclusions and reasons therefore. If two-thirds of the members of the Board of Directors do not concur in the conclusion that the charter of the affected component society should be revoked, the petition shall be deemed dismissed and the proceedings ended. If two-thirds of the members of the Board of Directors concur in the conclusion that the charter of the affected component society should be revoked, the Chair of the Board of Directors shall transmit to the House of Delegates a report, consisting of the decision of the Board of Directors with all records annexed, and shall serve a copy thereof on the affected component society. The House of Delegates shall at the next regular or special session thereof following the transmittal of such report, consider and take such action on the report as it may deem proper. In case the House of Delegates desires further proofs in relation to the issues involved, it may remand the matter to the Board of Directors for further hearing and report. The action of the House of Delegates on the report of the Board of Directors shall be the final decision with reference to the revocation of the charter of a component society; provided, that the component society, if it feels aggrieved by the decision of the House of Delegates, may, within six months, appeal to the Council on Judicial and Ethical Affairs of the American Medical Association, whose opinion shall be final.

2.00 MEMBERSHIP—CLASSIFICATION—ELECTION

2.10 DEFINITION - As used in these Bylaws, except as otherwise herein expressly qualified, whenever the terms “doctor of medicine” or “practice of medicine” or “medical profession” are used, these terms shall be deemed to include the terms “doctor of medicine and doctor of osteopathy,” “practice of medicine and practice of osteopathy,” and “medical profession and osteopathic profession.”

2.20 MEMBERSHIP PREREQUISITE-All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society where they reside or primary location of practice or direct members through the Resident and Fellow Section or the Medical Student Section.

2.30 ACTIVE MEMBERS - To be eligible for active membership in any component society, doctors of medicine must hold an unrevoked, permanent license that is not currently under suspension in Michigan, or if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, doctors of

medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society.

2.31 Suspended Member - If an Active Member's license is suspended, his/her component society may change his/her membership classification to "Suspended Member." Those in the Suspended Member classification shall be so recognized by this Society, will not be responsible for dues payments, nor be eligible for holding any office or serve on any committee. The component society shall reinstate anyone in the Suspended Member classification immediately upon notice of reinstatement of his/her license. The Society shall recognize such a reinstatement upon notice from a component society and the member shall again be obligated to pay dues, eligible to hold office and serve on committees.

2.40 ACTIVE MEMBERS - DUES EXEMPT - Members in any of the following three categories shall be classified "Active-Dues Exempt" and shall have all the privileges of active membership.

2.41 Hardship - Members for whom the payment of dues would be a financial hardship by reason of physician disability or illness may be excused, fully or partially, from payment of dues by the Board of Directors provided the member is fully or partially exempted from the payment of component society dues. Members may also be excused from payment of dues because of financial hardship, or for other reason, but these must be set forth by the secretary of the member's component society.

2.42 Postgraduate Study - Active membership may be maintained by those members who are out of practice on account of postgraduate medical studies, by payment of dues of PHYSICIANS-IN-TRAINING covered in Section 2.50.

2.43 Voluntary Service - Members who serve as missionaries or who participate, for nominal or no compensation in a government- sponsored volunteer medical program, either in the United States or abroad.

2.50 PHYSICIANS-IN-TRAINING - Physicians-in-training in AMA-approved programs who have licenses to practice in Michigan or fellowships, members serving as their primary occupation in a structured educational program begun immediately upon completion of medical school, residency, or fellowship training, may become active members of the State Medical Society through a component society or directly where no provision for reduced dues active membership exists at the component level. State Society dues for resident members shall be set by the Board of Directors of MSMS. Component dues, if any, shall be determined locally.

2.60 STUDENTS (MEDICAL STUDENT SECTION) - Medical students may become members of the State Medical Society through a component society or directly through the MSMS Medical Students Section.

Except as provided in Section 12.10 of these Bylaws, they may not vote or hold office. They may be appointed to MSMS committees as student members. State Society dues shall be set by the Board of Directors to cover administrative costs of membership except in the first year of membership. Component dues for students shall be determined at the local level.

2.70 EMERITUS MEMBERS—Members who have maintained active membership in any one or more component societies in Michigan for a period of five or more years, and who have retired from practice, may be transferred to the emeritus members roster of such component society and this society, provided the member's dues have been paid to the end of the preceding calendar year

2.71 ACTIVE EMERITUS—A member who has been elected an active emeritus member, who pays an annual fee set by the Board of Directors, shall be classified as an active emeritus member. Active emeritus members will receive Society publications; may serve on committees; may vote in elections and hold officer positions; may serve as delegate or alternate delegate to House of Delegates; will be included in the Society membership count; will be included in the count for Delegates to the House of Delegates; will be eligible for Society insurance and member rate for Society sponsored continuing education.

2.72 EMERITUS—A member who has been elected an emeritus member, who does not pay the annual fee set by the Board of Directors, shall be classified as an emeritus member. Emeritus members will not receive Society publications by mail but will be able to have member access to the MSMS website and to participate in MSMS online activities; may not serve on committees; may not vote in elections and hold officer positions; may not serve as delegate or alternate delegate to House of Delegates; will be included in the Society membership count; will not be included in the count for Delegates to the House of Delegates; will be eligible for Society insurance and member rate for Society sponsored continuing education.

2.80 LIFE MEMBERS

2.81 Doctors of medicine who have maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues paid for the previous calendar year and who 1) have attained the age of 70 years or 2) have been in practice for 50 years, may be transferred to the life membership roster of the component society and this Society.

2.82 Each President, Chair of the Board of Directors and Speaker of the House of Delegates of this Society shall, upon retiring from office, become a life member of this Society without further action.

2.83 Life members shall pay no dues or assessments but shall have the right to vote and hold office and shall be entitled to receive publications at such rates as the Board of Directors may determine.

2.84 No members shall be transferred to the former life member classification following the 149th session of the House of Delegates held on Sunday, April 27, 2014.

3.10 SERVICE MEMBERS

Service members shall pay no dues and are not entitled to vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.

3.11 Military - Members in good standing who serve on active duty in the military forces of the United States may be transferred by the component society to service member status for the period of time such service continues.

3.12 Commissioned Medical Officers - Commissioned medical officers of the United States Army, Navy, Public Health Service, or physicians employed by the Veterans Administration, on duty in this State, who are not engaged in the private practice of medicine, may be granted service members status by the component society in the area where the medical officer is located.

3.20 HONORARY MEMBERS - A component society may elect as an honorary member any person distinguished for service or attainments in medicine or the allied sciences, or who have rendered other services of unusual value to organized medicine or the medical profession. Upon recommendation of a component society, the House of Delegates may elect such persons honorary members of the Society. Honorary members shall pay no dues and shall be without the right to vote or hold office in either this or the component society.

3.30 NON-RESIDENT MEMBERS - A component society may elect as non-resident members any doctors of medicine residing and practicing outside of the county who are members in good standing of their Michigan component societies. Non-resident members shall not have the right to vote or hold office.

3.40 AFFILIATE MEMBERS - Component societies may elect to affiliate membership lay persons in areas of endeavor which are related to medicine and medical practice. Affiliate members shall pay no dues and

may not vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.

3.50 RESOLUTIONS CONCERNING MEMBERSHIP CHANGES - Any change in membership status which requires action by the House of Delegates shall be effected by resolution presented at an Annual Session of the House of Delegates after such secretarial certification as is required by these Bylaws.

4.00 MEMBERSHIP—REGULATION

4.10 MEMBERSHIP AS PRIVILEGE - NOT RIGHT—Anyone eligible may apply for component membership within the county where they reside or primary location of practice. Any exception would require written, mutual agreement between the physician and/or physician group, MSMS, and the respective county(ies). Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. Each component society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein. There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation.

4.20 DUTIES OF COUNTY SOCIETY—Each component society shall have general direction of the affairs of the profession in its county or counties and shall be under the continuing duty to exert its influence for the betterment of the scientific, moral, and material conditions of the doctors of medicine therein. It shall also be its duty to make systematic effort to bring every eligible doctor of medicine into membership therein.

4.30 ROSTERS—The secretary of each component society shall keep a roster of its members and, if practicable, a list of non-affiliated doctors of medicine in the county, and other doctors of medicine, such as commissioned officers of the Navy, Army, and Public Health Service, in which shall be shown the full name, the address, the college and date of graduation, the date of license to practice in this State, and such other information as may be deemed necessary, or desirable.

5.00 MEMBERSHIP—TRANSFERS

5.10 CHANGE OF LOCATION - PROCEDURE—When a member of a component society, by reason of change of residence or primary location of practice, desires to transfer membership to another component society, such member shall make application thereto accompanied by tender of dues for the remaining half of the current year (any major fraction of a half being regarded as a full half and any minor fraction being disregarded). Thereupon, the secretary of the society to which application is made shall request certification of standing from the Society from which the member desires to transfer and upon receipt of such request the secretary of the latter Society shall supply certification of good standing, provided the following requirements have been met:

5.11 All component society dues and assessments shall have been paid for the calendar year previous to the year in which application for transfer is made.

5.12 The member shall not be delinquent in the payment of dues and assessments to this Society.

5.13 Component society dues and assessments shall have been paid to cover that portion of the year in which application for transfer is made (any major fraction of a half year being regarded as a full half and any minor fraction being disregarded).

Upon favorable action by the component society to which application has been made, following compliance with the foregoing, the transfer of membership shall be in effect.

5.20 REFUND OF DUES—A member who has transferred to another component society in accordance with the provisions of paragraph 5.10 above, shall be entitled to a refund from the Society from which such member has transferred, of prepaid dues to such Society (any major fraction of a half year being regarded as a full half and any minor fraction being disregarded).

5.30 REMOVAL FROM STATE—A member of this Society who, by reason of removal from the State, desires to resign from membership in the component society and in this Society and make application for membership in a society of another state, may submit his or her resignation to the secretary of the component society and the Secretary of this Society and request certification of good standing. The resignation from each shall be effective at the end of the half year in which submitted. If, at the time of resignation, the member is in good standing, is not facing charges of unethical conduct and is not in arrears in the payment of dues and assessments to this or to the component society, the secretary of each Society shall furnish him or her certification of good standing.

If the resigning member shall have prepaid dues to this Society or to the component society for any period beyond the half year in which resignation becomes effective, such excess shall be refunded by the respective Societies.

6.00 DUES AND ASSESSMENTS

6.10 HOW FIXED—Members of this Society shall pay such dues and assessments as shall, from time to time, be fixed and determined by the House of Delegates.

6.11 Notwithstanding Section 6.10, the Board of Directors shall have the authority to implement pilot membership incentive programs within the standard dues structure.

Prior to implementing a pilot membership incentive program full consideration shall be given to the impact upon component society dues.

6.20 COLLECTION—All dues are to be collected on or before April 1 of each year in a manner set by this society in consultation with the component society.

6.30 NEW MEMBERS—For the purpose of determining the dues for new members only, the fiscal year of this Society shall be divided into two six-month periods. New members shall pay adjusted annual dues and assessments for the unexpired semiannual periods of that year. Such new members shall not be entitled to membership benefits until their election to membership has been duly reported to the Secretary of this Society and they shall not be entitled to membership benefits for any period prior to becoming members in good standing.

6.40 FIRST YEAR OF PRACTICE—The annual dues payable to this Society by a doctor of medicine who is elected to membership during the first year of practice, shall be 25 percent of the amount fixed and determined pursuant to Section 6.10 during the first year of practice, 50 percent of such amount during the second year of practice, 75 percent of such amount during the third year of practice and the full amount during the fourth year of practice. This reduction in annual dues shall not exempt such member from the payment of any regularly levied assessment.

6.50 ARREARS - SUSPENSION—Any member in arrears in the payment of dues assessments to this Society on the date in any year which coincides with the suspension date of the American Medical Association (currently March 1), if no extension of time for payment has been granted under the provisions of Section 6.60 of this Chapter, or upon the expiration of such extension as may have been granted there-under, shall stand suspended until all sums in arrears have been paid. However, if the secretary of the component society shall certify to the Secretary of this Society that the name of the member in arrears is to be submitted to the House of Delegates at its next Annual Session for election to a different classification of membership under the provisions of Chapter 2.00 hereof, such member shall not be suspended pending action by the House of Delegates upon such requested change of classification.

6.60 DEFERMENT—Upon written request of the governing body of a component society to the Board of Directors of this Society, a member shall be granted an extension of time for the payment of dues to this Society, provided, such extension shall not be beyond the close of the current fiscal year of this Society.

6.70 REINSTATEMENT—A member who is in arrears in the payment of dues or assessments to this or the component society for not more than one year may be

reinstated to good standing upon payment of all arrearages. If in arrears for more than one year, such member shall be deemed to have forfeited membership. In such case the component society may reinstate such member to membership in good standing upon the payment of all arrearages or may, at its option, require reapplication for election to membership.

6.80 DUES - RESIDENTS, FELLOWS AND STUDENTS—Dues for these membership categories shall be set by the Board of Directors as defined in Sections 2.50 and 2.60.

6.90 ACTIVE STATUS - PART-TIME DUES—Dues for the following categories will be one-half the annual active membership dues rate. Members in these categories will have all the privileges of active membership. Eligibility for these categories will be determined prior to the due date for the payment of dues each year and thereafter verified on a yearly basis.

6.91 A member who works less than 20 hours per week.

6.92 Members sharing one full-time position, each working 50 percent within a practice.

6.93 A physician spouse of a full dues paying active member.

7.00 CONDUCT AND DISCIPLINE OF MEMBERS

7.10 STANDARDS OF CONDUCT - GROUNDS FOR DISCIPLINE—Any conduct of a member of this or any component society, whether or not occurring in the course of a physician-patient relationship, which

7.11 is in violation of the Principles of Medical Ethics of the American Medical Association, or

7.12 constitutes unprofessional and dishonest conduct as defined by Act 368 or the Public Acts of Michigan of 1978, as amended, or

7.13 results in conviction of a felony under the laws of any state or of the United States of America, or

7.14 is in violation or disregard of the constitution, bylaws, principles, rules, regulations or orders of this Society ~~or of its Judicial Commission or~~ of the American Medical Association, or

7.15 constitutes defamation or otherwise unjust reflection on the integrity, character or professional performance or reputation of a fellow member of the profession, or

7.16 is prejudicial to or tends to expose the medical profession of this or a component society to contempt or reproach, or which is in anywise contrary to ethics, honesty or good morals, shall be grounds for discipline. The willful failure or refusal of a member whose conduct has been called into question to appear before any disciplinary body upon request or to cooperate with such disciplinary body ~~or the Judicial Commission~~ in any authorized investigation shall also, in and of itself, be grounds for discipline.

7.20 DISCIPLINE - WHAT CONSTITUTES— Discipline as used in this chapter shall include reprimand, suspension and expulsion, and for grievous offense, recommendation to the State licensing authority for revocation of license.

7.30 DISCIPLINE - WHAT PROCEDURE TO GOVERN—All disciplinary proceedings conducted by this Society ~~or by any component society,~~ shall be governed by the provisions of this chapter ~~and the current Official Procedures of the Judicial Commission, any provisions of the constitution or bylaws of any component society to the contrary notwithstanding. Any provisions of this chapter in conflict with the Official Procedures of the Judicial Commission shall be of no effect.~~.

~~7.40 SOCIETY OF MORE THAN 150 MEMBERS—Any component society having more than one hundred fifty active members may, by appropriate provisions in its Constitution or Bylaws, delegate its authority and power to discipline its members to the governing board of such Society, in which event, all of the functions, powers and duties of a component society as set forth in this Chapter shall be exercised and carried out by such governing board. Unless otherwise provided by the Constitution or Bylaws of such component society, any order of expulsion or suspension made by such governing board shall be subject to the approval of the component society in the same manner as may be provided for the approval of any other report of such governing board.~~

7.40 RESERVED

7.50 PEER REVIEW/ETHICS COMMITTEE—~~Every component society~~the Board of Directors shall have a standing committee designated the Peer Review/Ethics Committee, charged with duties and powers concerning the maintenance of standards of conduct and discipline of members, including the duties and powers specifically set forth in this chapter.

7.60 REQUEST FOR INVESTIGATION—Upon the receipt by ~~a component society~~the Board of Directors of a written request for investigation of the conduct of ~~one of its members~~a member of this Society, signed by an active member ~~or committee of such component society~~of this Society and setting forth briefly the alleged facts of such claimed misconduct, such request for investigation shall be referred to the Peer Review/Ethics ~~Committees~~Committee.

7.70 INFORMAL INVESTIGATION PROCEDURE—The Peer Review/Ethics Committee shall thereupon make such informal investigations as the circumstances and nature of the matter require. The procedure to be followed shall be determined by the Peer Review/Ethics Committee but shall be such as to insure that the member whose conduct is questioned has full opportunity to be heard and to offer any defense or explanation available to him or her.

7.80 INFORMAL INVESTIGATION - DISMISSAL—Upon conclusion of its informal investigation the Peer Review/Ethics Committee if it decides that there is no ground for discipline shall dismiss the matter and ~~so~~ report the dismissal to the ~~Society~~member whose conduct is questioned.

7.90 INFORMAL INVESTIGATION REPRIMAND—If, upon the conclusion of its informal investigation, the Peer Review/Ethics Committee decides that the member whose conduct is questioned is guilty of conduct warranting only a reprimand it shall forthwith administer such reprimand ~~and so report to the Society~~ unless a formal hearing is demanded by the member.

8.10 FORMAL COMPLAINT-NOTICE OF HEARING—If the Peer Review/Ethics Committee finds there is reasonable cause to believe that the respondent is guilty of misconduct warranting suspension or expulsion from membership, or if the respondent demands a formal hearing, a formal complaint setting forth the facts of the alleged misconduct shall be prepared by the Peer Review/Ethics Committee and subscribed by the Chair or Vice-Chair thereof. A copy of such complaint shall be filed with the ~~component society~~Board of Directors. Thereupon, it shall be the duty of the Peer Review/Ethics Committee or its Chair to fix the time and place for a formal hearing thereon. A written notice of such hearing, together with a copy of the formal complaint, shall be served on the respondent by registered or certified mail~~, or other appropriate means as approved by the MSMS Judicial Commission,~~ not less than thirty days before the date of such hearing.

8.20 ANSWER TO FORMAL COMPLAINT—It shall be the duty of the respondent to file an answer to the formal complaint. Such answer shall be in writing, signed by the respondent, and filed with the Peer Review/Ethics Committee within fifteen days after service of the copy of the formal complaint. The answer shall admit or deny each material allegation contained in the complaint, and shall set forth any special defenses which the respondent claims to have. If the answer is not filed within the time hereby limited, the complaint may be taken as confessed.

8.30 FORMAL HEARING - HOW CONDUCTED - RIGHT TO COUNSEL—It shall be the duty of the respondent to appear before the Peer Review/Ethics Committee in person at the time and place specified in such notice. Both the respondent and the Peer Review/Ethics Committee shall be entitled to be represented by counsel at such hearing. At such formal hearing, it shall be the duty of the respondent to answer fully and fairly all questions pertaining to conduct which may be asked by any member of the Peer Review/Ethics Committee ~~of the component society~~ or its counsel. Formal hearings shall be conducted fairly, but not necessarily in accordance with all rules governing court trials. A stenographic record shall be made of the proceedings at such hearings.

8.40 FINDINGS AND REPORT—If upon formal hearing the Peer Review/Ethics Committee finds that the charges of misconduct are not established by a preponderance of the evidence, the Committee shall dismiss the complaint. If the Committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant discipline by way of reprimand, the Committee shall administer such reprimand, and shall make a written report thereof, together with its findings of fact~~,~~ to the ~~component society~~Board of Directors. If the Committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant suspension or expulsion from membership ~~by action of the component society~~, the Committee shall make a written report of the proceedings held before the Committee, and shall include in such report a certified transcript of the evidence, including copies of all documents taken in proof, a summary statement of all previous misconduct for which the respondent has been disciplined, and the Committee's findings of fact and recommendations for discipline. Every such report shall be signed by not fewer than a majority of the members of the Peer Review/Ethics Committee, and shall be filed with the ~~component society~~Board of Directors.

8.50 ACTION ON REPORT - ADDITIONAL TESTIMONY—Whenever ~~a~~the Peer Review/Ethics Committee files a report with ~~its component society~~the Board of Directors recommending suspension or expulsion as herein provided, the respondent shall be served with a copy of the Committee's findings of fact and recommendations so filed, not less than twenty days before the meeting of the ~~component society~~Board of Directors at which such recommendations are to be considered and acted on, together with a notice of the time and place of such meeting. The respondent may thereupon file with the ~~Society~~Board of Directors not less than ten days before such meeting reasons in writing why the recommendations of the Peer Review/Ethics Committee should not be adopted. The respondent may also at such meeting appear in person and offer any further reasons why such respondent should not be suspended or expelled from membership; provided, however, that at such meeting no testimony as to any matter of misconduct shall be taken. If it is decided at such meeting that the interests of justice require additional testimony to be taken, the matter shall be referred to the Peer Review/Ethics

Committee for such purpose. In such event the Peer Review/Ethics Committee shall cause such additional testimony to be taken promptly, and shall make a supplemental report thereon, including findings of fact and recommendations based thereon, and shall file the same, together with a certified transcript of such additional testimony with the ~~component society~~Board of Directors. A copy of the findings of fact and recommendations contained in the supplemental report shall be served on the respondent as required in the case of an original report, and thereafter the same procedures shall be followed as in this section provided in relation to an original report.

8.60 ACTION BY ~~SOCIETY~~BOARD OF DIRECTORS—Following the filing of any such report of a Peer Review/Ethics Committee recommending suspension or expulsion, the ~~component society~~Board of Directors shall, at a regular meeting thereof, or at a special meeting called for such purpose, consider and act upon the report and recommendation of the Peer Review/Ethics Committee. Suspension or expulsion from membership shall require the affirmative vote of not less than two-thirds of members present at any such meeting and entitled to vote thereat, but not including the respondent, who shall have no right to vote on the question. If any measure for discipline is adopted by ~~a component society~~the Board of Directors, an appropriate order in accordance therewith shall be signed by the President and Secretary of ~~such~~the Society and a copy thereof served on the respondent ~~and on the Michigan State Medical Society~~.

8.70 FINALITY AND EFFECTIVENESS OF ORDER—No order of suspension or expulsion from membership shall be final or effective until the respondent shall have been given the opportunity to exhaust remedies of appeal and review in accordance with the provisions of this Chapter.

8.80 RESERVED

~~8.80 APPEAL PROCEDURE Any member feeling aggrieved by an order of suspension or expulsion may appeal to the Judicial Commission of the Michigan State Medical Society. Notice of such appeal shall be in writing, signed by the appellant and shall set forth specific reasons for the appeal. The notice shall be served on the Judicial Commission and on the appellant's component society by registered or certified mail, addressed to the respective secretaries thereof. Unless notice of appeal is so served within 30 days following the service on the member of a copy of the order of the suspension or expulsion as herein above provided, such member's right of appeal and review shall be conclusively treated as having been waived and the order of suspension or expulsion shall thereupon become final and effective. On receiving notice of appeal, the component society shall forward to the Judicial Commission the complete record of the matter, including copies of the order appealed from, all reports of the Peer Review/Ethics Committee, formal complaint, answer, transcript of testimony, exhibits and all other pertinent writings and data on which the order of suspension or expulsion was based. The Judicial Commission may request the component society or the appellant to furnish such further information in writing as the commission deems necessary for the proper and full review of the matter. Written arguments may be filed with the Judicial Commission by the component society and the appellant within 45 days following notice of appeal. The Judicial Commission shall, within 90 days after receiving the full records in the case, review the record on appeal and the written arguments, make such findings as it deems appropriate and, by majority vote of the participating members of the Commission, affirm, modify or reverse the order of expulsion or suspension appealed from, or remand the matter for further action by the component society. In the consideration of any appeal, not less than six members of the Commission shall participate, and in the event that the participating members of the Commission are equally divided, so that no majority prevails, the order or finding appealed from shall stand affirmed.~~

~~A copy of such decision shall be promptly served on the appropriate component society and on the appellant by registered or certified mail. Unless within twenty days after service on them of a copy of such decision the component society or the appellant shall take an appeal to the Judicial Council of the American Medical Association, the right to such further appeal and review will be conclusively treated as having been waived, and the decision of the Judicial Commission shall be final and effective.~~

8.90 APPEAL TO JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION—The ~~appellant~~Respondent, if a member in good standing of the American Medical Association at the date of the alleged misconduct~~, or the component society,~~ may, within twenty days after service of a copy of the final decision of the ~~Judicial Commission~~Board of Directors, take an appeal there from to the Council on Ethical and Judicial Affairs of the American Medical Association.

9.10 EXCEPTION TO PROCEDURES—Any member of ~~a component society~~the Society whose license to practice medicine shall have been revoked, or who shall have been convicted of a felony in any state or federal court, shall be expelled from the ~~component and State~~ Society without benefit of, or resort to, the procedures prescribed in this Chapter.

~~9.20 EFFECT OF SUSPENSION OR EXPULSION Whenever a member of any component society is suspended or expelled from such society, he or she shall thereby also stand automatically suspended or expelled from the Michigan State Medical Society.~~

9.20 RESERVED.

9.30 CONSTRUCTION—Procedures under this Chapter of the Bylaws shall be as summary as may be reasonable. No investigation or proceeding hereunder

shall be held invalid by reason of any non-prejudicial irregularity or for any error not resulting in a miscarriage of justice. The provisions of this Chapter shall be liberally construed for the maintenance of the dignity, integrity, purposes and high principles of this Society and its component societies.

10.00 ~~GRIEVANCES OF NON-MEMBERS PEER REVIEW/MEDIATION COMMITTEE~~RESERVED

~~10.10 PEER REVIEW/MEDIATION COMMITTEE—Every component society shall have a standing committee designated the Peer Review/Mediation Committee. Directors holding membership in a component society are eligible for membership on that component society's Peer Review/Mediation Committee.~~

~~10.20 PURPOSES—The purposes of such committee shall be:~~

~~10.21 to afford the public an informal means of making known to the profession any alleged grievance arising from a physician-patient relationship;~~

~~10.22 to resolve misunderstanding between physician and patient or between the component society and the public;~~

~~10.23 to reconcile differences between physician and patient by means of persuasion and explanation; and~~

~~10.24 to assist the Peer Review/Ethics Committee of its component society in maintaining among members high levels of professional deportment.~~

~~It shall not be the purpose of this committee to establish fees, but serve to resolve disputes. Each case should be considered on its own merits and it shall not be the intent of the committee to establish precedents.~~

~~10.30 POWERS AND DUTIES LIMITATION—The specific powers and duties to be exercised by such committee in furthering the purposes above set forth, shall be as fixed and determined by the component society, provided, however, that such committee shall function in the area of mediation or conciliation only and shall not have power to act as a trial body or to render decisions or awards, nor shall such committee have power to impose discipline or in any wise encroach upon the function of the Peer Review/Ethics Committee.~~

~~10.40 PROCEDURE TO GOVERN—The provisions of this chapter shall be governed by the current Official Procedures of the Judicial Commission regarding mediation committees and procedures. Any provisions of this chapter in conflict therewith shall be of no effect.~~

11.00 GENERAL MEETINGS

11.10 DETERMINATION OF TIME AND PLACE—During each Annual Session the Society may hold one or more General Meetings. The number and times of these General Meetings shall be determined by the Board of Directors. Such General Meetings shall be presided over by the President or in his/her absence the President-Elect or the Chair of the Board of Directors.

11.20 RIGHT TO PARTICIPATE—Each registered member at an Annual Session shall have an equal right to participate in the deliberations of a General Meeting and each active member, active emeritus member, and life member so registered shall have the right to vote on pending questions before the General Meeting.

11.30 ACTIONS—At any General Meeting or at any section meeting of this Society, there may be recommended to the House of Delegates or to the Board of Directors the appointment of committees or commissions for scientific investigations of special interest and importance to the profession and the public. Such investigations and reports shall not become official actions or expressions of this Society until approved by the House of Delegates or the Board of Directors.

12.00 HOUSE OF DELEGATES

12.10 COMPOSITION—The House of Delegates shall be composed of members elected by the component societies, a delegate from each recognized specialty society, a delegate from the Resident and Fellow Section, one delegate from the Organized Medical Staff Section, a delegate from the Young Physicians Section, a delegate from the International Medical Graduates Section and one voting at-large delegate for every 50 MSMS student members to be selected by the MSMS Medical Student Section. These student delegates and alternate delegates must be members of the MSMS Medical Student Section. All other delegates and alternate delegates must be voting members of MSMS.

Each component society shall be entitled to send to the House of Delegates each year one delegate for each fifty voting members (active, life, and active emeritus) and one delegate for each additional major fraction thereof. Any component society having less than fifty members shall be entitled to send one delegate.

The president of a component medical society that all or part of which is located more than 400 miles by road from the site of the House of Delegates may designate a Regional Director of its region to serve as a delegate to the House of Delegates, provided that no member of the component medical society will otherwise be present in person serving as a delegate in any capacity. In the case of such designation of a

single Regional Director by two or more component societies, said Regional Director shall have only one vote on all matters before the House of Delegates.

12.20 DELEGATES-AT-LARGE - EX OFFICIO MEMBERS—Except as provided by Section 12.10, the officers of this Society, members of the Board of Directors, and the Chair, Vice Chair, and Secretary of the MSMS Sections recognized by these Bylaws, shall be ex officio members of the House of Delegates, but with the exception of the Speaker and Vice Speaker of the House of Delegates, shall be without power to vote therein. The Past President shall be a member-at-large of the House of Delegates during the first year of past- presidency with right to vote and hold office. All other Past Presidents shall have the privilege of the floor, without the right to vote.

Except for the Speaker, Vice Speaker, Immediate Past President, and as otherwise provided in Section 12.10, members of the Board of Directors are not eligible for election as delegates by their component societies.

The dean of each accredited medical school in Michigan, if an active member of MSMS, shall be a delegate-at-large to the House of Delegates, with voting privileges. An alternate may not be seated for any dean, and any provisions of these Bylaws regarding the seating of an alternate shall not apply.

The Chief Medical Officer of the Michigan Department of Community Health, if an active MSMS member, shall be an ex officio member of the House of Delegates, but without power to vote therein. No alternate may be seated in place of that officer and any provision of these Bylaws regarding the seating of an alternate shall not apply.

12.30 ELECTION - CERTIFICATION—Each component society shall elect the number of delegates to which it is entitled. The number of delegates shall be determined by the State Society as of December 1, preceding the House of Delegates meeting. The component society shall also elect an equal number of alternate delegates and shall designate the order or seniority thereof. Promptly after election the secretary of the component society, recognized specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section shall certify the names of its delegates and alternate delegates to the Secretary of this Society.

12.40 SEATING - TENURE—A delegate becomes a member of the House of Delegates when the Speaker is notified in writing of the delegates election by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section. Such certification shall be submitted by February 1 of each year. The delegate shall remain a member of the House of Delegates until the Speaker is notified, in writing, by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section that the delegate has been replaced. The delegate shall remain a member of the House of Delegates regardless of whether or not an alternate substitutes for him/her at any meeting of the House.

12.50 SEATING OF ALTERNATE DELEGATES—An alternate delegate may substitute for a duly certified delegate at any regular or special meeting of the House of Delegates provided that such substitution is authorized in writing by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section.

12.60 OFFICERS—The officers of the House of Delegates shall be the Speaker and Vice Speaker. The Secretary of the Society shall be the Secretary of the House of Delegates. The Speaker and Vice Speaker shall be elected by the House of Delegates at the Annual Session from the members of the then-constituted House of Delegates for a one-year term. The Speaker and Vice Speaker of the House of Delegates shall be limited to no more than four one-year terms in each position.

12.70 MEETINGS - ANNUAL SESSION—The House of Delegates shall meet at least annually at the time and place of the Annual Session of this Society and may hold such number of meetings as the House may determine or its business require, recessing from day to day as may be necessary to complete its business and specifying its own time for the holding of its meeting. The House of Delegates may also be called into session at any time by the Speaker upon a two-thirds vote of the Board of Directors, or on petition of twenty-five percent of the Delegates. The purposes of such special session shall be stated in the notice of call and no other business shall be transacted.

12.80 QUORUM—A quorum of the House of Delegates shall consist of not less than 40 percent of the accredited delegates, provided that a majority of such quorum shall not come from any one component society, and the presence of a quorum established at the beginning of the business portion of a meeting shall be sufficient to conduct official business for the duration of the meeting.

12.90 POWERS AND DUTIES—As the legislative body of this Society, the House of Delegates shall have the power arid authority to adopt, institute, and carry out such methods and measures as it may deem to be in the best interests of the medical profession in Michigan. In the exercise of such powers and duties, but without limitation thereof:

12.91 It shall transact all of the business of this

Society not otherwise specifically provided for.

12.92 It shall adopt rules and regulations for its own government and for the administration of the affairs of the Society.

12.93 It shall provide for the organization of Regions which shall be depicted on Exhibit A.

12.94 It shall concern itself with and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws, and the health of the public.

12.95 It shall be active in the education of the public in regard to medical research and scientific medicine.

12.96 It shall have the power to identify areas of concern and to instruct the Board of Directors to appoint committees or task forces to study or act on those areas. These committees or task forces shall report to the Board of Directors, which in turn shall report in the annual report of the Board of Directors to the House of Delegates. The House of Delegates shall itself have necessary internal committees, such as I) Credentials, 2) Rules of Orders of Business, 3) Constitution and Bylaws, and 4) Ways and Means.

The seated House, by majority vote, reserves the right to instruct the Board of Directors to discharge a specific standing committee, liaison committee, or task force, and to require the Board of Directors to appoint an ad hoc committee with appointees nominated by the seated House. This ad hoc committee shall report through the Board of Directors to the House at the next session, and be discharged.

12.97 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.

12.98 It shall publish its minutes or a summary of its proceedings in the Journal of the Society.

12.99 It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge of hypothecation. It shall have the authority specifically to authorize the Board of Directors and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid.

13.10 REFERENCE COMMITTEES—The House of Delegates shall have the following reference committees, together with tellers and sergeants-at-arms, appointed by the Speaker of the House and approved by the House of Delegates, and such other reference committees as may be deemed necessary to conduct the business of the House:

1. Credentials
2. Rules and Order of Business
3. Constitution and Bylaws (which shall serve also as the standing Committee on Constitution and Bylaws)
4. Ways and Means

13.20 ELECTION OF REGIONAL DIRECTORS—Regional Directors shall be elected as provided in Article IX, Section 1(a) of the Constitution. Each component society in a Region shall be notified in writing by the Secretary of the Society at least sixty days in advance of the Annual Session when a Regional Director is to be elected from that Region.

If, by reason of death or resignation, a vacancy in the office of Regional Director occurs at any time other than during an Annual Session, each component society in that Region shall be promptly notified in writing by the Secretary of the Society. Thereupon the seated delegates of such Region may caucus, and if a majority of the seated delegates from such Region shall submit a nomination to the Board of Directors to fill such vacancy, the Board of Directors shall appoint such nominee to serve as interim Regional Director of such Region until a successor is elected in accordance with Article IX, Section 1(e) of the Constitution.

If a vacancy in the office of Regional Director occurs during an Annual Session of the Society, the delegates of the component societies in the Region affected shall be given notice thereof and afforded time to caucus and consider nominations to fill such vacancy.

13.30 ELECTION OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION—The House of Delegates shall elect delegates and alternate delegates to the American Medical Association in accordance with the regulations of that parent organization and as hereinafter provided.

Delegates and alternate delegates to the American Medical Association shall be elected for two-year terms.

Any physician filling the position of delegate or alternate delegate to the American Medical Association must spend the majority of his/her professional time in active clinical practice; teaching; research; and/or administrative practice and be a full-time Michigan resident, unless they hold an elected or appointed AMA Council position for which they are still eligible.

At each Annual Session, candidates for delegates to the House of Delegates of the American Medical

Association shall be nominated in number equal to or greater than the number to be elected that year. Election shall be by ballot. The required number of candidates receiving the greater number of votes shall be declared elected.

In case of a tie vote the winner or winners shall be decided by drawing lots under the supervision of the Speaker of the House of Delegates; provided, however, that any candidate thus tied shall have the right to a decision by ballot on request.

The number of alternate delegates shall equal the number of delegates. They shall be elected in the same manner after all delegates have been elected.

Alternate delegates shall have seniority according to the greatest length of service as an alternate delegate. When it occurs that two or more alternate delegates have equal lengths of service, seniority shall be determined by the respective number of votes received by each when first elected, and such seniority shall be designated at the time of the first election.

When a delegate shall be unable to attend a meeting of the House of Delegates of the American Medical Association that seat shall be filled by an alternate delegate chosen in order of seniority as defined in this Section.

Should the Society become entitled to one or more additional delegates subsequent to the Annual Session of the House of Delegate in any year, such additional delegate or delegates shall be designated and accredited by the Board of Directors until the next Annual Session. In filling such offices alternate delegates shall be designated in order of their seniority as defined in this section.

13.40 ELECTION OF OFFICERS—Election of officers of the Society shall take place at the House of Delegates at each Annual Session. All nominations shall be made from the floor of the House with the exception of the Secretary and Treasurer who are elected by the Board of Directors. If there is only one nomination for any office, the candidate so nominated may be elected viva voce.

13.50 RESOLUTIONS—Each resolution introduced in the House of Delegates shall be introduced by a delegate. It shall be presented in writing to the Secretary. It shall be referred by the Speaker to the proper reference committee before action is taken thereon.

13.60 NEW BUSINESS—No new business shall be introduced in the last meeting of a session of the House of Delegates without unanimous consent of the delegates present except when presented by the Board of Directors. All new business so introduced shall require the affirmative vote of three-fourths of the delegates present for adoption.

13.70 RULES OF ORDER—When not in conflict the Constitution or Bylaws of this Society, the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* shall govern the parliamentary procedure of the House of Delegates.

13.80 NOMINATING COMMITTEE - The House of Delegates shall form a Nominating Committee consisting of ten members. The Society's Immediate Past President shall be a member and serve as the chairperson and there shall be one member from each Region who shall be elected by the members holding membership in a county located in that Region. The elected members of the Nominating Committee must be a delegate with the right to vote in the House of Delegates and not be a member of the Board of Directors. It shall be the duty of the Nominating Committee to provide the Speaker of the House of Delegates at least thirty days prior to each annual session of the House of Delegates with at least one nomination for each of the Designated Director positions. The members of the Nominating Committee shall carefully review the credentials of each potential candidate, seek out the most qualified candidates for these positions and when possible insure that the candidates nominated reflect the diversity of the Society's membership.

14.00 THE BOARD OF DIRECTORS

14.10 ORGANIZATION—The Board of Directors is the executive body of the Society. Subject only to the following, it shall determine the times and places of its meetings. At its first meeting immediately following the Annual Session of the House of Delegates, the Board of Directors shall elect a Secretary and Treasurer, who shall serve for a term of office of one year or until a successor is elected and takes office. At the same meeting, the Board of Directors shall elect a Chair, a Vice-Chair, a Chair of the Finance Committee, a Chair of the Health Care Delivery Committee, a Chair of the Legislative Policy Committee, and a Chair of the Scientific and Educational Affairs Committee, who shall be duly elected Regional Directors or Designated Directors, each to take office immediately and to serve for a term of one year or until a successor is elected and takes office.

14.20 EXECUTIVE COMMITTEE—The Executive Committee of the Board shall consist of the President, President-Elect, Immediate Past President, Chair, Vice-Chair, Speaker, Secretary and Treasurer. The Chair of the Board shall serve as Chair of the Executive Committee.

14.30 REFERENCE COMMITTEES—The Reference Committees of the Board of Directors and their composition and duties shall be as follows:

14.31 The Scientific and Educational Affairs Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Scientific and Educational Affairs Committee

shall advise the Board of Directors on matters of scientific and educational activity and relationships with component medical societies, and consider other matters referred to it by the Board of Directors.

14.32 The Finance Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members, of which one shall be the Treasurer, ex officio, with power to vote, and the remainder appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Finance Committee shall advise the Board of Directors on administration of the Society's finances, and consider other matters referred to it by the Board of Directors.

14.33 The Legislative Policy Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Legislative Policy Committee shall advise the Board of Directors on matters of legislation and liaison with governmental agencies and shall consider other matters referred to it by the Board of Directors.

14.34 The Health Care Delivery Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Health Care Delivery Committee shall advise the Board of Directors on matters concerning the financing and delivery of health care and shall consider other matters referred to it by the Board of Directors.

14.40 REGIONAL DIRECTOR DUTIES—Each Regional Director shall be the organizer, peacemaker and censor for the Region. The Regional Director shall visit each component society in the Region at least once a year and shall keep in touch with the activities of the component societies constituting the Region. The Regional Director shall make such reports as the Chair of the Board of Directors shall request concerning the condition of the profession in the Region.

14.50 REMOVAL OF REGIONAL DIRECTOR—Upon written complaint signed by not less than one-half of the Delegates from a Region presented to the House of Delegates in Annual or Special Session charging that the Regional Director for such Region has been remiss in the duties prescribed above, and that at least one month's notice of such proposed action has been given, the Speaker shall bring the matter before the House of Delegates for consideration. By the vote of not less than two-thirds of the House of Delegates present at the meeting at which such matter is considered, such Regional Director may be removed from office and a successor elected.

14.60 DUTIES OF THE BOARD OF DIRECTORS—It shall be the duty of the Board of Directors:

14.61 To make careful inquiry into the condition of the profession in each county in the State. It shall have authority to adopt such methods as may be deemed most efficient for increasing interest in all existing component societies. It shall especially and systematically endeavor to promote friendly intercourse between doctors of medicine in the same locality. It shall make every effort to bring each reputable doctor of medicine in the State under the Society's influence;

14.62 To direct and control the publication of the Journal of the Michigan State Medical Society;

14.63 To provide and maintain such headquarters for this Society as may be required to conduct its business properly;

14.64 To render an Annual Report to the House of Delegates; and

14.65 At least every three years, review the composition of the Board of Directors including the geographical boundaries of the Regions making any recommendations in its discretion it deems necessary.

14.70 CONTROL OF FUNDS—The funds of this Society shall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.

14.71 The Board of Directors shall have the authority to borrow money upon the general credit of the Society. The Board of Directors shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Board of Directors shall authorize and empower the President or the Chair of the Board of Directors, and the Secretary or the Treasurer to execute such instruments as may be required.

14.80 REGIONS – For the purpose of electing Regional Directors and any other purposes described in these bylaws, there shall be those regions depicted on Exhibit A.

15.00 ~~THE JUDICIAL COMMISSION~~RESERVED

~~15.10 COMPOSITION – QUALIFICATIONS The Judicial Commission shall be composed of ten members, each of whom shall be a voting member of the Society in good standing. No member of the Judicial Commission shall, during tenure of office, hold any of the following offices or positions: Speaker or Vice Speaker of the House of Delegates of~~

this Society, or District Director of this Society. Any member of the governing board of a component society which serves in these capacities, shall not, as a Commissioner, participate in deliberations pertaining to a grievance involving a member of that component society or cast a vote in respect thereto.

15.20 JUDICIAL DISTRICTS There shall be seven Judicial Districts formed by grouping component societies as follows:

District 1 Wayne

District 2 Macomb, Oakland. St. Clair

District 3 Ingham, Livingston, Monroe, Shiawassee, Washtenaw

District 4 Bay, Iosco-Arenac, Genesee, Gratiot, Huron, Isabella-Clare, Lapeer, Midland, Saginaw, Sanilac, Tuscola

District 5 Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Jackson, Kalamazoo, Lenawee, St. Joseph, Van Buren

District 6 Barry, Clinton, Ionia-Montcalm, Kent, Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana, Ottawa

District 7 Alpena-Alcona-Presque Isle, Chippewa-Mackinac, Delta, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central Counties (Crawford, Gladwin, Kalkaska, Montmorency, Otsego, Roscommon), Northern Michigan (Antrim, Charlevoix, Cheboygan, Emmett), Ogemaw-Oscoda, Ontonagon, Schoolcraft, Wexford-Missaukee

15.30 NOMINATIONS On or before July 15 each year, the Chair of the Board of Directors shall, with the advice and consent of the Board of Directors, appoint a Nominating Committee composed of seven members of the Board of Directors. Such Nominating Committee shall select from the voting members in good standing of the Society in each Judicial District at least twice as many nominees for the office of Judicial Commissioner as are to be elected in such year from such District. After obtaining the consent of such nominees to become candidates, the Nominating Committee shall submit its list of nominations to the Secretary of the Society on or before September 1st each year. Within ten days thereafter, the Secretary of the Society shall post a list of such nominations in a conspicuous place in the headquarters building of the Society and shall mail a list of such nominations to the secretary of each component society and shall give notice to the secretary of each said component society that the voting members of this Society within the several Judicial Districts have the right to make additional nominations by petition as hereinafter set forth. Promptly upon receipt of such notice and list of nominations, the secretary of each component society shall make such nominations known to the voting members thereof in such manner as shall be determined by the component society. Additional nominations may be made by petition signed by not less than twenty-five voting members in good standing in any Judicial District. Such nominating petitions shall be filed with the Secretary of this Society not later than October 15.

15.40 BALLOT ELECTION Under the direction of the Secretary of the Society, ballots shall be prepared for each Judicial District from which a member of the Commission is to be elected. On or before November 10 each year in which a member of the Commission is to be elected from such district, the Secretary of the Society shall send a ballot containing the names of all nominees, arranged in alphabetical order, to each voting member in good standing of the Society in such Judicial District. Ballots shall be marked and returned to the office of the Society no later than December 1 and any ballot bearing a return date later than such date shall not be counted. Each ballot, to be valid, must be voted for neither a greater nor a smaller number of nominees than are to be elected from such district at such election. The ballot furnished to voting members shall have printed upon it a copy of the preceding sentence.

The valid ballots so cast shall be tabulated and the results certified by the Secretary of the Society. In case of a tie vote, the winning candidate shall be determined by lot under the supervision of the Secretary. Those elected shall be notified by the Secretary and the names of those elected shall be made known to the members of the Society through publication in the Journal of the Society or by such other means as shall be directed by the Board of Directors.

15.50 TERMS OF OFFICE At the election held in the year 1965, four members of the Commission shall be elected from District 1, and one each from District 2, 3, 4, 5, 6 and 7. At the first meeting of the Commission following the election in 1965, it shall be determined by lot that two of the members elected from District 1 shall serve for a term of three years each, one for a term of two years, and one for a term of one year. Thereafter, one member of the Commission shall be elected annually from District 1 to serve for a three year term, provided, however, that in the year 1968 and each third year thereafter, two members shall be elected from District 1 to serve for terms of three years each. It shall also be determined by lot at such meetings that two of the members elected from Districts 2, 3 ,4, 5, 6, and 7 shall serve for terms of three years each, two for terms of two years each and two for terms of one year each. Thereafter, one member of the Commission shall be elected annually from each of Districts 2, 3, 4, 5, 6, and 7 in which an elective term expires, such election to be for a term of three years.

15.60 VACANCIES Whenever a vacancy occurs as the result of the death or resignation of a Commissioner or from any other cause, the President of the Society shall have the authority, acting with the advice of the Regional Directors of the Judicial District affected, to appoint a Commissioner from the district affected, such appointee to serve until the next election of

~~Commissioners at which time a Commissioner shall be elected to serve for a remainder of the unexpired term.~~

~~15.70 ORGANIZATION OF THE COMMISSION—The Commission shall meet as soon as feasible after each annual election and at such meeting select a Chair, a Vice Chair, and such other officers as may be deemed desirable. The terms of such officers and their duties and responsibilities shall be as determined by the Commission.~~

~~15.80 POWERS AND DUTIES—The Judicial Commission shall have:~~

~~15.81 Authority to make binding interpretations of the Constitution and Bylaws of this Society and of the several component societies as they pertain to matters of ethics, mediation, grievance and discipline.~~

~~15.82 Authority to make ethical interpretations and decisions in accordance with the standards of the American Medical Association.~~

~~15.83 Sole appellate powers at the state level in all matters relating to ethics, professional conduct, mediation and discipline of members of component societies.~~

~~15.84 The power to entertain and exercise original jurisdiction in matters pertaining to ethics, mediation, conduct of members or discipline of members when requested to do so by any component society or by any member in good standing of this Society.~~

~~15.85 The power and authority to make and promulgate from time to time, rules and regulations governing all procedures pertaining to ethics, grievances, mediation, professional conduct and discipline of members, which rules and regulations shall be binding upon all component societies.~~

~~15.86 The power and authority to appoint such committees and to adopt such rules, regulations and procedures as, in the sole judgment of the Commission, are deemed desirable in carrying out the functions and purposes of the Commission.~~

16.00 COMMITTEES/TASK FORCES OF THE SOCIETY

16.10 STANDING COMMITTEES—The Board of Directors shall designate standing committees of the Society to deal with ongoing subjects. The chair and members shall be appointed by the Board of Directors upon recommendation of the Chair of the Board of Directors. Committee chairs shall be appointed to serve for a term of two years. Members shall be appointed to serve two-year staggered terms, and be eligible for re-appointment.

The Chair of the Board of Directors shall appoint at least one Board member to each standing committee. The Board member shall be a voting member of the committee. The Board member shall be expected to attend committee meetings, participate in committee activities, and interpret to the Board of Directors the committee's recommendations that come before it via special reports.

If necessary, a standing committee may appoint one or more of its members to research a subject. The subgroup shall report its findings to the standing committee.

Standing committees shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. Each standing committee shall submit an annual summary of its activities, without recommendations, to the House of Delegates.

16.20 LIAISON COMMITTEES—The Board of Directors shall designate liaison committees to carry out MSMS liaison relationships with selected organizations and agencies. The chair and members shall be appointed by the Board of Directors upon recommendation of the Board Chair. Committee chairs shall be appointed to serve for a term of two years. Members shall be appointed to serve two- year staggered terms, and be eligible for reappointment.

The Chair of the Board of Directors may appoint a District Director to selected liaison committees. The District Director shall be a voting member of the committee, and shall be expected to attend committee meetings, participate in committee activities, and interpret to the Board of Directors the committee's recommendations that come before it via special reports.

If necessary, a liaison committee may appoint one or more of its members to research a subject. This subgroup shall report its findings to the liaison committee.

Liaison committees shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. Each liaison committee shall submit an annual summary of its activities, without recommendations, to the House of Delegates.

16.30 TASK FORCES—The Board of Directors shall create task forces as needed for specific assignments. Each task force shall be charged to study certain problems and to recommend courses of action to the Board of Directors. The chair shall be appointed to serve for a term of two years. The members shall be appointed by the Board of Directors upon recommendation of the Board Chair.

Task forces shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and

informational reports as necessary to keep the Board of Directors informed. The action of the task forces may be included in the Board of Directors Annual Report to the House of Delegates, if the Board Chair deems it appropriate.

17.00 OFFICERS

17.10 TERM OF OFFICE—Except as herein otherwise provided, officers shall take office immediately after the election and shall serve until the next Annual Session and until their respective successors shall have been elected. Regional Directors shall serve for three years and may not serve more than three consecutive terms, provided, however that a Regional Director may serve additional terms after an absence of at least one year.

A physician may not serve on the Board of Directors for more than 12 years in any capacity. The slotted, one-year positions for the Student Section, the Resident and Fellow Section, and the Young Physician Section will not be counted in the lifetime aggregate of 12 years.

17.20 INDUCTION OF PRESIDENT—At the Annual Session of this Society, next following election, the President-Elect shall be installed into and assume the office of the President, and shall serve until a successor takes office. The assumption of office shall take place in a General Meeting of the Society as a whole or in a meeting of the Annual Session of the House of Delegates.

17.30 PRESIDENT—The President shall be the principal spokesperson for the Society, communicating to the membership and the public the official action and policies of the organization. The President shall be the principal officer to liaison with component societies, and to report on the conditions and concerns of the membership. The President shall preside over the General Meeting of the Society and shall deliver the President's Address to the House of Delegates and participate in its deliberations but without vote.

The President shall be an ex officio member of the Board of Directors and its Executive Committee with power to vote therein.

The President shall perform such other duties as are imposed by the Constitution and Bylaws of this Society.

17.40 PRESIDENT-ELECT-DUTIES-SUCCESSION—
The President-Elect shall act for the President in the President's absence or disability. Should the office of President become vacant, the President-Elect shall succeed to the presidency for the unexpired term. Should the office of President thereafter again become vacant, the Board of Directors at a regular or special meeting, shall elect a President to serve until the next Annual Session of the Society.

The President-Elect shall be an ex officio member of the Board of Directors with the right to vote therein.

17.50 CHAIR OF THE BOARD—The Chair shall preside at all meetings of the Board of Directors and its Executive Committee and direct and supervise the preparation of the agenda for the meetings of the Board and the Executive Committee. The Chair shall consult with the Presidents and Chief Executive Officer as necessary and appropriate on behalf of the Society.

The Chair of the MSMS Board shall be familiar with the day-to-day operations of the Society and its executive staff, to provide advice and guidance regarding the implementation of policy.

17.60 VICE-CHAIR—The Vice-Chair of the Board shall preside at meetings of the Board in the absence of the Chair or at the Chair's request, and shall perform such other duties as custom and parliamentary usage require.

In the event the office of Chair is vacated through death or resignation, the Vice-Chair shall become Chair Pro Term until the next meeting of the Board when a new Chair shall be elected.

17.70 TREASURER—The Treasurer, under the direction and control of the Board of Directors, shall be the custodian of all the invested funds and the securities of the Society. The Treasurer shall be accountable through the Board of Directors to the Society. The Board of Directors shall cause an annual audit of the accounts to be made. The Treasurer shall be bonded in amount considered sufficient by the Board of Directors, the cost of such bond to be paid from the funds of the Society. The Treasurer shall perform such other duties as are imposed by the Constitution and Bylaws of the Society.

17.80 SECRETARY—The Secretary shall be a member of the Society and shall serve as the recording officer of the House of Delegates and the Board of Directors.

The Secretary, in addition to having the rights and duties ordinarily devolving on the secretary of a corporation by law, custom of parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, shall perform the following specific duties unless otherwise directed or assigned by the Board of Directors.

17.81 Perform ceremonial duties, including the administering of the oath of office to the incoming President.

17.82 Serve as official contact with the component medical societies concerning memberships and dues transfers.

17.83 Review requests for the use of the MSMS mailing list and authorize its use.

17.84 Serve as an official MSMS signatory for official regulatory and governmental documents.

17.85 Be available to the Chief Executive Officer and staff for consultation and advice on day-to-day staff problems.

17.90 CHIEF EXECUTIVE OFFICER—There shall be Chief Executive Officer, not necessarily a doctor of medicine or a member of the Society, who shall be designated by contract approved by the Board of Directors on an annual basis and who shall be remunerated in an amount which shall be fixed by the Board of Directors. The Chief Executive Officer shall be bonded in an amount considered sufficient by the Board of Directors, the cost of which shall be paid from the funds of the Society.

18.10 SPEAKER OF THE HOUSE OF DELEGATES—The Speaker of the House of Delegates shall preside at sessions of the House of Delegates. The Speaker shall perform such duties as custom and parliamentary usage require, and shall be a member of the Board of Directors and of its Executive Committee with the power to vote.

18.20 VICE-SPEAKER OF THE HOUSE OF DELEGATES—The Vice-Speaker of the House of Delegates shall assume the duties of the Speaker when the Speaker is absent at a meeting of the House of Delegates and at such other times as the House of Delegates or the Board of Directors (between Sessions of the House) shall determine. The Vice-Speaker shall be a member of the Board of Directors with the power to vote.

18.30 REMUNERATION—Each of the following officers, namely, the President, the Chair of the Board of Directors, the Secretary, the Treasurer, the Speaker of the House of Delegates, the President-Elect, and the Immediate Past President shall be entitled to draw from the funds of the Society a special expenses allowance in each year of incumbency of the office. The annual amount will be recommended by the Finance Committee to the Ways and Means Committee and approved or amended by the House of Delegates. These officers shall not be required to account to the Society for the expenditure of such funds, which shall be in addition to ordinary reimbursable expenses.

19.00 INDEMNIFICATION

19.10 The Board of Directors may indemnify any person for any liability, claim or expenses incurred or to be incurred, by reason of the fact that such person was or is a director, officer, employee, agent, or committee member of the Society, or was or is serving at the request of the Society as a director, officer, employee, agent, or committee member of a corporation, partnership, joint venture, trust, or other entity owned, in whole or in part, by the Society, or established by the Board of Directors of the Society. The extent and terms of such indemnifications shall be determined by the Board of Directors of the Society, either in advance or on a case by case basis; provided, however, such indemnification shall not be broader or more inclusive than permitted by law either at the time of the act or omission to be indemnified against or at the time of carrying out such indemnification.

20.00 SPECIALTY AND ETHNIC MEDICAL SOCIETIES

20.10 RECOGNIZED SPECIALTY AND ETHNIC MEDICAL SOCIETIES—To provide representation for the interests of medical specialty and ethnic medical societies within the structure of the Michigan State Medical Society, Michigan specialty and ethnic medical societies can be recognized and eligible for a delegate and alternate delegate to the MSMS House of Delegates provided the criteria as set forth in Section 20.20 has been met. A list of recognized specialty and ethnic medical societies will reside in the MSMS Chief Executive Officer's Office.

20.20 CRITERIA—Specialty and ethnic medical societies that wish to be included as a recognized specialty or ethnic medical society must meet the following criteria: a) be statewide in scope, with a minimum of one meeting per year; b) be a statewide specialty or ethnic medical society at least five years old; c) have 25 or more active physician members of whom 50 or 50 percent or more maintain their membership in MSMS; and d) be approved by the House of Delegates.

The governing body of the specialty and ethnic medical society must take formal action requesting delegate representation by sending a letter to the MSMS Board of Directors. The Board would then determine if the society meets the criteria and, if so, make a recommendation to the House of Delegates.

The method of determining whether the specialty or ethnic medical society meets the membership criterion outlined in this section shall be the responsibility of the MSMS Board of Directors.

20.30 RESIDENT AND FELLOW SECTION—To provide representation for the interests of residents and fellows within the structure of the Michigan State Medical Society, there shall be a Section on Residents and Fellows, composed of resident physicians (physicians-in-training) who are residents in an AMA-recognized residency program in Michigan, fellows serving as their primary occupation in a structured educational program begun immediately upon completion of medical school, residency or fellowship training, and who are active members of MSMS, and of medical students after March 15 of their senior year.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to residents and fellows in Michigan.

At its annual meeting the Section shall elect a chair, a

vice-chair, a secretary, a delegate and an alternate delegate to the MSMS House of Delegates, each of whom shall serve for a term of one year.

At its annual meeting, the Section shall elect a representative to fill the residents' seat on the Board of Directors for a one-year renewable term to begin at the first Board of Directors meeting after the House of Delegates. If a vacancy in the residents' seat should occur during a term, the vacancy shall remain unfilled until the next term.

20.40 MEDICAL STUDENT SECTION—To provide representation for the interests of medical students within the structure of the Michigan State Medical Society, there shall be a Section on Medical Students, composed of students of each established medical school in Michigan who are student members of MSMS.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to medical students in Michigan.

At its annual meeting, the Section shall elect a Governing Council consisting of a chair, a vice-chair, a secretary, a member of the Michigan Delegation to the AMA, and a representative to the MSMS Board of Directors. These officers shall all serve for one year-renewable terms to begin after the House of Delegates.

The Section shall also elect delegates to the MSMS House of Delegates, each of whom shall serve for one year. There shall be one delegate for every 50 MSMS student members.

If a vacancy in any of the officers' positions should occur during the term, that seat shall be immediately filled by election as provided in the Student Section Bylaws, with approval of the Board of Directors.

20.50 ORGANIZED MEDICAL STAFF SECTION—To provide representation for the interests of hospital medical staffs and of other delivery systems within the structure of the Michigan State Medical Society, there shall be an Organized Medical Staff Section composed of MSMS members, one to be elected by and from the active voting physician members with clinical privileges of each JCAHO-accredited hospital in Michigan, and each other delivery system accepted by the Governing Council.

The purpose of this Section is to provide a direct means to address the relationship between MSMS members and organized medical staffs.

At its annual meeting, the Section shall elect a chair, a vice-chair, a secretary and two at-large members. It shall also elect one delegate and one alternate delegate to the MSMS House of Delegates, each of whom shall serve for a term of two years.

20.60 YOUNG PHYSICIANS SECTION—To provide representation for the interests of young physicians within the structure of the Michigan State Medical Society, there shall be a section on young physicians, composed of physicians under 40 years of age and/or professionally employed through eight (8) years after residency and fellowship training programs, who are active members of MSMS.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to young physicians in Michigan.

At its annual meeting the Section shall elect officers in accordance with the Bylaws of the MSMS Young Physicians Section and a representative to fill the young physicians' seat on the Board of Directors for a two-year renewable term to begin at the first Board of Directors meeting after the House of Delegates. If a vacancy in the young physicians' seat should occur during a term, a representative chosen by the Young Physicians Governing Council may be appointed to fill the term, with approval by the Board of Directors.

20.70 INTERNATIONAL MEDICAL GRADUATES SECTION—To provide representation of the interests of international medical graduates within the structure of the Michigan State Medical Society, there shall be a section for international medical graduates composed of international medical graduates who are members of MSMS.

The purpose of this Section will be to provide a forum within the organizational structure of this Society for the study and consideration of matters of special interest and significance to international medical graduate in Michigan.

At its annual meeting the Section shall elect a delegate and alternate delegate to the MSMS House of Delegates.

21.00 REFERENDUM

21.10 REFERENDUM AT SOCIETY MEETING—Any General or Special Meeting of this Society as a whole, may, by a two-thirds vote of the voting members present, order a general referendum upon any question pertinent to the purposes and objects of the Society, organized medicine, or health of the public; provided, however, that a quorum at such General or Special Meeting shall consist of not less than 300 voting members of the Society who are in good standing.

21.20 REFERENDUM BY HOUSE OF DELEGATES—The House of Delegates by a majority vote may submit any question pertinent to the community and organized medicine to the membership of the Society for its vote, such vote to be taken by county societies and certified by their respective secretaries to the Secretary of this Society.

Two-thirds of the vote cast shall be required to carry

the question.

22.00 SEAL

22.10 SEAL—The Society shall have a common seal. The power to change or renew the seal shall rest with the Board of Directors.

23.00 EMERGENCY

23.10 EMERGENCY ACTION BY BOARD OF DIRECTORS—When prompt speech or action is imperative, authority to speak or act in the name of this Society is vested in the Board of Directors or the Executive Committee of the Board of Directors.

24.00 DEFINITION OF SESSION AND MEETING

24.10 SESSION—A session shall mean all meetings at any one call.

24.20 MEETING—A meeting shall mean each separate convention at any one session.

25.00 AMENDMENTS

25.10 AMENDMENTS-PROCEDURE—These Bylaws may be amended by a majority vote of the delegates seated, after the proposed amendment is laid on the table until the next session, unless by consent of 75 percent of the delegates present and voting, such time requirement is waived, in which event the said amendment may be voted upon at the next meeting of the House of Delegates. The amendment or amendments to these Bylaws become effective immediately upon adoption.

~~Official Procedures for the Judicial Commission~~

~~of the Michigan State Medical Society~~

~~(ADOPTED APRIL 14, 1971, AND AMENDED JANUARY 31, 1973)~~

~~In accordance with Paragraphs 15.80 through 15.86 of the Bylaws of the Michigan State Medical Society, the Judicial Commission of the Michigan State Medical Society does hereby declare the following rules, regulations and procedures to govern all matters pertaining to ethics, grievances, mediation, professional conduct, and discipline binding on the Michigan State Medical Society and each of its component medical societies.~~

~~I. Disciplinary Procedure for Component Medical Societies~~

~~The procedure to be followed by each component society on its complaints of original jurisdiction with respect to the censure, suspension or expulsion of a member shall be in accordance with Paragraphs 7.00 through 9.30 of the Bylaws of MSMS. The procedure to be followed by each component society in cases referred to it by the Judicial Commission shall be expressly subject to the procedural rules hereinafter set forth.~~

~~II. Mediation Committees for Component Medical Societies~~

~~The procedure to be followed by each component medical society on its complaints of original jurisdiction regarding grievances of non-members shall follow the procedural outline in Paragraphs 10.00 through 10.40 of the Bylaws of MSMS. The procedure to be followed by each component society in cases referred to it by the Judicial Commission shall be expressly subject to the procedural rules hereinafter set forth.~~

~~III. Procedural Rules for the Judicial Commission involving ethics, grievances, mediation, professional conduct, and discipline of members of the Michigan State Medical Society~~

1. ~~All questions of ethics referred to the Judicial Commission must be in writing. No matter under active litigation will be accepted for processing. Matters involving alleged infractions of civil and criminal law are generally outside the scope of the Judicial Commission.~~
2. ~~When a proper complaint is received, it shall be recorded and forwarded when appropriate to the component medical society of which the physician named is a member.~~
3. ~~The component medical society shall process the complaint, review the case, determine its merits, and report its conclusions in writing to the complainant with copies to the physician involved and to the Judicial Commission.~~
4. ~~The Judicial Commission requires that a complainant and the physician involved be informed of the right of appeal to the Judicial Commission from the final ruling of a component society.~~
5. ~~All properly entered complaints shall be processed by the component medical society within 60 days. Each complaint and its investigation shall be kept confidential except to members of the Judicial Commission or its agents and the members of the committees of the component medical societies investigating the complaint.~~
6. ~~Jurisdiction over complaints received by the Judicial Commission and forwarded to a component medical society rests with the component medical society designated by and at the discretion of the Judicial Commission. Apart from supervisory function of the judicial mechanism, the Judicial Commission serves as an appellate tribunal except under circumstances deemed by the Judicial Commission such that regional jurisdiction by a component medical society would not properly serve the purposes of the complainant, the physician involved, or the public or profession in general. Such discretionary powers are set forth hereafter under the section of this document V. "Jurisdiction of the Judicial Commission."~~
7. ~~Complaints from a component medical society directed to the Judicial Commission which concern matters about another component society shall be processed by the Judicial Commission in a manner similar to a complaint from a member individual but shall remain the proper business of the Judicial Commission itself without reference.~~

~~IV. Procedure for Appeal to the Judicial Commission~~

1. ~~A member of a component society censured, suspended, or expelled by his or her county society may appeal from the action of such component society to the Judicial Commission of MSMS within a period of 60 days succeeding the date of such censure, suspension or expulsion. Appeals shall be in writing and be filed within said period of 60 days with the Chair of the Judicial Commission at the Michigan State Medical Society headquarters office. Said appeal shall be accompanied by a record of the entire proceedings before the component society duly certified by its secretary, provided the Chair of the Judicial Commission may, in his or her discretion, extend the time of the appellant to file such record. Upon the filing of such an appeal, the Chair shall present it to the next subsequent meeting of the Judicial Commission. Written notice of not less than 10 days of the time and place of the hearing shall be given to the appellant member and the president and secretary of~~

the component society involved.

2. In hearing appeals, the Judicial Commission shall review all questions of procedure, and may, in its discretion, review the evidence contained in the record of the original proceedings held before the proper committee of the component society. The Judicial Commission may make findings of fact contrary to, or in addition to, those made by the committee of the component society. Such findings may be based on the evidence adduced by the committee of the component medical society, either with or without the taking of evidence by the Judicial Commission. The Judicial Commission may, for the purpose of making such findings or for other purposes in the interest of justice, take additional evidence of or concerning facts material to the questions involved, or may, for such purpose, appoint a committee of its members to act as referees for the taking of such evidence.

   (a) Such referees shall render a report in writing to the Judicial Commission, which report shall contain a clear statement of the facts found by the referees from the testimony or evidence adduced.

3. The Judicial Commission may affirm, reverse, or modify the decision of the proper committee of the component society so reviewed or make such other disposition of the proceedings as it may deem proper.

4. The Judicial Commission may exert, through a committee thereof, prior to the hearing being held on the appeal, all proper efforts at conciliation and compromise.

5. The MSMS may be represented by its attorney to advise the Judicial Commission. The appellant may likewise be represented by his or her attorney.

6. The decision of the Judicial Commission shall be final and bind the appellant member and the component society unless further appealed to the American Medical Association as set forth hereunder.

V. Jurisdiction of the Judicial Commission in respect to all matters relating to discipline of members of MSMS

1. The Judicial Commission, within its sound discretion, may take original jurisdiction of any question appropriately referred to it and conduct hearings thereon without referral to a component society.

2. The procedure in original jurisdiction hearings shall follow rules set forth in the MSMS Bylaws, paragraphs 8.40 through 8.70.

3. In cases of original jurisdiction, the Judicial Commission will report its recommendations to the governing body of the component society for implementation.

4. Any decision of the Judicial Commission affirming a decision of a component medical society which disciplines a member or a component medical society itself so disciplined may be appealed to the appropriate agency of the American Medical Association upon such terms, conditions and in accordance with such procedure as may be set forth in the Constitution and Bylaws of the American Medical Association. Any decision of such agency of the AMA shall be final and binding upon all parties of the appeal.

5. The decision of the component medical society if not appealed or of the Judicial Commission if original or appealed for the settlement of a complaint, although binding upon a member physician, cannot be made binding upon a non-physician. Since, however, the submission of a complaint by a lay person to the judicial mechanism or settlement is an act of good faith, it can be assumed that the recommendation of the Judicial Commission or the proper committee of a component medical society will be accepted by non-physicians.

VI. Grievances Against Non-Member Physicians

The Judicial Commission is without jurisdiction over physicians who are not members of MSMS but recognizes the obligation of organized medicine to act in the best interests of those doctors and of the public. The Commission and the component medical societies will undertake to mediate grievances and matters of ethics and professional conduct when requested by the person or persons in controversy with the non-member M.D. physician, providing the latter agrees to accept the services of the Society in this aspect and agrees to abide by its procedural rules, and to the condition that the Society reserves the right at its discretion, when appropriate, to disclose pertinent information to the Michigan Board of Medicine. Lacking this agreement or such approval from the non-member, the Society may at its discretion forward the complaint as received to the Michigan Board of Medicine.

The procedures to be followed shall, to the extent relevant, be those set forth in the Official Procedures promulgated April 14, 1971, including the underlying MSMS Bylaws section recited therein. The original jurisdiction for component societies noted in the Official Procedures shall be emphasized in these mediations. If the non-member and the complaining party reside in different counties, the component society jurisdiction within which the non-member physician has his or her principal practice shall be the venue of the hearing unless the Judicial Commission exercises its power to take original jurisdiction. The procedural rules set forth in Article II of said Official Procedures shall be adhered to as literally as possible. The appeal procedures of Article IV, save for those sections which are patently irrelevant, shall likewise be controlling.

VII. The Judicial Commission expressly reserves to itself the jurisdiction to amend these rules from time to time as it deems appropriate, and to publish same.

These rules of procedure accepted and promulgated by the Judicial Commission of the MSMS on this date hereby govern the Michigan State Medical Society in all such matters and any provisions of the Constitution and

~~Bylaws of MSMS in conflict therewith shall have no effect.~~

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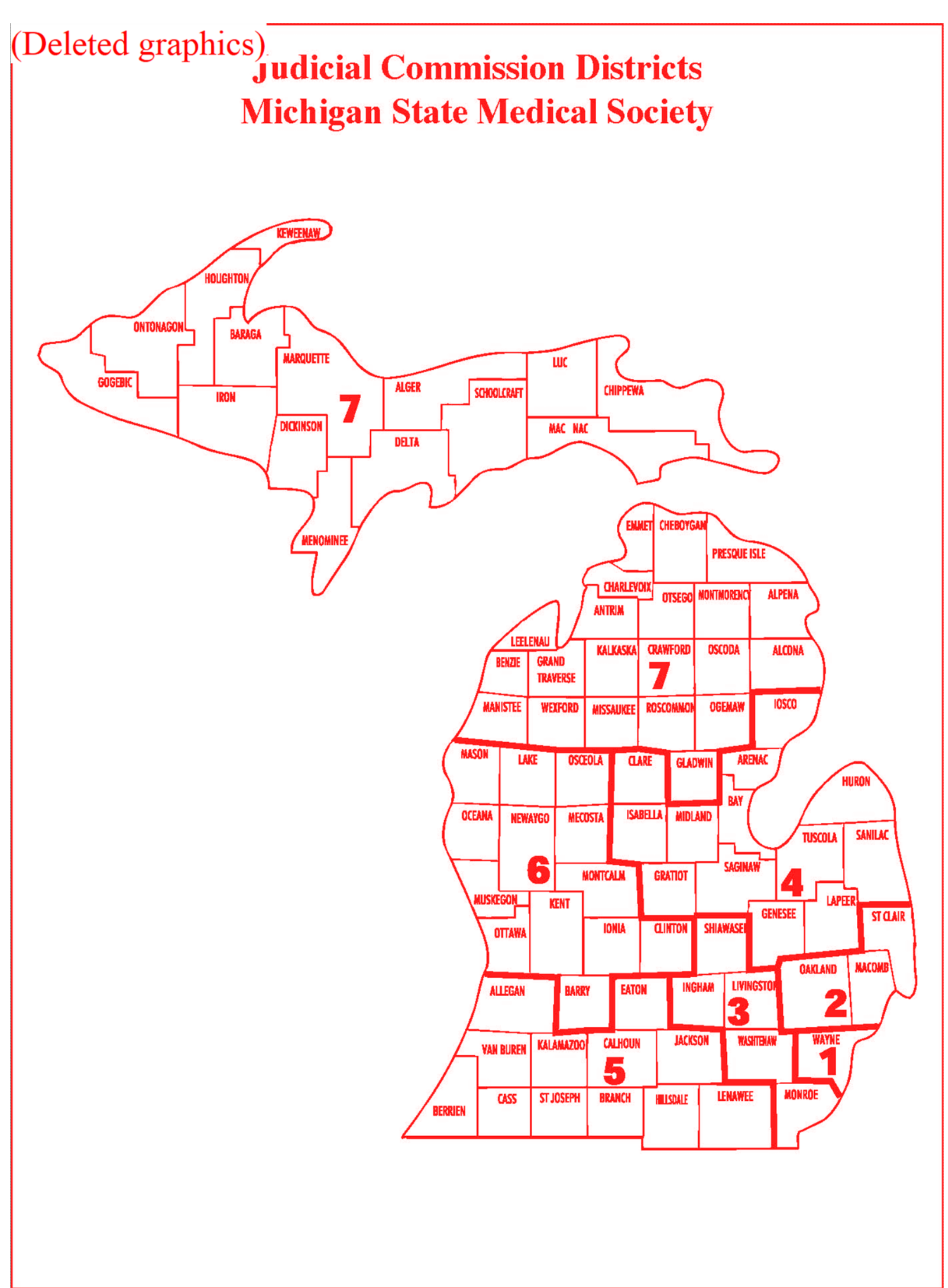

ACTION REPORT #9-26 OF THE BOARD OF DIRECTORS

SUBJECT: Board of Directors
14-25 - Rotation of MSMS House of Delegates Meeting Location
16-25 - County and State Medical Society Alliance
47-25 - Study Medical Society Structures

REFERRED TO: Reference Committee on Internal Affairs, Bylaws, and Rules

HOUSE ACTION:

RECOMMENDATION: THAT THE 2026 HOUSE OF DELEGATES CHANGE THE SIZE OF THE MSMS BOARD OF DIRECTORS FROM 36 TO 13 SKILL-BASED MEMBERS WITH INTENT TO HAVE DIVERSITY OF GEOGRAPHY, SPECIALTY, AND PRACTICE.

The Michigan State Medical Society (MSMS) faces significant structural, financial, and membership challenges that threaten its long-term viability. The Reorganization Task Force, appointed by the MSMS Board of Directors following resolutions adopted by the 2025 House of Delegates, was charged with developing recommendations to modernize governance, improve efficiency, and strengthen engagement across the organization.

After extensive review and deliberation, the Task Force unanimously recommends a series of comprehensive structural changes designed to position MSMS for the next decade of success.

MSMS is a significantly smaller organization than it was 25 years ago, but the governance size has not adjusted accordingly. Currently, the MSMS Board of Directors has 36 members, 18 Regional Directors, six Designated Directors, seven Officers, three Sections, and two ex-officio from the BCBSM Board.

Non-profit sector data shows a median board size of around nine, with an average of 13, and a trend towards smaller boards (BoardSource; Urban Institute). The American Society of Association Executives (ASAE) Foundation adds that right-sizing boards improves strategic performance. Their study of 1,583 associations found that effectiveness depends on aligning board size with mission scope, emphasizing strategy and skills over representation. Smaller, skills-based boards are recommended for profit-oriented governance models. Non-profits under $3 million in revenue, like MSMS, typically have seven to 13 board members. Larger boards with 25 – 40+ are usually reserved for national, multi-division organizations. For example, the Texas Medical Association has 18 Board members, 50 percent less than MSMS with 10 times the revenue and 15 times the members. The American Medical Association has 21 Board members with 150 times the revenue.

With declining membership and revenue there is a need to modernize not just the size, but the composition of the board to reflect these financial challenges. This would include a change from representational governance to skill-based governance. All board members are physicians, but

with distinct leadership, finance, and strategic skills. Intent would also include diversity of geography, specialty, and practice.

The officer structure would have a Chair to lead the board and set strategic direction, Vice-Chair to oversee initiatives and succession, Treasurer/Secretary to direct financial strategy and act as the recording officer, and President and President-Elect to represent MSMS internally and externally.

The current board term is three, three-year terms (nine years) plus three more years if holding an officer position (maximum of 12 years). MSMS has annual elections for President, President Elect, Immediate Past President, Treasurer, and Secretary (maximum 12 years).

President-Elect and Board members would be elected by members. Officers/Nominating Committee will administer the application process. Chair and Vice Chair would be elected by the Board annually with two-year limits. The Treasurer/Secretary would also be elected by the Board with a six-year limit. Terms would be staggered.

Current Board members not chosen for the new Board would be given priorities for leadership positions in the new Ad Hoc Board Advisory Committee, MSMS Committees, Task Forces, and other Boards.

In summary a smaller, more skill-based board with diversity of geography, specialty, and practice type of 13 will strengthen efficient decision-making, align governance with current resources, and allow a focus on strategic renewal and membership recovery. These changes further position the society for long-term sustainability.

Attachment

Task Force on Reorganization's Report (see Miscellaneous Tab)
Resolution 14-25
Resolution 16-25
Resolution 47-25
Proposed Changes to Bylaws

1 **RESOLUTION 14-25**
2
3 **Title:** Rotation of MSMS House of Delegates Meeting Location
4
5 **Introduced by:** E. Chris Bush, MD, for the Wayne County Delegation
6
7 **Original Author:** E. Chris Bush, MD
8
9 **Referred To:** Reference Committee C
10
11 **House Action:**
12

13
14 Whereas, the MSMS House of Delegates (HOD) is an annual meeting for all the Delegates from
15 across the state, and
16
17 Whereas, the MSMS HOD location has traditionally rotated to various locations across the state to
18 be more equitable for the attendees, and
19
20 Whereas, the majority of the Delegates attending the MSMS HOD each year are from the counties in
21 southeast Michigan, and
22
23 Whereas, the MSMS HOD approved Resolution 03-22 which states that the MSMS will continue to
24 rotate the annual HOD meeting between the east and west side of the state, but at least once every
25 12 years, the western meeting shall take place in a northern county, and
26
27 Whereas, moving to a one-day meeting in Lansing, that starts at 10:00 a.m., was done as a cost-
28 reduction measure for MSMS, the costs have been shifted to the Delegates who should have a say
29 in where the annual meeting is held, and
30
31 Whereas, the overall costs of a one-day meeting would be expected to be similar regardless of the
32 geographical location; therefore be it
33
34 RESOLVED: That the MSMS House of Delegates shall return to the rotation of alternating meetings
35 between an outstate venue and a southeast Michigan venue with the 2026 meeting to be held in the
36 Detroit area.
37

38
39 WAYS AND MEANS COMMITTEE FISCAL NOTE: $50,000

	2024/2025 Lansing Actual from Hotel Bill	**2026 Dearborn Actual Proposal – The Henry**
Delegate Beverage and Lunches	$10,400	$13,000
Presidents Reception	$5,400	$7,700
Conference Rooms Rental	$7,800	$29,000
Overnights Students, Staff and Board	$5,300	$22,500
Staff Meals	$2,000	$4,400
Staff Mileage	$0	$3,500
	$30,900	$80,100

Fiscal notes are estimates and should be used as one reference point in determining support or opposition of any resolution.

Of note:

- This comparison does not include the AV contractor, Audience Response System, Signs, Awards, Online Forum, Election Ballot or other meeting costs that do not differ based on location. This cost is approximately $20,000.
- The Henry was used as one comparison for purposes of developing a fiscal note because they are one of few locations in the Detroit area that can accommodate our dates, the combination of number of overnight rooms, number of conference rooms and the House set-up all at one-time. MSMS has received prior proposals from other hotels including the Motor City Casino and the Suburban Showcase which were both significantly more expensive than the Henry. And the Somerset, Novi Sheraton, Southfield Weston, all being either more expensive or lacking enough space for the general session. As regular practice, MSMS always requests multiple proposals for off-site events and would work with individual facilities and the CVB to do so if a Detroit location is needed.
- The Henry proposal includes room rental of $58,000. Only half was used in the fiscal note as staff expects some ability to negotiate contract. Similarly, the food and beverage minimum is $30,000 but only $25,000 is reference in the fiscal note as that is also an area of potential negotiation. That proposal is attached.
- Event documentation involved 3 different pieces. The contract locks in the date, space, pricing for the room rental and overnight rooms, food and beverage minimums, and cancelation clause. The Banquet Event Orders details room set-up, AV, and quantity and selections for food and drink. This will contain some pricing for those items. The final bill will itemize room set-up, AV, and quantity and selections for food and drink. The amounts will differ from the Banquet Event Order as onsite changes occur like additional easels were needed, extra lunches were ordered and typically some food and beverages are charged on consumption. These will be reflected in the final bill.
- Events are also subject to several taxes. As indicated in the Henry proposal, overnight rooms are subject to 6 percent state tax and 8 percent occupancy tax. Food, beverages and rental costs are subject to 24 percent taxable service charge and 6 percent state sales.
- Set up for the House begins at 12:00 noon the day before the meeting. Tear down is completed around 9:00 pm that evening. Staff are allowed to stay the night Friday and Saturday if they wish for the completion of the event and safety of our employees.
- MSMS manages the House of Delegates costs as frugally as possible. Many state associations utilize event management companies which range from $20,000 - $50,000 to assist in preparing for the meeting and staffing onsite. This includes work like loading, unloading, setting up, testing and tearing down the general session room for 300, registration, meeting rooms, event spaces, exhibits. MSMS staff balances this while maintaining their normal day-to-day workloads. Much of the preparation for the House is completed after work hours including the weekends.
- Room calculations

  $250 (includes all tax)
  25 staff/contractors x 2 nights = $12,500
  10 students = $2,500
  10 board x 2 nights = $5,000
  10 board x 1 night = $2,500

The information contained in the fiscal note was prepared by Rebecca Blake, Certified Meeting Planner (CMP) with 25 years of meeting planning experience with the House of Delegates, Annual Scientific Meeting, Board meetings, and thousands of other MSMS events.

Relevant MSMS Policy

Annual Financial Report
Please refer to the Annual Financial Report to the House of Delegates for more information on the organization's finances.

House of Delegates
MSMS continue to rotate the HOD meeting between the east and west 36 side of the state, but at least once every 12 years, the western meeting shall take place in a 37 northern county.

Relevant AMA Policy
None

Sources:

1. Past MSMS HOD Locations: 2010 - Dearborn, Michigan; 2011 - Kalamazoo, Michigan; 2012 - Dearborn, Michigan; 2013 - Grand Rapids, Michigan; 2014 - Dearborn, Michigan; 2015 - Grand Rapids, Michigan; 2016 - Dearborn, Michigan; 2017 - Grand Rapids, Michigan; 2018 - Dearborn, Michigan; 2019 - Kalamazoo, Michigan; 2020 - Dearborn, Michigan; 2021 – Virtual Meeting during COVID; 2022 - Kalamazoo, Michigan; 2023 - Dearborn, Michigan 2024 - Lansing, Michigan; 2025 - Lansing, Michigan
2. Approved MSMS Resolution 03-22 introduced by Ottawa County https://www.msms.org/hodresolutions/2022/3.pdf

RESOLUTION 16-25

Title: County and State Medical Society Alliance

Introduced by: Megan Edison, MD, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee C

House Action:

Whereas, MSMS has had declining membership and revenues, and

Whereas, this loss of membership revenue impacts all physicians across the state as our legislative impact and outreach is limited, and

Whereas, MSMS has significantly restructured itself into a relevant, physician-led, financially viable organization focused on the core mission, and

Whereas, MSMS is aggressively working to regain large group membership to increase membership revenue, diverse physician voices, and our political footprint, and

Whereas, MSMS bylaws and county medical society bylaws require joint membership of physicians in counties with an active medical society, and

Whereas, the number of active county medical societies has diminished significantly over the years so that some counties no longer charge dues while others charge dues, and

Whereas, MSMS has failed to secure large group memberships reportedly due to the cost of required county membership dues, and

Whereas, county medical societies have lost county members reportedly due to cost and/or value of the required MSMS membership, and

Whereas, creative efforts by MSMS to avoid county membership and membership "deals" recommended to and by county medical societies have created undue stress on this relationship as well as test the bylaws of both organizations, and

Whereas, the 10 percent billing fee charged to county medical societies for the required dual membership has proved financially challenging to county societies, and

Whereas, the historical financial binding of county and state medical societies may now be a hinderance to our mutual survival, and

Whereas, the survival and revival of all county medical societies benefits MSMS and Michigan physicians, as county medical societies are the voice to local politicians in a way lobbyists cannot achieve, and

Whereas, the survival and growth of MSMS is crucial to all Michigan physicians and our patients, as the only physician voice in Lansing representing all physicians, allopathic and osteopathic, of all specialties, and inclusive of all stages of their career and place of practice, and

Whereas, restructuring our state and county medical societies towards mutual growth and purposes will only strengthen organized medicine; therefore be it

RESOLVED: That MSMS create a task force of physicians across the state, in both county and state society leadership, to do the following:

1. Examine the history, finances, and bylaws of our county and state societies;
2. Be bold and creative in offering a unified solution to solve this historical issue, and future-proof our organizations so we can focus on our mission together;
3. Utilize MSMS legal counsel to aid in this effort by examining county medical society and state medical society bylaws and offering a clear plan on how to update county and state medical society bylaws to achieve the mutual goals; and
4. Present recommendations to county and state medical societies prior to the 2026 House of Delegates, with any MSMS bylaws changes presented for a first vote at that time.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy
None

Relevant AMA Policy
None

1 **RESOLUTION 47-25**
2
3 **Title:** Study Medical Society Structures
4
5 **Introduced by:** Paul Kocheril, MD
6
7 **Original Author:** Paul Kocheril, MD
8
9 **Referred To:** Reference Committee C
10
11 **House Action:**
12
13
14 Whereas, the MSMS Bylaws state the Board "shall have the custody and entire control of all funds
15 and property of the Society" and the House "shall transact all of the business of this Society not
16 otherwise specifically provided for," and
17
18 Whereas, in the past, occasional resolutions have lapsed into the financial responsibilities
19 assigned to the Board, and
20
21 Whereas, other state societies have clarified and streamlined their organizational structure
22 regarding medical policy and business/financial decisions, and
23
24 Whereas, the functioning of MSMS is critical to the future of MSMS and medicine in Michigan;
25 therefore be it
26
27 RESOLVED: That MSMS study the organizational structures, Constitution and Bylaws, and business
28 model of other state medical societies as potential options for improving the efficiency and
29 productivity of our organization.
30

31
32 WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,500-$5,000

Relevant MSMS Policy

ARTICLE IX—THE BOARD OF DIRECTORS

Section 2. - POWERS AND DUTIES—The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions.

14.00 THE BOARD OF DIRECTORS

14.60 DUTIES OF THE BOARD OF DIRECTORS—It shall be the duty of the Board of Directors:

14.61 To make careful inquiry into the condition of the profession in each county in the State. It shall have authority to adopt such methods as may be deemed most efficient for increasing interest in all existing component societies. It shall especially and systematically endeavor to promote friendly intercourse between doctors of medicine in the same locality. It shall make every effort to bring each reputable doctor of medicine in the State under the Society's influence;

14.62 To direct and control the publication of the Journal of the Michigan State Medical Society;

14.63 To provide and maintain such headquarters for this Society as may be required to conduct its business properly;

14.64 To render an Annual Report to the House of Delegates; and
14.65 At least every three years, review the composition of the Board of Directors including the geographical boundaries of the Regions making any recommendations in its discretion it deems necessary.
14.70 CONTROL OF FUNDS—The funds of this Society shall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.
14.71 The Board of Directors shall have the authority to borrow money upon the general credit of the Society. The Board of Directors shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Board of Directors shall authorize and empower the President or the Chair of the Board of Directors, and the Secretary or the Treasurer to execute such instruments as may be required.

12.00 HOUSE OF DELEGATES
12.90 POWERS AND DUTIES—As the legislative body of this Society, the House of Delegates shall have the power arid authority to adopt, institute, and carry out such methods and measures as it may deem to be in the best interests of the medical profession in Michigan. In the exercise of such powers and duties, but without limitation thereof:
12.91 It shall transact all of the business of this Society not otherwise specifically provided for.
12.92 It shall adopt rules and regulations for its own government and for the administration of the affairs of the Society.
12.93 It shall provide for the organization of Regions which shall be depicted on Exhibit A.
12.94 It shall concern itself with and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws, and the health of the public.
12.95 It shall be active in the education of the public in regard to medical research and scientific medicine.
12.96 It shall have the power to identify areas of concern and to instruct the Board of Directors to appoint committees or task forces to study or act on those areas. These committees or task forces shall report to the Board of Directors, which in turn shall report in the annual report of the Board of Directors to the House of Delegates. The House of Delegates shall itself have necessary internal committees, such as I) Credentials, 2) Rules of Orders of Business, 3) Constitution and Bylaws, and 4) Ways and Means. The seated House, by majority vote, reserves the right to instruct the Board of Directors to discharge a specific standing committee, liaison committee, or task force, and to require the Board of Directors to appoint an ad hoc committee with appointees nominated by the seated House. This ad hoc committee shall report through the Board of Directors to the House at the next session, and be discharged.
12.97 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.
12.98 It shall publish its minutes or a summary of its proceedings in the Journal of the Society.
12.99 It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge of hypothecation. It shall have the authority specifically to authorize the Board of Directors and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid.

Relevant AMA Policy
None

The Bylaws are being finalized by MSMS Legal Counsel and will be added as soon as possible. Delegates will be notified when they are available.

ACTION REPORT #10-26 OF THE BOARD OF DIRECTORS

SUBJECT: Revisions to the MSMS Policy Manual and the 2026 Sunset Report

REFERRED TO: Reference Committee C

HOUSE ACTION:

RECOMMENDATION: That the MSMS Board of Directors recommend to the 2026 MSMS House of Delegates approval of the attached additions to the MSMS Policy Manual and the 2026 Sunset report. Upon House approval, the updates will be placed in the Policy Manual on the MSMS website.

The MSMS Policy Manual Review Committee met virtually on February 24, 2026, to review existing policy slated for review pursuant to the MSMS sunset policy and the 2025 House of Delegates Resolutions and Board Action Reports. Following its review, the Committee voted to recommend that the MSMS Board of Directors recommend approval of the updates to the MSMS Policy and 2026 Sunset report.

At its meeting on March 18, 2026, the MSMS Board of Directors will vote to approve the updates to the MSMS Policy Manual and the 2026 Sunset Report and that upon House approval, the updates will be placed in the Policy Manual on the MSMS website.

Attachments
MSMS Policy Manual Updates
2026 Sunset Report

Policy Manual
Addendum to the 2025 Edition

CHILDREN AND YOUTH

Nutrition

Support for Michigan School Meals Program
MSMS supports federal and state efforts to adopt, fund, and implement universal school meal programs that include the provision of breakfast and lunch to all school-aged children and those enrolled in special education programs up to age 26, free of charge to families, regardless of income. (Res34-25)

CONTINUING MEDICAL EDUCATION

Decrease CME Requirements
MSMS supports legislative and/or regulatory relief to simplify and reduce the quantity of total CME and mandated training areas for physician licensure. (Res26-25)

ETHICS

Transparency

Resolution Authorship Transparency
MSMS supports the disclosure of conflicts of interest and disclosure of known same or similar resolutions in other states by authors of resolutions to the MSMS House of Delegates along with a process to easily collect and share that information on the respective resolutions in order to discloses any conflicts. Author conflicts of interest on the resolution submission form be listed within the MSMS notes at the bottom of the printed resolution in the HOD Handbook. (Res15-25)

FAMILY PLANNING AND SEX EDUCATION

Preserve Access to Contraceptives
MSMS supports the preservation of access to contraceptive services, including through Title X funds. MSMS opposes Title X eligibility restrictions that limit the ability of facilities that accept Title X funds to provide complete and accurate medical information and comprehensive care including pregnancy options counseling, referrals for abortion care, and abortion care. MSMS also supports state efforts to ensure that Title X care remains funded and accessible in Michigan. (Res76-17)
- Amended (Res07-25)

HEALTH CARE DELIVERY

Access

Standardizing Eye Report Forms to Improve Access to Vision Rehabilitation Services

MSMS supports standardizing the eye report form to improve access to vision rehabilitation services and remove barriers for individuals living with visual impairment. (Res17-25)

Prevention and Screening

Report on Breast Density Information
MSMS supports the 2023 United States Food and Drug Administration mandate to report breast density information in screening mammography reports. (Res04-25)

HEALTH CARE INSURANCE

Insurance Coverage for Supplemental Screening for Breast Cancer
MSMS supports mandatory insurance coverage for supplemental screening that is evidence- based and fits utilization guidelines for breast cancer with MRI and/or Ultrasound in patients with dense breast tissue, if supplemental screening is recommended by a patient's physician. (Res04-25)

Patient Choice of Physician
MSMS supports existing AMA policies, "Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901" and "Physician Penalties for Out-of-Network Services H-180.952. (Res23-25)

HEALTH INFORMATION TECHNOLOGY

Deepfake Technology and Harm to Physicians and Patients
MSMS supports the adoption of legislation and regulations aimed at enhancing the identification and mitigation of harmful and misleading deepfake content disseminated by internet service providers, social media platforms, and search engines, with a particular emphasis on protecting physicians and the integrity of medical practice. (Res10-25)

LICENSURE

Change to Regulations of Botulinum Toxin Usage
MSMS encourages regulators including, but not limited to, the Michigan Boards of Medicine and Osteopathic Medicine and Surgery and United States Food and Drug Administration, to recognize that the standard of care allows for the use of botulinum toxin more than 24 hours if refrigerated after reconstitution with bacteriostatic saline and in more than one patient per vial for cosmetic purposes. (Board Action Report #03-25, 2025 HOD, re: Res47-23)

Excessive Cost of Multi-State DEA Licensure
MSMS supports a national Drug Enforcement Agency licensure process with a single application and a single fee. (Res18-25)

Modernize Licensure Requirements for Unrestricted Licensure in Michigan
MSMS endorses the concept of requiring a physician to have completed either an Accreditation Council for Graduate Medical or American Osteopathic Association approved residency program or at least two years (ideally three years) of post-graduate training within the same specialty as a prerequisite for the granting of a new, unrestricted medical license to practice medicine in the state of Michigan. (Board Action Report #02-25, 2025 HOD, re: Res38-23)

MEDICAID

Equitable Medicaid Reimbursement
MSMS opposes all cuts in Medicaid reimbursement budgets and supports an increase in payments to a level that covers physician and hospital costs at a minimum of 100 percent of the geographically-adjusted Medicare Physician Fee Schedule rate. (Res99-91A)
- Amended 1993
- Edited 1998
- Reaffirmed (Sunset Report 2022)
- Amended (Res19-25)

Extending Medicaid Postpartum Coverage
MSMS supports codifying the extension of Medicaid coverage to 12 months postpartum to individuals who are eligible to enroll during their pregnancy. (Res39-25)

Vaginal Estrogen Treatment for Recurrent Urinary Tract Infections
MSMS supports the coverage of vaginal estrogen for UTI prevention by Michigan's Medicaid formulary. (Res37-25)

MEDICAL EDUCATION AND TRAINING

Preventing Sleep Deprivation and Supporting Medical Student Wellness
MSMS advocates for medical schools to formally adopt work-hour policies for medical students including limits on shift length, mandatory rest periods, and total weekly hours. (Res32-25)

MENTAL HEALTH

Support Physicians with Mental Health Diagnoses

MSMS opposes mandatory disclosures of physician mental health diagnoses and instead supports the availability of confidential, non-punitive health programs that allow physicians to seek care without fear of professional repercussions. Additionally, MSMS supports the implementation of alternative monitoring strategies that focus on physician function rather than diagnosis, ensuring that patient safety is maintained without unnecessarily penalizing physicians who proactively manage their mental health. (Res09-25)

PAIN MANAGEMENT

Address Acute and Chronic Pain
MSMS supports:
1. multidisciplinary/multimodality physician-led care,
2. insurance coverage for non-pharmacologic approaches to addressing pain set at parity with primary care visits to reduce financial barriers for patients, and
3. utilizing evidence-based methods for addressing acute and chronic pain. (Res48-17)

- Amended (Res41-25)

PHYSICIAN BUSINESS AND LEGAL RELATIONS

Open and Obvious Doctrine
Provisions from the “Open and Obvious” Doctrine that was stricken by the Michigan Supreme Court in [add court case] should be reinstated via legislation. (Board-July2025)

PUBLIC HEALTH

General

Ensuring Accessibility and Inclusivity of CDC Resources
MSMS encourages the Centers for Disease Control and Prevention to maintain essential medical and public health resources that remain evidence based on their website for continued accessibility to clinicians and patients. (Res30-25)

SAFETY AND ACCIDENT PREVENTION

Automobile, Bicycle, and Scooter Safety

Motor Vehicle Safety
MSMS supports the lack of safety belt use being designated a “primary enforcement offense.” (Res46-95A)
– Reaffirmed (Sunset Report 2022)
- Amended (Res03-25)

Preventing Head Injuries Associated with Standing Motorized Scooter Use
MSMS supports the Michigan Department of State Police issuing definitive guidance that standing electronic scooters that meet the definition of an "electric skateboard" are governed under the Michigan Vehicle Code and are therefore, subject to all applicable provisions pertaining to their use including, but not limited to, the use of helmets by people less than 19 years of age when operating standing electronic scooters. (Res03-25)

Safety Helmets
MSMS supports the use of helmets for all individuals when riding bicycles, standing motorized scooters, motorcycles, and other motorized and non-motorized vehicles. (Prior to 1990)
- Amended (Sunset Report 2022)
- Amended (Res03-25)

SUBSTANCE USE AND ADDICTION

Access to Opioid Agonist Treatment for Incarcerated Persons
MSMS supports the following activities to assist with the care and long-term recovery of individuals who are incarcerated and diagnosed with Opioid Use Disorder:
(1)Establishment of mandatory reporting requirements for all Michigan correctional facilities offering MAT, including annual data collection on treatment availability, patient outcomes, overdose rates, and continuity of care post-release;
(2) Creation of an independent oversight committee responsible for monitoring the implementation of MAT programs in Michigan correctional facilities, with authority to assess compliance, identify barriers, and recommend corrective actions; and
(3) State-funded transitional housing and transportation support for individuals receiving MAT post-release, addressing logistical barriers that contribute to treatment discontinuation, overdose deaths, and recidivism. (Res36-25)

Availability of Xylazine Tests Kits
MSMS supports the appropriate state agency making xylazine test strips available free to the public at various venues, including hospital emergency departments, local health departments, pharmacies, and other outlets throughout the state, for the purpose of detecting this intravenous drug adulterant. (Res01-25)

Oral Fluid Testing
MSMS supports allowable methods of testing intoxication or impairment to include oral fluid testing. (Board-January2026)

Substance Use During Pregnancy
MSMS opposes 1) making the use of controlled substances during pregnancy a felony; and 2) use of a positive drug test in the pregnancy or peripartum period as a disqualifier for coverage under publicly-funded programs or as the sole determinant in family separations, including removing the neonate from the parent during the birth hospitalization. (Board-July96)
- Amended (Res31-19)
- Amended 2023
- Amended (Res08-25)

WOMEN'S HEALTH

General

Free Menstrual Products in Public Spaces
MSMS encourages the State of Michigan to provide free menstrual hygiene products in public restrooms in state-owned buildings. (Res31-25)

Sunset Report to 2026 MSMS House of Delegates

At its 2018 Annual Meeting, the Michigan State Medical Society (MSMS) House of Delegates (HOD) established a sunset mechanism for House policies (Resolution 14-18, "Sunset Mechanism MSMS Policy"). Pursuant to this mechanism, a policy established by the HOD ceases to be viable after 10 years unless action is taken by the HOD to retain it.

The objective of the sunset mechanism is to help ensure the MSMS Policy Manual is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of MSMS to communicate and promote its policy positions, as well as contributes to the efficiency and effectiveness of HOD deliberations.

The MSMS Committee to Review the MSMS Policy Manual recommends that the House of Delegates policies listed in this report be acted upon in the manner indicated and the remainder of the report be filed.

Index	Policy	Recommendation
Children and Youth: Education	**Establish Physical Activity Requirements for All Public School Students** MSMS supports requiring public schools to offer a physical activity program for all students during the regular school year consisting of at least 20 minutes per day or an average of 100 minutes per week for grades kindergarten through five and at least 150 minutes per week for grades six through 12 through any combination of physical education classes, athletic extra-curricular activities, recess, or other programs and physical activities deemed appropriate by the local school Board. (Res26-15)	***Retain, policy is still relevant but modify to reflect current physical activity recommendations as follows:*** **Establish Physical Activity Requirements for All School Students** MSMS supports requiring schools to offer a physical activity program for all students during the regular school year through any combination of physical education classes, athletic extra-curricular activities, recess, or other programs and physical activities deemed appropriate by the local school Board. Currently, the Centers for Disease Control and Prevention and Play 60 recommend 60 min/day of vigorous activity year round. https://www.cdc.gov/physical-activity-education/guidelines/index.html https://www.nfl.com/causes/play60/

Index	Policy	Recommendation
End of Life Care	**CXR for Patients at Home on Hospice** MSMS supports allowing a blood test to screen for tuberculosis to be an acceptable alternative to a chest x-ray for patients receiving at-home hospice care who may need to be placed in a nursing home. (Res74-15)	***Retain, policy is still relevant.***
Ethics: Transparency	**Ethical Guidelines for Physicians** MSMS supports the disclosure by physicians to their patients and their families any possible conflict of interest from the source of payment to the physician, incentive or reimbursement for services rendered in their care. (Res132-99A) – Reaffirmed (Res13-15)	***Retain, policy is still relevant.***
Ethics: Transparency	**Improving Legislative Transparency** MSMS supports further transparency in the legislative process, including the source of legislation, language revisions, and each representative's vote. (Res69-15)	***Retain, policy is still relevant.***
Family Planning and Sex Education	**Parental Paid Leave** MSMS supports parental paid leave. (Res07-15)	***Retain, policy is still relevant.***
Health Care Insurance	**Oral Anti-Cancer Therapy Drug Parity** MSMS supports state and federal legislation similar to that passed in a majority of states mandating parity between intravenous medications and oral anti-cancer therapy drugs. (Res64-15)	***Retain, but modify to read as follows since federal and state legislation has passed since the adoption of this policy:*** **Oral Anti-Cancer Therapy Drug Parity** MSMS supports parity between intravenous medications and oral anti-cancer therapy drugs.
Health Care Insurance	**Protect HealthCare.gov Consumers' Personal Data** MSMS supports prohibiting the inappropriate sharing of personal health information obtained from state and federally facilitated Health Insurance Marketplaces such as HealthCare.gov. (Res16-15)	***Retain, policy is still relevant.***
Health Clinicians Other Than Physicians	**Opposing the Establishment of an Assistant Physician Program** MSMS opposes special licensing pathways, including the "assistant physician" pathway, for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or who have not completed at least one year of accredited post-graduate U.S. medical education. (Res45-15)	***Sunset. The 2025 MSMS House of Delegates adopted the following policy which supersedes the prior policy:*** **Alternative Physician Licensure Pathways** MSMS will engage in communications with policy makers when proposals arise related to alternative licensing pathways to ensure adequate training, supervision by physicians, external funding for training, and credentialing opportunities. MSMS will monitor national efforts related to alternative licensing pathways and share recommendations with policy makers as appropriate.

Index	Policy	Recommendation
Health Information Technology	**Repeal Penalties for Non-adoption of EHR** MSMS supports the current AMA policy that "Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria. (Res. 222, A-10; Reaffirmation I-10; Reaffirmation A-14; Appended: Res. 210, I-14)." (Res30-15)	***Sunset.***
Health Information Technology	**Revise Meaningful Use Stage 3 Guidelines** MSMS supports the American Medical Association's eight priorities for improving electronic health record (EHR) usability announced in 2014 in order to benefit eligible professionals and patients and to structure a federal Meaningful Use program that reflects the reality of medical practice and promotes the rationale use of EHRs. (Res57-15)	***Sunset.***
Immunizations	**Report Immunizations to Primary Care Physicians and MCIR** MSMS supports the requirement that pharmacies and other entities providing immunizations to patients report such action and enter all immunizations administered to patients into the Michigan Care Improvement Registry and, if feasible, to the patient's primary care physician either electronically or via fax. (Res03-15)	***Retain, policy is still relevant.***
Licensure	**Opposing the Federation of State Medical Boards Interstate Medical Licensure Compact** MSMS opposes participation with the Federation of State Medical Boards' Interstate Medical Licensure Compact. (Res48-15)	***Defer decision as Resolution 22-26, which would repeal this policy, will be considered by the 2026 HOD.***
Medicaid	**Physician Care for Michigan's Increased Medicaid Population** MSMS encourages Michigan physicians to accept Medicaid beneficiaries as their practice allows. (Board Action Report #6, 2016 HOD, re Res14-15)	***Retain, policy is still relevant.***
Medicaid	**Reform Michigan Medicaid GME Funding** MSMS supports requiring that all Medicaid Graduate Medical Education (GME) funding to hospitals be earmarked and spent for GME purposes only; that the current GME funding be replaced with a new formula of paying hospitals and institutions for direct medical education expenses (i.e., resident salaries and benefits, faculty salaries, program support staff, and hospital overhead) for additional slots exceeding the Medicare funding cap only; and that GME funding for innovative residency programs to promote access to patient care in urban and rural areas and in specialties with limited patient access be encouraged. (Res72-15)	***Retain, policy is still relevant.***
Mental Health	**Suicide Prevention Awareness and Education** MSMS supports efforts to raise awareness about the rising rate and devastating toll of suicide; to increase suicide prevention education for all physicians, residents, medical students, and allied health professionals; to encourage active engagement in suicide prevention awareness with their patients and colleagues; to increase research associated with suicides; and to reduce liability for those who provide suicide prevention care. (Res70-15)	***Retain, policy is still relevant.***

Index	Policy	Recommendation
Pharmacy and Pharmaceuticals	**Medication Substitution and Drug Formularies** MSMS opposes the dispensing of a therapeutic alternate for a prescribed drug or rejection of the prescribed drug without the consent of the prescribing physician. (Res34-15)	***Retain, policy is still relevant.***
Physician Business and Legal Relations	**Physician Involvement with Health Care Related Businesses** MSMS supports allowing physicians to create, own, and support health care related businesses; to utilize all available tools inside and outside of their practices; to refer patients to these businesses for medically necessary services; and that these businesses be held to the same business standards as nonphysician-owned health care businesses. (Res75-15)	***Retain, policy is still relevant.***
Public Health: Environmental Health Issues	**Ban Routine Use of Antibiotics in Animal Feed** MSMS supports a total ban of antibiotics in animal feed to reduce the incidence of spillage to natural systems and to reduce the emergence of multi-drug resistant organisms that are difficult to treat. (Res55-15)	***Retain, policy is still relevant.***
Public Health: Environmental Health Issues	**Health Concerns of Fracking in Michigan** MSMS opposes fracking in the state of Michigan until such time as it is proven to be of no significant health hazard to the population or the environment of the state of Michigan. (Res02-15)	***Retain, policy is still relevant.***
Public Health: Environmental Health Issues	**Plastic Microbeads in the Great Lakes** MSMS supports local, state, and federal laws banning the sale and manufacture of personal care products containing plastic microbeads. (AMA Res. 916, I-15); (Res61-15)	***Retain, policy is still relevant.***
Scope of Practice	**Limiting the Administration of Intravitreal Injections to Ophthalmologists** MSMS opposes intravitreal injections being performed by anyone other than a licensed physician appropriately trained to perform intravitreal injections. (Res04-15)	***Retain, policy is still relevant.***

RESOLUTION 27-25

Title: Remove Separate County Requirement for Regional Directors

Introduced by: Richard Burney, MD, for the Washtenaw County Delegation

Original Author: Richard Burney, MD

Referred To: Reference Committee C

House Action: **APPROVED ON 1ST READING**

Whereas, Article IX, Section 1a of the Michigan State Medical Society (MSMS) Constitution states: Two Directors (the "Regional Directors") from each of the nine regions depicted on Exhibit A to the Bylaws (each a "Region" and collectively the "Regions"). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula, and

Whereas, it is sometimes difficult to recruit Regional Directors from unstaffed counties, and

Whereas, Regional Directors from the same county can be relied upon to represent all the counties in their region; therefore be it

RESOLVED: That the MSMS Constitution, Article IX, Section 1a, be amended by deletion as follows:

Two Directors (the "Regional Directors") from each of the nine regions depicted on Exhibit A to the Bylaws (each a "Region" and collectively the "Regions"). The Regional Directors shall be elected by those members holding membership in a county located in that Region. ~~No more than one Regional Director may hold membership in a single county unless a region consists of a single county.~~ One Regional Director must hold membership in a county located in the upper peninsula.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000-$4,000

Relevant MSMS Policy
None

Relevant AMA Policy
None

RESOLUTION 49-25

Title: Membership Categories

Introduced by: Paul Kocheril, MD

Original Author: Paul Kocheril, MD

Referred To: Reference Committee C

House Action: **APPROVED ON 1ST READING**

Whereas, the current 15 categories of membership present MSMS and County staff and leadership with undue complexity, and

Whereas, members classified in some of those categories are low and even remote, and

Whereas, reducing that complexity would be beneficial to the administration and maintenance of the membership operations of the organization; therefore be it

RESOLVED: That membership categories be simplified to the following:

1. Active, Full - $495 Full dues paying members or group discounted
2. Active, Half - $245 Half dues paying would include first- year in practice, spouse of an Active-Full member and part-time
3. Physician in-training - $100 Includes all postgraduate
4. Medical Students - $75
5. Active Emeritus - $150
6. Non-dues Paying Members - Non-voting hardship, Government employees, Emeritus and Life
7. Remove the designations of Honorary, Nonresident and Affiliate

The amendment to the MSMS Constitution and Bylaws, 2.0 Membership-Classification-Election is as follows, deletions are indicated by strikethroughs.

3.20 ~~HONORARY MEMBERS - A component society may elect as an honorary member any person distinguished for service or attainments in medicine or the allied sciences, or who have rendered other services of unusual value to organized medicine or the medical profession. Upon recommendation of a component society, the House of Delegates may elect such persons honorary members of the Society. Honorary members shall pay no dues and shall be without the right to vote or hold office in either this or the component society.~~

~~3.30 NON-RESIDENT MEMBERS - A component society may elect as non-resident members any doctors of medicine residing and practicing outside of the county who are members in good standing of their Michigan component societies. Non-resident members shall not have the right to vote or hold office.~~

~~3.40 AFFILIATE MEMBERS - Component societies may elect to affiliate membership lay persons in areas of endeavor which are related to medicine and medical practice. Affiliate members shall pay no dues and may not vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.~~

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53 WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000 - $4,000

Relevant MSMS Policy
None

Relevant AMA Policy

2025 AMA membership dues
Physicians
- First year in practice: $60
- Second year in practice: $105
- Third year in practice: $210
- Fourth year in practice: $315
- Military physicians (and physicians working in the Department of Veterans Affairs): $280
- Regular practice: $420

Residents and Fellows
- 1-year membership: $45
- 2-year membership: $80
- 3-year membership: $120
- 4-year membership: $160

Retired Physicians
- Fully retired (working 0 hours per week): $84
- Semi-retired (physician working 1-20 hours per week and at least 65 years of age): $210

Military
Military and physicians working in the U.S. Department of Veterans Affairs: $280
Medical Students
- 1-year membership: $20
- 2-year membership: $38
- 3-year membership: $54
- 4-year membership: $68

RESOLUTION 50-25

Title: Revisions to Constitution and Bylaws

Introduced by: Bryan Huffman, MD

Original Author: Bryan Huffman, MD

Referred To: Reference Committee C

House Action: APPROVED on 1ST READING

Whereas, the MSMS Board Task Force on Bylaws reviewed the MSMS Constitution and Bylaws for needed updates, and

Whereas, the Task Force developed many revisions, some are technical in nature and represent basic grammar edits or something that no longer exists in the organization, there are several larger considerations that have been requested over the years, and

Whereas, a summary of the changes below provides additional detail; therefore be it

RESOLVED: That MSMS amend the MSMS Constitution and Bylaws recommended by the Task Force on Bylaws pursuant to the attached marked up version of the Constitution and Bylaws, deletions are indicated by strikethroughs and additions are indicated in bold type,

---

WAYS AND MEANS COMMITTEE FISCAL NOTE: $2,000 – $4,000

Relevant MSMS Policy
None

Relevant AMA Policy
None

Constitution and Bylaws Committee Task Force

Constitution

Eliminate the Constitution and move retained sections to the bylaws as you have previously proposed
Eliminate Articles IV, V, & VI (Divisions, Society as a Whole, Scientific Assembly).
Article XII Remove reference to the "Journal of the Society."

Bylaws

1. Allow student membership to be an annual membership by eliminating confusing language related to the need to "cover administrative cost of membership except in the first year." (2.60).
2. Eliminate the need for counties to screen for and attest to applicants' suitability (4.10). (Per the AMA, component societies should not require letters of recommendation or a vote to approve new members.)
3. Change the four-year dues phase-in for new members to a two-year phase in. (6.40) Change the current language, "Annual dues shall be 25% of the amount fixed and determined pursuant to section 6.10 during the first year of practice, 50% during the second-year of practice, 75% during the third year of practice, and the full amount during the fourth year," to "Annual dues shall be 50% of the amount fixed and determined pursuant to section 6.10 during the first year in practice, and the full amount during the second year in practice."
4. Eliminate the seats in HOD for deans of medical schools (12.20).
5. Eliminate the restriction on members of the BOD serving as delegates. (12.20).
6. 12.90 typo arid = and; 12.98 eliminate reference to the Journal of the Society.
7. Change language stating that AMA delegates or alternates "must spend the majority of his/her professional time" to "must average 20 hours per week or more in active clinical practice; teaching; research; and/or administrative practice." (13.30).
8. Allow the number of alternate delegates elected to the AMA to be "up to" instead of "shall equal" the number of delegates. (13.30)
9. Remove references to publishing a Journal of MSMS (12.98, 14.62).

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Michigan State Medical Society

Constitution and Bylaws

20232025 Revised Edition

CONSTITUTION

Regional Map (Exhibit A) 3
Article I - Name 4
Article II - Purposes 4
Article III - Component Societies 4
Article IV - Divisions 4
Article V - The Society as a Whole 4
Article VI - Scientific Assembly 4
Article VII - House of Delegates 4
Article VIII - Officers and AMA Delegates 4
Section 1 - Officers 5
Section 2 - AMA Delegates 5
Article IX - The Board of Directors 5
Section 1 - Composition 5
Section 2 - Powers and Duties 5
Section 3 - Executive Committee 5
Article X - Judicial Commission 5
Article XI - Finances 5
Section 1 - Method of Financing 5
Section 2 - Power to Fix 5
Article XII - Amendments 5
Section 1 - Method of Amendments 5
Section 2 - Effective Date 5

BYLAWS

1.001. Component Societies 61
1.1 Definition 1
1.2 Geographical Scope 1
1.101.3 .... Charter 61
1.201.4 .... Revocation of Charter 61
2.002. Membership—Classification—Election 61
2.102.1 .... Definition 61
2.202.2 .... Membership Prerequisite 61
2.302.3 .... Active Members 62
2.31 Suspended Member 62
2.402.4 .... Active Members—Dues Exempt 72
2.41 Hardship 72
2.42 Postgraduate Study 72
2.43 Voluntary Service 72
2.502.5 .... Physicians-In-Training 72
2.602.6 .... Students 72
2.702.7 .... Emeritus Members 72
2.71 Active Emeritus 72
2.72 Emeritus 72
2.802.8 .... Life Members 73
3.102.9 .... Service Members 83
3.112.9.1 .... Military 83
3.122.9.2 .... Commissioned Medical Officers 83
3.202.10 .... Honorary Members 83
3.302.11 .... Non-Resident Members 83
3.402.12 .... Affiliate Members 83
3.502.13 Resolutions Concerning Membership Changes 83
3. Reserved 3
4.004. Membership—Regulation 83
4.104.1 .... Membership as Privilege–Not Right 83
4.204.2 .... Duties of County Society 83
4.304.3 .... Rosters 83
5.005. Membership—Transfers 83
5.105.1 .... Change of Location – Procedure 83
5.205.2 .... Refund of Dues 94
5.305.3 .... Removal from State 94
6.006. Dues and Assessments 94
6.106.1 .... How Fixed 94
6.206.2 .... Collection 94
6.306.3 .... New Members 94
6.406.4 .... First Year of Practice 94
6.506.5 .... Arrears—Suspension 94
6.606.6 .... Deferment 94
6.706.7 .... Reinstatement 95
6.806.8 .... Dues—Resident Physicians and Students 105
6.906.9 .... Active Status—Part-Time Dues 105
7.007. Conduct and Discipline of Members 105
7.10 Standards of Conduct-Grounds for Discipline 10
7.20 Discipline-What Constitutes 10
7.30 Discipline-What Procedure to Govern 10
7.40 Society of More than 150 Members 10
7.50 Peer Review/Ethics Committee 10
7.60 Request for Investigation 10
7.70 Informal Investigation-Procedure 10
7.80 Informal Investigation-Dismissal 10
7.90 Informal Investigation-Reprimand 11
8.10 Formal Complaint-Notice of Hearing 11
8.20 Answer to Formal Complaint 11
8.30 Formal Hearing-How Conducted, Right to Counsel 11
8.40 Findings and Report 11
8.50 Action on Report-Additional Testimony 11
8.60 Action by Society 11
8.70 Finality and Effectiveness of Order 12
8.80 Appeal Procedure 12
8.90 Appeal to Judicial Council of the American Medical Association 12
9.10 Exception to Procedures 12
9.20 Effect of Suspension or Expulsion 12
9.30 Construction 12
10.00 Grievances of Non-Members-Peer Review/Mediation Committee 12
10.10 Peer Review/Mediation Committee 12
10.208. Purposes 125
9. Reserved 5
10. Reserved 5
10.30 Powers and Duties-Limitation 13
10.40 Procedure to Govern 13

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~~11.00~~11. **General Meetings** ~~13~~5
~~11.10~~11.1 Determination of Time and Place ~~13~~5
~~11.20~~11.2 Right to Participate ~~13~~5
~~11.30~~11.3 Actions ~~13~~5

~~12.00~~12. House of Delegates ~~13~~6
~~12.10~~12.1 Composition ~~13~~6
12.2 Composition 6
~~12.20~~12.3 Delegates-At-Large~~,~~ – Ex Officio Members ~~13~~6
~~12.30~~12.4 Election—Certification ~~14~~6
~~12.40~~12.5 Seating—Tenure ~~14~~6
~~12.50~~12.6 Seating of Alternate Delegates ~~14~~6
~~12.60~~12.7 Officers ~~14~~6
~~12.70~~12.8 Meetings—Annual Session ~~14~~6
~~12.80~~12.9 Quorum ~~14~~7
~~12.90~~12.10 Powers and Duties ~~14~~7
~~13.10~~12.11 Reference Committees ~~15~~7
~~13.20~~12.12 Election of Regional Directors ~~15~~7
~~13.30~~12.13 Election of Delegates to American Medical Association ~~15~~8
~~13.40~~12.14 Election of Officers ~~16~~8
~~13.50~~12.15 Resolutions ~~16~~8
~~13.60~~12.16 New Business ~~16~~8
~~13.70~~12.17 Rules of Order ~~16~~8
~~13.80~~12.18 Nominating Committee ~~16~~8
13. Reserved 9
~~14.00~~14. The Board of Directors ~~16~~9
~~14.10 Organization~~14.1 Composition ~~16~~9
14.2 Powers and Duties 9
~~14.20~~14.3 Executive Committee ~~16~~9
14.4 Organization 9
14.5 Executive Committee 9
~~14.30~~14.6 Reference Committees ~~16~~9
~~14.40~~14.7 Regional Director Duties ~~17~~10
~~14.50~~14.8 Removal of Regional Director ~~17~~10
~~14.60~~14.9 Duties of the Board of Directors ~~17~~10
~~14.70~~14.10 Control of Funds ~~17~~10
~~14.80~~14.11 Regions ~~17~~10
~~**15.00 The Judicial Commission** 17~~
~~15.10 Composition—Qualifications 17~~
~~15.20 Judicial Districts 17~~
~~15.30 Nominations 17~~
~~15.40 Ballot—Election 18~~
~~15.50 Terms of Office 18~~
~~15.60~~**15.** ~~Vacancies~~**Reserved** ~~18~~**10**
~~15.70 Organization of the Commission 18~~
~~15.80 Powers and Duties 18~~
~~16.00~~16. Committees/Task Forces of the Society ~~19~~10
~~16.10~~16.1 Standing Committees ~~19~~10
~~16.20 Liaison~~16.2 Liaisons Committees ~~19~~10
~~16.30~~16.3 Task Forces ~~19~~11
~~17.00~~17. Officers ~~19~~11
17.1 Officers 11
~~17.10~~ 17.2 Term of Office ~~19~~11
~~17.20~~17.3 Induction of President ~~19~~11
~~17.30~~17.4 President ~~19~~11
~~17.40~~17.5 President-Elect—Duties—Succession ~~20~~11
~~17.50~~17.6 Chair of the Board ~~20~~11
~~17.60~~17.7 Vice-Chair ~~20~~11
~~17.70~~17.8 Treasurer ~~20~~12
~~17.80~~17.9 Secretary ~~20~~12
~~17.90~~ 17.10 Chief Executive Officer ~~20~~12
~~18.10~~17.11 Speaker of the House of Delegates ~~20~~12
~~18.20~~17.12 Vice-Speaker of the House of Delegates ~~20~~12
~~18.30~~17.13 Remuneration ~~20~~12
18. Reserved 12
~~19.00~~19. Indemnification ~~20~~12
~~20.00~~20. Specialty and Ethnic Medical Societies ~~21~~12
~~20.10~~20.1 Recognized Specialty and Ethnic Medical Societies ~~21~~
~~20.20~~20.2 Criteria ~~21~~12
~~20.30~~20.3 Resident and Fellow Section ~~21~~13
~~20.40~~20.4 Medical Student Section ~~21~~13
~~20.50~~20.5 Organized Medical Staff Section ~~21~~13
~~20.60~~20.6 Young Physicians Section ~~22~~13
~~20.70~~20.7 International Medical Graduates Section ~~22~~14
~~21.00~~21. Referendum ~~22~~14
~~21.10~~21.1 Referendum at Society Meeting ~~22~~14
~~21.20~~21.2 Referendum by House of Delegates ~~22~~14
~~22.00~~22. Seal ~~22~~14
~~22.10~~22.1 Seal ~~22~~14
~~23.00~~23. Emergency ~~22~~14
~~23.10~~23.1 Emergency Action by Board of Directors ~~22~~14
~~24.00~~24. Definition of Session and Meeting ~~22~~14
~~24.10~~24.1 Session ~~22~~14
~~24.20~~24.2 Meeting ~~22~~14
~~25.00~~25. Amendments ~~22~~14
~~25.10~~25.1 Amendments—Procedure ~~22~~14
~~**OFFICIAL PROCEDURES FOR THE JUDICIAL COMMISSION** 23~~
~~Judicial Commission Districts Map 25~~

MSMS ~~Constitution~~ Bylaws

~~2023~~2025 Edition

~~ARTICLE I—NAME~~

~~Section I. - NAME—The name of this organization shall be the Michigan State Medical Society.~~

~~ARTICLE II—PURPOSES~~

~~Section I. - PURPOSES—The purposes of this Society shall be: To bring into one viable, effective organization the ethical physicians licensed to practice in Michigan in order that their contribution to human welfare will be enhanced.~~

~~In order to accomplish this effectively, the Society also will work to accomplish the following sub purposes:~~

~~a) To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.~~

~~b) To charter and organize component medical societies.~~

~~c) To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.~~

~~d) To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his or her patients and the public health generally.~~

~~e) To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.~~

~~f) To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals.~~

~~g) To preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care.~~

~~h) To promote quality medical and health care by development and support of activities appropriate to this goal.~~

~~i) To advocate fair remuneration for services rendered.~~

~~j) To ensure adequacy of the medical workforce by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.~~

~~k) To encourage medical students and physicians in training to participate in organized medicine in order to enable MSMS to be representative of all physicians.~~

~~l) To support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession.~~

~~m) To institute and provide specific services to meet the needs of the members.~~

~~n) To foster and support continuing medical education.~~

~~ARTICLE III—~~1. COMPONENT SOCIETIES

~~Section 1.~~ 1.1 DEFINITION—Component societies shall consist of those county medical societies which hold charters from this Society.

~~Section 2.~~ 1.2. GEOGRAPHICAL SCOPE—Not more than one component society shall be chartered in any county of the State. The House of Delegates may, however, in its discretion, grant a charter to a component society comprising two or more counties.

~~ARTICLE IV—DIVISIONS~~

~~Section 1. - DIVISIONS—The Society shall have three major divisions, namely:~~

~~1) The Society as a whole.~~

~~2) The Scientific Assembly with its subordinate or related bodies.~~

~~3) The House of Delegates with its subordinate or related bodies.~~

~~ARTICLE V—THE SOCIETY AS A WHOLE~~

~~Section 1. - SESSIONS—The Society as a whole shall hold such sessions at such times and places of such duration as the House of Delegates may determine. The power to so determine may be delegated to the Board of Directors or to the Executive Committee of the Board of Directors by the House of Delegates.~~

~~ARTICLE VI—SCIENTIFIC ASSEMBLY~~

~~Section I. - DEFINITION—The Scientific Assembly of this Society is the convocation of its members for the presentation and discussion of subjects pertaining to the science and art of medicine and to the conservation of the health of the public.~~

~~ARTICLE VII—HOUSE OF DELEGATES~~

~~Section 1. - COMPOSITION—The House of Delegates shall be the legislative body of the Society and shall consist of delegates elected by component societies, recognized specialty societies, delegates from the Residents and Fellows, Students, Young Physicians, Organized Medical Staff and International Medical Graduates Sections, and other sections as shall from time to time be approved by the House of Delegates, delegates at large and ex officio members, as prescribed by the Bylaws.~~

~~ARTICLE VIII—OFFICERS AND AMA DELEGATES~~

~~Section 1. - OFFICERS—The officers of this Society shall be a President; a President-Elect; the Immediate Past President; a Treasurer; a Secretary; a Speaker and a Vice Speaker of the House~~

~~of Delegates and shall be elected as provided in the Bylaws.~~

~~Section 2. - AMA DELEGATES - The Society's delegates and alternate delegates to the House of Delegates of the American Medical Association shall be elected as provided in the Bylaws. *(See Bylaws, Section 13.30)*~~

~~ARTICLE IX—THE BOARD OF DIRECTORS~~

~~Section 1. - COMPOSITION - The Board of Directors shall be the executive body of the Society. Effective at the first meeting of the Board of Directors immediately following the final meeting of the House of Delegates held at its 2020 Annual Session, the Board of Directors shall consist of:~~

~~a) Two Directors (the "Regional Directors") from each of the nine regions depicted on Exhibit A to the Bylaws (each a "Region" and collectively the "Regions"). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula.~~

~~b) The President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker and Vice Speaker of the House of Delegates.~~

~~c) One Director elected by those members in each of the membership classifications defined in Sections 2.50 and 2.60 of the Bylaws, and one Director elected by those members in the Young Physicians Section as defined in Section 20.60 of the Bylaws. These seats will be for one-year renewable terms, and the directors elected must remain in the category elected for the entire term.~~

~~d) The following ex officio Directors: (i) the Chair of the delegates to the AMA or another member of the delegation, designated as a substitute; and (ii) the two members serving as the physician representatives on the Blue Cross Blue Shield of Michigan Board of Directors.~~

~~e) Up to six Directors elected by the House of Delegates representing those constituencies deemed from time to time the most relevant to the current health care marketplace to be designated by the nominating committee of the House of Delegates with input from the Board of Directors and the House of Delegates (the "Designated Directors"). The Designated Directors shall serve three-year terms. Designated Directors may not serve more than three consecutive terms; the same individual may serve additional terms after an absence of at least one year.~~

~~Section 2. - POWERS AND DUTIES - The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions.~~

~~Section 3. - EXECUTIVE COMMITTEE - The Board of Directors may have an Executive Committee with power to act between meetings of the Board. The composition, powers and duties thereof shall be such as are prescribed by the Bylaws.~~

~~ARTICLE X—JUDICIAL COMMISSION~~

~~Section 1. - COMPOSITION - POWERS AND DUTIES - The Judicial Commission shall be the body having general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline of members and professional conduct generally. It shall consist of members to be elected by the voting members of the Society. The number of members, their terms of office, the time and manner of their election and the specific powers and duties of the Commission shall be as prescribed by the Bylaws.~~

~~ARTICLE XI—FINANCES~~

~~Section 1. - METHOD OF FINANCING - Funds for meeting the expenses of the Society shall be raised by annual dues and may be augmented by other methods including special assessments and voluntary contributions.~~

~~Section 2. - POWER TO FIX - Annual membership dues and assessments shall be fixed by the House of Delegates.~~

~~ARTICLE XII—AMENDMENTS~~

~~Section 1. - METHOD OF AMENDMENTS - The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates seated at any regular session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been published at least once during the interval in the Journal of the Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.~~

~~Section 2. - EFFECTIVE DATE - Unless otherwise provided herein, this Constitution and all amendments hereto shall become effective immediately upon adoption by the House of Delegates.~~

~~MSMS Bylaws~~

~~2023 Edition~~

~~1.00 COMPONENT SOCIETIES~~

~~1.10~~1.3 CHARTER - The charter of each component society shall be authorized by the House of Delegates and signed by the President and Secretary. Such charter shall require that the constitution and bylaws of such component society be at all times consistent with the provisions of the Constitution and Bylaws of this Society and with all amendments thereto hereafter adopted. Each component society shall file with the State Society headquarters a current copy of its constitution and bylaws.

~~1.20~~1.4 REVOCATION OF CHARTER - The House of Delegates is empowered to revoke the charter of any component society whenever it finds that such society has materially breached any of the provisions of the Constitution or Bylaws of this Society or has failed to function within the expressed spirit and purpose of this Society to such an extent that revocation of charter is compatible with the best interests of this

Society.

Petition for the revocation of charter of any component society may be filed with the Board of Directors by a Director of the Region within which such society is located, or by any three members of the Board of Directors of this Society or by the President of this Society. Such petition shall be in writing and set forth with reasonable particularity the matters complained of and upon which the petition is founded. A copy of such a petition together with written notice of the time and place of hearing on the petition shall be served on the affected component society by registered mail, return receipt requested, not less than 60 days before the date of such hearing.

The affected component society may, within 30 days after service upon it of copy of the petition, file with the Board of Directors by registered mail, return receipt requested, a written answer thereto. The Board of Directors shall afford the affected component society a fair hearing of the matters complained of and a suitable opportunity to present its defense. The component society may be represented by legal counsel. Written arguments may be filed on behalf of the affected component society and by the petitioner. Stenographic notes shall be made of the entire proceedings on such hearing and a complete record shall be prepared, which record shall consist of the petition, answer, testimony, exhibits, written arguments and other pertinent matter.

The Board of Directors shall make its decision based on the records, setting forth in writing the finding of facts, conclusions and reasons therefore. If two-thirds of the members of the Board of Directors do not concur in the conclusion that the charter of the affected component society should be revoked, the petition shall be deemed dismissed and the proceedings ended. If two-thirds of the members of the Board of Directors concur in the conclusion that the charter of the affected component society should be revoked, the Chair of the Board of Directors shall transmit to the House of Delegates a report, consisting of the decision of the Board of Directors with all records annexed, and shall serve a copy thereof on the affected component society. The House of Delegates shall at the next regular or special session thereof following the transmittal of such report, consider and take such action on the report as it may deem proper. In case the House of Delegates desires further proofs in relation to the issues involved, it may remand the matter to the Board of Directors for further hearing and report. The action of the House of Delegates on the report of the Board of Directors shall be the final decision with reference to the revocation of the charter of a component society; provided, that the component society, if it feels aggrieved by the decision of the House of Delegates, may, within six months, appeal to the Council on Judicial and Ethical Affairs of the American Medical Association, whose opinion shall be final.

~~2.00~~2. MEMBERSHIP—CLASSIFICATION—ELECTION

~~2.10~~2.1 DEFINITION - As used in these Bylaws, except as otherwise herein expressly qualified, whenever the terms “doctor of medicine” or “practice of medicine” or “medical profession” are used, these terms shall be deemed to include the terms “doctor of medicine and doctor of osteopathy,” “practice of medicine and practice of osteopathy,” and “medical profession and osteopathic profession.”

~~2.20~~ 2.2 MEMBERSHIP PREREQUISITE-All members of the several component societies, when in good standing, are thereby and must be members of this Society. All members of this Society must be members of a component medical society where they reside or primary location of practice or direct members through the Resident and Fellow Section or the Medical Student Section.

~~2.30~~2.3 ACTIVE MEMBERS - To be eligible for active membership in any component society, doctors of medicine must hold an unrevoked, permanent license that is not currently under suspension in Michigan, or if unlicensed, must be engaged in academic teaching, research or administration. To maintain active membership in any component society, doctors of medicine must maintain active membership in this Society and comply with all the provisions of the Bylaws of this Society and the component society.

~~2.31~~2.3.1 Suspended Member - If an Active Member’s license is suspended, his/her component society may change his/her membership classification to “Suspended Member.” Those in the Suspended Member classification shall be so recognized by this Society, will not be responsible for dues payments, nor be eligible for holding any office or serve on any committee. The component society shall reinstate anyone in the Suspended Member classification immediately upon notice of reinstatement of his/her license. The Society shall recognize such a reinstatement upon notice from a component society and the member shall again be obligated to pay dues, eligible to hold office and serve on committees.

~~2.40~~2.4 ACTIVE MEMBERS - DUES EXEMPT - Members in any of the following three categories shall be classified “Active-Dues Exempt” and shall have all the privileges of active membership.

2.4.1 ~~2.41~~ Hardship - Members for whom the payment of dues would be a financial hardship by reason of physician disability or illness may be excused, fully or partially, from payment of dues by the Board of Directors provided the member is fully or partially exempted from the payment of component society dues. Members may also be excused from payment of dues because of financial hardship, or for other reason, but these must be

set forth by the secretary of the member's component society.

2.4.2 ~~2.42~~ Postgraduate Study - Active membership may be maintained by those members who are out of practice on account of postgraduate medical studies, by payment of dues of PHYSICIANS-IN-TRAINING covered in Section ~~2.50~~2.5.

2.4.3 ~~2.43~~ Voluntary Service - Members who serve as missionaries or who participate, for nominal or no compensation in a government-sponsored volunteer medical program, either in the United States or abroad.

~~2.50~~2.5 PHYSICIANS-IN-TRAINING - Physicians-in-training in AMA-approved programs who have licenses to practice in Michigan or fellowships, members serving as their primary occupation in a structured educational program begun immediately upon completion of medical school, residency, or fellowship training, may become active members of the State Medical Society through a component society or directly where no provision for reduced dues active membership exists at the component level. State Society dues for resident members shall be set by the Board of Directors of MSMS. Component dues, if any, shall be determined locally.

~~2.60~~2.6 STUDENTS (MEDICAL STUDENT SECTION) - Medical students may become members of the State Medical Society through a component society or directly through the MSMS Medical Students Section. Except as provided in Section 12.10 of these Bylaws, they may not vote or hold office. They may be appointed to MSMS committees as student members. State Society dues shall be set by the Board of Directors~~ to cover administrative costs of membership except in the first year of membership~~. Component dues for students shall be determined at the local level.

~~2.70~~2.7 EMERITUS MEMBERS—Members who have maintained active membership in any one or more component societies in Michigan for a period of five or more years, and who have retired from practice, may be transferred to the emeritus members roster of such component society and this society, provided the member's dues have been paid to the end of the preceding calendar year

~~2.71~~ 2.7.1. ACTIVE EMERITUS—A member who has been elected an active emeritus member, who pays an annual fee set by the Board of Directors, shall be classified as an active emeritus member. Active emeritus members will receive Society publications; may serve on committees; may vote in elections and hold officer positions; may serve as delegate or alternate delegate to House of Delegates; will be included in the Society membership count; will be included in the count for Delegates to the House of Delegates; will be eligible for Society insurance and member rate for Society sponsored continuing education.

2.7.2 ~~2.72~~ EMERITUS—A member who has been elected an emeritus member, who does not pay the annual fee set by the Board of Directors, shall be classified as an emeritus member. Emeritus members will not receive Society publications by mail but will be able to have member access to the MSMS website and to participate in MSMS online activities; may not serve on committees; may not vote in elections and hold officer positions; may not serve as delegate or alternate delegate to House of Delegates; will be included in the Society membership count; will not be included in the count for Delegates to the House of Delegates; will be eligible for Society insurance and member rate for Society sponsored continuing education.

~~2.80~~2.8 LIFE MEMBERS

~~2.81~~2.8.1 Doctors of medicine who have maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues paid for the previous calendar year and who 1) have attained the age of 70 years or 2) have been in practice for 50 years, may be transferred to the life membership roster of the component society and this Society.

~~2.82~~2.8.2 Each President, Chair of the Board of Directors and Speaker of the House of Delegates of this Society shall, upon retiring from office, become a life member of this Society without further action.

~~2.83~~2.8.3 Life members shall pay no dues or assessments but shall have the right to vote and hold office and shall be entitled to receive publications at such rates as the Board of Directors may determine.

~~2.84~~2.8.4 No members shall be transferred to the former life member classification following the 149th session of the House of Delegates held on Sunday, April 27, 2014.

~~3.10~~2.9 SERVICE MEMBERS

Service members shall pay no dues and are not entitled to vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.

2.9.1 ~~3.11~~ Military - Members in good standing who serve on active duty in the military forces of the United States may be transferred by the component society to service member status for the period of time such service continues.

2.9.2 ~~3.12~~ Commissioned Medical Officers - Commissioned medical officers of the United States Army, Navy, Public Health Service, or physicians employed by the Veterans Administration, on duty in this State, who are not engaged in the private practice of medicine, may be granted service members status by the component society in the area where the medical officer is located.

~~3.20~~2.10 HONORARY MEMBERS - A component society may elect as an honorary member any person distinguished for service or attainments in medicine or the allied sciences, or who have rendered other services of unusual value to organized medicine or the medical profession. Upon recommendation of a component society, the House of Delegates may elect such persons honorary members of the Society. Honorary members shall pay no dues and shall be without the right to vote or hold office in either this or the component society.

~~3.30~~2.11 NON-RESIDENT MEMBERS - A component society may elect as non-resident members any doctors of medicine residing and practicing outside of the county who are members in good standing of their Michigan component societies. Non-resident members shall not have the right to vote or hold office.

~~3.40~~2.12 AFFILIATE MEMBERS - Component societies may elect to affiliate membership lay persons in areas of endeavor which are related to medicine and medical practice. Affiliate members shall pay no dues and may not vote or hold office. They shall be entitled to receive publications at such rates as the Board of Directors may determine.

~~3.50~~2.13 RESOLUTIONS CONCERNING MEMBERSHIP CHANGES - Any change in membership status which requires action by the House of Delegates shall be effected by resolution presented at an Annual Session of the House of Delegates after such secretarial certification as is required by these Bylaws.

3. RESERVED.

~~4.00~~4. MEMBERSHIP—REGULATION

~~4.10~~4.1 MEMBERSHIP AS PRIVILEGE - NOT RIGHT—Anyone eligible may apply for component membership within the county where they reside or primary location of practice. Any exception would require written, mutual agreement between the physician and/or physician group, MSMS, and the respective county(ies). Admission to membership in any component society is not a matter of right, but one of privilege, to be accorded or withheld at the sole discretion of such society. ~~Each component society may determine the manner of electing its members and shall be the sole judge of the qualifications of applicants for membership therein.~~ There shall be no discrimination on the basis of race, religion, sex, ethnic origin, or sexual orientation.

~~4.20~~4.2 DUTIES OF COUNTY SOCIETY—Each component society shall have general direction of the affairs of the profession in its county or counties and shall be under the continuing duty to exert its influence for the betterment of the scientific, moral, and material conditions of the doctors of medicine therein. It shall also be its duty to make systematic effort to bring every eligible doctor of medicine into membership therein.

~~4.30~~4.3 ROSTERS—The secretary of each component society shall keep a roster of its members and, if practicable, a list of non-affiliated doctors of medicine in the county, and other doctors of medicine, such as commissioned officers of the Navy, Army, and Public Health Service, in which shall be shown the full name, the address, the college and date of graduation, the date of license to practice in this

State, and such other information as may be deemed necessary, or desirable.

~~5.00~~5. MEMBERSHIP—TRANSFERS

~~5.10~~5.1 CHANGE OF LOCATION - PROCEDURE—When a member of a component society, by reason of change of residence or primary location of practice, desires to transfer membership to another component society, such member shall make application thereto accompanied by tender of dues for the remaining half of the current year (any major fraction of a half being regarded as a full half and any minor fraction being disregarded). Thereupon, the secretary of the society to which application is made shall request certification of standing from the Society from which the member desires to transfer and upon receipt of such request the secretary of the latter Society shall supply certification of good standing, provided the following requirements have been met:

5.1.1 ~~5.11~~ All component society dues and assessments shall have been paid for the calendar year previous to the year in which application for transfer is made.

5.1.2 ~~5.12~~ The member shall not be delinquent in the payment of dues and assessments to this Society.

5.1.3 ~~5.13~~ Component society dues and assessments shall have been paid to cover that portion of the year in which application for transfer is made (any major fraction of a half year being regarded as a full half and any minor fraction being disregarded).

Upon favorable action by the component society to which application has been made, following compliance with the foregoing, the transfer of membership shall be in effect.

~~5.20~~5.2 REFUND OF DUES—A member who has transferred to another component society in accordance with the provisions of paragraph 5.10 above, shall be entitled to a refund from the Society from which such member has transferred, of prepaid dues to such Society (any major fraction of a half year being regarded as a full half and any minor fraction being disregarded).

~~5.30~~5.3 REMOVAL FROM STATE—A member of this Society who, by reason of removal from the State, desires to resign from membership in the component society and in this Society and make application for membership in a society of another state, may submit his or her resignation to the secretary of the component society and the Secretary of this Society and request certification of good standing. The resignation from each shall be effective at the end of the half year in which submitted. If, at the time of resignation, the member is in good standing, is not facing charges of unethical conduct and is not in arrears in the payment of dues and assessments to this or to the component society, the secretary of each Society shall furnish him or her certification of good standing.

If the resigning member shall have prepaid dues to this Society or to the component society for any period beyond the half year in which resignation becomes effective, such excess shall be refunded by the respective Societies.

~~6.00~~6. DUES AND ASSESSMENTS

~~6.10~~6.1 HOW FIXED—Members of this Society shall pay such dues and assessments as shall, from time to time, be fixed and determined by the House of Delegates.

~~6.11~~6.1.1 Notwithstanding Section ~~6.10~~6.1, the Board of Directors shall have the authority to implement pilot membership incentive programs within the standard dues structure.

Prior to implementing a pilot membership incentive program full consideration shall be given to the impact upon component society dues.

~~6.20~~6.2 COLLECTION—All dues are to be collected on or before April 1 of each year in a manner set by this society in consultation with the component society.

~~6.30~~6.3 NEW MEMBERS—For the purpose of determining the dues for new members only, the fiscal year of this Society shall be divided into two six-month periods. New members shall pay adjusted annual dues and assessments for the unexpired semi-annual periods of that year. Such new members shall not be entitled to membership benefits until their election to membership has been duly reported to the Secretary of this Society and they shall not be entitled to membership benefits for any period prior to becoming members in good standing.

~~6.40~~6.4 FIRST YEAR OF PRACTICE—The annual dues payable to this Society by a doctor of medicine who is elected to membership during the first year of practice, shall be ~~25~~50 percent of the amount fixed and determined pursuant to Section 6.10 during the first year of practice, ~~50 percent of such~~and the full amount during the second year of ~~practice, 75 percent of such amount during the third year of practice and the full amount during the fourth year of~~ practice. This reduction in annual dues shall not exempt such member from the payment of any regularly levied assessment.

~~6.50~~6.5 ARREARS - SUSPENSION—Any member in arrears in the payment of dues assessments to this Society on the date in any year which coincides with the suspension date of the American Medical Association (currently March 1), if no extension of time for payment has been granted under the provisions of Section ~~6.60~~6.6 of this Chapter, or upon the expiration of such extension as may have been granted there-under, shall stand suspended until all sums in arrears have been paid. However, if the secretary of the component society shall certify to the Secretary of this Society that the name of the member in arrears is to be submitted to the House of Delegates at its next Annual Session for election to a different classification of membership under the provisions of Chapter 2.00 hereof, such member shall not be suspended pending action by the House of Delegates upon such requested change of classification.

~~6.60~~6.6 DEFERMENT—Upon written request of the governing body of a component society to the Board of Directors of this Society, a member shall be granted an extension of time for the payment of dues to this Society, provided, such extension shall not be beyond the close of the current fiscal year of this Society.

~~6.70~~6.7 REINSTATEMENT—A member who is in arrears in the payment of dues or assessments to this

or the component society for not more than one year may be reinstated to good standing upon payment of all arrearages. If in arrears for more than one year, such member shall be deemed to have forfeited membership. In such case the component society may reinstate such member to membership in good standing upon the payment of all arrearages or may, at its option, require reapplication for election to membership.

~~6.80~~6.8 DUES - RESIDENTS, FELLOWS AND STUDENTS—Dues for these membership categories shall be set by the Board of Directors as defined in Sections ~~2.50~~2.5 and ~~2.60~~2.6.

~~6.90~~6.9 ACTIVE STATUS - PART-TIME DUES—Dues for the following categories will be one-half the annual active membership dues rate. Members in these categories will have all the privileges of active membership. Eligibility for these categories will be determined prior to the due date for the payment of dues each year and thereafter verified on a yearly basis.

6.9.1 ~~6.91~~ A member who works less than 20 hours per week.

6.9.2 ~~6.92~~ Members sharing one full-time position, each working 50 percent within a practice.

6.9.3 ~~6.93~~ A physician spouse of a full dues paying active member.

~~7.00~~**7.** CONDUCT AND DISCIPLINE OF MEMBERS

~~7.10 STANDARDS OF CONDUCT - GROUNDS FOR DISCIPLINE—Any conduct of a member of this or any component society, whether or not occurring in the course of a physician-patient relationship, which~~

~~7.11 is in violation of the Principles of Medical Ethics of the American Medical Association, or~~

~~7.12 constitutes unprofessional and dishonest conduct as defined by Act 368 or the Public Acts of Michigan of 1978, as amended, or~~

~~7.13 results in conviction of a felony under the laws of any state or of the United States of America, or~~

~~7.14 is in violation or disregard of the constitution, bylaws, principles, rules, regulations or orders of this Society or of its Judicial Commission or of the American Medical Association, or~~

~~7.15 constitutes defamation or otherwise unjust reflection on the integrity, character or professional performance or reputation of a fellow member of the profession, or~~

~~7.16 is prejudicial to or tends to expose the medical profession of this or a component society to contempt or reproach, or which is in anywise contrary to ethics, honesty or good morals, shall be grounds for discipline. The willful failure or refusal of a member whose conduct has been called into question to appear before any disciplinary body upon request or to cooperate with such disciplinary body or the Judicial Commission in any authorized investigation shall also, in and of itself, be grounds for discipline.~~

7.1 The Board of Directors shall have the full power and authority to refer to a committee or task force or hear and decide all questions of discipline affecting the conduct of members of the Society. Its decisions in all cases, including questions regarding the right of membership in this Society, shall be final.

8. PURPOSES. The purposes of this Society shall be: To bring into one viable, effective organization the ethical physicians licensed to practice in Michigan in order that their contribution to human welfare will be enhanced.

In order to accomplish this effectively, the Society also will work to accomplish the following sub purposes:

8.1 To constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities.

8.2 To charter and organize component medical societies.

8.3 To conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, scientific progress and society's advancement.

8.4 To stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his or her patients and the public health generally.

8.5 To aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the total public.

8.6 To provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals.

8.7 To preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care.

8.8 To promote quality medical and health care by development and support of activities appropriate to this goal.

8.9 To advocate fair remuneration for services rendered.

8.10 To ensure adequacy of the medical workforce by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services.

8.11 To encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be

representative of all physicians.

8.12 To support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession.

8.13 To institute and provide specific services to meet the needs of the members.

8.14 To foster and support continuing medical education.

9. RESERVED.

10. RESERVED.

~~7.20 DISCIPLINE WHAT CONSTITUTES Discipline as used in this chapter shall include reprimand, suspension and expulsion, and for grievous offense, recommendation to the State licensing authority for revocation of license.~~

~~7.30 DISCIPLINE – WHAT PROCEDURE TO GOVERN All disciplinary proceedings conducted by this Society or by any component society, shall be governed by the provisions of this chapter and the current Official Procedures of the Judicial Commission, any provisions of the constitution or bylaws of any component society to the contrary notwithstanding. Any provisions of this chapter in conflict with the Official Procedures of the Judicial Commission shall be of no effect.~~

~~7.40 SOCIETY OF MORE THAN 150 MEMBERS Any component society having more than one hundred fifty active members may, by appropriate provisions in its Constitution or Bylaws, delegate its authority and power to discipline its members to the governing board of such Society, in which event, all of the functions, powers and duties of a component society as set forth in this Chapter shall be exercised and carried out by such governing board. Unless otherwise provided by the Constitution or Bylaws of such component society, any order of expulsion or suspension made by such governing board shall be subject to the approval of the component society in the same manner as may be provided for the approval of any other report of such governing board.~~

~~7.50 PEER REVIEW/ETHICS COMMITTEE Every component society shall have a standing committee designated the Peer Review/Ethics Committee, charged with duties and powers concerning the maintenance of standards of conduct and discipline of members, including the duties and powers specifically set forth in this chapter.~~

~~7.60 REQUEST FOR INVESTIGATION Upon the receipt by a component society of a written request for investigation of the conduct of one of its members, signed by an active member or committee of such component society and setting forth briefly the alleged facts of such claimed misconduct, such request for investigation shall be referred to the Peer Review/Ethics Committees.~~

~~7.70 INFORMAL INVESTIGATION PROCEDURE — The Peer Review/Ethics Committee shall thereupon make such informal investigations as the circumstances and nature of the matter require. The procedure to be followed shall be determined by the Peer Review/Ethics Committee but shall be such as to insure that the member whose conduct is questioned has full opportunity to be heard and to offer any defense or explanation available to him or her.~~

~~7.80 INFORMAL INVESTIGATION — DISMISSAL — Upon conclusion of its informal investigation the Peer Review/Ethics Committee if it decides that there is no ground for discipline shall dismiss the matter and so report to the Society.~~

~~7.90 INFORMAL INVESTIGATION REPRIMAND If, upon the conclusion of its informal investigation, the Peer Review/Ethics Committee decides that the member whose conduct is questioned is guilty of conduct warranting only a reprimand it shall forthwith administer such reprimand and so report to the Society unless a formal hearing is demanded by the member.~~

~~8.10 FORMAL COMPLAINT NOTICE OF HEARING If the Peer Review/Ethics Committee finds there is reasonable cause to believe that the respondent is guilty of misconduct warranting suspension or expulsion from membership, or if the respondent demands a formal hearing, a formal complaint setting forth the facts of the alleged misconduct shall be prepared by the Peer Review/Ethics Committee and subscribed by the Chair or Vice Chair thereof. A copy of such complaint shall be filed with the component society. Thereupon, it shall be the duty of the Peer Review/Ethics Committee or its Chair to fix the time and place for a formal hearing thereon. A written notice of such hearing, together with a copy of the formal complaint, shall be served on the respondent by registered or certified mail, or other appropriate means as approved by the MSMS Judicial Commission, not less than thirty days before the date of such hearing.~~

~~8.20 ANSWER TO FORMAL COMPLAINT It shall be the duty of the respondent to file an answer to the formal complaint. Such answer shall be in writing, signed by the respondent, and filed with the Peer Review/Ethics Committee within fifteen days after service of the copy of the formal complaint. The answer shall admit or deny each material allegation contained in the complaint, and shall set forth any special defenses which the respondent claims to have. If the answer is not filed within the time hereby limited, the complaint may be taken as confessed.~~

~~8.30 FORMAL HEARING – HOW CONDUCTED — RIGHT TO COUNSEL It shall be the duty of the respondent to appear before the Peer Review/Ethics Committee in person at the time and place specified in such notice. Both the respondent and the Peer Review/Ethics Committee shall be entitled to be represented by counsel at such hearing. At such formal hearing, it shall be the duty of the respondent~~

to answer fully and fairly all questions pertaining to conduct which may be asked by any member of the Peer Review/Ethics Committee of the component society or its counsel. Formal hearings shall be conducted fairly, but not necessarily in accordance with all rules governing court trials. A stenographic record shall be made of the proceedings at such hearings.

8.40 FINDINGS AND REPORT If upon formal hearing the Peer Review/Ethics Committee finds that the charges of misconduct are not established by a preponderance of the evidence, the Committee shall dismiss the complaint. If the Committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant discipline by way of reprimand, the Committee shall administer such reprimand, and shall make a written report thereof, together with its findings of fact, to the component society. If the Committee finds that the charges of misconduct or any of them are established by a preponderance of evidence and are such as to warrant suspension or expulsion from membership by action of the component society, the Committee shall make a written report of the proceedings held before the Committee, and shall include in such report a certified transcript of the evidence, including copies of all documents taken in proof, a summary statement of all previous misconduct for which the respondent has been disciplined, and the Committee's findings of fact and recommendations for discipline. Every such report shall be signed by not fewer than a majority of the members of the Peer Review/Ethics Committee, and shall be filed with the component society.

8.50 ACTION ON REPORT - ADDITIONAL TESTIMONY Whenever a Peer Review/Ethics Committee files a report with its component society recommending suspension or expulsion as herein provided, the respondent shall be served with a copy of the Committee's findings of fact and recommendations so filed, not less than twenty days before the meeting of the component society at which such recommendations are to be considered and acted on, together with a notice of the time and place of such meeting. The respondent may thereupon file with the Society not less than ten days before such meeting reasons in writing why the recommendations of the Peer Review/Ethics Committee should not be adopted. The respondent may also at such meeting appear in person and offer any further reasons why such respondent should not be suspended or expelled from membership; provided, however, that at such meeting no testimony as to any matter of misconduct shall be taken. If it is decided at such meeting that the interests of justice require additional testimony to be taken, the matter shall be referred to the Peer Review/Ethics Committee for such purpose. In such event the Peer Review/Ethics Committee shall cause such additional testimony to be taken promptly, and shall make a supplemental report thereon, including findings of fact and recommendations based thereon, and shall file the same, together with a certified transcript of such additional testimony with the component society. A copy of the findings of fact and recommendations contained in the supplemental report shall be served on the respondent as required in the case of an original report, and thereafter the same procedures shall be followed as in this section provided in relation to an original report.

8.60 ACTION BY SOCIETY Following the filing of any such report of a Peer Review/Ethics Committee recommending suspension or expulsion, the component society shall, at a regular meeting thereof, or at a special meeting called for such purpose, consider and act upon the report and recommendation of the Peer Review/Ethics Committee. Suspension or expulsion from membership shall require the affirmative vote of not less than two-thirds of members present at any such meeting and entitled to vote thereat, but not including the respondent, who shall have no right to vote on the question. If any measure for discipline is adopted by a component society, an appropriate order in accordance therewith shall be signed by the President and Secretary of such Society and a copy thereof served on the respondent and on the Michigan State Medical Society.

8.70 FINALITY AND EFFECTIVENESS OF ORDER No order of suspension or expulsion from membership shall be final or effective until the respondent shall have been given the opportunity to exhaust remedies of appeal and review in accordance with the provisions of this Chapter.

8.80 APPEAL PROCEDURE Any member feeling aggrieved by an order of suspension or expulsion may appeal to the Judicial Commission of the Michigan State Medical Society. Notice of such appeal shall be in writing, signed by the appellant and shall set forth specific reasons for the appeal. The notice shall be served on the Judicial Commission and on the appellant's component society by registered or certified mail, addressed to the respective secretaries thereof. Unless notice of appeal is so served within 30 days following the service on the member of a copy of the order of the suspension or expulsion as herein above provided, such member's right of appeal and review shall be conclusively treated as having been waived and the order of suspension or expulsion shall thereupon become final and effective. On receiving notice of appeal, the component society shall forward to the Judicial Commission the complete record of the matter, including copies of the order appealed from, all reports of the Peer Review/Ethics Committee, formal complaint, answer, transcript of testimony, exhibits and all other pertinent writings and data on which the order of suspension or expulsion was based. The Judicial Commission may request the component society or the appellant to furnish such further information in writing as the commission deems necessary for the proper and full review of the matter. Written arguments may be filed with the Judicial Commission by the component society and the

~~appellant within 45 days following notice of appeal. The Judicial Commission shall, within 90 days after receiving the full records in the case, review the record on appeal and the written arguments, make such findings as it deems appropriate and, by majority vote of the participating members of the Commission, affirm, modify or reverse the order of expulsion or suspension appealed from, or remand the matter for further action by the component society. In the consideration of any appeal, not less than six members of the Commission shall participate, and in the event that the participating members of the Commission are equally divided, so that no majority prevails, the order or finding appealed from shall stand affirmed.~~

~~A copy of such decision shall be promptly served on the appropriate component society and on the appellant by registered or certified mail. Unless within twenty days after service on them of a copy of such decision the component society or the appellant shall take an appeal to the Judicial Council of the American Medical Association, the right to such further appeal and review will be conclusively treated as having been waived, and the decision of the Judicial Commission shall be final and effective.~~

~~8.90 APPEAL TO JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION The appellant, if a member in good standing of the American Medical Association at the date of the alleged misconduct, or the component society, may, within twenty days after service of a copy of the final decision of the Judicial Commission, take an appeal there from to the Council on Ethical and Judicial Affairs of the American Medical Association.~~

~~9.10 EXCEPTION TO PROCEDURES Any member of a component society whose license to practice medicine shall have been revoked, or who shall have been convicted of a felony in any state or federal court, shall be expelled from the component and State Society without benefit of, or resort to, the procedures prescribed in this Chapter.~~

~~9.20 EFFECT OF SUSPENSION OR EXPULSION— Whenever a member of any component society is suspended or expelled from such society, he or she shall thereby also stand automatically suspended or expelled from the Michigan State Medical Society.~~

~~9.30 CONSTRUCTION Procedures under this Chapter of the Bylaws shall be as summary as may be reasonable. No investigation or proceeding hereunder shall be held invalid by reason of any non-prejudicial irregularity or for any error not resulting in a miscarriage of justice. The provisions of this Chapter shall be liberally construed for the maintenance of the dignity, integrity, purposes and high principles of this Society and its component societies.~~

~~10.00 GRIEVANCES OF NON-MEMBERS PEER REVIEW/MEDIATION COMMITTEE~~

~~10.10 PEER REVIEW/MEDIATION COMMITTEE— Every component society shall have a standing committee designated the Peer Review/Mediation Committee. Directors holding membership in a component society are eligible for membership on that component society's Peer Review/Mediation Committee.~~

~~10.20 PURPOSES The purposes of such committee shall be:~~

~~10.21 to afford the public an informal means of making known to the profession any alleged grievance arising from a physician-patient relationship;~~

~~10.22 to resolve misunderstanding between physician and patient or between the component society and the public;~~

~~10.23 to reconcile differences between physician and patient by means of persuasion and explanation; and~~

~~10.24 to assist the Peer Review/Ethics Committee of its component society in maintaining among members high levels of professional deportment.~~

~~It shall not be the purpose of this committee to establish fees, but serve to resolve disputes. Each case should be considered on its own merits and it shall not be the intent of the committee to establish precedents.~~

~~10.30 POWERS AND DUTIES LIMITATION The specific powers and duties to be exercised by such committee in furthering the purposes above set forth, shall be as fixed and determined by the component society, provided, however, that such committee shall function in the area of mediation or conciliation only and shall not have power to act as a trial body or to render decisions or awards, nor shall such committee have power to impose discipline or in any wise encroach upon the function of the Peer Review/Ethics Committee.~~

~~10.40 PROCEDURE TO GOVERN The provisions of this chapter shall be governed by the current Official Procedures of the Judicial Commission regarding mediation committees and procedures. Any provisions of this chapter in conflict therewith shall be of no effect.~~

~~11.00~~11. GENERAL MEETINGS

~~11.10~~11.1 DETERMINATION OF TIME AND PLACE—During each Annual Session the Society may hold one or more General Meetings. The number and times of these General Meetings shall be determined by the Board of Directors. Such General Meetings shall be presided over by the President or in his/her absence the President-Elect or the Chair of the Board of Directors.

~~11.20~~11.2 RIGHT TO PARTICIPATE—Each registered

member at an Annual Session shall have an equal right to participate in the deliberations of a General Meeting and each active member, active emeritus member, and life member so registered shall have the right to vote on pending questions before the General Meeting.

~~11.30~~11.3 ACTIONS—At any General Meeting or at any section meeting of this Society, there may be recommended to the House of Delegates or to the Board of Directors the appointment of committees or commissions for scientific investigations of special interest and importance to the profession and the public. Such investigations and reports shall not become official actions or expressions of this Society until approved by the House of Delegates or the Board of Directors.

~~12.00~~12. HOUSE OF DELEGATES

12.1. COMPOSITION—The House of Delegates shall be the legislative body of the Society and shall consist of delegates elected by component societies, recognized specialty societies, delegates from the Residents and Fellows, Students, Young Physicians, Organized Medical Staff and International Medical Graduates Sections, and other sections as shall from time to time be approved by the House of Delegates, delegates-at-large and ex officio members, as prescribed by the Bylaws.

~~12.10~~12.2 COMPOSITION—The House of Delegates shall be composed of members elected by the component societies, a delegate from each recognized specialty society, a delegate from the Resident and Fellow Section, one delegate from the Organized Medical Staff Section, a delegate from the Young Physicians Section, a delegate from the International Medical Graduates Section and one voting at-large delegate for every 50 MSMS student members to be selected by the MSMS Medical Student Section. These student delegates and alternate delegates must be members of the MSMS Medical Student Section. All other delegates and alternate delegates must be voting members of MSMS.

Each component society shall be entitled to send to the House of Delegates each year one delegate for each fifty voting members (active, life, and active emeritus) and one delegate for each additional major fraction thereof. Any component society having less than fifty members shall be entitled to send one delegate.

The president of a component medical society that all or part of which is located more than 400 miles by road from the site of the House of Delegates may designate a Regional Director of its region to serve as a delegate to the House of Delegates, provided that no member of the component medical society will otherwise be present in person serving as a delegate in any capacity. In the case of such designation of a single Regional Director by two or more component societies, said Regional Director shall have only one vote on all matters before the House of Delegates.

~~12.20~~12.3 DELEGATES-AT-LARGE - EX OFFICIO MEMBERS—Except as provided by Section 12.10, the officers of this Society, members of the Board of Directors, and the Chair, Vice Chair, and Secretary of the MSMS Sections recognized by these Bylaws, shall be ex officio members of the House of Delegates, but with the exception of the Speaker and Vice Speaker of the House of Delegates, shall be without power to vote therein. The Past President shall be a member-at-large of the House of Delegates during the first year of past- presidency with right to vote and hold office. All other Past Presidents shall have the privilege of the floor, without the right to vote.

~~Except for the Speaker, Vice Speaker, Immediate Past President, and as otherwise provided in Section 12.10, members~~Members of the Board of Directors are ~~not~~ eligible for election as delegates by their component societies.

~~The dean of each accredited medical school in Michigan, if an active member of MSMS, shall be a delegate-at-large to the House of Delegates, with voting privileges. An alternate may not be seated for any dean, and any provisions of these Bylaws regarding the seating of an alternate shall not apply.~~

The Chief Medical Officer of the Michigan Department of Community Health, if an active MSMS member, shall be an ex officio member of the House of Delegates, but without power to vote therein. No alternate may be seated in place of that officer and any provision of these Bylaws regarding the seating of an alternate shall not apply.

~~12.30~~12.4 ELECTION - CERTIFICATION—Each component society shall elect the number of delegates to which it is entitled. The number of delegates shall be determined by the State Society as of December 1, preceding the House of Delegates meeting. The component society shall also elect an equal number of alternate delegates and shall designate the order or seniority thereof. Promptly after election the secretary of the component society, recognized specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section shall certify the names of its delegates and alternate delegates to the Secretary of this Society.

~~12.40~~12.5 SEATING - TENURE—A delegate becomes a member of the House of Delegates when the Speaker is notified in writing of the delegates election by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section. Such certification shall be submitted by February 1 of each year. The delegate shall remain a

member of the House of Delegates until the Speaker is notified, in writing, by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section that the delegate has been replaced. The delegate shall remain a member of the House of Delegates regardless of whether or not an alternate substitutes for him/her at any meeting of the House.

~~12.50~~12.6 SEATING OF ALTERNATE DELEGATES—An alternate delegate may substitute for a duly certified delegate at any regular or special meeting of the House of Delegates provided that such substitution is authorized in writing by the secretary of the component society, specialty society, Resident and Fellow Section, Medical Student Section, Young Physicians Section, International Medical Graduates Section or Organized Medical Staff Section.

~~12.60~~12.7 OFFICERS—The officers of the House of Delegates shall be the Speaker and Vice Speaker. The Secretary of the Society shall be the Secretary of the House of Delegates. The Speaker and Vice Speaker shall be elected by the House of Delegates at the Annual Session from the members of the then-constituted House of Delegates for a one-year term. The Speaker and Vice Speaker of the House of Delegates shall be limited to no more than four one-year terms in each position.

~~12.70~~12.8 MEETINGS - ANNUAL SESSION—The House of Delegates shall meet at least annually at the time and place of the Annual Session of this Society and may hold such number of meetings as the House may determine or its business require, recessing from day to day as may be necessary to complete its business and specifying its own time for the holding of its meeting. The House of Delegates may also be called into session at any time by the Speaker upon a two-thirds vote of the Board of Directors, or on petition of twenty-five percent of the Delegates. The purposes of such special session shall be stated in the notice of call and no other business shall be transacted.

~~12.80~~12.9 QUORUM—A quorum of the House of Delegates shall consist of not less than 40 percent of the accredited delegates, provided that a majority of such quorum shall not come from any one component society, and the presence of a quorum established at the beginning of the business portion of a meeting shall be sufficient to conduct official business for the duration of the meeting.

~~12.90~~12.10 POWERS AND DUTIES—As the legislative body of this Society, the House of Delegates shall have the power ~~arid~~and authority to adopt, institute, and carry out such methods and measures as it may deem to be in the best interests of the medical profession in Michigan. In the exercise of such powers and duties, but without limitation thereof:

~~12.91~~ 12.10.1 It shall transact all of the business of this Society not otherwise specifically provided for.

~~12.92~~ 12.10.2 It shall adopt rules and regulations for its own government and for the administration of the affairs of the Society.

12.10.3 ~~12.93~~ It shall provide for the organization of Regions which shall be depicted on Exhibit A.

12.10.4 ~~12.94~~ It shall concern itself with and advise as to the interests of the profession and of the public in those matters of legislation pertaining to medical education, medical registration, medical laws, and the health of the public.

12.10.5 ~~12.95~~ It shall be active in the education of the public in regard to medical research and scientific medicine.

12.10.6 ~~12.96~~ It shall have the power to identify areas of concern and to instruct the Board of Directors to appoint committees or task forces to study or act on those areas. These committees or task forces shall report to the Board of Directors, which in turn shall report in the annual report of the Board of Directors to the House of Delegates. The House of Delegates shall itself have necessary internal committees, such as I) Credentials, 2) Rules of Orders of Business, 3) Constitution and Bylaws, and 4) Ways and Means.

The seated House, by majority vote, reserves the right to instruct the Board of Directors to discharge a specific standing committee, liaison committee, or task force, and to require the Board of Directors to appoint an ad hoc committee with appointees nominated by the seated House. This ad hoc committee shall report through the Board of Directors to the House at the next session, and be discharged.

~~12.97~~12.10.7 It shall approve each action and resolution in the name of this Society before the same shall become effective, provided that in the interim between Sessions of the House of Delegates the Board of Directors or the Executive Committee thereof may, when prompt action is necessary or desirable, act for the Society.

12.10.8 ~~12.98~~ It shall publish its minutes or a summary of its proceedings ~~in the Journal of the Society~~.

~~12.99~~12.10.9 It shall have the power to authorize the borrowing of money against the general credit of the Society or by way of mortgage, pledge of hypothecation. It shall have the authority specifically to authorize the Board of Directors and the Society's officers to execute such instruments as may be required to encumber the Society's assets as aforesaid.

12.10.10 Funds for meeting the expenses of the Society shall be raised by annual dues and may be augmented by other methods including special assessments and voluntary contributions. Annual membership dues and assessments shall be fixed by the House of Delegates

~~13.10~~12.11 REFERENCE COMMITTEES—The House of Delegates shall have the following reference committees, together with tellers and sergeants-at-arms, appointed by the Speaker of the House and approved by the House of Delegates, and such other reference committees as may be deemed necessary to conduct the business of the House:

1. Credentials
2. Rules and Order of Business
3. Constitution and Bylaws (which shall serve also as the standing Committee on Constitution and Bylaws)
4. Ways and Means

~~13.20~~12.12 ELECTION OF REGIONAL DIRECTORS—Regional Directors shall be elected as provided in Article IX, Section 1(a) of the Constitution. Each component society in a Region shall be notified in writing by the Secretary of the Society at least sixty days in advance of the Annual Session when a Regional Director is to be elected from that Region.

If, by reason of death or resignation, a vacancy in the office of Regional Director occurs at any time other than during an Annual Session, each component society in that Region shall be promptly notified in writing by the Secretary of the Society. Thereupon the seated delegates of such Region may caucus, and if a majority of the seated delegates from such Region shall submit a nomination to the Board of Directors to fill such vacancy, the Board of Directors shall appoint such nominee to serve as interim Regional Director of such Region until a successor is elected in accordance with Article IX, Section 1(e) of the Constitution.

If a vacancy in the office of Regional Director occurs during an Annual Session of the Society, the delegates of the component societies in the Region affected shall be given notice thereof and afforded time to caucus and consider nominations to fill such vacancy.

~~13.30~~12.13 ELECTION OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION—The House of Delegates shall elect delegates and alternate delegates to the American Medical Association in accordance with the regulations of that parent organization and as hereinafter provided.

Delegates and alternate delegates to the American Medical Association shall be elected for two-year terms.

Any physician filling the position of delegate or alternate delegate to the American Medical Association must ~~spend the majority of his/her professional time~~average 20 hours per week or more in active clinical practice; teaching; research; and/or administrative practice and be a full-time Michigan resident, unless they hold an elected or appointed AMA Council position for which they are still eligible.

At each Annual Session, candidates for delegates to the House of Delegates of the American Medical Association shall be nominated in number equal to or greater than the number to be elected that year. Election shall be by ballot. The required number of candidates receiving the greater number of votes shall be declared elected.

In case of a tie vote the winner or winners shall be decided by drawing lots under the supervision of the Speaker of the House of Delegates; provided, however, that any candidate thus tied shall have the right to a decision by ballot on request.

The number of alternate delegates shall ~~equal~~be up to the number of delegates. They shall be elected in the same manner after all delegates have been elected.

Alternate delegates shall have seniority according to the greatest length of service as an alternate delegate. When it occurs that two or more alternate delegates have equal lengths of service, seniority shall be determined by the respective number of votes received by each when first elected, and such seniority shall be designated at the time of the first election.

When a delegate shall be unable to attend a meeting of the House of Delegates of the American Medical Association that seat shall be filled by an alternate delegate chosen in order of seniority as defined in this Section.

Should the Society become entitled to one or more additional delegates subsequent to the Annual Session of the House of Delegate in any year, such additional delegate or delegates shall be designated and accredited by the Board of Directors until the next Annual Session. In filling such offices alternate delegates shall be designated in order of their seniority as defined in this section.

~~13.40~~12.14 ELECTION OF OFFICERS—Election of officers of the Society shall take place at the House of Delegates at each Annual Session. All nominations shall be made from the floor of the House with the

exception of the Secretary and Treasurer who are elected by the Board of Directors. If there is only one nomination for any office, the candidate so nominated may be elected viva voce.

~~13.50~~12.15 RESOLUTIONS—Each resolution introduced in the House of Delegates shall be introduced by a delegate. It shall be presented in writing to the Secretary. It shall be referred by the Speaker to the proper reference committee before action is taken thereon.

~~13.60~~12.16 NEW BUSINESS—No new business shall be introduced in the last meeting of a session of the House of Delegates without unanimous consent of the delegates present except when presented by the Board of Directors. All new business so introduced shall require the affirmative vote of three-fourths of the delegates present for adoption.

~~13.70~~12.17 RULES OF ORDER—When not in conflict the Constitution or Bylaws of this Society, the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* shall govern the parliamentary procedure of the House of Delegates.

~~13.80~~12.18 NOMINATING COMMITTEE - The House of Delegates shall form a Nominating Committee consisting of ten members. The Society's Immediate Past President shall be a member and serve as the chairperson and there shall be one member from each Region who shall be elected by the members holding membership in a county located in that Region. The elected members of the Nominating Committee must be a delegate with the right to vote in the House of Delegates and not be a member of the Board of Directors. It shall be the duty of the Nominating Committee to provide the Speaker of the House of Delegates at least thirty days prior to each annual session of the House of Delegates with at least one nomination for each of the Designated Director positions. The members of the Nominating Committee shall carefully review the credentials of each potential candidate, seek out the most qualified candidates for these positions and when possible insure that the candidates nominated reflect the diversity of the Society's membership.

13. RESERVED

~~14.00~~14. THE BOARD OF DIRECTORS

14.1. COMPOSITION—The Board of Directors shall be the executive body of the Society. Effective at the first meeting of the Board of Directors immediately following the final meeting of the House of Delegates held at its 2020 Annual Session, the Board of Directors shall consist of:

14.1.1 Two Directors (the "Regional Directors") from each of the nine regions depicted on Exhibit A to the Bylaws (each a "Region" and collectively the "Regions"). The Regional Directors shall be elected by those members holding membership in a county located in that Region. No more than one Regional Director may hold membership in a single county unless a region consists of a single county. One Regional Director must hold membership in a county located in the upper peninsula.

14.1.2 The President, President-Elect, Immediate Past President, Secretary, Treasurer, Speaker and Vice Speaker of the House of Delegates.

14.1.3 One Director elected by those members in each of the membership classifications defined in Sections 2.5 and 2.6 of the Bylaws, and one Director elected by those members in the Young Physicians Section as defined in Section 2.60 of the Bylaws. These seats will be for one-year renewable terms, and the directors elected must remain in the category elected for the entire term.

14.1.4 The following ex officio Directors: (i) the Chair of the delegates to the AMA or another member of the delegation, designated as a substitute; and (ii) the two members serving as the physician representatives on the Blue Cross Blue Shield of Michigan Board of Directors.

14.1.5 Up to six Directors elected by the House of Delegates representing those constituencies deemed from time to time the most relevant to the current health care marketplace to be designated by the nominating committee of the House of Delegates with input from the Board of Directors and the House of Delegates (the "Designated Directors"). The Designated Directors shall serve three-year terms. Designated Directors may not serve more than three consecutive terms; the same individual may serve additional terms after an absence of at least one year.

14.2 POWERS AND DUTIES—The Board shall have the custody and entire control of all funds and property of the Society and shall act for the Society as a whole and for the House of Delegates between sessions.

14.3 EXECUTIVE COMMITTEE—The Board of Directors may have an Executive Committee with power to act between meetings of the Board. The composition, powers and duties thereof shall be such as are prescribed by the Bylaws.

~~14.10~~14.4 ORGANIZATION—The Board of Directors is the executive body of the Society. Subject only to the following, it shall determine the times and places of its meetings. At its first meeting immediately following the Annual Session of the House of Delegates, the Board of Directors shall elect a Secretary and Treasurer, who shall serve for a term of office of one year or until a successor is elected and takes office. At the same meeting, the Board of Directors shall elect a Chair, a Vice-Chair, a Chair of

the Finance Committee, a Chair of the Health Care Delivery Committee, a Chair of the Legislative Policy Committee, and a Chair of the Scientific and Educational Affairs Committee, who shall be duly elected Regional Directors or Designated Directors, each to take office immediately and to serve for a term of one year or until a successor is elected and takes office.

~~14.20~~14.5 EXECUTIVE COMMITTEE—The Executive Committee of the Board shall consist of the President, President-Elect, Immediate Past President, Chair, Vice-Chair, Speaker, Secretary and Treasurer. The Chair of the Board shall serve as Chair of the Executive Committee.

~~14.30~~14.6 REFERENCE COMMITTEES—The Reference Committees of the Board of Directors and their composition and duties shall be as follows:

14.6.1 ~~14.31~~ The Scientific and Educational Affairs Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Scientific and Educational Affairs Committee shall advise the Board of Directors on matters of scientific and educational activity and relationships with component medical societies, and consider other matters referred to it by the Board of Directors.

14.6.2 ~~14.32~~ The Finance Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members, of which one shall be the Treasurer, ex officio, with power to vote, and the remainder appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Finance Committee shall advise the Board of Directors on administration of the Society's finances, and consider other matters referred to it by the Board of Directors.

14.6.3 ~~14.33~~ The Legislative Policy Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Legislative Policy Committee shall advise the Board of Directors on matters of legislation and liaison with governmental agencies and shall consider other matters referred to it by the Board of Directors.

14.6.4 ~~14.34~~ The Health Care Delivery Committee shall consist of a Chair elected by the Board of Directors as provided in Section 14.10 and members appointed by the Chair of the Board of Directors with the advice and approval of the Board of Directors. The Health Care Delivery Committee shall advise the Board of Directors on matters concerning the financing and delivery of health care and shall consider other matters referred to it by the Board of Directors.

~~14.40~~ 14.7 REGIONAL DIRECTOR DUTIES—Each Regional Director shall be the organizer, peacemaker and censor for the Region. The Regional Director shall visit each component society in the Region at least once a year and shall keep in touch with the activities of the component societies constituting the Region. The Regional Director shall make such reports as the Chair of the Board of Directors shall request concerning the condition of the profession in the Region.

~~14.50~~ 14.8 REMOVAL OF REGIONAL DIRECTOR—Upon written complaint signed by not less than one-half of the Delegates from a Region presented to the House of Delegates in Annual or Special Session charging that the Regional Director for such Region has been remiss in the duties prescribed above, and that at least one month's notice of such proposed action has been given, the Speaker shall bring the matter before the House of Delegates for consideration. By the vote of not less than two-thirds of the House of Delegates present at the meeting at which such matter is considered, such Regional Director may be removed from office and a successor elected.

~~14.60~~14.9 DUTIES OF THE BOARD OF DIRECTORS—It shall be the duty of the Board of Directors:

~~14.61~~ 14.9.1 To make careful inquiry into the condition of the profession in each county in the State. It shall have authority to adopt such methods as may be deemed most efficient for increasing interest in all existing component societies. It shall especially and systematically endeavor to promote friendly intercourse between doctors of medicine in the same locality. It shall make every effort to bring each reputable doctor of medicine in the State under the Society's influence;

~~14.62 To direct and control the publication of the Journal of the Michigan State Medical Society;~~

~~14.63~~ 14.9.2 To provide and maintain such headquarters for this Society as may be required to conduct its business properly;

~~14.64~~ 14.9.3 To render an Annual Report to the House of Delegates; and

~~14.65~~ 14.9.4 At least every three years, review the composition of the Board of Directors including the geographical boundaries of the Regions making any recommendations in its discretion it deems necessary.

14.10 ~~14.70~~ CONTROL OF FUNDS—The funds of this

Society shall be disbursed only by order or action of the Board of Directors. This authority may be delegated to the Executive Committee of the Board of Directors.

14.10.1 ~~14.71~~ The Board of Directors shall have the authority to borrow money upon the general credit of the Society. The Board of Directors shall not have the power to mortgage the real estate of the Society or to pledge or hypothecate any of its other assets. The Board of Directors shall authorize and empower the President or the Chair of the Board of Directors, and the Secretary or the Treasurer to execute such instruments as may be required.

~~14.80~~14.11 REGIONS – For the purpose of electing Regional Directors and any other purposes described in these bylaws, there shall be those regions depicted on Exhibit A.

15. RESERVED.

~~15.00 THE JUDICIAL COMMISSION~~

~~15.10 COMPOSITION – QUALIFICATIONS The Judicial Commission shall be composed of ten members, each of whom shall be a voting member of the Society in good standing. No member of the Judicial Commission shall, during tenure of office, hold any of the following offices or positions: Speaker or Vice-Speaker of the House of Delegates of this Society, or District Director of this Society. Any member of the governing board of a component society which serves in these capacities, shall not, as a Commissioner, participate in deliberations pertaining to a grievance involving a member of that component society or cast a vote in respect thereto.~~

~~15.20 JUDICIAL DISTRICTS There shall be seven Judicial Districts formed by grouping component societies as follows:~~

~~District 1 – Wayne~~

~~District 2 – Macomb, Oakland. St. Clair~~
~~District 3 – Ingham, Livingston, Monroe, Shiawassee, Washtenaw~~
~~District 4 – Bay, Iosco-Arenac, Genesee, Gratiot, Huron, Isabella-Clare, Lapeer, Midland, Saginaw, Sanilac, Tuscola~~
~~District 5 – Allegan, Berrien, Branch, Calhoun, Cass, Eaton, Hillsdale, Jackson, Kalamazoo, Lenawee, St. Joseph, Van Buren~~
~~District 6 – Barry, Clinton, Ionia-Montcalm, Kent, Mason, Mecosta-Osceola-Lake, Muskegon, Newaygo, Oceana, Ottawa~~
~~District 7 – Alpena-Alcona-Presque Isle, Chippewa-Mackinac, Delta, Dickinson-Iron, Gogebic, Grand Traverse-Leelanau-Benzie, Houghton-Baraga-Keweenaw, Luce, Manistee, Marquette-Alger, Menominee, North Central Counties (Crawford, Gladwin, Kalkaska, Montmorency, Otsego, Roscommon), Northern Michigan (Antrim, Charlevoix, Cheboygan, Emmett), Ogemaw- Oscoda, Ontonagon, Schoolcraft, Wexford- Missaukee~~

~~15.30 NOMINATIONS On or before July 15 each year, the Chair of the Board of Directors shall, with the advice and consent of the Board of Directors, appoint a Nominating Committee composed of seven members of the Board of Directors. Such Nominating Committee shall select from the voting members in good standing of the Society in each Judicial District at least twice as many nominees for the office of Judicial Commissioner as are to be elected in such year from such District. After obtaining the consent of such nominees to become candidates, the Nominating Committee shall submit its list of nominations to the Secretary of the Society on or before September 1st each year. Within ten days thereafter, the Secretary of the Society shall post a list of such nominations in a conspicuous place in the headquarters building of the Society and shall mail a list of such nominations to the secretary of each component society and shall give notice to the secretary of each said component society that the voting members of this Society within the several Judicial Districts have the right to make additional nominations by petition as hereinafter set forth. Promptly upon receipt of such notice and list of nominations, the secretary of each component society shall make such nominations known to the voting members thereof in such manner as shall be determined by the component society. Additional nominations may be made by petition signed by not less than twenty-five voting members in good standing in any Judicial District. Such nominating petitions shall be filed with the Secretary of this Society not later than October 15.~~

~~15.40 BALLOT – ELECTION Under the direction of the Secretary of the Society, ballots shall be prepared for each Judicial District from which a member of the Commission is to be elected. On or before November 10 each year in which a member of the Commission is to be elected from such district, the Secretary of the Society shall send a ballot containing the names of all nominees, arranged in alphabetical order, to each voting member in good standing of the Society in such Judicial District. Ballots shall be marked and returned to the office of the Society no later than December 1 and any ballot bearing a return date later than such date shall not be counted. Each ballot, to be valid, must be voted for neither a greater nor a smaller number of nominees than are to be elected from such district at such election. The ballot furnished to voting members shall have printed upon it a copy of the preceding sentence.~~

~~The valid ballots so cast shall be tabulated and the results certified by the Secretary of the Society. In case of a tie vote, the winning candidate shall be determined by lot under the supervision of the Secretary. Those elected shall be notified by the Secretary and the names of those elected shall be made known to the members of the Society through publication in the Journal of the Society or by such~~

~~other means as shall be directed by the Board of Directors.~~

~~15.50 TERMS OF OFFICE—At the election held in the year 1965, four members of the Commission shall be elected from District 1, and one each from District 2, 3, 4, 5, 6 and 7. At the first meeting of the Commission following the election in 1965, it shall be determined by lot that two of the members elected from District 1 shall serve for a term of three years each, one for a term of two years, and one for a term of one year. Thereafter, one member of the Commission shall be elected annually from District 1 to serve for a three year term, provided, however, that in the year 1968 and each third year thereafter, two members shall be elected from District 1 to serve for terms of three years each. It shall also be determined by lot at such meetings that two of the members elected from Districts 2, 3 ,4, 5, 6, and 7 shall serve for terms of three years each, two for terms of two years each and two for terms of one year each. Thereafter, one member of the Commission shall be elected annually from each of Districts 2, 3, 4, 5, 6, and 7 in which an elective term expires, such election to be for a term of three years.~~

~~15.60 VACANCIES—Whenever a vacancy occurs as the result of the death or resignation of a Commissioner or from any other cause, the President of the Society shall have the authority, acting with the advice of the Regional Directors of the Judicial District affected, to appoint a Commissioner from the district affected, such appointee to serve until the next election of Commissioners at which time a Commissioner shall be elected to serve for a remainder of the unexpired term.~~

~~15.70 ORGANIZATION OF THE COMMISSION—The Commission shall meet as soon as feasible after each annual election and at such meeting select a Chair, a Vice Chair, and such other officers as may be deemed desirable. The terms of such officers and their duties and responsibilities shall be as determined by the Commission.~~

~~15.80 POWERS AND DUTIES—The Judicial Commission shall have:~~

~~15.81 Authority to make binding interpretations of the Constitution and Bylaws of this Society and of the several component societies as they pertain to matters of ethics, mediation, grievance and discipline.~~

~~15.82 Authority to make ethical interpretations and decisions in accordance with the standards of the American Medical Association.~~

~~15.83 Sole appellate powers at the state level in all matters relating to ethics, professional conduct, mediation and discipline of members of component societies.~~

~~15.84 The power to entertain and exercise original jurisdiction in matters pertaining to ethics, mediation, conduct of members or discipline of members when requested to do so by any component society or by any member in good standing of this Society.~~

~~15.85 The power and authority to make and promulgate from time to time, rules and regulations governing all procedures pertaining to ethics, grievances, mediation, professional conduct and discipline of members, which rules and regulations shall be binding upon all component societies.~~

~~15.86 The power and authority to appoint such committees and to adopt such rules, regulations and procedures as, in the sole judgment of the Commission, are deemed desirable in carrying out the functions and purposes of the Commission.~~

~~16.00~~16. COMMITTEES/TASK FORCES OF THE SOCIETY

~~16.10~~16.1 STANDING COMMITTEES—The Board of Directors shall designate standing committees of the Society to deal with ongoing subjects. The chair and members shall be appointed by the Board of Directors upon recommendation of the Chair of the Board of Directors. Committee chairs shall be appointed to serve for a term of two years. Members shall be appointed to serve two-year staggered terms, and be eligible for re-appointment.

The Chair of the Board of Directors shall appoint at least one Board member to each standing committee. The Board member shall be a voting member of the committee. The Board member shall be expected to attend committee meetings, participate in committee activities, and interpret to the Board of Directors the committee's recommendations that come before it via special reports.

If necessary, a standing committee may appoint one or more of its members to research a subject. The subgroup shall report its findings to the standing committee.

Standing committees shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. Each standing committee shall submit an annual summary of its activities, without recommendations, to the House of Delegates.

~~16.20~~16.2 LIAISON COMMITTEES—The Board of Directors shall designate liaison committees to carry out MSMS liaison relationships with selected organizations and agencies. The chair and members shall be appointed by the Board of Directors upon recommendation of the Board Chair. Committee chairs shall be appointed to serve for a term of two years. Members shall be appointed to serve two- year

staggered terms, and be eligible for reappointment.

The Chair of the Board of Directors may appoint a District Director to selected liaison committees. The District Director shall be a voting member of the committee, and shall be expected to attend committee meetings, participate in committee activities, and interpret to the Board of Directors the committee's recommendations that come before it via special reports.

If necessary, a liaison committee may appoint one or more of its members to research a subject. This subgroup shall report its findings to the liaison committee.

Liaison committees shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. Each liaison committee shall submit an annual summary of its activities, without recommendations, to the House of Delegates.

~~16.30~~16.3 TASK FORCES—The Board of Directors shall create task forces as needed for specific assignments. Each task force shall be charged to study certain problems and to recommend courses of action to the Board of Directors. The chair shall be appointed to serve for a term of two years. The members shall be appointed by the Board of Directors upon recommendation of the Board Chair.

Task forces shall submit action reports to the Board of Directors on matters concerning MSMS policy or requiring the expenditure of MSMS funds, and informational reports as necessary to keep the Board of Directors informed. The action of the task forces may be included in the Board of Directors Annual Report to the House of Delegates, if the Board Chair deems it appropriate.

~~17.00~~17. OFFICERS

17.1 OFFICERS—The officers of this Society shall be a President; a President-Elect; the Immediate Past President; a Treasurer; a Secretary; a Speaker and a Vice-Speaker of the House of Delegates and shall be elected as provided in the Bylaws.

~~17.10~~17.2 TERM OF OFFICE—Except as herein otherwise provided, officers shall take office immediately after the election and shall serve until the next Annual Session and until their respective successors shall have been elected. Regional Directors shall serve for three years and may not serve more than three consecutive terms, provided, however that a Regional Director may serve additional terms after an absence of at least one year.

A physician may not serve on the Board of Directors for more than 12 years in any capacity. The slotted, one-year positions for the Student Section, the Resident and Fellow Section, and the Young Physician Section will not be counted in the lifetime aggregate of 12 years.

~~17.20~~17.3 INDUCTION OF PRESIDENT—At the Annual Session of this Society, next following election, the President-Elect shall be installed into and assume the office of the President, and shall serve until a successor takes office. The assumption of office shall take place in a General Meeting of the Society as a whole or in a meeting of the Annual Session of the House of Delegates.

~~17.30~~17.4 PRESIDENT—The President shall be the principal spokesperson for the Society, communicating to the membership and the public the official action and policies of the organization. The President shall be the principal officer to liaison with component societies, and to report on the conditions and concerns of the membership. The President shall preside over the General Meeting of the Society and shall deliver the President's Address to the House of Delegates and participate in its deliberations but without vote.

The President shall be an ex officio member of the Board of Directors and its Executive Committee with power to vote therein.

The President shall perform such other duties as are imposed by the Constitution and Bylaws of this Society.

~~17.40~~17.5 PRESIDENT-ELECT-DUTIES-SUCCESSION—The President-Elect shall act for the President in the President's absence or disability. Should the office of President become vacant, the President-Elect shall succeed to the presidency for the unexpired term. Should the office of President thereafter again become vacant, the Board of Directors at a regular or special meeting, shall elect a President to serve until the next Annual Session of the Society.

The President-Elect shall be an ex officio member of the Board of Directors with the right to vote therein.

~~17.50~~17.6 CHAIR OF THE BOARD—The Chair shall preside at all meetings of the Board of Directors and its Executive Committee and direct and supervise the preparation of the agenda for the meetings of the Board and the Executive Committee. The Chair shall consult with the Presidents and Chief Executive Officer as necessary and appropriate on behalf of the Society.

The Chair of the MSMS Board shall be familiar with the day-to-day operations of the Society and its executive staff, to provide advice and guidance regarding the implementation of policy.

~~17.60~~17.7 VICE-CHAIR—The Vice-Chair of the Board shall preside at meetings of the Board in the absence of the Chair or at the Chair's request, and shall perform such other duties as custom and parliamentary usage require.

In the event the office of Chair is vacated through

death or resignation, the Vice-Chair shall become Chair Pro Term until the next meeting of the Board when a new Chair shall be elected.

~~17.70~~17.8 TREASURER—The Treasurer, under the direction and control of the Board of Directors, shall be the custodian of all the invested funds and the securities of the Society. The Treasurer shall be accountable through the Board of Directors to the Society. The Board of Directors shall cause an annual audit of the accounts to be made. The Treasurer shall be bonded in amount considered sufficient by the Board of Directors, the cost of such bond to be paid from the funds of the Society. The Treasurer shall perform such other duties as are imposed by the Constitution and Bylaws of the Society.

~~17.80~~17.9 SECRETARY—The Secretary shall be a member of the Society and shall serve as the recording officer of the House of Delegates and the Board of Directors.

The Secretary, in addition to having the rights and duties ordinarily devolving on the secretary of a corporation by law, custom of parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, shall perform the following specific duties unless otherwise directed or assigned by the Board of Directors.

~~17.81~~17.9.1 Perform ceremonial duties, including the administering of the oath of office to the incoming President.

~~17.82~~17.9.2 Serve as official contact with the component medical societies concerning memberships and dues transfers.

~~17.83~~ 17.9.3 Review requests for the use of the MSMS mailing list and authorize its use.

~~17.84~~17.9.4 Serve as an official MSMS signatory for official regulatory and governmental documents.

~~17.85~~17.9.5 Be available to the Chief Executive Officer and staff for consultation and advice on day- to-day staff problems.

~~17.90~~17.10 CHIEF EXECUTIVE OFFICER—There shall be Chief Executive Officer, not necessarily a doctor of medicine or a member of the Society, who shall be designated by contract approved by the Board of Directors on an annual basis and who shall be remunerated in an amount which shall be fixed by the Board of Directors. The Chief Executive Officer shall be bonded in an amount considered sufficient by the Board of Directors, the cost of which shall be paid from the funds of the Society.

~~18.10~~17.11 SPEAKER OF THE HOUSE OF DELEGATES— The Speaker of the House of Delegates shall preside at sessions of the House of Delegates. The Speaker shall perform such duties as custom and parliamentary usage require, and shall be a member of the Board of Directors and of its Executive Committee with the power to vote.

~~18.20~~17.12 VICE-SPEAKER OF THE HOUSE OF DELEGATES—The Vice-Speaker of the House of Delegates shall assume the duties of the Speaker when the Speaker is absent at a meeting of the House of Delegates and at such other times as the House of Delegates or the Board of Directors (between Sessions of the House) shall determine. The Vice-Speaker shall be a member of the Board of Directors with the power to vote.

~~18.30~~17.13 REMUNERATION—Each of the following officers, namely, the President, the Chair of the Board of Directors, the Secretary, the Treasurer, the Speaker of the House of Delegates, the President-Elect, and the Immediate Past President shall be entitled to draw from the funds of the Society a special expenses allowance in each year of incumbency of the office. The annual amount will be recommended by the Finance Committee to the Ways and Means Committee and approved or amended by the House of Delegates. These officers shall not be required to account to the Society for the expenditure of such funds, which shall be in addition to ordinary reimbursable expenses.

18. RESERVED

~~19.00~~19. INDEMNIFICATION

~~19.10~~19.1 The Board of Directors may indemnify any person for any liability, claim or expenses incurred or to be incurred, by reason of the fact that such person was or is a director, officer, employee, agent, or committee member of the Society, or was or is serving at the request of the Society as a director, officer, employee, agent, or committee member of a corporation, partnership, joint venture, trust, or other entity owned, in whole or in part, by the Society, or established by the Board of Directors of the Society. The extent and terms of such indemnifications shall be determined by the Board of Directors of the Society, either in advance or on a case by case basis; provided, however, such indemnification shall not be broader or more inclusive than permitted by law either at the time of the act or omission to be indemnified against or at the time of carrying out such indemnification.

~~20.00~~20. SPECIALTY AND ETHNIC MEDICAL SOCIETIES

~~20.10~~20.1 RECOGNIZED SPECIALTY AND ETHNIC MEDICAL SOCIETIES—To provide representation for the interests of medical specialty and ethnic medical societies within the structure of the Michigan State Medical Society, Michigan specialty and ethnic medical societies can be recognized and eligible for a delegate and alternate delegate to the MSMS House of Delegates provided the criteria as set forth in Section 20.20 has been met. A list of recognized specialty and ethnic medical societies will reside in

the MSMS Chief Executive Officer's Office.

~~20.20~~20.2 CRITERIA—Specialty and ethnic medical societies that wish to be included as a recognized specialty or ethnic medical society must meet the following criteria: a) be statewide in scope, with a minimum of one meeting per year; b) be a statewide specialty or ethnic medical society at least five years old; c) have 25 or more active physician members of whom 50 or 50 percent or more maintain their membership in MSMS; and d) be approved by the House of Delegates.

The governing body of the specialty and ethnic medical society must take formal action requesting delegate representation by sending a letter to the MSMS Board of Directors. The Board would then determine if the society meets the criteria and, if so, make a recommendation to the House of Delegates.

The method of determining whether the specialty or ethnic medical society meets the membership criterion outlined in this section shall be the responsibility of the MSMS Board of Directors.

~~20.30~~20.3 RESIDENT AND FELLOW SECTION—To provide representation for the interests of residents and fellows within the structure of the Michigan State Medical Society, there shall be a Section on Residents and Fellows, composed of resident physicians (physicians-in-training) who are residents in an AMA-recognized residency program in Michigan, fellows serving as their primary occupation in a structured educational program begun immediately upon completion of medical school, residency or fellowship training, and who are active members of MSMS, and of medical students after March 15 of their senior year.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to residents and fellows in Michigan.

At its annual meeting the Section shall elect a chair, a vice-chair, a secretary, a delegate and an alternate delegate to the MSMS House of Delegates, each of whom shall serve for a term of one year.

At its annual meeting, the Section shall elect a representative to fill the residents' seat on the Board of Directors for a one-year renewable term to begin at the first Board of Directors meeting after the House of Delegates. If a vacancy in the residents' seat should occur during a term, the vacancy shall remain unfilled until the next term.

~~20.40~~20.4 MEDICAL STUDENT SECTION—To provide representation for the interests of medical students within the structure of the Michigan State Medical Society, there shall be a Section on Medical Students, composed of students of each established medical school in Michigan who are student members of MSMS.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to medical students in Michigan.

At its annual meeting, the Section shall elect a Governing Council consisting of a chair, a vice-chair, a secretary, a member of the Michigan Delegation to the AMA, and a representative to the MSMS Board of Directors. These officers shall all serve for one year-renewable terms to begin after the House of Delegates.

The Section shall also elect delegates to the MSMS House of Delegates, each of whom shall serve for one year. There shall be one delegate for every 50 MSMS student members.

If a vacancy in any of the officers' positions should occur during the term, that seat shall be immediately filled by election as provided in the Student Section Bylaws, with approval of the Board of Directors.

~~20.50~~20.5 ORGANIZED MEDICAL STAFF SECTION—To provide representation for the interests of hospital medical staffs and of other delivery systems within the structure of the Michigan State Medical Society, there shall be an Organized Medical Staff Section composed of MSMS members, one to be elected by and from the active voting physician members with clinical privileges of each JCAHO-accredited hospital in Michigan, and each other delivery system accepted by the Governing Council.

The purpose of this Section is to provide a direct means to address the relationship between MSMS members and organized medical staffs.

At its annual meeting, the Section shall elect a chair, a vice-chair, a secretary and two at-large members. It shall also elect one delegate and one alternate delegate to the MSMS House of Delegates, each of whom shall serve for a term of two years.

~~20.60~~20.6 YOUNG PHYSICIANS SECTION—To provide representation for the interests of young physicians within the structure of the Michigan State Medical Society, there shall be a section on young physicians, composed of physicians under 40 years of age and/or professionally employed through eight (8) years after residency and fellowship training programs, who are active members of MSMS.

The purpose of the Section will be to provide a forum within the organizational structure of the Society for the study and consideration of matters of special interest or significance to young physicians in Michigan.

At its annual meeting the Section shall elect officers in accordance with the Bylaws of the MSMS Young Physicians Section and a representative to fill the young physicians' seat on the Board of Directors for a two-year renewable term to begin at the first Board

of Directors meeting after the House of Delegates. If a vacancy in the young physicians' seat should occur during a term, a representative chosen by the Young Physicians Governing Council may be appointed to fill the term, with approval by the Board of Directors.

~~20.70~~20.7 INTERNATIONAL MEDICAL GRADUATES SECTION—To provide representation of the interests of international medical graduates within the structure of the Michigan State Medical Society, there shall be a section for international medical graduates composed of international medical graduates who are members of MSMS.

The purpose of this Section will be to provide a forum within the organizational structure of this Society for the study and consideration of matters of special interest and significance to international medical graduate in Michigan.

At its annual meeting the Section shall elect a delegate and alternate delegate to the MSMS House of Delegates.

~~21.00~~21. REFERENDUM

~~21.10~~21.1 REFERENDUM AT SOCIETY MEETING—Any General or Special Meeting of this Society as a whole, may, by a two-thirds vote of the voting members present, order a general referendum upon any question pertinent to the purposes and objects of the Society, organized medicine, or health of the public; provided, however, that a quorum at such General or Special Meeting shall consist of not less than 300 voting members of the Society who are in good standing.

~~21.20~~21.2 REFERENDUM BY HOUSE OF DELEGATES— The House of Delegates by a majority vote may submit any question pertinent to the community and organized medicine to the membership of the Society for its vote, such vote to be taken by county societies and certified by their respective secretaries to the Secretary of this Society.

Two-thirds of the vote cast shall be required to carry the question.

~~22.00~~22. SEAL

~~22.10~~22.1 SEAL—The Society shall have a common seal. The power to change or renew the seal shall rest with the Board of Directors.

~~23.00~~23. EMERGENCY

~~23.10~~23.1 EMERGENCY ACTION BY BOARD OF DIRECTORS—When prompt speech or action is imperative, authority to speak or act in the name of this Society is vested in the Board of Directors or the Executive Committee of the Board of Directors.

~~24.00~~24. DEFINITION OF SESSION AND MEETING

~~24.10~~24.1 SESSION—A session shall mean all meetings at any one call.

~~24.20~~24.2 MEETING—A meeting shall mean each separate convention at any one session.

~~25.00~~25. AMENDMENTS

~~25.10~~25.1 AMENDMENTS-PROCEDURE—These Bylaws may be amended by a majority vote of the delegates seated, after the proposed amendment is laid on the table until the next session, unless by consent of 75 percent of the delegates present and voting, such time requirement is waived, in which event the said amendment may be voted upon at the next meeting of the House of Delegates. The amendment or amendments to these Bylaws become effective immediately upon adoption.

Official Procedures for the Judicial Commission EXHIBIT A

of the Michigan State Medical Society

(ADOPTED APRIL 14, 1971, AND AMENDED JANUARY 31, 1973)

DIRECTOR REGIONS

In accordance with Paragraphs 15.80 through 15.86 of the Bylaws of the Michigan State Medical Society, the Judicial Commission of the Michigan State Medical Society does hereby declare the following rules, regulations and procedures to govern all matters pertaining to ethics, grievances, mediation, professional conduct, and discipline binding on the Michigan State Medical Society and each of its component medical societies.

I. Disciplinary Procedure for Component Medical Societies

The procedure to be followed by each component society on its complaints of original jurisdiction with respect to the censure, suspension or expulsion of a member shall be in accordance with Paragraphs 7.00 through 9.30 of the Bylaws of MSMS. The procedure to be followed by each component society in cases referred to it by the Judicial Commission shall be expressly subject to the procedural rules hereinafter set forth.

II. Mediation Committees for Component Medical Societies

The procedure to be followed by each component medical society on its complaints of original jurisdiction regarding grievances of non-members shall follow the procedural outline in Paragraphs 10.00 through 10.40 of the Bylaws of MSMS. The procedure to be followed by each component society in cases referred to it by the Judicial Commission shall be expressly subject to the procedural rules hereinafter set forth.

III. Procedural Rules for the Judicial Commission involving ethics, grievances, mediation, professional conduct, and discipline of members of the Michigan State Medical Society

1. All questions of ethics referred to the Judicial Commission must be in writing. No matter under active litigation will be accepted for processing. Matters involving alleged infractions of civil and criminal law are generally outside the scope of the Judicial Commission.

2. When a proper complaint is received, it shall be recorded and forwarded when appropriate to the component medical society of which the physician named is a member.

3. The component medical society shall process the complaint, review the case, determine its merits, and report its conclusions in writing to the complainant with copies to the physician involved and to the Judicial Commission.

4. The Judicial Commission requires that a complainant and the physician involved be informed of the right of appeal to the Judicial Commission from the final ruling of a component society.

5. All properly entered complaints shall be processed by the component medical society within 60 days. Each complaint and its investigation shall be kept confidential except to members of the Judicial Commission or its agents and the members of the committees of the component medical societies investigating the complaint.

6. Jurisdiction over complaints received by the Judicial Commission and forwarded to a component medical society rests with the component medical society designated by and at the discretion of the Judicial Commission. Apart from supervisory function of the judicial mechanism, the Judicial Commission serves as an appellate tribunal except under circumstances deemed by the Judicial Commission such that regional jurisdiction by a component medical society would not properly serve the purposes of the complainant, the physician involved, or the public or profession in general. Such discretionary powers are set forth hereafter under the section of this document V. "Jurisdiction of the Judicial Commission."

7. Complaints from a component medical society directed to the Judicial Commission which concern matters about another component society shall be processed by the Judicial Commission in a manner similar to a complaint from a member individual but shall remain the proper business of the Judicial Commission itself without reference.

IV. Procedure for Appeal to the Judicial Commission

1. A member of a component society censured, suspended, or expelled by his or her county society may appeal from the action of such component society to the Judicial Commission of MSMS within a period of 60 days succeeding the date of such censure, suspension or expulsion. Appeals shall be in writing and be filed within said period of 60 days with the Chair of the Judicial Commission at the Michigan State Medical Society headquarters office. Said appeal shall be accompanied by a record of the entire proceedings before the component society duly certified by its secretary, provided the Chair of the Judicial Commission may, in his or her discretion, extend the time of the appellant to file such record. Upon the filing of such an appeal, the Chair shall present it to the next subsequent meeting of the Judicial Commission.

Written notice of not less than 10 days of the time and place of the hearing shall be given to the appellant member and the president and secretary of the component society involved.

2. In hearing appeals, the Judicial Commission shall review all questions of procedure, and may, in its discretion, review the evidence contained in the record of the original proceedings held before the proper committee of the component society. The Judicial Commission may make findings of fact contrary to, or in addition to, those made by the committee of the component society. Such findings may be based on the evidence adduced by the committee of the component medical society, either with or without the taking of evidence by the Judicial Commission. The Judicial Commission may, for the purpose of making such findings or for other purposes in the interest of justice, take additional evidence of or concerning facts material to the questions involved, or may, for such purpose, appoint a committee of its members to act as referees for the taking of such evidence.

   (a) Such referees shall render a report in writing to the Judicial Commission, which report shall contain a clear statement of the facts found by the referees from the testimony or evidence adduced.

3. The Judicial Commission may affirm, reverse, or modify the decision of the proper committee of the component society so reviewed or make such other disposition of the proceedings as it may deem proper.

4. The Judicial Commission may exert, through a committee thereof, prior to the hearing being held on the appeal, all proper efforts at conciliation and compromise.

5. The MSMS may be represented by its attorney to advise the Judicial Commission. The appellant may likewise be represented by his or her attorney.

6. The decision of the Judicial Commission shall be final and bind the appellant member and the component society unless further appealed to the American Medical Association as set forth hereunder.

V. Jurisdiction of the Judicial Commission in respect to all matters relating to discipline of members of MSMS

1. The Judicial Commission, within its sound discretion, may take original jurisdiction of any question appropriately referred to it and conduct hearings thereon without referral to a component society.

2. The procedure in original jurisdiction hearings shall follow rules set forth in the MSMS Bylaws, paragraphs 8.40 through 8.70.

3. In cases of original jurisdiction, the Judicial Commission will report its recommendations to the governing body of the component society for implementation.

4. Any decision of the Judicial Commission affirming a decision of a component medical society which disciplines a member or a component medical society itself so disciplined may be appealed to the appropriate agency of the American Medical Association upon such terms, conditions and in accordance with such procedure as may be set forth in the Constitution and Bylaws of the American Medical Association. Any decision of such agency of the AMA shall be final and binding upon all parties of the appeal.

5. The decision of the component medical society if not appealed or of the Judicial Commission if original or appealed for the settlement of a complaint, although binding upon a member physician, cannot be made binding upon a non-physician. Since, however, the submission of a complaint by a lay person to the judicial mechanism or settlement is an act of good faith, it can be assumed that the recommendation of the Judicial Commission or the proper committee of a component medical society will be accepted by non-physicians.

VI. Grievances Against Non-Member Physicians

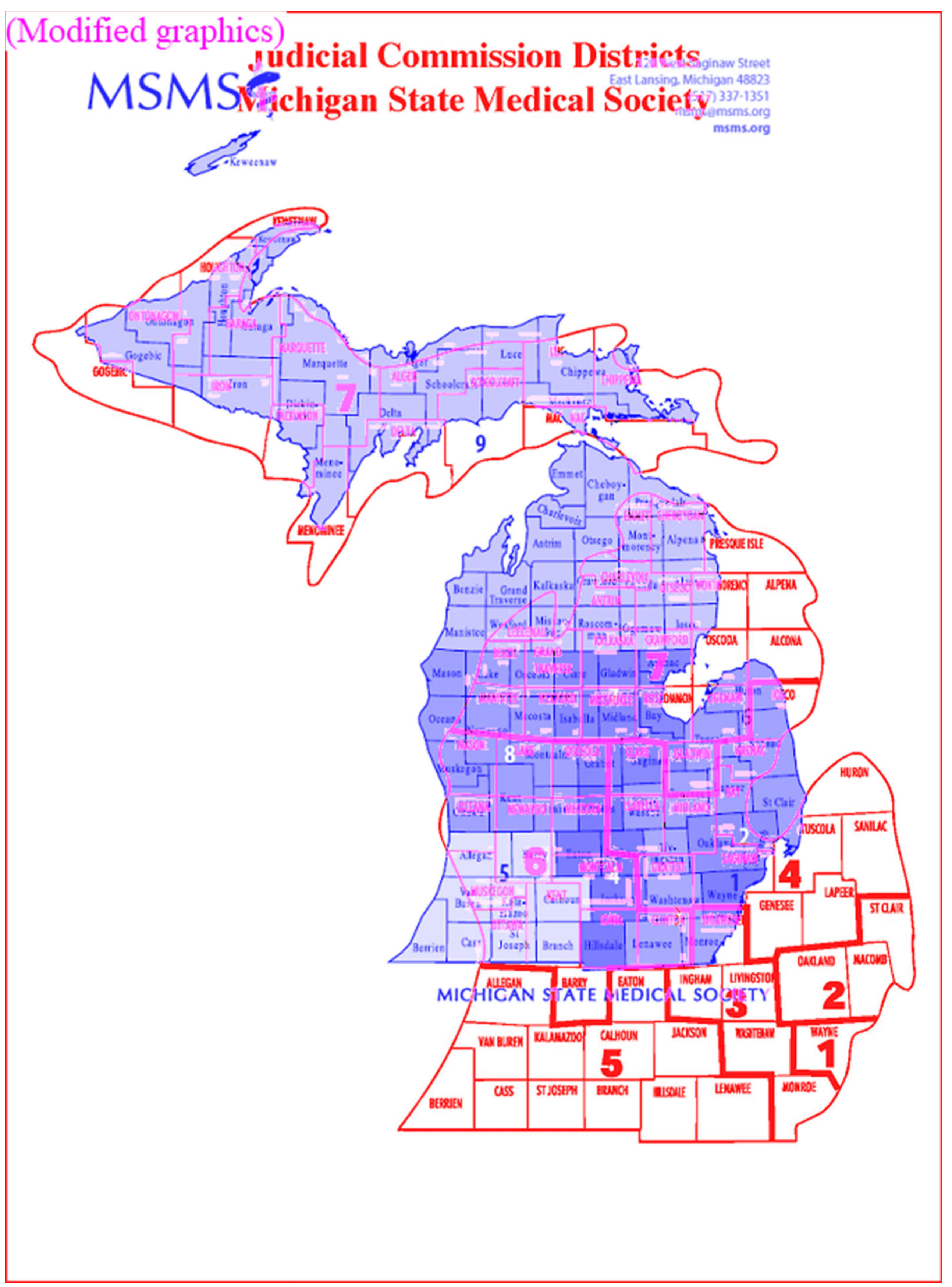
The Judicial Commission is without jurisdiction over physicians who are not members of MSMS but recognizes the obligation of organized medicine to act in the best interests of those doctors and of the public. The Commission and the component medical societies will undertake to mediate grievances and matters of ethics and professional conduct when requested by the person or persons in controversy with the non-member M.D. physician, providing the latter agrees to accept the services of the Society in this aspect and agrees to abide by its procedural rules, and to the condition that the Society reserves the right at its discretion, when appropriate, to disclose pertinent information to the Michigan Board of Medicine. Lacking this agreement or such approval from the non-member, the Society may at its discretion forward the complaint as received to the Michigan Board of Medicine.

The procedures to be followed shall, to the extent relevant, be those set forth in the Official Procedures promulgated April 14, 1971, including the underlying MSMS Bylaws section recited therein. The original jurisdiction for component societies noted in the Official Procedures shall be emphasized in these mediations. If the non-member and the complaining party reside in different counties, the component society jurisdiction within which the non-member physician has his or her principal practice shall be the venue of the hearing unless the Judicial Commission exercises its power to take original jurisdiction. The procedural rules set forth in Article II of said Official Procedures shall be adhered to as literally as possible. The appeal procedures of Article IV, save for those sections which are patently irrelevant, shall likewise be controlling.

VII. The Judicial Commission expressly reserves to itself the jurisdiction to amend these rules from time to time as it deems appropriate, and to publish same.

These rules of procedure accepted and promulgated by

~~the Judicial Commission of the MSMS on this date hereby govern the Michigan State Medical Society in all such matters and any provisions of the Constitution and Bylaws of MSMS in conflict therewith shall have no effect.~~


(Modified graphics)
Judicial Commission Districts
Michigan State Medical Society
MSMS
East Lansing, Michigan 48823
msms.org
KEWEENAW
HOUGHTON
ONTONAGON
GOGEBIC
BARAGA
MARQUETTE
IRON
DICKINSON
ALGER
SCHOOLCRAFT
DELTA
MENOMINEE
CHIPPEWA
LUCE
MACKINAC
PRESQUE ISLE
MONTMORENCY
ALPENA
OSCODA
ALCONA
IOSCO
HURON
TUSCOLA
SANILAC
LAPEER
ST CLAIR
GENESEE
OAKLAND
MACOMB
LIVINGSTON
INGHAM
EATON
BARRY
ALLEGAN
VAN BUREN
KALAMAZOO
CALHOUN
JACKSON
WASHTENAW
WAYNE
BERRIEN
CASS
ST JOSEPH
BRANCH
HILLSDALE
LENAWEE
MONROE
MICHIGAN STATE MEDICAL SOCIETY
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The Bylaws are being finalized by MSMS Legal Counsel and will be added as soon as possible. Delegates will be notified when they are available.

Reference Committee D/E

MICHIGAN STATE MEDICAL SOCIETY
2026 HOUSE OF DELEGATES

RESOLUTIONS BY COMMITTEE

REFERENCE COMMITTEE D/E– PUBLIC HEALTH AND EDUCATION

RESOLUTION	DESCRIPTION
03-26	Medication Safety at Home Post-Discharge
04-26	Access to Clothing for Patients in Inpatient Psychiatric Facilities
06-26	Supervision of Children and Public Education to Mitigate the Dangers of Dog Bites
09-26	Safe Clinical Learning and Practice Environments
10-26	Adopt Evidence-Based Child, Adolescent, and Adult Immunization Schedules
14-26	Gender Affirming Care Education for Elected Officials
20-26	Revise Michigan's Universal Lead Testing Law
21-26	Delay Gender-Related Surgeries in Minors
24-26	Endorsement of AAP and AAFP Vaccine Recommendations
30-26	Access to Stock Albuterol in Schools
34-26	Hemorrhage Control Kits and Bleeding-Control Training in Schools
35-26	Making Transportation Accessible, Reliable, and Patient-Centered
36-26	Self-Collected HPV Screening for Cervical Cancer Prevention
38-26	Gradual Return-to-Learn Protocol for Youth After Concussion
40-26	Ethical Engagement with Private Equity
42-26	Financial Incentive Programs for Smoking Cessation
BOARD ACTION REPORT	**TITLE**
#03-26	Resolution 11-25: Resolutions Are Not Publications or Presentations
#05-26	Resolution 25-25: Regulation of Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions

Resolution: 03-26

Title: Medication Safety at Home Post-Discharge

Introduced by: Anushree Jagtap, MD, for the Saginaw County Delegation

Author(s): Abishek Bala, MD, MPH, Anushree Jagtap, MD, and Elsa Varughese

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, lack of secure medication storage at home following discharge increases the risk of medication misuse, diversion, or overdose; and

Whereas, patients discharged with prescription medications such as opioids, benzodiazepines, or antidepressants may be at increased risk for self-harm; and

Whereas, recent contact with the healthcare system presents a critical opportunity to address medication safety and prevent overdose; and

Whereas, drug overdoses are a leading cause of death in Michigan, with 2,738 overdose fatalities reported in 2020, more than six times the number reported in 1999, underscoring the urgent need for effective prevention strategies; and

Whereas, in 2017 nearly 52,000 children under the age of six were treated in U.S. emergency departments for medication poisonings, and focus-group research indicates that parent education is essential to understanding the difference between keeping medications accessible and storing them securely; and

Whereas, improving medication safety following hospital discharge can contribute to reducing medication-related overdoses and injuries in the home; therefore be it

RESOLVED, that the Michigan State Medical Society (MSMS) provides education to the public and to healthcare professionals on the importance of safe medication storage at home following discharge, including the use of medication lockboxes, vials, or safety kits; and be it further

RESOLVED, that the MSMS advocates for the routine provision of medication lockboxes, vials, or safety kits to patients at risk for medication-related harm at the time of hospital or emergency department discharge; and be it further

RESOLVED, that the MSMS works with hospitals, pharmacies, and community organizations in the State of Michigan to increase access to and awareness of safe medication storage solutions to help prevent overdoses and medication-related injuries in the home.

Fiscal Note: $$12,000-$24,000

References

1. Austin AE, Proescholdbell SK, Creppage KE, Asbun A. *Characteristics of self-inflicted drug overdose deaths in North Carolina*. Drug Alcohol Dependence. 2017;181:44–49. doi:10.1016/j.drugalcdep.2017.09.014.
2. Michigan Department of Health and Human Services (MDHHS). *Drug Poisoning (Overdose)*. Michigan Overdose Surveillance. Accessed December 2025.
3. Safe Kids Worldwide. *Medicine Safety Study*. Washington, DC; 2019.

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY
Prescription Drug Diversion, Misuse and Addiction H-95.945

1. Our American Medical Association supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions.
2. Our AMA considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information.
3. Our AMA recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance.
4. Our AMA recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries.
5. Our AMA recommends that prescription drug monitoring program (PDMP) viewing access as a mainstay of appropriate and comprehensive medical training for clinical medical students and residents.
6. Our AMA will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
Excerpt from the MSMS Policy Manual:
All members of the Michigan State Medical Society House of Delegates should declare any conflict of interest to the House of Delegates and its Reference Committees prior to testimony.

The MSMS House of Delegates considers a potential conflict of interest to exist when a Delegate, Alternate Delegate, other physician member or non-member testifying on the floor of the House of Delegate or in Reference Committee has a relationship, or engages in any activity, or has any personal financial or commercial interest that might impair his or her independence or judgment or inappropriately influence his or her decisions or actions concerning MSMS matters. (Board Action Report #4, 2000 HOD, re Res10-99A & Res13-99A)

Additionally, Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires author conflicts of interest to be disclosed and printed on the resolution.

☒ The author(s) have no conflict(s) of interest to disclose
☐ The author(s) has/have the following conflict(s) of interest to disclose: Click or tap here to enter text.

DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS
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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 04-26

Title: Access to Clothing for Patients in Inpatient Psychiatric Facilities

Introduced by: Anushree Jagtap, MD, for the Saginaw County Delegation

Author(s): Natalie Aguilar, Abishek Bala, MD, MPH, Anushree Jagtap, MD, and Kayleigh Watson, MD

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, access to clean, appropriate clothing is a basic human need and an important component of dignity, comfort, and overall well-being, particularly for individuals experiencing acute psychiatric illness; and

Whereas, patients admitted to inpatient psychiatric hospitals may lack adequate clothing due to crisis circumstances, socioeconomic hardship, or emergency transport, which can negatively affect comfort, sense of identity, and engagement in treatment; and

Whereas, unmet basic needs, including clothing insecurity, are associated with worsened mental health outcomes and may exacerbate feelings of shame, isolation, or dehumanization during psychiatric hospitalization; and

Whereas, establishing reliable and accessible processes to provide clothing for patients during any point in their psychiatric hospitalization can provide immediate support to patients in need, promote dignity, foster a more therapeutic and recovery-oriented environment, and reduce psychiatric re-hospitalization by improving access to essential resources for individuals experiencing socioeconomic vulnerability; and

Whereas, inpatient psychiatric facilities may address this need through a variety of models, including, but not limited to, hospital-funded basic clothing supplies, donation programs, community partnerships, or hybrid approaches; and

Whereas, there are currently no standardized statewide policies or guidance in Michigan regarding the establishment and/or maintenance of hospital-based processes to ensure access to clothing in inpatient psychiatric hospitals; therefore be it

RESOLVED, that the MSMS recognizes access to appropriate clothing as an important component of patient-centered mental health care in inpatient psychiatric settings; and be it further

RESOLVED, that the MSMS encourages inpatient psychiatric hospitals to develop, expand, and standardize programs that grant access to clothing to ensure patients' basic needs to appropriate clothing during hospitalization and, when necessary, at discharge, using models such as, but not limited to, hospital-funded supplies, donation programs, community partnerships, or hybrid models; and be it further

RESOLVED, that the MSMS advocates for the development of statewide guidance or best practices for implementing and maintaining clothing access programs in inpatient psychiatric hospitals across Michigan.

Fiscal Note: $4,500-$9,000

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY
None

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 06-26

Title: Supervision of Children and Public Education to Mitigate the Dangers of Dog Bites

Introduced by: Anthony M. Zacharek, MD, for the Michigan Academy of Plastic Surgeons and the Saginaw County Delegation

Author(s): Natalie Aguilar and Anthony M. Zacharek, MD

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, dog bites are a preventable cause of injury in children and may result in significant physical trauma, increased risk of infection, psychological distress and trauma, and long-term functional or cosmetic deficits; and

Whereas, children are at increased risk of being bitten by a dog due to their smaller stature, limited ability to recognize canine warning behaviors, and tendency to be at face-level interactions with dogs; and

Whereas, dog bites to the head, face, neck, and hands are prevalent in the pediatric population and may require emergency care, surgical intervention, and specialty follow-up, including functional and cosmetic reconstructive procedures; and

Whereas, the majority of dog bites occur in familiar settings, such as the child's own home or that of a friend or relative, where caregivers may underestimate risk due to familiarity, resulting in lapses in adult supervision; and

Whereas, current prevention strategies emphasize the importance of constant adult supervision of children when a dog is present and education for both adults and children regarding safe interactions and recognition of canine stress signals; therefore be it

RESOLVED, that the MSMS advocates for continuous adult supervision when children are near dogs and securing dogs when appropriate, to reduce the number of dog bites in children; and be it further

RESOLVED, that the MSMS advocates for increased education and awareness regarding safe practices in interactions with dogs for both children and adults to prevent dog bite-related injuries.

Fiscal Note: $4,500-$9,000

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY
None

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 09-26

Title: Safe Clinical Learning and Practice Environments

Introduced by: Kai Anderson, MD, for the Saginaw County Delegation

Author(s): Kai Anderson, MD, Abishek Bala, MD, MPH, and Anushree Jagtap, MD

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, physicians and medical students have an ethical obligation to provide medically necessary care consistent with professional standards, federal law, and public health best practices; and

Whereas, safe and stable clinical environments are essential to patient safety, physician well-being, and high-quality medical education; and

Whereas, Michigan faces ongoing physician workforce shortages, including projected physician deficits and widespread health professional shortage area designations, particularly affecting rural and underserved communities; and

Whereas, Michigan invests substantially in physician training through graduate medical education, with thousands of residency and fellowship positions statewide and strong evidence that physicians who train in Michigan are significantly more likely to remain and practice in Michigan; and

Whereas, disruptions to clinical care and training environments contribute to moral distress, burnout, workforce attrition, and reduced return on Michigan's investment in physician education and training; and

Whereas, national data demonstrates that fear related to enforcement activity near health care settings can delay care, reduce preventive service utilization, and worsen public health outcomes; and

Whereas, these disruptions directly affect physicians, trainees, and interprofessional teams by undermining the therapeutic alliance, compromising trauma-informed care, and creating ethically distressing conditions that interfere with the delivery of safe, effective, and equitable medical care and education; and

Whereas, these downstream effects undermine the psychological and physical safety of clinical learning environments, which is essential for the recruitment, training, and long-term retention of physicians practicing in Michigan; therefore be it

RESOLVED, that the MSMS supports efforts to protect physicians, medical students, and healthcare teams from physical harm, intimidation, or non-clinical disruptions that interfere with patient care, workforce stability, or medical education; and be it further

RESOLVED, that the MSMS advocates for policies that protect Michigan's investment in graduate medical education and support long-term retention of physicians trained in Michigan; and be it further

RESOLVED, that the MSMS reaffirms that safe clinical care and training environments are essential to protecting access to care for Michigan communities.

Fiscal Note: $12,000-$24,000

REFERENCES
1. American Medical Association. Code of Medical Ethics. American Medical Association. Current edition.
2. National Academy of Medicine. Taking Action Against Clinician Burnout: A Systems Approach. Washington, DC: National Academies Press; 2019.
3. Accreditation Council for Graduate Medical Education. Common Program Requirements (Residency). Updated 2023.
4. Association of American Medical Colleges. Principles for a Safe and Supportive Learning Environment. Washington, DC: AAMC; 2022.
5. Michigan State Medical Society. Future Supply and Demand for Physicians in Michigan. East Lansing, MI: MSMS; recent update.
6. Association of American Medical Colleges. State Physician Workforce Data Report / Data Book. 2019.
7. National Academies of Sciences, Engineering, and Medicine. Communities in Action: Pathways to Health Equity. Washington, DC: National Academies Press; 2017.
8. Dean W, Talbot S, Dean A. Reframing clinician distress: Moral injury not burnout. *Fed Pract.* 2019;36(9):400-402.
9. House Resolution 172 (2025): Offered by Rep. Bierlein to declare September 17, 2025, as Patient Safety Day in Michigan, directly addressing the need for safe healthcare environments and the role of physicians as protectors of patient safety.
10. Senate Resolution 22 (2025): Adopted on March 19, 2025, this resolution recognized March 30th as Doctors Day, highlighting the need for support, appreciation, and safe environments for physicians working in hospitals and clinics to address burnout.

RELEVANT MSMS POLICY

RELEVANT AMA POLICY

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
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Resolution: 10-26

Title: Adopt Evidence-Based Child, Adolescent, and Adult Immunization Schedules

Introduced by: Catherine Bodnar, MD, MPH, for the Michigan Association of Preventive Medicine and Public Health Physicians

Author(s): Catherine Bodnar, MD, MPH

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, vaccines are recognized as one of the top 10 public health achievements of the 20th century in the Centers for Disease Control's (CDC) Morbidity and Mortality Report (MMWR); and

Whereas, the CDC's Advisory Committee on Immunization Practice (ACIP) was established in 1964 by the Surgeon General of the US Public Health Service to provide expert external advice on vaccine use for the civilian population; and

Whereas, the ACIP has historically worked closely with professional medical societies including the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and American College of Obstetricians and Gynecologists (ACOG); and

Whereas, the ACIP underwent abrupt restructuring including replacement of all 17 voting members and leadership in June 2025, which was a significant divergence from longstanding norms of continuity and governance avoiding the usual vetting process for scientific advisory committees; and

Whereas, National Immunization Technical Advisory Groups (NITAGs) use the NITAG Maturity Assessment Tool (NMAT) to assess independence and bias, resources, recommendation making, integration into policy, and stakeholder recognition. Using the NMAT to evaluate ACIP's policymaking showed an overall rating drop from 100 percent to 58 percent between April 2025 to September 2025. The greatest reductions were in disclosures and conflict of interest process, access to external expertise, government consideration and solicitation and decision-making process; and

Whereas, the January 2026 CDC Child and Adolescent Immunization Schedule was released decreasing the number of diseases covered from 18 to 11, based upon immunization schedules followed by Denmark which has a significantly different population and healthcare system compared to the United States, despite any new evidence-based data to recommend a change; and

Whereas, these changes were implemented without the typical public meetings, expert input and thorough review process traditionally used by the CDC's ACIP. While the change to shared clinical decision making for an additional seven diseases does not currently threaten immunization availability or insurance coverage, weakening the "routine" recommendation may effectively reduce accessibility by creating confusion and doubt; and

Whereas, the AAP, AAFP, and ACOG have adopted evidence-based immunization recommendations for their patient populations; and

Whereas, the AAP's 2026 Child and Adolescent Immunization Schedule, which recommends immunizations for 18 diseases for children and adolescents, has been endorsed by 12 medical and health organizations representing more than one million physicians, pharmacists, and other pediatric health care professionals; and

Whereas, the Michigan Department of Health and Human Services (MDHHS), which has previously endorsed ACIP, updated their guideline recommendations to AAP, AAFP, and ACOG immunization schedules which is consistent with more than a dozen other state's recommendations; and,

Whereas, the Michigan Health & Hospital Association (MHA), representing perspectives from chief medical officers and chief nursing officers across Michigan, confirms alignments with MDHHS's evidence-based immunization recommendations; therefore be it

RESOLVED, that the MSMS officially endorses the evidence-based immunization schedules of the American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP) and American College of Obstetricians and Gynecologists (ACOG) for Child, Adolescents, and Adults, in place of the 2026 Centers of Disease Control (CDC) Immunization Schedule; and be it further

RESOLVED, that the MSMS advocates and promotes to relevant organizations the adoption into clinical practice the evidence-based immunization recommendations of AAP, AAFP and ACOG.

Fiscal Note: $2,000-$4,000

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11. AAP's 2026 immunization schedule keeps routine recommendations intact after overhaul of federal schedule | AAP News | American Academy of Pediatrics
12. MDHHS January 6, 2026 Press Release: press release January 6
13. MHA Reinforces Evidence-Based Vaccination Guidelines: https://www.mha.org/newsroom/mha-reinforces-evidence-based-vaccination-guidelines/

RELEVANT MSMS POLICY

Immunizations and Preventive Health Care for Children

MSMS supports coverage for preventative health care visits and immunizations for all children. MSMS also supports immunization records being kept by the child's physician, parents and schools.

Opposition to Vaccination Exemption Efforts

MSMS opposes legislation or regulations that prevent local public health officials from excluding unvaccinated children from schools in the event of a disease outbreak. MSMS supports the requirement in Michigan that parents or guardians who request a nonmedical immunization waiver for their child must first complete mandatory health education from a county health department regarding the benefits of vaccination and the risks of disease before obtaining such waiver.

Support for Public Health Vaccine Initiatives

MSMS supports the broad authority of the Michigan Department of Health and Human Services to protect all Michigan citizens from vaccine-preventable disease using evidence-based policies for public health.

RELEVANT AMA POLICY

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830

1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

2. Our AMA: (a) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (b) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. All persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as of May 1, 2025, or national medical specialty society recommended vaccines as soon as possible following publication of these recommendations.
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of recommended vaccines, and the timely distribution of recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of our AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines, including those from national medical specialty societies.

Adult Immunization H-440.849

1. Our American Medical Association supports the development of a strong adult and adolescent immunization program in the United States.
2. Our AMA encourages physicians and other health and medical workers (in practice and in training) to set positive examples by assuring that they are completely immunized.
3. Our AMA urges physicians to advocate immunization with all adult patients to whom they provide care, to provide indicated vaccines to ambulatory as well as hospitalized patients, and to maintain complete immunization records, providing copies to patients as necessary;
4. Our AMA encourages the National Adult and Influenza Immunization Summit to examine mechanisms to ensure that patient immunizations get communicated to their personal physician.
5. Our AMA promotes use of available public and professional educational materials to increase use of vaccines and toxoids by physicians and to increase requests for and acceptance of these antigens by adults for whom they are indicated.
6. Our AMA encourages third party payers to provide coverage for adult immunizations.

Immunization Programs for Children H-440.991

Our AMA (1) continues to support efforts toward the prevention of childhood disease through immunizations; (2) favors using its position in international health organizations to promote appropriate immunization programs for children throughout the world, especially in such critical and cost-effective areas as the prevention of poliomyelitis and measles; and (3) expresses the need for private and public research institutions to help develop more technically advanced products, such as new heat stable vaccines, necessary for the effective immunization of children throughout the world.

Advisory Committee on Immunization Practices D-440.902

1. Our American Medical Association will initiate sustained public advocacy in support of the current Advisory Committee on Immunization Practices structure, including the liaison representative program.
2. Our AMA will immediately send a letter to the Secretary of Health and Human Services calling for an immediate reversal of the recent changes to the Advisory Committee on Immunization Practices.
3. Our AMA will immediately send a letter to the Senate Committee on Health, Education, Labor, and Pensions (HELP) and request an investigation into the actions of the Secretary regarding his administration of the Centers for Disease Control and Prevention and Advisory Committee on Immunization Practices.
4. Our AMA will identify and evaluate alternative evidence-based vaccine advisory structures and invest resources in such initiatives, as necessary.

Protecting Evidence-Based Medicine, Public Health Infrastructure and Biomedical Research D-440.905

1. Our AMA affirms that protecting science, clinical integrity, and the patient-physician relationship is central to the organization's mission.
2. Our AMA assertively and publicly leads the House of Medicine in collective, sustained advocacy for federal and state policies, proposals, and actions that safeguard public health infrastructure, advance biomedical research, improve vaccine confidence, and maintain the integrity of evidence-based medicine and decision-making processes.

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
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DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 14-26

Title: Gender Affirming Care Education for Elected Officials

Introduced by: Federico G. Mariona, MD, MHSA, FACOG, FACS, for the Wayne County Delegation

Author(s): Federico G. Mariona, MD, MHSA, FACOG, FACS

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, in recent weeks elected officials have developed a number of medical practice initiatives that will impact the use of treatments with chemical and surgical modifications to a person's sex traits, including minors; and

Whereas, the role of legislators interfering in medical practices and public health leads to overreach, especially as they lack the education, training, and clinical experience that healthcare professionals have and the need to uphold the basis for evidence-based medical practice, age-appropriate, gender-related care, supported by basic scientific research, patient-centered care, and established clinical protocols; and

Whereas, as defined by the Diagnostic and Statistical Manual of Mental Disorders or DSM-V, the accurate diagnosis of gender dysphoria persons in need to undergo these invasive and frequently irreversible therapies is reported to affect approximately 0.6 percent of the US population regardless of age, race, color, or creed and frequently compounded by comorbid mental health disorders that increased the complexity of the clinical picture; and

Whereas, an in-depth analysis of gender affirming care must encompass biological foundations, the complexities of gender dysphoria and age-appropriate therapy approach, the ethical dilemmas attached despite the support by certain major medical organizations as medically necessary; and

Whereas, the evidence supporting these therapies long-term safety and efficacy remain limited worldwide and have not been extensively studied; therefore be it

RESOLVED, that the MSMS works in close collaboration with the American Medical Association, Michigan Department of Health and Human Services, Endocrine Society, state medical academic centers, and other organizations representing multidisciplinary team members such as the American College of Obstetricians & Gynecologists, American College of Surgeons, and American Academy of Pediatrics, to develop and disseminate a comprehensive educational program associated with gender diversity clinical issues for elected officials and the general public, addressing best practices, the most recent available evidence based, patient centered, scientific information on gender affirming care in the general population and most especially on vulnerable minors.

Fiscal Note: $2,000-$4,000

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RELEVANT MSMS POLICY
Access to Gender-Affirming Care
MSMS: (1) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender, and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth; (2) supports access to and health insurance
coverage of gender-affirming care including the spectrum of behavioral, psychological, medical, and surgical interventions for the treatment of gender dysphoria or gender incongruence; (3) opposes criminalization and legislative interference in the provision of gender-affirming care as
outlined by generally-accepted standards of medical and surgical practice; (4) supports education on gender diversity and gender-affirming care at all levels of medical education, including medical school, residency, and continuing professional development; and (5) affirms that physicians
should assist in transferring and referring transgender patients to the appropriate health care when they are unable to provide the gender-affirming services the patient needs.

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 20-26

Title: Revise Michigan's Universal Lead Testing Law

Introduced by: Megan Edison, MD, for the Kent County Delegation

Author(s): Megan Edison, MD

Referred to: Reference Committee Public Health and Education

House Action:

Whereas, Michigan Public Acts 145 and 146 of 2023, effective April 30, 2025, mandate universal blood lead testing for all children at ages 12 months and 24 months (or by age 72 months if no prior test is recorded in the Michigan Care Improvement Registry (MCIR)), with additional testing required between ages 48 and 60 months for children residing in one of the 82 cities and townships designated by the Michigan Department of Health and Human Services (MDHHS) as high-risk for lead exposure, and further testing within three months if high risk is determined or based on specific risk factors; and

Whereas, Michigan law places sole responsibility on the physician to order testing at the specified ages and intervals, document parental refusal, and ensure entry of results into MCIR, regardless of specialty or the reason for the patient visit; and

Whereas, non-compliance with the universal testing mandate exposes physicians to potential fines of up to $10,000 per violation under Michigan's Public Health Code; and

Whereas, this law lacks a built-in sunset provision or automatic expiration, making it a permanent requirement without scheduled legislative reevaluation, in contrast to many public health mandates that include time-limited reviews to assess ongoing necessity, effectiveness, costs, and alignment with evolving evidence; and

Whereas, the Centers for Disease Control and Prevention (CDC) does not recommend universal blood lead testing for all children but instead advises risk-based testing, emphasizing targeted screening for high-risk children such as those in older housing or low-income areas; and

Whereas, the American Academy of Pediatrics (AAP) does not recommend universal blood lead testing, instead recommending universal screening via risk-assessment questionnaires to identify high-risk children for targeted blood lead testing, aligning with CDC guidance to focus resources on those most vulnerable; and

Whereas, evidence comparing universal testing to targeted approaches shows that universal testing increases detection rates in high-risk patients without definitive data proving universal testing significantly reduces lead poisoning incidence beyond well implemented targeted strategies; and

Whereas, universal testing imposes additional financial burdens on families, painful and potentially unnecessary testing on children, increased administrative costs for physicians in documentation, follow-up, and compliance, diverting resources from other essential pediatric care; and

Whereas, the majority of states follow CDC and AAP guidance by implementing targeted or hybrid lead testing approaches for children not enrolled in Medicaid, with only a minority requiring universal testing statewide, making Michigan's broad mandate an outlier that imposes unnecessary testing on low-risk populations without clear evidence of superior outcomes over well-implemented targeted strategies; and

Whereas, Michigan is the only state that explicitly places responsibility on physicians to order and document results in a state database, as well as the only state with an explicit fine for physicians; and

Whereas, primary prevention efforts, such as removing lead sources from environments, remain the most effective strategy for reducing childhood lead poisoning in Michigan, achieving a more than 95 percent decline in blood lead levels since 1999, a stunning public health success effort bringing childhood lead levels to the lowest in recorded history, and resources should prioritize these proven measures over mandatory universal testing without clear evidence of superior outcomes; therefore be it

RESOLVED, that our MSMS collaborate with state legislators and the Michigan Department of Health and Human Services to revise Michigan's lead testing requirements to align with American Academy of Pediatrics and Centers for Disease Control recommendations on universal risk screening followed by targeted blood lead testing, while eliminating physician-specific fines and reducing administrative burdens in this public health effort.

Fiscal Note: $2,000 - $4,000

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RELEVANT MSMS POLICY

Lead Screening for Young Children
MSMS urges all its members to screen children for their risk on contact with lead hazards and subsequent lead poisoning, and to complete a capillary or venous blood test for any child deemed to be at high risk for this serious health problem.

Lead Screening
MSMS supports the evidence-based performance of lead blood testing for all ages during doctor visits based on indication of lead exposure.

Lead Toxicity Awareness
Programs, recommendations, and education concerning lead toxicity designed for health care professionals and patients is necessary for purposes of public protection and safety.

RELEVANT AMA POLICY

Reducing Lead Poisoning H-60.924
Our American Medical Association:

   a. supports regulations and policies designed to protect young children from exposure to lead;
   b. urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure;
   c. encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories;
   d. promotes community awareness of the hazard of lead-based paints; and
   e. urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 μg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant people and children, so that by 2030, no child would have a blood lead level >1 μg/dL (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals:
   a. adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant people and children from lead toxicity and neurodevelopmental impairment;
   b. identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed;
   c. continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services;
   d. eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions;
   e. provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and
   f. establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant people and children, defined as blood lead levels above 1 μg/dL (10 ppb).
4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.
5. Our AMA advocates for accessible testing of domestic water supplies, prioritizing testing for lead in potable water used by pregnant people, newborns and young children, and with the provision of accessible water filters in homes found to have elevated lead levels in potable water.
6. Our AMA supports increased funding for lead pipe replacement and other steps to eliminate lead from public and private drinking water supplies.
7. Our AMA promotes community awareness and education campaigns on the causes and risks of lead in drinking water and steps that can be taken to eliminate these risks.

8. Our AMA supports the development and use of searchable registries of housing units known to have unresolved lead in the drinking water due to lead connectors to water mains or other sources of lead in the drinking water in cities with significant public lead exposure.
9. Our AMA urges healthcare providers to increase screening for lead exposure, particularly in areas known to have lead pipes, and particularly in underserved areas.
10. Our AMA calls for research into innovative and cost-effective methods for elimination of lead in public and private water supplies and lead from lead pipe connectors to such water supplies.

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Resolution: 21-26

Title: Delay Gender-Related Surgeries in Minors

Introduced by: Megan Edison, MD, for the Kent County Delegation

Author(s): Patrick Droste, MD

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, the American Society of Plastic Surgeons (ASPS), in its position statement dated February 3, 2026, recommends that surgeons delay gender-related breast/chest, genital, and facial surgeries until a patient is at least 19 years old, citing insufficient evidence demonstrating a favorable risk-benefit ratio for these interventions in children and adolescents; and

Whereas, the American Medical Association, in its statement issued in February 2026, agrees with the ASPS that surgical interventions for gender dysphoria in minors should generally be deferred to adulthood; and

Whereas, the Cass Review, an independent assessment commissioned by National Health Service England, concluded that the evidence base for medical interventions in youth gender care is of low quality and uncertain, leading to restrictions on such treatments in the United Kingdom and emphasizing the need for holistic, non-medical approaches to address gender-related distress; and

Whereas, systematic reviews and international health authorities, including those in Finland, Sweden, and England, have highlighted the weak evidentiary foundation for gender-affirming interventions in minors, with risks often outweighing potential benefits, while noting that many children with gender dysphoria naturally desist without medical intervention; and

Whereas, studies indicate that gender-affirming surgeries for transgender minors are rare, but when performed, they carry risks of regret, complications, and long-term health issues, with insufficient high-quality, long-term data to support their routine use in adolescents; and

Whereas, ethical considerations in pediatric care emphasize nonmaleficence and the need for rigorous evidence before irreversible interventions, particularly given developmental vulnerabilities and the potential for co-occurring mental health conditions that may resolve with supportive therapy; therefore be it

RESOLVED, that our MSMS opposes gender-related breast/chest, genital, and facial surgical interventions for individuals under the age of 19, recognizing the insufficient evidence of long-term benefits and the potential for significant harms; and be it further

RESOLVED, that our MSMS advocates for a holistic, evidence-based approach to caring for minors with gender dysphoria and gender incongruence, prioritizing psychological support, mental health treatment, and non-invasive interventions while calling for further high-quality research into long-term outcomes.

Fiscal Note: $1,000 - $2,000

REFERENCES
1. American Society of Plastic Surgeons. Position Statement on Gender Surgery for Children and Adolescents. Issued February 3, 2026. https://www.plasticsurgery.org/documents/ health-policy/positions/2026-gender-surgery-children-adolescents.pdf
2. American Medical Association. Statement on gender-affirming surgical interventions for minors. Issued February 2026. (As reported in contemporaneous coverage, e.g., The New York Times, February 4, 2026: https://www.nytimes.com/2026/02/04/health/gender-surgery-minorsama.html)
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6. 2025 HHS Report: Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices. https://opa.hhs.gov/gender-dysphoria-report

RELEVANT MSMS POLICY

Access to Gender-Affirming Care

MSMS: (1) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender, and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth; (2) supports access to and health insurance coverage of gender-affirming care including the spectrum of behavioral, psychological, medical, and surgical interventions for the treatment of gender dysphoria or gender incongruence; (3) opposes criminalization and legislative interference in the provision of gender-affirming care as outlined by generally-accepted standards of medical and surgical practice; (4) supports education on gender diversity and gender-affirming care at all levels of medical education, including medical school, residency, and continuing professional development; and (5) affirms that physicians should assist in transferring and referring transgender patients to the appropriate health care when they are unable to provide the gender-affirming services the patient needs.

Protecting Access to Gender-Affirming Care

MSMS supports patient access to gender affirming care and opposes efforts to ban or restrict patient access to such care. MSMS also opposes punishing, imprisoning, or fining health care providers for providing gender-affirming care as recommended by established medical guidelines.

Sex and Gender-Based Medicine in Clinical Medical Education

MSMS encourages the inclusion of sex and gender-based medicine in clinical medical education in Michigan, including but not limited to, medical schools, residency programs and Continuing Medical Education programs.

Surgical Sex Assignment of Infants with Differences of Sex Development

MSMS opposes the assignment of gender binary sex to infants with differences in sex development through surgical intervention outside of the necessity of physical functioning for an infant. MSMS believes efforts should be made to ensure shared decision making between the minor patient and physician prior to any gender assignment surgery.

RELEVANT AMA POLICY

Clarification of Evidence-Based Gender-Affirming Care H-185.927

1. Our American Medical Association recognizes that medical and surgical treatments for gender dysphoria and gender incongruence, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice.
2. Our AMA will work with state and specialty societies and other interested stakeholders to:
   a. advocate for federal, state, and local laws and policies to protect access to evidence-based care for gender dysphoria and gender incongruence;
   b. oppose laws and policies that criminalize, prohibit or otherwise impede the provision of evidence-based, gender-affirming care, including laws and policies that penalize parents and guardians who support minors seeking and/or receiving gender-affirming care;
   c. support protections against violence and criminal, civil, and professional liability for physicians and institutions that provide evidence-based, genderaffirming care and patients who seek and/or receive such care, as well as their parents and guardians; and

   d. communicate with stakeholders and regulatory bodies about the importance of gender-affirming care for patients with gender dysphoria and gender incongruence.
3. Our AMA will advocate for equitable, evidence-based coverage of gender-affirming care by health insurance providers, including public and private insurers.

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY
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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution: 24-26

Title: Endorsement of AAP and AAFP Vaccine Recommendations

Introduced by: Richard E. Burney, MD, for the Washtenaw County Delegation

Author(s): Richard E. Burney, MD, and Juan L. Marquez, MD, MPH

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, the Department of Health and Human Services has changed the recommended guideline for vaccine administration without new data or evidence, effectively placing thousands if not millions of children at risk for preventable disease; and

Whereas, the American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP) have advocated for maintaining and supporting the existing vaccine schedule that continues to recommend routine immunization for protection against 18 diseases, including RSV, hepatitis A, hepatitis B, rotavirus, influenza, and meningococcal diseases; and

Whereas, the Chief Medical Officer of the Michigan Department of Health and Human Services has also endorsed the existing vaccine schedule; and

Whereas, parents may be confused about vaccinating their children and not request the vaccines their children need; therefore be it

RESOLVED, that our MSMS publicly endorses and advocates in support the American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP), and Michigan Department of Health and Human Services recommendations for childhood vaccination.

Fiscal Note: $1,000 - $2,000

REFERENCES

1. https://www.ama-assn.org/public-health/prevention-wellness/pediatric-vaccines-questions-parents-will-ask-and-how-answer#:~:text=The%20American%20Academy%20of%20Pediatrics,pharmacists%20and%20pediatric%20health%20professionals.

RELEVANT MSMS POLICY

Children's Preventive Care
MSMS supports requiring insurance companies to cover well-baby check-ups, pediatric check-ups and child immunizations.

Adequate Vaccine Funding and Reimbursement
MSMS supports:
1). Efforts to immunize children and adults consistent with recommendations by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices;
2). Increased federal funding for vaccines; and,
3). Collaboration with local payers and other stakeholders to ensure the availability of CDC recommended vaccines and full reimbursement for physician practices if unable to find a supplier charging lower than the reimbursement fee.

Immunizations and Preventive Health Care for Children
MSMS supports coverage for preventative health care visits and immunizations for all children. MSMS also supports immunization records being kept by the child's physician, parents and schools.

Insurance Coverage for Immunizations
MSMS urges employers to provide health coverage that includes coverage of all immunizations that are recommended by the Centers for Disease Control and the Advisory Committee on Immunization Practices for persons living in the U.S.

Support for Public Health Vaccine Initiatives
MSMS supports the broad authority of the Michigan Department of Health and Human Services to protect all Michigan citizens from vaccine-preventable disease using evidence-based policies for public health.

Universal Access to Child Immunizations
MSMS supports a policy of universal access to immunizations for all Michigan children. It further supports a strategy whereby the immunizations are purchased by the state at the lowest possible price and made available to all health care providers administering immunizations.

RELEVANT AMA POLICY

Childhood Immunizations H-60.969
1. Our American Medical Association will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.
2. Our AMA supports the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices as of May 1, 2025, and recommended by the American Academy of Family Physicians and the American Academy of Pediatrics.
3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.
4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.
5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.
6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.
7. Our AMA recognizes that immunization requirements, including those for school attendance, serve as a strong motivator for parents and families to immunize their children according to the schedule recommended by the Centers for Disease Control and Prevention.

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Resolution: 30-26

Title: Access to Stock Albuterol in Schools

Introduced by: Nick Bara for the Medical Student Section

Author(s): Sooin Choi and Sirapa Vichaikul

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, asthma is one of the most common chronic diseases among children, including Michigan, and a leading cause of school absenteeism, emergency department visits, and preventable hospitalizations; and

Whereas, acute asthma exacerbations can occur unexpectedly in school-age children with or without prior diagnosis of asthma and may become life-threatening without timely access to short-acting bronchodilator therapy; and

Whereas, inhaled albuterol is the evidence-based first-line treatment and emergency first aid for acute asthma symptoms and respiratory distress; and

Whereas, national medical organizations have issued evidence-based policy statements supporting stock albuterol in schools as a safe and effective strategy to improve emergency response for children with diagnosed or undiagnosed asthma; and

Whereas, more than twenty states have enacted laws allowing or requiring public schools to maintain a stock of quick-relief asthma medications, such as albuterol, for use during respiratory emergencies; and

Whereas, Michigan's current asthma policy focuses on education and students' personal inhalers, while policies addressing the availability of stock albuterol inhalers in Michigan public schools are limited, resulting in variable access to a life-saving medication during school hours; and

Whereas, concerns regarding medical authorization and liability may delay or prevent school personnel from administering albuterol in emergency situations; and

Whereas, children of low-income households, under-resourced school districts, and inner-city populations have the lowest rates of adherence to prescribed inhaled corticosteroids and the highest rates of morbidity; and

Whereas, timely access to stock albuterol in school settings has been shown to reduce emergency department visits, hospitalizations, and associated healthcare costs; and

Whereas, Michigan public schools are already authorized to maintain and administer stock epinephrine for anaphylaxis under similar standing order and liability protection frameworks; and

Whereas, Michigan law already provides liability protection for school personnel who in good faith administer emergency medications pursuant to standing orders, including stock epinephrine, establishing a legal framework that supports similar protections for the administration of stock albuterol in public schools; therefore be it

RESOLVED, that the Michigan State Medical Society supports policy for statewide implementation allowing Michigan public schools to maintain a readily accessible stock of albuterol inhalers with appropriate spacers for use in students experiencing acute respiratory distress during school hours; and be it further

RESOLVED, that the Michigan State Medical Society supports policy for physician-approved standing orders authorizing trained school personnel to administer stock albuterol during respiratory emergencies when a student's personal inhaler is unavailable or when asthma has not been previously diagnosed; and be it further

RESOLVED, that the Michigan State Medical Society supports policy for staff training and extension of existing liability protections to ensure school nurses and trained personnel to administer stock albuterol in good faith pursuant to standing orders.

Fiscal Note: $2,000 - $4,000

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11. Michigan Legislature. (n.d.). *Public school code of 1976: Section 380.1179 — Epinephrine auto-injectors; acquisition, storage, administration; immunity from liability.* https://legislature.mi.gov/Laws/MCL?objectName=MCL-380-1179

RELEVANT MSMS POLICY
None

RELEVANT AMA POLICY

Childhood Anaphylactic Reactions D-60.976

1. Our American Medical Association will urge all schools, from preschool through 12th grade, to:
    a. develop Medical Emergency Response Plans (MERP);
    b. practice these plans in order to identify potential barriers and strategies for improvement;
    c. ensure that school campuses have a direct communication link with an emergency medical system (EMS);
    d. identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (
    e. designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families;
    f. train school personnel in cardiopulmonary resuscitation;
    g. adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and
    h. ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment;
2. Our AMA will work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis.

3. Our AMA supports increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis.
4. Our AMA urges the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies.
5. Our AMA urges physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan.
6. Our AMA will work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

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Resolution: 34-26

Title: Hemorrhage Control Kits and Bleeding-Control Training in Schools

Introduced by: Nick Bara for the Medical Student Section

Author(s): India Behl, Michael Fernandes, Gabrielle Forman, Arvind Ganeshram, Blas Garcia-Canga, and McKenzie Miller

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, firearm injuries represent a significant and ongoing pediatric public health crisis, and in 2022, firearm injuries were the leading cause of death among children and teens ages 1–17, highlighting the need for continued prevention and harm-reduction strategies; and

Whereas, Michigan has experienced multiple school shootings and mass-casualty incidents, including the 2021 shooting at Oxford High School that resulted in four student deaths and multiple injuries,[2] emphasizing the need for immediate hemorrhage-control capacity in school settings; and

Whereas, since 2018, there have been eight grade K-12 school shootings in the state of Michigan resulting in eleven casualties; and

Whereas, literature indicates that approximately 35 percent of trauma-related deaths are due to uncontrolled hemorrhage,[4] and federal guidance notes that death from uncontrolled bleeding can occur within five minutes, while Emergency Medical Services response times average around seven minutes; and

Whereas, the Michigan State Medical Society has adopted policy supporting efforts to mitigate the public health consequences of firearm-related injuries; and

Whereas, the American Medical Association has policy supporting bleeding-control training and increased availability of hemorrhage-control kits within schools and workplaces; and

Whereas, current legislation in the Michigan State Legislature (HB 4107) would amend public school health education standards to include instruction on use of bleeding-control response kits; and

Whereas, trauma and disaster medicine research supports co-locating bleeding-control kits with automated external defibrillators (AEDs) and other emergency equipment in public settings to improve rapid bystander response and survivability in life-threatening hemorrhage events; therefore be it

RESOLVED, that our MSMS supports policies to encourage schools to develop implementation plans for hemorrhage control kits, including staff training, routine inventory checks, and integration into school emergency preparedness and active-violence response plans; and be it further

RESOLVED, that our MSMS supports policies that would require school buildings to maintain at least one hemorrhage control kit containing a tourniquet, bleeding-control dressings, compression bandages, nitrile or latex-free protective gloves, trauma shears, and clear instructions, aligned with the *Stop the Bleed* and American College of Surgeons framework.

Fiscal Note: $1,000 - $2,000

REFERENCES

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2. https://www.pbs.org/newshour/nation/michigan-teen-gets-life-in-prison-for-oxford-school-shooting
3. https://www.edweek.org/leadership/school-shootings-this-year-how-many-and-where/2026/01
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8. https://legislature.mi.gov/documents/2025-2026/billintroduced/House/htm/2025-HIB-4107.htm
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RELEVANT MSMS POLICY

Address Gun Violence Using a Public Health Approach

MSMS supports physicians working with local and state public health agencies, law enforcement agencies, and other community organizations and leaders to identify, develop and evaluate strategies to increase firearm safety and prevent firearm injury and death.

Firearm-Related Injury and Death: Adopt A Call to Action

MSMS endorses the specific recommendations made in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association."

Guiding Principles for Reforms to Reduce Violence and Improve Firearm Safety

"The principles listed in Addendum T, in addition to existing MSMS policy, shall assist MSMS in evaluating legislative and regulatory proposals related to firearms, as well as opportunities to engage with other organizations on this issue." (Board-March2023)

RELEVANT AMA POLICY

Support for Hemorrhage Control Training H-130.935

1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.

Gun Violence as a Public Health Crisis D-145.995

Our AMA will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution.

Further Action to Respond to the Gun Violence Public Health Crisis D-145.992

Our AMA will report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.
2. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and

members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis."

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Resolution: 35-26

Title: Making Transportation Accessible, Reliable, and Patient-Centered

Introduced by: Nick Bara for the Medical Student Section

Author(s): Alexander Ky

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, lack of dependable transportation is a major barrier to preventative care, chronic disease management, prenatal care, behavioral health care, and pharmacy access which contributes to delayed care; and

Whereas, Medicaid programs are required to assure necessary non-emergency medical transportation (NEMT) to and from covered services, and states operationalize this benefit; and

Whereas, NEMT access in Michigan varies by Medicaid Health Plan and contractor workflows, and members are commonly required to schedule rides 2-3 business days in advance with limited ability to accommodate short-notice appointments or delays; and

Whereas, Medicare generally covers ambulance transportation only when medically necessary, leaving Medicare beneficiaries reliant on supplemental transportation benefits, community resources, or family support for routine health visits; and

Whereas, Michigan has a large rural population with healthcare facilities concentrated in select urban areas; and

Whereas, public transportation in Michigan is unreliable and often delayed; and

Whereas, missed or late rides can result in missed appointments, disrupted continuity of care, increased patient anxiety, and increased downstream health system costs; and

Whereas, other states have improved NEMT reliability through clearer statewide standards, stronger brokerage requirement (call access expectations), and coordinated regional models that emphasize accountability and quality improvement; therefore be it

RESOLVED, that our MSMS supports policies to make non-emergency medical transportation for preventive care, primary care, prenatal care, behavioral health, chronic disease follow-up, and pharmacy access more accessible, timely, and reliable for Medicaid and Medicare beneficiaries; and be it further

RESOLVED, that our MSMS supports statewide minimum access and reliability standards for non-emergency medical transportation such as guaranteed scheduling windows and same-day/next-day for clinically appropriate urgent visits with transparent criteria, on-time performance metrics with public reporting, language access, accommodations for hearing/vision impairment, standardized grievance timelines and resolution expectations that patients can understand and use for all Medicaid plans; and be it further

RESOLVED, that our MSMS supports sustainable funding and contracting strategies for non-emergency medical transportation that improve reliability without restricting access by having contract incentives tied to trip completion, on-time performance, adequate network capacity in rural and underserved areas, and support for mileage reimbursement and family/neighbor driver models; and be it further

RESOLVED, that our MSMS collaborate with organizations to develop a model and implement pathways that provide more reliable time estimates for appointments and flexibility when non-emergency medical transportation is used by patients especially in high-needed regions such as rural counties or areas with high missed-appointment rates.

Fiscal Note: $12,000 - $24,000

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RELEVANT MSMS POLICY

Expand Medicaid Transportation to Include Healthy Grocery Destinations

MSMS supports the inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations covered by Medicaid transportation policy. (Res29-19)

RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Medicare Coverage for Non-Emergent Dialysis Transport D-330.893

1. Our American Medical Association advocates for Medicare coverage of non-emergent medical transportation specifically for patients requiring dialysis treatment.
2. Our AMA will partner with Center for Medicare and Medicaid Services (CMS) to develop policies to ensure financial assistance for non-emergent medical transportation for dialysis treatments and to transplant centers for kidney transplant evaluation and related care for Medicare beneficiaries.

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY

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☐ The author(s) has/have the following conflict(s) of interest to disclose: Click or tap here to enter text.

DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS
Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires authors to disclose any current, very similar, or pending resolutions at other state medical societies of which they are aware.

☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Title: Self-Collected HPV Screening for Cervical Cancer Prevention

Introduced by: Nick Bara for the Medical Student Section

Author(s): Lyndsey Braman and Mahnoor Khan

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, cervical cancer is a largely preventable disease, and almost all cases of cervical cancer are caused by persistent infection with high-risk types of human papillomavirus (HPV); and

Whereas, cervical cancer screening is one of the most effective cancer prevention strategies, yet over half of new cervical cancer cases in the United States occur among individuals who were never or infrequently screened; and
Whereas, current cervical cancer screening guidelines from the American College of Obstetricians and Gynecologists (ACOG) emphasize routine screening to detect HPV infection and precancerous changes before progression to malignancy; and

Whereas, the traditional provider-collected cervical cancer screening method requires a pelvic examination with speculum placement performed in a clinical setting, which may pose substantial barriers to participation; and
Whereas, barriers to clinician-collected screening include but are not limited to speculum exam avoidance, limited access to health care facilities, physical disability, prior sexual trauma, cultural or language barriers, and logistical constraints such as transportation, time off work, or childcare, all of which contribute to lower screening rates; and

Whereas, self-collected vaginal HPV screening offers a patient-centered alternative that reduces many of these barriers and has the potential to increase screening participation among historically underserved and under-screened populations; and

Whereas, nationally representative research shows that more than 70 percent of women aged 21–49 are willing to use HPV self-collection for cervical cancer screening, with over half preferring self-collection at home, and willingness is highest among individuals who are overdue or not up to date with screening, indicating that self-collection may improve participation among populations most at risk of being unscreened; and
Whereas, multiple studies demonstrate a high level of agreement between self-collected vaginal HPV specimens and clinician-collected specimens, supporting the clinical efficacy and reliability of self-collection as a screening method; and

Whereas, the Food and Drug Administration (FDA) approved HPV self-collection testing in 2024 (in-office) and 2025 (at home), recognizing self-collected vaginal specimens as a safe and effective option for cervical cancer screening; and

Whereas, the American Cancer Society released updated cervical cancer screening guidelines in December 2025 that include self-collected vaginal specimens as an acceptable screening option, and when self-collected vaginal specimens are HPV negative in the screening setting, repeat testing in three years is recommended; and
Whereas, on January 5, 2026, the Health Resources and Services Administration (HRSA) announced updated Women's Preventive Services Guidelines that include patient self-collection of HPV samples as an option for cervical cancer screening; and

Whereas, the HRSA guideline includes language requiring most non-grandfathered health insurance plans to cover cervical cancer screening and any additional testing necessary to complete the screening process without cost-sharing, with required implementation beginning January 1, 2027; and

Whereas, the ACOG has publicly supported this updated HRSA guidance, but they caution that expanding access to self-collected HPV screening must be accompanied by appropriate clinical and public health infrastructure to ensure that patients can complete the full cervical cancer screening continuum, including timely follow-up testing, diagnostic evaluation, and treatment when indicated, in order to avoid delays in diagnosis and achieve meaningful health outcomes; and

Whereas, preventative services, such as colorectal cancer screening using at-home stool DNA testing (Cologuard), are currently already covered by Medicaid and many other insurance plans, demonstrating that coverage for at-home preventative cancer screening exams already exist; and

Whereas, Michigan's Breast and Cervical Cancer Control Navigation Program (BC3NP) provides funding for cervical cancer screening and certain diagnostic and treatment services for income-eligible individuals, but eligibility requirements may exclude some patients who would otherwise benefit from cervical cancer screening; and

Whereas, although national guidelines and regulatory approvals support self-collected HPV screening, Michigan currently lacks clearly articulated, statewide implementation guidance, including standardized billing pathways, care coordination processes, and follow-up infrastructure, which may hinder effective and equitable adoption by 2027; therefore be it

RESOLVED, that our MSMS supports equitable access to evidence-based cervical cancer screening, including self-collection of vaginal samples for human papillomavirus testing, consistent with national clinical guidelines; and be it further

RESOLVED, that our MSMS advocates for proactive statewide planning, infrastructure development, and stakeholder coordination to support implementation of self-collected human papillomavirus screening in Michigan in advance of the January 1, 2027, federal coverage requirement; and be it further

RESOLVED, that our MSMS urges the Michigan Department of Health and Human Services to provide clear clinical and administrative implementation guidance including follow-up, referral, and care coordination pathways to ensure patients can complete the full cervical cancer screening continuum after self-collection.

Fiscal Note: $2,000 - $4,000

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RELEVANT MSMS POLICY

Physician Support of Statewide Breast and Cervical Cancer Control Program
MSMS supports and endorses the Breast and Cervical Cancer Control Program and urges members to refer eligible patients to the Program for screening as part of ongoing care.

Promote Prostate Cancer Screening for Minority Populations
MSMS encourages outreach to diverse community organizations that serve African American/Native American and other at-risk minority men in an effort to promote prostate cancer screening and prostate cancer education in this high-risk population.

Prostate Cancer Screening
MSMS supports third party coverage of prostate cancer screening.

Mammography Screening
MSMS endorses baseline mammography screening and women talking with their doctor about when to start breast cancer screening with mammograms and how often to be screened. Decisions should be based a variety of considerations including national guidelines, benefits and harms of mammography, and risk factors such as family history, radiation therapy to the chest between the ages of 10 and 30 years, and having or at high risk for mutations in certain genes that greatly increase the risk of breast cancer.

RELEVANT AMA POLICY

Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971
1. Our American Medical Association supports programs to screen all at-risk individuals for breast and cervical cancer and that government funded programs be available for low income indivduals; the development of public information and educational programs with the goal of informing all at-risk individuals about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income individuals for breast and cervical cancer and to assure access to definitive treatment.
2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
3. Our AMA encourages the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies to ensure coverage is consistent with current evidence-based guidelines.

4. Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.

HPV Associated Cancer Prevention H-440.872

1. Our American Medical Association;
    a. strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents or caregivers when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and
    b. encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
4. Our AMA;
    a. encourages the integration of HPV vaccination and appropriate HPV-related cancer screening into all appropriate health care settings and visits;
    b. supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups , including but not limited to low-income and pre-sexually active populations; and
    c. recommends HPV vaccination for all groups for whom national medical specialty societies or the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
5. Our AMA supports efforts by states to increase HPV vaccine availability and accessibility, and HPV vaccination rates through a combination of policies such as facilitating administration of HPV vaccinations in community-based settings including local health departments and schools, reminder-based interventions, school-entry requirements, and requirements for comprehensive and evidence-based sexual education.
6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination, according to ACIP recommendations as of May 1, 2025, and subsequent vaccine recommendations developed by national medical specialty societies, to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines.
8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; (b) the impact of broad opt-out provisions on HPV vaccine uptake; and (c) the impact of the COVID-19 pandemic and vaccine misinformation on HPV vaccine uptake.

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DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution 38-26

Title: Gradual Return-to-Learn Protocol for Youth After Concussion

Introduced by: Nick Bara for the Medical Student Section

Author(s): Mackenzie Mahnken and Ashley Simone

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, concussions result from a direct blow to the head and present with cognitive and physical symptoms; and

Whereas, 6.8 percent of children 17 years of age and younger experienced concussion-related symptoms in 2020; and

Whereas, it is estimated about a third of children with concussion develop post-concussion syndrome[3]; and
Whereas, persistent post-concussion symptoms are primarily cognitive; and
Whereas, cognitive symptoms such as slowed thinking, poor concentration, and memory lapses poorly affect school performance, including perceived learning and poorer letter grades; and

Whereas, teachers and school administrators vary in their perceptions of concussion and management of cognitive symptoms; and

Whereas, teachers reported feeling ill-equipped to implement return to learn guidelines and expressed interest in more specific instructions; and

Whereas, a return-to-learn protocol is a stepwise, individualized plan that gradually reintroduces academic activities as concussion symptoms improve and recovery progresses; and

Whereas, although all 50 states have concussion laws regarding return-to-play guidelines, only 12 states currently have concussion laws that include a section regarding return-to-learn policy; and

Whereas, supporting youth post-concussion can support easier return to school and minimize other worsening symptoms; and

Whereas, ensuring that youth are able to gradually return to school can help support student success; therefore be it

RESOLVED, that our MSMS supports implementation of gradual return-to-learn protocol for youth after concussion; and be it further

RESOLVED, that our MSMS encourages the inclusion of implementation of gradual return-to-learn protocol for youth after concussion through policy and legislation.

Fiscal Note: $1,000 - $2,000

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RELEVANT MSMS POLICY

None

RELEVANT AMA POLICY

Reduction of Sports-Related Injury and Concussion H-470.954

1. Our American Medical Association:
   a. will work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan.
   b. will promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to:
   a. assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span;
   b. identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions;
   c. develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and
   d. develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.

5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).
6. Our AMA encourages evidence-based studies regarding post-injury management protocols and return-to-play criteria that can help guide physicians who are caring for injured athletes.

Reducing the Risk of Concussion and Other Injuries in Youth Sports H-470.959

1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.
2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.
3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.
4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports.

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Resolution 40-26

Title: Ethical Engagement with Private Equity

Introduced by: Nick Bara for the Medical Student Section

Author(s): Brett Arenberg, Mira Bookman, Ikenna Ezenwa, Michael Fernandes, and Jack Xin

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, the dramatic increase in physicians working under a corporation or hospital system over the past decade, rise in private equity (PE) acquisition of health systems, hospitals, and physician practices and expanded PE market share across all specialties have led to negative downstream effects on patient care; and

Whereas, private equity ownership decreases patient safety and outcomes by prioritizing short-term, cost-saving measures while subsequently increasing patient costs due to decreased intramarket competition; and

Whereas, private equity ownership decreases physician autonomy and job satisfaction leading to increased physician burnout and

Whereas, graduate medical education is ill-prepared to instruct students on the ethical implications of private practice along with the intersection of PE and healthcare; and

Whereas, there are incentives for physicians to engage in private equity takeovers in the context of tax-advantaged financial gain; and

Whereas, little to no guidelines or criteria for graduate medical trainees and physicians regarding ethical private investment in healthcare currently exist; therefore be it

RESOLVED, that our MSMS supports educational initiatives within medical schools and residency programs that address the business, ethical, and clinical implications of private equity ownership in healthcare; and be it further

RESOLVED, that our MSMS supports policies requiring full transparency for medical students and trainees regarding the ownership and corporate structure of their clinical training sites; and be it further

RESOLVED, that the Michigan Delegation to the American Medical Association (AMA) ask the AMA to develop comprehensive educational resources and guidelines to help future physicians evaluate the professional and ethical risks of working within private equity-owned practices.

Fiscal Note: $1,000 - $2,000

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RELEVANT MSMS POLICY

None

RELEVANT AMA POLICY

Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices D-140.951

Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices D-140.951Our American Medical Association will study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices.

The Impact of Private Equity on Medical Training H-310.901

1. Our American Medical Association will affirm that an institution or medical education training program academic mission should not be compromised by a clinical training site's fiduciary responsibilities to an external corporate or for-profit entity.
2. Our American Medical Association will encourage GME training institutions, programs, and relevant stakeholders to:
   a. Demonstrate transparency on mergers and closures, especially as it relates to private equity acquisition of GME programs and institutions, and demonstrate institutional accountability to their trainees by making this information available to current and prospective trainees.
   b. Uphold comprehensive policies which protect trainees, including those who are not funded by Medicare dollars, to ensure the obligatory transfer of funds after institution closure.
   c. Empower designated institutional officials (DIOs) to be involved in institutional decision-making to advance such transparency and accountability in protection of their residents, fellows, and physician faculty.
   d. Develop educational materials that can help trainees better understand the business of medicine, especially at the practice, institution, and corporate levels.
   e. Develop policies highlighting the procedures and responsibilities of sponsoring institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites and make these policies available to current and prospective GME learners.
3. Our AMA will encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to allow medical students and physicians to enroll in the program even if they receive some or all of their training at a for-profit or governmental institution.
4. Our AMA will support publicly funded independent research on the impact that private equity has on graduate medical education.

5. Our AMA will encourage physician associations, boards, and societies to draft policy or release their own issue statements on private equity to heighten awareness among the physician community.
6. Our AMA will encourage physicians who are contemplating corporate investor partnerships to consider the ongoing education and welfare for trainee physicians who train under physicians in that practice, including the financial implications of existing funding that is used to support that training.

AMA MEMBERSHIP ATTESTATION

Pursuant to approved HOD Resolution 65-14, any resolutions "submitted to the MSMS House of Delegates that require action by the AMA may only be submitted by MSMS members that are also members of the AMA."

I am a current member of the American Medical Association.
☑ Yes
☐ No

HOUSE OF DELEGATES CONFLICT OF INTEREST POLICY

Excerpt from the MSMS Policy Manual:

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Additionally, Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires author conflicts of interest to be disclosed and printed on the resolution.

☑ The author(s) have no conflict(s) of interest to disclose
☐ The author(s) has/have the following conflict(s) of interest to disclose:

DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS

Resolution 15-25, approved as amended by the 2025 MSMS HOD, requires authors to disclose any current, very similar, or pending resolutions at other state medical societies of which they are aware.

☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

Title: Financial Incentive Programs for Smoking Cessation

Introduced by: Nick Bara for the Medical Student Section

Author(s): Mahnoor Khan and Sirapa Vichaikul

Referred to: Reference Committee on Public Health and Education

House Action:

Whereas, smoking is the number one preventable cause of mortality and systemic diseases in the US, leading to 480,000 deaths per year through primary and secondary exposure; and

Whereas, it is estimated that of 28.8 million US adults who smoke, 67.7 percent want to quit, 53.5 percent have attempted to quit, but only 8.8 percent successfully quit; and

Whereas, of the adult smokers in the United States, 50 percent were supported by health care professionals to engage in cessation and 38.3 percent used a form of counseling or medication treatment, and yet the success rate remains low; and

Whereas, in Michigan, smoking causes approximately 16,200 adult deaths annually and costs the state an estimated $4.6 billion in healthcare expenditures and $5.5 billion in lost productivity each year; and

Whereas, Michigan's adult smoking prevalence is 19.3 percent (approximately 1.5 million adults), which is higher than the national average of 16.5 percent, and smoking-related mortality disproportionately affects low-income Michigan residents and communities of color; of Michigan's 2.8 million Medicaid enrollees, an estimated 25–30 percent are current smokers; and

Whereas, a non-randomized trial of a digital, monetary-incentive program for Medicaid beneficiaries showed that 97.1 percent of participants endorsed the program with about 70 percent showing active engagement in program practices; and

Whereas, a randomized trial comparing efficacy of reward-based and deposit-based programs showed significantly higher participation in the reward versus deposit programs, and sustained abstinence through six months through the incentive programs compared with baseline care; and

Whereas, from the healthcare sector perspective, financial incentive programs were relatively cost-effective, ranging from approximately $2,500–$5,100 per quality-adjusted life year (QALY) gained compared to usual care; however; in the U.S., interventions under $50,000–$100,000 per QALY are generally considered cost-effective; and

Whereas, multiple studies demonstrate that financial-incentive smoking cessation interventions significantly improve quit rates and are cost-effective from healthcare and societal perspectives, leading to reduced long-term morbidity, mortality, and healthcare expenditures; and

Whereas, several states, including Massachusetts, New York, and California, have successfully implemented Medicaid-funded smoking cessation programs that include financial incentives, demonstrating feasibility within state-level healthcare systems; a Massachusetts study (2012) estimated savings of $571 per patient with a $2.12 return on investment to the Medicaid program for every dollar spent; and

Whereas, Michigan Medicaid currently covers smoking cessation counseling and FDA-approved medications but not yet evidence-based financial-incentive programs, which, if used in conjunction, could improve quit rates among Michigan's Medicaid enrollees; and

Whereas, Michigan's Healthy Michigan Plan has demonstrated success in implementing preventive health incentives through the MI Health Account program, establishing precedent for incentive-based public health interventions in Michigan Medicaid; therefore be it

RESOLVED, that our MSMS supports the use of evidence-based financial-incentive programs as an adjunct to smoking cessation efforts, given their demonstrated long-term cost-effectiveness and ability to improve patient engagement, participation, and sustained abstinence; and be it further

RESOLVED, that our MSMS encourages Michigan healthcare systems, Federally Qualified Health Centers, local health departments, and Medicaid-supported organizations to evaluate and consider adopting financial-incentive smoking cessation programs, particularly in high-risk and underserved communities; and be it further

RESOLVED, that our MSMS encourages collaboration among the Michigan Department of Health and Human Services, Michigan Medicaid, healthcare systems, and public health agencies to explore sustainable funding mechanisms for evidence-based incentive programs that support smoking cessation and chronic disease prevention.

Fiscal Note: $2,000 - $4,000

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4. Campaign for Tobacco-Free Kids. *The Toll of Tobacco in Michigan.* 2025. Accessed February 22, 2026. https://www.tobaccofreekids.org/problem/toll-us/michigan
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RELEVANT MSMS POLICY

Fresh Produce Access and Intake in Food Deserts
MSMS supports access to fresh produce and food education programs within food desert communities (as defined by the US Department of Agriculture) including programs and policies that remove barriers to and incentivize mobile produce market operations and the purchasing and consumption of fresh produce.

Physical Fitness and Nutrition Incentives for Regular Physical Exercise
MSMS encourages initiatives that positively incentivize regular physical exercise as a means of improving health.

MSMS Position/Program of Action re: Smoking-Health
MSMS encourages its members to reflect their knowledge of the hazards of smoking by personally stopping smoking; asks its members to encourage their individual employees and hospital staff members to stop smoking; is opposed to the use of tobacco products in all hospitals and health facilities; urges its members to avail themselves of all opportunities to lead or participate in the dissemination of information regarding the hazards of smoking, cooperating with existing agencies with like goals; is opposed to smoking in public places; encourages members to record on death certificates the use of tobacco, exposure to environmental tobacco smoke, drugs or alcohol, and other risk factors as a contributing factor to deaths. (Prior to 1990) – Edited 1998 – Reaffirmed (Res116-98A) – Amended (Sunset Report 2022)

Tobacco Related Ordinances
MSMS supports local units of government passing tobacco-related ordinances that are more restrictive than state law. (Board-Jan99) – Reaffirmed (Sunset Report 2022)

RELEVANT AMA POLICY

AMA Policy H-490.914 — Tobacco Product Cessation
The AMA supports evidence-based tobacco cessation interventions including medications and behavioral counseling, and advocates for coverage of tobacco cessation services by all health insurance plans.

AMA Policy H-490.892 — Smoking Cessation Initiatives
The AMA encourages physicians to become involved in community and school-based smoking prevention and cessation programs.

AMA Policy H-490.892 — Smoking Cessation Initiatives
The AMA encourages physicians to become involved in community and school-based smoking prevention and cessation programs.

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☑ The author(s) have no conflict(s) of interest to disclose

☐ The author(s) has/have the following conflict(s) of interest to disclose: Click or tap here to enter text.

DISCLOSURE OF KNOWLEDGE OF OTHER SAME OR SIMILAR RESOLUTIONS

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☐ The author(s) are aware of the following same or similar pending resolutions under consideration by the following state medical societies:

ACTION REPORT #03-26 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 11-25
Resolutions Are Not Publications or Presentations

REFERRED TO: Reference Committee E

HOUSE ACTION:

The MSMS Board of Directors recommended Resolution 11-25 be appointed to a House of Delegates Task Force. The Task Force understood the issues surrounding this resolution from the perspectives of the authors, residency program directors, and medical students. Since this issue has been discussed by delegates for years, the Task Force attempted to develop recommendations that could eventually deliver a long-term fix by addressing the root cause of the disagreement. As has been identified, the residency application does not include a section for resolutions. Many students and residency directors have used the presentations or publications fields for resolutions. By working with the Electronic Residency Application Service (ERAS), an appropriate section could be added which appropriately acknowledges the work involved in writing and advocating for policy within the organized medicine system. Furthermore, the Task Force included a recommendation for MSMS policy on resolution authorship. MSMS regards resolutions as such and once resolutions are accepted by the House of Delegates, they become the intellectual property of MSMS.

RECOMMENDATION: THAT THE 2026 MSMS HOUSE OF DELEGATES APPROVE RESOLUTION 11-25, "RESOLUTIONS ARE NOT PUBLICATIONS OR PRESENTATIONS" AS AMENDED.

RESOLVED: the Michigan Delegation to the American Medical Association (AMA) work with the Electronic Residency Application Service to include a designated area on the residency application that differentiates the work required for publications, presentations, and resolutions.

RESOLVED: MSMS values the effort by members in the presentation of resolutions to the House of Delegates and the peer review process that ultimately forms official policy. MSMS regards House of Delegates resolutions as resolutions, not as publications or scientific presentations, and once approved they become intellectual property of MSMS.

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Attachment
Resolution 11-25

RESOLUTION 11-25

Title: Resolutions Are Not Publications or Presentations

Introduced by: Megan Edison, MD, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To: Reference Committee E

House Action:

Whereas, resolutions are written to enact change in organized medicine policy and/or to seek legislation, and

Whereas, resolutions require limited research to determine the historical accuracy of the information used to support the resolution, rather than any formal research, and

Whereas, resolutions are not thoroughly reviewed or vetted for evidence-based scientific accuracy by any peers, including any attached references, and

Whereas, some resolutions are copied from other state medical societies and advocacy organizations, which, if listed as a publication, could be viewed as plagiarism which is unprofessional behavior, and

Whereas, defending a resolution is not a formal or informal presentation, it is just a verbal explanation or defense of the resolution, and

Whereas, some resolution authors list resolutions as "publications" or "presentations" on applications, rather than the more appropriate designation as involvement in organized medicine and legislative advocacy as an impactful volunteer experience; therefore, be it

RESOLVED: That MSMS educate and advise all authors of resolutions that resolutions are resolutions, not publications or presentations, by physicians and staff; and be it further

RESOLVED: That the MSMS Constitution & Bylaws be amended to clearly indicate that resolutions are not publications or presentations and any reference to a resolution as publication or presentation is unprofessional and potentially unethical behavior as well as a violation of MSMS policy.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000-$2,000

Relevant MSMS Policy
None

Relevant AMA Policy
None

ACTION REPORT #05-26 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 25-25
Regulation of Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions

REFERRED TO: Reference Committee E

HOUSE ACTION:

Resolution 25-25 directs MSMS to pursue and support legislative and regulatory action related to the use of artificial intelligence (AI) by health insurers especially when utilized for purposes such as prior authorizations, coverage decisions, etc. Some states are starting to review and adopt legislation to provide guardrails around the use of AI. The authors attended and presented their rationale. They are seeing increased claims denials which they attribute to the increased use of AI algorithms that lack transparency. They recognized that it's not feasible to prohibit the use of AI so, instead, they are asking for increased oversight and the requirement that there be human oversight. Committee members were supportive of the Resolution's intent. There was discussion about making the Resolved statements stronger to focus on claims and coverage denials, the involvement of physicians at the appeals level, and increased transparency. The Committee voted unanimously to recommend approval as amended.

RECOMMENDATION: THAT THE 2026 MSMS HOUSE OF DELEGATES APPROVE RESOLUTION 25-25, "REGULATION OF ARTIFICIAL INTELLIGENCE IN HEALTH INSURANCE REIMBURSEMENT AND COVERAGE DECISIONS" AS AMENDED TO READ AS FOLLOWS:

RESOLVED: that MSMS advocates for legislation requiring that reimbursement denials or negative coverage decisions by insurers using any artificial intelligence-assisted technology be reviewed and approved by qualified human personnel at the initial level and board-certified physicians in a similar specialty upon appeal; and be it further

RESOLVED: that MSMS supports prohibiting health insurers from relying solely on artificial intelligence-based algorithms to deny, delay, or downcode health care claims or services and urge the Michigan Department of Insurance and Financial Services to establish regulations requiring human oversight in these decisions to protect patient care and physician interests; and be it further

RESOLVED: that MSMS supports that artificial intelligence algorithms used in health care decision-making and the datasets they are trained on should be transparent, accountable, based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature, and subject to oversight by qualified health care professionals.

Attachment
Resolution 25-25

RESOLUTION 25-25

Title:	Regulation of Artificial Intelligence in Health Insurance Reimbursement and Coverage Decisions
Introduced by:	Sara Chakel, MD, FACEP, for the Michigan College of Emergency Physicians
Original Authors:	Sara Chakel, MD, FACEP, Gregory Gafni-Pappas, DO, FACEP, and Luke Saski, MD, FACEP
Referred To:	Reference Committee E
House Action:	**REFERRED TO MSMS BOARD OF DIRECTORS**

Whereas, artificial intelligence (AI) is increasingly utilized by health insurers to automate reimbursement and coverage decisions, including down-coding and prior authorization processes, and

Whereas, the use of AI in these contexts can lead to insurers reducing reimbursement rates through the automation of decision-making processes, and

Whereas, companies such as Cotiviti are employed by insurers to implement AI-driven systems for claims processing, often without disclosing the underlying algorithms to healthcare entities, thereby limiting transparency and understanding of decision-making criteria, and

Whereas, the lack of transparency and potential biases in AI algorithms may result in inappropriate down-coding, claim denials, and delays in patient care, adversely affecting both patients and physicians, and

Whereas, multiple states have recognized the risks associated with AI-driven insurance decision-making and have introduced legislation to regulate its use, including: 1) Georgia (HB 887), which aims to prohibit the use of AI in making certain insurance coverage decisions without human oversight; 2) Arizona (HB 2130 & HB 2175), which requires health insurers to provide detailed explanations for any denied claim or prior authorization, including contact information for personnel who can address related questions, and which prohibits the use of AI to deny a claim or prior authorization that requires medical judgment; 3) Pennsylvania (Title 40), which includes provisions that allow for the suspension or revocation of an insurer's license if decisions are made without proper review by authorized individuals; and 4) Texas (HB 2060, SB 815), which established an AI advisory council to ensure that AI-driven decisions are transparent, accountable, and subject to appropriate regulation in state government, and which prohibits the use of AI-based algorithms as the sole basis of utilization review decisions in healthcare; therefore be it

RESOLVED: That MSMS advocate for legislation requiring health insurers operating in Michigan to ensure that any artificial intelligence-assisted prior authorization, reimbursement or coverage decisions are subject to review and approval by qualified human personnel; and be it further

RESOLVED: That MSMS support legislation that prohibits insurers from solely relying on artificial intelligence-based algorithms to wholly or partially deny, delay, or modify healthcare claims; and be it further

RESOLVED: That MSMS urge the Michigan Department of Insurance and Financial Services to establish regulations prohibiting the exclusive reliance on artificial intelligence in making prior

54 authorization, coverage and reimbursement decisions, ensuring that all such decisions involve
55 appropriate human oversight to protect patient care and physician interests.
56

57
58 WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000

Relevant MSMS Policy
None

Relevant AMA Policy

Use of Augmented Intelligence for Prior Authorization D-480.956
Our American Medical Association advocates for greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that:
1. is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature.
2. includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review.
3. requires such reviews include human examination of patient records prior to a care denial.

Creation of an AMA Council with a Focus on Digital Health Technologies and AI G-615.998
Our American Medical Association will establish a task force by I-24 focused on digital health, technology, informatics, and augmented/artificial intelligence with the potential to transition this task force to a new council and report back A-25 on this transition.

Sources:
1. Georgia House Bill 887: https://www.legis.ga.gov/legislation/65973
2. Arizona House Bill 2130: https://www.azleg.gov/legtext/57leg/1R/bills/HB2130H.htm
3. Arizona House Bill 2175: https://www.azleg.gov/legtext/57leg/1R/bills/HB2175H.htm
4. Pennsylvania Title 40: https://www.legis.state.pa.us/cfdocs/legis/LI/consCheck.cfm?ttl=40&txtType=HTM
5. Texas House Bill 2060: https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=88R&Bill=HB2060
6. Texas Senate Bill 815: https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=89R&Bill=SB815
7. Cotiviti's role in AI-driven claims processing: https://www.modernhealthcare.com/technology/ai-does-what-insurers-ask-providers-say-thats-problem

Late Resolutions

Title: In Memory of Charles Eugene Jessup, DO, FACEP

Introduced by: Mildred J. Willy, MD. for the Michigan College of Emergency Physicians

Author(s): Mildred J. Willy, MD

Referred to: Reference Committee on Internal Affairs, Bylaws and Rules

House Action:

Whereas, with the passing of Charles "Charlie" Eugene Jessup, DO, on January 27, 2026, Emergency Medicine lost a pioneer, leader and teacher; and

Whereas, Doctor Jessup received his bachelor's degree from Albion College in 1960 and his medical degree from Chicago College of Osteopathy in 1964, completed his internship at Lansing General Hospital in Lansing, Michigan in 1965, and began a Family Medicine practice in Bay City, Michigan for several years; and

Whereas, Doctor Jessup developed an interest in Emergency Medicine while covering shifts in the Emergency Department at Mercy Hospital, and served as medical director of Emergency Management Services (EMS) in Bay City, Michigan, instrumental in implementing EMS services for the Tri-County Region; and

Whereas, Doctor Jessup joined the staff of St. Mary's of Michigan as an Emergency Physician in 1981 seeing patients there for over three decades, co-founded the first area all Emergency Medicine board certified group in 1982 known as Timberline Emergency Physicians, P.C., and served as president and vice-president through 2007; and

Whereas, Doctor Jessup served in numerous administrative leadership roles at St. Mary's including Chairman of the Emergency Department, Chief of Staff, Chairman of the Hospital Board, and Chairman of Quality and Patient Safety; served as the EMS Medical Director for the Saginaw Medical Control Authority; and received the Spirit of St. Vincent Award from the Ascension St. Mary's Foundation for his long-time commitment in improving care for the community; and

Whereas, Doctor Jessup became a Diplomate of the American Board of Emergency Physicians and a Fellow of the American College of Emergency Physicians; and Associate Clinical Professor of Emergency Medicine at Michigan State University College of Human Medicine; and

Whereas, Doctor Jessup believed in continuous learning and professional development, and assisted with starting an Emergency Medicine residency program in Saginaw, Michigan teaching many residents and students in the area throughout his career over the years; and one of his proudest honors was the receipt of the "Physician of the Year" award from the Michigan College of Emergency Physicians (MCEP) in 1999; and

Whereas, Doctor Jessup was a member of the Saginaw County Medical Society and Michigan State Medical Society for nearly 40 years; and

Whereas, Doctor Jessup served on MCEP's Legislative Committee, and encouraged many in his group to become engaged in advocacy for the practice of Emergency Medicine through MCEP; and

Whereas, Doctor Jessup was thought of as a father figure, mentor, and friend who made every individual crossing his path feel like family and an important member of his entourage; therefore, be it

Resolved, that our Michigan State Medical Society recognize the outstanding love for and contributions to Emergency Medicine of Charles E. Jessup, DO, FACEP, to the specialty of Emergency Medicine as a clinician, partner, educator, leader and mentor; and be it further

Resolved, that our Michigan State Medical Society extend to the family of Charles E. Jessup, DO, FACEP, especially his son, Tom, an Emergency Medicine Physician Assistant, and his daughter Debbie, his colleagues, partners, former staff, and friends, our condolences along with our profound gratitude for his lifetime of service to his patients and the specialty of Emergency Medicine in Michigan, where his impact will be felt for generations to come.

Fiscal Note: $1,000 - $2,000

RELEVANT MSMS POLICY
NONE

RELEVANT AMA POLICY
NONE

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Committee on Ways and Means

Instructions for Accessing the Annual Financial Report

The Annual Financial Report is a separate PDF of the handbook. The report is password protected. The password for delegates and alternates is included in the delegate email from March 13, 2026. The Annual Financial Report may be found at www.msms.org/hod. If you need assistance, please email Rebecca Blake at rblake@msms.org or 517-336-5729.

Message from Ways and Means Committee Chair, Edward Rutkowski, MD

The Ways and Means Committee discusses financial "policy" of MSMS at the annual House of Delegates meeting. If anyone has "bookkeeping" type questions on the MSMS Annual Financial Report, please email your questions prior to the meeting to Lauchlin MacGregor, Chief Financial Officer, at lmacgregor@msms.org. Reponses to these questions will be given prior to the meeting. This will allow the Ways and Means Committee meeting to be more efficient and effective with its time by focusing its discussion on the financial policy of MSMS. Thank you.