**RESOLUTION 17-01 SUPPORT FOR AN INDIANA "RIGHT TO CARE" ACT**

Introduced by: Christopher Magiera, MD; Pam Galloway, MD; and Mark Hamilton, MD

Action: Referred to the Board of Trustees for Action

RESOLVED, that our ISMA will continue to work for optimal medical care for Hoosiers by opposing maintenance of certification requirements and supporting the passage of an Indiana Right to Care Act in the next session of the Indiana legislature.

**RESOLUTION 17-02 PRETERM LABOR AND DELIVERY**

Introduced by: James Mauck, MD

Action: Adopted

RESOLVED, that ISMA petition the secretary of the Indiana Family and Social Services Administration and the commissioner of the Indiana Department of Insurance to require Medicaid and insurance companies to provide and compensate providers' offices for one nurse-education visit in the early second trimester of pregnancy and one nurse-education visit in the early third trimester of pregnancy to discuss signs and symptoms of preterm labor, preterm premature rupture of membranes, incompetent cervix and the dangers to an infant of low or very low birth weight. Reimbursement would be in addition to the global prenatal care reimbursement.

**RESOLUTION 17-03 GOVERNMENT MANDATED SEQUESTER**

Introduced by: Tom Vidic, MD

Action: Adopted as Amended (Only the title was amended.)

RESOLVED, that ISMA encourage the AMA to actively work to remove the sequester provision for Part B Medicare reimbursement.

**RESOLUTION 17-04** **PROPOSED REVISIONS OF ISMA BRAIN DEATH GUIDELINES**

Introduced by: Emil Weber, MD

Action: Adopted as Amended

RESOLVED, that ISMA adopt updated brain death guidelines for adults and children, as provided by the Ad Hoc Committee to establish Brain Death Guidelines for the state of Indiana for 2017.

Proposed Revision of ISMA Adult Brain Death Guidelines of 2017

ADULT GUIDELINES FOR DETERMINATIN OF BRAIN DEATH

ADULT DIAGNOSTIC CRITERIA-
PATIENTS ABOVE 18 YEARS OF AGE

I. **Diagnostic criteria for clinical diagnosis of brain death.**

A. Prerequisites. Brain death is the absence of clinical brain function when the proximate cause is known and demonstrably irreversible.

1. Clinical or neuroimaging evidence of an acute CNS catastrophe that is compatible with the clinical diagnosis of brain death.
2. Exclusion of complicating medical conditions that may confound clinical assessment (no severe electrolyte, acid-base, or endocrine disturbance)
3. No drug intoxication or poisoning.
4. Core temperature $\geq$ 32° C (90° F).
5. In any patient who has a recorded core body temperature of 34° C or lower, prior to or during hospitalization, a cerebral blood flow study must be performed which shows no cerebral blood flow before brain death can be declared by physical examination. A core body temperature of 36° C or higher should be maintained for at least 24 hours prior to initiating the brain death examination.

B. The three cardinal findings in brain death are coma or unresponsiveness,

3. Apnea-testing performed as follows:

a) Prerequisites

I. Core temperature $\geq$ 36° C or 97° F
II. Systolic blood pressure $\geq$ 90 mm HG
III. Euvolemia. Option: positive fluid balance in the previous 6 hours
IV. Normal $pCO_2$ , *Option*: arterial $pCO_2 \geq$ 40 mm Hg
V. Normal $pO_2$. *Option*: preoxygenation to obtain arterial $pO_2 \geq$ 200 mm Hg

b) Connect a pulse oximeter and disconnect the ventilator.

c) .

c) If oxygen saturation falls to 85 % or less, abort the apnea test and reconnect the respirator; otherwise, continue with apnea test.

d) Look closely for respiratory movements (abdominal or chest excursions that produce adequate tidal volumes).

e) Measure arterial $pO_2$, $pCO_2$ and pH after approximately 8 minutes and reconnect the ventilator.

f) If respiratory movements are absent and arterial $pCO_2$is > 60 mm Hg

absence of brainstem reflexes and apnea.

1. Coma or unresponsiveness-no cerebral motor response to pain in all extremities (nail-bed pressure and supraorbital pressure).
2. Absence of brainstem reflexes
   a) Pupils
      i. No response to bright light
      ii. Size: midposition (4mm) to dilated (9mm).
   b) Ocular movement
      i. No oculocephalic reflex (testing only when no fracture or instability of the cervical spine is apparent)
      ii. No deviation of the eyes to irrigation in each ear with 50 ml of cold water (allow 1 minute after injection and at least 5 minutes between testing on each side)
   c) Facial sensation and facial motor response
      i. No corneal reflex to touch with a throat swab
      ii. No jaw reflex
      iii. No grimacing to deep pressure on nail bed, supraorbital ridge, or temporomandibular joint
   d) Pharyngeal and tracheal reflexes
      i. No response after stimulation of the posterior pharynx with tongue blade
      ii. No cough response to bronchial suctioning

(option: 20 mm Hg increase in $pCO_2$ over a baseline normal $pCO_2$), the apnea test result is positive (i.e., it supports the diagnosis of brain death).

g) If respiratory movements are observed, the apnea test result is negative (i.e., it does not support the clinical diagnosis of brain death), and the test should be repeated.

h) Connect the ventilator if, during testing, the systolic blood pressure becomes $\leq$ 90 mm Hg or the pulse oximeter indicates significant oxygen desaturation and cardiac arrhythmias are present; immediately draw an arterial blood sample and analyze arterial blood gas. If $pCO_2$ is $\geq$ 60 mm Hg or $pCO_2$ increase is $<$ 20 mm Hg over baseline normal $pCO_2$, the result is indeterminate, and an additional confirmatory test can be considered.

C. Brain Death Declaration in Patients Who Cannot Be Examined.

In patients who cannot be examined to determine brain death because of severe injuries to the face and head or because of high levels of sedative drugs, brain death can be declared after a cerebral arteriogram or isotope cerebral blood flow study demonstrates

| | |
|---|---|
| | unequivocally there is no blood flow to the brain. This study must be read by two (2) radiologists certified in the interpretation of cerebral blood flow studies.<br><br>**II. Pitfalls in the diagnosis of brain death**<br>The following conditions may interfere with the clinical diagnosis of brain death, so that the diagnosis cannot be made |

# GUIDELINES FOR DETERMINATION OF BRAIN DEATH

with certainty on clinical grounds alone. Confirmatory tests are recommended.

A. Severe facial trauma
B. Preexisting pupillary abnormalities
C. Toxic levels of any sedative drugs, aminoglycosides, tricyclic antidepressants, anti-cholinergics, antiepileptic drugs, chemotherapeutic agents, or neuromuscular blocking agents
D. Sleep apnea or severe pulmonary disease resulting in chronic retention of $CO_2$
E. Pregnancy is a special situation

**III. Clinical observations compatible with the diagnosis of brain death**

These manifestations are occasionally seen and should not be misinterpreted as evidence for brainstem function.

A. Spontaneous movements of limbs other than pathologic flexion or extension response
B. Respiratory-like movements (shoulder elevation and adduction, back arching, intercostals expansion without significant tidal volumes)
C. Sweating, blushing, tachycardia
D. Normal blood pressure without pharmacologic support or sudden increases in blood pressure
E. Absence of diabetes insipidus
F. Deep tendon reflexes; superficial abdominal reflexes; triple flexion response
G. Babinski reflex

**IV. Confirmatory laboratory tests** (options)

Brain death is a clinical diagnosis. A repeat clinical evaluation 6 hours later is recommended, but this interval is arbitrary. A confirmatory test is not mandatory but is desirable in patients in whom specific components of clinical testing cannot be reliably performed or evaluated. It should be emphasized that any of the suggested confirmatory tests may produce similar results in patients with catastrophic brain damage who do not (yet) fulfill the clinical criteria of brain death. The following confirmatory test findings are listed in the order of the most definitive test first. Consensus criteria are identified by individual tests.

A. Conventional angiography. No intracerebral filling at the level of the carotid bifurcation or circle of Willis. The external carotid circulation is patent, and filling of the superior longitudinal sinus may be delayed.
B. Electroencephalography. No electrical activity during at least 30 minutes of recording that adheres to the minimal technical criteria for EEG recording in suspected brain death as adopted by the American Electroencephalographic Society, including 16-channel EEG instruments.
C. Transcranial Doppler ultrasonography
    1. Ten percent of patients may not have temporal insonation windows. Therefore, the initial absence of Doppler signals cannot be interpreted as consistent with brain death.
    2. Small systolic peaks in early systole without diastolic flow or reverberating flow, indicating very high vascular resistance associated with greatly increased intracranial pressure.
D. Technetium-99m hexamethylpropyleneamineoxime (HMPAO or Ceretec) or Technetium 99m (ethyl cysteinate dimmer (ECD, Bicisate or Neurolite) brain perfusion scintigraphy; otherwise known as isotope flow study with brain scan. No flow to brain and no uptake of isotope in brain parenchyma (hollow skull phenomenon) is consistent with brain death.
E. Somatosensory evoked potentials. Bilateral absence of N20-P22 response with median nerve stimulation. The recordings should adhere to the minimal technical criteria for somatosensory evoked potential recording in suspected brain death as adopted by the American Electroencephalographic Society.

**V. Medical record documentation** (standard)

A. Etiology and irreversibility of condition
B. Absence of brainstem reflexes
C. Absence of motor response to pain
D. Absence of respiration with $pCO_2 > 60$ mm Hg
E. Justification for confirmatory test and result of confirmatory test
F. Optional: Repeat neurologic examination. The interval is arbitrary, but a six-hour period is reasonable.
G. Document repeat neurological examination if performed.

*See Checklist for Determination of Brain Death on back.*

# Checklist for Determination of Brain Death in Patients 18 Years of Age or Older in the State of Indiana

Patient's Name: _____ Room No.: _____ Medical Record No.: _____

Patient's Age: _____ Sex: Male ☐ Female ☐ Attending Physician: _____, MD, DO

Has the cause of patient's present neurological state been determined? Yes ☐ No ☐

Have metabolic diseases or toxins been ruled out by history? Yes ☐ No ☐

Exclude: Hypothermia, Hypotension, depressant medication and correctable metabolic imbalance.

Temperature: Fahrenheit _____ or Centigrade _____ Blood Pressure: _____ mm. Hg

Barbiturate level and Depressant Medication Survey:

Blood drawn: Date: _____ Time: _____ Barbiturate Level: _____

Significant levels of other depressants: Yes ☐ No ☐

| **Movements** | Present ( ✓ ) | Absent ( ✓ ) |
|---|---|---|
| Spontaneous | | |
| Evoked | | |
| Pectoral pinch | | |
| Pressure on supraciliary ridge | | |
| Pressure on sternum | | |
| Pressure on tibia | | |

| **Reflexes** | Right Pupil | | Left Pupil | |
|---|---|---|---|---|
| Pupils – Size: | mm. | | mm. | |
| | Yes ( ✓ ) | No ( ✓ ) | Yes ( ✓ ) | No ( ✓ ) |
| Reaction to light | | | | |
| Reaction to facial pinch | | | | |
| Corneal Reflex | | | | |
| | Right Eye | | Left Eye | |
| | Yes ( ✓ ) | No ( ✓ ) | Yes ( ✓ ) | No ( ✓ ) |
| Response to head turning (Doll's Eye Maneuver) | | | | |
| Response to ice water stimulation (50 ml. each ear 3 min. apart) | | | | |

| **Pontomedullary Reflexes** | Yes ( ✓ ) | No ( ✓ ) |
|---|---|---|
| 1. Chewing movements | | |
| 2. Tongue movements | | |
| 3. Gag reflex | | |
| 4. Jaw jerk | | |
| 5. Response to loud noise | | |

| **Apnea Test**<br>Patient's temperature must be at least 36.5° C (97° F) to perform this test. | Any Breath Taken<br>Yes ( ✓ ) | Any Breath Taken<br>No ( ✓ ) |
|---|---|---|
| 1st Date _____ Time _____ | | |
| Arterial $pCO_2$ before disconnection _____ | | |
| Arterial $pCO_2$ after disconnection _____ | | |
| 2nd Date (if needed) _____ Time _____ | | |
| Arterial $pCO_2$ before disconnection _____ | | |
| Arterial $pCO_2$ after disconnection | | |

| **CONFIRMATORY TESTS, if needed – Results** |
|---|
| |
| |

| **Is the patient brain dead?** | Yes ☐ ( ✓ ) | No ☐ ( ✓ ) |
|---|---|---|

Date: _____ Time: _____ Signed: _____, MD, DO

Proposed Revision of ISMA Children Brain Death Guidelines of 2017

# Pediatric Brain Death Diagnostic Criteria – 37 Weeks Gestational Age to 18 Years of Age

*Only qualified physicians caring for seriously ill ~~neonatal~~ patients under one year of age should establish brain death in patients under one year of age.*

***Issues to be considered and protocol to be followed relating to brain death examination:***

1. Determination of brain death in neonates, infants, and children relies on a clinical diagnosis that is based on the absence of neurologic function with a known irreversible cause of coma. Coma and apnea must coexist to diagnose brain death. This diagnosis should be made by physicians who have evaluated the history and completed the neurologic examinations.

2. Prerequisites for initiating a brain death evaluation:
   a. Hypotension, hypothermia, and metabolic disturbances that could affect the neurologic examination must be corrected before examination for brain death.
   b. Sedatives, analgesics, neuromuscular blockers, and anticonvulsant agents should be discontinued for a reasonable time period based on elimination half-life of the pharmacologic agent to ensure they do not affect the neurological examination. Knowledge of the total amount of each agent (mg/kg) administered since hospital admission may provide useful information concerning the risk of continued medication effects. Blood or plasma levels to confirm high or supratherapeutic levels of anticonvulsants with sedative effects that are not present should be obtained (if available) and repeated as needed or until the levels are in the low to midtherapeutic range. See Medications sheet, Appendix A.
   c. The diagnosis of brain death based on neurologic examination alone should not be made if supratherapeutic or high therapeutic levels of sedative agents are present. When levels are in the low or in the midtherapeutic range, medication effects sufficient to affect the results of the neurologic examination are unlikely. If uncertainty remains, an ancillary study should be performed. In patients who cannot be examined, refer to # 6 of Physical Examination To Determine Brain Death section in the Guidelines For the Determination of Brain Death in Infants and Children in the State of Indiana.
   d. Assessment of neurologic function may be unreliable immediately after cardiopulmonary resuscitation or other severe acute brain injuries and evaluation for brain death should be deferred for a minimum of 24 hours if there are concerns or inconsistencies in the examination.
   e. In any patient who has a recorded core body temperature of 34 $^{o}$ C or less, prior to or during hospitalization, a cerebral blood flow study must be performed which shows no cerebral blood flow before brain death can be declared by physical examination. A core body temperature of 35$^{o}$ C or greater should be maintained for at least 24 hours prior to initiating brain death examinations.

3. Number of examinations, examiners, and observation periods:
   a. Two examinations including apnea testing with each examination separated by an observation period are required.
   b. The examinations should be performed by different attending physicians involved in the care of the child. The apnea test may be performed by the same physician, preferably the attending physician who is managing ventilator care of the child.
   c. Recommended observation periods:
      1. Twenty-four hours for neonates (37 weeks gestation to term infants 30 days of age)
      2. Twelve hours for infants and children (>30 days to 18 years)

d. The first examination determines the child has met neurologic examination criteria for brain death. The second examination, performed by a different attending physician, confirms that the child has fulfilled criteria for brain death.
e. Physicians attesting to brain death cannot be part of the organ procurement team.

4. Apnea testing:
   a. Apnea testing must be performed safely and requires documentation of an arterial $Paco_2$ 20 mm Hg above the baseline $Paco_2$ and $\geq$ 60 mm Hg with no respiratory effort during the testing period to support the diagnosis of brain death. Some infants and children with chronic respiratory disease or insufficiency may only be responsive to supranormal $Paco_2$ levels. In this instance, the $Paco_2$ level should increase to $\geq$ 20 mm Hg above the baseline $Paco_2$ level.
   b. If the apnea test cannot be performed as a result of a medical contraindication or cannot be completed because of hemodynamic instability, desaturation to <85%, or an inability to reach a $Paco_2$ of $\geq$ 60 mm Hg, an ancillary study should be performed.

5. Ancillary studies:
   a. Ancillary studies (electroencephalography, cerebral angiography, and radionuclide cerebral blood flow) are not required to establish brain death unless the clinical examination or apnea test cannot be completed.
   b. Radionuclide cerebral blood flow study must be performed with a lipophilic isotope. Both dynamic and static phases of the study must be performed. Two of these isotopes available in the United States are:
      1. Technetium – 99m hexamethylpropylene-amineoxime (HMPAO or Ceretec)
      2. Technetium – 99m ethyl cysteinate dimer (ECD, Bicisate, or Neurolite)
   c. An EEG (electroencephalogram) demonstrating electrocerebral silence in the absence of other causative factors (i.e. drugs) is supportive of brain death.
   d. Ancillary studies are not a substitute for the neurologic examination.
   e. It must be recognized that both EEG and cerebral blood flow studies are less sensitive and less reliable in infants <30 days of age. A cerebral blood flow may be preferred over EEG in this age group.
   f. For all age groups, ancillary studies can be used to assist the clinician in making the diagnosis of brain death to reduce the observation period or when 1) components of the examination or apnea testing cannot be completed safely as a result of the underlying medical condition of the patient; 2) if there is uncertainty about the results of the neurologic examination; or 3) if a medication effect may interfere with evaluation of the patient. If the ancillary study supports the diagnosis, the second examination and apnea testing can then be performed. When an ancillary study is used to reduce the observation period, all aspects of the examination and apnea testing should be completed and documented.
   g. When an ancillary study is used because there are inherent examination limitations (i.e., 1-3 in 5d), then components of the examination done initially should be completed and documented.
   h. If the ancillary study is equivocal or if there is concern about the validity of the ancillary study, the patient cannot be pronounced dead. The patient should continue to be observed until brain death can be declared on clinical examination criteria and apnea testing or a follow-up ancillary study can be performed to assist with the determination of brain death. A waiting period of 24 hours is recommended before further clinical re-evaluation or repeat ancillary study is performed. Supportive patient care should continue during this time period.

6. Declaration of death
   a. The time of death is declared after the second clinical examination and apnea test are completed and confirm brain death.
   b. When ancillary studies are used, documentation of components from the second clinical examination that can be completed must remain consistent with brain death. All aspects of the clinical examination, including the apnea test, or ancillary studies must be appropriately documented.

# PHYSICAL EXAMINATION TO DETERMINE BRAIN DEATH

**Reversible conditions or conditions that can interfere with the neurologic examination must be excluded before brain death testing.**

1. **Coma**.

The patient must exhibit complete loss of consciousness, vocalization, and volitional activity.

Patients must lack all evidence of responsiveness. Eye opening or eye movement to noxious stimuli is absent.

Noxious stimuli should not produce a motor response other than spinally mediated reflexes. The clinical differentiation of spinal responses from retained motor responses associated with brain activity requires expertise.

2. **Loss of all brain stem reflexes, including:**

Midposition or fully dilated pupils which do not respond to light.

Absence of pupillary response to a bright light is documented in both eyes.

Usually the pupils are fixed in a midsize or dilated position (4-9mm).

When uncertainty exists, a magnifying glass should be used.

Absence of movement of bulbar musculature including facial and oropharyngeal muscles.

Deep pressure on the condyles at the level of the temporomandibular joints and deep pressure at the supraorbital ridge should produce no grimacing or facial muscle movement.

Absent gag, cough, sucking, and rooting reflex.

The pharyngeal or gag reflex is tested after stimulation of the posterior pharynx with a tongue blade or suction device. The tracheal reflex is most reliably tested by examining the cough response to tracheal suctioning. The catheter should be inserted into the trachea and advanced to the level of the carina followed by one or two suctioning passes.

Absent corneal reflexes.

Absent corneal reflex is demonstrated by touching the cornea with a piece of tissue paper, a cotton swab, or squirts of water. No eyelid movement should be seen. Care should be taken not to damage the cornea during testing.

Absent oculovestibular reflexes.

The oculovestibular reflex is tested by irrigating each ear with ice water (caloric testing) after the patency of the external auditory canal is confirmed. The head is elevated to 30 degrees. Each external auditory canal is irrigated (one ear at a time) with approximately 10-50mL of ice water. Movement of the eyes should be absent during 1 minute of observation. Both sides are tested with a minimum interval of five (5) minutes.

3. **Apnea.**

The patient must have the complete absence of documented respiratory effort (if feasible) by formal apnea attesting demonstrating a $Paco_2 \geq 60$ mm Hg and $\geq$ 20 mm Hg increase above baseline.

Normalization of the pH and $Paco_2$ measured by arterial blood gas analysis, maintenance of core temperature >35°C, normalization of blood pressure appropriate for the age of the child, and correcting for factors that could affect respiratory effort are a prerequisite to testing.

The patient should be preoxygenated using 100% oxygen for 5-10 minutes before initiating this test.

Intermittent mandatory mechanical ventilation should be discontinued once the patient is well oxygenated and a normal $Paco_2$ has been achieved.

The patient's heart rate, blood pressure, and oxygen saturation should be continuously monitored while observing for spontaneous respiratory effort throughout the entire procedure.

Follow-up blood gases should be obtained at 5-10 minute intervals to monitor the rise in $Paco_2$ while the patient remains disconnected from mechanical ventilation.

If no respiratory effort is observed from the initiation of the apnea test to the time the measured $Paco_2 \geq 60$ mm Hg and $\geq$ 20 mm Hg above the baseline level, the apnea test is consistent with brain death.

The patient should be placed back on mechanical ventilator support and medical management should continue until the second neurologic examination and apnea test confirming brain death is completed.

If oxygen saturations fall <85%, hemodynamic instability limits completion of apnea testing, or a $Paco_2$ level of $\geq$ 60 mm Hg cannot be achieved, the infant or child should be placed back on ventilator support with appropriate treatment to restore normal oxygen saturations, normocarbia, and hemodynamic parameters. Another attempt to test for apnea may be performed at a later time or an ancillary study may be pursued to assist with determination of brain death.

Evidence of any respiratory effort is inconsistent with brain death and the apnea test should be terminated.

4. **Flaccid tone and absence of spontaneous or induced movements, excluding spinal cord events such as reflex withdrawal or spinal myoclonus.**

The patient's extremities should be examined to evaluate tone by passive range of motion assuming that there are no limitations to performing such an examination (e.g., previous trauma, etc.) and the patient observed for any spontaneous or induced movements.

If abnormal movements are present, clinical assessment to determine whether these are spinal cord reflexes should be done.

5. **Brain Death Declaration.**

After the second physical examination demonstrates no brain life, the patient is brain dead and is to be declared brain dead at that time.

6. **Brain Death Declaration in Patients Who Cannot be Examined**

In patients who cannot be examined to determine brain death because of severe injuries to the face and head or because of high levels of sedative drugs, brain death can be declared after a cerebral arteriogram or isotope cerebral blood flow study demonstrates unequivocally no blood flow to the brain. This study must be read by two (2) radiologist certified in the interpretation of cerebral blood flow studies.

**DRUG ELIMINATION TABLE TO SERVE AS REFERENCE FOR PRACTITIONERS WHEN DEALING WITH PATIENTS RECEIVING SPECIFIC PHARMACOLOGICAL AGENTS AND WHO ARE UNDERGOING BRAIN DEATH TESTING**

Appendix A

**MEDICATIONS ADMINISTERED TO CRITICALLY ILL PEDIATRIC PATIENTS AND RECOMMENDATIONS FOR TIME INTERVAL TO TESTING AFTER DISCONTINUATION OF MEDICATIONS**

| Medication | Infants/Children Elimination Half-Life | Neonates Elimination Half-Life |
|---|---|---|
| Intravenous induction, anesthetic, and sedative agents | | |
| Thiopental | Adults: 3-11.5 hrs (shorter half life in children) | |
| Ketamine | 2.5 hrs | |
| Etimodate | 2.6-3.5 hrs | |
| Midazolam | 2.9-4.5 hrs | 4-12 hrs |
| Propofol | 2-8 mins, terminal half-life 200 mins (range, 300-700 mins) | |
| Dexmedetomidine | Terminal half-life 83-159 mins | Infants have faster clearance |
| Antiepileptic drugs | | |
| Phenobarbital | Infants: 20-133 hrs*<br>Children 37-73 hrs* | 45-500 hrs* |
| Pentobarbital | 25 hrs* | |
| Phenytoin | 11-55 hrs* | 63-88 hrs* |
| Diazepam | 1 mo. to 2 yrs: 40-50 hrs<br>2-12 yrs: 15-21 hrs<br>12-16 yrs: 18-20 hrs | 50-95 hrs |
| Lorazepam | Infants: 40.2 hrs (range 18-73 hrs)<br>Children: 10.5 hrs (range 6-17 hrs) | 40 hrs |
| Clonazepam | 22-33 hrs | |
| Valproic acid | Children >2 months: 7-13 hrs*<br>Children 2-14 yrs: mean 9 hrs; range, 3.5-20 hrs | 10-67 hrs* |
| Levetiracetam | Children 4-12 yrs: 5 hrs | |
| Intravenous narcotics | | |
| Morphine sulfate | Infants 1-3 months: 6.2 hrs (5-10 hrs)<br>6 months to 2.5 yrs: 2.9 hrs (1.4-7.8 hrs)<br>Children: 1-2 hrs | 7.6 hrs (range, 4.5-13.3 hrs) |
| Meperidine | Infants <3 months: 8.2-10.7 hrs (range, 4.9-31.7 hrs); Infants 3-18 months: 2.3 hrs<br>Children: 5-8 yrs: 3 hrs | 23 hrs (range, 12-39 hrs) |
| Fentanyl | 5 months to 4.5 yrs: 2.4 hrs (mean); 0.5-14 yrs: 21 hrs (range, 11-36 hrs for long-term infusions) | 1-15 hrs |
| Sufentanil | Children 2-8 yrs: 97 + 42 mins | 382-1,162 mins |
| Muscle relaxants | | |
| Succinylcholine | 5-10 mins; prolonged duration of action in patients with pseudocholinesterase deficiency or mutation | |
| Pancuronium | 110 mins | |
| Vecuronium | 41 mins | 65 mins |
| Atracurium | 17 mins | 20 mins |
| Rocuronium | 3-12 months: 1.3 $\pm$ 0.5 hrs<br>1 to <3 yrs: 1.1 $\pm$ 0.7 hrs<br>3 to <8 yrs: 0.8 $\pm$ 0.3 hrs<br>Adults: 1.4-2.4 hrs | |

*Elimination half-life does not guarantee therapeutic drug levels for longer-acting medications or medications with active metabolites. Drug levels should be obtained to ensure that levels are in a low to midtherapeutic range before neurologic examination to determine brain death. In some instances, this may require waiting several half-lives and rechecking serum levels of the medication before conducting the brain death examination.

Metabolism of pharmacologic agents may be affected by organ dysfunction, age, patient condition, and hypothermia. Physicians should be aware of total amounts of administered medication that can affect drug metabolism and levels.

# Checklist for Documentation of Brain Death in Infants and Children

**Two physicians must perform independent examinations separated by specified intervals.**

| Age of Patient | Timing of First Exam | Inter-exam, Interval |
|---|---|---|
| Term newborn 37 weeks gestational age and up to 30 days old | ☐ First exam may be performed 24 hours after birth OR following cardiopulmonary resuscitation or other severe brain injury. | ☐ At least 24 hours<br>☐ Interval shortened because ancillary study (Section 4) is consistent with brain death |
| 31 days to 18 years | ☐ First exam may be performed 24 hours following cardiopulmonary resuscitation or other severe brain injury | ☐ At least 12 hours OR<br>☐ Interval shortened because ancillary study (Section 4) is consistent with brain death |

**Section 1. PREREQUISITES for brain death examination and apnea test**

**A. IRREVERSIBLE AND IDENTIFIABLE Cause of Coma (Please check)**

☐ Traumatic brain injury ☐ Anoxic brain injury ☐ Known metabolic disorder ☐ Other (specify)

| **B. Correction of contributing factors that can interfere with the neurologic examination** | Examination One | | Examination Two | |
|---|---|---|---|---|
| a. Core body temp is over 95°F (35°C) | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| b. Systolic blood pressure or MAP in acceptable range (systolic BP not less than 2 standard deviations below age appropriate norm) based on age | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| c. Sedative/analgesic drug effect excluded as a contributing factor | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| d. Metabolic intoxication excluded as a contributing factor | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| e. Neuromuscular blockade excluded as a contributing factor | ☐ Yes | ☐ No | ☐ Yes | ☐ No |

☐ If ALL prerequisites are marked YES, then proceed to Section 2, OR

☐ Confounding variable was present. Ancillary study was therefore performed to document brain death (Section 4)

| **Section 2. Physical Examination (Please check)**<br>**Note: SPINAL CORD REFLEXES ARE ACCEPTABLE.** | Examination One Date / Time | | Examination Two Date / Time | |
|---|---|---|---|---|
| a. Flaccid tone, patient unresponsive to deep painful stimuli | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| b. Pupils are midposition or fully dilated and light reflexes are absent | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| c. Corneal, cough, gag reflexes are absent | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Sucking and rooting reflexes are absent (in neonates and infants) | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| d. Oculovestibular reflexes are absent | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| e. Spontaneous respiratory effort while on mechanical ventilation is absent | ☐ Yes | ☐ No | ☐ Yes | ☐ No |

☐ The _____ *(specify)* element of the exam could not be performed because_____

Ancillary study (EEG or radionuclide (CBF) was therefore performed to document brain death (Section 4).

| **Section 3. APNEA Test** | Examination One Date / Time | Examination Two Date / Time |
|---|---|---|
| No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq$ 60 mm Hg and a $\geq$ 20 mm Hg increase above baseline. (Examination One) | | |
| No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq$ 60 mm Hg and a $\geq$ 20 mm Hg increase above baseline. (Examination Two) | | |

Apnea test is contraindicated or could not be performed to completion because _____

_____

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death (Section 4).

| **Section 4. ANCILLARY testing** | Date / Time |
|---|---|
| Ancillary testing is required when:<br>1. Any components of the examination or apnea testing cannot be completed;<br>2. If there is uncertainty about the results of the neurologic examination; or<br>3. If a medication effect may be present.<br><br>Ancillary testing can be performed to reduce the inter-examination period; however, a second neurologic examination is required. Components of the neurologic examination that can be performed safely should be completed in close proximity to the ancillary test. | |
| ☐ Electroencephalogram (EEG) report documents electrocerebral silence OR | ☐ Yes ☐ No |
| ☐ Cerebral Blood Flow (CBF) study report documents no cerebral perfusion | ☐ Yes ☐ No |

**Section 5**. Signatures

**Examiner One**

I certify that my examination is consistent with cessation of function of the brain and brainstem. Confirmatory exam to follow.

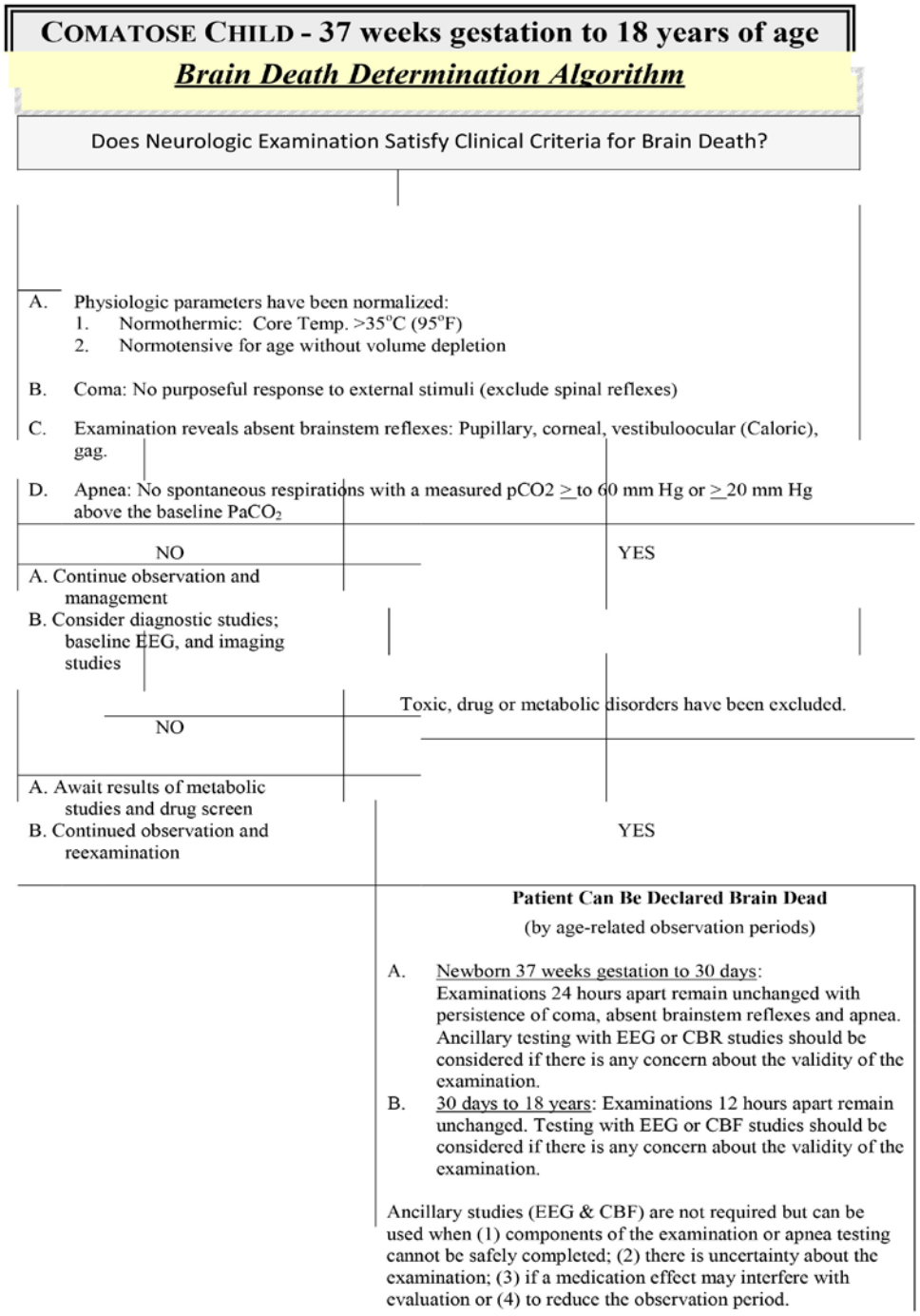
| (Printed Name) | | (Signature) | |
|---|---|---|---|
| (Specialty) | (Pager # /License # | (Date mm/dd/yyyy) | (Time) |

**Examiner Two**

I certify that my examination ☐ and/or ancillary test report ☐ confirms unchanged and irreversible cessation of function of the brain and brainstem. The patient is declared brain dead at this time.

Date/Time of death: _____

| (Printed Name) | | (Signature) | |
|---|---|---|---|
| (Specialty) | (Pager # /License # | (Date mm/dd/yyyy) | (Time) |




**The content of these Brain Death Guidelines is largely excerpted from an article published in *Critical Care Medicine* 2011 Vol. 39, No. 9, entitled "Guidelines for the determination of brain death in infants and children; An update of the 1987 Task Force recommendations." For documentation and supportive information, including an extensive bibliography, please refer to the aforementioned publication.**

**RESOLUTION 17-05 MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) AND SMALL PRACTICES**

Introduced by: Doug Morrell, MD

Action: Adopted as Amended

RESOLVED, that the ISMA delegation to the AMA encourage the AMA to adopt policy that exempts self-employed small practices, defined as solo practitioners up to five physician providers, from the burdensome regulation of the merit-based incentive payment system (MIPS).

**RESOLUTION 17-06 MEDICAL CANNABIS**

Introduced by: Clark Brittain, DO

Action: Referred to the Board of Trustees for Action

RESOLVED, that ISMA join the American College of Physicians (ACP) and the Institute of Medicine (IOM) in encouraging legislation allowing Indiana licensed physicians to legally recommend medical cannabis to patients suffering medical conditions when, in a physician's medical judgment, it is the best therapeutic option for the patient. Specifically, the ACP and the IOM request the Indiana legislature to provide a legislative mechanism permitting the production and distribution of cannabis for medical purposes. Such legislation would optimally provide legal means, such as a medical necessity defense, to protect against prosecution of patients or physicians. This would in no way constitute supporting the legalization of cannabis for general use, outside of medical practice.

**RESOLUTION 17-07 AMENDMENT TO THE BYLAWS OF ISMA PERTAINING TO THE COMMISSION ON MEDICAL EDUCATION**

Introduced by: Paul S. Rider, MD, Chairman of the Commission on Medical Education

Action: Adopted

RESOLVED, that the Bylaws of ISMA section 7.03 and 7.1009, as they pertain to the Commission on Medical Education, be amended as follows:

7.03 **COMMISSION STRUCTURE**
The President may appoint one commission member for each 600 regular members of a trustee medical district, or a major fraction thereof; but in any event, each district shall have one member on each commission.

The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise.

The President may appoint a maximum of five (5) At-Large members, one of whom may be a resident physician and one of whom may be a medical student, for a term of one year, with the right to vote, to each commission. The President shall appoint the Chairman of each commission. The Commission Chairman shall appoint a Vice Chairman.

In addition to the above-mentioned appointments, the Commission on Medical Education ~~shall~~ may maintain in its membership CME professionals needed to carry out its duties. They will be appointed by the Chairman of the Commission with the approval of the physician members. They may vote at Commission meetings. They will have three-year terms that may be renewed or terminated by the Commission Chairman with the approval of the physician members. ~~A faculty member of the Indiana University School of Medicine, who~~

~~is a member of the Association of Indiana Directors of Medical Education (AIDME). Appointed annually by the President upon recommendation of the Chairman of the Commission.~~

7.1009 **Commission on Medical Education**

~~The Commission on Medical Education shall maintain liaison with, and be of assistance to medical schools and the Medical Licensing Board. It shall keep in contact with, and endeavor to assist in improving and maintaining high quality undergraduate, graduate, and continuing medical education within the state~~. The Commission on Medical Education shall serve as the accrediting body to accredit institutions and organizations for the presentation of ~~intrastate~~ accredited continuing medical education (CME) programs in Indiana or contiguous states. The Commission on Medical Education shall review and approve the CME mission of the ISMA on an annual basis and provide advice on the overall direction of the ISMA with reference to the changes in continuing medical education. ~~and provide guidance on CME offerings and their applicability to the CME mission.~~

**RESOLUTION 17-08** **REAFFIRMING THE ISMA ADVOCACY POSITION ON FAMILY VIOLENCE**

Introduced by: ISMA Family Violence Committee

Action: Adopted

RESOLVED, that ISMA readopt Resolution 07-07 to continue supporting and advocating for measures that will strengthen the protection of children and endangered adults from acts of abuse; and be it further

RESOLVED, that ISMA oppose all state and federal legislation and actions that will in any way hinder, obstruct or weaken the ability of law enforcement agencies to investigate suspected cases of abuse of children and endangered adults.

**RESOLUTION 17-09 REDUCING IMPAIRED DRIVING**

Introduced by: Dick Huber, MD

Action: Adopted as Amended

RESOLVED, that ISMA promote educational efforts against impaired driving, including operating a passenger vehicle in Indiana with a blood alcohol concentration (BAC) of 0.04 percent or greater.

**RESOLUTION 17-10** **REAFFIRMING THE ISMA POSITION ON PROTECTING CHILDREN FROM SECONDHAND SMOKE**

Introduced by: Dick Huber, MD

Action: Adopted

RESOLVED, that ISMA support legislation, policy, rules and regulation that would ban smoking in a vehicle with children; and further be it

RESOLVED, that ISMA readopt Resolution 07-27 and continue to seek and support legislation, policy, rules and regulations that would protect children in foster or guardianship care from secondhand smoke in enclosed areas.

**RESOLUTION 17-11** **REAFFIRMING THE ISMA POSITION ON SMOKING BANS IN INDIANA IN PUBLIC AREAS**

Introduced by: Dick Huber, MD

Action: Adopted

RESOLVED, that ISMA readopt Resolution 07-28 to continue policy and support legislation, rules and regulations that would ban smoking in public places in Indiana.

**RESOLUTION 17-12 REAFFIRMING THE ISMA POSITION ON PHYSICIAN IDENTIFICATION**

Introduced by: Dick Huber, MD

Action: Adopted as Amended

RESOLVED, that because professional abbreviations are increasingly complex and confusing, they should not be used on health professional ID tags; and be it further

RESOLVED, that nationally standardized whole word labels should be used on health professional and health worker ID tags; and be it further

RESOLVED, that these recommendations will be sent to the AMA House of Delegates for consideration and adoption.

**RESOLUTION 17-13 REAFFIRMING THE ISMA POSITION ON RESTRICTING THE USE OF ELECTRONIC DEVICES WHILE DRIVING**

Introduced by: Dick Huber, MD

Action: Adopted

RESOLVED, that ISMA work with all groups to educate the public about the hazards of using a cell phone and electronic messaging while driving; and be it further

RESOLVED, that ISMA work with groups trying to create legislation to make using a hand-held cell phone and electronic text messaging while driving a fineable offense and support such legislation to the extent supported by scientific data, with appropriate exemptions for law enforcement, public safety workers and medical professionals; and be it further

RESOLVED, that Resolutions 97-51 and 07-29A, which promote education about the dangers of cell phone use while driving, continue as ISMA policy.

**RESOLUTION 17-14 RESTRICTIONS FOR INDOOR TANNING FACILITIES**

Introduced by: Carrie Davis, MD, and Deborah Armstrong, MD

Action: Adopted

RESOLVED, that Resolution 07-37 be readopted to continue ISMA policy and support legislation that would:

- Prohibit minors from using tanning devices
- Require the posting of the surgeon general's warning on all tanning devices
- Prohibit a person or tanning facility from disseminating false or misleading information regarding the safety or medical benefits of indoor tanning. Specifically, no person or tanning facility should advertise the use of any sunlamp devices as having positive health benefits, including use of phrases such as "safe," "safe tanning," "no harmful rays," "no adverse effect," or similar wording or concepts.

**RESOLUTION 17-15 SUN PROTECTION IN SCHOOLS**

Introduced by: Carrie L. Davis, MD; Lori J. Sanford, MD; Sarah Bosslet, MD; Mary I. McAteer, MD; and the Indianapolis Medical Society

Action: Adopted

RESOLVED, that ISMA support legislative efforts allowing students at schools, day cares and youth camps to bring, possess and be given adequate time to apply and to self-apply non-aerosol sunscreen when exposed to UV light without requiring physician authorization and without requiring storage and application in the nurse's office; and be it further

RESOLVED, that ISMA support legislative efforts allowing students at schools, day cares and youth camps to bring and wear sun-protective clothing when exposed to UV light, including hats and sunglasses that are not otherwise banned from school policy; and be it further

RESOLVED, that ISMA support legislative efforts that incorporate age-appropriate instruction on UV-protective behavior and skin cancer prevention in schools.

**RESOLUTION 17-16 PERPETUAL, SUSTAINABLE SUPPORT OF MEDICAL STUDENT SCHOLARSHIPS AND ACTIVITIES**

Introduced by: ISMA Executive Committee, Thomas Whiteman, MD, FACS, Chair; and ISMA Board of Trustees, Lisa Hatcher, MD, Chair

Action: Adopted

RESOLVED, that the ISMA House of Delegates authorizes the ISMA Board of Trustees to convert the Medical Student Loan Fund, Medical Student Scholarship Fund and Medical Education Fund into one $500,000 endowed scholarship at the IU School of Medicine, one $500,000 endowed scholarship at the Marian University College of Osteopathic Medicine, and an ISMA medical student support fund with the remainder of the funds; and be it further

RESOLVED, that ISMA cease the annual dues offset of $10 per dues-paying member as no longer necessary to support the new IU School of Medicine and Marian University College of Osteopathic Medicine self-sustaining endowed scholarships and the ISMA medical student support fund; and be it further

RESOLVED, that the Medical Education Fund Trust be dissolved as no longer necessary; and be it further

RESOLVED, that the ISMA Medical Education Fund Committee be sunset; and be it further

RESOLVED, that the following conforming amendments be made to the ISMA Bylaws:

~~6.05~~ ~~STUDENT LOANS~~

~~The Executive Committee, with the approval of the Board, shall have the authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. Rules and regulations adopted shall be subject to the approval of the Board. The Executive Vice President shall have the duty and responsibility of keeping minutes of all transactions and shall file a copy of such minutes, as well as a copy of all papers pertaining to any applications or loans, in the Headquarters Office of the Association.~~

7.1002 Indiana Medical Education Fund Committee

The purpose of this committee shall be to promote, develop and improve medical education in the Indiana University School of Medicine and the Marian University College of Osteopathic Medicine for the general benefit of the entire public by obtaining and using funds from private sources to accomplish that result. The funds collected will be deposited in a trust and at periodic intervals, the committee shall make a distribution from the trust in good faith and according to equitable criteria approved by the ISMA Board of Trustees to be used by the Indiana University School of Medicine and the Marian University College of Osteopathic Medicine.

The Indiana Medical Education Fund Committee shall consist of seven persons, five of whom shall be from the Indiana State Medical Association, appointed by the President thereof, and shall be voting members. The other two members (the President of the Indiana State Medical Association; and the Executive Vice President of the Association, who shall also act as Secretary), shall be ex-officio and nonvoting.

The five members shall serve staggered three-year terms to insure continuity. The actions of this committee shall be certified to the Board of Trustees. Each year a report of the committee's activities, including a financial accounting report of the fund itself as administered by the trustees, shall be annually reported to the House of Delegates.

**RESOLUTION 17-17 HEALTH POLICY FELLOWSHIP**

Introduced by: Medical Student Society (MSS)

Action: Adopted as Amended

RESOLVED, that ISMA allocate annual funding in the sum of $6,000 in support of the Health Policy Fellowship, $3,000 for a student from the Indiana University School of Medicine and $3,000 for a student from the Marian University College of Osteopathic Medicine, to sustain the program in future years and keep it competitive among other opportunities students might explore; and be it further

RESOLVED, that the ISMA Board of Trustees re-evaluate the Health Policy Fellowship every five years to keep the program competitive.

**RESOLUTION 17-18 REAFFIRMING THE ISMA POSITION ON METHADONE DEATHS**

Introduced by: Dick Huber, MD

Action: Adopted as amended

RESOLVED, that ISMA reaffirm Resolution 07-15A and continue to seek and support legislation that provides additional state regulations beyond federal guidelines for methadone clinics; and be it further

RESOLVED, that ISMA continue the support for the inclusion of methadone clinic patients in the INSPECT program; and be it further

RESOLVED, that ISMA continue the support of a statewide physician narcotic educational program with prescribing and patient monitoring guidelines.

**RESOLUTION 17-19 REAFFIRMING THE ISMA POSITION ON INCREASE IN THE ALCOHOL TAX**

Introduced by: Dick Huber, MD

Action: Adopted

RESOLVED, that ISMA reaffirm Resolution 07-19 and support increasing the tax on alcohol with revenue from the tax allocated to improving the health of Hoosiers.

**RESOLUTION 17-20 CHARLES DARWIN DAY**

Introduced by: Scott Sanders, MD

Action: Not Adopted

RESOLVED, that ISMA, in furthering scientific theory and reason and acknowledging Charles Darwin's contributions to the scientific explanation of life on Earth, support legislation that would name February 12, Charles Darwin's birthday, "Charles Darwin Day"; and be it further

RESOLVED, that ISMA oppose legislation that would allow the teaching of non-scientific "alternative theories" in our public schools; and be it further

RESOLVED, that ISMA support legislation that would prohibit tax dollars in the form of school choice "vouchers" to any private institution that teaches non-science theories, such as intelligent design, as part of its science curriculum.

**RESOLUTION 17-21** **MEDICUS FOR THE REST OF US**

Introduced by: Scott Sanders, MD

Action: Referred to the Board of Trustees for Study

Pardeep Kumar, MD, research:
**www.ismanet.org/pdf/convention/MedicarePresentation.pdf**

RESOLVED, that ISMA support a Medicare-type plan in Indiana called "Medicus" (Medicare for the rest of us) for those under 65 years of age to purchase, with the following features:

- Budget neutral - premiums, co-pays and deductibles are adequate to cover all costs of the program
- Overhead to run Medicus would be similar to Medicare
- Physician pay for services set at 150 percent to 200 percent of Medicare fee schedule
- Negotiate with drug companies on prices of medications

**RESOLUTION 17-22 ENHANCE, GROW AND SUSTAIN ISMA**

Introduced by: ISMA Future Directions Task Force

Action: The House of Delegates took action on each Resolved statement.

**RESOLVED (1): Referred to the Board of Trustees for Study**

RESOLVED, that the ISMA amend its bylaws (effective 2019) to eliminate county society membership as a requirement for ISMA membership, as follows:

**1.01 CATEGORIES**

Categories of membership are: 1) Regular, 2) Dues Exempt, ~~3) Provisional, 4~~3) Resident, ~~5~~4) Medical Student, ~~6~~5) Distinguished, ~~7~~6) Honorary, ~~8~~7) Military, and ~~9~~8) ~~-~~Senior.

1.0101 **Regular Member**

The term "Regular Member" as used in these Bylaws shall be a person who:

1) Holds the degree of Doctor of Medicine or Bachelor of Medicine or Doctor of Osteopathic Medicine;
2) Currently holds a valid, unrestricted or probationary license to practice medicine in the State of Indiana, except as specified in 1.0303(b);
3) Is currently a member in good standing of a component ~~county~~ society; and
4) Has paid to this Association annual dues.

1.0102 **Dues-exempt Member**

The term "Dues-exempt Member" in these Bylaws shall include the following:

*1.010201* ***Disabled Member***

Disabled Members shall consist of physicians of the state of Indiana who are certified by a member physician to be permanently disabled and no longer able to practice medicine. Proof of permanent disability shall be provided ~~by notification to the Executive Vice President of the Association~~ by the member ~~secretary of the component county medical society in which the permanently disabled~~ physician ~~holds membership~~.

*1.010202* ***Inactive Membership***

Members who are no longer working in a capacity that requires the use of their medical license or medical education or who are working in an uncompensated medical capacity shall be deemed inactive. Inactive physicians may request to be exempt from payment of membership dues for the duration of their inactive status and may be required to show proof that they are inactive. ~~Such request shall be granted when notification is received by the Executive Vice President of the Association from the secretary of the physician's county medical society that the county medical society has determined the physician is inactive.~~

*1.010203* ***Financial Hardship***

~~In the event the county relieves a member from the payment of dues because of financial hardship, the secretary of the county medical society shall recommend in writing to T~~the Executive Vice President of ISMA may permit the relief from State Association dues ~~i~~of ~~said~~ a member ~~of the society, showing why such recommendation should be granted~~ provides evidence of financial hardship.

~~1.0103 **Provisional Member**~~

~~The ISMA shall, upon receipt of a completed ISMA membership application and dues, and upon verification of data, forward the application to the county medical society for approval and immediately grant the applicant provisional membership in the county and district medical societies and in the ISMA. Provisional membership shall include all the rights and privileges of a regular membership. Provisional membership shall end immediately if the county medical society subsequently rejects the applicant for membership. If the county medical society does not appropriately reject the applicant for membership or fails to either notify the ISMA or make a decision regarding membership within 60 days of the date of submission to the county medical society for approval, the applicant will no longer be considered a provisional member and shall be designated as one of the other categories of membership outlined in Section 1.01, as applicable.~~

1.010~~8~~7 **Military Member**

Any physician-member of the active duty military service stationed in Indiana, not to include physicians in the Reserve on temporary active duty shall be permitted to ~~join a component medical society of ISMA and~~ become a member of ISMA at reduced dues that shall be determined by the Board of Trustees.

*1.010~~9~~8* ***Senior Member***

Senior Members shall automatically achieve Senior Membership on January 1 following their 70th birthday so long as they are physicians of the state of Indiana who have held their membership in the Indiana State Medical Association for 20 years or more. Senior physicians may request a fifty percent reduction in membership dues if they certify that they work no more than fifty percent of the full-time work schedule for their position. Such request shall be granted when ~~notification is received by the Executive Vice President of~~ the Association ~~from the secretary of the physician's county medical society that the county medical society~~ has verified the physician's eligibility for the dues reduction.

**1.02 QUALIFICATIONS**

The Regular, Dues-exempt, and Distinguished Members of this Association shall be the members of component district medical societies or the component Medical Student Society and no component medical society (other than a county medical society) shall grant membership therein on a basis that does not include membership in the district medical society and in the Indiana State Medical Association. Members of the ~~Resident and Fellow Society and the~~ Medical Student Society have the same qualifications except for the requirement of membership in a district medical society.

1.0302 **Attendance at Annual Convention**

Members attending the Annual Convention and other meetings shall register by indicating the ~~component~~ district society of which they are members or if they are members of the Medical Student Society. At the Annual Convention when membership has been verified by reference to the roster of members (students excepted), they shall receive a badge which shall be evidence of their right to all the privileges of membership at that convention. Members may not take part in any of the proceedings of an Annual Convention until they have complied with the provisions of this section.

1.0303 **(a) Suspension or Revocation of License**

No person whose license to practice medicine has been suspended or revoked by the Medical Licensing Board of Indiana, ~~or who is under sentence of suspension or expulsion from a component society,~~ or whose name has been dropped

from its roll of members, shall be entitled to any of the rights or benefits of this Association or of a ~~component society~~ district society, the Resident and Fellow Society, the Medical Student Society, or the Young Physician Society nor shall said person be permitted to take part in any of their proceedings until the license ~~and/or component membership~~ has been restored.

**(b) Exception**

A member of the Indiana State Medical Association who is in need of assistance because of neuropsychiatric illness, physical infirmity, alcohol or other substance dependence, and who has submitted himself to the ISMA Commission on Physician Assistance or a comparable county or hospital committee, may continue as a member of ISMA with full membership privileges, even after suspension of his license by the Medical Licensing Board, if he is actively cooperating with an appropriate committee and is making satisfactory progress in his rehabilitation. It is incumbent upon the member in need of assistance to provide the ISMA Commission on Physician Assistance with semi-annual reports from the committee with which he is cooperating, documenting his cooperation and satisfactory progress in rehabilitation.

**(c) Extension of Health Insurance**

A member of the Indiana State Medical Association who is enrolled in the group health insurance program sponsored by the ISMA may continue this coverage with payment of premiums for a period of one year from the date of license suspension or revocation.

2.0101 **Dues**

Membership dues may be collected by the Indiana State Medical Association. ~~or by the component county societies. The amount of dues of each component society shall be fixed by the society itself, and t~~The amount of dues for this Association shall be fixed from time to time by the House of Delegates.

Dues are payable in advance by January 15 and become delinquent on that date. The ISMA shall suspend any member who has not paid dues in full by March 1. ~~when the County Medical Society notifies the ISMA in writing that the physician should be dropped from membership.~~ The member shall sacrifice all rights and privileges of membership of this

Association until said annual dues are received in full by the Indiana State Medical Association. For new members joining ISMA, dues will be calculated on a pro-rated monthly basis.

*2.010101* ***Dues Refund***

A request for refund of dues will be acted upon by the Board of Trustees of the Indiana State Medical Association in its wisdom. ~~A letter of certification from the component county society secretary to the Executive Vice President of the Indiana State Medical Association to request an exemption of dues must state that the county is also exempting said dues.~~ Upon request and approval, dues will be refunded on a monthly pro-rated basis. Dues-exempt members may receive any publication of ISMA upon payment of the applicable subscription price set by the ISMA Board of Trustees. All Dues-exempt Members ~~will~~ may be reviewed annually ~~by their county medical societies~~ to determine their eligibility for dues exemption.

*2.010102* ***Reduced Dues***

The Indiana State Medical Association dues for Regular Members in their first year of practice following formal training shall be one-half the amount as may be established by the House of Delegates. ~~County medical societies are encouraged to follow the same policy.~~

3.0209 **Organizing Districts**

The House of Delegates shall provide for the organization of such Trustee District Societies as will promote the best interests of the profession~~, such societies to be composed exclusively of members of component county societies~~. Trustee districts shall be defined by the House of Delegates.

The House shall divide the state into Trustee Districts, specifying which counties each district shall include, and when the best interest of the Association and profession will be promoted thereby, organize in each district a component district medical society~~, and all members of component county societies, and no others, shall be members of such district societies~~.

4.0301 **President**

The President or a member designated by the President shall preside at all general meetings of the Association. The President

shall appoint all committees not otherwise provided for; shall appoint the chairman of each commission and committee; shall fill the vacancies resulting from the expiration of terms of members of commissions, and also appoint members to fill the unexpired term where any other vacancy occurs. The President will have the power, with the approval of the Board, to remove any member of any committee or commission as defined in 7.05. Within 60 days after the Annual Convention, the President may call all commissions and committees into a joint meeting as defined in 7.08.

Charters of county societies as defined in 11.01, and component societies, as defined in 12.01, and approved by the Board, shall be signed by the President and Executive Vice President.

Special meetings of either the Association or the House of Delegates shall be called by the President as defined in 3.020302 and 3.0404 of these Bylaws.

The President shall deliver an annual address and shall perform such other duties as custom and parliamentary usage may require. The President shall be the real head of the profession of the state during the term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the trustees in building up the ~~county~~ district societies and in making their work more practical and useful.

Unless otherwise specified in the Bylaws, ex-officio, the President shall be a member, without vote, of all commissions and committees.

**5.05** **VACANCIES**

In the event of a vacancy occurring from any cause, except expiration of the term of office in the office of a district trustee, the duly elected alternate trustee from the same district shall temporarily assume, on an interim basis, the office of the trustee in that district, until such time as the vacancy is filled by election. In the event of a vacancy in the office of the alternate trustee, the president of the district medical society shall temporarily assume, on an interim basis, the office of alternate trustee until such time as the alternate trustee can resume the duties of that office, or until such time as a new alternate trustee is elected.

In the event vacancies occur in any trustee district in the offices of either the trustee or alternate trustee, the vacancies shall be filled on a permanent basis by an election by the members of the ~~a~~Association within the trustee district in which the vacancies occur. A call for such elections shall be issued by the Executive Vice President of the Indiana State Medical Association following a conference(s) with the officers of the district organization. The call shall state the date, time and place of holding the election and shall be sent registered mail to ~~the county secretary, as filed in the Indiana State Medical Association Executive Vice President's office, of each component society within~~ the district. Such call shall be mailed within ten days after the Executive Vice President of ISMA has learned of the vacancies. The election may be held at a regular meeting at which business other than the election may be transacted. Such election shall be within 15 days after the Executive Vice President of the Indiana State Medical Association shall have mailed such call. If an alternate trustee is elected as trustee in such an election, the resultant vacancy in the position of alternate trustee may be filled immediately by election at the same meeting, without further notice.

5.0606 ~~County~~District **Visitation, Expenses and Reports**

Each Trustee shall be organizer, ~~peacemaker~~arbiter, and censor for the represented district. The Trustee ~~shall~~ is encouraged to visit the counties in the represented district at least once a year for the purpose of ~~organizing component societies where none exist; for inquiring into the condition of the profession, and for~~ improving and increasing the zeal of the ~~county~~ district societies and their members.

The Trustee ~~shall~~is encouraged to make an annual report of official work and of the condition of the profession of each county in the represented district. The House of Delegates may take such action, if any, as it deems appropriate, upon such reports. The necessary expenses incurred by such Trustee in the line of the duties herein imposed may be allowed by the Board on a properly itemized statement, but this shall not be construed to include the Trustee's expense of attending the Annual Convention of the Association.

5.0607 **~~Organizing~~ County Societies**

The Board shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist.~~, and for organizing the profession in counties where societies do not exist.~~ It shall especially and systematically endeavor to promote friendly relations among physicians of the same locality. The Board encourages county medical societies..~~ and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence. In sparsely settled sections, it shall have authority to organize the physicians of two or more counties into societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.~~

5.0611 **Board of Censors**

The Board shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Board without discussion.

~~It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Trustee, and its decision in all such matters shall be final.~~

**6.03 BUDGET RESPONSIBILITY**

The fiscal year of the Association shall be from January 1 to December 31 of the same calendar year. It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee

shall have the power, by a two-thirds vote, to amend the budget to provide such funding.

All recommendations and resolutions calling for expenditure of funds, passed by the House of Delegates, shall be referred to the Executive Committee.

**11.02 MEMBERSHIP QUALIFICATIONS**

Each component county society shall be judge of the qualifications of its own members~~, but, as such societies are the only portals to regular membership in this Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine, a degree of Bachelor of Medicine, or a degree of Doctor of Osteopathy and who holds a valid, unrestricted license to practice medicine in Indiana shall be eligible for membership~~.

~~Provided, however, that e~~Each component county society may deny membership in such society for infraction or violation of any law relating to the practice of medicine or of the Constitution and Bylaws of such society, the Constitution and Bylaws of the Indiana State Medical Association, the Constitution and Bylaws of the American Medical Association, or for a violation of the Preamble to the Principles of Medical Ethics of the American Medical Association; and may, after due notice and hearing, censor, suspend or expel any member for any such infraction. Before a charter is issued to any component county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

~~**11.03 RIGHT OF APPEAL**~~

~~Physicians who may feel aggrieved by the action of the society of their county in refusing them membership, or in suspending or expelling them, shall have the right to appeal to the Board whose decision shall be final. In hearing appeals, the Board may admit oral or written evidence as in its judgment will best and most fairly present the facts. In case of every appeal, both as a Board and as individual Trustees in district and county work, efforts at conciliation and compromise shall precede all such hearings.~~

~~11.04~~ **MEMBERSHIP ~~TRANSFER~~**

~~When members in good standing in a component society move to another county in this state, their names shall be transferred without cost to the roster of the component county society into whose jurisdiction they move, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed. Physicians who have the major part of their practice in a county other than the county in which they reside may hold membership in the component county society of their residence or in the component county society of the county in which they have the major part of their practice. However, a physician shall not hold active memberships in more than one component county society at the same time.~~

~~11.05~~ ~~**DIRECTION OF PROFESSION**~~

~~Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.~~

**11.047 SECRETARIAL DUTIES**

The Secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster, the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county; and in making the required annual report, the Secretary shall be certain to account for every physician who has lived in the county during the year.

The Secretary of each component society shall prepare and send to the Trustee of the Secretary's district a quarterly report briefly stating the activities of the Secretary's component county society including meetings, programs, changes in officers and personnel or membership. A copy of this quarterly report to the Trustee shall also be sent to the Executive Vice President of the Indiana State Medical Association. The Indiana State Medical Association shall supply each County Secretary with a form for these reports.

~~11.08 FISCAL YEAR AND DUES~~

~~The fiscal year of the Association shall be from January 1 to December 31 of the same calendar year. The dues shall be collected by the calendar year and be payable in advance. Unless collected by the Indiana State Medical Association, the secretary of each component society shall forward the dues for the society to the Executive Vice President of this Association and shall furnish the Indiana State Medical Association Headquarters with a roster of officers, members, and a listing of non-affiliated physicians of the county, on or before January 1 of each year, and shall promptly report thereafter the names of any new members elected to membership in the society, and promptly forward to the Executive Vice President of this Association the dues for such members.~~

~~The dues and the rights and benefits of all members shall be as provided in 1.00 *et seq*. of the Bylaws.~~

~~11.09 FAILURE TO PAY DUES~~

~~Any component county society which fails to pay dues or make the report required by January 15 of each year shall be delinquent. Any component county society which fails to pay~~

~~dues or make the report by March 1 shall be held suspended and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.~~

~~11.10 SECRETARY DIRECTION~~

~~Each component county society shall be held responsible for the faithfulness in the performance of duty on the part of its Secretary in making reports and remitting dues to the Association.~~

11.04~~11~~ CONSTITUTION AND BYLAWS

Each component county society shall have its own Constitution and Bylaws which shall not be in conflict with the Constitution and Bylaws of this Association or of the American Medical Association.

An up-to-date copy thereof shall be filed with the Executive Vice President of the Indiana State Medical Association not later than May 1 of each calendar year; or where such copy is on file and no change has been made, it shall then be sufficient to file a certificate to that effect with the Executive Vice President.

12.0301 **Composition**

Residents enrolled in Accreditation Council for Graduate Medical Education (ACGME) and American Osteopathic Association (AOA)-accredited programs in the state of Indiana shall be eligible to join the Resident and Fellow Society with all rights and privileges as a regular member of ISMA. Any member of this society shall be eligible to hold office. There shall be only one RFS.

All Resident physicians ~~who hold membership in the Resident and Fellow Society or the County and District Medical Societies,~~ shall be required to hold membership in the Resident and Fellow Society of the Indiana State Medical Association and the ~~County and District Medical societies, with the County Medical Society membership to be held in the county District~~ District Medical Society in which the resident lives or works.

12.0304 **Dues**

Resident and Fellow Society members shall pay one time state dues as determined by the ISMA Executive Committee, and these dues will cover their dues obligation for the entire training period. RFS members shall be exempt from paying ~~county, district and~~ state dues from July to December of the year in which they become a member. ~~Any subsequent dues for county and district societies shall be determined by those societies.~~ Dues shall be collected in accordance with ISMA Bylaws. No relief of dues shall be possible.

**13.01 COMPOSITION**

A Trustee District Medical Society, hereinafter called the district society, shall be a society whose members consist of the Association members ~~of the county medical societies in the counties which constitute the trustee district~~ who reside in the district; or alternatively, ~~however,~~ members who have a major part of their practice in a district other than the district in which they reside may hold membership in the district in which they have a major part of their practice.

**14.03 ELIGIBILITY - REQUEST FOR ISMA INVOLVEMENT**

Before a request for ISMA involvement will be considered by the ISMA Board of Trustees, the following conditions should be met:

(a) The physician making the request should be an ISMA member in good standing.

(b) A written request for ISMA involvement in medical defense and/or countersuit litigation should be sent to the Board of Trustees detailing the facts of the case as well as why the issues involved are of such a nature that they impact on the practice of medicine as a whole.

~~(c) A written statement of support from the physician's component county medical society should accompany the request for ISMA involvement.~~

**15.02 FIFTY YEAR CLUB**

The Fifty Year Club is an honorary club and should not be confused with the classification of Senior Member (1.0109). Fifty Year Club membership shall be officially recognized

annually. Eligibility for honorary membership in the Club includes:

(a) Shall have practiced medicine for fifty (50) years; and

(b) Shall have been a member of ~~a~~ the ISMA ~~component county medical society~~ for at least a ~~—~~portion of those fifty years; ~~and~~

~~(c) Shall have been approved for Fifty Year Club membership by a county medical society.~~

**RESOLVED (2): Referred to the Board of Trustees for Study**

RESOLVED, that ISMA amend its bylaws (effective 2019), so that every ISMA member who pre-registers and attends the annual convention is a delegate, as follows:

*3.020101* ***Voting Members***

~~1)~~ ~~Delegates or the designated Alternates, selected by the component societies~~All Association members who pre-register by the deadline established by the Speaker and attend convention shall be voting delegates. ~~;~~

~~2)~~ The following individuals who pre-register by the deadline established by the Speaker and attend convention shall also be voting delegates: Trustees or the designated Alternates ~~, 3)~~ Speaker; ~~, 4)~~ Vice ~~S~~Speaker~~, 5)~~ ; Past Presidents; ~~., 6)~~President; President-elect; Treasurer; Assistant Treasurer; Delegates and Alternate Delegates to the American Medical Association.

3.0202 **Parliamentarian**

The Speaker may appoint a parliamentarian for the annual convention, who need not be a member of the House and who shall advise the House about parliamentary matters. ~~, but without voting privileges.~~

3.0205 **Delegate ~~Apportionment~~Designation**

Any member of the Association who pre-registers by the deadline established by the Speaker and attends convention shall be a delegate.~~Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty (50) members and one for each major fraction thereof; but irrespective of the number of members, each component society which has made its annual report and~~

~~paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one Delegate. The Young Physician Society delegates, Resident and Fellow Society delegates, and medical student delegates shall be seated with full power to vote. In the absence of a Young Physician Society, Resident and Fellow Society, or medical student delegate, a corresponding alternate delegate shall be seated with full power to vote.~~

~~Where a component society is made up of physicians of more than one county, each county shall be entitled to at least one Delegate and one Alternate Delegate; however, a multiple-county society may have all of its delegates from the same county, if it is the desire of the majority of the members of each participating county (provided that this would not decrease the total number of delegates from the component medical society and provided each county of the component medical society has at least one physician member of ISMA).~~

~~*3.020501* ***Method of Determination of the Number of Delegates***~~
~~The number of Delegates to which each component society is entitled shall be based upon the number of members in good standing with dues fully paid as of December 31 of the preceding year.~~

~~*3.020502* ***Section Delegates***~~
~~All Specialty Sections listed in 3.030103 of these Bylaws and which are in compliance with 3.030102 and 3.030106 of these Bylaws shall be entitled to send to the House of Delegates each year a Delegate or Alternate Delegate with all rights and privileges except the power to vote.~~

*3.0205031* ***Delegate Credentials***
~~The names of duly elected Delegates and Alternates from each component society shall be sent to the Executive Vice President of this Association at least 45 days prior to the annual convention at which such Delegates are to serve.~~ No one shall be entitled to a seat in the House of Delegates unless a credential card as a Delegate ~~or Alternate, properly signed by the Secretary of the appropriate component medical society or the Executive Secretary or Executive Vice President of the larger societies,~~ is ~~presented to the Committee on Credentials~~ issued by the Association at the time of the annual convention.

*3.020504 **Delegate Replacement***

Other provisions (to include those in Sections 3.020101, and 3.020503) in these bylaws notwithstanding, if no delegate or alternate is selected by the deadline date 45 days prior to the annual meeting, then the previous year's delegate is automatically designated. Thereafter, the county officers, or if not available, the district officers may substitute a new delegate upon certification of eligibility. If the officer(s) is/are not available, the county executive may perform the delegate substitution. This substitution may be done until the time of the beginning of the closing session of the House of Delegates.

## 3.03 SECTION MEETINGS

### 3.0301 Specialty Sections

#### 3.030101 Purpose

*The purpose of specialty sections of ISMA is to provide a forum in ISMA and the House of Delegates, to have an active input into the scientific meeting, to introduce resolutions and have a voice on the floor of the House.*

#### 3.030102 Meetings

*Each section will be required to have a minimum of one meeting annually. Minutes of the meeting will be required. A copy of the minutes and the names of the officers shall be forwarded to the Speaker of the House and will become a permanent record of the House.*

#### 3.030103 Official Sections

*During the Annual Convention the Association, in addition to the general meetings, may hold the following section meetings:*

(a) Allergy
(b) Anesthesia
(c) Cutaneous Medicine
(d) Directors of Medical Education
(e) Emergency Medicine
(f) Family Physicians
(g) Internal Medicine
(h) Medical Directors and Staff Physicians of Nursing Facilities
(i) Neurological Surgery
(j) Neurology
(k) Nuclear Medicine

(l) Obstetrics and Gynecology
(m) Oncology
(n) Ophthalmology
(o) Orthopedic Surgery
(p) Otolaryngology, Head and Neck Surgery
(q) Pathology and Forensic Medicine
(r) Pediatrics
(s) Physical Medicine and Rehabilitation
(t) Preventive Medicine and Public Health
(u) Psychiatry
(v) Radiation Oncology
(w) Radiology
(x) Surgery
(y) Urology

3.030104 **Formation of Sections**

*Any future section can only be formed by a properly constituted resolution and shall include the signatures of a minimum of 15 members or 25 percent of the members, whichever is greater, who are practicing that specialty in the State of Indiana. The resolution shall be subject to the decision of the House of Delegates.*

3.030105 **Officers**

*The officers of each section shall be a chairman, a vice-chairman, and a secretary, and they shall preside over the meetings of the section and shall be responsible for the section speakers and papers.*

3.030106 **Officer Elections**

*The election of officers shall be held at a meeting of the section annually. The names of the officers shall be forwarded to the Speaker and will become a permanent record of the House.*

3.030107 **Restriction on Meetings**

*No section meeting shall be allowed to conflict with a general meeting.*

3.030108 **Failure to Comply**

*Any section not complying with the preceding shall not have a delegate in the House.*

3.0302 **Hospital Medical Staff Section**

~~3.030201 **Composition**~~

~~*Membership in the Hospital Medical Staff Section shall be limited to ISMA members selected by physician members of the medical staffs from each licensed hospital in the state of Indiana.*~~

~~3.030202 **Organization**~~

~~*The organization of the Hospital Medical Staff Section shall consist of an Executive Committee, which shall consist of the chairman, vice-chairman, secretary/treasurer, two members at large and the delegate and alternate delegate to the ISMA House of Delegates, with duties as may be prescribed in the Hospital Medical Staff Section Bylaws.*~~

~~**11.06 SELECTION OF DELEGATES**~~

~~In advance of the annual convention of this Association, each component county society shall elect delegates and alternate delegates to represent it in the House of Delegates of this association. The secretary of the society shall send a list of such delegates and alternate delegates to the Executive Vice President of this association annually, at least 45 days prior to the annual convention at which such delegates are to serve. In the event that a component county society is unable to seat a full delegation from its elected delegates and alternate delegates, the secretary of the county society may certify other qualified members of the component county society to be seated as replacement delegates.~~

**RESOLVED (3): Adopted as amended**

RESOLVED, that ISMA amend its bylaws (effective 2019) to make the current district medical societies part of the ISMA and not separate legal entities, and to require that each district medical society hold trustee elections to be held at a meeting of their choice by ~~during~~ the annual convention, as follows:

**5.03 ELECTION - TRUSTEE AND ALTERNATE**

The Trustees shall be elected by the respective district societies ~~at a time during the ISMA convention~~. If any district fails to meet and elect its Trustee(s) or Alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Vice President of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

12.0302 **Organization**

The Resident and Fellow Society will hold an annual meeting with the election of appropriate officers, ~~four delegates and four altern~~appropriate delegates and alternate delegates to the Resident Physicians Section of the AMA, and a resident trustee and alternate trustee to the ISMA Board of Trustees. The election of the trustee and alternate trustee shall be held at a meeting of its choice by ~~occur during~~ the Annual Convention, but not during a House of Delegates session. The term of office for the trustee and alternate trustee shall be for one year.

12.0402 **Organization**

The Medical Student Society will hold an annual meeting with the annual meeting with the election of its Governing Council, ~~four delegates and four alternate delegates to the ISMA House of Delegates,~~ appropriate delegates and alternate delegates to the Medical Student Section of the AMA, and a trustee and alternate trustee to the ISMA Board of Trustees. The election of the trustee and alternate trustee shall be held at a meeting of its choice by ~~occur during~~ the Annual Convention, but not during a House of Delegates session. The term of office for the trustee and alternate trustee shall be for one year.

12.0502 **Organization**

The Young Physician Society will hold an annual meeting with the election of appropriate officers, to include ~~four voting delegates and four alternate delegate to the ISMA House of Delegates,~~ appropriate delegates and alternate delegates to the Young Physician Section of the AMA, and a trustee and alternate trustee to the ISMA Board of Trustees. The election of the trustee and alternate trustee shall be held at a meeting of its choice by ~~occur during~~ the Annual Convention, but not during a House of Delegates session. The term of office for the trustee and alternate trustee shall be for one year.

**13.03** **~~CONSTITUTION AND BYLAWS~~ CHARTER**

~~Each district society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the Indiana State Medical Association or those of the American Medical Association, and only one district society shall exist within any one trustee district.~~ The authorized district society in each trustee district shall receive a charter from the Indiana State Medical Association, and the Secretary of the district

society shall have custody of the charter. The districts shall be geographical regions of the Indiana State Medical Association and not separate legal entities.

**13.04 OFFICERS**

Each district society shall organize by electing a President, a Secretary and a Treasurer and Trustee(s) and Alternate Trustee(s) as the current Trustee(s) term and Alternate Trustee(s) term for the district expires~~, and such others as may be provided for in its Constitution and Bylaws~~. The offices of Secretary and Treasurer may be held by the same physician. The Trustee(s) shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

**13.06 DUES**

The ~~dues of the~~ district societ~~y~~ies shall not collect dues but shall receive funds from~~, in an amount fixed by the district society to meet the society needs, shall be collected by the Secretaries of the component county societies, or by~~ the Indiana State Medical Association. Following a recommendation from the Executive Committee, the Board shall, on an annual basis, determine the amount of funds to allocate for each district society's approved expenses. ~~, and delivered to the Treasurer of the district society. The Secretary of each district society shall report to the office of the Indiana State Medical Association the names and addresses of the members of the district society, together with a copy of the minutes of each meeting of the district society.~~

**13.07 MEETINGS**

Each district society shall meet at least once each year at a time and place to be fixed by the district society. ~~District societies shall elect Trustees and Alternates at a meeting which occurs during the Annual Convention, and such meeting can serve as the annual meeting required herein.~~ On or before January 1 of each year, each district society shall notify the headquarters of the Indiana State Medical Association of the time and place of the annual district meeting for that year; but if no such notification has been received in the headquarters on or before the ~~January~~first calendar meeting of the Board, the Trustee shall fix the time and place of the district meeting, and notice of such

meeting shall be sent to the members of the county medical societies in such district.

13.0801 **Election of Trustee or Alternate**
~~District societies shall elect Trustees and Alternates at the Annual Convention, but not during a House of Delegates session.~~ Whenever a district society is to elect a Trustee and/or Alternate, the headquarters office of the Indiana State Medical Association shall so notify the individual members of such district society not later than six weeks in advance of said election date.

**RESOLVED (4): Adopted**

RESOLVED (4), that ISMA amend its bylaws to allow electronic voting when roll call vote is required and to clarify that voting may include electronic voting; and

*2.010103* ***Change in Dues Structure***
The final vote on any issue calling for changes in dues or in dues structure shall be by roll call or electronic vote of the House of Delegates. Each member's vote shall be permanently recorded.

*3.021201* ***Method of Election***
If there is only one candidate nominated for an office, election may be by voice or electronic vote. All other elections shall be by ballot (including electronic voting) and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. In the event of a tie vote on any ballot, the House of Delegates may, by majority vote, order an additional ballot, or may order resolution of the tie by drawing lots.

**RESOLVED (5): Adopted as amended**

RESOLVED, that ISMA amend its bylaws to make minor updates regarding the convention and submission of resolutions in writing or electronically.

3.0101 **Selection of Site**
~~The Convention site shall be recommended by the Board of Trustees to the House of Delegates for its approval. If conditions should prove difficult, t~~The Board shall have the

power to change the location of the Convention. The Annual Convention shall be held in Indianapolis and Marion County or in areas adjacent to or in close proximity to the Indianapolis area. The date and time for the Convention shall be fixed by the Board.

*3.020701* ***Resolutions and Proposals***

Only members of the Indiana State Medical Association may sponsor resolutions to the House of Delegates. The House of Delegates shall approve all memorials and resolutions issued in the name of the Association before same shall become effective.

***(a) Fiscal Note***

Proposals calling for appropriation of funds by the House of Delegates shall be accompanied by a fiscal note and shall be submitted to the Executive Committee and the Board for review, presentation and recommendation for final action of the House. No proposal calling for appropriations shall be considered if not accompanied by a fiscal note.

***(b) Deadlines for Resolutions***

Except as noted in 3.020701(c) and in 3.021102, all resolutions to be presented to the House of Delegates for action shall be prepared and ~~mailed~~ submitted in writing or electronically to the Executive Vice President of the Association so that they will be received not later than 60 days prior to the session of the House of Delegates to which the resolutions will be presented.

***(c) Late Resolutions***

Except for matters of extreme emergent nature, all late resolutions must be received by the Executive Vice President seven (7) days prior to the opening session of the House of Delegates. Those resolutions received after 60 days prior to the first session of the House of Delegates will be referred to the Committee on Rules and Order of Business. The Committee on Rules and Order of Business shall submit a report to the House concerning all items considered by same with recommendation(s) limited to the appropriateness of consideration of said resolutions.

The Committee on Rules and Order of Business will meet approximately seven (7) days prior to the Annual Convention to consider resolutions that have been first submitted to the Committee together with a written statement setting forth the reasons why the resolution was not mailed to the Executive Vice President more than 60 days prior to the first session of the House of Delegates and also setting forth in the written statement the reasons why the resolution is of such an emergency nature that it cannot wait until the next meeting of the House.

The report of the Committee on Rules and Order of Business shall be considered in the same manner as any other reference committee report. The House may accept or reject any recommendation of the Committee, which shall make recommendations on each resolution considered.

Discussion on the floor will be limited to one speaker in dissension with the Committee's recommendation. This discussion will be limited to the appropriateness of consideration and not the merits of the resolution itself.

Section 3.020701(b) may be suspended only upon a two-thirds affirmative vote of the House of Delegates when considering the report of the Committee on Rules and Order of Business. Each member of the House shall be furnished a copy of all proposed late resolutions for consideration of the report of the Committee on Rules and Order of Business.

***(d) Resolution Expiration***

Any resolution adopted by the House of Delegates shall expire on November 1 following the tenth anniversary of its adoption or its subsequent re-adoption. Prior to each annual meeting, delegates shall be notified of all resolutions that will expire in that calendar year pursuant to this section, in sufficient time to permit submission of a resolution for re-adoption. Nothing in this section shall restrict the power of the House of Delegates to rescind or amend any resolution in force at any time.

***(e) Withdrawal of Resolutions***

The withdrawal of ISMA resolutions may not occur later than the publication and distribution date of all resolutions, except by majority approval of the ISMA House of Delegates during the first meeting of that House of Delegates.

**RESOLUTION 17-23 MEMBERSHIP DUES ADJUSTMENT**

Introduced by: ISMA Future Directions Task Force

Action: Adopted as Amended

RESOLVED, that ISMA increase regular membership dues to $490 effective for the 2019 dues year; and be it further

RESOLVED, that ISMA modify the amount of the annual group dues discounts for groups of five or more physicians to the following amounts:

- 100% group participation - $115 discount per member per year
- 90% group participation - $75 discount per member per year
- 80% group participation - $40 discount per member per year
- 75% group participation - $20 discount per member per year

To be effective for the 2019 dues year; and be it further

RESOLVED (3), that ISMA modify the amount of the multi-year dues discount to the following:

- 10-year membership - $115 discount per year
- 5-year membership - $75 discount per year
- 3-year membership - $40 discount per year
- 2-year membership - $20 discount per year

To be effective for the 2019 dues year. Discounts cannot be combined.

**RESOLUTION 17-24 RECOGNIZING FIVE WISHES IN INDIANA**

Introduced by: Stacie Wenk, DO, and Heidi M. Dunniway, MD

Action: Referred to the Board of Trustee for Action

RESOLVED, that ISMA seek legislation that recognizes Five Wishes as a legal document for end-of-life decision-making in Indiana.

**RESOLUTION 17-25** **INSURANCE COVERAGE FOR CHRONIC PAIN MANAGEMENT**

Introduced by: Stacie Wenk, DO, and Heidi M. Dunniway, MD

Action: Adopted as Amended

RESOLVED, that consistent with AMA Policy H-185.931 *Coverage for Chronic Pain Management*, ISMA advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician-led, and recognize the interdependency of treatment methods in addressing chronic pain; and be it further

RESOLVED, that ISMA advocate for private and government-sponsored health plans that provide coverage that gives patients access to the full range of evidence-based chronic pain-management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits; and be it further

RESOLVED, that ISMA support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process; and be it further

RESOLVED, that ISMA seek legislation to require health insurers and government-sponsored plans to cover the full range of physician-led, evidence-based chronic pain management modalities at a level commensurate to other medical or surgical benefits.

**RESOLUTION 17-26 PARLIAMENTARY AUTHORITY**

Introduced by: Heidi M. Dunniway, MD, and Stacie Wenk, DO

Action: Adopted as Amended

Whereas, deliberations of ISMA are governed by the fourth edition of *The Standard Code of Parliamentary Procedure*, first published in 2000 and commonly referred to as "Sturgis," as set forth in Section 16.00 of the Bylaws; and

Whereas, revisions to Sturgis were made and released in the 2012 *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*; and

Whereas, ISMA wishes to remain current in its parliamentary practices to facilitate efficient and equitable deliberations; therefore, be it

RESOLVED, that ISMA adopt the updated *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* to govern deliberations of ISMA when not in conflict with the ISMA's Constitution and Bylaws; and be it further

RESOLVED, that Section 16.00 of the Bylaws be amended to read:
"The deliberations of this association shall be governed by the ~~fourth edition of~~ current standards established by The ***American Institute of Parliamentarians*** *Standard Code of Parliamentary Procedure* when not in conflict with this Constitution and Bylaws and when not in conflict with special rules of procedure that may be adopted by the various deliberative bodies within the association."

**RESOLUTION 17-27 ALL-PURPOSE EVIDENCE-BASED INDIANA MEDICAL HISTORY POWERPOINT SLIDES/FACT SHEET(S) FOR GENERAL ISMA LEADERSHIP/STAFF USE**

Introduced by: Thomas S. Whiteman, MD, FACS

Action: Adopted as Amended

RESOLVED, that ISMA develop an ongoing long-term effort to compile an evidence-based historical record of medicine in Indiana in PowerPoint slides and fact-sheet form, which would be available to ISMA leadership and staff for use in public presentations and reference-material form; and be it further

RESOLVED, that on a voluntary basis an ISMA Historian(s) designation is given to physician or physician(s) who wish to contribute to this effort.

**RESOLUTION 17-28 BASIC PRACTICE PROFESSIONAL STANDARDS OF PHYSICIAN EMPLOYMENT**

Introduced by: Thomas Whiteman, MD, FACS

Action: Adopted as Amended

RESOLVED, that ISMA support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.
2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.
3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.
4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of *locum tenens* coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other "greater societal good" organizations.
5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region; and be it further

RESOLVED, that Resolution 17-28 is referred through our Indiana AMA Delegation to both the Organized Medical Staff Section (OMSS) of the AMA and to the AMA House of Delegates before the 2018 AMA Annual Meeting.

**RESOLUTION 17-29** **ISMA TRACKING OF MEDICAL SCHOOL GRADUATES FROM THE STATE OF INDIANA**

Introduced by: Thomas S. Whiteman MD, FACS

Action: Adopted as Amended

RESOLVED, that ISMA collect data from various medical schools in Indiana regarding demographics of acceptance into medical schools, graduation, specialty, residency and practice location.

**RESOLUTION 17-30** **HEALTH PLAN MEDICAL DIRECTOR ACCOUNTABILITY**

Introduced by: Indianapolis Medical Society

Action: Adopted as amended

RESOLVED, that ISMA support medical competency at health-plan medical-director levels by defining and creating policy that coverage decisions are indeed the practice of medicine and, therefore, subject to all laws and regulations attached to that designation; and be it further

RESOLVED, ISMA seek legislation that requires health-plan medical directors to be physicians with a broad knowledge of medical services, or a physician of the same specialty as the requesting physician (when feasible) to make care determinations impacting patients and practicing physicians.

**RESOLUTION 17-31 PRIOR AUTHORIZATION (PA)**

Introduced by: Indianapolis Medical Society

Action: Adopted as Amended

RESOLVED, that ISMA promote the appropriate use of prior authorization primarily for initial requests and services that fall outside the standard of care; and be it further

RESOLVED, that ISMA implement and promote policy that minimizes the need for prior authorization annually or on any other schedule when the request is for continuity of care and the prior authorization is for regimens that are working well to control a patient's condition; and be it further

RESOLVED, the ISMA create a policy that prior authorizations need to be completed within three working days by the health plan or pharmacy if approved, or if the prior authorization is denied, the denial must include an explanation, unique and specific to the individual patient, and, if no answer is obtained within three days, the prior authorization is deemed approved and patient care may proceed; and be it further

RESOLVED, that ISMA create a policy for the prior authorization process that, unless a health plan, pharmacy vendor or other payer source can document that medical care or a specific service or pharmaceutical is NOT appropriate or medically-indicated based on nationally recognized evidence-based guidelines, the health plan, pharmacy vendor or other payer source shall approve the request of the attending physician; and be it further

RESOLVED, that ISMA schedule quarterly meetings with insurance companies to discuss any prior authorization issues, as well as any other matters pertinent to physicians and patients; and be it further

RESOLVED, that ISMA support any effort to allow the physician to bill the insurance company directly for prior authorization time, and that the cost not be a pass-through charge to the patient; and be it further

RESOLVED, that the ISMA-AMA Delegation take this resolution to the AMA meeting for consideration and advocacy action both by administrative and/or legislative means; and be it further

RESOLVED, that the ISMA and the AMA work to address the problem of excessive burden from prior authorizations and meaningful use regulations by regulatory and/or legislative means; and be it further

RESOLVED, that the AMA delegation from the ISMA take the information to the AMA that Medicare Advantage plans follow Medicare guidelines if the plan chooses to follow their own guidelines. The plan must be transparent on the criteria for approval or denial.

**RESOLUTION 17-32 DISTRICT FISCAL RELIEF**

Introduced by: Indianapolis Medical Society

Action: Withdrawn by author

RESOLVED, that, upon appropriate application to ISMA, ISMA offer grants in the amount of $100 per member per year for each district member annually for two years to ease the districts' financial distress; and that the ISMA Board of Trustees prepare an annual report to the ISMA House of Delegates summarizing these awarded grants and their financial impact on ISMA reserves.

**RESOLUTION 17-33** **ASSISTING COUNTY MEDICAL SOCIETIES AND DISTRICTS**

Introduced by: Indianapolis Medical Society

Action: Withdrawn by author

RESOLVED, that the ISMA Board of Trustees, after receiving, reviewing, and approving grant proposals, by a simple majority allocate grants in the amount of $100,000 per year for four years to each county society and/or district that applies for a grant for regional infrastructure development and aggressive membership recruitment, and any county society/district receiving a grant will annually send a comprehensive report of activities and membership metrics to the ISMA Board of Trustees' November meeting during the grant period.

**RESOLUTION 17-34 DATA COLLECTION RELATED TO NAS**

Introduced by: John Ellis, MD, and Maria Del Rio Hoover, MD

Action: Adopted

RESOLVED, that ISMA seek and/or support legislation to expand the collection of all applicable data related to the identification and treatment of infants at risk for Neonatal Abstinence Syndrome (NAS) from all Indiana hospitals where such patients have been identified, with the information to be collected and submitted to the Indiana State Department of Health.

**RESOLUTION 17-35 TREATING OPIOID ADDICTION IN INDIANA**

Introduced by: Deepak Azad, MD, and Kevin Burke, MD

Action: Adopted

RESOLVED, the ISMA support increased funding for inpatient and outpatient treatment of drug addiction; and be it further

RESOLVED, ISMA support the establishment of a mandatory registry that contains inpatient bed census data so that available inpatient drug-addiction treatment beds would be easily identifiable. This would enhance the speed of treatment and provide a more efficient use of inpatient resources. It is expected that these facilities would readily accept these patients from more distant locations.

**RESOLUTION 17-36 EXPANDING NALOXONE PROGRAMS IN INDIANA**

Introduced by: Deepak Azad, MD, and Kevin Burke, MD

Action: Adopted as Amended

RESOLVED, that ISMA support expanding naloxone training for the lay population in order to decrease the risk of fatal overdose. Additionally, the training program and naloxone supply that is funded by the Indiana State Department of Health should be expanded to provide two separate doses of naloxone because of the risk posed by fentanyl and carfentanyl with overdose relapse; and be it further

RESOLVED, that ISMA support the continuing availability of over-the-counter naloxone either through order by the Indiana State Health Commissioner or legislative action; and be it further

RESOLVED, that the ISMA support the expansion of programs linking users of Naloxone for the purpose of reversing opioid overdose to long-term addictions management; and be it further

RESOLVED, that the AMA be asked to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

**RESOLUTION 17-37 PHYSICIANS RIGHT TO PRACTICE AGAINST NON-COMPETITION AND NO DEFENSE PROVISION**

Introduced by: Deepak Azad, MD, and Kevin Burke, MD

Action: Referred to the Board of Trustees for Action

RESOLVED, that ISMA request the Indiana state legislature to bar enforcement of non-competition agreement and no defense provision in physicians' contracts in the best interest of patients and continue the care of patients with chronic conditions.

**RESOLUTION 17-38 DANGER FROM BRIGHT VEHICLE HEADLIGHTS**

Introduced by: Deepak Azad, MD, and Kevin Burke, MD

Action: Adopted

RESOLVED, the ISMA send this resolution to the AMA House of Delegates for consideration with the recommendation that it is referred to the Council of Science and Public Health for study, and report back to the House of Delegates; and be it further

RESOLVED, ISMA ask the AMA to study the safety risks to drivers and their passengers when they approach vehicles with incandescent, xenon gas or LED headlights as well as the use of other technologies such as automated steering and automated windshield tinting to mitigate the risk; and be it further

RESOLVED, the ISMA ask the AMA to advocate for mandatory automated high-beam to low-beam headlight switching systems that would operate when an approaching vehicle head light is detected.

**RESOLUTION 17-39** **EXCLUSIVE STATE CONTROL OF METHADONE CLINICS**

Introduced by: Deepak Azad, MD, and Kevin Burke, MD

Action: Adopted as Amended

RESOLVED, the ISMA send this resolution to the AMA House of Delegates to support complete state control of all aspects of methadone clinic approval and operations; and, if deemed necessary, this control could be granted on a state by state basis; and be it further

RESOLVED, the ISMA restate some of our current methadone clinic policies and add new ones as follows.
1) The medical director of an Indiana-based methadone clinic should be licensed in Indiana and have admitting privileges at a local hospital that is most appropriate for this patient population.

2) Indiana-based methadone clinics should have substantial counseling and drug rehab programs with the expectation that these would occur with every visit.

3) Indiana-based methadone clinics may benefit from limiting the number of clients served because of the logistics and efficiency issues that come in a crowded clinic operation.

4) Indiana-based methadone clinics should be required to periodically taper opioids provided to their clients. Pregnant clients should be tapered or referred to a program that specializes in managing pregnancy in opioid-addicted women.

5) All opioids dispensed by Indiana-based methadone clinics should be reported to INSPECT, along with a periodic INSPECT query.

**RESOLUTION 17-40 BURDEN OF PRIOR AUTHORIZATIONS AND MEANINGFUL USE REGULATIONS**

Introduced by: 13th District Medical Society

Action: Not Adopted

RESOLVED, that the ISMA and the AMA work to address the problem of excessive burden from prior authorizations and meaningful use regulations by both regulatory and legislative means.

**RESOLUTION 17-41** **SUPPORTING THE CREATION OF A MATERNAL MORTALITY REVIEW PROGRAM FOR INDIANA**

Introduced by: Mary Pell Abernathy, MD

Action: Adopted

RESOLVED, the ISMA support legislation creating a maternal mortality review program in Indiana. This program will allow confidential collection, investigation and review of maternal mortality in Indiana to develop strategies to prevent future maternal-related mortality.

**RESOLUTION 17-42 AMA POLICY STATEMENT WITH EDITORIALS**

Introduced by: Tom Vidic, MD

Action: Referred to the Board of Trustees for Action

RESOLVED, our AMA include a policy statement after all editorials in which policy has been established to clarify our position

**MEMORIAL RESOLUTION** **John Merritt Records, M.D.**

Introduced by: Indianapolis Medical Society
7th District Medical Society

Whereas, he has served his county, district, state, and national medical organizations with distinction; and

Whereas, he has also served his community and his colleagues as a Charter Fellow in the American Academy of Family Physicians, American Board of Family Practice, American Medical Association, Indiana State Medical Association (3-term Trustee), Seventh District President, Seventh District Secretary/Treasurer (6 terms), Johnson County Medical Society (Past President, 2 terms), and American Medical Political Action Committee. He also served as President of Johnson County Indiana University Alumni Association (4 terms), B.P.O.E. Elks (55-year Life Member), Masonic Lodge, Murat Shrine and 32nd Degree Scottish Rite. He was a former member of Hillview Country Club, Franklin, and more recently, as a member of Moon Valley Country Club, Phoenix, Arizona; and

Whereas, his dedication, compassion, and patience were unparalleled during his more than 50 years of practice in Indiana; and

Whereas, he was a devoted patient advocate and an enthusiastic participant in organized medicine, having served this House of Medicine for many years as a District President, Trustee, Alternate Trustee, Delegate, and Alternate Delegate, and, for many years as Credentialing Coordinator; and

Whereas, he was a devoted, caring and loving husband to his wife, Pamela, and father to their children and grandchildren; and

Whereas, his passing has left an enormous vacuum in the lives of those who knew and loved him that will neither easily nor soon be filled; therefore, be it

RESOLVED, that **John Merritt Records, M.D.,** be honored and memorialized by this House for the extraordinary service he has given on behalf of patients and physicians in Indiana and Arizona.