



BETTER

MSV Annual Meeting, Oct. 13-16, 2016
The Roanoke Hotel & Conference Center

DELEGATE HANDBOOK



MSVSM
MEDICAL SOCIETY
OF VIRGINIA



Date: October 2016

To: House of Delegates Members

From: Kurtis S. Elward, MD, Speaker
Arthur J. Vayer Jr., Vice Speaker

Subject: 2016 Meeting of the MSV House of Delegates

Welcome to the 2016 Annual Meeting and the House of Delegates. Our efforts will be enhanced by your fullest participation. Your Speakers stand ready to assist you in your deliberations.

Items for consideration will be introduced on Friday, Oct. 14. Full testimony on these items will be received from any member of the MSV at the Reference Committees on Friday, Oct. 14. Please attend and participate. This is where the strength of the decisions of the House originates. We recommend that you become familiar with the reports and resolutions. Reports and Resolutions have been posted on the MSV Web site at www.msv.org. The agenda for each session of the House can be referenced in this handbook.

Finally, as the meeting progresses, be mindful of your obligation to report our actions and decisions and their rationale back to your constituents.

We look forward to working with you at in Roanoke.

HOUSE OF DELEGATES - First Session Agenda
Friday, October 14, 2016, 9:30 am
Crystal Ballroom

Call to Order
The Speakers

Pledge of Allegiance
Monica Melmer

Invocation
Lawrence K. Monahan, M.D.

MSVPAC Award
Joel T. Bundy, M.D.

In Memoriam
The Speakers

Speaker Remarks
The Speakers

Introduction of Guests
The Speakers

Recognize New Delegates
The Speakers

**Recognize 50 Year
Medical School Graduates**
The Speakers

Presidential Address
Edward G. Koch, M.D.

AMA Update
Randolph J. Gould, M.D.

Credentials Committee Report
Janet G. Hickman, M.D. and
Edilberto O. Pelausa, M.D.

**Request for approval of the 2015 MSV
House of Delegates sessions minutes**
Alan L. Wagner, M.D.

Rules Committee Report
Richard A. Szucs, MD

Consent Calendar: Informational Reports
(Any item is eligible for extraction;
Reports will be posted online)
The Speakers

1. Actions of the 2015 MSV House of Delegates Sessions
2. MSVPAC Report
3. Medical Student Section Report
4. Physician Assistant Section Report
5. Intrastate Accreditation Committee Report
6. Virginia Board of Medicine Annual Report

**MSV Board Actions on the 2015
MSV House of Delegates
Resolutions**
The Speakers

**MSV Executive Vice President
Remarks**
Melina Davis-Martin

New Business
The Speakers

Announcements
The Speakers

Recess until 8:30 a.m.
Sunday, October 16, 2016

HOUSE OF DELEGATES - Second Session Agenda
Sunday, October 16, 2016, 8:30 am
CRYSTAL BALLROOM

Call to Order
The Speakers

Introduction of Guests
The Speakers

MSVPAC Update and Awards
Joel T. Bundy, M.D.

Secretary of Health and Human Resources
William A. Hazel Jr., MD

Credentials Committee Report
Janet G. Hickman, M.D. and
Edilberto O. Pelausa, M.D.

Nominating Committee Report
David A. Ellington, M.D.

Election of Officers and Directors
The Speakers

- a. President-Elect
- b. Speaker of the House
- c. Vice-Speaker of the House
- d. Directors for one-year terms – Resident and Medical Student
- e. Directors for two-year terms – Districts 2, 6, 8, 10 and Academic
- f. Associate Director for one-year term – District 9, Resident and Medical Student
- g. Associate Director for two-year term – Districts 2, 6, 8, 10 and Academic
- h. Delegates and Alternate Delegates to the American Medical Association

Installation of Officers, Directors and Membership

Carol S. Shapiro, M.D.

Introduction of New President
Carol S. Shapiro, M.D.

Incoming President's Remarks
Bhushan H. Pandya, M.D.

Election of the 2016-2017 Nominating Committee
The Speakers

Special Resolutions
The Speakers

Reference Committee Reports
a. Reference Committee 1
Daniel Carey, M.D.
b. Reference Committee 2
Stuart I. Henochowicz, M.D.

Announcements
The Speakers

Adjournment
The Speakers



<i>American Institute of Parliamentarians Standard Code of Parliamentary Procedure</i>								
Basic Rules Governing Motions								
Order of Rank/Precedence ¹	Interrupt	Second	Debate	Amend	Vote	Applies to what other motions?	Can have other motions applied? ⁵	Renewable
Privileged Motions								
1. Adjourn	No	Yes	Yes ²	Yes ²	Majority	None	Amend, Close Debate, Limit Debate	Yes
2. Recess	No	Yes	Yes ²	Yes ²	Majority	None	Amend, Close Debate, Limit Debate	Yes ⁶
3. Question of Privilege	Yes	No	No	No	None	None	None	Yes
Subsidiary Motions								
4. Table	No	Yes	No	No	2/3	Main Motion	None	No
5. Close Debate	No	Yes	No	No	2/3	Debatable Motions	None	Yes
6. Limit Debate	No	Yes	Yes ²	Yes ²	2/3	Debatable Motions	Amend, Close Debate	Yes ⁶
7. Postpone to a Certain Time	No	Yes	Yes ²	Yes ²	Majority	Main Motion	Amend, Close Debate, Limit Debate	Yes ⁶
8. Refer to Committee (or Board)	No	Yes	Yes ²	Yes ²	Majority	Main Motion	Amend, Close Debate, Limit Debate	Yes ⁶
9. Amend	No	Yes	Yes ³	Yes	Majority	Rewordable Motions	Close Debate, Limit Debate	No ⁶
Main Motions								
10a. The Main Motion	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
10b. Specific Main Motions								
Adopt in-lieu-of	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
Amend a Previous Action	No	Yes	Yes	Yes	Same Vote	Adopted MM	Subsidiary	No
Ratify	No	Yes	Yes	Yes	Same Vote	Adopted MM	Subsidiary	No
Recall from Committee	No	Yes	Yes ²	No	Majority	Referred MM	Close/Limit Debate	No
Reconsider	Yes ⁴	Yes	Yes ²	No	Majority	Vote on MM	Close/Limit Debate	No
Rescind	No	Yes	Yes	No	Same Vote	Adopted MM	Subsidiary; <i>not</i> amend	No

American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table

Incidental Motions (non-ranking within the classification)								
Motions								
No order of Rank/Precedence	Interrupt	Second	Debate	Amend	Vote	Applies to what other motions?	Can have other motions applied?	Renewable
Appeal	Yes	Yes	Yes	No	Majority ⁷	Ruling of Chair	Close/limit debate	No
Suspend the Rules	No	Yes	No	No	2/3	Procedural Rules	None	Yes
Consider Informally	No	Yes	No	No	Majority	Main Motion or Subject	None	Yes
Requests								
Point of Order	Yes	No	No	No	None	Procedural error	None	No
Inquiries	Yes	No	No	No	None	All motions	None	No
Withdraw a Motion	Yes	No	No	No	None ⁸	All motions	None	No
Division of a Question	No	No	No	No	None ⁸	Main Motion	None	No
Division of Assembly	Yes	No	No	No	None ⁸	Indecisive Vote	None	No

MM = Main Motion

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

²Restricted

³Not debatable when applied to undebatable motion

⁴Member may interrupt proceedings, but not a speaker

⁵Withdraw may be applied to all motions

⁶Renewable at discretion of presiding officer (chair)

⁷Tie or majority vote sustains the ruling of the presiding officer; majority vote in negative reverses the ruling

⁸If decided by assembly (by motion), requires a majority vote to adopt

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American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table

Annual Meeting of the Medical Society of Virginia

Minutes of the First Session of the House of Delegates Friday, October 23, 2015

The 2015 session of the Medical Society of Virginia House of Delegates convened on Friday, October 23, at The Westfields Marriott in Chantilly, Virginia. Speaker Kurtis S. Elward, M.D. called the 168th annual meeting to order at 9:30 a.m. The Pledge of Allegiance to the flag was led by Dr. Jonathan Schaaf, and the invocation was given by Dr. Patricia Pletke.

An "In Memoriam" of those MSV members who have passed in the last year was projected.

Guests were acknowledged by the Speakers and included: Dr. John Poole, Mid-Atlantic/Eastern representative of AMPAC; Dr. Theodore H. Miller, President, Kentucky Medical Association; Dr. Brian Bachelder, President, Ohio State Medical Association, Dr. Paula Taylor, President, West Virginia State Medical Society, Mr. James Cole, Chairman, Virginia Hospital and Health Care Association and Mr. Sean Connaughton, President/CEO, Virginia Hospital & Healthcare Association.

The Speakers recognized new delegates and 50-year medical school graduates.

Dr. William C. Reha, outgoing MSV President, shared remarks regarding his year as president.

Dr. John Poole, Mid-Atlantic/Eastern representative of AMPAC, provided an update.

Dr. Peter Kemp, Credentials Committee Chair, reported 80 delegates representing 11 Component and 4 Specialty Societies, 2 Medical Student Sections, 1 Academic Medical School and the Resident Physician Section. Health Systems and the Hospital Medical Staff Section was not represented.

Dr. Bhushan Pandya, MSV Secretary-Treasurer, asked for comments on minutes from the 2014 meetings of the House of Delegates. The minutes were approved without objection.

Rules Committee Chair, Dr. Joseph S. Galeski III, recommended adoption of the Rules of Procedure provided. They were adopted by unanimous vote.

The Rules committee voted to accept one late resolution, 15-210L Address Barriers To The Safe Production And Sale Of Cannabidiol And THC-A Oils, which will be assigned to Reference Committee 2.

The following Informational Reports were presented as Consent Calendar items:

1. Actions of the 2014 Session of the MSV House of Delegates
2. MSVPAC Report
3. MSV Foundation Report
4. Resident and Fellow Section Report
5. Medical Student Section Report
6. Physician Assistant Section Report
7. Organized Medical Staff Section Report
8. Intrastate Accreditation Committee Report
9. Virginia Board of Medicine Annual Report

The Speakers asked for comments on the Board Actions on 2014 Annual Meeting Resolutions report. Policy statements regarding Cannabis for Medicinal Use and Opioid Prescribing and/or Addiction Education were extracted. Cannabis for Medicinal Use was assigned to Reference Committee 2 and Opioid Prescribing and/or Addiction Education was assigned to Reference Committee 1. The rest of the report was unanimously adopted.

Ms. Melina Davis-Martin, EVP, Davis-Martin and staff presented an overview of the 2016 Strategic Plan. The primary focus of the strategic plan will be on strategic positioning and relationships. Key highlights and areas of focus of the strategic plan are:

- Health Policy & Practice Services
- Government Affairs
- Segmentation
- Engagement
- Member advocates
- Full lifecycle of services
- Practice Services & Business Services
- Exceptional Member Experience
- Finance & Accounting

President, Dr. William Reha, and Dr. Sterling Ransone, of Deltaville, Past President of the Medical Society of Virginia, and Dr. Randy Gould, of Norfolk, Chair, AMA Delegation, and also Past President of the Medical Society of Virginia presented Commendation Awards to Dr. Carol Shapiro and Mr. Cort Kirkley.

The First Session of the House of Delegates recessed at 10:55 a.m.

**Minutes of the Second Session of the House of Delegates
Sunday, October 25, 2015**

Speaker Kurtis S. Elward, M.D. called the meeting to order at 8:30 a.m.

Guests were acknowledged by the Speakers and included: Dr. Robert Wah, Immediate Past President of the American Medical Association and Secretary William Hazel, Secretary of Health and Human Resources for Virginia.

Dr. Sterling Ransone, MSVPAC Chair, provided the MSVPAC update.

Secretary William Hazel, Secretary of Health and Human Resources for Virginia provided an update.

Dr. Robert Wah, Immediate Past President of the American Medical Association provided an AMA update.

Dr. Robert Wah, Immediate Past President of the American Medical Association conducted the installation of our new MSV President, Dr. Edward Koch. Dr. Wah then introduced incoming President, Dr. Edward Koch, who addressed the House.

Dr. Peter Kemp, Credentials Committee Chair, reported 109 delegates representing 15 Component and 7 Specialty Societies, 4 Medical Student Sections, 1 Health System, 1 Academic Medical Schools and the Resident Physician Section. The Hospital Medical Staff Section was not represented.

The Nominating Committee report was presented Dr. David Ellington, Chair of the Nominating Committee. A motion was then made to accept the nominations and the following were elected by unanimous vote:

OFFICERS

President-Elect	Bhushan H. Pandya, MD
Secretary-Treasurer	Alan L. Wagner, MD
Speaker	Kurtis S. Elward, MD
Vice Speaker	Arthur J. Vayer Jr., MD

DIRECTORS (Elected for 2-year term)

District 1	James R. Dudley, MD
District 3	John F. Butterworth IV, MD
District 3	Clifford L. Deal, III, MD
District 5	Jacqueline M. Fogarty, MD
District 7	Mohit Nanda, MD
District 7	Michael S. Amster, MD
District 9	S. Hughes Melton, MD
Foundation	Ibe O. Mbanu, MD

DIRECTORS (Elected for 1-year term)

District 2	Joel T. Bundy, MD
Resident	Jonathan T. Schaaf, MD
Medical Student	Ehsan Dowlati

ASSOCIATE DIRECTORS (Elected for 2-year term)

District 1	Timothy L. Raines, MD
District 3	Richard A. Szucs, MD
District 5	Pradeep K. Pradhan, MD
District 7	Samuel D. Caughron, MD
District 9	Larry G. Mitchell, MD

ASSOCIATE DIRECTORS (Elected for 1-year term)

District 2	Edilberto O. Pelausa, MD
District 6	James J. Gooding, MD
Resident	Joshua Lesko, MD

AMA DELEGATES (Elected for 2-year calendar terms)

Claudette Dalton, MD
David A. Ellington, MD
Randolph J. Gould, MD
Hazle S. Konerding, MD

AMA ALTERNATE DELEGATES (Elected for 2-year calendar terms)

Clifford L. Deal, III, MD
Russell C. Libby, MD
Bhushan H. Pandya, MD

Dr. Bhushan Pandya was elected unanimously as MSV president-elect.

Dr. Robert Wah, Immediate Past President of the American Medical Association, conducted the installation of officers.

The Nominating Committee was presented for election and elected by unanimous vote and included the following members:

District 1	Hugh M. Bryan III, M.D.
District 2	Mitchell B. Miller, M.D.
District 3	Hazle S. Konerding, M.D.
District 5	William R. Bell, M.D.
District 6	David A. Ellington, M.D.
District 7	Claudette E. Dalton, M.D.
District 8	Carol S. Shapiro, M.D.
District 9	Larry G. Mitchell, M.D.
District 10	Russell C. Libby, M.D.
Academic	Karen S. Rheuban, M.D.
Student	Sheela R. Damle
AMA Advisor	Randolph J. Gould, M.D.
Advisor	Sterling N. Ransone Jr., M.D. (2014-2016)
Advisor	William C. Reha, M.D., M.B.A. (2015-2017)

Dr. Barbara A. Allison-Bryan presented the reports of Reference Committee 1 and Dr. S. Hughes Melton presented the reports of Reference Committee 2. The Final Actions of the House of Delegates for all resolutions are attached to these minutes.

The 2015 Annual Meeting of the House of Delegates of the Medical Society of Virginia adjourned at 10:40 a.m.



ACTIONS OF THE 2015 ANNUAL MEETING OF THE MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES

15-101: MEDICAL SOCIETY OF VIRGINIA PROPOSED 2016 BUDGET

RESOLVED, that the Medical Society of Virginia approve, as presented, the proposed budget for 2016.

Adopted.

15-102: MSV 2015 POLICY COMPENDIUM UPDATE

RESOLVED, that the Medical Society of Virginia adopt the recommendations in the enclosed report with the following amendments.

85.001 – Disagreements Regarding Treatment of the Terminally Ill

Date: 11/4/1995

Reaffirmed 11/06/2005

Medical treatment of the terminally ill remains the responsibility of the physician to apply his best medical judgment in each instance and always suggest what he feels to be the proper course of treatment. Should there be any disagreement, it is the physician's prerogative to withdraw from the case after proper notification and assistance in the obtaining of another physician. Conversely, it is the prerogative of the family, parent, guardian, spouse, or committee to replace ~~him~~ the physician as they wish.

Recommendation: ~~Reaffirm~~ Reaffirm as amended.

122.000 Drugs: Substance Abuse and Prevention

122.001 – Urine Collection

Date: 11/4/1995

Reaffirmed 11/06/2005

When chain of custody is required, the Medical Society of Virginia supports legislation requiring national standardized custody control processes and forms for collection of urine for drug screening.

Recommendation: ~~Reaffirm~~ Reaffirm as amended.

420.002 - Post-Delivery Care for Mothers and Newborns

Date: 11/4/1995

Reaffirmed 11/06/2005

The Medical Society of Virginia believes: a) any insurer that offers maternity benefits shall provide ~~coverage of minimum of forty-eight (48) hours of inpatient care for a mother and her newborn infant following a normal vaginal delivery and a minimum of ninety-six (96) hours of inpatient care for a mother and her newborn infant following a cesarean delivery;~~ that is consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services. b) any decision to shorten the length of inpatient stay to less than that provided under subsection (a) shall be made by the attending physician after conferring with the mother; c) if a mother and newborn are discharged pursuant to subsection (b) prior to the inpatient length of stay provided under subsection (a), coverage shall be provided for a follow-up visit within 48 hours of

ACTIONS OF THE 2015 ANNUAL MEETING OF THE MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES

~~discharge. Services provided shall include, but not be limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and the performance of any medically necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services; d) no insurer may deselect, terminate the services of, require additional documentation from, require additional utilization review, reduce payments, or otherwise provide financial disincentives to any attending physician who orders care consistent with the provisions of this legislation; e) every insurer shall provide notice to policyholders regarding the coverage required under this legislation. The notice shall be in writing and shall be transmitted at the earliest of either the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following the effective date of the legislation.~~

~~Recommendation: Archive. This policy was developed to address a specific bill. The speakers encourage that policies be drafted in such a way that positions are documented but not tied to any one particular piece of legislation. Reaffirm as amended.~~

15-103: ASSOCIATE DIRECTORS

RESOLVED, that the Medical Society of Virginia amend Article V (House of Delegates), Section 1 (Composition) of the bylaws as follows:

The House of Delegates shall be the policy making body of the Society. The House of Delegates shall consist of delegates elected by the component societies, component student societies, component resident physician sections, specialty sections, the hospital medical staff section, health systems, academic medical schools and the following ex-officio members: The President, President-Elect, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, Secretary-Treasurer, directors and associate directors ~~any member of the Board of Directors who was elected to the Board of Directors as a representative of a District~~, all Past Presidents of the Society, any general officer of the American Medical Association who also is a member of the Society, and the delegates and alternate delegates of the Society to the American Medical Association. Delegates elected by component societies, specialty sections, component student societies, component resident physician sections, the hospital medical staff section, health systems, and academic medical schools shall serve a one-year term. Ex-officio members of the House of Delegates, except for the Speaker, as provided in Article VII, Section ~~5-14~~, shall have full voting rights and will not be included in the delegate allotment for each component society. No voting by proxy shall be permitted in the House of Delegates. Each member of the House of Delegates also must be a member of the Society.

Adopted.

15-104: BAN ON TOBACCO USE IN CARS WITH MINORS

RESOLVED, that the Medical Society of Virginia support legislative efforts to make it illegal for anyone to smoke tobacco in a car with a minor inside of the car.

Adopted.



ACTIONS OF THE 2015 ANNUAL MEETING OF THE MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES

15-105: ERADICATING FOOD DESERTS AND FOOD INSECURITY

RESOLVED, that the Medical Society of Virginia supports ~~legislative~~ efforts to reduce or eliminate food deserts and food insecurity in Virginia.

Adopted as amended.

15-106: WORK RELATIVE VALUE UNITS (wRVU)

RESOLVED, that MSV provide by means of written documentation, presentations, symposia, user guides, etc. any information they collect on wRVU education, including advice on physician reimbursement (median, 25 percentile, 75 percentile) based on circumstance and specialty, procedural wRVUs lists, and mean collections for procedural codes based on published data (MGMA), and be it further

RESOLVED, that MSV provide to the membership recommended lists of legal and accounting firms who are well-versed in medical employment contracts, and encourage the membership to seek legal and accounting advice first, prior to signing employment contracts.

Referred to the Board of Directors.

15-107: HOUSE STAFF DEPRESSION

RESOLVED, that the Medical Society of Virginia ~~or one of its subsidiary organizations~~ supports the availability of appropriate mental health services for medical students, residents and physicians. ~~group therapy programs for house staff in Virginia hospitals as well as work-life balance initiatives.~~

Adopted as amended.

15-108: MAINTENANCE OF CERTIFICATION COMPLETELY VOLUNTARY

RESOLVED, that the Medical Society of Virginia support ~~efforts to make Maintenance of Certification completely voluntary~~ the updated 2014 AMA MOC Principles, including:

- *MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.*
- *The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, and intent to maintain or change practice.*
- *MOC should be used as a tool for continuous improvement.*
- *The MOC program should not be a mandated requirement for licensure, credentialing, payment, network participation or employment.*
- *Actively practicing physicians should be well-represented on specialty boards developing MOC.*
- *MOC activities and measurement should be relevant to clinical practice.*
- *The MOC process should not be cost-prohibitive or present barriers to patient care.*

Adopted as amended.



ACTIONS OF THE 2015 ANNUAL MEETING OF THE MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES

15-110: RESOLUTION TO ASK THE UVA MEDICAL SCHOOL TO COLLABORATE WITH THE UVA LAW SCHOOL TO STUDY AND PRESENT TO THE MSV A PLAN FOR THE CREATION OF AN ENTITY WITHIN THE STATE OF VIRGINIA TO BE RESPONSIBLE FOR AND CARRY OUT THE DELIVERY OF MEDICAL CARE

RESOLVED, that the Medical Society of Virginia (MSV) ask the Dean of the University of Virginia Medical School to initiate the creation of a Liaison Committee with the University of Virginia Law School to create an entity within the State of Virginia managed by physicians whose purpose and authority is to deliver medical care within the state and to present it to the MSV in order that it be presented and ratified by MSV and then presented to the House of Delegates of the state of Virginia.

Not adopted.

15-111: OPIOID PRESCRIBING EDUCATION

RESOLVED, that policy 300.003 be deleted (~~not archived~~) from the Policy Compendium, and be it further

~~RESOLVED, that the Board of Directors take no action that might conflict with existing MSV Policy 300.001, and be it further~~

~~RESOLVED, that MSV continues to support efforts to have educational programs on opioid prescribing, the Prescription Monitoring Program (PMP) use and on addiction education programs available, to Virginia physicians and other prescribers that are easily accessible and affordable for prescribers, and be it further~~

~~RESOLVED, that MSV encourage the Board of Medicine (along with the Boards of Nursing and Dentistry) to monitor prescribing habits of providers, and be it further~~

~~RESOLVED, that MSV encourage the Board of Medicine (along with the Boards of Nursing and Dentistry) to require remedial opioid and addiction education programs for those providers who are in violation of federal and state prescribing requirements and guidance.~~

RESOLVED, that the Medical Society of Virginia (MSV) acknowledges that Virginia's prescriber licensing bodies (the Virginia Board of Medicine, the Virginia Board of Nursing, and the Virginia Board of Dentistry) may consider requiring specific topic-area continuing education of licensees regarding opioid prescribing and/or addiction education. The development of any such requirements should be undertaken in collaboration with public health experts and the relevant professional and specialty organizations, should include provisions for measuring the effect of implementing the requirements as compared to the desired outcome, and should incorporate an appropriate sunset clause. Further, the licensing bodies should be mindful of current specialty training requirements that may already address the concern, such as maintenance of board certification. Further, the licensing bodies should be mindful of current specialty training requirements that may already address the concern, such as maintenance of board certification.

In response to any such requirements, the MSV should strive to make the prescribed programming easily accessible and affordable for its members.

Adopted as amended.



**ACTIONS OF THE 2015 ANNUAL MEETING OF THE MEDICAL SOCIETY OF VIRGINIA
HOUSE OF DELEGATES**

15-201: REGULATION ON PORTABLE FLAMETHROWERS

RESOLVED, that the Medical Society of Virginia support legislative efforts to regulate the sale of personal, portable flamethrowers in Virginia.

Not adopted.

15-202: SUPPORT LEGISLATION FOR VIRGINIA TO PARTICIPATE IN THE REGIONAL GREENHOUSE GAS INITIATIVE

RESOLVED, that the Medical Society of Virginia hereby support legislation in the 2016 General Assembly session that aims to make Virginia a participant in the Regional Greenhouse Gas Initiative (RGGI), that establishes a regional CO₂ electric power sector cap and trade program.

Not adopted.

15-203: RESOLUTION TO RESCIND §54.1-2962.01 WHICH PREVENTS CASH-BASED PRACTITIONERS FROM CHARGING PATIENTS MORE FOR THEIR ANATOMIC PATHOLOGY SERVICES SUCH AS PAP SMEARS THAN THE PRACTITIONER PAYS THE LAB FOR SUCH TEST

RESOLVED, that the Medical Society of Virginia work with the Virginia legislature to entirely rescind regulation 54.1-2962.01.

Not adopted.

15-204: DISCLOSURE OF SCREENING TEST RISK AND BENEFITS PERFORMED WITHOUT A DOCTOR'S ORDER

RESOLVED, in the absence of a doctor patient relationship and order from that provider, any provider of screening tests not rated "A" or "B" must inform the customer of the U.S. Preventative Services Task Force (USPSTF) recommendation including that the evidence does not support the screening test, and be it further,

RESOLVED, if the test is not listed as an A or B by the USPSTF and the customer still would like the screening test, the patient must be offered the opportunity to discuss the risk benefits and alternatives with a physician, and be it further

RESOLVED, that the Medical Society of Virginia will seek state and national legislation to enact this resolution.

Referred to the Board of Directors.



ACTIONS OF THE 2015 ANNUAL MEETING OF THE MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES

15-205: NO PRIOR AUTHORIZATIONS FOR GENERICS

RESOLVED, that the Medical Society of Virginia make the removal of prior authorizations of generics one of its primary lobbying efforts.

Not adopted.

15-206: ELIMINATION OF PRE-AUTHORIZATION FOR IMAGING SERVICES IN THE COMMONWEALTH OF VIRGINIA

RESOLVED, that the Medical Society of Virginia, without delay, seek means to eliminate pre-authorization for imaging services in the Commonwealth of Virginia.

Not adopted.

15-207: INCREASING FUNDING FOR RESIDENCY TRAINING

RESOLVED, that the Medical Society of Virginia, without delay, seek means to increase state public and/or private sector funding allocated to medical residency in the areas of physician shortage ~~primary care and psychiatry~~, and be it further

RESOLVED, that the Medical Society of Virginia report its progress to the membership ~~quarterly~~ through current MSV communications.

Adopted as amended.

15-208: CLARIFYING RELIGIOUS NON-MEDICAL EXEMPTION REQUIREMENTS FOR VACCINES

RESOLVED, that the Medical Society of Virginia pursue support ~~legislation~~ that would eliminate all non-medical vaccine exemptions ~~require that the religious exemption requirements for vaccines at least mirror the religious exemption requirements for compulsory school attendance and that all statements submitted be notarized as the provision of false information to a notary is a Class I misdemeanor in Virginia.~~

Adopted as amended.

15-209: SUPPORT EFFORTS TO ADOPT INTERSTATE LICENSURE COMPACT IN VIRGINIA

RESOLVED, that the Medical Society of Virginia support the development and implementation of an Interstate Medical Compact in Virginia, and be it further

RESOLVED, that the Medical Society of Virginia support the required legislative and regulatory efforts necessary to adopt the Interstate Licensure Compact in Virginia.

Adopted.



**ACTIONS OF THE 2015 ANNUAL MEETING OF THE MEDICAL SOCIETY OF VIRGINIA
HOUSE OF DELEGATES**

15-210L: ADDRESS BARRIERS TO THE SAFE PRODUCTION AND SALE OF CANNABIDIOL AND THC-A OILS

RESOLVED, that the Medical Society of Virginia support legislation that would make legal the possession, production and sale of cannabidiol oil or THC-A oil when written certification is provided for by a physician that the oil is necessary for treatment or to alleviate the symptoms of intractable epilepsy, and be it further

RESOLVED, that the Medical Society of Virginia form a workgroup to (1) assess the utilization of the certification process and any further perceived barriers to care; and (2) determine MSV's future role in promoting access to cannabidiol oil or THC-A oil for treatment purposes.

Referred to the Board of Directors.



RESOLUTION	BOARD ACTION	FINAL ACTION
<p>15-101: MEDICAL SOCIETY OF VIRGINIA PROPOSED 2016 BUDGET</p> <p><i>RESOLVED, that the Medical Society of Virginia approve, as presented, the proposed budget for 2016.</i></p> <p>HOD Action: Adopted</p>	N/A	Budget was approved; no further action required.
<p>15-102: MSV 2015 POLICY COMPENDIUM UPDATE</p> <p><i>RESOLVED, that the Medical Society of Virginia adopt the recommendations in the enclosed report (Addendum A) with the following amendments:</i></p>	N/A	Policy Compendium updated accordingly.
<p>85.001 – Disagreements Regarding Treatment of the Terminally Ill</p> <p>Date: 11/4/1995 Reaffirmed 11/06/2005</p> <p>Medical treatment of the terminally ill remains the responsibility of the physician to apply his best medical judgment in each instance and always suggest what he feels to be the proper course of treatment. Should there be any disagreement, it is the physician's prerogative to withdraw from the case after proper notification and assistance in the obtaining of another physician. Conversely, it is the prerogative of the family, parent, guardian, spouse, or committee to replace him <u>the physician</u> as they wish.</p> <p><i>Recommendation: Reaffirm <u>Reaffirm as amended</u>.</i></p> <p>122.000 Drugs: Substance Abuse and Prevention</p> <p>122.001 – Urine Collection</p> <p>Date: 11/4/1995 Reaffirmed 11/06/2005</p> <p><u>When chain of custody is required,</u> the Medical Society of Virginia supports legislation requiring national standardized custody control processes and forms for collection of urine for drug screening.</p> <p><i>Recommendation: Reaffirm <u>Reaffirm as amended</u>.</i></p>		

RESOLUTION	BOARD ACTION	FINAL ACTION
<p><i>the American Medical Association. Delegates elected by component societies, specialty sections, component student societies, component resident physician sections, the hospital medical staff section, health systems, and academic medical schools shall serve a one-year term. Ex-officio members of the House of Delegates, except for the Speaker, as provided in Article VII, Section 4, shall have full voting rights and will not be included in the delegate allotment for each component society. No voting by proxy shall be permitted in the House of Delegates. Each member of the House of Delegates also must be a member of the Society.</i></p> <p><u>HOD Action:</u> Adopted</p>		
<p>15-104: BAN ON TOBACCO USE IN CARS WITH MINORS</p> <p><i>RESOLVED, that the Medical Society of Virginia support legislative efforts to make it illegal for anyone to smoke tobacco in a car with a minor inside of the car.</i></p> <p><u>HOD Action:</u> Adopted</p>	N/A	Policy Compendium updated accordingly.
<p>15-105: ERADICATING FOOD DESERTS AND FOOD INSECURITY</p> <p><i>RESOLVED, that the Medical Society of Virginia supports efforts to reduce or eliminate food deserts and food insecurity in Virginia.</i></p> <p><u>HOD Action:</u> Adopted as amended</p>	N/A	Policy Compendium updated accordingly.
<p>15-106: WORK RELATIVE VALUE UNITS (wRVU)</p> <p><i>RESOLVED, that MSV provide by means of written documentation, presentations, symposia, user guides, etc. any information they collect on wRVU education, including advice on physician reimbursement (median, 25 percentile, 75 percentile) based on circumstance and specialty, procedural wRVUs lists, and mean collections for procedural codes based on published data (MGMA), and be it further</i></p> <p><i>RESOLVED, that MSV provide to the membership recommended lists of legal and</i></p>	<p>At its January 2016 meeting, the Board of Directors approved the following recommendation:</p> <p><i>The Medical Society of Virginia has recently developed a system for identifying and vetting potential partners that meet certain criteria and standards as well as our</i></p>	<p>MSV staff continues to provide education as needed on wRVU via the Practice Services department.</p> <p>In addition, MSV staff refers interested individuals to legal firms that assist with employment contracts.</p>

RESOLUTION	BOARD ACTION	FINAL ACTION
<p><i>accounting firms who are well-versed in medical employment contracts, and encourage the membership to seek legal and accounting advice first, prior to signing employment contracts.</i></p> <p>HOD Action: Referred to the Board of Directors</p>	<p><i>members' needs. Any company or organization whose products or services fit the needs for the MSV Marketplace is encouraged to participate. Staff recommends that vendors that can provide these types of consulting and informational services will be identified and included in the MSV Marketplace. Once established in the MSV Marketplace, these vendors will become part of the list of consulting, accounting, and legal services to which MSV can refer its members.</i></p>	
<p>15-107: HOUSE STAFF DEPRESSION</p> <p><i>RESOLVED, that the Medical Society of Virginia supports the availability of appropriate mental health services for medical students, residents and physicians.</i></p> <p>HOD Action: Adopted as amended</p>	<p>N/A</p>	<p>Policy Compendium updated accordingly.</p>
<p>15-108: MAINTENANCE OF CERTIFICATION COMPLETELY VOLUNTARY</p> <p><i>RESOLVED, that the Medical Society of Virginia support the updated 2014 AMA MOC Principles, including:</i></p> <ul style="list-style-type: none"> <i>MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.</i> <i>The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, and intent to maintain or change practice.</i> <i>MOC should be used as a tool for continuous improvement.</i> <i>The MOC program should not be a mandated requirement for licensure, credentialing, payment, network participation or employment.</i> 	<p>N/A</p>	<p>Policy Compendium updated accordingly.</p>

RESOLUTION	BOARD ACTION	FINAL ACTION
<ul style="list-style-type: none"> • <i>Actively practicing physicians should be well-represented on specialty boards developing MOC.</i> • <i>MOC activities and measurement should be relevant to clinical practice.</i> • <i>The MOC process should not be cost-prohibitive or present barriers to patient care.</i> <p><u>HOD Action:</u> Adopted as amended</p>		
<p>15-110: RESOLUTION TO ASK THE UVA MEDICAL SCHOOL TO COLLABORATE WITH THE UVA LAW SCHOOL TO STUDY AND PRESENT TO THE MSV A PLAN FOR THE CREATION OF AN ENTITY WITHIN THE STATE OF VIRGINIA TO BE RESPONSIBLE FOR AND CARRY OUT THE DELIVERY OF MEDICAL CARE</p> <p><i>RESOLVED, that the Medical Society of Virginia (MSV) ask the Dean of the University of Virginia Medical School to initiate the creation of a Liaison Committee with the University of Virginia Law School to create an entity within the State of Virginia managed by physicians whose purpose and authority is to deliver medical care within the state and to present it to the MSV in order that it be presented and ratified by MSV and then presented to the House of Delegates of the state of Virginia.</i></p> <p><u>HOD Action:</u> Not adopted</p>		
<p>15-111: OPIOID PRESCRIBING EDUCATION</p> <p><i>RESOLVED, that policy 300.003 be deleted from the Policy Compendium, and be it further</i></p> <p><i>RESOLVED, that MSV continues to support efforts to have educational programs on opioid prescribing, the Prescription Monitoring Program (PMP) and on addiction available, easily accessible and affordable for prescribers, and be it further</i></p> <p><i>RESOLVED, that the Medical Society of Virginia (MSV) acknowledges that Virginia's prescriber licensing bodies (the Virginia Board of Medicine, the Virginia Board of Nursing, and the Virginia Board of Dentistry) may consider requiring specific topic-area continuing education of licensees regarding opioid prescribing and/or addiction education. The development of any such requirements should be undertaken in collaboration with public health experts and the relevant professional and specialty organizations, should include provisions for measuring the effect of implementing the requirements as compared to the desired outcome, and should incorporate an appropriate sunset clause. Further, the licensing bodies should be mindful of current specialty training requirements that may already address the</i></p>	N/A	Policy Compendium updated accordingly.

RESOLUTION	BOARD ACTION	FINAL ACTION
<p>concern.</p> <p><i>In response to any such requirements, the MSV should strive to make the prescribed programming easily accessible and affordable for its members.</i></p> <p><u>HOD Action:</u> Adopted as amended</p>		
<p>15-201: REGULATION ON PORTABLE FLAMETHROWERS</p> <p><i>RESOLVED, that the Medical Society of Virginia support legislative efforts to regulate the sale of personal, portable flamethrowers in Virginia.</i></p> <p><u>HOD Action:</u> Not adopted</p>		
<p>15-202: SUPPORT LEGISLATION FOR VIRGINIA TO PARTICIPATE IN THE REGIONAL GREENHOUSE GAS INITIATIVE</p> <p><i>RESOLVED, that the Medical Society of Virginia hereby support legislation in the 2016 General Assembly session that aims to make Virginia a participant in the Regional Greenhouse Gas Initiative (RGGI), that establishes a regional CO2 electric power sector cap and trade program.</i></p> <p><u>HOD Action:</u> Not adopted</p>		
<p>15-203: RESOLUTION TO RESCIND §54.1-2962.01 WHICH PREVENTS CASH-BASED PRACTITIONERS FROM CHARGING PATIENTS MORE FOR THEIR ANATOMIC PATHOLOGY SERVICES SUCH AS PAP SMEARS THAN THE PRACTITIONER PAYS THE LAB FOR SUCH TEST</p> <p><i>RESOLVED, that the Medical Society of Virginia work with the Virginia legislature to entirely rescind regulation 54.1-2962.01.</i></p> <p><u>HOD Action:</u> Not adopted</p>		
<p>15-204: DISCLOSURE OF SCREENING TEST RISK AND BENEFITS PERFORMED WITHOUT A DOCTOR'S ORDER</p> <p><i>RESOLVED, in the absence of a doctor patient relationship and order from that provider, any provider of screening tests not rated "A" or "B" must inform the customer of the U.S. Preventative Services Task Force (USPSTF) recommendation including that the evidence does not support the screening test,</i></p>	<p>At its January 2016 meeting, the Board of Directors approved the following recommendation:</p> <p><i>Staff recommends referring this issue to the AMA for further engagement with</i></p>	<p>AMA delegation is pursuing resolution nationally.</p>

RESOLUTION	BOARD ACTION	FINAL ACTION
<p><i>and be it further,</i></p> <p><i>RESOLVED, if the test is not listed as an A or B by the USPSTF and the customer still would like the screening test, the patient must be offered the opportunity to discuss the risk benefits and alternatives with a physician, and be it further</i></p> <p><i>RESOLVED, that the Medical Society of Virginia will seek state and national legislation to enact this resolution.</i></p> <p><u>HOD Action:</u> Referred to the Board of Directors</p>	<p><i>federal regulators and where possible continued work with state medical societies, and state agencies.</i></p> <p><i>The MSV should promote tools for physicians to better inform our members and patients in the Commonwealth of the value and appropriateness of medical testing. As such, staff recommends promoting tools such as EPSS and the Choosing Wisely campaign in MSV publications. Staff will continue to monitor the issue and look for ways to work cooperatively with the AMA to enact change, both in Virginia and across the country.</i></p>	
<p>15-205: NO PRIOR AUTHORIZATIONS FOR GENERICS</p> <p><i>RESOLVED, that the Medical Society of Virginia make the removal of prior authorizations of generics one of its primary lobbying efforts.</i></p> <p><u>HOD Action:</u> Not adopted</p>		
<p>15-206: ELIMINATION OF PRE-AUTHORIZATION FOR IMAGING SERVICES IN THE COMMONWEALTH OF VIRGINIA</p> <p><i>RESOLVED, that the Medical Society of Virginia, without delay, seek means to eliminate pre-authorization for imaging services in the Commonwealth of Virginia.</i></p> <p><u>HOD Action:</u> Not adopted</p>		

RESOLUTION	BOARD ACTION	FINAL ACTION
<p>15-207: INCREASING FUNDING FOR RESIDENCY TRAINING</p> <p><i>RESOLVED, that the Medical Society of Virginia, without delay, seek means to increase state public and/or private sector funding allocated to medical residency in areas of physician shortage, and be it further</i></p> <p><i>RESOLVED, that the Medical Society of Virginia report its progress to the membership through current MSV communications.</i></p> <p><u>HOD Action:</u> Adopted as amended</p>	N/A	<p>During the 2016 General Assembly Session, the Medical Society of Virginia supported increasing funding for residency training that was included in the final budget:</p> <ul style="list-style-type: none"> • \$2,500,000 in FY2018 to fund 25 new graduate medical education residency slots effective July 1, 2017 • Of the 25 slots, 13 shall be for primary care and 12 shall be for high need specialties and preference shall be given for residency slots located in underserved areas
<p>15-208: NON-MEDICAL EXEMPTION REQUIREMENTS FOR VACCINES</p> <p><i>RESOLVED, that the Medical Society of Virginia pursue legislation that would eliminate all non-medical vaccine exemptions in Virginia.</i></p> <p><u>HOD Action:</u> Adopted as amended</p>	N/A	<p>The Medical Society of Virginia supported HB1342 during the 2016 General Assembly Session.</p> <p>The Health, Welfare and Institutions Committee voted to send a letter to the Joint Commission on Health Care to study this issue further.</p>
<p>15-209: SUPPORT EFFORTS TO ADOPT INTERSTATE LICENSURE COMPACT IN VIRGINIA</p> <p><i>RESOLVED, that the Medical Society of Virginia support the development and implementation of an Interstate Medical Compact in Virginia, and be it further</i></p> <p><i>RESOLVED, that the Medical Society of Virginia support the required legislative and regulatory efforts necessary to adopt the Interstate Licensure Compact in Virginia.</i></p> <p><u>HOD Action:</u> Adopted</p>	N/A	<p>MSV will continue to engage on this issue and work with the Board of Medicine.</p>

RESOLUTION	BOARD ACTION	FINAL ACTION
<p>15-210L: ADDRESS BARRIERS TO THE SAFE PRODUCTION AND SALE OF CANNABIDIOL AND THC-A OILS</p> <p><i>RESOLVED, that the Medical Society of Virginia support legislation that would make legal the possession, production and sale of cannabidiol oil or THC-A oil when written certification is provided for by a physician that the oil is necessary for treatment or to alleviate the symptoms of intractable epilepsy, and be it further</i></p> <p><i>RESOLVED, that the Medical Society of Virginia form a workgroup to (1) assess the utilization of the certification process and any further perceived barriers to care; and (2) determine MSV's future role in promoting access to cannabidiol oil or THC-A oil for treatment purposes.</i></p> <p><u>HOD Action:</u> Referred to the Board of Directors</p>	<p>At its January 2016 meeting, the Board of Directors approved the following recommendation:</p> <p><i>Staff recommends the Board should convene a workgroup to comprehensively research the issue, legal barriers to implementation and required MSV policy changes. The workgroup should present a report to the 2016 House of Delegates.</i></p>	<p>Board has approved workgroup and workgroup will present resolution to 2016 House of Delegates.</p>



Date: September 2016
To: MSV Membership
From: MSV Nominating Committee
Re: Nominating Committee Report for 2016 Annual Meeting

The Nominating Committee has met and proposes the following slate for the 2016-2017 year:

OFFICERS

President-Elect Kurtis S. Elward, MD
Speaker Arthur J. Vayer Jr., MD
Vice Speaker Alan H. Wynn, MD

DIRECTORS (Elected for 2-year term)

District 2 Joel T. Bundy, MD
District 2 Edilberto O. Pelausa, MD
District 6 Patricia A. Pletke, MD
District 8 Chi Young, MD
District 10 Sandy L. Chung, MD
District 10 William E. Prominski, MD
Academic John D. Ward, MD

DIRECTORS (Elected for 1-year term)

Resident Joshua Lesko, MD
Medical Student Monica Melmer

ASSOCIATE DIRECTORS (Elected for 2-year term)

District 2 Lisa S. Kennedy, MD
District 6 Trevar O. Chapmon, MD
District 8
District 10 Andrea R. Giacometti, MD
Academic Teresa W. Babineau, MD

ASSOCIATE DIRECTORS (Elected for 1-year term)

District 9 William D. Kiser, MD
Resident Mark Hylton, MD
Medical Student Kathleen Carlson

AMA DELEGATES (Elected for 2-year calendar terms)

Edward G. Koch, MD
Mitchell B. Miller, MD
Lawrence K. Monahan, MD

AMA ALTERNATE DELEGATES (Elected for 2-year calendar terms)

Thomas W. Eppes Jr., MD
Sterling N. Ransone Jr., MD
William C. Reha, MD, MBA
Cynthia C. Romero, MD

MEDICAL SOCIETY OF VIRGINIA PROPOSED 2017 BUDGET

Submitted by the MSV Board of Directors

To ensure that the proposed budget is consistent with evolving financial conditions, the MSV Board of Directors will review and approve an updated budget at its October meeting immediately preceding the House of Delegates; the approved budget will then be distributed to the House of Delegates at its first session.

MSV 2016 POLICY COMPENDIUM UPDATE

Dr. Kurtis S. Elward, Speaker
Dr. Arthur J. Vayer Jr., Vice-Speaker

- WHEREAS, the policy making procedure for implementation and utilization of the *Policy Compendium of the Medical Society of Virginia* was adopted by the Board in September 1992, and updated in 2001, and
- WHEREAS, the procedure requires that 10 years after the adoption of each policy action, the Speakers and MSV Staff will present to the House of Delegates a “Ten Year Policy Review Report,” encouraging appropriate consideration of each item, and that unless each such policy is acted upon by the subsequent House of Delegates, it will cease to be policy to the MSV and will be placed in the archives section of the Compendium, and
- WHEREAS, consideration by the House of Delegates to add, amend or archive additional policies prior to ten years after their adoption may be included in the review as deemed appropriate by the Speakers and MSV Staff, and
- WHEREAS, upon review, it is evident that some items in the Policy Compendium should be removed or revised based on their relevance or timeliness, therefore be it
- RESOLVED, that the Medical Society of Virginia adopt the recommendations in the enclosed report.

2016 MSV POLICY COMPENDIUM REVIEW

15.000 Accident Prevention: Motor Vehicles

15.001 - Alcoholism and Drug Abuse Screening

Date: 11/2/1996

The Medical Society of Virginia supports the establishment of a program in school districts to screen randomly those applying to be school bus drivers to detect such characteristics as the presence of alcohol or drugs, which are difficult to detect through physical examination.

Reaffirmed 11/5/2006

Recommendation: Reaffirm.

15.009 - Physical Examination Form

Date: 11/2/1996

The Medical Society of Virginia recommends that physical examinations of school bus drivers include questions about history of mental illness, diabetes, hypertension, epilepsy, previous alcoholism or drug abuse, and the use of medication, all of which might affect the ability to drive a bus.

Reaffirmed 11/5/2006

Recommendation: Reaffirm.

55.000 Cancer

55.002 - Diagnostic Screening for Breast Cancer

Date: 11/2/1996

~~The Medical Society of Virginia advises third-party payers that diagnostic imaging for breast cancer in asymptomatic women is considered appropriate for women at risk on the basis of a family history of breast cancer and/or personal history of prior breast disease.~~

~~The Medical Society of Virginia endorses diagnostic screening for women past the age of 35 consistent with the American College of Radiology, American College of Obstetrics and Gynecology and Society of Breast Imaging guidelines. Diagnostic imaging of the breast for women at risk should be interpreted as a medically appropriate service and should be covered by third party payers.~~

~~The Medical Society of Virginia advises third party payers that screening mammography for asymptomatic women by age 40 (baseline) and annually thereafter is appropriate.~~

~~The Medical Society further advises third party payers that diagnostic imaging for breast cancer in asymptomatic women, at an earlier age and more frequently, is considered appropriate for those with a family history of breast cancer and/or personal history of prior breast disease.~~

Recommendation: Reaffirm as amended.

60.000 Children and Youth

60.003 - AMA Program on Child and Adolescent Health

Date: 11/2/1996

The Medical Society of Virginia endorses the AMA Program on Child and Adolescent Health.

Reaffirmed 11/5/2006

Recommendation: Reaffirm.

185.000 Health Insurance: Benefits and Coverage

185.003 - Insurance Coverage for Surgical and Medical Treatment of Obesity and Morbid Obesity

Date: 11/7/2004

The Medical Society of Virginia affirms the need for government and commercial insurance coverage of legitimate medical diagnostic evaluation and treatments for obesity. The Medical Society of Virginia supports mandated insurance coverage for those surgical and medical treatments for morbid obesity that are nationally recognized as effective for the long-term reversal of morbid obesity.

Reaffirmed 11/5/2006

Recommendation: Reaffirm.

205.000 Health Planning

205.001 - COPN Policy

Date: 1/20/2016

The Medical Society of Virginia supports the deregulation of COPN. MSV will consider supporting individual COPN legislation on a case-by case-basis, with decision for approval derived from previously adopted principles of patient safety and access to quality, affordable health care. The MSV continues to support the economic viability of Virginia's academic health centers. Newly deregulated services should be required to meet a charity care commitment as well as recognized standards of accreditation or quality.

Recommendation: Reaffirm.

285.000 Managed Care

285.005 - Medical Utilization Review

Date: 10/30/1993

The Medical Society of Virginia supports legislation to make the Medical Utilization Review statute more effective by deleting the exclusion in the present definition of "private review agent" as found in the Code

of Virginia.

The Medical Society of Virginia supports legislation to make certain that all persons performing utilization review be included in the Medical Utilization Review statute.

The Medical Society of Virginia supports amendments that would include utilization review agents operating under ERISA.

Reaffirmed 11/5/2006

Recommendation: Reaffirm.

285.013 - The Credentialing Of Physicians By Insurance Companies And Other Third Parties And Competition In The Health Care Market Place

Date: 10/30/1993

The Medical Society of Virginia shall work with the AMA and appropriate governmental agencies to pass laws that would outlaw the exclusion of physicians from access to the health care market place on the sole basis of lack of board certification or particular hospital affiliation.

Reaffirmed 11/5/2006

Recommendation: Reaffirm.

440.000 Public Health and Preventive Medicine

440.005 - Establishment of Adult Fatality Review Team

Date: 11/5/2006

The Medical Society of Virginia supports legislation to establish an the 2015 statute in the Code of Virginia regarding the Adult Fatality Review Team under the jurisdiction of the Office of the Chief Medical Examiner along with appropriate budget amendments to fully fund the work of the team. The legislation became effective July 1, 2015.

Recommendation: Reaffirm as amended.

440.009 - Immunizations for all Students Entering College

Date: 10/30/1993

The Medical Society of Virginia supports the Code of Virginia requirement that immunizations for students entering institutions of higher education be immunized ~~by vaccine against diphtheria, tetanus, poliomyelitis, measles (rubeola), German measles (rubella), and mumps.~~

Reaffirmed 11/5/2006

Recommendation: Reaffirm as amended.

470.000 Sports and Physical Fitness

470.006 - Promote Physical Fitness; Schools

Date: 11/8/1997

The Medical Society endorses activities and will support legislation which would promote daily physical fitness in the K-12 school environment as well as in other areas.

Reaffirmed 11/5/2006

Recommendation: Reaffirm.

560.004 - Statement of Individual Board Member's Responsibility

Date: 1/22/2000

GENERAL EXPECTATIONS

- 1) Know (and regularly review, update, and uphold) the organization's mission, purposes, goals, policies, programs, services, strengths, and needs.
- 2) Perform duties for Board membership responsibly and conform to the level of competence expected from Board members as outlined in the duties of care and loyalty as they apply to nonprofit board members.
- 3) Adhere to local, state, and federal laws and regulations that apply to nonprofit organizations.
- 4) Have special knowledge/ strengths/ competencies as demonstrated by a history of serving the MSV actively in a broad range of society activities; and a future declaration to serve in leadership positions and undertake special assignments willingly and enthusiastically.
- 5) Be accountable.
- 6) Demonstrate ability in, and commitment to teamwork.
- 7) Represent the Board of Directors, Executive Vice President, and President at district and component society meetings.
- 8) Follow trends in the organization's field of interest.
- 9) Bring good will and a sense of humor to the Board's deliberations.
- 10) Suggest possible nominees to the Board who are clearly women and men of achievement and distinction and who can make significant contributions to the work of the Board and the organization's progress.
- 11) Avoid prejudiced judgments on the basis of information received from individuals and urge those with grievances to follow established policies and procedures through their supervisors. (All matters of potential significance should be called to the attention of the Executive Vice President and the President as appropriate).
- 12) Stay in frequent communication with the Board, Executive Vice President, Committees and the constituency whom you serve.

MEETINGS

- 1) Prepare for and participate in Board and committee meetings, including appropriate organizational activities. Study the Board meeting notebook well before each Board meeting, be informed about the informational items. The Board of Directors will consider and discuss only those items where discussion and action are needed.
- 2) Ask timely and substantive questions at Board and committee meetings consistent with your conscience and convictions while supporting the majority decision on issues decided by the Board.
- 3) Suggest agenda items periodically for Board and committee meetings to ensure that significant policy related matters are addressed.
- 4) Maintain confidentiality of the Board's executive sessions and speak for the Board or organization only when authorized to do so.
- 5) Be prepared and eager to spend: three to four weekends (Friday and/ or Saturday) for Executive Committee and Board of Directors meetings; the two-to-three day Interim, and Annual Meetings; committee meetings as needed; two to three days of lobbying at the Legislature; two to three days for Strategic Planning workshops.

RELATIONSHIP WITH STAFF

- 1) Visit the Society headquarters and educate yourself in the structure and function of the staff and its departments.
- 2) Counsel the President and Executive Vice President as appropriate and support him or her through any difficult relationships with groups or individuals.
- 3) Avoid asking for special favors of the staff, including special requests for extensive information without at least prior consultation with the Executive Vice President or President.

AVOIDING CONFLICTS

Be prepared to consider and respect the ideas and suggestions from an individual board member's constituency; but after presenting an idea from a particular perspective, conclude the debate and then...

- 1) Serve the organization as a whole rather than any special interest group or constituency. Regardless of whether or not you were invited to fill a vacancy reserved for a certain constituency or organization, your first obligation is to avoid any preconception that you "represent" anything but the organization's best interests.
- 2) Avoid even the appearance of a conflict of interest that might embarrass the board or the organization and disclose any possible conflicts to the board in a timely fashion.
- 3) Maintain independence and objectivity and do what a sense of fairness, ethics, and personal integrity dictate, even though not necessarily obliged to do so by law, regulation, or custom.
- 4) Never accept (or offer) favors or gifts from (or to) anyone who does business with the organization.

FIDUCIARY RESPONSIBILITIES

- 1) Exercise prudence with the board in the control and transfer of funds.
- 2) Faithfully read and understand the organization's financial statements and otherwise help the board fulfill its fiduciary responsibility.
- 3) Assertively recruit new MSV members.
- 4) Contribute to MSVPAC annually.

Reaffirmed 10/24/2010

Members of the MSV Board of Directors will uphold the duties and responsibilities outlined in the MSV Board of Directors Handbook and its appendices.

Recommendation: Reaffirm as amended.

560.005 - Statement of Responsibilities of the Board of Directors as a Whole

Date: 1/22/2000

EXPECTATIONS

- 1) to determine, define, and redefine MSV's Mission and Purpose with the aid of the Strategic Planning Task Force and House of Delegates
- 2) to select the Executive Vice President
- 3) to support the Executive Vice President and review his performance
- 4) to ensure effective organizational planning
- 5) to manage resources effectively
- 6) to determine, monitor, and strengthen the MSV's programs and services

Reaffirmed 10/24/2010

The MSV Board of Directors will uphold the duties and responsibilities outlined in the MSV Board of Directors Handbook and its appendices.

Recommendation: Reaffirm as amended.

Prohibit the Use of MOC as a Means to Limit Physicians' Scope of Practice

Submitted by the Richmond Academy of Medicine

- WHEREAS, the American Medical Association House of Delegates recently passed Resolution 309, "Continuing Medical Education Pathway for Recertification," which calls for "the immediate end of any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination, and
- WHEREAS, Resolution 309 further reaffirms "that our AMA continue to support the requirement of Continuing Medical Education (CME) and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients, and
- WHEREAS, the American Board of Medical Specialties (ABMS) continue to press efforts coupling insurance payments, hospital privileges and other employment opportunities to active enrollment in "time limited" Board Certification and the associated MOC program in a nationwide fashion, imposing this upon the practice of medicine in Virginia, and
- WHEREAS, the MOC program is expensive, unproven, directed toward bureaucratic compliance and entry level medical knowledge, wastes resources by requiring participation in time limited MOC-CME programs directly benefiting ABMS and its executives and directors, and
- WHEREAS, the ABMS has changed the concept of Board Certification for life as representing quality of specialty training (just as a diploma bestows the lifelong medical degree to physicians) to a business model of "time limited certification" and further implemented yearly participation enrollment (MOC) to generate exorbitant profits from fees against active physician opposition, and
- WHEREAS, the American Medical Association's Physician Recognition Award and CME program was successfully formed in the late 1960's and meets all needs of documenting lifelong commitment to learning to include individual physician's choice and a competitive offering of educational materials in CME, and that the unrestricted practice of medicine by Virginia physicians should never require what is meant to be a voluntary specialty-driven certification process, and
- WHEREAS, these ABMS national efforts continue to impose additional regulations on medical care in Virginia created by an un-accountable and un-elected body, which has resulted in active AMA opposition on a national level, and
- WHEREAS, the Medical Society of Virginia pursues to uphold and maintain the importance of the patient-physician relationship independent of outside interference as the key to excellent medical care, that physicians are bound by generally accepted professional and ethical values in pursuit of best care for patients, therefore be it
- RESOLVED, that the Medical Society of Virginia continues to support and advocate lifelong continuing medical education and lifelong Specialty Board Certification as determined by the physician him/herself, to advocate against time-limited specialty medical board certificates, and advocate against discrimination against physicians who are not certified or are certified and choose NOT to engage in corporate re-certification programs labeled as "voluntary" by the specialty medical boards, and be it further
- RESOLVED, that the Medical Society of Virginia support legislation in Virginia that will prohibit discrimination by hospitals and any employer, insurer, Medicare, Medicaid, or other entity, which might restrict a physician's right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of certification, lack of participation in ABMS- prescribed corporate programs including Maintenance of Certification or expiration of time limited Board Certification, and be it further
- RESOLVED, that the Medical Society of Virginia promote and/or implement a policy forbidding discrimination by hospitals or employers, insurers, Medicare, Medicaid, and other entities, which might restrict a

physician's right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of certification or participation in ABMS- prescribed corporate programs including Maintenance of Certification or time limited Board certification, and be it further

RESOLVED, that the Medical Society of Virginia urge the AMA to adopt as policy this resolution forbidding discrimination by hospitals or employers, insurers, Medicare, Medicaid, and other entities, which might restrict a physician's right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of certification or participation in ABMS- prescribed corporate programs including Maintenance of Certification or time limited Board certification, in accordance with the letter and spirit of AMA House of Delegates Resolution 309.

Staff Analysis – Resolution 16-103: Prohibit the Use of MOC as a Means to Limit Physicians’ Scope of Practice.

Submitted by the Richmond Academy of Medicine

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>This resolution calls for MSV to:</p> <ul style="list-style-type: none"> • Support legislation that would prohibit discrimination by hospitals and any employer, insurer, Medicare, Medicaid, or other entity, which might restrict a physician's right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of certification, lack of participation in ABMS- prescribed corporate programs including Maintenance of Certification or expiration of time limited Board Certification • Promote and/or implement a policy forbidding the discrimination discussed above • Urge the AMA to adopt as policy this resolution 	<p>Empower physicians to manage change</p>	<p>300.004 – Maintenance of Certification Completely Voluntary</p> <p>MSV supports the 2014 AMA MOC Principles, including the principal that the MOC program should not be a mandated requirement for licensure, credentialing, payment, network participation or employment.</p>	<p>Benefits:</p> <ul style="list-style-type: none"> • Would ensure that physicians do not have to participate in MOC as a condition of employment or payment <p>Drawbacks:</p> <ul style="list-style-type: none"> • Regardless of recent findings by the AMA and other organizations, there remains a public perception that MOC makes physicians more qualified to practice their specialty. • May be an imposition on private employers. 	<p><u>REFER TO BOARD OF DIRECTORS</u></p> <ul style="list-style-type: none"> • Prohibiting discrimination by hospitals and other employers could prove to be an imposition on private business practices. It may even run afoul of Virginia employment laws. • Staff recommends this resolution be referred to the Board of Directors for further discussion, given the changing landscape of MOC.

Burnout and Suicide Prevention

Submitted by the Medical Student Section

- WHEREAS, rates of burnout, depression and suicide among medical school students, residents, and physicians are growing across the nation, and
- WHEREAS, among medical students, suicide is the second most common cause of death, and
- WHEREAS, rates of depression and burnout often increase in residency programs, and
- WHEREAS, the American Foundation for Suicide Prevention cites that approximately 1 physician per day commits suicide, and
- WHEREAS, the stigma of mental health issues can prevent those within the healthcare community from seeking appropriate care, therefore be it
- RESOLVED, the Medical Society of Virginia will support efforts to address the mental health of medical students, residents, and physicians, and be it further
- RESOLVED, the Medical Society of Virginia will work cooperatively with state and national stakeholders to develop and promote strategies for comprehensive education, screening and treatment.

Staff Analysis – Resolution 16-104: Burnout and Suicide Prevention.

Submitted by the MSV Medical Student Section

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>Proposal:</p> <p>This resolution calls for MSV to support efforts to address the mental health of medical students, residents, and physicians. It also calls for MSV to work cooperatively with state and national stakeholders to develop and promote strategies for comprehensive education, screening and treatment.</p> <p>Issues:</p> <ul style="list-style-type: none"> • Rates of burnout, depression, and suicide among medical school students, residents, and physicians are growing. • Among medical students, suicide is the second most common cause of death. • The American Foundation for Suicide Prevention estimates that approximately one physician commits suicide each day. 	<p>Empower physicians to manage change.</p>	<p>305.010 – House Staff Depression (Adopted 2015)</p> <ul style="list-style-type: none"> • MSV supports the availability of appropriate mental health services for medical students, residents and physicians. <p><u>AMA Policy</u></p> <p>H-345.973 – Mental Health Services for Medical Students and Resident and Fellow Physicians (Adopted 2015)</p> <ul style="list-style-type: none"> • The AMA promotes confidential, accessible, and affordable mental health services for medical students and resident and fellow physicians. 	<p>Benefits:</p> <ul style="list-style-type: none"> • A national commitment to support residents and fellows throughout the challenges of medical training will help ensure the well-being of future generations of physicians and their patients. • Support for these efforts would demonstrate MSV's commitment to the health and well-being of the Commonwealth's future physician workforce. <p>Drawbacks:</p> <ul style="list-style-type: none"> • None 	<p><u>ADOPT</u></p> <ul style="list-style-type: none"> • This resolution should be used to amend the existing language of MSV Policy 305.010. • Builds upon MSV policy 305.010 (adopted in 2015), but with an increased emphasis on burnout and depression among medical students specifically.

To Ask The University Of Virginia Medical School To Collaborate With The University Of Virginia Law School To Present A Plan For An Entity Within The State To Be Responsible For And Deliver Medical Care

Submitted by Monroe G. Baldwin, Jr., M. D.

- WHEREAS, only physicians and doctors are responsible for health care and they are licensed by the states, and
- WHEREAS, the confidentiality of medical records in insurance companies has come suspect because of data exposed in the government's Snowden case, the "hacked" Democratic Party's data base, the hacked data of BlueCross Blue Shield, etc., and
- WHEREAS, the spiritual base of medicine has been eroded with the understood permission by the Supreme Court to allow veterinary procedures to be done on humans by the human medical profession such as euthanasia (Oregon) and abortion, and
- WHEREAS, the "free market" environment in which the practice of medicine is now carried out stimulates a drive for profit causing hospitals and doctors to move towards patients "able to pay" in order to provide funds for offices, staff, families, and hospitals whereas the preponderance of illness is in the lower socio-economic level who are "unable to pay" resulting in maldistribution of doctors and hospitals away from areas of great need such as dense urban and rural areas, and
- WHEREAS, the supply demand curve automatically operational in a free market guarantees prices to rise above what some working people are able to pay.in order to obtain greater profits thereby creating a charity population out of working people which is unethical and violates the medical profession's time honored solution of accepting what the patient is able to pay and no more, and
- WHEREAS, whereas family practice, the bedrock of medical delivery, is unable to attract medical graduates and doctors because of insufficiency of income because of pay scales as set by insurance companies, and
- WHEREAS, the independent agency status of doctors and their corporations renders physicians unable to fully comprehend the gross inequality of income among specialties, and
- WHEREAS, there has been a prohibitive increase in the cost of medical education such that by some counts as much as eighty percent of medical students are from wealthy families forcing qualified poorer students to turn away from a medical career, and
- WHEREAS, with misplacement geographically of physicians to address preventive disease and the cost of office visits our medical statistics are below that of other industrialized countries who spend far less of their gross national product on medical care which is illogical, unprofessional, and a disgrace to our state, nation, and the medical profession, therefore be it
- RESOLVED, that the Medical Society of Virginia (MSV) ask the Dean of the University of Virginia Medical School to initiate the creation of a liaison committee with the University of Virginia Law School whose purpose is to create an entity within the State of Virginia to deliver and be responsible for health care delivery and to present it to MSV for approval in order that MSV can, if approved, present it to the House of Delegates of the State of Virginia.

Staff Analysis – Resolution 16-105: To Ask The University Of Virginia Medical School To Collaborate With The University Of Virginia Law School To Present A Plan For An Entity Within The State To Be Responsible For And Deliver Medical Care.

Submitted by Dr. Monroe G. Baldwin, Jr., M.D.

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<ul style="list-style-type: none"> Health care in Virginia is facing multifaceted challenges, including but not limited to: lack of patient access to care, high cost, physician shortages, geographic and socioeconomic health disparities, and lower health care quality outcomes compared to other industrialized nations. No other state has implemented a similar plan. 	N/A	No relevant policies	<p>Benefits:</p> <ul style="list-style-type: none"> No benefits have been identified. <p>Drawbacks:</p> <ul style="list-style-type: none"> It is not clear that a singular UVA-owned entity responsible for all health care delivery would solve the challenges facing health care in Virginia. The current political landscape favors competition in the health care sector. By limiting health care delivery to one organization, competition would disappear. For this reason, this resolution would face vehement political opposition. Other Virginia medical schools and health care delivery entities would oppose the development of a single UVA-owned entity that removes their autonomy and excludes them from health care delivery and decision making. All health care providers would be employed under a single employer. The logistical challenges of transitioning to a new health care delivery system would create a barrier to patient care. 	<p><u>NOT ADOPT</u></p> <ul style="list-style-type: none"> Previously considered in past House of Delegates sessions and has not advanced. The challenges facing health care and physicians in Virginia are better suited to be addressed through collaborative efforts that include participation from all relevant stakeholders.

A Resolution to Support the AMA's Recently Amended Policy Calling for an End to Re-Certification Examinations

Submitted by the Richmond Academy of Medicine

- WHEREAS, physicians believe that the fundamental cornerstone of what it means to be a physician is three-fold: continual professional development, lifelong learning and providing quality patient-care based on the best science and evidence to guide medical decision-making, and
- WHEREAS, the consensus within the medical community is that Maintenance of Certification (MOC) mandates and time-limited certification examinations imposed by the American Board of Medical Specialties (ABMS) are of unproven clinical or quality benefit to patient care, impose unnecessary financial burdens, and place unreasonable time constraints upon physicians, and
- WHEREAS, for years, physicians have repeatedly expressed their dissatisfaction in the ABMS Maintenance of Certification (MOC) processes with numerous efforts made to express this dissatisfaction and to collaborate on a permanent solution, and
- WHEREAS, during this time the ABMS has been unable to provide reliable independent evidence that participating in MOC or requiring routine re-certification leads to better patient care, and
- WHEREAS, there is clear support for initial board certification and fulfillment of the Continuous Medical Education (CME) requirements already monitored by the Board of Medicine, and
- WHEREAS, at the recent meeting of the AMA House of Delegates, support for strong and positive action aimed at curtailing this high-cost, low-value process and returning to a credible method of physician certification that is grounded on high quality and appropriate continuing medical education has gained momentum among physicians nationwide, therefore be it
- RESOLVED, that the Medical Society of Virginia support the AMA's recently adopted policy on re-certification (AMA Resolution 309) which does the following:
1. Calls for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination;
 2. Calls for the AMA to support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning;
 3. Calls for the AMA to continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam;
 4. Calls for the AMA to continue to support the requirement of Continuing Medical Education (CME) and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

Staff Analysis – Resolution 16-106: Support for the AMA’s Recently Amended Policy Calling for an End to Re-Certification Exams.

Submitted by the Richmond Academy of Medicine

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>This resolution calls for MSV to support the AMA’s recently adopted policy on re-certification. Resolution 309:</p> <ol style="list-style-type: none"> 1. Calls for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination; 2. Calls for the AMA to support a recertification process based on high quality, appropriate CME material directed by the AMA recognized specialty societies covering the physician’s practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty; 3. Calls for the AMA to continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam; 4. Calls for the AMA to continue to support the requirement of Continuing Medical Education (CME) and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care 	<p>Empower physicians to manage change</p>	<p>300.02 – Maintenance of Certification</p> <p>MSV supports the following AMA policies:</p> <ul style="list-style-type: none"> • H-275.950 Board Certification – AMA opposes the use of board certification as a requirement for licensure or reimbursement • H-275.924 AMA Principles on Maintenance of Certification <p>Further, MSV opposes maintenance of certification as a mandated requirement for licensure, credentialing, or reimbursement.</p> <p>300.004 – Maintenance of Certification Completely Voluntary</p> <p>MSV supports the 2014 AMA MOC Principles, including the principal that the MOC program should not be a mandated requirement for licensure, credentialing, payment, network participation or employment.</p>	<p>Benefits:</p> <ul style="list-style-type: none"> • Brings MSV in line with new, stronger policies that call for the <i>end</i> of any mandatory recertifying exams for all specialties that still require them • Supports a recertification process based on CMS material directed by the AMA instead of the ABMS or other certifying organizations <p>Drawbacks:</p> <ul style="list-style-type: none"> • Given the public perception challenges physicians currently face (e.g., the opioid crisis), a public campaign in opposition to physician education/recertification may be received poorly. • It is unclear whether “calling” for the end of ABMS recertification will be an effective way of addressing the issue. 	<p><u>REFER TO THE BOARD OF DIRECTORS</u></p> <ul style="list-style-type: none"> • Staff recommends this resolution be referred to the Board of Directors for further discussion, given the changing landscape of MOC.

Resolution 309, Continuing Medical Education Pathway for Recertification, was adopted as amended. The final recommendations are as follows:

RESOLVED, That our American Medical Association call for the immediate end of any mandatory, secured recertifying examination by the American Board of Medical Specialties (ABMS) or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination; and be it further

RESOLVED, That our AMA support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning; and be it further

RESOLVED, That our AMA reaffirm Policies H-275.924 and D-275.954; and be it further

RESOLVED, That our AMA continue to work with the American Board of Medical Specialties (ABMS) to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high-stakes exam; and be it further

RESOLVED, That our AMA continue to support the requirement of Continuing Medical Education (CME) and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

Maintenance of Certification H-275.924

Topic: Licensure and Discipline	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2016
Action: Reaffirmed	Type: Health Policies
Council & Committees: NA	undefined

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

Maintenance of Certification and Osteopathic Continuous Certification D-275.954

Topic: Licensure and Discipline	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2016
Action: Appended	Type: Directives
Council & Committees: Council on Medical Education	undefined

Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.

Updating MSV Bylaws to Increase Physician Participation

Submitted by the MSV Board of Directors

- WHEREAS, the Medical Society of Virginia is a membership organization and should encourage increasing physician participation in all MSV activities, including House of Delegates, and
- WHEREAS, in 2016 a bylaws Committee was appointed by MSV President Dr. Edward Koch to review the MSV bylaws and discuss concepts related to increasing member involvement, and
- WHEREAS, during the review of the bylaws, it became clear there were some gaps in standard business protocols that need to be addressed, and
- WHEREAS, the bylaws Committee is comprised of Dr. Richard Szucs as Chair, with Dr. Bhushan Pandya, President-Elect, Dr. William Reha, Immediate Past-President, Dr. Larry Monahan, Past-President and Dr. Michael Amster also serving on the Committee, and
- WHEREAS, on Saturday, September 10, the bylaws Committee reported to the MSV Board of Directors, and engaged in extensive discussion, additional refinement, and ultimately a vote by the Board to recommend these bylaw changes advance to the 2016 HOD, therefore be it
- RESOLVED, the Medical Society of Virginia will amend its bylaws as specified in the provided draft.

MSV Bylaws Board: Discussion Draft

This document outlines options considered by MSV's 2016 Bylaws Board and approved on September 10, 2016 by the MSV Board of Directors. The amended draft of the bylaws reflects these approved concepts.

Goal 1: Increase HOD delegate participation.

Option to Achieve Goal	Current Bylaws Language	Considerations	Board of Directors Approved Bylaws Recommendation	Benefits/Drawbacks	Line Numbers in Bylaws Draft
Option 1: Increase specialty society participation in HOD	Currently, specialties listed in the bylaws must have a minimum of 60 percent of their members that are also are MSV members to be recognized by the Society. Recognized specialties receive one delegate and one alternate.	<ul style="list-style-type: none"> Specialty societies have asked for more opportunities to engage with MSV Size of specialty societies; increasing delegates, based on MSV membership will impact large and small specialties differently. Need to balance increasing specialty representation with geographic representation. 	<p>The Board recommends MSV recognize specialty societies that have a minimum of 40 percent of their members have MSV membership.</p> <p>Subsequently, the Board recommends that MSV increase the number of delegates for recognized specialties as their participation in MSV membership increases. The Board proposes the following ratios:</p> <p>1 delegate = 40% MSV membership 2 delegates = 60% MSV membership 3 delegates = 80% MSV membership</p> <p>Recognized specialties would be listed in Appendix A to keep current.</p>	<p>This would align and unify the house of medicine by incentivizing the specialties to promote MSV membership to their own members.</p> <p>Allows for a diverse point of view within the HOD, while ensuring a balance among different types of practice.</p> <p>All specialties would have the same opportunity to increase their delegate counts.</p>	128-132 145-148 325-330
Option 2: Allow for	Currently, only	The Board discussed the	The Board recommends MSV	This would allow all MSV	353-357

districts to nominate “at large” delegates from orphan/unrepresented counties/cities within the district.	component societies within a district may nominate delegates.	<p>following, when considering this objective:</p> <ul style="list-style-type: none"> • What opportunities are there for MSV members that reside in orphaned cities and counties? • How will at-large district delegates be approved? • How should delegates be calculated? 	<p>allow districts to nominate “at large” delegates, to allow MSV members that reside in orphaned/unrepresented cities/counties within the district to participate in HOD.</p> <p>Districts would be able to nominate one delegate and one alternate for each thirty-five (35), or major fraction thereof, of MSV members that reside in orphaned/unrepresented cities/counties.</p> <p>Delegates would be approved by the District Directors. Leadership of component societies would be informed of the delegate selections to encourage unity.</p>	<p>members to have a path for representation at HOD. In addition, this would allow for more robust dialogue on policy issues.</p> <p>This would also allow the component societies to maintain their representation model while collaborating at the HOD with the at-large district members.</p>	
Option 3: Allow components the option to nominate MSV members that are not component society members but are within their geographic territory, to serve as delegates.	Currently components may only nominate MSV members that are also component society members as their delegates	<ul style="list-style-type: none"> • Impact on components and possibility of using this as a recruiting tool for local components. 	The Board recommends MSV allow components the option to nominate MSV members that reside within the component’s territory to serve as a delegate.	<p>May encourage local MSV members to join their component.</p> <p>Would be fully at the discretion of the component society.</p>	305

The Bylaws Board also considered the following items, but **did not** recommend adoption at this time:

- Modifying the delegate ratio to 1 delegate per 35 members to 1 delegate per 25 members
- Allowing groups with 100 percent membership in MSV to nominate a delegate

Goal 2: Streamline component recognition process to increase HOD participation.

Option to Achieve Goal	Current Bylaws Language	Considerations	Bylaws Board Recommendation	Benefits/Drawbacks	Line Numbers in Bylaws Draft
Option 1: Modify the frequency of the component membership roster requirement.	Each component society, component student society and component resident physician section must send a roster of members by July 1.	<ul style="list-style-type: none"> Currently many components do not submit membership rosters to MSV Many components are unable to perform this task annually due to the restraints on volunteer time and budget. Student and resident society rosters are generally maintained by staff MSV staff can use the new CRM to assist components with the submission process for easier reconciliation 	The Board recommends MSV require component societies submit a membership roster in odd years, no later than July 1.	Modifying these requirements will make it easier for components to be recognized as active societies to participate. While MSV may not always have the most up to date records of components' members, it would cultivate the practice, while making it less onerous.	233-236
Option 2: Refine and define how a component can be deemed as active	<p>The component societies, component student societies and component resident physician sections shall cooperate are required to meet at least twice each year.</p> <p>The EVP may request minutes or reports from the component societies.</p> <p>There is an ambiguous process for deeming a component inactive now; if a component fails to comply with the bylaws, the BOD may request the Membership Board make a report to the BOD.</p>	<ul style="list-style-type: none"> Many component societies are operating under constrained budget and frequent meetings may not always be possible. What information would be helpful to provide to determine if a component is active? 	<p>The Board recommends MSV modify the definition of active to include one component society meeting each year.</p> <p>In addition, components must notify MSV in writing of active status and their current officers no later than May 1.</p>	<p>Modifying these requirements would allow component to meet less frequently, which may increase participation in local meetings.</p> <p>This would also allow for the BOD to certify a component is active in time for HOD meeting to maximize participation.</p> <p>However, this provision would still require components to provide some information to MSV.</p>	240-251

Goal 3: Adjust quorum pursuant to other bylaws changes.

Option to Achieve Goal	Current bylaws language	Considerations	Bylaws Board Recommendation	Benefits/Drawbacks	Line Numbers in Bylaws Draft
Option 1: Modify the quorum requirements to achieve diversity in opinion and balance at the House of Delegates.	Quorum is comprised of 25 percent of the number of delegates allowed representing at least ten (10) component societies shall constitute a quorum of the House of Delegates.	<ul style="list-style-type: none"> How does MSV balance representation among different stakeholders, such as specialties, systems, groups, components, etc.? How does MSV protect the integrity of HOD to ensure a diverse delegate base? How do we balance new delegate types? 	<p>The Board recommends MSV change quorum requirements 25 percent of number of delegates allowed representing at least eight (8) districts to constitute a quorum.</p> <p>This would ensure diversity at the HOD.</p>	<p>This change increases the diversity of delegates and ensures that one entity cannot sway policy.</p> <p>However, the quorum is still tied primarily to geographic representation at the moment.</p>	360

Goal 4: Define the Compensation Board and outline responsibilities.

Option to Achieve Goal	Current bylaws language	Considerations	Bylaws Board Recommendation	Benefits/Drawbacks	
Option 1: Define the composition and responsibilities of the Compensation Board.	None	<ul style="list-style-type: none"> Organizational best practices for executive compensation MSV's past practices for Compensation Board What MSV leaders are engaged with the EVP to provide feedback and review? 	The Board recommends MSV codify the Compensation Board as a standing Board with 8 members – President, President-Elect, Immediate Past President (Chair), Speaker of the House of Delegates, Chair of the Nominating Board, Secretary-Treasurer, Chair of the AMA Delegation and a member of the MSV Board of Directors to be appointed by the President.	Upon review of executive compensation best practices, the Dodd Frank Act made the Board mandatory for publicly traded entities and some nonprofits have used some elements of Dodd Frank to serve as guidelines for good governance. In addition, the IRS Form 990 does ask if there is a compensation policy and to describe the manner in which compensation is determined.	648-654

Goal 5: Align Responsibilities and Conduct for all MSV Leadership

Option to Achieve Goal	Current bylaws language	Considerations	Bylaws Board Recommendation	Benefits/Drawbacks	Line Numbers in Bylaws Draft
Option 1: Align responsibilities and conduct for all MSV leaders to coincide with approved Board handbook and MSV strategic plan.	None	<ul style="list-style-type: none"> The Board of Directors adopted a new Code of Conduct that reflect the current leadership principles and aligns with MSV strategic plan Would require 1/3 of the BOD to file a written complaint Would provide for a hearing. Individual would have the right to bring personal counsel, question witnesses, evidence, and provide their own witness and evidence. Hearing would require 2/3 of Board present (double current quorum count) and 2/3 vote of the BOD are present at such hearing. Creating a transparent and rigorous process by which any member that is not in compliance with the bylaws or Code of Conduct may no longer serve in that role 	The Board recommends MSV adopt a transparent process by which any MSV leader that is not in compliance with the bylaws or Code of Conduct may be removed from office; while preserving every officer, Associate Director and Director's right to a fair and equitable hearing on any such matters.	<p>Defining a process for removal provides transparency to ensure that no such action can be taken without adequate cause and review by the majority of MSV leadership.</p> <p>Ensuring that MSV leadership embodies a high-degree of professionalism and integrity</p> <p>Majority of organizations' bylaws include such type of process</p>	621-622 675-676 680-720

Goal 6: Create uniform process to address vacancies.

Option to Achieve Goal	Current bylaws language	Considerations	Bylaws Board Recommendation	Benefits/Drawbacks	Line Numbers in Bylaws Draft
Option 1: Define how to handle officer, Associate Director, or Director resignations and how to fill subsequent vacancies.	None	<ul style="list-style-type: none">Who should receive such notificationWhat is the appropriate way to address vacancies	<p>The Board recommends MSV adopt a policy that allows any officer, Associate Director or Director to provide written notice to the Executive Vice President.</p> <p>The Board recommends MSV adopt a policy that would allow a vacancy in an office to be filled temporarily by appointment by the President until the next meeting of the House of Delegates.</p>	This process will ensure that every vacancy is handled in the same manner and provides clarity as to whom an individual should contact should they need to resign from their post.	503-507 609-619

MSV Bylaws Board: Additional Technical Items for Review

Upon review of the MSV bylaws, General Counsel has found several areas that are in conflict or need to be updated to reflect current and best practices. The options below were approved by the Board:

- Remove the list of component societies from the bylaws and reference appendix A. This will prevent the bylaws from becoming outdated as components change (Lines 115-117).
- Removing conflicting section on proxy voting. Currently proxy voting is not allowed at HOD, but there are outdated references to proxy voting within the bylaws (Lines 268-280).
- Add cities to the definition of a district (Line 499).
- Update the list of individuals who may be invited to Board of Directors meetings to include Secretary of Health and Human Resources and deans of allopathic and osteopathic medical schools, as is current practice (Line 665-667).
- Adds American Osteopathic Association Code of Ethics to ethics portion (Line 876).
- Update the ethics portion as Board of Medicine rarely revokes licenses, but suspends on final order (Line 877-878).

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**AMENDED AND RESTATED BYLAWS OF
THE MEDICAL SOCIETY OF VIRGINIA
EFFECTIVE October ~~25XX~~, 20152016**

**ARTICLE I
NAME AND PURPOSE**

Section 1. Name. The name of the corporation is The Medical Society of Virginia (the "Society"), a Virginia nonstock corporation.

Section 2. Purpose. The Society is incorporated to promote the science and art of medicine for the benefit of the people of Virginia, the protection of public health, and the betterment of the medical profession. Notwithstanding the foregoing, the Society shall not operate in a manner that could jeopardize the federal tax-exempt status under Section 501(c)(6) of the Internal Revenue Code of 1986, as amended (the "Code").

Section 3. Use of Funds. The Society shall use its funds only to accommodate these objectives, and no part of said funds shall inure or be distributed to or for the benefit of any individual member of the Society.

**ARTICLE II
MEMBERSHIP, VOTING, FUNDS, DUES**

Section 1. Classes of Membership. The Society shall have the following classes of membership: (a) active, (b) resident physician, (c) student, (d) associate, (e) honorary active, (f) honorary associate, and (g) affiliate.

Section 2. Active Members. An active member must be a doctor of medicine or osteopathy licensed to practice that profession in Virginia, provided, however, that a doctor of medicine or osteopathy may hold active membership without an active Virginia license if fully retired from practice.

Any active member shall have the right to vote, service on the Board of Directors, hold any office in the Society and serve on any committee. Each active or associate member shall pay dues unless (i) he/she has been granted an exemption because of financial or physical disability, or (ii) he/she has been an active or associate member of the Society for at least ten years and has become fully retired, in which event he/she shall be granted lifetime membership effective on January 1 of the year immediately following the year of application. Physicians granted such lifetime membership status shall not be charged annual dues.

Section 3. Resident Physician Members. A resident physician member must be an intern, resident or fellow in an approved training program in Virginia. Any resident physician member may hold any office and serve on any committee of the Society.

Section 4. Student Members. A student member must be a member in good standing of a component student society (as defined in Article III below). Any student membership shall terminate automatically when the member graduates from medical school or when he/she no longer is enrolled in a medical school at which there is a component student society. Any student member may hold any office and serve on any committee of the Society.

Section 5. Associate Members. An Associate member must be: (1) a non-resident of Virginia, not currently practicing medicine in Virginia and who holds or has held an active license as a physician by the Virginia Board of Medicine; (2) a medical officer of the armed forces; (3) a member of the Public Health Service; or (4) a doctor of medicine or osteopathy attached to a veterans' hospital. Associate members, other than honorary associate members, shall pay dues unless at the time of payment they have been active members in good standing for more than ten (10) years and are retired.

Section 5.1. No Right to Vote. Associate members shall have no right to vote, hold office or serve on committees, but shall be entitled to all other privileges of membership.

Section 6. Honorary Active Members; Honorary Associate Members. Honorary active or honorary associate membership may be granted by a majority vote of the House of Delegates at its annual meeting to no more than two (2) Virginia residents and one non-resident as an acknowledgement of long, faithful and distinguished service. Honorary active members shall not pay dues, but otherwise shall have the same rights as active members.

Section 6.1. No Right to Vote. Honorary associate members shall not vote, hold office, or serve on committees, but shall be entitled to all other privileges of membership.

Section 7. Affiliate Members. An Affiliate member shall be a healthcare provider or person in good standing with their profession, their community and the Medical Society of Virginia and who has an interest in supporting physicians and healthcare in Virginia. Affiliate membership is restricted to those persons specified in this section. Affiliate members shall pay dues.

Section 7.1. No Right to Vote. Affiliate members shall have no right to vote in the House of Delegates or hold office but shall be entitled to all other privileges of membership including serving on committees or task forces.

Section 7.2. Physician Assistants. Affiliate members who are physician assistants shall, as a condition of membership, hold an active license as a physician assistant from the Virginia Board of Medicine or, if such physician assistant is retired, hold an inactive license from the Virginia Board of Medicine.

Section 7.3. Physician Assistant Students. Affiliate members who are physician assistant students shall be a full-time student in a Virginia program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).

Section 8. Funds. In addition to annual dues, funds for the Society may be raised by a per capita assessment approved by the House of Delegates or by the Board of Directors subject to ratification by the House of Delegates, voluntary contributions and other business activities. The funds shall be expended to carry out the general purposes of the Society.

Section 9. Dues. The amount of membership dues for active members in full-time medical practice shall be determined by the House of Delegates for each fiscal year. At each annual meeting for which a change in the dues structure is recommended, such recommendation shall be presented by the Board of Directors to the House of Delegates for action. Membership dues for all classes of membership other than active members in full-time medical practice shall be determined by the Board of Directors and be reviewed annually by the House of Delegates.

Section 10. Fiscal Year. The fiscal year of the Society for membership purposes shall correspond with the calendar year.

Section 11. Approval and Removal of Members. An applicant shall not be accepted as an active physician, affiliate or associate member of the Society until he/she has paid annual dues. Any member may be censured, suspended or expelled by a majority vote of the House of Delegates for sufficient cause, when such action has been recommended by an ad hoc committee, which will be appointed by the Board of Directors specifically for the task of investigating complaints and providing recommendations for action to the Board of Directors. Any member may be dropped from the membership rolls for non-payment of dues (or any other assessment) or for failure to satisfy any other requirement for membership detailed in these Bylaws.

ARTICLE III

COMPONENT SOCIETIES, COMPONENT STUDENT SOCIETIES, COMPONENT RESIDENT PHYSICIAN SECTIONS, SPECIALTY SECTIONS, THE HOSPITAL MEDICAL STAFF SECTION, PHYSICIAN ASSISTANT SECTION, ACADEMIC MEDICAL SCHOOLS, and HEALTH SYSTEMS

Section 1. Component Societies & Qualifications. A component society shall be comprised of physicians from one or more political subdivisions of the Commonwealth of Virginia. One component society in a county or city shall be recognized by the Society. No component society will be recognized if it is established in a territorial

area included in the jurisdiction of another component society unless two (2) or more political subdivisions have become a single political subdivision by merger, annexation, or otherwise. In such case, any component societies in the said political subdivisions may be recognized as separate component societies or unite to form a single component society. Component Societies deemed active by the Board of Directors can be found in Appendix A. ~~Component societies are comprised of the following:~~

Accomack County Medical Society	Newport News Medical Society
Albemarle County Medical Society	Norfolk Academy of Medicine
Alleghany-Bath Counties Medical Society	Northampton County Medical Society
Arlington County Medical Society	Northern Neck Medical Association
Augusta-Highland County Medical Society	Northern Virginia Medical Society
Bedford County Medical Society	Orange County Medical Society
Buchanan-Dickenson Counties Medical Society	Patrick Henry Medical Society
Chesapeake Medical Society	Portsmouth Academy of Medicine
Culpeper County Medical Society	Prince William County Medical Society
Danville-Pittsylvania Academy of Medicine	Richmond Academy of Medicine
Fauquier County Medical Society	Roanoke Valley Academy of Medicine
Floyd County Medical Society	Rockbridge County Medical Society
Fredericksburg Area Medical Society	Rockingham County Medical Society
Halifax County Medical Society	Southside Virginia Medical Society
Hampton Medical Society	Southwestern Virginia Medical Society
James River Medical Society	Stuart Medical Society
Lee County Medical Society	Tazewell County Medical Society
Lynchburg Academy of Medicine	Tri-County Medical Society
Medical Society of Northern Virginia	Virginia Beach Medical Society
Mid-Tidewater Medical Society	Williamsburg-James City County Medical Society
	Wise County Medical Society

Section 1.1. A physician is eligible to join a component society in the political subdivision where he/she carries on the major portion of his/her practice. If a physician practices both in Virginia and in an adjoining state or the District of Columbia, and the major portion of his/her practice is not in Virginia, he/she may join a component society in the political subdivision in which he/she resides. Notwithstanding the foregoing, a member may join a more convenient component society in the same or an adjoining political subdivision if the component society, or societies, having jurisdiction in the county or city in which the physician carries on the major portion of his/her practice consents. Any member may join a component society in an adjoining political subdivision if there is no component society in the political subdivision in which the physician carries on the major portion of his/her practice.

Section 2. Specialty Sections, Qualifications and Guidelines. Each specialty section deemed active by the Board of Directors can be found in Appendix A. ~~shall be composed of members of the Society who are practicing in one of the following specialties:~~

Allergy	Neurology	Physical Medicine & Rehabilitation
Anesthesiology	Obstetrics/Gynecology	Plastic Surgery
Cardiology	Occupational & Environmental Medicine	Preventive Medicine
Dermatology	Ophthalmology	Psychiatry
Emergency Medicine	Orthopaedic Surgery	Radiology
Family Practice	Otolaryngology	Surgery
Gastroenterology	Pathology	Thoracic Surgery
Internal Medicine	Pediatrics	Urology
Neurological Surgery		

Section 2.1. The following guidelines must be satisfied in order for a specialty organization to be recognized as a specialty section of the Society:

A. The specialty organization's constitution and bylaws must not be in conflict with the Articles of Incorporation and these Bylaws of the Society.

B. The specialty organization must not discriminate in membership on the basis of race, religion, national origin, gender, or handicap.

C. The specialty organization must represent a field of medicine that has recognized scientific validity.

D. ~~The specialty organization must represent an area of expertise that is not adequately represented in the House of Delegates.~~

E. At least ~~sixty-fourty~~ percent (~~60~~40%) of the specialty organization's physician members who are eligible for Society membership are members of the Society.

F. The specialty organization must be stable and have been in existence for at least five (5) years prior to submitting its application.

G. Licensed Virginia physicians must comprise the majority of the voting membership of the specialty organization.

H. The specialty organization must have a voluntary membership and must report as active members only those who are current in payment of dues, have full voting privileges and are eligible to hold office.

I. The specialty organization must be active within its field of medicine and hold at least one (1) meeting of its members annually.

J. The specialty organization must submit a resolution or other official statement to show that the request is approved by the governing body of the specialty organization.

Section 2.2. The members of each specialty section shall adopt rules and regulations to provide for the conduct of the meetings of the section and for the selection of the section's officers and its delegate and alternate to the House of Delegates. Every five (5) years the Board of Directors should cause each specialty section to be reviewed for compliance with these guidelines.

Section 3. Component Student Societies, Qualifications and Guidelines. Component student societies shall be comprised of students in medical schools accredited by the Liaison Council on Medical Education (LCME) or the American Osteopathic Association (AOA) and located in the Commonwealth of Virginia. One component student society shall be recognized by the Society at each medical school in the Commonwealth of Virginia accredited by the LCME or the AOA.

Section 4. Component Resident Physician Sections, Qualifications and Guidelines. There shall be one component resident physician section recognized by the Society. Any intern, resident or fellow in good standing in an Accreditation Council for Graduate Medical Education (ACGME) approved training program in the Commonwealth of Virginia shall be eligible for membership in the section.

Section 5. Hospital Medical Staff Section, Qualifications and Guidelines. The hospital medical staff section shall consist of members of the Society who also are active voting members of hospital medical staffs with clinical privileges who have been selected for membership. The hospital medical staff section shall consist of one (1) physician selected by the medical staff of each hospital located in Virginia. This section shall adopt rules and regulations to provide for the conduct of its meetings and for the selection of its officers and its delegate and alternate to the House of Delegates.

Section 6. Academic Medical Schools, Qualifications and Guidelines. Each medical school shall be accredited by the LCME or the American Osteopathic Association.

Section 6.1. The following guidelines must be satisfied in order for a medical teaching institution to be recognized as an academic medical school of the Society:

A. The academic medical school must not discriminate employment on the basis of race, religion, national origin, gender, or handicap.

B. The academic medical school must represent a field of medicine that has recognized scientific validity.

C. The academic medical school must have a group contract with the Society.

D. One hundred percent (100%) of the academic medical school's full-time faculty (physicians) who are eligible for Society membership are members of the Society.

Section 7. Health Systems, Qualifications and Guidelines. Each health system shall be composed of a medical group with one hundred (100) or more employed physicians affiliated under a single entity.

Section 7.1. The following guidelines must be satisfied in order for an employed medical group to be recognized as a health system of the Society:

A. The health system must not discriminate employment on the basis of race, religion, national origin, gender, or handicap.

B. The health system must represent a field of medicine that has recognized scientific validity.

C. One hundred percent (100%) of the health system's employed physicians who are eligible for Society membership are members of the Society.

Section 8. Physician Assistant Section. There shall be a section comprised of Physician Assistants and Physician Assistant students who are members of the Society. Organization and governance within the section shall be as determined by the section. The physician assistant section may introduce resolutions to the House of Delegates.

Section 9. Attendance at Annual Meeting. Each component society, component student society, component resident physician section, specialty section, the hospital medical staff section, health systems, and academic medical schools shall send to each annual meeting of the Society the number of delegates and alternates fixed by Article V, Section 3 herein.

Section 10. Member Rosters. The secretary of each component society, component student society and component resident physician section shall keep a roster of its members. Once a year, not later than July 1, the secretary of ~~each component society,~~ component student society and component resident physician section shall send a list of its members to the Executive Vice President of the Society. In odd-years, not later than July 1, the secretary of each component society shall send a list of its members to the Executive Vice President of the Society.

Section 11. Component Meetings. The component societies, component student societies and component resident physician sections shall cooperate with the officers of the Society to carry out the plans and objectives of the Society and to this end shall meet at least ~~twice-once~~ each year. Once a year, each component society shall notify the Society in writing, by mail or electronically, of their active status and current officers, no later than May 1, and shall send minutes of meetings and such reports as may be requested to the Executive Vice President of the Society.—The Society shall support component society membership for its members and emphasize that an active component society membership results in a strong state society.

Section 12. Failure to Comply with Bylaws. If a component society, component student society, component resident physician section, or physician assistant section fails to comply with the provisions of these Bylaws, the

Board of Directors shall request a report of ~~the Membership Committee~~the component regarding the organization in question. After considering such report, the Board of Directors then may make a recommendation concerning the status of the organization as a component society, component student society or component resident physician section as being active or inactive.

ARTICLE IV MEETINGS OF MEMBERS

Section 1. Annual Meeting. There shall be an annual meeting of the Society, with the date and place to be determined by the Board of Directors.

Section 2. Attendees. Meetings of members of the Society shall be open to all registered members and guests.

Section 3. Voting. Active, student and resident physician members may vote on any matter that the House of Delegates determines is of sufficient importance that it should be submitted to the voting members of the Society.

~~**Section 4.** Proxy Voting. At any general meeting of members of the Society, voting by proxy shall be permitted on any matter that the Board of Directors, subject to ratification by the House of Delegates, or the House of Delegates has determined is of sufficient importance to the Society that proxy voting should be permitted. With respect to any vote for which proxy voting will be permitted, the Society shall distribute a form of proxy to each voting member of the Society, such form to provide for both a positive and negative vote on the question presented. In order for a proxy vote to be valid, the proxy (a) must be on the form of proxy provided by the Society, (b) must direct the holder to vote for or against the question presented rather than leaving the vote to the discretion of the holder, and (c) must be received by the Secretary-Treasurer of the Society not less than seventy-two (72) hours prior the meeting of the membership at which the vote is to be taken. The number of proxy votes cast either for or against a particular question shall not be disclosed until the vote of those physically present and voting has been called for and received by the presiding officer. The final vote on any issue for which proxy voting is permitted shall be announced by the presiding officer by first stating the vote of those physically present and voting on the question, followed by the results of the proxy voting.~~

ARTICLE V HOUSE OF DELEGATES

Section 1. Composition. The House of Delegates shall be the policy making body of the Society. The House of Delegates shall consist of delegates elected by the component societies, component student societies, component resident physician sections, specialty sections, the hospital medical staff section, health systems, academic medical schools and the following ex-officio members: The President, President-Elect, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, Secretary-Treasurer, directors and associate directors, all Past Presidents of the Society, any general officer of the American Medical Association who also is a member of the Society, and the delegates and alternate delegates of the Society to the American Medical Association. Delegates elected by component societies, specialty sections, component student societies, component resident physician sections, the hospital medical staff section, health systems, and academic medical schools shall serve a one-year term. Ex-officio members of the House of Delegates, except for the Speaker, as provided in Article VII, Section 4, shall have full voting rights and will not be included in the delegate allotment for each component society. No voting by proxy shall be permitted in the House of Delegates. Each member of the House of Delegates also must be a member of the Society.

Section 2. Assembly. The first assembly of the House of Delegates shall be held on the first (1st) day of the annual meeting. The House of Delegates shall adopt rules of procedure to govern the conduct of business during the meeting.

Section 3. Election of Membership. Each component society shall annually elect to membership in the House of Delegates, one delegate and one alternate for each thirty-five (35), or major fraction thereof, of its members, or non-component society members that reside within the component's geographic territory, who are members of the Society or, in its discretion, may elect one delegate and one alternate from each county and each city in its territorial area. For purposes of determining the number of delegates and alternates to which it is entitled, a component society may count (a) direct Society members the major portion of whose practice is within the territorial jurisdiction of the component society and (b) a resident physician only if he/she is a member of the component society, and an active member of the Society. In any event, each component society is entitled to at least one delegate and one alternate in the House of Delegates. In the event a delegate is not present at any meeting of the House of Delegates, his/her alternate shall succeed to all of his/her privileges. Delegates and alternates shall be active members, student active members or resident physician members of the Society.

Section 3.1. Each component student society annually may elect to membership in the House of Delegates two (2) delegates and two (2) alternates. Student active members, their component student society, and the delegates from the component student society shall be considered members, societies and delegates of the territorial area in which is located the medical school with which they are affiliated.

Section 3.2. The component resident physician section annually may elect to membership in the House of Delegates one delegate and one alternate for each thirty-five (35), or major fraction thereof, of its members who are members of the Society.

Section 3.3. Each specialty section recognized by the Society shall elect annually delegates to membership in the House of Delegates. The apportionment of delegates from each specialty society is one delegate and one alternate if at least forty (40) -percent of its members, are members of the Society; two delegates and two alternates if at least sixty (60) percent of its members, are members of the Society; three delegates and three alternates if at least eighty (80) percent of its members. ~~one delegate and one alternate~~ — Prior to the annual meeting each specialty section shall submit the name(s) of its delegate(s) and alternate delegate(s) to the Speaker of the House of Delegates or his designee. In the event a delegate for a specialty section is not present at any meeting of the House of Delegates, his/her alternate shall succeed to all privileges.

Section 3.4. If the full number of delegates accredited to a component society, component student society, component resident physician section, specialty section, the hospital medical staff section, health system or academic medical school are not present at a meeting of the Society, those members present from such component society, component student society, component resident physician section, specialty section, the hospital medical staff section, health system or academic medical school may, from members of that society, section, system or school present, who are voting members of the Society, elect or appoint a sufficient number of delegates to complete its quota.

Section 3.5. The hospital medical staff section shall elect annually to membership in the House of Delegates one delegate and one alternate. In the event the delegate for hospital medical staff section is not present at any meeting of the House of Delegates, his/her alternate shall succeed to all privileges.

Section 3.6. Each health system shall elect annually to membership in the House of Delegates one delegate and one alternate. In the event the delegate for the health system is not present at any meeting of the House of Delegates, his/her alternate shall succeed to all privileges.

Section 3.7. Each academic medical school shall elect annually to membership in the House of Delegates one delegate and one alternate. In the event the delegate for the academic medical school is not present at any meeting of the House of Delegates, his/her alternate shall succeed to all privileges.

Section 3.8. Each district shall annually elect to membership in the House of Delegates, one delegate and one alternate for each thirty-five (35), or major fraction thereof, of its members who are members of the Society that reside in a city or county not represented by a component society within the district. Such delegates will be approved by the District Director. Presidents of component societies located within the District shall be informed of such selection prior to the House of Delegates.

Section 4. Quorum. Twenty-five (25) percent of the number of delegates allowed representing at least ~~ten~~eight (408) ~~component societies~~districts shall constitute a quorum of the House of Delegates.

Section 5. Election of Delegates and Alternates. The House of Delegates shall elect delegates and alternates to the House of Delegates of the American Medical Association in accordance with the Bylaws of that organization. Except where the number of nominees does not exceed the number of delegates to be elected, such delegates shall be elected by ballot, and a majority vote shall be necessary for election. The nominee receiving the fewest votes will be dropped on each ballot in succession until the requisite number receives a majority. Following the election of delegates, the same method shall be used to elect alternate delegates.

Section 6. Budget. The House of Delegates, at each annual meeting, shall adopt a budget for the ensuing fiscal year.

Section 7. Special Meetings. The Board of Directors may, by majority vote, call a special meeting of the House of Delegates when in its opinion such a meeting is necessary. The President shall call such meeting, upon petition of at least one-third (1/3) of the Delegates serving at the last regular meeting of the House of Delegates. Written notice stating the date, place and time of the meeting, and the purpose for which the meeting is called, shall be given not less than ten (10) nor more than fifty (50) days before the date of the meeting, either personally or by mail, or at the direction of the President or Executive Vice President, to each member of the House of Delegates serving, or who was authorized to serve, at the last regular meeting of the House of Delegates. If any member is unable to serve, then another member shall be elected or appointed by the Board of Directors to serve. The transaction of business at any special meeting of the House of Delegates shall be limited to the purpose in the notice for the meeting.

ARTICLE VI ELECTIONS

Section 1. Nominating Committee. The House of Delegates, at its second session of the Annual Meeting, shall elect from its membership a Nominating Committee consisting of one member from each District who shall be nominated by the delegates present from that district, and one member from the academic medical schools who shall be nominated by the academic medical school Director, and one member from the Medical Student Section (MSS) nominated by the MSS.

Section 1.1. The Nominating Committee is charged with the task of identifying, recruiting, promoting and nominating those individuals that will best serve the needs of the Society, and to encourage their decision to be active in Society leadership.

A. The Nominating Committee shall recommend to the House of Delegates one or more members for each of the offices to be filled at the Annual Meeting, including Delegates and Alternate Delegates to the Society's AMA Delegation. The Nominating Committee shall present its recommendations to the membership in conjunction with the September Board meeting or within thirty (30) days prior to the Annual Meeting.

B. Further nominations for each office may be made at the Annual Meeting from the floor by members of the House of Delegates. Except where there is only one nominee for an office, the election of officers and AMA representatives shall be by ballot, and a majority vote shall be necessary for election. The nominee with the fewest votes shall be dropped on each ballot in succession until one receives a majority vote.

C. The two immediate former presidents of the Society, and the Chair of the Society's AMA Delegation, shall be non-voting advisory members. If for any reason there is a vacancy on the Nominating Committee, the District may nominate a replacement and recommend to the Board of Directors for approval to fill that vacancy. If the District does not nominate a replacement for the vacant Nominating Committee position, the President may recommend a replacement from that District for approval by the Board. In the event of a vacancy of the medical student Nominating Committee member, the student section may provide a nominee for appointment by the President for the remainder of the term. Should a vacancy occur in the academic medical schools' representation to the committee, the academic medical schools may provide a nominee for appointment by the President for the remainder of the term. Any Nominating Committee member so elected to fill a vacant

415 seat on the committee shall serve until the next annual meeting unless earlier removed in accordance with these
416 Bylaws and applicable law.

417
418 D. The Chair of the Nominating Committee shall be chosen by majority vote of those
419 members elected to serve on the committee by the House of Delegates. No person shall serve more than two
420 consecutive one year terms as chair. It is encouraged that the chair rotate throughout geographic areas of the
421 Commonwealth.

422
423 **Section 2.** Election of President-Elect. At each annual meeting, the House of Delegates shall elect a
424 President-Elect for a term of one (1) year. At the end of this term, the President-Elect shall become President for
425 a term of one (1) year.

426
427 **Section 3.** Election of Secretary-Treasurer, Speaker and Vice Speaker. At each annual meeting, the House
428 of Delegates shall elect a Secretary-Treasurer. The House of Delegates also shall elect a Speaker and Vice
429 Speaker. The term of office for each of the officers described in this Article shall be one (1) year except for the
430 Secretary-Treasurer, whose term shall be three (3) years.

431
432 **Section 4.** Board of Directors: Composition. There shall be members of the Board of Directors consisting of
433 one representative from Board Districts 1, 5, 6, 8, and 9, two (2) representatives from Board Districts 2, 3, 7, and
434 10, one representative from the academic medical schools, one (1) representative from the Medical Student
435 Section, one (1) representative from the Resident and Fellow Section, one (1) representative of the MSVF who is
436 a member of the Society and who is a physician and the following ex-officio members: The President, the
437 President-Elect, the immediate past President, the Speaker of the House of Delegates and the Secretary-
438 Treasurer. Ex-officio members of the Board of Directors shall have full voting rights.

439
440 **Section 5.** Board of Directors, Election. Directors shall be elected by a majority vote of the House of
441 Delegates at the annual meeting Directors shall be elected for a term of two (2) years; those from odd numbered
442 Districts are elected in odd-years, and those from even numbered Districts are elected in even years. Any
443 Director eligible for re-election shall not attend the meeting of his/her District during the time the District is
444 selecting its nominee for the Board of Directors. Any Director who has served three (3) consecutive full two-year
445 terms shall not be eligible for a fourth consecutive term, but may be re-elected after being out of office for at least
446 one (1) year. If at the time of the annual meeting there is a vacancy in the membership of the Board of Directors
447 and the District is not represented in the meeting, the House of Delegates, on nomination by the Speaker, shall
448 elect a Director for that District. If any representative qualifies as a member of the Board of Directors as a result
449 of his/her election or appointment to an office in the Society, his/her membership on the Board of Directors as a
450 representative of a District shall cease.

451
452 **Section 5.1.** A medical student from one of the recognized medical schools shall be elected by the
453 House of Delegates to the Board of Directors for a term of one (1) year.

454
455 **Section 5.2.** A resident, fellow, or intern shall be nominated by the Resident and Fellow Section, and
456 elected by the House of Delegates to the Board of Directors for a term of one (1) year.

457
458 **Section 5.3.** An Associate Director from each District shall be elected by a majority vote of the House
459 of Delegates at the annual meeting to assist the Director(s) for the District and to substitute when a Director for
460 the District is unable to perform his/her duties. Associate Directors shall be elected for a term of two (2) years;
461 those from odd numbered Districts are elected in odd-years, and those from even numbered Districts are elected
462 in even years. Any Associate Director who has served three (3) consecutive full two (2) year terms shall not be
463 eligible for a fourth consecutive term, but may be re-elected after being out of office for at least one (1) year.
464 Associate Directors shall be requested to attend all meetings. Any Associate Director may speak on behalf of
465 his/her District, but shall not vote in Board meetings.

466
467 **Section 5.4.** A medical student from one of the recognized medical schools shall be elected by the
468 House of Delegates as an Associate Director for a term of one (1) year.

Section 5.5. A resident, fellow or intern from the Resident and Fellow Section shall be elected by the House of Delegates as an Associate Director for a term of one (1) year.

Section 5.6. A representative from the academic medical schools duly accredited or licensed by the Commonwealth of Virginia shall be elected by the House of Delegates as a Director for a term of two years provided all such schools annually achieve and maintain the established membership equivalency requirements for their respective full time academic physicians as of the annual meeting of the Society coincident with the election. Annual membership equivalency requirements shall be determined by the Board of Directors and communicated by the President or his designee to all such schools. Such requirements are incorporated herein by reference. For subsequent elections, a representative shall only be elected by the House of Delegates provided all such schools have achieved and continue to maintain annually the membership equivalency requirements established for their respective full time academic physicians. In the event that the membership equivalency requirements are not achieved or maintained annually for all such schools, the seat on the Board of Directors, seat on the Associate Directors and seat on the Nominating Committee shall terminate until such time as the membership equivalencies are achieved, as determined by the President of the Society. For regular term elections, the nominee to serve as the representative shall be selected by such schools in a method agreed upon by the schools. The name of the nominee shall be submitted to the Speaker of the House of Delegates or his designee in advance of the annual meeting together with the number of full time academic physicians for all such schools. The term limits in Section 5 shall apply to this section.

Section 5.7. An Associate Director representing the academic medical schools accredited or licensed by the Commonwealth of Virginia shall be elected by majority vote of the House of Delegates at the annual meeting to assist the Director and to substitute when the director is unable to perform his/her duties. The Associate Director shall be elected for a term of two (2) years. Any Associate Director who has served three (3) consecutive full two (2) year terms shall not be eligible for a fourth consecutive terms, but may be re-elected after being out of office for at least one (1) year. Associate Directors shall be requested to attend all meetings. Any Associate Director may speak on behalf of the academic medical schools, but shall not vote in Board meetings.

Section 6. Districts Described. The Districts for the Society shall be composed of the component societies, component student societies and orphan cities/counties set forth on Appendix A attached hereto and incorporated by this reference. The number and configuration of Districts may be changed by vote of two-thirds majority of members of the House of Delegates present.

Section 7. Vacancies. Each Director or Associate Director of the Society may resign at any time by giving written notice to the Executive Vice President, who will inform the President. The resignation will take effect on the date of the receipt of that notice or at a later date as specified in the notice. Any resignation is without prejudice to the rights, if any, of the organization, as long as the resigning party continues to abide by the bylaws and pays dues.

At the time of a Board of Directors meeting, if there is a vacancy in the membership of the Board of Directors, the Board of Directors may fill the vacancy from nomination(s) by the President. If the vacancy is from a District with an Associate Director, the Associate Director shall automatically be nominated to the Board of Directors for approval to fill the vacancy of the Director seat and the District may nominate a new Associate Director and may recommend to the Board of Directors for approval to fill the vacancy of the Associate Director until the next annual meeting. If for any other reason there is a vacancy in the Director or Associate Director position, the District may nominate a replacement and recommend to the Board of Directors for approval to fill that vacancy. If the District does not nominate a replacement for the Director or Associate Director position, the President may recommend a replacement from that District for approval by the Board. In the event a vacancy of the medical student or resident Director occurs, the President may contact the respective section to obtain a nomination to be submitted to the Board for approval. Any Director so elected to fill a vacant Director's seat shall serve until the next annual meeting unless earlier removed in accordance with these Bylaws and applicable law. Such Director shall be eligible to serve three consecutive two (2) year terms in addition to the partial term for which the Director was elected to fill the vacancy. Should a vacancy occur in the academic medical schools' representation to the Board, the academic medical schools shall provide a nominee for appointment by the President for the remainder of the term.

Section 8. Term. The officers shall begin service at the adjournment of the annual meeting of the House of Delegates and continue until the end of the next meeting of the House of Delegates or until a successor qualifies, except as provided for in Article VII, Section 6.3.

ARTICLE VII OFFICERS

Section 1. President.

Section 1.1. The President shall be the chief elected officer of the Society.

Section 1.2. The President shall preside over meetings of the members of the Society, and shall be a member of the House of Delegates, chair of the Board of Directors, and a voting, ex-officio member of all committees.

Section 1.3. The President shall fill any vacancy in any committee or in the Society's delegation to the House of Delegates of the American Medical Association occurring between annual meetings, and such appointment shall be valid until the adjournment of the next annual meeting. The President may appoint any necessary special committees during his/her term.

Section 1.4. The President shall visit as many of the component societies of the Society as possible during the year, in the interest of the Society, actual expenses incurred being paid in accordance with the budget.

Section 2. President-Elect.

Section 2.1. The President-Elect shall be a member of the House of Delegates, the Board of Directors and the Executive Committee. The President-Elect shall succeed to the presidency at the end of the President's term.

Section 2.2. In case there is a vacancy in the office of President-Elect and the House of Delegates is not in session, the Board of Directors may appoint a President-Elect pro tempore. If at the annual meeting there is a vacancy in the office of President-Elect, or in case the President-Elect was appointed pro tempore by the Board of Directors, the House of Delegates shall elect a President for the following term.

Section 3. Executive Vice President.

Section 3.1. The Board of Directors, upon the recommendation of the Executive Committee of the Board of Directors, shall appoint the Executive Vice President. The Executive Vice President need not be a member of the Society. The Executive Vice President of the Society shall be the executive agent of the Society, and shall assist the Secretary-Treasurer of the Society in developing minutes of general meetings, the House of Delegates, the Board of Directors and the Executive Committee. In addition, the Executive Vice President shall function as the Chief of the Society's staff and shall be responsible for the allocation of resources towards the Society's strategic goals and program portfolios across all entities. The Executive Vice President also shall serve as the general manager of the official publications of the Society.

Section 3.2. The Executive Vice President shall be the custodian of all property of the Society, provide for registration of members at meetings of members, conduct the general correspondence of the Society, and, with the consent of the President, employ necessary assistance.

Section 3.3. The Executive Vice President shall collect all money due the Society and pay out these funds under the joint supervision of the President and Secretary-Treasurer, or upon their designated authority.

Section 3.4. The Executive Vice President shall make an annual report to the House of Delegates.

Section 4. Speaker and Vice Speaker of the House of Delegates.

Section 4.1. The Speaker of the House of Delegates shall preside over all meetings of the House of Delegates, but shall vote only in the case of a tie. The Speaker shall appoint all special committees whose duties are concerned primarily with the operation and function of the House of Delegates.

Section 4.2. The Speaker of the House of Delegates shall serve as an ex-officio voting member of the Board of Directors and the Executive Committee.

Section 4.3. The Vice Speaker of the House of Delegates shall preside over the House of Delegates in the absence of the Speaker, or at the Speaker's request. The Vice Speaker shall vote, if serving as the Speaker, only in case of a tie. The Vice Speaker, serving in the capacity of Vice Speaker, shall be entitled to vote on all matters before the House of Delegates.

Section 4.4. In the event of a vacancy of the Vice Speaker of the House of Delegates, the President shall appoint a successor to serve through the next annual meeting.

Section 5. Secretary-Treasurer.

Section 5.1. The Secretary-Treasurer of the Society shall have the responsibility for preparing, and maintaining custody of minutes of the meetings of the Board of Directors, its Executive Committee, the House of Delegates and any other meeting of the Society's members, and for authenticating records of the Society. The Secretary-Treasurer shall serve as the Chair of the Finance Committee.

Section 5.2. The Secretary-Treasurer shall serve as an ex-officio, voting member of the House of Delegates, the Board of Directors, and Executive Committee.

Section 5.3. The term of office of the Secretary-Treasurer of the Society shall be three (3) years. In the event of a vacancy, the President shall appoint a successor to serve through the next annual meeting.

Section 6. Officer resignations and vacancies

Section 6.1 Each officer of the Society may resign at any time by giving written notice to the Executive Vice President, who will inform the President. The resignation will take effect on the date of the receipt of that notice or at a later date as specified in the notice. Any resignation is without prejudice to the rights, if any, of the organization, as long as the resigning party continues to abide by the bylaws and pays dues.

Section 6.2 A vacancy in any office because of death, resignation, removal, disqualification or any other cause shall be filled in a manner as prescribed in the Bylaws for regular appointment to the office. In the event of a vacancy in any office other than the President, such vacancy shall be filled temporarily by appointment by the President and shall remain in office until the next meeting of the House of Delegates.

Section 7. Professional Conduct. Each officer will remain in compliance with the duties as described in Article VXi Section 1 of these bylaws.

**ARTICLE VIII
BOARD OF DIRECTORS**

Section 1. Duties. The Board of Directors shall have charge of the affairs of the Society, when the House of Delegates is not in session.

Section 2. Qualifications. Each Director and Associate Director who represents a District must be a member of, and for the purpose of these Bylaws be considered a representative of, a component society or component student society, in that District.

Section 3. Executive Committee. There shall be a five (5) member Executive Committee of the Board of Directors composed of the President, the President-Elect, the immediate Past-President, the Speaker of the House of Delegates and the Secretary-Treasurer. The President may appoint non-voting advisory members to

the Executive Committee. The Executive Committee shall act in an advisory capacity to the Board of Directors and to the President, who shall serve as its Chair.

Section 4. Finance Committee. There shall be a six (6) member Finance Committee of the Board of Directors composed of the President, the President-Elect, the immediate Past-President, the Speaker of the House of Delegates, the Secretary-Treasurer and the Executive Vice President. The Executive Vice President will be a non-voting member. The Secretary-Treasurer shall serve as its Chair. The Finance Committee shall have oversight responsibilities for budget development, business agreements, and for investment, accounting and auditing matters of the Society. The President may appoint non-voting advisory members to the Finance Committee.

Section 5. Compensation Committee. There shall be an eight (8) member Compensation Committee of the Board of Directors comprised of the President, President-Elect, Immediate Past President, the Speaker of the House of Delegates, the Chair of the Nominating Committee, the Secretary-Treasurer, the Chair of the AMA Delegation, and one member of the MSV Board of Directors as appointed by the President. The Immediate Past President shall serve as Chair of the Compensation Committee. The Compensation Committee shall have responsibility for recommending to the Board of Directors adjustments to the compensation and benefits package for the Executive Vice President which shall be voted on by the Board of Directors in executive session.

Section 56. Meetings. Meetings of the Board of Directors shall be held upon call of the Executive Vice President at the request of the President or any five (5) members of the Board of Directors, upon reasonable notice. Actual expenses may be paid members attending meetings of the Board of Directors between annual meetings.

Section 67. Additional Duties. The Executive Committee and the Board of Directors shall receive reports at least semi-annually on the Society's budget. At each annual meeting, the Board of Directors shall present to the House of Delegates for its action a budget for the next fiscal year.

Section 78. Other Attendees. The Secretary of Health and Human Resources, State Health Commissioner, the Executive Director of the Virginia Board of Medicine and the Dean of each allopathic or osteopathic medical school in Virginia ~~shall~~ may be requested to attend all meetings of the Board of Directors.

Section 89. Nominations for Virginia State Board of Medicine. The Society shall submit nominations to the Governor of Virginia for membership on the Virginia State Board of Medicine.

Section 910. Quorum. One-third of the Directors representing at least one-third of the districts, and either the President or President-Elect, shall constitute a quorum of the Board of Directors.

Section 11. Professional Conduct. Each member of the Board of Directors will remain in compliance with the duties as described in Article VXi Section 1 of these bylaws.

ARTICLE IX
PROFESSIONAL CONDUCT

Section 1. Professional Conduct. Each officer, Associate Director, or Director of the Society shall conduct themselves in a professional and ethical manner in discharging the duties of the respective office, while taking appropriate action to advance and foster the business of the Society. Each officer or director of the Society will remain in compliance with the Society's Code of Conduct and these bylaws.

Any officer, Associate Director, Director may be removed from office for cause. Grounds for removal include but are not limited to any of the following circumstances:

1. Continued, gross, or willful neglect of the duties of the office, which in part include duties of care, loyalty, and diligence, in addition to fiduciary duty
2. Actions that intentionally violate the bylaws
3. Failure to comply with the proper direction given by the Board
4. Failure or refusal to disclose necessary information on matters of organization business
5. Unauthorized expenditures or misuse of organization funds
6. Unwarranted attacks on any officer, member of the board of directors, board as a whole, or staff, on an ongoing basis
7. Misrepresentation of the organization and its officers to outside persons
8. Conviction for a felony
9. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of the Society

Proceedings for the removal from office of an officer, Associate Director, or Director of this Society shall be commenced by the filing to the Executive Vice President a written complaint signed by not less than one-third of the Board of Directors. Such complaint shall name the person sought to be removed, shall state the cause for removal, and shall demand that a meeting of the Board of Directors be held for the purpose of conducting a hearing on the charges set forth in the complaint.

At the hearing upon such charges the person named in the complaint shall be afforded full opportunity to be heard in his/her own defense, to be represented by legal counsel at personal expense or any other person of his/her own choosing, to cross-examine the witnesses who testify against him/her, and to examine witnesses and offer evidence in his/her own behalf. The Board of Directors shall convene for the purposes of hearing the charges in such complaint no less than sixty (60) days subsequent to the date of the service of the written notice upon such person sought to be removed.

A quorum for the purposes of this section shall consist of two-thirds (2/3) of the members of the Board of Directors. Removal shall occur by a vote of two-thirds of the Board of Directors present at such meeting.

The hearing rights under these bylaws do not apply if an individual voluntarily resigns in accordance with these Bylaws.

ARTICLE X
INDEMNIFICATION

Section 1. Definitions.

"Applicant" means the person seeking, indemnification pursuant to this Article IX.

"Expenses" includes reasonable counsel fees.

"Liability" means the obligation to pay a judgment, settlement, penalty, fine, including any excise tax assessed with respect to an employee benefit plan, or reasonable expenses incurred with respect to a proceeding.

"Official capacity" means (a) when used with respect to a Director, the office of Director in the Society, or (b) when used with respect to an individual other than a Director, the office in the Society held by the officer or the employment or agency relationship undertaken by the employee or agent on behalf of the Society. "Official capacity" does not include service for any other foreign or domestic corporation or any partnership, joint venture, employee benefit plan, or other enterprise.

"Party" includes an individual who was, or is threatened to be made a named defendant or respondent in a proceeding.

"Proceeding" means any threatened, pending or completed action, suit, or proceeding, whether civil, criminal, administrative, investigative, formal or informal.

Section 2. Right of Indemnification. The Society shall indemnify any person who was or is a party to any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative, arbitative or investigative by reason of the fact that he/she is or was a Director, officer or employee of the Society, or a member of any committee of the Society or is or was serving at the request of the Society as a director, trustee, partner or officer of another corporation, partnership, joint venture, trust, employee benefit plan or other enterprise, against any liability incurred by him/her in connection with such proceeding if (a) he/she believed, in the case of conduct in an official capacity, that his/her conduct was in the best interests of the Society, and in all other cases that his/her conduct was at least not opposed to its best interests, and, in the case of any criminal proceeding, had no reasonable cause to believe his/her conduct was unlawful, (b) in connection with a proceeding by or in the right of the Society, he/she was not adjudged liable to the Society, and (c) in connection with any, other proceeding charging improper benefit to him/her, whether or not involving action in his/her official capacity, he/she was not adjudged liable on the basis that personal benefit improperly was received. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of *nolo contendere* or its equivalent, shall not, of itself, create a presumption that the applicant did not act in good faith and in a manner which he/she believed to be in, or not opposed to, the best interests of the Society, and, with respect to any criminal proceeding or action, that the person had no reasonable cause to believe that her/his conduct was unlawful. A person serves an employee benefit plan at the Society's request if his/her duties to the Society also impose duties on, or otherwise involve services by, him/her to the plan or to participants in or beneficiaries of the plan. A person's conduct with respect to an employee benefit plan for a purpose believed to be in the interests of the participants and beneficiaries of the plan is conduct that satisfies the requirements of this section.

Section 3. Expenses of Successful Defense. To the extent that the applicant has been successful on the merits or otherwise in the defense of any proceeding referred to in Section 2 of this Article, or in the defense of any claim, issue or matter therein, he/she shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred in connection therewith.

Section 4. Determination of Proprietary of Indemnification. Any indemnification under this Article (unless ordered by a court) shall be made by the Society only as authorized in the specific case upon a determination that indemnification of the applicant is proper in the circumstances because he/she has met the applicable standard of conduct set forth in this Article. Such determination shall be made either:

A. By the Board of Directors by a majority vote of a quorum consisting of Directors not at the time parties to the proceeding; or

B. If a quorum cannot be obtained under subsection (A) of this section, by majority vote of a committee duly designated by the Board of Directors (in which designation Directors who are parties may participate), consisting of two (2) or more Directors not at the time parties to the proceeding; or

C. By special legal counsel in a written opinion:

(i) Selected by the Board of Directors or its committee in the manner prescribed in subsection (A) or (B) of this section; or

(ii) If a quorum of the Board of Directors cannot be obtained under subsection (a) of this section and a committee cannot be designated under subsection (b) of this section, selected by majority vote of the full Board of Directors, in which selection Directors who are parties may participate; or

D. By the House of Delegates, but members of the House of Delegates who are Directors who are at the time parties to the proceeding may not vote on the determination.

Section 5. Expenses of Counsel. Authorization of indemnification and evaluation of the reasonableness of expenses shall be made in the same manner as the determination that indemnification is permissible, except that if the determination is made by special legal counsel, authorization of indemnification and evaluation of the reasonableness of expenses shall be made by those entitled under subsection C of this Section 4 above to select counsel.

A. The Society may pay or reimburse the reasonable expenses incurred by any applicant who is a party to a proceeding in advance of final disposition of the proceeding if:

(i) The applicant furnishes the Society a written statement of his/her good faith belief that he/she has met the standard of conduct described in Section 2;

(ii) The applicant furnishes the Society, a written undertaking, executed personally, or on his/her behalf, to repay the advance within a specified period of time if it is ultimately determined that he/she did not meet the standard of conduct; and

(iii) A determination is made that the facts then known to those making the determination would not preclude indemnification under this Article.

B. The undertaking required by paragraph (ii) of subsection (A) of this section shall be an unlimited general obligation of the applicant but need not be secured and may be accepted without reference to financial ability to make repayment.

C. Determinations and authorizations of payments under this section shall be made in the manner specified in Section 5.

Section 6. Authority to Indemnify. The Board of Directors is hereby authorized, by majority vote of a quorum of disinterested Directors, to cause the Society to indemnify, or contract in advance to indemnify, any person not specified in Section 2 of this Article who was or is a party to any proceeding, by reason of the fact that he/she is or was an agent of the Society, or is or was serving at the request of the Society as an employee or agent of another corporation, partnership, joint venture, trust, employee benefit plan or other enterprise, to the same extent as if such person were specified as one to whom indemnification is granted in Section 2. The provisions of Sections 3 through 5 of this Article shall be applicable to an indemnification provided hereafter pursuant to this Section 6.

Section 7. Insurance. The Society may purchase and maintain insurance to indemnify it against the whole or any portion of the liability assumed by it in accordance with this Article and may also procure insurance, in such amounts as the Board of Directors may determine, on behalf of any person who is or was a Director, officer, employee or agent of the Society, or is or was serving at the request of the Society, as a Director, officer, employee or agent of another corporation, partnership, joint venture, trust, employee benefit plan or other enterprise, against any liability, asserted against or incurred in an such capacity, whether or not the Society would have authority, to indemnify him/her against such liability under the provisions of this Article.

Section 8. References Included. Every reference herein to Directors, officers, committee members, employees or agents shall include former Directors, officers, committee members, employees and agents and their respective heirs, personal representatives, executors and administrators. The indemnification provided shall not be exclusive or any other rights to which any person may be entitled, including any right under policies of insurance that may be purchased and maintained by the Society or others, with respect to claims, issues or matters in relation to which the Society would not have the power to indemnify such person under the provisions

of this Article, but no individual shall be entitled to be indemnified more than once for the same claim and that credit will be given to the Society for any collateral source reimbursement.

Section 9. Limitation of Liability of Officers and Directors. To the extent permitted by Section 13.1-870.1 of the Code of Virginia, as it may be amended from time to time, or any successor provision to that Section, officer and Directors of the Society shall not be liable for actions or conduct in their capacity as officers and Directors of the Society.

ARTICLE XI COMMITTEES

Section 1. Power to Appoint. The President shall appoint committees and subcommittees, as he/she deems appropriate, as well as the chair of each committee or subcommittee. The chair of any committee shall have the privilege of the floor when reporting to the House of Delegates or in any incidental discussions. The President shall appoint one or more representative member(s) of the Virginia Medical Group Management Association, or any of its successor organizations, as a voting member of selected committees and subcommittees of the Society.

Section 2. Expenses. Actual expenses of members of any committee required to do official work between annual meetings may be paid upon the recommendation of the chair of such committee and the endorsement of the President, if presented within thirty (30) days after the meeting for which expenses are sought, provided budget allowance be made for such purpose. All unexpended balances of any fund authorized in the budget shall, on or before the end of each fiscal year, revert to the General Treasury.

Section 3. Authority. Except as otherwise provided in these Bylaws, members of committees shall serve at the pleasure of the President.

ARTICLE XII ETHICS

Section 1. Removal and Guiding Principles. The Principles of Medical Ethics governing the members of the American Medical Association or American Osteopathic Association Code of Ethics shall govern members of the Society. Any member whose license to practice medicine in Virginia has been revoked or suspended when such order becomes final by the Board of Medicine shall be deleted from membership in the Society.

ARTICLE XIII RULES OF ORDER

Section 1. Rules of Order. In all matters not covered by its bylaws, special rules of order, and standing rules, this organization shall be governed by the current edition of the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*.

ARTICLE ~~XIII~~-XIV AMENDMENTS

Section 1. Authority to Amend Bylaws. Bylaw amendments may be proposed by any member. Proposed amendments shall be submitted in writing through the Executive Vice President. The Bylaws Committee shall consider and make written recommendations for disposition of all properly proposed amendments in its report to the House of Delegates. Amendments made at the time of the annual meeting shall lay on the table at least twenty-four (24) hours before they may be considered for adoption and shall be handled in accordance with rules established by the House of Delegates in accordance with Article V, Section 2. All previous Bylaws of the Society are repealed when these Bylaws are adopted and put into effect.

Section 2. Vote to Amend Bylaws. These Bylaws shall be amended only by a two-thirds majority vote of the members of the House of Delegates present and shall be effective as of the vote or as provided for in the Resolution of the House of Delegates.

APPENDIX A

First District:

Hampton Medical Society; Mid-Tidewater Medical Society; Newport News Medical Society; Northern Neck Medical Association; Williamsburg-James City County Medical Society.

Second District:

Accomack County Medical Society; Chesapeake Medical Society; Norfolk Academy of Medicine; Northampton County Medical Society; Portsmouth Academy of Medicine; Tri-County Medical Society; Virginia Beach Medical Society; Eastern Virginia Medical School Student Section; orphan counties of Surry and Sussex.

Third District:

Richmond Academy of Medicine; Southside Virginia Medical Society; VCU Student Medical Association.

Fourth District:

Reserved

Fifth District:

Danville-Pittsylvania Academy of Medicine; Halifax County Medical Society; Patrick Henry Medical Society; Stuart Medical Society; Charlotte County Medical Society (inactive); orphan counties of Lunenburg and Mecklenburg.

Sixth District:

Allegheny-Bath Counties Medical Society; Bedford County Medical Society; Lynchburg Academy of Medicine; Roanoke Valley Academy of Medicine; Rockbridge County Medical Society; Amherst-Nelson County Medical Society (inactive).

Seventh District:

Albemarle County Medical Society; Augusta-Highland County Medical Society; Fauquier County Medical Society; James River Medical Society; Northern Virginia Medical Society; Rockingham County Medical Society; University of Virginia Student Medical Society; Culpeper County Medical Society (inactive); Louisa County Medical Society (inactive); Orange County Medical Society (inactive).

Eighth District:

Fredericksburg Area Medical Society; Prince William County Medical Society.

Ninth District:

Buchanan-Dickenson Counties Medical Society; Floyd County Medical Society; Lee County Medical Society; Southwestern Virginia Medical Society; Tazewell County Medical Society; Wise County Medical Society; Scott County Medical Society (inactive).

Tenth District:

Arlington County Medical Society; Medical Society of Northern Virginia.

Specialties:

[Allergy](#)
[Anesthesiology](#)
[Cardiology](#)
[Dermatology](#)
[Emergency Medicine](#)
[Family Practice](#)
[Gastroenterology](#)
[Internal Medicine](#)
[Neurological Surgery](#)

[Neurology](#)
[Obstetrics/Gynecology](#)
[Occupational & Environmental Medicine](#)
[Ophthalmology](#)
[Orthopaedic Surgery](#)
[Otolaryngology](#)
[Pathology](#)
[Pediatrics](#)

[Physical Medicine & Rehabilitation](#)
[Plastic Surgery](#)
[Preventive Medicine](#)
[Psychiatry](#)
[Radiology](#)
[Surgery](#)
[Thoracic Surgery](#)
[Urology](#)

Protecting Human Health in a Changing Climate

Submitted by Medical Society of Northern Virginia

- WHEREAS, a warming world poses significant risks to human health, from: extreme weather events; heat illness; air pollution; allergies; food and water contamination; infectious disease, and
- WHEREAS, these effects are felt disproportionately in vulnerable populations, including children, the elderly and the disadvantaged, and
- WHEREAS, United States Federal Agencies including the U.S. Global Change Research Program, Centers for Disease Control & Prevention (CDC)ⁱⁱ, the Department of Defense the National Institutes of Health and National Oceanic and Atmospheric Administration (NOAA)^v have issued reports and programs that address the health threats posed to humans by a changing climate, and
- WHEREAS, leading national medical organizations including the American College of Physicians, American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists, American Public Health Association, and others have published statements and resolutions recognizing the threat that the changing climate poses to human health and promoting physician engagement, and
- WHEREAS, the 2015 Lancet Commission on Health and Climate Change observes that the effects of climate change are being felt today, and future projections represent an unacceptably high and potentially catastrophic risk to human health, and
- WHEREAS, the Fifth Assessment of the United Nations Intergovernmental Panel on Climate Change, made up of over 2500 of the world's leading scientists, concludes, "Warming of the climate system is unequivocal, and since the 1950s, many of the observed changes are unprecedented over decades to millennia, and
- WHEREAS, the Fifth Assessment, as well as the National Aeronautics and Space Administration (NASA), NOAA, the American Academy for the Advancement of Science (AAAS) and 97% of publishing climate scientists concur that this warming is primarily a result of human generated greenhouse gas emissions, and
- WHEREAS, the American Medical Association, Resolution H-135.938 Global Climate Change and Human Health, supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that the anthropogenic contributions are significant, and
- WHEREAS, regions of coastal Virginia, some of which are sites of major military installations, are at high risk to sea level rise and storm surge associated with climate change, and
- WHEREAS, climate change is very likely affecting plant and animal species in Virginia, ultimately affecting the health, prosperity and quality of life of Virginians, and
- WHEREAS, reported cases of several vector-borne diseases, including Lyme Disease, Ehrlichiosis/Anaplasmosis and Spotted fever riskettsiosis, increased by 3-10 fold between 2005-2014 in Virginia, and
- WHEREAS, heat-related injury is a cause of illness and death in Virginians, therefore be it
- RESOLVED, that the Medical Society of Virginia supports the findings of leading U.S. and international scientific bodies that the Earth is undergoing adverse changes in the global climate and that anthropogenic contributions are the primary driver. These climate changes create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor, and be it further
- RESOLVED, supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as sea level rise, population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and be it further

- RESOLVED, recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change through reduced greenhouse gas emissions to protect the health of the public and encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability, and be it further
- RESOLVED, encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort, and be it further
- RESOLVED, supports epidemiological, translational, clinical and basic science research necessary for evidence based global climate change policy decisions related to health care and treatment.

Staff Analysis – Resolution 16-201: Protecting Human Health in a Changing Climate.

Submitted by the Medical Society of Northern Virginia

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<ul style="list-style-type: none"> Evidence suggests that global climate change poses a number of significant risks to human health, including but not limited to: extreme weather events; heat illness; air pollution; allergies; food and water contamination; and infectious disease. A number of national medical organizations, including the AMA, the ACP, and the AAP have adopted policies recognizing the threat of climate change and promoting physician engagement, education and advocacy. This resolution supports the findings of U.S. and international scientific bodies, and encourages physician involvement in policymaking related to climate change at the state, national and global level. 	<p>Raise the perceived value of physicians</p> <p>Empower physicians to manage change</p>	<p>135.001 - Repeal of EPA Requirements on Medical Waste</p>	<p>Benefits:</p> <ul style="list-style-type: none"> Aligns MSV policy with the climate change policies of the AMA and other national/state associations Supports educating the medical community on the adverse public health effects of global climate change Encourages collaboration between physicians and health departments to strengthen public health infrastructure <p>Drawbacks:</p> <ul style="list-style-type: none"> Politically contentious Encourages physicians to assist in educating patients on environmentally sustainable practices <ul style="list-style-type: none"> This activity is not a part of traditional physician responsibilities, and may be better suited for other health professionals 	<p><u>NOT ADOPT</u></p> <ul style="list-style-type: none"> Climate change is a national issue, and is therefore unlikely to be addressed by state-level legislation or regulation. National organizations, including the American Medical Association, have adopted climate change policies in recent years. This resolution is nearly identical to AMA policy H-135.938, which was adopted by the organization in 2008 and reaffirmed in 2014.

Medical Practitioner Drug Addiction Guidelines**Submitted by 2nd District, Edilberto O. Pelausa MD, FACS**

- WHEREAS, there has been a deluge of information regarding the opioid addiction epidemic affecting our country and our patients, and
- WHEREAS, the CDC has created guidelines in prescribing opioid medication to patients, and
- WHEREAS, prescription drug/opioid overdose deaths are now exceeding car crash deaths in some age groups - 20,000 Americans now die from this yearly, and
- WHEREAS, there is little attention being paid to a population at higher risk for drug/opioid addiction such as physicians and other healthcare givers who have easier access and the financial resources to buy drugs and the social status to avoid suspicion, and
- WHEREAS, there is little data as to the severity of this drug/opioid addiction problem affecting physicians and other healthcare providers, therefore be it
- RESOLVED, that the MSV create a study group/subcommittee to study this problem of drug/opioid abuse among physicians and healthcare provider, gathering more information, and be it further
- RESOLVED, that the MSV recommend guidelines for its members and the medical community on how to handle the issue of suspected or known medical practitioner drug addiction, and be it further
- RESOLVED, that the MSV coordinate with the Virginia Board of Medicine and the state legal system on therapeutic interventions, rehabilitation and medical licensure/practice restrictions to help addicted practitioners.

Staff Analysis – Resolution 16-202: Medical Practitioner Drug Addiction Guidelines.

Submitted by Dr. Edilberto O. Pelausa MD, FACS (2nd District)

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>Physician Addiction:</p> <ul style="list-style-type: none"> Medical practitioners may be at a higher risk for drug/opioid addiction due to easier access, financial resources, and social status to avoid suspicion 10% to 12% of physicians develop a substance abuse disorder, which is a rate similar to or even exceeding that of the general population There is often a delay in diagnosis due to fear of professional repercussions and loss of social status Opioid abuse represents 35% of the primary drugs of abuse by physicians <p>Current Law:</p> <ul style="list-style-type: none"> The Virginia Department of Health Professions has an established disciplinary process for licensed health professionals, which includes a complaint process related to substance abuse issues. The appropriate health regulatory Board reviews the case and oversees disciplinary proceedings. Boards are authorized to take disciplinary actions, including suspending or revoking a license. In Virginia, practitioners who meet certain criteria may receive approval for a stay of disciplinary action by participating in the Health Practitioners' Monitoring Program (HPMP). Requests for stayed disciplinary action are reviewed by a designated board liaison, with the final decision being made by the Monitoring Program Committee. 	<p>Raise the perceived value of physicians</p>	<p>No relevant policies</p>	<p>Benefits:</p> <ul style="list-style-type: none"> The physician community will gain clarity on existing processes to report suspected medical practitioner drug addiction. This will lead to an improved professional environment for physicians and a safer environment for patients as physicians experiencing drug addiction are identified and receive treatment. <p>Drawbacks:</p> <ul style="list-style-type: none"> Physicians who fear penalty may attempt to hide their addiction from peers, delaying identification and treatment. New licensure/practice restrictions may duplicate the Virginia Board of Medicine's established disciplinary process. Similarly, new therapeutic interventions and rehabilitation efforts may duplicate the existing Health Practitioners' Monitoring Program. 	<p><u>AMEND AND ADOPT</u></p> <ul style="list-style-type: none"> The proposed workgroup provides a process for the MSV to gain clarity around the prevalence of drug addiction among physicians. Creating guidelines to handle the issue of suspected or known drug addiction would clarify existing processes and best practices to encourage reporting. Staff recommends amending by striking the third resolved clause until more information about the gaps in existing processes is gathered by the proposed workgroup.

Opioid history: From 'wonder drug' to abuse epidemic

By Sonia Moghe, CNN

Updated 1:31 PM ET, Thu May 12, 2016

(CNN) The abuse of opioids, including prescription painkillers and drugs like heroin, is something the United States has struggled with since before the 1900s. But it's a problem that keeps coming back.

Now, federal agencies are trying to tackle the problem in different ways. The Centers for Disease Control and Prevention recently issued guidelines for prescribing opioids for chronic pain, part of an effort to push doctors to prescribe pain medications responsibly. The U.S. Food and Drug Administration announced that immediate-release opioid painkillers such as oxycodone and fentanyl will now have to carry [a "black box" warning](#) about the risk of abuse, addiction, overdose and death.

To understand how we got to this current epidemic, let's take a look back.

Early 1900s: Morphine and the creation of pain management

Civil War veterans whose injuries were treated with morphine were among those hooked on opioids at the turn of the century. But "drugs were already on the scene and being consumed at alarming rates long before the start of the war," said Mark A. Quinones, a scholar who studied drug abuse during the Civil War.

In 1898, the Bayer Co. started production of another opioid, heroin, on a commercial scale. From its first clinical trials, it was considered a "wonder drug," and its use spread as addicts discovered that its effects could be amplified by injecting it.

Prescription addiction: Doctors must lead us out

Kimberly Johnson, director of the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration, said that in the early 1900s, there wasn't much known about these poppy derivatives. Drugs like heroin were used as cough suppressants.

"They are effective pain relievers, and that's what they were being used for," Johnson said. "There weren't many other options."

In 1914, the Harrison Narcotics Tax Act imposed a tax on those making, importing or selling any derivative of opium or coca leaves. By the 1920s, doctors were aware of the highly addictive nature of opioids and tried to avoid treating patients with them. Heroin became illegal in 1924.

World War II was a turning point for physicians treating pain as doctors worked to treat severely injured soldiers. Anesthesiologists opened "nerve block clinics" in the 1950s and

1960s to manage pain without having to resort to surgery, according to [a history published in the Journal of the American Medical Association in 2003](#).

1970s, '80s and early '90s: A change in thought

Drug use in the United States escalated so much in the 1970s that President Gerald Ford set up a task force to study the problem. It recommended that the Drug Enforcement Administration and the Customs Service focus less on intercepting marijuana and cocaine traffickers and more on heroin.

By the mid- and late-1970s, when Percocet and Vicodin came on the market, doctors had long been taught to avoid prescribing highly addictive opioids to patients.

Should you tough out pain or take painkillers?

But an 11-line letter printed in the New England Journal of Medicine in January 1980 pushed back on the popular thought that using opioids to treat chronic pain was risky. In it, Jane Porter and Dr. Hershel Jick mentioned their analysis of 11,882 patients who were treated with narcotics. They wrote that "the development of addiction is rare in medical patients with no history of addiction."

Jick told the Washington Post in 1977 that less than [1% of patients he studied](#) died from a reaction to the drugs: "I think very serious adverse reactions are about as infrequent as one could possibly expect given the enormous amount of exposure to drugs."

Patients with terminal illnesses started being treated more with prescription opioids, and doctors and researchers wanted to look at treating patients with chronic pain.

Six years later, a paper by pain-management specialist Dr. Russell Portenoy [chronicled 38 patients](#) treated with opioids for non-cancer pain. Two of them had issues with addiction to the drug, but he concluded that "opioid maintenance therapy can be a safe, salutary and more humane alternative" to surgery or to not treating a patient with chronic pain.

The studies by Portenoy and others created a discussion in the '90s around making pain treatment a priority for all patients. Johnson, of the Center for Substance Abuse Treatment, said that after a heroin epidemic in the 1970s, doctors were concerned about abuse of opioids in the '80s, but things started to shift in the '90s.

"People started talking about pain as the fifth vital sign," Johnson said. "There was a real push to do a better job of treating pain."

1996: The birth of OxyContin

Purdue Pharma started testing OxyContin as a long-term painkiller in 1994, and it went on the market in 1996.

In the early '90s, the number of painkiller prescriptions filled at U.S. pharmacies increased by 2 million to 3 million each year, according to a [National Institute on Drug Abuse study](#). From 1995 to 1996, the number of prescriptions jumped by 8 million.

In 1998, Purdue Pharma created a video promotion called "I Got My Life Back." It followed six people who suffered from chronic pain and were treated with OxyContin. [The company](#)

[distributed](#) (PDF) 15,000 copies of the video to be used in in "physician waiting rooms as a 'check out' item for an office's patient education library."

"They don't wear out; they go on working; they do not have serious medical side effects," a doctor featured in the video said. "So, these drugs, which I repeat, are our best, strongest pain medications, should be used much more than they are for patients in pain."

A year after the video came out, the overall number of opioid painkiller prescriptions filled jumped by 11 million.

Purdue Pharma took out ads for OxyContin in medical journals across the nation in 2000. Seven years later, the company and three of its executives would be charged with misbranding its drug and downplaying the possibility of addiction. Three executives pleaded guilty, and the company settled with the U.S. government for \$635 million.

A spokeswoman for Purdue Pharma said that the company's products represent "less than 2% of all opioid prescriptions" and that Purdue has led the industry in creating medicines with abuse-deterrent properties.

"Opioid abuse and addiction is one of our top national health challenges, and that's why for more than a decade Purdue Pharma has undertaken efforts to help address this crisis," the company said in a statement.

2001: A new standard

Making pain treatment a priority came to the attention of the Joint Commission, a nonprofit that sets standards and accredits hospitals and medical centers.

The group created this standard in 2001: "Pain is assessed in all patients." Medical centers and their doctors were required to examine their patients' pain levels -- and the Joint Commission would give hospitals "requirements for Improvement" if they failed to meet this standard.

Though the standard makes no mention of treating pain with drugs or even mentioning opioids as a treatment, the Joint Commission printed a book in 2000 for purchase by doctors as part of required continuing education seminars. The book cited studies that claimed "there is no evidence that addiction is a significant issue when persons are given opioids for pain control." It also called doctors' concerns about addiction side effects "inaccurate and exaggerated." The book was sponsored by Purdue Pharma.

Dr. David W. Baker, the Joint Commission's executive vice president for health care quality evaluation, said the information was sourced with conventional wisdom among pain experts at the time.

"There is no doubt that the widely held belief that short-term use of opioids had low risk of addiction was an important contributor to inappropriate prescribing patterns for opioids and the subsequent opioid epidemic," Baker said in an emailed statement. "The Joint Commission was one of the dozens of individual authors and organizations that developed educational materials for pain management that propagated this erroneous information."

The Joint Commission removed its standard to assess pain in all patients in 2009.

August 2010: From pills to heroin

The makers of OxyContin released a newly formulated version of the drug -- one with an "abuse deterrent" -- with the hope of making it more difficult to crush and abuse by snorting or injecting it.

A [study published in the New England Journal of Medicine](#) surveyed more than 2,500 people who used OxyContin before and after safety measures were added. It found that before the anti-abuse measures were put in place, 35.6% of people questioned admitted abusing the drug. Nearly two years after the deterrent was added, that number dropped to 12.8%. But 24% of those surveyed still found a way defeat the tamper-resistant properties of the medicine.

Opioids and overdoses: 4 things to know

"Most people that I know don't use OxyContin to get high anymore," one opioid user said in the study. "They have moved on to heroin [because] it is easier to use, much cheaper and easily available."

The study also showed that 66% of those surveyed switched to other opioids. Still, makers of some of the other opioid drugs on the market maintain that their products are safe.

Endo Pharmaceuticals, the maker of Percocet, said pain medications still play an important role in treating more than 100 million Americans suffering from chronic pain.

"We manufacture and develop high-quality products that are safe and effective when used as prescribed by physicians," a spokesman said in an emailed statement.

2011: 'If I had an inkling of what I know now ... '

Portenoy, the doctor who wrote one of several studies that claimed there was little risk of addiction in using opioids to treat chronic pain, spoke out about his own role in the epidemic.

"What I was trying to do was create a narrative so that the primary care audience would ... feel more comfortable about opioids in a way they hadn't before. In essence, this was education to destigmatize, and because the primary goal was to destigmatize, we often left evidence behind," Portenoy said.

"Clearly if I had an inkling of what I know now then, I wouldn't have spoken in the way that I spoke. It was clearly the wrong thing to do."

March 2016: 'We know of no other medication ... that kills patients so frequently'

The FDA and CDC have started taking steps to address the opioid abuse epidemic. In March, CDC Director Dr. Tom Frieden wrote in the New England Journal of Medicine that there still aren't enough data about long-term use of prescription opioids.

But, he wrote, "We know of no other medication routinely used for a nonfatal condition that kills patients so frequently."

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He shared some information gathered from studies on prescription opioids used to treat pain long-term:

- Most trials have lasted six weeks or less, and the few that have been longer had "consistently poor results." In fact, several studies have showed that use of opioids for chronic pain may actually worsen pain and functioning, possibly by increasing pain perception.
- Opioid dependence may be as high as 26% for patients using opioids for chronic non-cancer pain.
- One out of every 550 patients started on opioid therapy died of opioid-related causes a median of 2.6 years after their first opioid prescription.

Treatment of Dying Patients

Submitted by 2nd District, Edilberto O. Pelausa MD, FACS

WHEREAS, medical schools are not preparing present and future physicians adequately to deal with the issue of dying patients, and

WHEREAS, dying patients are being aggressively treated even with obviously hopeless conditions, therefore be it

RESOLVED, that the MSV encourage medical schools, post-graduate specialty programs, and all physicians of Virginia to improve their “at end of life” training, and be it further

RESOLVED, that the MSV encourage universal use of ‘Advance Care Plans’ such as “Living Wills” in Virginia so that every patient expresses his or her wishes for care in end of life decisions.

Staff Analysis – Resolution 16-203: Treatment of Dying Patients.

Submitted by 2nd District; Edilberto O. Pelausa MD, FACS

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>This resolution calls for MSV to encourage the use of advanced care plans and calls for additional training on end of life care in medical schools and residency programs.</p> <p><u>End of Life Training</u></p> <ul style="list-style-type: none"> The Institute of Medicine (IOM) recommends training in basic palliative care for all physicians caring for patients close to end of life, as well as additional specialty-specific training. Trainings should occur both as part of the medical school curriculum and in the form of continuing education. <p><u>Advance Directives</u></p> <ul style="list-style-type: none"> Existing MSV policy, 130.017, supports the Physician Orders for Scope of Treatment (POST) form as a uniform, portable and legal document A POST form is not a living will, but instead supports the living will as a document that is readily accessible by the physician Advance Directives, including living wills, are not required in Virginia (Va. Code §54.1-2983) MSV participates as a representative to the Virginia POST Collaborative and RAM's Honoring Choices program. 	<p>Raise the perceived value of physicians</p>	<p>130.017 – Advocacy for Physician Orders for Scope of Treatment</p> <p>130.002 – Do Not Resuscitate Orders – Hospital Policies</p>	<p>Benefits:</p> <ul style="list-style-type: none"> By providing improved end of life training, physicians will be better equipped to have difficult yet important conversations with patients to establish treatment expectations Patients will benefit from having all information about treatment options By encouraging universal use of Advance Care Plans, both physicians and patients will gain clarity regarding expectations for end of life care Does not mandate training, but encourages additional education. <p>Drawbacks:</p> <ul style="list-style-type: none"> As Advance Directives are currently not required by Virginia Law, it may be challenging to accomplish universal adherence 	<p><u>ADOPT</u></p> <ul style="list-style-type: none"> Improved and expanded access to end of life training will enable more meaningful conversations with patients regarding treatment options and setting expectations. Encouraging universal use of Advance Care Plans, such as Living Wills, will provide patients the opportunity to express their wishes for end of life care and give physicians a concrete understanding of the patient's decision prior to a health event.

The family said, “Do everything.”

DEBBIE MOORE-BLACK, RN / CONDITIONS | JULY 27, 2016

They said, “Do everything.”

She knew something was wrong. And by the time she was 85 she had forgotten the names of her children, the town she raised them in, even the name of her deceased husband. In her 70s she was diagnosed with Alzheimer’s. Still coherent, she talked to her physician about becoming a DNR: do not resuscitate. She did not want to live on a machine that would breathe for her and she did not want CPR on her chest. She just wanted to go “home” peacefully; to go home to her Lord.

Instead of entering a nursing home, her son demanded on taking his momma home to live with him. So in her late 80s, she became more despondent, unable to talk, unable to feed herself, unable to go to the bathroom. And her son, who couldn’t wait to take care of her in his home, slowly, ignored all of her basic needs. He’d quietly shut her bedroom door. Johnny had to work. And Johnny had to play. He was too busy to turn her, too busy to clean her, too busy to feed her. And after two years in his home, sweet Mrs. Sally became contractured, bed-ridden and riddled with decubitus ulcers. A neighbor caught wind of potential neglect of Mrs. Sally and notified social services.

When social services arrived, they found Mrs. Sally lying in feces and urine, malnourished and her body cover in decubitus ulcers. Everywhere. Within due time, social services strongly encouraged Johnny to admit his mother to a nursing home.

Mrs. Sally arrived at the nursing home. Unable to eat, unable to talk, unable to walk, and her skeletal body lay in bed with permanent contractures.

Mrs. Sally was ready to die. Her DNR status was current, and the nursing staff gave her the best tender loving care possible. They made Mrs. Sally comfortable, as best they could. They held her hand and talked to her and cleaned her up. But Mrs. Sally never responded. Within a few months, Mrs. Sally showed more signs of deterioration. And one night, her breaths were so shallow, and her pulse was irregular and thready, that the nursing home thought she was dying. The staff made her as comfortable as possible and called the son to let him know that his momma was dying.

Johnny wasn’t ready to see his momma die, and told the nursing home staff to call 911 and send her to the ER. The staff reminded Johnny that his mom was a DNR. Johnny said, “bring her in.”

And so, the EMTs and paramedics arrived at the nursing home to take Mrs. Sally into the hospital. Since Mrs. Sally was now unresponsive, and unable to talk or to make any decisions about her DNR that she signed herself, Johnny was able to rescind the DNR.

And upon arrival to the ER, Johnny and his sisters burst through the ER doors screaming, “Do everything!”

Upon admittance to the emergency department, Mrs. Sally had a thready pulse and gasping respirations, sometimes agonal. Within minutes, a code blue was called overhead in the ER. Mrs. Sally lost her pulse, she was straight lining and had no respirations.

And against our morals, against our compassion, against our need to have dignity to this little lady and her last days on earth, we presented her with rapid CPR compressions; we felt her tiny ribs crunch and break, and her heart rate speed up to a chaotic fibrillation. Ventricular fibrillation is announced by the ER nurse, and she screams, “all clear,” as we force an electrical current through her heart. And we watch her have seizures and loss of oxygen to her brain and leave her with a faint thready pulse and too much time for no oxygen to her brain. And she “survives” these insults that we forced upon her, leaving an anoxic brain in her contracted body.

And the family is pleased: “Praise be, she’ll live to be 100.”

And we, the EMTs, the doctors, the ER nurses and the ICU nurses, bow our heads, because we know we brought torment and pain and assault to this tiny, malnourished lady, who once had a vibrant life. Who once had a full life, but slipped into the tunnel of dying. Almost peacefully, until her family forced us nurses, us EMT and paramedics, us doctors to bring her back. And instead of Mrs. Sally going to her heaven, instead of being in her heaven, and resting in peace forever, We condemned her to a living hell.

Prepare your moms and dads and grandmoms and grandpas and allow them to drift peacefully into that other world.

It is not heaven on earth. It is a hatred left here on earth. A hatred that is hell-bent.

Two days later, Mrs. Sally died on a ventilator in the ICU. We were unable to bring her back.

And her family that said, “Do everything,” was nowhere to be found. Her nurse held her hand, as Mrs. Sally died, on the ventilator with a bruised chest and fractured ribs from her CPR.

If your loved one has reached an end-stage of life, do the right thing. Let them die peacefully.

Debbie Moore-Black is a nurse who blogs at [Do Not Resuscitate](#).

Image credit: [Shutterstock.com](#)

TAGGED AS: PALLIATIVE CARE

Physician oversight of medical services in the school setting

Submitted by Cynthia DiLaura Devore, M.D., F.A.A.P.

- WHEREAS, over a million children spend roughly seven hours daily for 180 days annually in schools, and many of these children have special health care needs requiring medical management during the school day, and
- WHEREAS, schools are required by various laws, such as but not limited to Individuals with Disabilities Education Act (IDEA), to provide health services within schools to allow all children, including, but not limited to those with special health care needs, to obtain “a free and appropriate education” in a safe and “least restrictive” setting, and
- WHEREAS, physicians are trained as leaders and medical experts to oversee medical aspects of programs schools generally provide, such as, but not limited to athletic programs with potential medical risks to student athletes, the public health, safety, and welfare of the entire school community in infectious disease outbreaks, Public Access Defibrillator Programs, emergency medical sites for widespread community disasters, as well as daily and emergency care and medication delivery systems, and
- WHEREAS, licensed practical nurses or professional registered nurses do not have the training or expertise of a licensed board certified physician to oversee broader school health issues in school divisions independently of a physician; and
- WHEREAS, the American Academy of Pediatrics and the American Medical Association support that a physician with expertise in the care of children oversee all health services programs involving children and adolescents in schools, therefore be it
- RESOLVED, the Medical Society of Virginia recognizes it is within the scope of practice of a licensed physician to oversee health programs in school divisions, and further advocates that the Commonwealth of Virginia require that each school division has a licensed, registered physician (MD or DO), ideally a board certified pediatrician or family practitioner, to oversee all health and safety aspects of all school health services programs.

Staff Analysis – Resolution 16-204: Physician Oversight of Medical Services in the School Setting.

Submitted by Dr. Cynthia Devore

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>This resolution supports legislation that would require each school division to have a registered physician, ideally a board certified pediatrician or family practitioner, to oversee all health and safety aspects of all school health services programs.</p> <p>Current Law:</p> <p>Va. Code § 22.1-274 states: “A school board may employ school nurses, physicians, physical therapists, occupational therapists, and speech therapists... Subject to the approval of the appropriate local governing body, a local health department may provide personnel for health services for the school division.”</p> <p>Va. Code § 22.1-253.13:2(O) states: “Each local school board shall provide those support services that are necessary for the efficient and cost-effective operation and maintenance of its public schools... Student support positions, including...(3)(v) health and behavioral positions, including school nurses and school psychologists”</p>	<p>Raise the perceived value of physicians</p>	<p>60.009 – In-school Health Services (Adopted in 1992)</p> <p>MSV supports legislation requiring that every school division in Virginia be required to have a formal relationship with a specific physician for supervision of school nursing services and for arranging specialty consultation as necessary.</p>	<p>Benefits:</p> <ul style="list-style-type: none"> • Could provide new employment opportunities for pediatricians and family practitioners. <p>Drawbacks:</p> <ul style="list-style-type: none"> • Could have a disproportionate financial impact on small and/or rural school divisions. • There may not be enough work available to justify the cost of employing physicians. • Mandates physician employment relationships. 	<p><u>NOT ADOPT</u></p> <ul style="list-style-type: none"> • Current Virginia law allows individual school districts to employ physicians and other health professionals. • Physicians can have a professional relationship with schools in many ways, such as a full- or part-time employee, an independent contractor, or a volunteer on a school health advisory group.

Registered professional nurse care in the school setting**Submitted by Cynthia DiLaura Devore, M.D., F.A.A.P.**

- WHEREAS, over a million children spend roughly seven hours daily for 180 days annually in schools, and many of these children have special health care needs requiring medical management during the school day, and
- WHEREAS, schools are required by various laws, such as but not limited to Individuals with Disabilities Education Act (IDEA), to provide health services within schools to allow all children, including, but not limited to those with special health care needs, to obtain “a free and appropriate education” in a safe and “least restrictive” setting, and
- WHEREAS, registered professional nurses are trained to provide direct nursing assessment, as well as routine and emergency care to children and adolescents before during and after school, as well as to manage the public health, safety, and welfare of the entire school community in infectious disease outbreaks according to the medical regimen prescribed by a licensed physician or other licensed prescriber, including, but not limited to anaphylaxis management, concussion care management, Public Access Defibrillator Programs, emergency medical sites for widespread community disasters, as well as daily and emergency care and medication delivery systems, and
- WHEREAS, the American Academy of Pediatrics and the National Association of School Nurses support that a registered professional nurse with expertise in the care of children should be in every school building at ratios consistent with those recommended by the National Association of School Nurses to oversee direct health care involving children and adolescents in schools, therefore be it
- RESOLVED, the Medical Society of Virginia recognizes it is within the scope of practice of a registered professional nurse to serve as a school nurse, and further advocates that the Commonwealth of Virginia require that each school division has sufficient nursing coverage to ensure the health and safety aspects of children and adolescents attending schools in the Commonwealth of Virginia in every school at ratios consistent with the recommendations of the National Association of School Nurses.

Staff Analysis – Resolution 16-205: Registered Professional Nurse Care in the School Setting.

Submitted by Dr. Cynthia Devore

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<ul style="list-style-type: none"> This resolution supports legislation that would require each school division to have sufficient nursing coverage at ratios consistent with the recommendations of the National Association of School Nurses (NASN). Current Law does not mandate the NASN ratios. Va. Code § 22.1-274(B) states that each school board may strive to employ, or contract with local health departments for, nursing services consistent with a ratio of at least one nurse: <ul style="list-style-type: none"> (i) per 2,500 students by July 1, 1996; (ii) per 2,000 students by July 1, 1997; (iii) per 1,500 students by July 1, 1998; and (iv) per 1,000 students by July 1, 1999. 	<p>Raise the perceived value of physicians</p>	<p>60.009 – In-school Health Services (Adopted 1992)</p> <ul style="list-style-type: none"> MSV supports legislation requiring that every school division in Virginia employ or contract through the Health Department for registered nurses, at an appropriate staffing level. <p>60.012 – School Nurse Shortage (Adopted 1997)</p> <ul style="list-style-type: none"> MSV supports the HHS recommendations for nurse-to-student ratios and encourages every system to meet or exceed these recommendations. 	<p>Benefits:</p> <ul style="list-style-type: none"> Appropriate school nurse staffing is related to better student attendance and academic success. Studies suggest that the benefits of full-time registered nurse in every school may well exceed the costs of those services. <p>Drawbacks:</p> <ul style="list-style-type: none"> Could have a disproportionate financial impact on small and/or rural school divisions. 	<p><u>NOT ADOPT</u></p> <ul style="list-style-type: none"> The current nurse-to-student ratio in Virginia is 1:873 which exceeds the NASN and HHS recommended ratios. HHS recommends a ratio of 1:750. NASN, the organizations cited in the proposed resolution, recommends the following ratios: <ul style="list-style-type: none"> 1:750 WELL students 1:225 in the student populations that may require daily professional school nursing services 1:125 in student populations with complex health care needs 1:1 may be necessary for individual students with multiple disabilities

Resolution for physician participation in efforts to control increased healthcare costs**Submitted by the Richmond Academy of Medicine**

- WHEREAS, the total cost of health care in Virginia and in our nation is now higher than all other developed nations due, undoubtedly, to what are probably excessive charges for some aspects of care, and
- WHEREAS, charges leading to these increased costs are primarily from charges for products and services other than those from physicians such as pharmaceuticals, equipment, all forms of testing including radiology as well as other services, and
- WHEREAS, the relationship of some of these charges for products and services to the actual cost of providing them is not now publicly known, and
- WHEREAS, these increasing charges have led to an increasing burden on patients and/or the increase in cost of health insurance coverage for both patients and employers, and
- WHEREAS, physicians participating in organized medicine are in an ideal position to effect some cost containment for such services by lobbying efforts at legislatures at both the state and national level, therefore be it
- RESOLVED, the Medical Society of Virginia will support legislative efforts to increase transparency for charges that do not relate directly to the provision of health care.

Staff Analysis – Resolution 16-206: Resolution for Physician Participation in Efforts to Control Increased Health Care Costs.

Submitted by the Richmond Academy of Medicine

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<ul style="list-style-type: none"> During the 2016 General Assembly session, HB 1113 and SB487 were introduced to increase prescription drug price transparency. Both were carried over to the 2017 session. Virginia Code § 32.1-137.05. Advance disclosure of charge for elective procedure, test, or service requires hospitals to provide, upon request, patients with an estimate of the payment for which the patient will be responsible. Virginia has implemented an all-payer claims database (APCD) Despite efforts by many states, including Virginia, to introduce drug cost transparency bills, only Vermont has succeeded in passing legislation. AMA has numerous policies that support price transparency. <ul style="list-style-type: none"> D-155.987– Price Transparency D-155.990 – Responsibility for Transparency H-450.938 – Value-Based Decision-Making in the Health Care System 	<p>Raise the perceived value of physicians</p> <p>Empower physicians to manage change</p>	<p>155.001 – Truth in Virginia Health Care Database</p> <p>165.021 – Guidelines for Health Care System Reform (excerpt)</p>	<p>Benefits:</p> <ul style="list-style-type: none"> As health care plans continue to shift toward high deductible benefit structures, patients are responsible for an increasing portion of out of pocket costs. Price transparency prior to procedures would enable patients to make well-informed decisions that consider cost. Price transparency would better enable physicians to consider the treatment cost. <p>Drawbacks:</p> <ul style="list-style-type: none"> Any legislation aimed at health care cost transparency opens the door for cost transparency legislation regarding physicians. Healthcare costs include negotiated pricing components that are protected as proprietary information and by antitrust laws. Literature suggests that price transparency laws may not have a direct effect on price reduction. The pharmaceutical industry has initiated successful campaigns against drug pricing transparency legislation in other states. Support for such legislation would require a vast mobilization of political and financial resources. 	<p><u>NOT ADOPT</u></p> <ul style="list-style-type: none"> Health care cost transparency is a complicated issue that encompasses a wide variety of health care products and services, each of which require specific considerations for analysis. As this resolution calls for a blanket support for any cost transparency legislation, the MSV staff recommends not adopting at this time to allow for separate evaluations of each introduced legislative bill for merits.

Resolution to Provide Education to Patients Regarding Ionizing Radiation from Medical Procedures

Submitted by the Richmond Academy of Medicine

- WHEREAS, there have been significant advances in radiologic imaging which have greatly enhanced our ability to diagnose and monitor disease, and
- WHEREAS, these imaging modalities are widely available and widely used, and
- WHEREAS, there are safety concerns, particularly the 600% increase in medical radiation exposure in the US since 1980 (according to American Cancer Society), and
- WHEREAS, most of this increase is from these diagnostic procedures, and
- WHEREAS, ionizing radiation is clearly linked to human carcinogenesis and the risk has a definite relationship to accumulated dosage, and
- WHEREAS, alerting our patient population to these safety concerns may be more successful than our earlier attempts to alert Virginia Physicians through MSV electronic communications that had limited impact on the possible overuse and duplication of such studies, therefore be it
- RESOLVED, that the MSV encourage and facilitate the voluntary distribution of information from the American College of Radiology on radiation safety concerns to patients in radiology waiting areas in Virginia using educational brochures similar to or the same as those now being employed by the VCU Health System.

Staff Analysis – Resolution 16-207: Resolution to Provide Education to Patients Regarding Ionizing Radiation from Medical Treatment.

Submitted by the Richmond Academy of Medicine

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>Proposal:</p> <ul style="list-style-type: none"> This resolution calls for MSV to encourage and facilitate the voluntary distribution of information from the American College of Radiology on radiation safety concerns to patients in radiology waiting areas in Virginia using educational brochures similar to or the same as those now being employed by the VCU Health System. <p>Issues:</p> <ul style="list-style-type: none"> Repeated exposure to the levels of ionized radiation present in diagnostic imaging tests presents a health risk to patients. When conducted sparingly and only when medically necessary, diagnostic imaging tests benefit patients and present only a limited risk. A previous effort by MSV to distribute information directly to physicians had a limited effect on reducing unwarranted imaging tests. 	<p>Raise the perceived value of physicians</p>	<p>455.001 – Radiation Control; Needless Exposure:</p> <p>MSV supports methods and practices of radiation control that will reduce needless exposure of patients and workers to ionizing radiation.</p>	<p>Benefits:</p> <ul style="list-style-type: none"> Provision of safety information to patients may increase patient participation in healthcare decisions and reduce unnecessary exposure to ionized radiation. May increase patients' trust that their physician is considering their best interest. Patients may decide against clinically sound diagnostic tests due to an unfounded safety concern. <p>Drawbacks:</p> <ul style="list-style-type: none"> None. 	<p><u>ADOPT</u></p> <ul style="list-style-type: none"> Increase patient awareness of potential risks and improve the perceived value of physicians by increasing trust.

Safety First

The Department of Radiology is a leader in radiation safety for patients. The Department's strong and comprehensive Radiation Safety Program is unmatched anywhere in the area. The Department is committed to obtaining quality images while minimizing the risk of radiation exposure to patients whenever and wherever possible.

What you need to know

Radiologic imaging plays a major role in patient care by helping provide early and concise diagnosis of disease, improved treatment planning and image-guided therapies that help save lives every day.

Although there may be a small risk from radiation exposure from most forms of radiologic imaging, **the medical benefits of having a needed examination far outweigh the risk.** Many of these x-ray examinations have been safely used in medicine for over a century. Conventional x-rays, CT scans, fluoroscopy, mammography and nuclear medicine are examples of studies which involve the use of ionizing radiation. (Ultrasound utilizes high frequency sound waves and MRI utilizes radiofrequency waves and magnetic fields).

There is some small increased risk of developing some forms of cancer in individuals exposed to **very high** doses of radiation; however, the amount of radiation used in most x-ray examinations is **very low** and poses a negligible risk of causing cancer.

Pregnancy & Medical Imaging

Your safety and the safety of your unborn child is our top priority. If you are pregnant or think that you may be pregnant, please inform your radiologic technologist before your examination. As a precaution, we ask all females ages 12-50 about their pregnancy status.

Comparative Risks

Did you know...?

We are all exposed to radiation from natural sources all the time. The average person in the US receives a dose of 3.1 mSV* per year from naturally occurring sources (varies by location).⁴

Natural sources include:

- ◆ cosmic rays from the sun and outer space
- ◆ exposure to radioactivity in rocks, soil and building materials
- ◆ exposure to radon gas

The risk of radiation exposure from radiologic imaging examinations should be kept in perspective and compared to exposure from naturally-occurring radiation and to risks related to other activities of daily life.



Clinical Radiation Safety Office

Our radiation safety program includes:

- Full accreditation of all services (*where applicable*) and equipment by the American College of Radiology (ACR)¹
- Use of low-dose CT techniques for all patients
- State-of-the-art equipment to minimize radiation exposure
- Utilization of "Image Gently"² techniques for pediatric patients and "Image Wisely"³ techniques for adult patients.
- Utilization of gonadal shielding and thyroid shielding as indicated
- Onsite radiation physicists with regular monitoring of equipment to ensure safe use.

Radiation Exposures from Common X-ray Examinations

Procedure	*Adult approximate effective radiation dose	Compared to natural background radiation received over:	Additional Lifetime risk of fatal cancer from examination
Head CT	2 mSv	8 months	Very Low
Head CT repeated with and without contrast	4 mSv	16 months	Low
Spine CT	6 mSv	2 years	Low
Chest CT	7 mSv	2 years	Low
Chest CT for Lung Cancer Screening	1.5 mSv	6 months	Very Low
Abdomen/Pelvis CT	10 mSv	3 years	Low
Abdomen/Pelvis CT with and without contrast	20 mSv	6 years	Moderate
Chest X-ray	0.1 mSv	10 days	Minimal
Extremity X-ray	0.001 mSv	3 hours	Negligible
Upper GI X-ray	8 mSv	3 years	Low
Coronary CT Angiography (CTA)	12 mSv	4 years	Low
Bone Densitometry (DEXA)	0.001 mSv	3 hours	Negligible
Mammography	0.4 mSv	7 weeks	Very Low
Positron Emission Tomography – Computed Tomography (PET-CT)	25 mSv	8 years	Moderate

Risk Level	Approximate additional risk of fatal cancer for an adult from examination
Negligible	Less than 1 in 1,000,000
Minimal	1 in 1,000,000 to 1 in 100,000
Very Low	1 in 100,000 to 1 in 10,000
Low	1 in 10,000 to 1 in 1,000
Moderate	1 in 1,000 to 1 in 500

***Note:** The descriptive unit of radiation in terms of effective dose, is the millisievert(mSv). Interventional radiology examinations will vary in the amount of effective radiation dose due to the multiple types of procedures and equipment that is used.

Proud Participants

Of the



Radiation Safety Programs of
The American College of Radiology

References

1. American College of Radiology www.acr.org
2. Image Gently – Alliance for Radiation Safety in Pediatric Imaging www.pedrad.org/associations/5364/ig/
3. Image Wisely – Radiation Safety in Adult Medical Imaging <http://imagewisely.org/>
4. RadiologyInfo www.radiologyinfo.org/en/safety

Clinical Radiation Safety Office

1300 East Marshall Street
North Hospital Room 7-073
Richmond, VA 23298
E-mail: radphysics@vcuhealth.org

Locations Covered by Clinical Radiation Safety Office

- ♦ MCV Campus (Main Hospital, Nelson Clinic Ambulatory Care Center and Children's Pavilion)
- ♦ Stony Point
- ♦ Mayland Clinic
- ♦ Children's Hospital of Richmond
- ♦ Community Memorial Hospital (South Hill)
- ♦ Center for Advanced Health Management (CAHM)
- ♦ Neuroscience, Orthopedic & Wellness (Short Pump)



Proud to participate in these American College of Radiology programs:

- General Radiology Improvement Database
- Dose Index Registry
- Lung Cancer Screening Center

Safety First Every Day.

Clinical Radiation Safety Office



VCU Health™

It is the VCU Health safety vision to be America's safest health system. It is the VCUHealth safety goal to have zero events of preventable harm to patients, employees and visitors."

- John Duval, CEO VCU Health

Diagnostic Imaging Children's Pavilion



Safety First

Your child's safety is very important to us. Our Department of Radiology is leading the way in pediatric radiation safety and our comprehensive radiation safety program is unmatched in the region. We are committed to obtaining quality images while minimizing the risk of radiation exposure whenever possible.

Our radiation safety program includes:

- Low-dose CT techniques
- State-of-the-art equipment that minimizes exposure
- *Image Gently* techniques
- Radiation shielding (gonadal and thyroid) as needed
- On-site radiation physicists (team members who ensure proper radiation levels are delivered), regular equipment monitoring to ensure safety and dose management alerts
- Full accreditation of services (where applicable) and equipment by the American College of Radiology²

Comparing risks

Did you know that we are all exposed to radiation from natural sources all the time? The average person in the U.S. receives a dose of 3.1 mSV* per year from naturally occurring sources including³:

- Cosmic rays from the sun and outer space
- Exposure to radioactivity in rocks, soil and building materials
- Exposure to radon gas

The risk of radiation exposure from medical imaging examinations should be kept in perspective and is considered to be acceptable for medically justified examinations.

Are x-rays safe?

Our medical team uses imaging examinations (x-rays, CT scans, etc.) to make an accurate diagnosis and develop a treatment plan for your child's injury or illness. The amount of radiation used is kept as low as reasonably achievable.

Conventional x-rays, CT scans, fluoroscopy and nuclear medicine are examples of studies that use ionizing radiation; while ultrasound uses high frequency sound waves; and MRI uses radiofrequency waves and magnetic fields. There may be a small risk or radiation exposure from most forms of radiologic imaging, but the medical benefits of the imaging study far outweigh the risk.

To maximize safety, we only use x-rays in quantities sufficient for medical care. For example, x-rays for children are minimized, and examinations are limited to those that are essential. Due to a child's size, pediatric diagnostic examinations often use far less radiation than what is used for adult studies.³

Pregnancy and medical imaging

Patient safety and the safety of the unborn child are top priorities. If your child is pregnant, or you think that she may be pregnant, please inform the technologist before the examination. Please be aware that we ask all female patients 12 and older about their pregnancy status.

Do the benefits outweigh the small risk?

Please speak with your child's doctor before scheduling a diagnostic exam. If you have questions about the benefits and risks of imaging studies. Here are some questions you may want to ask to determine if the benefit is worth the small risk:

- Is the imaging examination medically necessary?
- Can my child's previous imaging examinations be reviewed in lieu of a new one?
- Could alternative examinations (MRI, ultrasound, etc.) that do not require radiation be used?

Questions about safety?

Contact our Clinical Radiation Safety Office at (804) 828-6368.

Resources:

1. Image Gently – Alliance for Radiation Safety in Pediatric Imaging: pedrad.org
2. American College of Radiology: acr.org
3. RadiologyInfo: radiologyinfo.org



MSV-NRA School Gun Violence Deterrence Initiative

Submitted by District 8

- WHEREAS, the American College of Physicians (ACP) and the American Medical Association (AMA) recommend the development of coalitions that bring different perspectives together on the issues of firearm injury and death. These groups, comprising health professionals, injury prevention experts, parents, teachers, law enforcement professionals and other recognized groups should build consensus for bringing about social and legislative change, and
- WHEREAS, after the Sandy Hook school tragedy, the National Rifle Association (NRA) assembled a task force (the "National School Shield Task Force") comprised of experts in homeland security, law enforcement training and school safety experts to explore current security standards and innovative deterrents to gun violence in American schools. The Task Force issued "The National School Shield Report", and
- WHEREAS, the NRA's National School Shield Program and the AMA and the ACP have distinct areas of joint concern and goal-directed overlap involving 1) self-assessment tools for determining the level of school risk 2) federal and state coordination of funding 3) the development of enhanced armed safety on school grounds 4) formal training of staff and students in the event of a threat and 5) development of a pilot program on threat assessments and mental health interventions., therefore be it
- RESOLVED, therefore the MSV and NRA shall engage in an exploratory discussion on the enhancement of protective measures for child safety and the deterrence of gun violence in the Virginia public school system, and be it further
- RESOLVED, the MSV and NRA establish a representative committee of MSV medical representatives and NRA policy experts to explore our mutual areas of overlap and utilize these areas of overlap to enhance the safety of children matriculating in the Virginia public school system, and be it further
- RESOLVED, that the coalition formed by the MSV and NRA will provide a model for collaborative leadership nationally in our mutual desire to deter gun violence in our nation's schools.

Staff Analysis – Resolution 16-208L: MSV-NRA School Gun Violence Deterrence Initiative.

Submitted by MSV District 8

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>Proposal:</p> <ul style="list-style-type: none"> Resolution calls for the MSV to work with the NRA to form a coalition to address gun violence in schools. The American College of Physicians (ACP) position recommends a multi-faceted public health approach to firearms-related violence, which includes coalition development, physician counseling to patients about the risk of firearms in the house, regulation of firearms, ban of civilian purchase of assault weapons, as well as other approaches. AMA policies support classifying gun violence as a public health crisis and increasing federal research. The NRA is outside the scope of organizations the ACP recommended coalition participants. 	<p>Raise the perceived value of physicians</p> <p>Strengthen the value of MSV</p>	<p>145.001 –Children and Gun Safety</p> <p>145.002 – Control of Violent Use of Firearms</p> <p>145.003 – Support for Firearm Laws Promoting Increased Public Safety</p>	<p>Benefits:</p> <ul style="list-style-type: none"> School gun violence is an important issue that affects the health of children. <p>Drawbacks:</p> <ul style="list-style-type: none"> Gun violence issues are politically contentious and divisive among MSV members. As the NRA is not a healthcare organization, a partnership may be out of MSV's scope. 	<p><u>NOT ADOPT</u></p> <ul style="list-style-type: none"> An initiative of this nature would conflict with AMA policy as well as the ACP recommendations. A partnership with the NRA may be outside of the scope of addressing gun violence as a public health issue.

Reducing Firearm-Related Injuries and Deaths in the United States: Executive Summary of a Policy Position Paper From the American College of Physicians

Renee Butkus, BA; Robert Doherty, BA; and Hilary Daniel, BS, for the Health and Public Policy Committee of the American College of Physicians*

In 1995, the American College of Physicians (ACP) issued its first statement that raised concern about the epidemic of firearm violence in the United States and advocated for policies to reduce the rate of firearm injuries and deaths (1). Nineteen years later, although rates of firearm-related death, injury, and disability have decreased, firearm-related mortality rates in the United States remain the highest among industrialized countries (2).

The mass shooting that occurred in December 2012 at Sandy Hook Elementary School in Newtown, Connecticut, which left 6 adults and 20 children dead, and other mass shootings have brought firearm violence to the forefront of national discussion. It is critical that strategies are developed to prevent massacres like those that occurred in Newtown; in Tucson, Arizona; at Virginia Tech University; in Aurora, Colorado; at Columbine High School; and at the Washington Navy Yard. Yet, the ACP is equally concerned about the deaths and injuries that affect our nation on a daily basis when persons are injured or killed or commit suicide with firearms. Each year, firearms kill more than 32 000 persons in the United States, or approximately 88 per day (3). These deaths include homicides, suicides, and unintentional fatalities. Firearm injury is the second leading cause of death due to injury after motor vehicle crashes (4). Homicide and suicide by firearms result in 11 000 and 19 000 deaths, respectively, each year (5). The number of nonfatal firearm injuries in the United States is more than twice the number of fatal firearm injuries, with 73 883 nonfatal firearm injuries documented in 2011 (6). The ACP believes that immediate action is necessary to reduce these unnecessary injuries and deaths.

Firearm violence is not only a criminal justice issue but also a public health threat. A comprehensive, multifaceted

approach is necessary to reduce the burden of firearm-related injuries and deaths on individuals, families, communities, and society in general. Strategies to reduce firearm violence will need to address culture, substance use and mental health, firearm safety, and reasonable regulation, consistent with the Second Amendment, to keep firearms out of the hands of persons who intend to use them to harm themselves and others, as well as measures to reduce mass casualties associated with certain types of firearms.

As an organization representing physicians who have firsthand experience with the devastating impact firearm-related injuries and deaths have on the health of their patients, the ACP has a responsibility to participate in efforts to mitigate these needless tragedies. Because patients trust their physicians to advise them on issues that affect their health, physicians can help to educate the public on the risks of firearms and the need for firearm safety through their encounters with their patients. This Executive Summary provides a synopsis of the full position paper, which is available in **Appendix 1** (available at www.annals.org).

METHODS

The ACP's Health and Public Policy Committee, which is charged with addressing issues affecting the health care of the U.S. public and the practice of internal medicine and its subspecialties, developed these recommendations. The committee reviewed available data on the impact of access to firearms on health-related outcomes, the association of mental health conditions and firearm violence, state and federal firearm laws, and the effect of efforts to reduce firearm violence. The ACP also surveyed its members on their attitudes on firearms and firearm injury prevention (7). Draft recommendations were reviewed by ACP's Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies, as well as non-ACP members with expertise in mental health and firearm safety. The policy paper and related recommendations were reviewed by the ACP Board of Regents and approved on 7 April 2014.

See also:

Related article. 821

Web-Only

CME quiz

Appendix 1: Full Position Paper

Ann Intern Med. 2014;160:858-860.

This article was published online first at www.annals.org on 10 April 2014.

* This paper, written by Renee Butkus, BA; Robert Doherty, BA; and Hilary Daniel, BS, was developed for the Health and Public Policy Committee of the American College of Physicians. Individuals who served on the Health and Public Policy Committee at the time of the project's approval were Thomas Tape, MD (*Chair*); Jacqueline W. Fincher, MD (*Vice Chair*); Vineet Arora, MD; Ankit Bhatia; James F. Bush, MD; Douglas M. DeLong, MD; Susan Glennon, MD; Gregory A. Hood, MD; Mary Newman, MD; Kenneth E. Olive, MD; Shakaib U. Rehman, MD; Zoe Tseng; and Jeffrey G. Wiese, MD. Approved by the ACP Board of Regents on 7 April 2014.

ACP POSITION STATEMENTS AND RECOMMENDATIONS

The following statements represent the official policy positions and recommendations of the ACP. The rationale for each is provided in the full position paper (see Appendix 1).

1. *The American College of Physicians recommends a public health approach to firearms-related violence and the prevention of firearm injuries and deaths.*

a. *The College supports the development of coalitions that bring different perspectives together on the issues of firearm injury and death. These groups, comprising health professionals, injury prevention experts, parents, teachers, law enforcement professionals, and others should build consensus for bringing about social and legislative change.*

2. *The medical profession has a special responsibility to speak out on prevention of firearm-related injuries and deaths, just as physicians have spoken out on other public health issues. Physicians should counsel patients on the risk of having firearms in the home, particularly when children, adolescents, people with dementia, people with mental illnesses, people with substance use disorders, or others who are at increased risk of harming themselves or others are present.*

a. *State and federal authorities should avoid enactment of mandates that interfere with physician free speech and the patient–physician relationship.*

b. *Physicians are encouraged to discuss with their patients the risks that may be associated with having a firearm in the home and recommend ways to mitigate such risks, including best practices to reduce injuries and deaths.*

c. *Physicians should become informed about firearms injury prevention. Medical schools, residency programs, and continuing medical education (CME) programs should incorporate firearm violence prevention into their curricula.*

d. *Physicians are encouraged, individually and through their professional societies, to advocate for national, state, and local efforts to enact legislation to implement evidence-based policies, including those recommended in this paper, to reduce the risk of preventable injuries and deaths from firearms, including but not limited to universal background checks.*

3. *The American College of Physicians supports appropriate regulation of the purchase of legal firearms to reduce firearms-related injuries and deaths. The College acknowledges that any such regulations must be consistent with the Supreme Court ruling establishing that individual ownership of firearms is a constitutional right under the Second Amendment of the Bill of Rights.*

a. *Sales of firearms should be subject to satisfactory completion of a criminal background check and proof of satisfactory completion of an appropriate educational program on firearms safety. The American College of Physicians supports a universal background check system to keep guns out of the hands of felons, persons with mental illnesses that put them at a greater risk of inflicting harm to themselves or others, persons with substance use disorders, and others who already are prohibited from owning guns. Clear guidance should be issued on*

what mental and substance use records should be submitted to the National Instant Criminal Background Check System (NICS). This should include guidance on parameters for inclusion, exclusion, removal, and appeal. States should submit mental health records and report persons with substance use disorders to the NICS. The federal government should increase incentives and penalties related to state compliance. The law requiring federal agencies to submit substance use records should be enforced.

b. *Although there is limited evidence on the effectiveness of waiting periods in reducing homicides, waiting periods may reduce the incidence of death by suicide, which account for nearly two thirds of firearm deaths, and should be considered as part of a comprehensive approach to reducing preventable firearms-related deaths.*

c. *Lawmakers should carefully weigh the risks and benefits of concealed-carry legislation prior to passing laws.*

d. *The College supports a ban on firearms that cannot be detected by metal detectors or standard security screening devices.*

e. *The College favors strong penalties and criminal prosecution for those who sell firearms illegally and those who legally purchase firearms for those who are banned from possessing them (“straw man sales”).*

4. *The American College of Physicians recommends that guns be subject to consumer product regulations regarding access, safety, and design. In addition, the College supports law enforcement measures, including required use of tracer elements or taggants on ammunition and weapons, and identifying markings, such as serial numbers on weapons, to aid in the identification of weapons used in crimes.*

5. *Firearm owners should adhere to best practices to reduce the risk of accidental or intentional injuries or deaths from firearms. They should ensure that their firearms cannot be accessed by children, adolescents, people with dementia, people with mental illnesses or substance use disorders who are at increased risk of harming themselves or others, and others who should not have access to firearms. Firearm owners should report the theft or loss of their firearm within 72 hours of becoming aware of its loss.*

6. *The College cautions against broadly including those with mental illness in a category of dangerous individuals. Instead, the College recommends that every effort be made to reduce the risk of suicide and violence, through prevention and treatment, by the subset of individuals with mental illness who are at risk of harming themselves or others. Diagnosis, access to care, treatment, and appropriate follow-up are essential.*

a. *Physicians and other health professionals should be trained to respond to patients with mental illness who might be at risk of injuring themselves or others.*

b. *Ensuring access to mental health services is imperative. Mental health services should be readily available to persons in need throughout their lives or through the duration of their conditions. Ensuring an adequate availability of psychiatric beds and outpatient treatment for at-risk persons seeking im-*

mediate treatment for a condition that may pose a risk of violence to themselves or others should be a priority.

c. Community understanding of mental illness should be improved to increase awareness and reduce social stigma.

d. Laws that require physicians and other health professionals to report those with mental illness who they believe pose an imminent threat to themselves or others should have safeguards in place to protect confidentiality and not create a disincentive for patients to seek mental health treatment. Such laws should ensure that physicians and other health professionals are able to use their reasonable professional judgment to determine when a patient under their care should be reported and should not hold them liable for their decision to report or not report.

7. The College favors enactment of legislation to ban the sale and manufacture for civilian use of firearms that have features designed to increase their rapid killing capacity (often called “assault weapons” or semiautomatic weapons) and large-capacity ammunition and retaining the current ban on automatic weapons for civilian use. Although evidence on the effectiveness of the Federal Assault Weapons Ban of 1994 is limited, the College believes that there is enough evidence to warrant appropriate legislation and regulation to limit future sales and possession of firearms that have features designed to increase their rapid killing capacity and can, along with a ban on large-capacity ammunition magazines, be effective in reducing casualties in mass shooting situations. Such legislation should be carefully designed to make it difficult for manufacturers to get a semiautomatic firearm exempted from the ban by making modifications in its design while retaining its semiautomatic functionality. Exceptions to a ban on such semiautomatic firearms for hunting and sporting purposes should be narrowly defined.

8. The College supports efforts to improve and modify firearms to make them as safe as possible, including the incorporation of built-in safety devices (such as trigger locks and signals that indicate a gun is loaded). Further research is needed on the development of personalized guns.

9. More research is needed on firearm violence and on intervention and prevention strategies to reduce injuries caused by firearms. The Centers for Disease Control and Prevention, National Institutes of Health, and National Institute of Justice should receive adequate funding to study the impact of gun violence on the public's health and safety. Access to data should not be restricted.

CONCLUSION

Firearm violence is a public health problem in the United States that requires the nation's immediate atten-

tion. The ACP has long advocated for policies to reduce the rate of firearm injuries and deaths in the United States and once again calls on its members, nonmember physicians, policymakers, and the public to take action on this important issue. Although there is much more to learn about the causes and prevention of firearm violence, the available data support the need for a multifaceted and comprehensive approach that addresses culture, substance use and mental health, firearm safety, and reasonable regulation, consistent with the Second Amendment, to prevent the devastating effects of needless firearm-related injuries and deaths.

From the American College of Physicians, Washington, DC.

Disclaimer: The authors of this article are responsible for its contents, including any clinical or treatment recommendations.

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APPENDIX 1: REDUCING FIREARM-RELATED INJURIES AND DEATHS IN THE UNITED STATES: RECOMMENDATIONS FROM THE AMERICAN COLLEGE OF PHYSICIANS

Why Should Physicians Care About Firearm Injury Prevention?

The ACP Ethics Manual states that “Physicians should help the community and policymakers recognize and address the social and environmental causes of disease, including human rights concerns, discrimination, poverty, and violence” (8).

Whether it is a 75-year-old widower who commits suicide; a 17-year-old who accidentally shoots himself; a 20-year-old bystander killed on a city street; or a horrific mass shooting, such as the one that occurred in Newtown, Connecticut, physicians witness firsthand the devastating consequences of firearm violence for victims and their families. In a February 2013 survey of internists, 63% of respondents reported having had patients who were injured or killed by a gun. The survey is discussed in more detail later in this paper. These unnecessary injuries and deaths occur to patients and affect their families and the communities that they are a part of.

Physicians play an important role in intervening with patients who risk injuring themselves or others through the use of firearms. Patients and families of those who risk firearm injury have indicated a willingness to discuss concerns and safety options with their physicians (9). Brief counseling efforts by physicians have been shown to have a significant positive effect on the firearm storage habits of their patients. In one study (10), patients who completed an enrollment questionnaire and indicated that they had guns in their household agreed to participate in a study of the effect of office counseling by family physicians. The study found that groups receiving verbal counseling only or verbal counseling and written information made safe changes in gun storage (64% and 58%, respectively) compared with those who received no office counseling (33%). Twelve percent of study participants reported removing guns from their household altogether. Physician education in the recognition and treatment of depression and restricting access to lethal methods, including firearms, has been shown to reduce suicide rates (11). Screening

for and treating explosive rage and violence, such as workplace violence, domestic abuse, and road rage (12), can decrease the risk for future violence. Discussions about firearms during routine examinations were well-received and recalled more than any other preventive medicine issue discussed among young African American men (13). In fact, 81% of African American men believed that it was important for a physician to talk to them about guns. A study of families in a predominantly Hispanic pediatric clinic (14) revealed that of those who received gun safety counseling or other intervention, 61.6% either removed all guns from their homes or improved their gun storage safety practice in some way. In households that still had guns at follow-up, 50.9% of patients in the intervention group were found to have some type of improvement in safe gun storage compared with 12.3% of those in the control group.

As Christine Laine, MD, Editor in Chief, and the deputy editors of *Annals of Internal Medicine* wrote in a March 2013 editorial, “Just as physicians worked to safeguard public health by promoting smoking bans in public places, we should draw on similar motivations and strategies to promote sensible, evidence-based laws to decrease the harms associated with gun violence. It is our responsibility to do so” (15).

Attitudes of Internists on Firearms and Injury Prevention

In February 2013, ACP performed a cross-sectional survey among a large, nationally representative panel of internists in the United States about their attitudes toward firearms and firearm injury prevention. Most respondents (85%) believed that firearm injury is a public health issue.

Respondents’ support for policies related to firearm regulation was strong. Seventy-six percent of respondents agreed that stricter gun control legislation would help to reduce the risk for gun-related injuries or deaths. An overwhelming majority also favored mandatory background checks on all gun purchases (95%); mandatory registration of all firearms (81%); banning the possession of assault weapons (86%), high-capacity magazines (85%), and armor-piercing bullets (87%); preventing persons with mental illness from purchasing guns (85%); and requiring safety features to make guns more child-proof (86%) (Table 1).

Few respondents involved in patient care were asking their patients about gun use or discussing gun safety (Table 2). Fifty-eight percent of respondents reported never discussing with patients whether they had guns in the home, and 80% reported never discussing whether their patient used guns. Most (77%) reported never discussing ways to reduce the risk for gun-related injury or death or the importance of keeping guns away from children (62%). Respondents indicating that there were gun owners in their homes more often reported asking their patients about guns (54% vs. 40%). Despite this, there is interest in educational programs to help physicians counsel their patients on firearm injury prevention. When asked the extent to which there is a need for an educational program designed to increase the knowledge and skills of physicians in how to counsel patients in firearm injury prevention, 74% indicated “somewhat/to a great extent.” Non-gun owners more often reported support of such a

Table 1. Support by Internists for Specific Measures to Deal With Firearm Violence

Measure	Respondents Who Favor Measure, %		
	All Internists (n = 573)	Gun Owner in Home (n = 121)	No Gun Owner in Home (n = 452)
Mandatory background check on all gun purchases regardless of whether through an authorized dealer, gun show, or other private sale	95	88	97
Mandatory registration of all guns, including handguns, rifles, shotguns, and semiautomatic weapons	81	50	89
Mandatory safety training before buying a gun	88	74	91
Banning the possession of assault weapons except by the military and other authorized persons	86	63	92
Banning the possession of high-capacity magazines except by the military and other authorized persons	85	68	89
Banning armor-piercing bullets	87	79	89
Preventing persons with mental illness from purchasing guns	85	85	85
Preserving the rights of physicians to counsel their patients on preventing deaths and injuries from firearms	86	84	86
Improving access to mental health services	97	98	96
Requiring safety features to make guns more child-proof	86	67	91
Banning sale of firearms to persons younger than 21 y	83	63	88
Creating a federal database to track gun sales	79	60	84

program than did those from a home with gun owners (77% vs. 63%).

Firearm Violence Is a Public Health Problem

The number of guns owned by civilians in the United States ranges from 270 million to 310 million (16, 17), which amounts to 101.05 firearms per 100 persons (18). The United States ranks first among 178 countries in the number of privately owned guns (16). Each year, more than 32 000 persons are killed in the

United States by firearms. This includes homicides, suicides, and unintentional fatalities and amounts to 88 deaths per day (19). Homicides by firearm result in 11 000 deaths each year (19). More than 19 000 firearm deaths are suicides (20). The number of nonfatal firearm injuries is more than double the number of deaths. It is estimated that nearly 74 000 nonfatal firearm injuries occurred in the United States in 2011 (21). Since its peak in 1993, the rate of gun homicide has decreased by 49%; however,

Table 2. Frequency of Discussions About Gun-Related Issues

Issue	Frequency of Discussion, %*		
	Total Respondents (n = 542)†	Respondents With Gun Owner in Home (n = 112)	Respondents Without Gun Owner in Home (n = 430)
Whether the patient has guns in his/her home			
Always	3	5	3
Sometimes	39	48	37
Never	58	46	60
Whether the patient uses guns even if a gun is not present in the home			
Always	1	1	1
Sometimes	19	23	18
Never	80	76	81
Ways to reduce the risk for gun-related injury or death			
Always	2	2	2
Sometimes	21	28	19
Never	77	71	79
Importance of keeping guns in the home away from children			
Always	6	12	5
Sometimes	32	39	30
Never	62	49	65
Voluntarily removing the gun from the home			
Always	1	1	1
Sometimes	22	31	20
Never	77	68	79

* Percentages may not sum to 100 because of rounding.

† Respondents who reported time spent in direct patient care.

the change in the overall number of firearm deaths has not been as substantial (39 595 in 1993 vs. 31 672 in 2010) and is still a major concern.

In 2010, 15 576 children aged 20 years or younger were treated in emergency departments for nonfatal firearm-related injuries. Adolescents aged 15 to 19 years had a nonfatal firearm injury rate nearly 3 times higher than the general population (22). Between 2000 and 2010, 703 children aged 14 years or younger were killed by unintentional firearm injuries (23). A 2013 analysis of available data on unintentional or accidental firearm injury and death in 5 states found that official estimates may underestimate the number of accidental firearm deaths in children by as much as half, due in part to inconsistent classification and reporting (24). Misclassification of firearm homicide, suicide, and accidents, particularly in young victims, is of concern with many of the current reporting practices. As much as 38% of true cases of unintentional firearm deaths were missed, as were 42% of cases reported as false-positives in an analysis of firearm death data from the National Violent Death Reporting System, State Vital Statistics Registry, medical examiner or coroner reports, and police Supplementary Homicide Reports (25).

Firearm-related violence cost the United States \$174 billion in 2010. The societal cost for each firearm assault injury amounted to \$5.1 million for each fatality, \$433 000 for each hospitalized patient, and \$123 000 for each firearm assault that resulted in only an emergency department visit. The costs included work loss, medical or mental health care, emergency transportation, police or criminal justice activities, insurance claims processing, employer costs, and decreased quality of life (26).

Firearm Violence and Mental Health

Studies have shown that “stranger homicide” is still a relatively uncommon occurrence, and psychosis has not been shown to be an accurate predictor in the risk for such homicides (27). Additional epidemiologic research has shown that persons with mental illness are less likely to seek treatment before committing a violent act; thus, no disqualifying patient or criminal record would exist to prevent the person from purchasing a firearm (28). Certain psychiatric conditions also have a stronger association with violent behaviors than others. A survey on the frequency of violent behavior in persons with mental illness found that certain psychiatric disorders were indicators of an increased risk for violent behavior. The results of the survey showed that those with anxiety or depressive disorders were 3 to 4 times more likely to engage in violent behavior, and those with bipolar disorder or alcohol and other substance use disorders were up to 9.5 times more likely to develop violent behavior (29). A study by the National Institute of Mental Health (30) revealed that persons with serious mental illness (schizophrenia, major depression, or bipolar disorder) were 2 to 3 times more likely than those without serious mental illness to commit acts of aggression. The study also found that those with serious mental illness had a lifetime prevalence of violence of 16% compared with a 7% prevalence among those without mental illness (7%). However, because

serious mental illness is rare, the attributable risk to the overall rate of violence in the general population is only 3% to 5% (30). Thus, the overwhelming majority of persons with mental illness do not pose a threat of violence to others or themselves.

Studies that have looked at various types of mental illness in conjunction with substance abuse have established drug and alcohol use or abuse to be a stronger predictor of violent behavior than mental health alone. One study (31) found that persons with mental illness are no more likely to be violent unless they also have a substance use disorder or a history of violence. Fazel and colleagues (32) found that persons with substance use disorders but no mental health disorders had a risk for violence similar to that of persons with substance use disorders and some level of mental health disorder. A study of 132 persons with mental illness (33) revealed that they were 1.7 times more likely to engage in serious violence on days when they consumed alcohol and 3.4 to 7.1 times more likely to engage in serious violence when they used alcohol and other substances.

Access to Firearms Increases Likelihood of Injury and Death

Although some studies suggest that firearms can serve a protective function (34), evidence suggests that firearm availability increases the likelihood that persons will be killed, either by homicide or suicide. A study by Kellermann and Reay (35) that examined all firearm deaths in King County, Washington, over a 6-year period found 1.3 accidental deaths, 4.5 criminal homicides, and 37 suicides involving firearms for every death associated with self-defense or protection. A study that compared the frequency with which guns in the home are used for self-defense with the number of times the weapons were involved in accidental injury, suicide attempt, or criminal assault or homicide in 3 U.S. cities (36) found that for every time a gun was used in self-defense or for a legally justifiable reason, there were 4 accidental shootings, 7 criminal assaults or homicides, and 11 attempted or completed suicides. A report on firearm injury prevention by the Firearm & Injury Center at the University of Pennsylvania (37) found several associations among ownership of a firearm, firearm availability, and presence of firearms in the home and an increased risk for homicide and suicide by firearm. Even general ownership of a gun has been associated with a net increase in the risk for death by firearm compared with a typical person (38). The association between having a firearm in the home and homicide risk is of particular relevance because persons are more likely to be killed by a family member or intimate acquaintance than a stranger (39). Although an assessment of reports from the Federal Bureau of Investigation (FBI) Uniform Crime Reporting Program showed that the rate of homicide is still higher for men than women, the risk of being killed by a firearm is high among women. More than twice as many women were shot and killed by their husband or an intimate acquaintance than by strangers using guns, knives, or other means (40).

An analysis of data on homicides that occurred in the home in 3 metropolitan counties (41) showed that keeping a gun in the home increases the risk for homicide in the home independent of other factors. The same study found that a significant portion of

homicides in the home (76.7%) are committed by someone known to the victim, such as a family member or intimate acquaintance. The relative risk for homicide or violent death has been shown to continue for up to several years after the initial purchase of a weapon. This long-term relative risk is also reflected in the potential for suicide among gun owners several years after purchase (42).

Access to firearms in the home and general access have been shown to contribute to the increase in the risk for suicide among adolescents and adults (43–48). A 6-year study of handgun purchases among California residents aged 21 years or older (42) found that the primary cause of death in the group was suicide within the first year after the purchase and that the suicide rate among the group in the first week after the purchase was 57 times higher than in the general population. The fact that access to a firearm can increase the risk for suicide by firearm has been well-established; however, it has been shown that a decrease in household ownership of firearms is associated with a decrease in the rate of suicide. Miller and colleagues (49) explored the change in suicide rates compared with the decrease in firearm ownership from 1981 to 2002 among 4 census regions. They found a reduction in firearm ownership across all 4 regions. After adjustment for multivariate and regional factors, the study found an association with significant reductions in the rate of firearm suicides and suicides overall (4.2% and 2.5%, respectively) for each 10% decrease in household firearm ownership. Children aged 0 to 19 years were affected the most; in that population, for each 10% decrease, the rate of firearm suicide decreased by 8.3% and the rate of suicides overall decreased by 4.1%.

Although the focus of most firearm safety efforts has been geared toward households with children, evidence suggests that firearms in the home may also be a danger to elderly persons. Geriatric persons are more likely to suffer self-inflicted accidental or intentional gunshot wounds. The most common suicide method for this population is a firearm (50). A study of elderly persons with memory impairment (51) found that they frequently have access to firearms, often unlocked and with readily available ammunition.

Recommendations of the American College of Physicians

1. *The American College of Physicians recommends a public health approach to firearms-related violence and the prevention of firearm injuries and deaths.*

a. *The College supports the development of coalitions that bring different perspectives together on the issues of firearm injury and death. These groups, comprising health professionals, injury prevention experts, parents, teachers, law enforcement professionals, and others should build consensus for bringing about social and legislative change.*

The preventable loss of more than 32 000 lives per year; the preventable injury of nearly 74 000 persons per year due to firearms; and the resulting pain, suffering, cost, and consumption of human and health care resources demand that firearm injuries be considered a public health issue requiring immediate attention. According to the Institute of Medicine, “a public health approach involves three elements: a focus on prevention, a focus on scien-

tific methodology to identify risk and protective factors, and multidisciplinary collaboration to address the issue” (52). The College strongly supports this approach toward reducing firearm violence. Such an approach has produced major achievements in the reduction of tobacco use, motor vehicle fatalities, and unintentional poisoning (53). Although firearms should not be equated with these other hazards, many lessons can be learned from the approaches used to increase awareness of the risks associated with tobacco use and to increase common-sense safety policies to promote the safe use of automobiles and medications. It should be noted, however, that there are significant differences in how a public health approach to firearms might be implemented compared with other public health interventions because firearm ownership is a constitutionally protected right, unlike using tobacco, driving, or taking medications.

A national public health effort to reduce firearm-related injuries and deaths would need to address cultural, behavioral, educational, and safety issues related to firearms. First and foremost, availability of good data and adequate funding for analyses of the data are essential in order to obtain a greater understanding of the issue and better assess and target interventions. Other actions include education on safe practices to reduce the risk for accidental or intentional deaths in homes; physician counseling of patients on such risks and how to mitigate them; advocacy for public health interventions, including access to mental health, treatment for substance and alcohol abuse, screening for depression, and child-proofing guns; changing social norms, including the way that firearm violence is depicted in advertising, television, and video games; and educational campaigns to reduce firearm violence, suicides, and unintentional deaths and to recognize persons at risk for harming themselves or others.

Firearms are becoming the leading cause of trauma-related death and disability in the United States; in 12 states and the District of Columbia, firearm-related deaths equaled or exceeded deaths from motor vehicles (54). The rate of deaths resulting from motor vehicle accidents decreased from 15.2 to 11.7 per 100 000 persons between 2005 and 2009 (55). Meanwhile, the number of deaths from firearm-related injuries has increased over a similar time frame (2005 to 2010) despite the rate of firearm deaths remaining at a similar level (10.3 and 10.1 per 100 000 persons, respectively) (23, 56). A national effort must be devoted to reducing firearm injuries and deaths.

Any effort to reduce firearm violence will require a real and lasting commitment from all stakeholders to work together to find meaningful solutions that address culture, substance abuse and mental health, firearms safety, and reasonable regulation to keep firearms out of the hands of persons who will use them to harm themselves and others. No community is immune from firearm injuries and deaths. Collaboration is critical to bringing about social and legislative change.

2. *The medical profession has a special responsibility to speak out on prevention of firearm-related injuries and deaths, just as physicians have spoken out on other public health issues. Physicians should counsel patients on the risk of having firearms in the home, particularly when children, adolescents, people with dementia, people*

with mental illnesses, people with substance use disorders, or others who are at increased risk of harming themselves or others are present.

a. State and federal authorities should avoid enactment of mandates that interfere with physician free speech and the patient–physician relationship.

b. Physicians are encouraged to discuss with their patients the risks that may be associated with having a firearm in the home and recommend ways to mitigate such risks, including best practices to reduce injuries and deaths.

c. Physicians should become informed about firearms injury prevention. Medical schools, residency programs, and continuing medical education (CME) programs should incorporate firearm violence prevention into their curricula.

d. Physicians are encouraged, individually and through their professional societies, to advocate for national, state, and local efforts to enact legislation to implement evidence-based policies, including those recommended in this paper, to reduce the risk of preventable injuries and deaths from firearms, including but not limited to universal background checks.

The ACP's 2013 survey of internists revealed that 66% of respondents believed that the rights of physicians to counsel their patients on preventing deaths and injuries from firearms should be preserved. The College is pleased that the 2011 Florida gun law that forbade physicians from discussing a patient's gun ownership was found by U.S. District Judge Marcia Cooke to be a violation of physicians' First Amendment rights. In her written argument, Judge Cooke stated, "The Act does not impose a mere incidental burden on free speech. Rather, truthful, non-misleading speech is the direct target of the Act. *Cf. Gentile*, 501 U.S. at 1034. I am unconvinced that the State's interest in regulating the medical profession outweighs practitioners' free speech rights" (57). The U.S. District Court relied heavily on the argument made by the American Academy of Pediatrics, the American Academy of Family Physicians, and ACP's Florida Chapter that any such law was an unconstitutional abridgement of a physician's First Amendment right to free speech and would deprive patients of their First Amendment rights to receive potentially life-saving information on safety measures they can take to protect their children, families, and others from injury or death resulting from unsafe storage or handling of firearms. It is important that the sanctity of the physician–patient relationship continue to be preserved. Free speech between physicians and patients, as protected by the Constitution, is necessary in order to provide the highest-quality care.

The College was disheartened to find that in the 2013 survey of internists, 58% of respondents reported never asking whether patients have guns in their homes. Internists who are gun owners are more likely to ask their patients about guns than non-gun owners (54% vs. 40%). This may be due to their familiarity with guns and appropriate safety measures. Physician engagement with patients on the topic of gun safety and gun violence prevention can help in normalizing what can sometimes be a polarizing dialogue (58). Although it may not be practical or necessary to include such counseling in every patient encounter, internists should be prepared to offer such patient education, as

appropriate, within an overall regimen of preventive health care.

Communities across the country face different dangers and have differing views and uses for firearms. Members of a rural community may have reasons for owning a gun that are different from those of persons in heavily populated urban communities. An analysis by *The Washington Post* of data from the Centers for Disease Control and Prevention (CDC) on firearm death between 2008 and 2010 (59) showed that the rate of firearm suicides is higher in rural areas, whereas the rate of firearm homicide is greater in urban areas. Some parts of the country have a strong culture of firearm use. However, no community is immune from firearm injuries and deaths. Wyoming is among the states with a strong culture of firearm use and has a low firearm homicide rate; however, it has the highest rate of suicide and the largest number of suicides by firearm per capita (59). A report by the Wyoming Department of Health (60) found that the state's suicide rate could be placed among the 10 countries in the world with the highest suicide rate for which the World Health Organization has data. Physicians need to recognize how firearms are used in their community and counsel patients accordingly. When counseling patients on firearm safety, physicians should also consider the demographics of the patient and the type of firearm involved. For example, in a study of firearm ownership and safety practices in rural and nonrural settings, gun type was associated with storage habits, with handgun owners more likely to use gun locks but keep their weapons loaded. Owners of long guns were more likely to keep ammunition separate from the firearm but not to keep the firearm in a locked gun safe or cabinet (61).

Best practices to mitigate the risk of firearms in the home include storing firearms and ammunition separately in secure and locked safes, using trigger locks, and encouraging firearm owners to obtain expert training on their use and safety. In households with children; adolescents; mentally ill persons; and others at greater risk for firearm-related accidents, violence, or suicide, the physician may recommend that the patient consider not keeping firearms in the home.

Nearly 3 out of 4 non-gun owners in ACP's survey of internists expressed support for educational programs to help them counsel their patients. Such evidence-based programs could be developed and offered by medical schools, residency programs, and organizations that provide continuing medical education. Not only is it important for physicians to become properly educated about the risks of gun ownership and the need for safety measures, it is also essential that they be taught how to communicate this to their patients through proper screening, counseling, and education.

3. *The American College of Physicians supports appropriate regulation of the purchase of legal firearms to reduce firearms-related injuries and deaths. The College acknowledges that any such regulations must be consistent with the Supreme Court ruling establishing that individual ownership of firearms is a constitutional right under the Second Amendment of the Bill of Rights.*

a. *Sales of firearms should be subject to satisfactory completion of a criminal background check and proof of satisfactory completion of an appropriate educational program on firearms safety. The Amer-*

ican College of Physicians supports a universal background check system to keep guns out of the hands of felons, persons with mental illnesses that put them at a greater risk of inflicting harm to themselves or others, persons with substance use disorders, and others who already are prohibited from owning guns. Clear guidance should be issued on what mental and substance use records should be submitted to the National Instant Criminal Background Check System (NICS). This should include guidance on parameters for inclusion, exclusion, removal, and appeal. States should submit mental health records and report persons with substance use disorders to the NICS. The federal government should increase incentives and penalties related to state compliance. The law requiring federal agencies to submit substance use records should be enforced.

b. Although there is limited evidence on the effectiveness of waiting periods in reducing homicides, waiting periods may reduce the incidence of death by suicide, which account for nearly two thirds of firearm deaths, and should be considered as part of a comprehensive approach to reducing preventable firearms-related deaths.

c. Lawmakers should carefully weigh the risks and benefits of concealed-carry legislation prior to passing laws.

d. The College supports a ban on firearms that cannot be detected by metal detectors or standard security screening devices.

e. The College favors strong penalties and criminal prosecution for those who sell firearms illegally and those who legally purchase firearms for those who are banned from possessing them ("straw man sales").

A recent study (62) found that the number of firearms per capita per country strongly correlated with and was an independent predictor of firearm-related deaths. The authors found that the United States, with the most firearms per capita in the world, has the highest rate of deaths from firearms, whereas Japan, which has the lowest rate of firearm ownership, has the lowest rate of firearm deaths. Within the United States, analyses comparing the quantity and type of gun laws enacted in states find an association between stringent gun laws and lower firearm death rates. A summary of existing gun laws can be found in **Appendix 2**. The Law Center to Prevent Gun Violence, an organization that issues grades to states by using a points-based formula, found that 7 of the top 10 states with the most stringent gun laws had the lowest rates of firearm deaths (63). The correlation between stringent gun laws and reduction in firearm violence can be seen in the turnaround between the high levels of gun violence in California during the early 1990s and the relatively low rate of gun violence after the adoption of state laws and city and county ordinances aimed at reducing gun deaths. In the early 1990s, California had a rate of gun violence 15% higher than the national average—17.48 compared with 15 per 100 000 persons. The rate of gun violence in California has since decreased substantially: The number of Californians killed by gunfire decreased by 56% between 1993 and 2010 to 7.7 per 100 000 persons compared with the national average of 10.1 per 100 000 persons (64, 65). The abundance of firearms in the United States is a public health hazard, and sensible regulations must be put in place to ensure that persons who should not possess firearms are unable to access them.

Background Checks

The College supports requiring criminal background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and private sales. The "gun show loophole" should be closed to ensure that prohibited purchasers, such as felons, persons involuntarily committed for mental illness or otherwise "adjudicated mentally defective," and others prohibited from owning firearms cannot make purchases. Such a system will only be successful if records are complete and submitted in a timely manner.

In 2010, according to the FBI and state officials (66), more than 14 million persons submitted to a background check to purchase or transfer possession of a firearm and 153 000 persons were denied purchase. However, in the United States, it is estimated that up to 40% of gun transfers take place without a licensed dealer, including online and at gun shows. From that calculation, it can be estimated that 6.6 million guns were sold to a buyer with no background check (67).

Evidence suggests that states with laws to address the gun show background check loophole export fewer guns later used in crime. States with laws limiting or eliminating the gun show loophole have an average export rate (controlled for population) of 7.5 crime guns per 100 000 inhabitants. In contrast, 34 states that do not require background checks for all handgun sales at gun shows have an average export rate of 19.8 crime guns per 100 000 inhabitants (68).

There is considerable public support for a comprehensive background check requirement and for closing the private seller and gun show loopholes. The College's February 2013 survey of internists revealed that respondents overwhelmingly favored universal background checks (94%). A survey conducted in January 2013 by the Pew Research Center for the People and the Press (69) found that 85% of Americans favored closing the loopholes, with a similar level of Democratic and Republican support; in May 2013, when the poll was conducted again, 81% of all Americans favored expanded background checks. The Pew Research Center published a report in March 2013 showing that 74% of households with National Rifle Association members favored background checks, and surveys and polls conducted by Quinnipiac University (70), CNN/Opinion Research Corporation (71), CBS (72), and *The Washington Post* (73) found similar positive support for background checks. In addition, a survey conducted by the UC Davis Violence Prevention Research Center found that 55.4% of gun dealers in 43 states supported comprehensive background checks on firearm purchases; 37.5% said they were strongly in favor (74).

Despite mostly positive public opinion toward comprehensive background checks, a bill introduced in the Senate in 2013 by Senators Joe Manchin (D-WV) and Pat Toomey (R-PA) that would have required background checks on all commercial gun sales did not gain enough support to proceed. The Public Safety and Second Amendment Rights Protection Act would have expanded background checks to online sales and sales at gun shows and would have cleared the way to send information on violently mentally ill persons to the NICS database by clarifying Health Insurance Portability and Accountability Act of 1996 (HIPAA) laws (75).

Mental Health and Substance Abuse Record Reporting

Federal law currently prohibits convicted felons; persons who use or are addicted to unlawful substances; those who have been involuntarily committed to inpatient mental health institutions; and those who have been deemed incompetent to stand trial, found not guilty on the grounds of serious mental illness, or otherwise deemed adjudicated mentally defective from receiving or possessing a firearm (76). Reporting of disqualifying records to NICS by states is voluntary and varies in what and how much states report. In 2007, the NICS Improvement Amendments Act (NIAA) included certain financial incentives and penalties to encourage states to submit disqualifying records to NICS. A U.S. Government Accountability Office (GAO) report examining progress made by states reporting to NICS after NIAA (77) found a 9-fold increase in reporting, growing the database from 126 000 records in 2007 to 1.2 million in 2011, primarily from 12 states. The GAO acknowledged that this increase in records could be a factor in the increase in the number of denials based on mental health records from 0.5% of total purchase denials in 2004 to 1.7% in 2011 (77).

Despite the increase in reporting after NIAA, underreporting of certain records continues to be of concern. One analysis of available reporting data (78) found that even after the enactment of NIAA, 4 states had not submitted any mental health records and 33 states had not submitted any substance abuse records to NICS. In addition, federal departments and agencies are required to report disqualifying records quarterly, as stipulated in NIAA; however, a lag in reporting continues, with most substance abuse and mental health records coming from the federal Court Services and Offender Supervision Agency and the Department of Veterans Affairs, respectively (79).

Waiting Periods

Waiting periods have generally been considered to act as “cooling-off” periods for persons who would commit suicide or an act of violence in the heat of the moment. Opponents of waiting periods believe that they hamper a law-abiding citizen’s right to access firearms and could hinder their ability to protect themselves. The evidence on waiting periods is limited, and more research is needed on the benefits of waiting periods and ideal waiting period times. One study (80) showed that waiting periods enacted in the interim portion of the Brady Handgun Violence Protection Act (Brady Act) slightly reduced suicide rates in adults aged 55 years or older but caused no statistically significant reduction in homicides. The College cannot make an evidence-based recommendation on waiting periods because of the lack of data but believes that they should be considered as part of a comprehensive approach to reducing firearm-related deaths because of the potential positive effect they may have on suicides.

Concealed-Weapons Laws

Supporters of concealed-carry laws argue that criminals are less likely to attack someone who they believe to be armed. They also argue that most persons who legally carry a concealed firearm abide by the law and do not misuse their firearms. Opponents of

concealed-carry laws argue that concealed firearms increase the risk for preventable injuries and deaths and may increase impulsive acts of violence. Research on the topic of concealed-carry laws ultimately found that any increase or decrease in firearm-related criminal activity cannot be considered statistically significant to determine the efficacy of the laws. A study by Romero and colleagues (81) compared the violent crime rate of the state of California, a “may-issue” state, with that of a small town in Sacramento County, California, that granted concealed-carry permits to anyone who applied and passed a standard background check. The authors followed up 3 years later to examine the violent crime arrest records for the 691 persons issued a concealed-weapons permit with only a background check and found a slightly higher rate of violent crime per 100 000 person-years.

A national study that evaluated the effect of 5 types of state gun laws on homicide rates on all 50 states and the District of Columbia over a 10-year span (a “shall-issue” law, a minimum age requirement for handgun purchase, a minimum age requirement for handgun possession, a 1-gun-per-month purchasing restriction, and a junk gun ban) (82) found that states with a shall-issue law had a higher rate of firearm homicides than those without the law; however, none of the laws was associated with a statistically significant reduction in firearm homicide or suicide rates.

Additional data from studies looking at violence related to concealed-carry laws on homicide rates, suicide rates, and types of crimes committed by incarcerated criminals who possessed concealed-carry permits can only suggest that concealed-carry laws may increase the incidence of certain violent crimes. Although other studies have shown little statistical significance between the enactment of a concealed-carry law in a jurisdiction and increases or decreases in homicide rates (83), studies indicate that policymakers need to carefully weigh the risk and benefits of concealed-carry legislation before passing such laws (84).

The College cannot make an evidence-based recommendation on concealed-carry laws on the basis of the available evidence but recommends that lawmakers carefully consider the risks and benefits of concealed-carry legislation before passing such laws.

Undetectable Firearms

Under the Undetectable Firearms Act of 1988, it is a federal offense to manufacture, sell, import, export, deliver, possess, transfer, or receive a firearm capable of passing through an airport metal detector undetected or unseen. It requires that any firearm, minus the stock, grips, and magazine, have an x-ray detection signature no less than that of a calibration sample containing 3.7 ounces of stainless steel (85). The law contained a sunset provision after 10 years and was allowed to expire in 1998. A 5-year extension of the law was signed by President Bill Clinton in 1998, and a 10-year extension was signed by President George W. Bush in 2003. On 9 December 2013, the law was reauthorized for an additional 10 years.

Before the reauthorization, Congressman Steve Israel (D-NY) and Senator Charles Schumer (D-NY) unsuccessfully at-

tempted to modify the law to address potential loopholes that may emerge with the advent of three-dimensional (3D) printing technology and the successful 3D printing of guns and gun pieces, such as magazines and triggers. Congressman Israel, in addition to cosponsoring the 10-year reauthorization of the existing law, introduced H.R. 3643, the Undetectable Firearms Modernization Act, which would require plastic guns to have a permanent metal or steel component (86). Senator Schumer attempted to reduce the length of the reauthorization from 10 years to 1 year. Neither H.R. 3643 nor Senator Schumer's efforts was voted on before reauthorization.

A relatively new process, 3D printing works by using software to map out blueprints of a subject, slicing it into sections for the machine to read and using various materials to layer the sections until the item is built. On 6 May 2013, Cody Wilson, the director and founder of the nonprofit organization Defense Distributed, successfully built and fired the first 3D-printed weapon, which he called "the Liberator." Wilson previously demonstrated an ability to print magazines capable of firing up to 30 rounds without breaking or melting as well as printing the receiver of a semiautomatic assault rifle, which is considered the primary component of a firearm and is regulated by the government. The process of building the firearm entailed assembling several distinct parts printed individually. The Liberator, which requires standard ammunition and a metal firing pin, shot 1 bullet without damage (87).

Wilson obtained a federal firearms license from the U.S. Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), which allowed him to manufacture and sell firearms that do not violate the Undetectable Firearms Act. A week after the blueprints were published online, Wilson complied with a request by the U.S. State Department to remove them because of potential violations of International Traffic in Arms Regulations (88). Despite the removal of the blueprints from Wilson's Web site, they have been downloaded more than 100 000 times and others have modified and printed other 3D weapons and accessories, including a rifle.

In November 2013, the ATF released a question-and-answer sheet explaining its knowledge and monitoring of 3D-printed firearms (89). In conjunction with this release, the agency posted videos of tests conducted under controlled circumstances using various 3D-printed versions of the Liberator gun. Although some of the tests showed the gun firing effectively, others did not and 1 gun exploded into several pieces upon firing. Still, the ATF considers 3D-printed guns to be dangerous and lethal weapons (90).

Straw Purchases

Straw purchasers—persons who unlawfully purchase firearms for other persons who are in a prohibited category—move several thousand firearms into criminal channels each year, and penalties for such purchasers must be strong (91). In a 2000 report released by the ATF, *Following the Gun: Enforcing Federal Laws Against Firearms Traffickers* (92), the agency found that over the 2.5-year period between 1996 and 1998, 46% of all traffick-

ing investigations involved straw purchases; approximately a third of illegally diverted firearms were associated with straw purchasing. The proportion is of concern to the ATF, which reported that the numbers underscore a significant public safety problem. A survey of federally licensed firearm dealers in 2011 found that 67.3% of respondents reported potential straw purchases (93), indicating that straw purchasing and attempted straw purchasing remain obstacles in stymieing the flow of guns into the hands of persons who are prohibited from having them.

The month after *Following the Gun* was released, the ATF, the U.S. Department of Justice, the Office of Justice Programs, and the National Shooting Sports Foundation collaborated on the creation of the "Don't Lie for the Other Guy" campaign to educate gun dealers about detecting potential straw purchases. The program added an awareness component for consumers about the consequences of participating in straw purchasing through the Department of Justice's Project Safe Neighborhoods initiative in 2008 (94).

4. *The American College of Physicians recommends that guns be subject to consumer product regulations regarding access, safety, and design. In addition, the College supports law enforcement measures, including required use of tracer elements or taggants on ammunition and weapons, and identifying markings, such as serial numbers on weapons, to aid in the identification of weapons used in crimes.*

There is currently no federal law or regulatory authority to set minimum safety standards for domestically manufactured firearms. The American Academy of Pediatrics, the American Bar Association, and other organizations recommend that firearms meet minimum safety standards in order to protect the public from unreasonable risks for injury. Proven safety features should be required to be incorporated in the manufacture and sale of all applicable firearms, such as gunlocks, load indicators, and magazine-disconnect safeties, to prevent accidents and unauthorized access to guns in the home by teenagers and children. Firearms should also be the subject of product recall authority, injury surveillance data collection, and public safety information dissemination in order to better protect the public (95). According to the Firearm & Injury Center at the University of Pennsylvania, evidence from regulation of consumer products shows that designing safer products and restricting access to dangerous products can prevent injuries and death (37). Informed consumer choice can help reduce household risks from firearms and can increase the value of product safety for firearm design and marketing.

Steps must be taken to assist law enforcement authorities in identifying persons who use guns in criminal activities. Some states and municipalities already require registration of firearms and licensing of gun owners. Registration, use of identification taggants, and encryption of identifying markings will help ensure that guns are used as intended if they are to remain available for hunting, target shooting, collecting, self-defense, or other purposes. These measures also facilitate reporting of stolen weapons and aid police in their identification and recovery.

5. *Firearm owners should adhere to best practices to reduce the risk of accidental or intentional injuries or deaths from firearms.*

They should ensure that their firearms cannot be accessed by children, adolescents, people with dementia, people with mental illnesses or substance use disorders who are at increased risk of harming themselves or others, and others who should not have access to firearms. Firearm owners should report the theft or loss of their firearm within 72 hours of becoming aware of its loss.

Firearm owners, particularly those whose households include children; adolescents; persons with dementia; or persons with mental illness, including substance use disorders, who are at increased risk of harming themselves or others, should take every step possible to reduce the risk for accidental or intentional injuries or deaths from firearms. A disproportionately large share of unintentional firearm fatalities was found to occur in states where gun owners were more likely to store their firearms loaded. The greatest risk occurred in states where loaded firearms were more likely to be stored unlocked (96). Parents of adolescents, who have the highest risk for firearm-related injuries among youths, were found to be more likely than parents of younger children to keep household firearms stored unsafely (42% vs. 29%) (97). A study of rural households (98) found that the prevalence of loaded, unlocked guns in households with a handgun was 4.5 times higher than in households with a long gun only. The study also found that households with someone with a lifetime prevalence of alcohol abuse or dependence were about twice as likely as other households to report having loaded, unlocked firearms. A study of household firearm storage practices in Oregon (99) revealed that an estimated 6.2% of households with children had firearms that were loaded and unlocked, and about 40 000 children lived in these households. Drinking 5 or more alcoholic beverages on 1 or more occasions in the past month or drinking 60 or more alcoholic beverages in the past month were independently associated with living in households with loaded and unlocked firearms. Keeping a gun locked, keeping it unloaded, storing ammunition locked, and storing it in a separate location have each been found to be associated with a protective effect (100).

In addition to taking measures to protect members of their household from firearm injuries or deaths, firearm owners should help protect the public by reporting theft or loss of their firearms within 72 hours of becoming aware of its loss so that law enforcement can track down the firearms and the criminals who use them. Nearly 1.4 million firearms, or an annual average of 232 400, were stolen during burglaries and other property crimes between 2005 and 2010 (101). According to ATF reports, more than a quarter of its criminal gun trafficking investigations involve stolen guns. Seven states (Connecticut, Massachusetts, Michigan, New Jersey, New York, Ohio, and Rhode Island) and the District of Columbia currently require that lost or stolen firearms be reported to law enforcement (102). The College supports these laws and urges law-abiding firearm owners to take every measure possible to keep their firearms out of the hands of criminals and others who should not have access to them.

6. *The College cautions against broadly including those with mental illness in a category of dangerous individuals. Instead, the College recommends that every effort be made to reduce the risk of suicide and violence, through prevention and treatment, by the subset of individuals with mental illness who are at risk of harming them-*

selves or others. Diagnosis, access to care, treatment, and appropriate follow-up are essential.

a. *Physicians and other health professionals should be trained to respond to patients with mental illness who might be at risk of injuring themselves or others.*

b. *Ensuring access to mental health services is imperative. Mental health services should be readily available to persons in need throughout their lives or through the duration of their conditions. Ensuring an adequate availability of psychiatric beds and outpatient treatment for at-risk persons seeking immediate treatment for a condition that may pose a risk of violence to themselves or others should be a priority.*

c. *Community understanding of mental illness should be improved to increase awareness and reduce social stigma.*

d. *Laws that require physicians and other health professionals to report those with mental illness who they believe pose an imminent threat to themselves or others should have safeguards in place to protect confidentiality and not create a disincentive for patients to seek mental health treatment. Such laws should ensure that physicians and other health professionals are able to use their reasonable professional judgment to determine when a patient under their care should be reported and should not hold them liable for their decision to report or not report.*

Although reducing firearm-related violence requires keeping firearms out of the hands of persons who may harm themselves or others, the College cautions against broadly including those with mental illness in a category of dangerous persons. It is important that firearm restrictions be applied appropriately by limiting access to persons with mental illness who exhibit risk factors for dangerous behavior (103). Mental illness continues to have a stigma in our society, and many persons with mental illness remain unidentified and untreated. Although persons with certain types of serious mental illness are more prone to violence, the overall proportion of violent acts committed by those with mental illness is relatively low (30). Persons with mental illness are more likely to be victims than perpetrators of violence, and those that receive adequate treatment from health professionals are less likely to commit acts of violence (104).

Ensuring access to mental health services is critical. To date, such services have been minimally available, hugely undervalued, and poorly financed. Although positive steps have been taken to expand access to mental health services, more must be done. For example, the College supported the passage of the Mental Health Parity and Addiction Equity Act of 2008, but better access to psychiatric treatment will not be a reality without essential federal and state funding. The College is pleased that the Patient Protection and Affordable Care Act requires all health plans sold in the United States to cover preventive services, such as depression screenings, at no cost to the patient. Mental health and substance use disorder services are classified as part of 10 essential health benefits that all health plans must cover, and the law prohibits health insurers from denying patients coverage or charging them more because of preexisting conditions. The U.S. Department of Health and Human Services estimates that about 3.9 million persons who currently have insurance in the individual market will gain access to mental health or substance use disorder ser-

vices (105). It is vital that access to mental health services continue to be increased and that state, local, and community-based behavioral health systems have the resources they need to provide care, raise awareness, and reduce social stigma. Coordination of mental health care with general health and social services is also essential.

Ideally, a person with mental illness would not become a threat to himself or others. The College supports the American Psychiatric Association's position that early identification and treatment of mental disorders should be a national priority and would reduce the consequences of untreated mental disorders (106). It is important that the necessary resources are available to those who seek help at any stage. Sufficient investment in the infrastructure is especially critical to accommodate persons with an urgent need for mental health care so that they are not turned away simply because there are not enough inpatient beds, facilities, or health professionals to care for them. According to a study by the Treatment Advocacy Center (107), the number of public psychiatric beds available per 100 000 persons decreased from 340 in 1950 to 17 in 2005. The study suggested a minimum of 50 public psychiatric beds per 100 000 persons and found that 42 states had less than half the minimum number needed. Persons with mental health disorders are increasingly turning to already overcrowded emergency departments because of an inability to access psychiatric care. A study by the Agency for Healthcare Research and Quality (108) found that approximately 12 million emergency department visits in 2007 were due to mental health or substance use disorders in adults. This accounted for one eighth of the 95 million visits to emergency departments by adults that year.

Most states have "duty-to-warn" or "duty-to-protect" laws that permit or require physicians and other health professionals to report patients with mental illness who pose an imminent threat to themselves or others. Several laws, notably the New York Secure Ammunition and Firearms Enforcement Act (NY SAFE Act), require mental health professionals to report patients who, in their professional judgment, are likely to cause serious harm to themselves or others. Because many states have or are considering reporting laws, it is important to establish safeguards on what should be reported and how.

Several concerns have been raised about the reporting provision in the NY SAFE Act and similar laws. One concern is that the law may adversely affect the willingness of persons who would benefit from mental health treatment to seek treatment or continue with ongoing treatment. Another concern is that it does not give health professionals the option to try to treat the patient first through such interventions as hospitalization or altering medication. There is also concern that the law intrudes into the health professional-patient relationship by mandating disclosure of information in circumstances that may not necessarily require immediate action. The American Psychiatric Association believes that laws with blanket reporting requirements "are likely to be counterproductive and should not be adopted."

The College agrees with the American Psychiatric Association that blanket reporting laws may have unintended consequences that need to be carefully assessed by legislators when they

are considering proposals to mandate that physicians and other health professionals report on patients with mental illness who are likely to cause serious harm to themselves and others. However, if states decide to enact such laws, they should be written in a way that protects confidentiality and does not serve as a deterrent for patients seeking mental health treatment. These laws have risks and benefits that should be carefully considered. Although such laws may help prevent avoidable deaths and injuries, they can also stigmatize persons with mental illness, create a disincentive for them to seek treatment, and undermine the patient-physician relationship.

As discussed later in this paper, the College calls for more research on the effect of laws requiring physicians to report persons with mental illnesses or substance use disorders that potentially put them at greater risk of inflicting harm on themselves and others through the use of firearms.

There are times when confidentiality must be breached in order to protect public safety. In these instances, care must be taken to allow health professionals to use their own judgment to determine when a patient presents enough of a threat that they must be reported under the criteria defined by statute as representing an imminent threat to themselves or others. In addition, unless there is evidence of malice or misconduct, health professionals should not be held liable for their decision to report or not report (109). More research is needed on the effect of these laws, methods to assist in the identification of high-risk persons, and interventions to assist the subset of persons with mental illness who are at risk of harming themselves or others.

7. The College favors enactment of legislation to ban the sale and manufacture for civilian use of firearms that have features designed to increase their rapid killing capacity (often called "assault weapons" or semiautomatic weapons) and large-capacity ammunition and retaining the current ban on automatic weapons for civilian use. Although evidence on the effectiveness of the Federal Assault Weapons Ban of 1994 is limited, the College believes that there is enough evidence to warrant appropriate legislation and regulation to limit future sales and possession of firearms that have features designed to increase their rapid killing capacity and can, along with a ban on large-capacity ammunition magazines, be effective in reducing casualties in mass shooting situations. Such legislation should be carefully designed to make it difficult for manufacturers to get a semiautomatic firearm exempted from the ban by making modifications in its design while retaining its semiautomatic functionality. Exceptions to a ban on such semiautomatic firearms for hunting and sporting purposes should be narrowly defined.

The College has long supported a ban on automatic weapons and was in favor of the 1994 Public Safety and Recreational Firearms Use Protection Act (Federal Assault Weapons Ban). This act, which was included as part of the Violent Crime Control and Law Enforcement Act of 1994, sought to reduce the level of gun violence by prohibiting the sale of 18 models and variations of semiautomatic weapons with military-style features or features that seem to have an innately criminal application and create the appearance of an automatic weapon. The ban also applied to copies or duplicates of those weapons. Thus, the law is considered by many to be more of an accessories ban than a ban

on the actual weapon. Arguably, the most important provision of the bill prohibited the use of most large-capacity magazines (LCMs), which could be used by weapons within and outside the scope of the weapons ban. Such magazines are considered to be ammunition-feeding devices with more than 10 rounds of ammunition. When the ban became effective, an estimated 40% of guns not included in the ban had the ability to use LCMs (110). An estimated 18% of civilian-owned firearms and 21% of civilian-owned handguns were equipped with LCM capability when the ban took effect (110).

The law contained a grandfather clause that allowed for the continued possession and use of semiautomatic weapons and LCMs that were banned under the law but were obtained legally before the implementation of the ban. This provision is sometimes cited as the reason that the law did not have as much of an effect on crime rates related to assault weapons or LCMs.

The effect of the Federal Assault Weapons Ban has been greatly debated. Inconsistent reporting after the ban took effect and a large increase in production of assault weapons and LCMs that would be grandfathered under the law before the implementation of the ban made it difficult to accurately judge the effect of the overall law or the assault weapons and LCM bans independently. The Urban Institute published an impact assessment of the law in 1997 (111) and found the grandfathering stipulation to be a limitation to measuring the overall effect of the law. A report submitted to the Department of Justice (111) noted a lack of evidence but suggested that the ban may have reduced crime slightly if it had been in place for an extended period.

Nevertheless, some evidence suggests that the Federal Assault Weapons Ban had an effect on the use of assault weapons in crimes. The final of 3 reports submitted to the Department of Justice on the ban's impact (112) analyzed crime data in 6 major cities after the ban took effect and found that crimes involving the most common types of assault weapons decreased by 17% to 72% and that the number of assault weapons used in crimes decreased by 24% to 60% in the same areas. The author noted a steady or increasing use of other guns equipped with LCMs in the same jurisdictions studied.

A ban on LCMs has been shown to be effective in reducing the number of casualties associated with mass shootings. One study (91) found that semiautomatic weapons were 34% to 56% more likely to be used in a crime. Such weapons are associated with significantly more wounds per gun in homicides than revolvers or long guns and are associated with higher mortality (113, 114). Semiautomatic and automatic pistols are believed to be capable of inflicting greater injury because more bullets can be fired in a shorter period (115). Thirty-seven percent of police departments surveyed indicated an increase in the use of assault weapons by criminals after the Federal Assault Weapons Ban was lifted (116). When Maryland imposed a more stringent ban on assault pistols and high-capacity magazines in 1994, it led to a 55% decrease in assault pistols recovered by the Baltimore Police Department.

Although evidence on the effectiveness of the Federal Assault Weapons Ban is limited, the College believes that there is sufficient evidence that appropriate legislation and regulation to

limit future sales and possession of firearms that have features designed to increase their rapid killing capacity can, along with a ban on LCMs, be effective in reducing casualties in mass shooting situations. Although such a ban may not reduce overall crime or deaths from firearms significantly, it would reduce the number of casualties in mass shooting incidents before the shooter could be disarmed, arrested, or subdued by police. The College acknowledges the need for more research in this area to better inform policy.

8. *The College supports efforts to improve and modify firearms to make them as safe as possible, including the incorporation of built-in safety devices (such as trigger locks and signals that indicate a gun is loaded). Further research is needed on the development of personalized guns.*

The College advocates for improved engineering controls to improve firearm safety.

Personalized or "smart" firearms are those that can only be fired by an authorized user or that use an internal mechanism incorporated in the design of the weapon as opposed to an external locking device or accessory attached to the weapon. Research and development of gun designs with the potential to prevent unintentional shootings can be traced to the late 19th century but experienced a resurgence in the 1980s and 1990s as a result of several high-profile shootings and greater public outcry for increased gun safety. The idea behind personalized firearms is that if a gun can only be accessed by a single or several authorized users, unintentional deaths and suicides would be reduced and a stolen firearm would be worthless to a perpetrator.

Although personalization technology exists, whether the concept is commercially viable in the United States remains to be seen. The German company Armatix obtained approval to sell its iP1 smart gun in the United States. The gun communicates with a watch (the Armatix iW1) using radio frequency identification signals that activate the gun for use. The watch requires a personal identification number that releases the firing pin lock in the weapon, allowing the user to fire (117). If the watch is outside of the specified range, the gun will not fire. The Utah-based company Kodiak Arms developed an accessory called the Intelligun, a locking system that allows up to 20 authorized users to unlock the weapon using their fingerprint (118). Owner-authorized firearms continue to be researched and developed by companies.

Three states currently have laws for personalized firearms. In 2002, New Jersey enacted legislation requiring all new guns sold in the state to be personalized within 3 years of a personalized gun being introduced for sale in the state (119–121). Maryland law defines personalized or smart gun technology and requires the state Handgun Roster Board to report to the Governor and General Assembly annually on the status of personalized handgun technology (122). Massachusetts law requires that handguns or large-capacity weapons be sold with a safety device that would prevent unauthorized users from firing the weapon and considers personalization an alternative to locking devices, although no personalization technology has been identified as acceptable (123). No federal laws exist that define or consider personalized gun technology.

9. *More research is needed on firearm violence and on intervention and prevention strategies to reduce injuries caused by firearms. The Centers for Disease Control and Prevention, National Institutes of Health, and National Institute of Justice should receive adequate funding to study the impact of gun violence on the public's health and safety. Access to data should not be restricted.*

The ACP believes that additional research is needed on proposed or current policy proposals, laws, and regulations for which there are limited or conflicting data on their effectiveness in reducing preventable firearm-related injuries and death. While conducting its literature review, the College identified significant gaps in data where more evidence would be useful to guide policy on firearm violence. These issues should be made a priority in a national research agenda:

The effectiveness of concealed-carry laws on increasing or decreasing firearm-related injuries and deaths, specifically exploring the protective and deterrent value that some argue supports the value of concealed-carry laws versus the risk that such laws may increase the risk for preventable injuries and deaths, as opponents argue. Research should explore the effect of “must-issue” versus “shall-issue” laws.

The effectiveness of “waiting periods” in preventing firearm-related injuries and deaths, particularly exploring the potential preventive value of reducing suicides and spontaneous acts of violence versus limiting access to persons who believe that they have an urgent need for a firearm for self-defense.

Requiring physicians to report persons with mental illness or substance use disorders that potentially put them at greater risk of inflicting harm on themselves and others through the use of firearms. Such research should explore:

- Predictive ability of clinicians to identify patients at risk;
- Potential stigmatization of patients with mental illness;
- Potential for such reporting to deter persons with mental illness from seeking treatment;
- Impact on the patient–physician relationship and confidentiality;
- Better defining what mental health conditions should be reportable and the clinical criteria for making such judgments; and
- Overall effectiveness of reporting requirements in preventing patients who are at risk of harming themselves and others from obtaining firearms, and how to structure reporting laws to have the greatest preventive impact without creating unintended adverse consequences for patients with mental illness.

Several congressional efforts from the 1990s to 2011 limited federal research on firearm violence, greatly reducing the available scientific data on the issue. The College was pleased that an executive order issued by President Obama in January 2013 to reduce firearm violence included a charge to the CDC to research the causes and prevention of firearm violence. The CDC asked the Institute of Medicine and the National Research Council to identify the most pressing research needs for the public health aspects of firearm-related violence. The Institute of Medicine released a report in June 2013 with a recommendation that research should focus on 5 high-priority areas: the characteristics of firearm violence, risk and protective factors, prevention and other

interventions, firearm safety technology, and the influence of video games and other media (52).

The College supports this research agenda and urges Congress and the Obama administration to provide adequate funding to the CDC, National Institutes of Health, and National Institute of Justice to study the effect of firearm violence on the public's health and safety. Access to data should be unrestricted so that researchers can effectively study the causes of firearm violence and develop evidence-based policies to reduce the rate of firearm injuries and deaths in the nation (15).

Conclusion

Firearm violence is a public health problem that requires the nation's immediate attention. The ACP has long advocated for policies to reduce the rate of firearm injuries and deaths in the United States and once again calls on its members, policymakers, and the public to take action on this important issue. Although there is more to learn about the causes and prevention of firearm violence, the available data support the need for a multifaceted and comprehensive approach that addresses culture, substance abuse and mental health, firearm safety, and reasonable regulation, consistent with the Second Amendment, to prevent the devastating effects of needless firearm-related injuries and deaths.

APPENDIX 2: EXISTING FIREARM LAWS

Background Checks

Federal background checks are mandated by the Brady Act. The NICS, which was established under the Brady Act, was launched on 30 November 1998, and more than 160 million background checks have been requested (with nearly 2 million of them resulting in denials) (124) by federal and state authorities to date. The Brady Act requires a background check if a purchase is being made with a federally licensed firearm dealer but exempts private sellers and sales made at gun shows (gun show loophole). Several states have gone further and adopted legislation to address areas of the gun show loophole, including California, Colorado, Illinois, New York, Oregon, and Rhode Island. The 1986 Firearm Owners' Protection Act changed a previous definition of a private seller as someone who sells 4 or fewer guns a year to someone who does not sell guns as their primary livelihood, ostensibly making the field of private sellers larger and increasing the access to purchasers who do not want to undergo a background check (125).

NICS Database Overview

The NICS consists of 3 databases: the National Crime Information Center, the Interstate Identification Index, and the NICS Index. Whereas the National Crime Information Center and Interstate Identification Index provide information on criminal history maintained by the FBI, the NICS Index relies heavily on the voluntary participation of state and local authorities to add potentially prohibiting information to NICS, such as mental health records. Of note, no actual medical history or medical records are stored in the system—only a person's name and other individual identifying information, such as date of birth, is

stored. If a hold or denial is issued, the system does not identify the reason for denial.

NICS Improvement Amendments Act of 2007

The NIAA was passed in 2007 and signed into law in January 2008 in the wake of a mass shooting on the campus of Virginia Tech University, which killed 32 persons and injured 17, by a man who had been found to have severe mental illness but was not included in the NICS database because of a loophole in the law. It authorized the U.S. Attorney General to make additional grants to states to improve electronic access to records and provide incentives to states to turn over prohibiting records with an emphasis on domestic violence records and persons adjudicated as mentally defective. It also clarified the standard for mental adjudication:

- No department may provide any such record if the record had been set aside or the person released from treatment.
- The person has been found by a court or board to no longer have the condition that was the basis of adjudication or commitment.
- The adjudication or commitment is based solely on a medical finding of disability without opportunity to be heard by a court or board.

The NIAA also allowed states to be eligible for a 2-year waiver of the matching requirement in the National Criminal History Improvement grants program provided that they supply at least 90% of the records relevant to determining whether a person is disqualified from possessing a firearm under federal or applicable state law (79).

State Reporting Requirements

State reporting requirements vary depending on state law. Most states maintain the minimum federal standards for reporting an individual as adjudicated mentally defective, and the most common variations consist of what degree and type of involuntary commitment requires reporting (time of involuntary hold and inpatient vs. outpatient mandated treatment). Concerns about HIPAA Privacy Rule violations by state agencies not explicitly mandated to share information directly with NICS also account for difficulty in determining the strength of state reporting requirements.

A summary of the range in state reporting laws is as follows:

- All persons prohibited by federal or state law from purchasing or possessing a firearm due to mental illness (Illinois, Nebraska, and Pennsylvania; Connecticut, Iowa, and Kentucky only refer to the federal prohibition)
- Any person determined by a court or other lawful authority to be a danger to self or others because of a mental disorder or defect (California, Florida, Illinois, Indiana, Nebraska, Oregon, and Tennessee), including any person ordered to undergo outpatient treatment on this basis (15 states)
- Any person determined by a court or other lawful authority to lack the mental capacity to contract or manage his or her own affairs because of a mental disorder or defect (Florida, Illinois, Tennessee, and West Virginia), including any person appointed a guardian on this basis (11 states)

- Any person formally committed involuntarily to a mental institution or asylum as an inpatient (38 states report at least some persons)

- Any person found not guilty by reason of insanity, mental disease or defect, or lack of mental responsibility in a criminal case (21 states)

- Any person found guilty but insane in a criminal case (Indiana, Nevada, Oregon, Tennessee, and Utah)

- Any person found incompetent to stand trial (20 states)

- Any person who falls within the categories of persons prohibited under state law from possessing firearms (California, Illinois, Nebraska, Pennsylvania, and Texas)

- Any person placed on a 72-hour involuntary psychiatric hold triggers a 5-year prohibition against firearms possession (California)

- Licensed psychotherapists must report particularly dangerous persons, who become prohibited from possessing firearms (California)

- Courts must ensure that information is reported to NICS and to an in-state agency (Colorado, Minnesota, Tennessee, and Washington), which is also charged with ensuring reporting to NICS (Connecticut and Illinois)

- Law enforcement agencies other than NICS that conduct firearm purchaser background checks or issue firearm purchaser licenses have access to any databases containing relevant mental health records (California, Colorado, and Illinois)

- Mental health facilities must report persons who are prohibited from possessing firearms for mental health reasons if such persons are not reported by courts (California and Delaware)

- Mental health records are reported immediately upon adjudication or commitment that renders a person prohibited from purchasing or possessing a firearm (Arkansas, California, and Michigan) (126)

Interaction of Federal HIPAA Rule and State Law

A U.S. Congressional Research Service analysis of HIPAA with regard to state privacy law determined:

Although the HIPAA privacy rule provides a federal floor with respect to the uses and disclosures of PHI {protected health information}, the overall scope of the privacy rule may be modulated by state law. If a state requires covered entities {health plans, health clearinghouses, or health care providers who transmit health information electronically} to disclose prohibiting mental health records to NICS, the HIPAA privacy rule does not prohibit that disclosure. Therefore, the privacy rule is most relevant as a potential obstacle where prohibiting mental health records are held by covered entities in a state that does not require disclosure of such records to NICS. This would be the case even if the state expressly allowed, but did not explicitly require, disclosure of prohibiting mental health records to NICS because merely permissive state laws are insufficient to exempt disclosure from the HIPAA privacy rule." (127)

HIPAA privacy mandates have not been shown to be a source of significant difficulty or problematic in the 10 states with the most gun regulations (California, New Jersey, Massachusetts, Connecticut, Hawaii, New York, Maryland, Illinois, Rhode Island, and Michigan) or the 10 states with the fewest gun fatalities (adjusted for population) (Hawaii, Massachusetts, Rhode Island, New York, New Jersey, Connecticut, Minnesota, Iowa, California, and Maine). Except for Rhode Island, the states listed as having the most gun regulations and fewest gun fatalities have some type of NICS reporting mandate, NICS reporting authorization, or system for the collection of mental health records pursuant to state law (127).

California NICS Mental Health Reporting Model

California, despite not having a HIPAA reporting mandate, has one of the highest NICS mental health reporting rates. A memorandum of understanding between the state and the federal government directs that the federal government would only use state records for purposes permissible under state law (78). California state law requires that mental health facilities report mental health records to the state department of justice, ultimately removing HIPAA privacy obstacles. California has the highest total number of records submitted to NICS (279 589) and the fifth most records submitted per 100 000 citizens (750.5) (78).

Virginia After the Virginia Tech Shooting

More than a year before the Virginia Tech shooting, the shooter had been determined to be a potential threat to himself and was ordered by a judge to an outpatient mental health treatment program. However, because only those who are ordered into an inpatient treatment program are reported to NICS, he was able to legally obtain some of the firearms used in the attack. Soon afterward, then-Governor Tim Kaine signed an executive order (codified in 2008) requiring that any involuntary treatment order, including outpatient treatment, be reported to NICS (128). In the first 3 years after the order was issued, 438 firearm purchases were ordered to be denied as the result of the new state reporting requirements (126).

Dangerous Persons Laws

Some states have taken a different approach to situations in which the risk for injury to a person or those around them may be heightened. Indiana has implemented a “dangerous persons” law that is not tied to involuntary commitment or even necessarily to having a diagnosis of mental illness but to a determination of dangerousness. In addition, the law focuses on removing current access to guns rather than merely foreclosing the future purchase of a new gun. The Indiana law allows clinicians or the police to take steps to have firearms removed without a warrant from persons who are assessed to pose a danger to themselves or others. An analysis of weapons seizure cases resulting from the law in 2006 and 2007 examined the demographics of defendants and the circumstances of the weapon seizure. Defendants were primarily white men, and risk for suicide was the leading cause of confiscation (56% in 2006 and 71% in 2007) (129).

Another approach to dangerous persons is California’s law allowing seizure of guns from persons with mental illness who are

detained for dangerousness in a 72-hour hold, pending a judicial hearing in 14 days. The law provides for a 5-year ban on firearm possession after placement on a 72-hour involuntary psychiatric hold for danger to self or others. However, this restriction does not trigger a federal ban. Were such an individual to attempt to purchase a firearm in another state, the required background check would not reflect the California prohibition (130).

New York State has implemented one of the strictest dangerous person reporting requirements in the nation. The NY SAFE Act, enacted in 2013, requires mental health professionals—physicians, psychiatrists, psychologists, registered nurses, or licensed clinical social workers—to report to their local director of community services (DCS) or their designee when, in his or her reasonable professional judgment, a patient is “likely to engage in conduct that would result in serious harm to self or others.” The DCS then reviews the case to determine whether to report it to the state Division of Criminal Justice Services (DCJS). If the case is reported, the DCJS receives basic information from the DCS that allows it to determine whether the patient has a firearm license and, if so, whether it should be suspended or revoked; whether the patient is ineligible for a license; or whether the patient is no longer permitted under state or federal law to possess a firearm (131). No health records are shared with the DCJS. The information may also be used to determine eligibility for a firearm license in the 5 years after the patient was reported to the DCJS (132). The law allows for an exemption if, in the mental health professional’s opinion, a report would endanger the health professional or increase the risk for danger to potential victims.

Concealed-Carry, Right-to-Carry, and Shall-Issue Laws

All 50 states have concealed-weapons or right-to-carry laws or do not require a permit to carry a concealed weapon. Alaska and Vermont do not require their citizens to obtain concealed-carry permits but will issue them for those who travel to states that honor concealed-carry permits from other states. Forty states are considered shall-issue states (issuing authority is required to grant a permit if certain statutory criteria are met), and 10 states are considered may-issue states (issuing authority has the discretion to grant or deny the permit on the basis of certain factors) (133). It is widely believed that shall-issue states are more lenient than may-issue states, which can deny a person on the basis of state-specific criteria, such as moral character or perceived need (133).

The District of Columbia is considered a “no-issue” jurisdiction, in which one is allowed to carry a weapon in public, either openly or concealed, only under limited circumstances. The Supreme Court decision in *District of Columbia v. Heller* overturned the District’s ban on weapons possession but did not explicitly address the right to carry, and the issue remains unresolved.

Waiting Periods

A 5-day waiting period was enacted as part of the Brady Act. The waiting period was in effect between 1993 and 1998, when it was replaced by the NICS instant background check system. Since then, states have voluntarily passed additional laws pertain-

ing to waiting periods for all or some types of firearms. Eleven states and the District of Columbia currently have waiting periods that apply to the purchase of some or all firearms (134). Of these states, 7 rank in the top 10 for lowest gun death rates in the country.

Multiple Purchases of Firearms and Gun Trafficking or Exporting

Under the Gun Control Act of 1968, federal law requires federally licensed firearm dealers to report multiple sales of handguns to the same purchaser if the individual purchases 2 or more handguns at the same time or within 5 business days of each other but does not limit the number of firearms a person can purchase during a given period. Any record of multiple sales reported to the ATF by state or local law enforcement agencies must be destroyed within 20 days of receipt (135). The ATF was recently authorized to implement similar reporting requirements for multiple sales of certain rifles in Arizona, California, New Mexico, and Texas for a 3-year span.

Only 5 states (California, Maryland, New Jersey, South Carolina, and Virginia) and the District of Columbia have enacted laws limiting the number of handgun purchases or registrations. New York City strictly limits all firearm purchases to 1 handgun and 1 rifle or shotgun every 90 days; however, the restrictions do not apply statewide (136). Two states (South Carolina and Virginia) repealed their 1-gun-per-month restrictions in 2004 and 2012, respectively, over doubts about effectiveness, claims of infringement on Second Amendment rights, and excessive exemptions potentially limiting the value of the law.

Straw Purchases

Straw purchases occur when a person obtains a firearm from a federally licensed dealer with the express intent to sell it to another individual unable to complete the application and pass a background check on the grounds of criminal or mental health history, age, domestic violence convictions, or other federal or state-specific disqualifying criteria. Purchasing a firearm for a person legally prohibited from possessing one is a federal offense punishable by up to 10 years in prison and a \$250 000 fine (137). Several states have enacted legislation for straw purchasing, including California, Illinois, Colorado, Delaware, Maryland, Nebraska, Ohio, and Oregon.

Role of Physicians in Reducing Firearm Injuries and Death

Duty to Warn and Duty to Protect

Duty-to-warn and duty-to-protect statutes can be dated to the California Supreme Court decision in *Tarasoff v. Regents of the University of California*. In the fall of 1969, a college student was murdered by a classmate who had expressed his intent to kill her during a session with a psychologist earlier that summer. The psychologist informed campus police that the man was a potential danger to others, and the man was detained. Campus police released him, claiming that they did not see evidence of irrational behavior. However, neither the woman nor her family was informed of the threat, and she was killed a short time later (138). Her parents sued the psychologist and university health care providers and administrators. In 1974, the Court determined that

psychotherapists have a “duty to warn” prospective victims of violent acts. That ruling was vacated in 1976, and the subsequent ruling by the Court broadened the statute to a “duty to protect,” stating that when a therapist determines “that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim . . .” (139).

Some states have adopted statutes similar to those adopted in the wake of the *Tarasoff* case, and case law determined by individual state jurisdictions has broadened or narrowed the scope of legal protection for psychologists, psychotherapists, and health care providers to disclose information (140). Most states require or permit health care providers to share confidential information about patients with the appropriate authorities when their patients make serious and identifiable threats against a third party. Four states do not have duty-to-warn or duty-to-protect laws: Maine, Nevada, North Carolina, and North Dakota.

Guidance on HIPAA From the U.S. Department of Health and Human Services

The HIPAA Privacy Rule permits a covered entity to disclose protected health information, including psychotherapy notes, when the covered entity has a good-faith belief that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others and is made to a person reasonably able to prevent or lessen the threat. This may include, depending on the circumstances, disclosure to law enforcement, family members, the target of the threat, or others who the covered entity has a good-faith belief can mitigate the threat. The disclosure also must be consistent with applicable law and standards of ethical conduct, such as those codified at 45 C.F.R. §164.512(j)(1)(i). For example, consistent with other law and ethical standards, a mental health care provider whose teenage patient has made a credible threat to inflict serious and imminent bodily harm on one or more fellow students may alert law enforcement, a parent or other family member, school administrators or campus police, or others the provider believes may be able to prevent or lessen the chance of harm. In such cases, the covered entity is presumed to have acted in good faith, where its belief is based on the covered entity’s actual knowledge (such as the covered entity’s own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (such as a credible report from a family member or other person). More information can be found in 45 C.F.R. §164.512(j)(4).

For threats or concerns that do not rise to the level of “serious and imminent,” other HIPAA Privacy Rule provisions may apply to permit the disclosure of protected health information. For example, covered entities generally may disclose protected health information about a minor to the minor’s personal representative (a parent or legal guardian), consistent with state or other laws, such as 45 C.F.R. §164.502(b).

Right of Physicians to Counsel Patients on Firearm Safety

The physician's first and primary duty is to put the patient first. To accomplish this, physicians and the medical profession have been granted a privileged position by society and the government. In recent years, several states have proposed or adopted legislation or regulations that interfere, or have the potential to interfere, with appropriate clinical practice.

In Florida, legislation expressly restricted health care practitioners from asking patients questions related to gun safety or recording information from those conversations in patients' medical records on penalty of harsh disciplinary sanctions, including fines and permanent revocation of their licenses to practice medicine. Under the law, physicians following established protocol by informing patients how they may limit the lethal risks posed by firearms could be at risk of losing their medical licenses. The ACP Florida Chapter joined in a suit contesting the law, arguing that it would deprive physicians and other health care practitioners of their First Amendment right to freedom of speech and also would deprive patients of their First Amendment right to receive potentially life-saving information on safety measures they can take to protect their children, families, and others from injury or death resulting from unsafe storage or handling of firearms. The federal district court judge agreed, and an injunction has been issued preventing the law from being enforced. The state of Florida appealed the decision, and arguments were heard by the U.S. Court of Appeals for the Eleventh Circuit in July 2013. An opinion has yet to be issued, and the injunction remains in place. In response to the Florida legislation and other recent attempts to introduce regulations that would infringe on clinical practice and patient-physician relationships, the College issued a statement of principles on the role of governments in regulating the patient-physician relationship (141). The College's Chief Executive Officer, Steven Weinberger, MD, and his counterparts at the American Academy of Family Physicians, American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists, and American College of Surgeons wrote an editorial urging legislators to abide by principles that put patients' best interests first by respecting the importance of scientific evidence, patient autonomy, and the patient-physician relationship (142).

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Additional report for Resolution 16-208L was excluded from the Delegate Handbook due to length. The report is the April 2013 Report of the National School Shield Task Force which may be found at <https://www.nationalschoolshield.org/media/1844/summary-report-of-the-national-school-shield-task-force.pdf>

Associate Physician

Submitted the Medical Student Section

- WHEREAS, residency is a unique and necessary component of the medical training of future physicians, and
- WHEREAS, there is a growing/ongoing shortage of physicians nationwide as well as a shortage of residency spots, and
- WHEREAS, the supervision outlined for practicing with an Associate Physician licensure does not match the level of supervision required in residency with respect to safe patient care, and
- WHEREAS, the proposed licensure does not decrease the total number of students applying for residency, just defers them to later match years when the pool of students may be even greater and the bottleneck of medical school graduates seeking residency slots is projected to get worse, and
- WHEREAS, there is no current evidence that working under an Associate Physician license would improve a student's application for future rounds of residency matching, and
- WHEREAS, there are existing mechanisms of medical schools supporting unmatched students including personalized research positions, and
- WHEREAS, a primary care-focused associate physician role may not fit the specialty interests of students deferring to re-match, and
- WHEREAS, there is no data from other states to address the regulatory or financial specifics of Associate Physician licensure, and
- WHEREAS, our focus should remain on increasing availability of accredited residency slots, therefore be it
- RESOLVED, that our MSV oppose special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate U.S. medical education.

Staff Analysis – Resolution 16-209: Associate Physician.

Submitted by the MSV Medical Student Section

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>Proposal:</p> <ul style="list-style-type: none"> This resolution calls for MSV to oppose special licensing pathways for physicians who are not currently enrolled in an ACGME or AOA training program, or have not completed at least one year of accredited post-graduate U.S. medical education. <p>Activity in Other States:</p> <ul style="list-style-type: none"> A 2014 Missouri law made it the first state in the U.S. to allow medical school graduates to bypass residency programs to start treating patients in physician shortage areas. It created a new category of provider called “assistant physicians.” 	<p>Raise the perceived value of physicians</p> <p>Empower physicians to manage change</p>	<p>305.009 – Increasing Funding for Residency Training</p> <ul style="list-style-type: none"> MSV will seek means to increase state public and/or private sector funding allocated to medical residency in areas of physician shortage. <p>35.010 – Scope of Practice Position Statement</p> <ul style="list-style-type: none"> <i>Appropriate Supervision and Oversight by the Physician</i> - Physicians must take the time to educate their legislators on the risk to patient safety and quality of care when non-medically trained individuals seek to treat and diagnose patients with medical conditions, particularly when they seek direct access. 	<p>Benefits:</p> <ul style="list-style-type: none"> The supervision outlined for practicing with an Associate Physician licensure does not match the level of supervision required in residency. The proposed licensure does not decrease the total number of students applying for residency; instead it simply defers them to later match years when the pool of students may be even larger. There is no evidence that working as an Associate Physician improves a student’s application for future rounds or residency matching. A primary care-focused Associate Physician role may not fit the specialty interests of students deferring to re-match. <p>Drawbacks:</p> <ul style="list-style-type: none"> None. 	<p><u>ADOPT</u></p> <ul style="list-style-type: none"> This is consistent with the position approved by the MSV Executive Committee and Board of Directors on the 2016 legislation in Virginia. The Missouri law has drawn considerable criticism from organized medicine, including strong rebukes from the Association of American Medical Colleges (AAMC), the American Medical Association (AMA), and the American Academy of Physician Assistants (AAPA). In the two years since Gov. Nixon signed the Missouri bill into law, zero “assistant physician” licenses have been issued.

Evaluating the Effectiveness of Step 2 Clinical Skills Exam

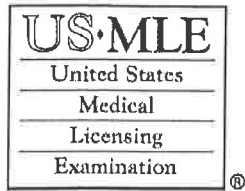
Submitted by the Medical Student Section

- WHEREAS, Ensuring medical school graduates have exceptional patient care skills is vital to the profession, and
- WHEREAS, an objective evaluation of medical school students and their clinical skills is important to advancing their medical education, and
- WHEREAS, the USMLE Step 2 Clinical Skills Exam was introduced in 2004, and
- WHEREAS, the passing rate for Step 2 is traditionally high and therefore not used as a significant factor in residency applications, and
- WHEREAS, there are only five testing locations in the country: Atlanta, Chicago, Los Angeles, Houston and Philadelphia, and
- WHEREAS, the exam registration fee is \$1,275 and additional expense are incurred due to travel and lodging, and
- WHEREAS, the cost and accessibility of the USMLE Step 2 Clinical Skills Exam is becoming increasingly prohibitive for students, therefore be it
- RESOLVED, the Medical Society of Virginia will establish a workgroup to evaluate the USMLE Step 2 Clinical Skills Exam, including relative value, cost, and accessibility, and be it further
- RESOLVED, that the workgroup shall be comprised of students from the Medical Student Section, physician members, academic representation, and residency directors, and be it further
- RESOLVED, the Medical Society of Virginia will work with the AMA to address issues of cost and accessibility of the USMLE Step 2 Clinical Skills Exam.

Staff Analysis – Resolution 16-210: Evaluating the Step 2 Clinical Skills Exam.

Submitted by the MSV Medical Student Section

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<p>Proposal:</p> <ul style="list-style-type: none"> This resolution calls for MSV to establish a workgroup to evaluate the USMLE Step 2 Clinical Skills Exam, including relative value, cost, and accessibility. The work group would comprise students from the MSV Medical Student Section, physician members, academic representation, and residency directors. The resolution also calls on MSV to work with the AMA to address issues of cost and accessibility of the USMLE Step 2 Clinical Skills Exam. 	<p>Empower physicians to manage change</p> <p>Strengthen the value of MSV</p>	<p>No Current MSV Policies</p> <p>AMA Policy: D-295.988(3) - Clinical Skills Assessment During Medical School; The AMA will work to:</p> <ol style="list-style-type: none"> Ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; Encourage a significant and expeditious increase in the number of available testing sites; Allow international students and graduates to take the same examination at any available testing site; Engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and Include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. 	<p>Benefits:</p> <ul style="list-style-type: none"> The passing rate for Step 2 is traditionally high and therefore not used as a significant factor in residency applications. The cost and accessibility of Step 2 is becoming increasingly prohibitive for students. <p>Drawbacks:</p> <ul style="list-style-type: none"> The public could perceive such an initiative as “lowering the bar” for physicians. There is no other test that addresses “patient skills.” 	<p><u>ADOPT</u></p> <ul style="list-style-type: none"> A workgroup will allow for MSV to develop an appropriate policy response and collaborate with the AMA delegation on next steps.



UNITED STATES MEDICAL LICENSING EXAMINATION®

STEP 2 CLINICAL SKILLS (CS) SCORE REPORT

This score report is provided for the use of the examinee.

Third-party users of USMLE information are advised to rely solely on official USMLE transcripts.

USMLE ID: [REDACTED]

Test Date: [REDACTED]

The USMLE is a single examination program consisting of three Steps designed to assess an examinee's understanding of and ability to apply concepts and principles that are important in health and disease and that constitute the basis of safe and effective patient care. Step 2 is designed to assess whether an examinee can apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision, including emphasis on health promotion and disease prevention. The inclusion of Step 2 in the USMLE sequence is intended to ensure that due attention is devoted to principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine. There are two components to Step 2: a Clinical Knowledge (CK) examination and a Clinical Skills (CS) examination. This report represents results for the Step 2 CS examination only. Results of the examination are reported to medical licensing authorities in the United States and its territories for use in granting an initial license to practice medicine. The overall Pass/Fail outcome provided below represents your result for the administration of the Step 2 CS on the test date shown above.

<i>Overall Pass/Fail Outcome</i>
PASS

The overall outcome for Step 2 CS, reported above, is based upon the minimum passing levels set by USMLE for the three Step 2 CS subcomponents. The three subcomponents are Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), and Spoken English Proficiency (SEP). It is necessary to pass all three subcomponents in order to obtain an overall passing outcome on the Step 2 CS. Results for the three Step 2 CS subcomponents are reported below.

<i>ICE</i>	<i>CIS</i>	<i>SEP</i>
PASS	PASS	PASS

INFORMATION PROVIDED FOR EXAMINEE USE ONLY

The Performance Profile below is provided solely for the benefit of the examinee.

These profiles are developed as self-assessment tools for examinees only and will not be reported or verified to any third party.

USMLE STEP 2 CS PERFORMANCE PROFILE

	Lower Performance	Borderline Performance	Higher Performance
Integrated Clinical Encounter (ICE)			xxxxxxxxxxxx
Communication and Interpersonal Skills (CIS)			xxxxxxxxxxxx
Spoken English Proficiency (SEP)			*

The above Performance Profile is provided to aid in self-assessment. The shaded area defines a borderline level of performance for each subcomponent (ICE, CIS, SEP); borderline performance is comparable to a HIGH FAIL/LOW PASS on the subcomponent.

Performance bands indicate areas of relative strength and weakness. Some bands are wider than others. The width of a performance band reflects the precision of measurement: narrower bands indicate greater precision. The band width for a given content area is the same for all examinees. An asterisk indicates that your performance band extends beyond the displayed portion of the scale. Small differences in the location of bands should not be over interpreted. If two bands overlap, performance in the associated areas should be interpreted as similar.

Additional information concerning the Step 2 CS subcomponents can be found in the *USMLE Step 2 CS Content Description and General Information Booklet*.

Medical Marijuana

Submitted by the MSV Medical Marijuana Taskforce

- WHEREAS, in 2015 law was enacted that authorizes a practitioner of medicine or osteopathy licensed by the Board of Medicine in the course of his professional practice to issue a written certification for the use of cannabidiol oil or THC-A oil for treatment or to alleviate the symptoms of a patient's intractable epilepsy, and
- WHEREAS, in 2016 a law was enacted that would permit production of cannabidiol oil or THC-A oil for treatment or to alleviate the symptoms of a patient's intractable epilepsy in Virginia, and
- WHEREAS, the MSV Medical Marijuana Taskforces was convened to comprehensively research the issue, legal barriers to implementation and required MSV policy changes, therefore be it
- RESOLVED, that the Medical Society of Virginia amend 120.008 - Cannabis for Medicinal Use and adopt the recommended policy changes in the enclosed report.

Expanding Research on Medicinal Cannabis

The Medical Society of Virginia calls for further adequate and well-designed studies of marijuana and related cannabinoids in patients who have serious conditions for which evidence suggests possible efficacy and a reasonable likelihood that application of such research findings would improve the understanding and treatment of specific disease states.

MSV supports down-scheduling marijuana's status as a federal Schedule I controlled substance, with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines and alternate delivery methods and minimizing patient barriers to treatment by removing legal and logistical obstacles.

Medicinal Use of Cannabinoids

The MSV believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions.

The Medical Society of Virginia recognizes that a physician may deem the use of medical cannabinoids to be appropriate for some patients with severely debilitating conditions , such as intractable epilepsy, that have exhausted other available therapies.

In these situations, MSV urges collaboration between the medical community, local, state and national authorities to remove undue barriers.

Medical cannabinoids should be manufactured, processed and dispensed in a consistent and regulated fashion to ensure patient safety. When medical cannabinoids are incorporated as part of a patient's care plan, pursuant to applicable state and federal laws, the patient and their care team, including family caregivers, should not be subject to criminal sanctions.

The Medical Society of Virginia recognizes the significant health issues involving nonmedical use of marijuana and emphasizes that these recommendations apply to proven medical use and does not apply to nonmedical use of marijuana.

Nothing in this policy is intended to encourage the violation of existing state or federal law.

Staff Analysis – Resolution 16-211: Medical Marijuana.

Submitted by the MSV Medical Marijuana Taskforce

Background	Strategic Plan (RISE)	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
<ul style="list-style-type: none"> This resolution would amend MSV's current policy on medical marijuana to include specific research recommendations and limited use of cannabinoids in certain patients. The resolution would allow for physician discretion. A 2015 Virginia law authorizes a practitioner of medicine or osteopathy licensed by the Board of Medicine in the course of his professional practice to issue a written certification for the use of cannabidiol oil or THC-A oil for treatment or to alleviate the symptoms of a patient's intractable epilepsy. A 2016 Virginia law would permit production of cannabidiol oil or THC-A oil to be used for medical treatment. 	<p>Raise the perceived value of physicians</p> <p>Empower physicians to manage change</p>	<p>120.008 – Cannabis for Medicinal Use</p> <ul style="list-style-type: none"> The Medical Society of Virginia calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. MSV supports review of marijuana's status as a federal Schedule I controlled substance with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines and alternate delivery methods. Further, MSV believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. 	<p>Benefits:</p> <ul style="list-style-type: none"> Would support additional research opportunities related to medical cannabis. Encourages physician discretion for use of cannabinoids in patients with severely debilitating conditions. Addresses the barriers to access therapies and encourages collaboration with local, state, and federal authorities. Does not support recreational use. <p>Drawbacks:</p> <ul style="list-style-type: none"> Current law only authorizes intractable epilepsy. Limited peer-reviewed clinical evidence due to scheduling status. 	<p><u>ADOPT</u></p> <ul style="list-style-type: none"> This position would allow MSV to support the use of medical marijuana for limited circumstances as deemed appropriate by the treating physician.

Telemedicine

Submitted by Russell C. Libby, M.D.

- WHEREAS, it is ideal for medical care to be delivered by a face-to-face encounter between a patient and their chosen physician in the context of a physician-led care team that provides the opportunity for comprehensive, continuous, high quality care, and
- WHEREAS, many practices have developed care coordination programs, invested in health information technology, and participate in payer contracts that rely on the appropriate, cost effective care of their patients, and
- WHEREAS, many physician-led care teams provide telemedicine services through their practices, thereby improving access and continuity of care, and, in some situations, providing care otherwise unavailable for patients in remote locations and/or with disabilities, and
- WHEREAS, the patient's established physician has the best perspective on what medical situations can be appropriately managed without a face-to-face encounter, and
- WHEREAS, there is an increasing number of commercial entities attempting to solicit patients for telemedicine services outside of their established physician's practice(s), potentially allowing for medical mistakes and inadequate follow up, and
- WHEREAS, the current statutes in the state of Virginia do not require that a provider of a telemedicine encounter ask the patient to identify their personal physician or medical care setting and have no requirement to report that encounter, therefore, be it
- RESOLVED, that our MSV develop legislation and/or regulations requiring telemedicine services provided by entities outside of the patient's primary medical setting to ask the patient to identify a physician or care setting of record and to provide that clinical setting with a full record of the provided telemedicine service, including the encounter record, prescriptions provided, studies ordered, and referrals within 24 consecutive hours of an encounter, as well as forward all lab or other diagnostic test results when they become available, and be it further
- RESOLVED, that our MSV educate and advocate to MSV members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.

Supporting the Interstate Medical Licensure Compact

Submitted by Kaiser Permanente / Mid-Atlantic Permanente Medical Group

WHEREAS, a large number of medical practices and health systems in Virginia are currently required to license their physicians with the boards of medicine in numerous states, and

WHEREAS, this increases the administrative burden for physician practices, requires a tremendous amount of staff time, duplicate work, and further delays credentialing, and

WHEREAS, 17 states have already enacted compact legislative, including West Virginia, and

WHEREAS, the MSV supports state-based licensure for physicians and the interstate medical licensure compact further supports this model, therefore be it

RESOLVED, the Medical Society of Virginia (MSV) supports the Interstate Medical Licensure Compact model and will pursue enactment in Virginia, and be it further

RESOLVED, the MSV will work with the medical societies in bordering states and the District of Columbia to encourage them to support and enact the interstate medical licensure compact.

Virginia Board of Medicine

Telemedicine

Section One: Preamble.

The Virginia Board of Medicine ("Board") recognizes that using telemedicine services in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these services can enhance medical care by facilitating communication between practitioners, other health care providers, and their patients, prescribing medication, medication management, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice. The Virginia General Assembly has not established statutory parameters regarding the provision and delivery of telemedicine services. Therefore, practitioners must apply existing laws and regulations to the provision of telemedicine services. The Board issues this guidance document to assist practitioners with the application of current laws to telemedicine service practices.

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method used to enable practitioner-to-patient communications. For clarity, a practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in Virginia Code § 54.1-3303 and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care.

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine services in the practice of medicine. The Board is committed to ensuring patient access to the convenience and benefits afforded by telemedicine services, while promoting the responsible provision of health care services.

It is the expectation of the Board that practitioners who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;
- Adhere to recognized ethical codes governing the applicable profession;
- Adhere to applicable laws and regulations;
- In the case of physicians, properly supervise non-physician clinicians when required to do so by statute; and
- Protect patient confidentiality.

Section Two: Definitions.

For the purpose of these guidelines, “telemedicine services” shall be defined as it is in HB 2063,¹ which was approved by the Virginia General Assembly as an amendment to § 38.2-3418.16 of the Code of Virginia. Under that definition,

“telemedicine services,” as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient’s diagnosis or treatment. “Telemedicine services” does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire. Va. Code § 38.2-3418.16 (as amended by HB 2063).²

Section Three: Establishing the Practitioner-Patient Relationship.

The practitioner-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that practitioners recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a practitioner-patient relationship.

Where an existing practitioner-patient relationship is not present,³ a practitioner must take appropriate steps to establish a practitioner-patient relationship consistent with the guidelines identified in this document, with Virginia law, and with any other applicable law.⁴ While each circumstance is unique, such practitioner-patient relationships may be established using telemedicine services provided the standard of care is met.

Specifically, Virginia Code § 54.1-3303(A) provides the requirements to establish a practitioner-patient relationship. *See* Va. Code § 54.1-3303(A).⁵

A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner’s identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient.

¹ HB 2063 amended Virginia Code §§ 38.2-3418.16 and 54.1-3303. HB2063 was passed by the Virginia General Assembly during the 2015 Legislative Session and, if signed by the governor, will become law on July 1, 2015.

² The Board reserves the right to revisit these Guidelines and in particular this definition should the General Assembly further alter the statutory definition of “telemedicine services” or authorize the Board to provide a definition of telemedicine or telehealth.

³ This guidance document is not intended to address existing patient-practitioner relationships established through in-person visits.

⁴ The practitioner must adhere not only to Virginia law defining a practitioner-patient relationship, but the law in any state where a patient is receiving services that defines the practitioner-patient relationship.

⁵ By passing HB 2063, the General Assembly amended Virginia Code § 54.1-3303(A), which amendment specifically addresses the establishment of a patient-practitioner relationship for the purposes of prescribing Schedule VI controlled substances via telemedicine services. Once signed by the governor, this amendment will become law on July 1, 2015. All licensees are responsible for ensuring and maintaining compliance with applicable laws.

Section Four: Guidelines for the Appropriate Use of Telemedicine Services.

The Board has adopted the following guidelines for practitioners utilizing telemedicine services in the delivery of patient care, regardless of an existing practitioner-patient relationship prior to an encounter.

Licensure:

The practice of medicine occurs where the patient is located at the time telemedicine services are used, and insurers may issue reimbursements based on where the practitioner is located. Therefore, a practitioner must be licensed by, or under the jurisdiction of, the regulatory board of the state where the patient is located and the state where the practitioner is located. Practitioners who treat or prescribe through online service sites must possess appropriate licensure in all jurisdictions where patients receive care. To ensure appropriate insurance coverage, practitioners must make certain that they are compliant with federal and state laws and policies regarding reimbursements.

Evaluation and Treatment of the Patient:

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, which treatment includes the issuance of prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional, in-person encounters. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine services must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following:

- Identification of the patient, the practitioner, and the practitioner's credentials;
- Types of activities permitted using telemedicine services (e.g. prescription refills, appointment scheduling, patient education, etc.);
- Agreement by the patient that it is the role of the practitioner to determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine services, such as encrypting date of service, password protected screen savers, encrypting data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-practitioner communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine services. Informed consents obtained in connection with an encounter involving telemedicine services should also be filed in the medical record. The patient record established during the use of telemedicine services must be accessible to both the practitioner and the patient, and consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records and Exchange of Information:

Written policies and procedures should be maintained for documentation, maintenance, and transmission of the records of encounters using telemedicine services. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the practitioner addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Prescribing:

Prescribing medications, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe medications as part of telemedicine encounters in accordance with applicable state and federal law.

Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A) as amended by HB 2063. Additionally, practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship.

Section Five: Guidance Document Limitations.

Nothing in this document shall be construed to limit the authority of the Board to investigate, discipline, or regulate its licensees pursuant to applicable Virginia statutes and regulations. Additionally, nothing in this document shall be construed to limit the Board's ability to review the delivery or use of telemedicine services by its licensees for adherence to the standard of care and compliance with the requirements set forth in the laws and regulations of the Commonwealth of Virginia. Furthermore, this document does not limit the Board's ability to determine that certain situations fail to meet the standard of care or standards set forth in laws and regulations despite technical adherence to the guidance produced herein.

(34) RESOLUTION 234 - TELEMEDICINE ENCOUNTERS BY THIRD PARTY VENDORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent provide the patient's established physician(s) with a full record of the provided telemedicine service, including the encounter record, prescriptions provided, studies ordered, and referrals within 24 consecutive hours of an encounter, as well as forward all lab or other diagnostic test results when they become available(Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, the model legislation and/or regulations also require the vendor to abide by laws addressing the privacy and security of patients' medical information offer the patient a real-time, secure, and HIPAA compliant connection to their established physician through the vendor's program (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 234 be amended by the addition of a new Resolve to read as follows:

RESOLVED, That our AMA include in that model state legislation the following concepts based on AMA policy: 1) A valid patient-physician relationship must be established before the provision of telemedicine services; 2) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and 3) The standards and scope of telemedicine services should be consistent with related in-person services.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 234 be adopted as amended.

Code of Virginia

§ 38.2-3418.16. Coverage for telemedicine services.

A. Notwithstanding the provisions of § [38.2-3419](#), each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section, "telemedicine services," as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio or video, for the purpose of diagnosing or treating a patient or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum

that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, or limited or specified disease policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 32.1-127.1:03

Health records privacy

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by other provisions of state law, no health care entity, or other person working in a health care setting, may disclose an individual's health records. Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, except as provided in subsections E and F and subsection B of § [8.01-413](#).
2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § [8.01-413](#) or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.
3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human

Services as required by the Health Insurance Portability and Accountability Act (HIPAA)(42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

4. Health care entities shall, upon the request of the individual who is the subject of the health record, disclose health records to other health care entities, in any available format of the requestor's choosing, as provided in subsection E.

B. As used in this section: "Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ [54.1-2981](#) et seq.). "Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted. "Guardian" means a court-appointed guardian of the person. "Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity. "Health care entity" means any health care provider, health plan or health care clearinghouse. "Health care provider" means those entities listed in the definition of "health care provider" in § [8.01-581.1](#), except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine. "Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" shall include any entity included in such definition as set out in 45 C.F.R. § 160.103. "Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual. "Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services. "Individual" means a patient who is receiving or has received health services from a health care entity. "Individually

identifying prescription information” means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.”Parent” means a biological, adoptive or foster parent.”Psychotherapy notes” means comments, recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session with an individual or a group, joint, or family counseling session that are separated from the rest of the individual’s health record. “Psychotherapy notes” shall not include annotations relating to medication and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual’s progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ [65.2-604](#) and [65.2-607](#) of the Virginia Workers’ Compensation Act;
2. Except where specifically provided herein, the health records of minors; or
3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § [16.1-248.3](#).

D. Health care entities may, and, when required by other provisions of state law, shall, disclose health records:

1. As set forth in subsection E, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § [54.1-2969](#) or (b) the minor himself, if he has consented to his own treatment pursuant to § [54.1-2969](#), or (iii) in emergency cases or situations where it is impractical to obtain an individual’s written authorization, pursuant to the individual’s oral authorization for a health care provider or health plan to discuss the individual’s health records with a third party specified by the individual;
2. In compliance with a subpoena issued in accord with subsection H, pursuant to a search warrant or a grand jury subpoena, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § [8.01-413](#). Regardless of the manner by which health records relating to an individual are compelled to be disclosed pursuant to this subdivision, nothing in this subdivision shall be construed to prohibit any staff or employee of a health care entity from providing information about such individual to a law-enforcement officer in connection with such subpoena, search warrant, or court order;
3. In accord with subsection F of § [8.01-399](#) including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity’s employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity’s conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ [8.01-399](#) and [8.01-400.2](#);
5. In compliance with the provisions of § [8.01-413](#);
6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ [32.1-36](#), [32.1-36.1](#), [32.1-40](#), [32.1-41](#), [32.1-127.1:04](#), [32.1-276.5](#), [32.1-283](#), [32.1-283.1](#), [32.1-320](#), [37.2-710](#), [37.2-839](#), [53.1-40.10](#), [54.1-2400.6](#), [54.1-2400.7](#), [54.1-2403.3](#), [54.1-2506](#), [54.1-2966](#), [54.1-2966.1](#), [54.1-2967](#), [54.1-2968](#), [54.1-3408.2](#), [63.2-1509](#), and [63.2-1606](#);
7. Where necessary in connection with the care of the individual;
8. In connection with the health care entity's own health care operations or the health care operations of another health care entity, as specified in 45 C.F.R. § 164.501, or in the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ [54.1-3410](#), [54.1-3411](#), and [54.1-3412](#);
9. When the individual has waived his right to the privacy of the health records;
10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;
11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Chapter 20 (§ [64.2-2000](#) et seq.) of Title 64.2;
12. To the guardian ad litem and any attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a commitment proceeding under § [19.2-169.6](#), Article 5 (§ [37.2-814](#) et seq.) of Chapter 8 of Title 37.2, Article 16 (§ [16.1-335](#) et seq.) of Chapter 11 of Title 16.1, or a judicial authorization for treatment proceeding pursuant to Chapter 11 (§ [37.2-1100](#) et seq.) of Title 37.2;
13. To a magistrate, the court, the evaluator or examiner required under Article 16 (§ [16.1-335](#) et seq.) of Chapter 11 of Title 16.1 or § [37.2-815](#), a community services board or behavioral health authority or a designee of a community services board or behavioral health authority, or a law-enforcement officer participating in any proceeding under Article 16 (§ [16.1-335](#) et seq.) of Chapter 11 of Title 16.1, § [19.2-169.6](#), or Chapter 8 (§ [37.2-800](#) et seq.) of Title 37.2 regarding the subject of the proceeding, and to any health care provider evaluating or providing services to the person who is the subject of the proceeding or monitoring the person's adherence to a treatment plan ordered under those provisions. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person.

Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained;

14. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

15. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § [9.1-156](#);

16. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ [54.1-2981](#) et seq.);

17. To third-party payors and their agents for purposes of reimbursement;

18. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § [32.1-127.1:04](#);

19. Upon the sale of a medical practice as provided in § [54.1-2405](#); or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

20. In accord with subsection B of § [54.1-2400.1](#), to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

21. Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § [32.1-127](#);

22. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

23. In connection with the work of any entity established as set forth in § [8.01-581.16](#) to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

24. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

25. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

26. To the Office of the State Inspector General pursuant to Chapter 3.2 (§ [2.2-307](#) et seq.) of Title 2.2;

27. To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ [32.1-122.10:001](#) et seq.) of Chapter 4, pursuant to subdivision 1;

28. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § [32.1-116.1](#);

29. To law-enforcement officials, in response to their request, for the purpose of identifying or locating a suspect, fugitive, person required to register pursuant to § [9.1-901](#) of the Sex Offender and Crimes Against Minors Registry Act, material witness, or missing person, provided that only the following information may be disclosed: (i) name and address of the person, (ii) date and place of birth of the person, (iii) social security number of the person, (iv) blood type of the person, (v) date and time of treatment received by the person, (vi) date and time of death of the person, where applicable, (vii) description of distinguishing physical characteristics of the person, and (viii) type of injury sustained by the person;

30. To law-enforcement officials regarding the death of an individual for the purpose of alerting law enforcement of the death if the health care entity has a suspicion that such death may have resulted from criminal conduct;

31. To law-enforcement officials if the health care entity believes in good faith that the information disclosed constitutes evidence of a crime that occurred on its premises;

32. To the State Health Commissioner pursuant to § [32.1-48.015](#) when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ [32.1-48.05](#) et seq.) of Chapter 2;

33. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § [32.1-116.1](#) and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment;

34. To notify a family member or personal representative of an individual who is the subject of a proceeding pursuant to Article 16 (§ [16.1-335](#) et seq.) of Chapter 11 of Title 16.1 or Chapter 8 (§ [37.2-800](#) et seq.) of Title 37.2 of information that is directly relevant to such person's involvement with the

individual's health care, which may include the individual's location and general condition, when the individual has the capacity to make health care decisions and (i) the individual has agreed to the notification, (ii) the individual has been provided an opportunity to object to the notification and does not express an objection, or (iii) the health care provider can, on the basis of his professional judgment, reasonably infer from the circumstances that the individual does not object to the notification. If the opportunity to agree or object to the notification cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the health care provider may notify a family member or personal representative of the individual of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition if the health care provider, in the exercise of his professional judgment, determines that the notification is in the best interests of the individual. Such notification shall not be made if the provider has actual knowledge the family member or personal representative is currently prohibited by court order from contacting the individual;

35. To a threat assessment team established by a local school board pursuant to § [22.1-79.4](#), by a public institution of higher education pursuant to § [23-9.2:10](#), or by a private nonprofit institution of higher education; and

To a threat assessment team established by a local school board pursuant to § [22.1-79.4](#), by a public institution of higher education pursuant to § [23.1-805](#), or by a private nonprofit institution of higher education; and

36. To a regional emergency medical services council pursuant to § [32.1-116.1](#), for purposes limited to monitoring and improving the quality of emergency medical services pursuant to § 32.1-

111.3. Notwithstanding the provisions of subdivisions 1 through 35, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any accusation of wrongful conduct; (iii) in the discharge of the duty, in accordance with subsection B of § [54.1-2400.1](#), to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Health care records required to be disclosed pursuant to this section shall be made available electronically only to the extent and in the manner authorized by the federal Health Information Technology for Economic and Clinical Health Act (P.L. 111-5) and implementing regulations and the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.) and implementing regulations. Notwithstanding any other provision to the contrary, a health care entity shall not be required to provide records in an electronic format requested if (i) the electronic format is not reasonably available without additional cost to the health care entity, (ii) the records would be subject to modification in the format requested, or (iii) the health care entity determines that the integrity of

the records could be compromised in the electronic format requested. Requests for copies of or electronic access to health records shall (a) be in writing, dated and signed by the requester; (b) identify the nature of the information requested; and (c) include evidence of the authority of the requester to receive such copies or access such records, and identification of the person to whom the information is to be disclosed; and (d) specify whether the requester would like the records in electronic format, if available, or in paper format. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within 15 days of receipt of a request for copies of or electronic access to health records, the health care entity shall do one of the following: (A) furnish such copies of or allow electronic access to the requested health records to any requester authorized to receive them in electronic format if so requested; (B) inform the requester if the information does not exist or cannot be found; (C) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (D) deny the request (1) under subsection F, (2) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (3) as other provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of state law.

F. Except as provided in subsection B of § [8.01-413](#), copies of or electronic access to an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of or electronic access to health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual. The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense. Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical

psychologist determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider. Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information: AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS Individual's Name Health Care Entity's Name Person, Agency, or Health Care Entity to whom disclosure is to be made Information or Health Records to be disclosed Purpose of Disclosure or at the Request of the Individual As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity. This authorization expires on (date) or (event) Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign Relationship or Authority of Legal Representative Date of Signature

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena. No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena. Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty. In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or

issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters: **NOTICE TO INDIVIDUAL** The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language: **NOTICE TO HEALTH CARE ENTITIES** A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA. YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT: NO MOTION TO QUASH WAS FILED; OR ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION. IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE: PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivision 5 or 8 from the party on whose behalf the subpoena duces tecum was issued. If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such

portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later. A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § [8.01-413](#), or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct. The provisions of this subsection

shall apply to subpoenas for the health records of both minors and adults. Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed. A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ [8.01-399](#) and [8.01-400.2](#).

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, “individual” shall subsume a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.

K. Nothing in this section shall prohibit a health care provider who prescribes or dispenses a controlled substance required to be reported to the Prescription Monitoring Program established pursuant to Chapter 25.2 (§ [54.1-2519](#) et seq.) of Title 54.1 to a patient from disclosing information obtained from the Prescription Monitoring Program and contained in a patient’s health care record to another health care provider when such disclosure is related to the care or treatment of the patient who is the subject of the record.

MSV Policy:

485.000 Telemedicine

485.001: Establishing a Physician-Patient Relationship via Telemedicine

Date 10/26/2014

The Medical Society of Virginia supports the following principles:

1. A physician-patient relationship with prescribing can only be established via telemedicine if the encounter a) provides information equivalent to an in-person exam, b) conforms to the standard of care expected of in-person care (for example, if a component of a physical examination is generally the considered standard of care in diagnosing and treating a particular condition, then such a physical examination must also be performed), including through the use of peripheral devices appropriate to the patient's condition, c) incorporates diagnostic tests sufficient to provide an accurate diagnosis (for example, if a diagnostic test is required for an accurate diagnosis of strep throat or urinary tract infection, then such diagnostic test should be performed), or d) there is a duly licensed practitioner (such as a nurse, NP, PA, or physician) as a telepresenter with the patient.
2. A physician-patient relationship resulting in prescribing cannot be established through an examination by telephone (audio-only) or email, except in cases of public health emergency as determined by the Secretary of Health and the Commissioner of Health.
3. Such regulation outlined above shall not prohibit currently accepted on-call or cross coverage practices.

485.002: Reimbursement of Telemedicine and Disclosure of Ownership Interests in Telemedicine Companies

The Medical Society of Virginia supports the following principles and will pursue appropriate strategies to enact these principles, including but not limited to direct negotiation with third party payers, regulation through the Board of Medicine, or, if necessary, through state legislation:

1. Physicians should receive appropriate reimbursement for telemedicine encounters for patients with whom they have an established physician-patient relationship.
2. Any financial or equity arrangements between insurance companies and direct-to-consumer telemedicine companies should be fully disclosed to patients.

INFORMATION PROVIDED FOR EXAMINEE USE ONLY

The Performance Profile below is provided solely for the benefit of the examinee.

These profiles are developed as self-assessment tools for examinees only and will not be reported or verified to any third party.

USMLE STEP 2 CS PERFORMANCE PROFILE

	Lower Performance	Borderline Performance	Higher Performance
Integrated Clinical Encounter (ICE)			xxxxxxxxxxxx
Communication and Interpersonal Skills (CIS)			xxxxxxxxxxxx
Spoken English Proficiency (SEP)			*

The above Performance Profile is provided to aid in self-assessment. The shaded area defines a borderline level of performance for each subcomponent (ICE, CIS, SEP); borderline performance is comparable to a HIGH FAIL/LOW PASS on the subcomponent.

Performance bands indicate areas of relative strength and weakness. Some bands are wider than others. The width of a performance band reflects the precision of measurement: narrower bands indicate greater precision. The band width for a given content area is the same for all examinees. An asterisk indicates that your performance band extends beyond the displayed portion of the scale. Small differences in the location of bands should not be over interpreted. If two bands overlap, performance in the associated areas should be interpreted as similar.

Additional information concerning the Step 2 CS subcomponents can be found in the *USMLE Step 2 CS Content Description and General Information Booklet*.