

2022 ANNUAL MEETING Delegates Handbook



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- D. AMA Virginia Delegation Report
- E. MSV Medical Student Section Report
- F. Virginia Board of Medicine Annual Report
- G. Physician Assistant Section Report



MEMORANDUM

Date:	July 29, 2022
Memo to:	Presidents, Secretaries and Executive Directors of Component and Specialty Societies Academic Medical Schools Health Systems
From:	Alan Wynn, MD, Speaker Michele A Nedelka, MD, Vice Speaker
Subject:	Call for Resolutions 2022 Annual Meeting of the Medical Society of Virginia House of Delegates

Resolutions should be submitted online by September 13th, 2022 to the MSV House of Delegates to be considered as regular business.

- Visit <u>http://www.msv.org/submit-resolution</u> to submit a resolution and for additional materials.
- Late resolutions, submitted after September 13, 2022 will be subject to consideration under the Rules of Procedure.
- If your society has a scheduled meeting that occurs after September 13, 2022, your society may submit a resolution within 7 days of the meeting. Resolutions submitted on behalf of a society must be submitted no later than September 27, 2022. Please email <u>healthpolicy@msv.org</u> to let us know.
- Receipt of resolutions will be confirmed by return e-mail message. If you do not receive a confirmation, your resolution has not been received.

To be considered at the MSV House of Delegates, all resolutions must meet the following criteria:

- Identify who is submitting the resolution and include a point of contact;
- Submitted in final form resolution(s) submitted on behalf of a society must be approved by the society;
- "Whereas" clauses shall include where appropriate and available evidence-based guidelines, and with appropriate citations upon the submission of the resolution per MSV Policy 55.3.05 Establish Evidence Based Guidelines for MSV Resolutions;
- The "Resolved" must not refer back to any "Whereas" statement, nor to an appended table or report.
- Changes or additions to MSV policy should refer to the Policy Compendium with appropriate policy numbers, strikethroughs, and underlines; and
- Supporting background material may be submitted electronically with the resolution.

Please visit our "How to Write a Resolution Guide" and "Sample Resolution" for additional assistance.

Questions: Email <u>healthpolicy@msv.org.</u>

OCTOBER 28, 2022 @ 10:00AM House of Delegates-First Session



Call to Order The Speakers

Pledge of Allegiance The Speakers

Invocation Atul Marathe, MD

Speaker Remarks

The Speakers Introduction of Guests In Memoriam MSV Past Presidents

Presidential Address Mohit Nanda, MD

MSVPAC Update & Awards Lee Ouyang, MD

MSV Foundation Raffle Drawing The Speakers

Meditation Break Tiffany Niide, MD (Sponsored by Carilion Medical Center)

Credentials Committee Report Quinn Lippman, MD

Rules Committee Report Samuel Bartle, MD

Request for approval of the 2021 MSV House of Delegates sessions minutes Larry Mitchell, MD

Consent Calendar: Resolutions submitted to the House of Delegates (Any resolution is eligible for extraction) The Speakers

Consent Calendar: Informational Reports (Any item is eligible for extraction)

The Speakers

MSV Board of Directors Actions on the 2021 Resolutions Referred to the Board MSVPAC Report MSV Foundation Report AMA Virginia Delegation Report Medical Student Section Report Virginia Board of Medicine Annual Report Physician Assistant Section Report

New Business The Speakers

Announcements and Recess The Speakers

Recess until 8:00 a.m. Sunday, October 30, 2022

Recognize New Delegates Recognize 20+ year MSV members Recognize Second Century Circle members

OCTOBER 30, 2022 @ 8:00AM House of Delegates-Second Session



Call to Order The Speakers

Speakers Remarks The Speakers

MSV Chief Executive Officer & EVP Remarks Melina Davis

Credentials Committee Report Quinn Lippman, MD

Nominating Committee Report Edward Koch, MD

Election of Officers and Directors The Speakers

Installation of MSV Board of Directors Officers

Incoming President's Remarks Harry Gewanter, MD

Election of the 2022-2023 Nominating Committee The Speakers

Meditation Break Tiffany Niide, MD (Sponsored by Carilion Medical Center)

Resolutions Referred to the Board Speakers

Reference Committee Reports Reference Committee 1 Reference Committee 2

Announcements The Speakers

Adjournment The Speakers



Delegate Handbook 2022 Delegate References

1. New Delegate Orientation PowerPoint

2. Quick Guide to Parliamentary Procedure

3. Rules of Procedure 2022



New Delegate Orientation 2022 MSV Annual Meeting



WILLIAM C. REHA, MD, MBA

Former Speaker and MSV Past President, Vice Chair-AMA Delegation

MSV House of Delegates

- Policymaking body of the Society
- Comprised of physician 'delegates' from around the state
- Key part of MSV; policy drives year-round advocacy efforts

Your Delegate Handbook

- Order of Business
- Parliamentary Procedure
- Business Items (Minutes, Reports)
- Resolutions

Definitions 101

- Delegates
 - Physicians or Medical Students
 - Vote on resolutions, approve the budget, and elect officers
 - Represent local medical society, specialty society, academic institution, students, residents, or hospital.
- Resolutions
 - After approval by the HOD become policy
 - Determine MSV's official position on an issue
 - Are used to guide legislative and regulatory action

MSV HOD: Parliamentary Procedure

- MSV HOD uses the AIP Standard Code of Parliamentary Procedure to run the meeting
- You do not need to be an expert!
- Review the 'cheat sheet in your Delegate Handbook'

Motions

- Resolution is a "main motion"
- Main motions can be amended
- Amendments can be amended one at a time

Subsidiary Motions

- "Higher Order" than a motion
- In descending order:
 - Adjourn, recess, question of privilege, table, vote, limit debate, postpone debate, refer, amend

Session 1

- Speeches, Addresses, Updates
- Clarence A. Holland, MD Award
- Member Appreciation

Session 2

- Committee Reports
- Elections
- Reference Committee Reports

HOD Committees

- Credentials
- Tellers
- Rules
- Reference

MSV HOD: Resolutions

- Resolutions determine MSV's policy position on a variety of issues
 - Any MSV member, component organization, or society can propose a resolution
- The "Whereas" clause(s) provide background information
- The "Resolved" clause(s) stand alone and will be voted on by the House of Delegates
 - All resolutions will be discussed in Reference Committees on Friday, October 28th

MSV HOD: Resolution Example

PROMOTING AUTOMATIC DUES PAYMENT

Submitted by John Smith, M.D.

WHEREAS, the Medical Society of Virginia launched its new website www.msv.org; and

WHEREAS, the new site is capable of exciting new online features, including the ability to join and renew membership online and automatically pay dues via credit card; and

WHEREAS, payment of dues by credit card is the most efficient method to renewing your membership year after year; therefore be it

RESOLVED, that the Medical Society of Virginia encourage its members and others to pay dues online and via credit card at www.msv.org.

Reference Committees and Extractions

- Reference Committees have provided recommendations on each Resolution to the Full House of Delegates
- Recommendations include
 - Adopt
 - Not Adopt
 - Adopt as amended
 - Adopt in Lieu of Another Resolution
- Reference Committee reports reflect all of the recommendations of the Committee to be placed on the Consent Calendar
 - Example Reference Committee Report on next slide
- Committee recommendations move to Consent Calendar for an en bloc vote unless individual resolutions are "extracted" from that calendar

Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Society.
MEDICAL SOCIETY OF VIRGINIA HOUSE OF DELEGATES Report of Reference Committee 1
Dr. Patricia Pletke, Chair
The Reference Committee recommends the following consent calendar for acceptance:
RECOMMENDED FOR ADOPTION
19-101 2020 Budget 19-102 2019 MSV Policy Compendium 10 Year Review
RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED 19-104 Opposition to Maintenance of Certification 19-107 American "Equal Rights Amendment" 19-108 Advancing Gender Equity in Medicine 19-110 Organ Donation as an Opt-Out or Mandated Choice Program 19-111 Resolution on Medical Care of the Terminally III 19-112 Resolution to Stop Robocalls in Virginia
RECOMMENDED FOR REFERRAL TO BOARD OF DIRECTORS None
RECOMMENDED FOR NOT ADOPTION 19-106 Form a Patient Advocacy Section in the Medical Society of Virginia and Its Component Medical Societies
RECOMMENDED FOR ADOPTION IN LIEU OF 19-103 Resolution Regarding the Maintenance of Certification Process 19-105 Promoting Alternatives to Proprietary ABMS Maintenance of Certification 19-109 GME Funding and Support for Rural Hospitals

- If an item is extracted from the Reference Committee report, the original report or Resolution, which has been accepted by the House as its business, is the Main Motion before the Assembly.
- If a Reference Committee consolidates closely related items, the Reference Committee Substitute will be the matter before the House or the Main Motion (Adopt In-Lieu of Motion).

Amendments

- Amendments are intended to clarify or improve a resolution
- Reference Committees can recommend that resolutions be adopted with amendments crafted by the Committee
- Amendments (and amendments to amendments second order amendments) are permitted on the floor of the House
- Debate begins by consideration of the item of business in the Reference Committee report

HOD Actions

Resolutions may...

- Be adopted as MSV Policy
- Be adopted as amended
- Be not adopted
- Be referred to the MSV Board of Directors

MSV Policy Compendium

- If approved by the full body, resolutions are put in our <u>Policy Compendium</u>
- The Policy Compendium governs MSV's legislative positions and actions

Questions?

MSV

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MSV



A	merican Ins	stitute of I		urians Standar ules Governin		iamentary Procedu	re	
Order of Rank/Precedence ¹	Interrupt	Second		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 Motio	ons							
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; not amend	No

American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table



	I	ncidental	Motions (non-ranking w	vithin the classi	fication)		
Motions								
No order of						Applies to what	Can have other	
Rank/Precedence	Interrupt	Second	Debate	Amend	Vote	other motions?	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	None	Yes
						Subject		
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

American Institute of Parliamentarians (888) 664-0428 www.aipparl.org aip@aipparl.org

American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table



Rules of Procedure

of the

Medical Society of Virginia

House of Delegates

2022 Proposed Changes

Adopted Nov. 1995 Revised Nov. 2001, 2005, Oct. 2008, Nov. 2011, Oct. 2013, Oct. 2014, Oct. 2016, Oct. 2017, Oct. 2018, Oct. 2019

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I. FORWARD

The House of Delegates, the policy making body of the Medical Society of Virginia (MSV), conducts its business according to a blend of rules including:

- The Medical Society of Virginia Articles of Incorporation and Bylaws;
- American Medical Association's Procedures of the House of Delegates;
- American Institute of Parliamentarians Standard Code of Parliamentary Procedure; and
- Rulings from the Speaker, Vice Speaker, or chair, with approval of the majority opinion of the House of Delegates.

At each meeting the House of Delegates adopts the current version of the MSV Rules of Procedures as the official method of procedure when it adopts the report of the Rules Committee.

The Rules of Procedure are designed to aid the House achieve its business, while maintaining the rights of free speech and fair debate; of the majority to decide; and of the minority to be heard, represented, and protected.

II. INTRODUCTION AND CONDUCT OF BUSINESS

The agenda at all sessions of the House of Delegates shall be established by the Speaker. The House may change the agenda by majority vote.

Tradition governs a substantial portion of each formal session of the House of Delegates. The Speaker may permit these agenda items as appropriate while ensuring the time necessary for the House to accomplish its regular business. In general, such items are scheduled in advance in the published order of business.

Unscheduled presentations may be arranged, either with the Speaker, or by a request for unanimous consent of the House to hear them. Unscheduled presentations are generally discouraged because of the primary obligation to conserve the time of the House for its deliberations.

Non-members addressing the House will be limited to not more than five minutes.

If necessary, additional sessions of the House shall be upon the call of the Speaker.

III. GUIDELINES FOR RESOLUTIONS

A. THE **<u>PURPOSE</u>** OF A RESOLUTION

The purpose of a resolution is to bring a proposed policy statement on a particular issue before the House of Delegates. Adopted resolutions become official MSV policy, guide all advocacy efforts, and commit the organization to the stated proposal.

Possible actions by the House may include:

- (1) the establishment of policy;
- (2) the reaffirmation (or modification) of previously established policy;
- (3) request for action by the Society, Board, its committees, or staff;
- (4) any others, described on page 11 in section V.

B. <u>WHO</u> MAY PROPOSE A RESOLUTION

A resolution may be proposed by:

- (1) any member of the MSV;
- (2) any member of the House of Delegates of the MSV;
- (3) any Component Society;
- (4) any Component Student Society;
- (5) any Component Resident Physician Section;
- (6) the Hospital Medical Staff Section;
- (7) any Specialty Society;
- (8) any Committee of the Society;
- (9) the Board
- (10) any district of the MSV.

C. <u>WHEN</u> A RESOLUTION MAY BE PROPOSED

A resolution must be received at the MSV headquarters office no later than 45 days prior to the first session of the House of Delegates.

- EXCEPTIONS:
 1. A Component Society or Specialty Section or District whose latest regularly scheduled meeting adjourns within the 45 days is allowed 7 days after the close of such meeting to submit any resolution.
 - 2. The Board, as a result of its meeting before the first session of the House of Delegates, may submit any business or resolution for routine consideration by the House.
 - 3. Any Committee of the Society.
 - Resolutions from the business meeting of the Resident Physician Section or the Hospital Medical Staff Section of the ongoing meeting of the House of Delegates may be presented for consideration by the House of Delegates any time before the beginning of the second session of the House.

<u>LATE RESOLUTIONS</u> are those received after the deadline described above, but before noon of the day before the first session of the House of Delegates.

Late Resolutions will be considered by the Rules Committee in a meeting immediately before the first session of the House of Delegates. This committee will provide late resolution sponsors an opportunity to explain the reasons for their failure to meet the announced deadlines. If the sponsor(s) can provide a reasonable explanation or if the Committee determines that deferral of the resolution would result in significant harm to the MSV, its members, or their patients, the Committee may recommend accepting a late resolution.

The House of Delegates, by a two-thirds affirmative vote of those delegates present and voting, may accept for discussion any late resolution presented during its first session.

D. ADDITIONAL RESOLUTION TYPES

Emergency Resolutions: The sponsor of an emergency resolution must notify the Speakers of their intent to introduce an emergency resolution before the start of the second session of the House of Delegates. A resolution of an emergency nature may be referred by the Speakers to an appropriate reference committee which shall then report to the House as to whether the matter involved is, or is

not, of an emergency nature. If the committee reports that the matter is of an emergency nature, it shall be presented to the House without further consideration by a reference committee; favorable action shall require 3/4 of the delegates present and voting, to accept for discussion the emergency resolution. If the committee reports that the matter is not of an emergency nature, the Speakers shall defer its introduction until the next meeting of the House of Delegates.

Emergency resolutions may not address a topic already before the House considered by a Reference Committee.

<u>Courtesy Resolutions:</u> will be in order on the agenda of the second session of the House of Delegates, and, if indicated, at other times. Please coordinate the introduction of courtesy resolutions with the Speakers, by informal conference with them.

<u>Commendation Resolutions</u>: Commendation proposals should be sent to the Board, for careful consideration for an award or other appropriate recognition.

<u>Memorial Resolutions</u>: The House of Delegates may receive memorial resolutions to remember a physician who has made significant contributions to MSV. At an appropriate time in the meeting, the Speaker will announce the memorial resolutions and call for a moment of silence.

E. RESOLUTION STRUCTURE

1. General Qualities of an Effective Resolution

An effective resolution will enable the House of Delegates to consider its purpose expeditiously. Resolutions are encouraged to be concise, precise, and stated in the affirmative.

Each resolution will contain reference to current MSV policy, or absence of any, and will conform to the Policymaking Procedure, which is reported in Section IV.

2. The Title

The title should accurately reflect the subject of the resolution.

3. The "Resolved" Section

The essential element of a resolution is the portion expressed as one or more "Resolved" sections, setting forth specific intent or action.

In adopting a resolution, the House of Delegates **only** formally adopts the "Resolved" section. The goal of a resolution is to state, in a freestanding and self-sufficient "Resolve", <u>precisely</u> the position or action upon which the author wishes the House of Delegates to act.

The "Resolved" must not refer back to any "Whereas" statement, nor to an appended table or report.

4. The Preliminary Statement, Preamble, Or "Whereas"

The resolution may carry with it a preliminary statement explaining the rationale behind the resolution, such as preliminary statement, preamble, or "Whereas."

Such introductory statements may:

- identify the problem;
- advise the House as to the timeliness or urgency of the problem;
- advise as to the effect of the problem on the MSV; and
- indicate if the proposed action is in concert with, or contrary to, current MSV policy.

Please refer to the MSV Annual Meeting website for resources on <u>"How to Write a Resolution" as well</u> as a "Sample Resolution."

<u>"Whereas" clauses should include, where appropriate, and available evidence-based guidelines, the strength of recommendations, or level of evidence if applicable information and with appropriate citations upon the submission of the resolution per MSV Policy 55.3.05 Establish Evidence Based Guidelines for MSV Resolutions.</u>

These statements will have no impact on policy decisions as the House of Delegates formally adopts only the "resolved" portion of a resolution.

It is out of order to propose formal amendments to the wording of accessory preliminary statements, or even to the language of descriptive comments of reference committee reports, unless it is the particular desire to the majority of the House of Delegates to do so.

5. The Addenda

Tables, reference data, etc., may be appended to the resolution at the time of submission. This data is not voted upon by the House of Delegates.

6. The Fiscal Note

In the MSV at the present time, a Fiscal Note is <u>suggested</u> as follows:

- a. All reports and resolutions introduced in the House of Delegates, whose implementation necessitates an expenditure of funds, may include a fiscal note supplied by the sponsor, but they may be considered by the House without the attachment of such fiscal data.
- b. Resolutions requiring the expenditure of funds should show a specific dollar amount where possible.
- c. The office of the Executive Vice President can assist sponsors with the development of fiscal information; requests of this nature should be forwarded well in advance of the deadline for submitting resolutions.
- d. Resolutions, which call for the institution of legal action, the repeal of legislation or similar action for which a precise cost estimate cannot be determined, should indicate that a substantial commitment of resources might be necessary for implementation.
- e. Resolutions which establish or reaffirm policy, and which do not require other specific action beyond that covered by the MSV's routine work, need not have fiscal notes appended; MSV staff may provide the appropriate fiscal notes.

F. <u>REVIEW</u> OF A PROPOSED RESOLUTION

When resolutions are properly prepared and are submitted in timely fashion, the Speakers, the MSV administration and legal counsel will be able to consider, with the sponsor, possible improvements in form or language. If changes are indicated, they will be accomplished with the agreement of the sponsor.

When a resolution is not accompanied by sufficient data to allow proper advance consideration of that resolution, it will be sent back to the submitter. If the deficiency is not remedied in time, the resolution will be deemed a "late" resolution and submitted to the Rules Committee for consideration at its meeting held immediately before the first session of the House of Delegates.

When a resolution presents a legal problem to the Medical Society of Virginia or its component societies, the Speakers and staff will contact the sponsor to discuss the problem. If such a conference with the sponsor is able to remedy the situation, the resolution will be distributed in a routine manner. If, for whatever reason (such as a mandate from the sponsoring Component Society that the resolution not be altered) resolution of the legal problem cannot be accomplished, the Speakers will refer the resolution to the MSV Board of Directors Rules Committee. A two thirds-majority of the MSV Board of Directors makes any proposed resolution a "Deferred Resolution." If the BOD determines the resolution is will designate it as a "Deferred Resolution," and it will not be distributed in the advance handbook.

Deferred Resolutions will be considered by the Rules Committee prior to the first session of the House of Delegates. Legal Counsel of the Society will be present if a deferred resolution is to be heard. The Rules Committee, subject to a majority vote of committee members, will recommend that the House either accept or not accept the resolution. A two-thirds majority vote of the House is required for acceptance of a deferred resolution.

G. <u>PRESENTATION</u> OF A PROPOSED RESOLUTION AT HOUSE OF DELEGATES

Resolutions in the delegates' handbook, which have complied with the established deadlines, will be regarded as officially received for consideration by the House of Delegates.

At the appropriate time, the Speaker will call for introduction of resolutions. For each resolution there must be a "sponsor" and a "second" who act officially in introducing as business of the House.

The Speakers will also allow for sponsors the opportunity to present any changes to their resolution or withdraw any resolution without vote, when this is desired by the sponsor.

At the time of introduction of any resolution, it is possible for any delegate to object to its consideration; in that event, sustained by a 2/3 vote of the delegates present and voting, the resolution is not accepted as business of the House. It is likewise possible, at the time of introduction of any resolution, for any delegate to move that it be adopted by unanimous consent, or that it be voted upon without referral to a reference committee; objection to such a motion is always in order.

IV. POLICYMAKING PROCEDURE

The first policy compendium (PC) was accepted by Council in September 1992, along with Procedure for Implementation and Utilization. Parts of those documents are referenced here.

Policymaking Procedure

- The authors (officers, Board, committees, component societies, individual members, et al.) of all resolutions and reports will utilize the PC as the reference point for policymaking. Proposed statements of policy shall be clearly identified as policy recommendations; they shall clearly identify and refer to existing pertinent policy (if any) on the issue addressed, indicating whether the proposed policy is a new addition to the policy base, or a modification of existing policy.
- 2. While the House of Delegates is the official policymaking body of the Society, not all actions taken by the House are considered policy. Statements of "policy" are general principles by which the Society is guided in its management of public affairs. Actions taken by the House of Delegates that are not considered policy, and that would not be subject to this procedure include the following:

- a. Amendments to the Articles of Incorporation or Bylaws of the MSV.
- b. Items considered by the House of Delegates, which are referred or filed.
- c. Action of the House of Delegates directing the Society, its staff, or some other entity, to undertake a particular activity ("Directives").
- d. Temporary policy, e.g., a resolution to change the order of the agenda in a meeting.
- e. Appointments, elections, awards, commendations and memorial resolutions.
- f. Action dealing with internal business operations of the MSV, e.g., adoption of the annual budget.
- 3. There are two general classes of policymaking instruments used by the House, namely resolutions and reports.

"Policy actions" refer to those resolutions or reports which either create new policy or modify existing policy. There are four major categories of possible action within the broad category of "policy actions," namely: A) Adoption of new policy where there is no pertinent existing policy; B) Amending of existing policy; C) Substitution of a proposed policy statement for an existing policy; and D) Rescission of an existing policy.

Hereafter follows the description of the policymaking procedure in reference to each of these types of policy actions. The PC also should be referenced by resolutions or reports that direct some particular action with regard to a particular statement of policy, i.e., study of the need to establish or change a particular policy.

- 4. Mechanisms for presenting resolutions and recommendations of reports:
 - a. Adoption of New Policy Where There is No Pertinent Existing Policy
 - (1) In the "whereas" section, the sponsor explains the rationale for the proposed new policy.
 - (2) In the "resolved" section, the sponsor explicitly identifies the proposal of new policy.
 - b. <u>Amending of Existing Policy</u>
 - (1) In the first "whereas" section, the sponsor identifies the existing relevant policy, by PC policy number (with a brief description of it if the policy is long, or with the actual quotation of it if it is shorter).
 - (2) In the subsequent "whereas" section(s), the sponsor presents the rationale for the proposed change(s).
 - (3) In the "resolved" section(s), the sponsor precisely identifies the proposed change(s) by <u>underlining the proposed additions</u> and by striking out the proposed deletions or changes.
 - c. <u>Substitution of a Proposed Policy Statement for Existing Policy</u>, where a sponsor wants to change substantially existing policy through adoption of a new policy statement.

- (1) In the first "whereas" section, the sponsor identifies the relevant existing policy by PC number (with a brief description of it if the policy is long, or with the actual quotation of it if it is shorter).
- (2) In the subsequent "whereas" section(s), the sponsor presents the rationale for the proposed change(s).
- (3) In the first "resolved" section, the sponsor calls for the rescission of the existing policy by PC number.
- (4) In the subsequent "resolved" section(s), the sponsor states the proposed substitution.
- d. <u>Rescission</u> would be indicated if the proponent believes the existing policy is no longer needed and there is no need for a substitute policy on the subject.
 - (1) In the first "whereas" section, the sponsor identifies the existing policy number (with a brief description of it if the policy is long, or with the actual quotation of it if it is shorter).
 - (2) In the subsequent "whereas" section(s), the sponsor presents the rationale for the proposed rescission.
 - (3) In the "resolved" section, the sponsor calls for rescission of the existing policy by only the PC policy number.

Any policy which is rescinded will be transferred to the "Archives," which will be the last section in the Policy Compendium, utilizing the same number, title and category, adding the date of its rescission, together with the reason.

- e. <u>Reaffirmation</u> is actually not needed because current MSV policy continues to be MSV policy until altered by one of the above four mechanisms. However, occasionally a sponsor feels compelled to encourage the House of Delegates to reaffirm policy on a particular issue.
 - (1) In the first "whereas" section, the sponsor identifies the existing policy by PC number, with a brief description of it if the policy is long, or with the actual quotation of it if it is shorter.
 - (2) In the subsequent "whereas" section(s), the sponsor presents reasons necessitating a restatement or repetition of that existing policy.
 - (3) In the "resolved" section, the sponsor calls for reaffirmation by only the PC policy number.
- f. <u>Directives</u> would be appropriate when the proponent has either identified existing policy in the MSV PC and desired to call for the MSV to undertake some activity in regard to it, or has identified the need for the MSV to study some issue and to develop appropriate policy.

In regard to either issue:

- (1) In the first "whereas" section, the sponsor identifies the relevant MSV policy number, with a brief description of it if the policy is long, or with the actual quotation of it if it is shorter.
- (2) In the subsequent "whereas" section(s), the sponsor discusses the rationale for the proposed directive.

- (3) In the "resolved" section, the sponsor identifies the requested action. In the former example of a directive, a proposal might include encouraging the MSV to contact some group(s) in support of the policy, forwarding MSV policy to the AMA requesting action, preparing a study or model to be utilized by the Society, or encouraging activity to implement existing policy. In regard to the latter example of a directive, a proposal might include studying a given issue to provide the proper basis for creating further policy.
- 5. A Reaffirmation (Consent) Calendar will be established in the agenda of the House of Delegates to consider established policy where a sponsor of a resolution desires to reaffirm that current policy without changing it. This procedure will allow for the expeditious reaffirmation and reemphasis of established policy, without the lengthy reconsideration process of the reference committee system and subsequent full debate by the House of Delegates --- on policy already in force. Any item on the Reaffirmation Consent Calendar can be extracted from it for full debate by the reference committee and the House, by simple request of a single member of the House of Delegates.
- 6. If two or more policies concerning the same subject are found in the PC, and the two statements either are substantially the same, or are inconsistent or contradictory with one another, the statement most recently adopted by the House of Delegates will prevail, and the less current policy will be removed from the next edition of the PC.
- 7. The Ten Year (Sunset) Provision of the New Policy Procedure: Ten years after the adoption of each policy action, the Speakers and MSV Staff will present to the MSV Board a "Ten Year Policy Review Report," encouraging consideration of each item in that report by the mechanisms reported above in paragraphs 4 b through e, or referral of such policies to an appropriate committee for the same purpose. Unless each such policy is acted upon by the subsequent House of Delegates via the 4 b-e mechanisms, it will cease to be policy of the MSV.
- 8. After each Annual Meeting of the House of Delegates of the MSV, the Speakers and MSV staff will:
 - a. Incorporating all statements of new policy and policy changes into the PC;
 - b. Assigning a topic category or categories for the index of the PC;
 - c. Removing statements of policy that have been rendered moot by changes in law, or that have been superseded by later action of the House of Delegates; and transferring them to the Archives section of the Policy Compendium;
 - d. Including any item inadvertently omitted during the process of creating the PC and the new Policymaking Procedure;
 - e. As in all matters, the House of Delegates has the final authority over the Speakers and Staff in these largely procedural and secretarial matters.
- 9. The Speakers and Staff will work diligently with the Board and House of Delegates to fairly execute the new Policymaking Procedure, and to further modify it as necessary in coming years.

V. REFERENCE COMMITTEES

Reference Committees are groups of delegates or alternate delegates selected by the Speaker to conduct open hearings on matters of business of the Society, which are referred to it by the Speaker. Having heard discussion on the subjects referred to it, the Committee draws up a report with its recommendations to the House.

- A. <u>Organization</u>: The Speaker shall appoint Reference Committees and a Chair for each Committee. The number of Reference Committees appointed shall be at the discretion of the Speaker. Each Reference Committee shall be composed of not less than six seven delegates, each from a different District, a non-voting Board member and a non-voting Student or Resident Section member. The Speaker shall refer all resolutions to an appropriate Reference Committee. In the assignment of business to Reference Committees, the ruling of the Speaker shall be final, unless the House of Delegates by majority vote directs otherwise.
- B. <u>Conduct of the Reference Committee Hearings</u>: Reference Committee hearings are open to all members of the Association, guests, and official observers. interested outsiders and the press. Any member of the Society may speak on the resolution or report under consideration. The chair is privileged to call upon anyone attending the hearing if, in his/her opinion, the individual called upon may have information, which would be helpful to the committee. Non-member physicians, or guests or interested outsiders may upon recognition by the chair, be permitted to speak. When a Reference Committee member has a special interest in a matter referred to the Committee of which he/she is not a member, he/she may appear before that Committee and participate in the presentation of the subject, but may vote only in the Committee of which he/she is a member.

Resolutions are accepted for business at the first session of the HOD. Even if the resolution's proposer or their representative are not at the Reference Committee Hearing, all Resolutions are discussed at the Reference Committee Hearings, Executive Session, and presented to the HOD for vote.

Equitable hearings are the responsibility of the committee chair, and the committee may establish its own rules on the presentation of testimony with respect to limitations of time, repetitive statements, etc. The chair also has the jurisdiction over such matters as photography, television filming, and the introduction of recording devices. If, in his/her estimation, such factors would be, or become, undesirable for the conduct of an orderly hearing, he or she may act to prohibit them. It is recommended that reference committee chairs **not** ask for an expression of the sentiments of those attending the hearing by an informal vote on particular items. The committee members may ask questions to be sure that they understand the opinions being expressed, or may answer questions if a member seeks clarification; however, the committee members should not enter into debate with speakers or express opinions during the hearings. It is the responsibility of the committee to listen carefully and evaluate all the opinions presented so that it may provide the voting body with a carefully considered recommendation.

The reference committee hearing is the proper forum for discussion of controversial items of business. In general, delegates who have not taken advantage of such hearings for the presentation of their viewpoints or the introduction of evidence should be reluctant to do so on the floor of the House. It is recognized, however, that some conflicts will prevent a delegate from being present at a Reference Committee hearing, so there is never compulsion for mute acceptance of reference committee recommendations at the time of the presentation of its report.

Following its open hearings, a reference committee will go into executive session for deliberation and construction of its report. It may call into such executive session anyone whom it may wish to hear or question.

C. <u>Reference Committee Reports</u>: Reference committee reports comprise the bulk of the official business of the House of Delegates. They need to be constructed swiftly and succinctly after completion of the hearings in order that they may be processed and made available to the delegates as far as possible in advance of formal presentation to the House.

Reference committees have wide latitude in their efforts to facilitate expression of the will of the majority on the matters before them and to give credence to the testimony they hear. They may amend resolutions, consolidate kindred resolutions by constructing substitutes, and they may recommend the usual parliamentary procedure for disposition of the business before them, such as adoption, rejection, amendment, referral and the like.

The reports of the Reference Committees shall be presented to the House at a meeting subsequent to the first session. A Reference Committee may recommend any method of disposal of business, which is in accordance with the current Parliamentary Authority. The method of presentation of Reference Committee reports shall follow the format employed by the House of Delegates of the AMA.

Your Speakers recommend that each item referred to a reference committee be reported to the House as follows:

- 1. Identify the resolution or report by number and title;
- 2. State concisely the committee's recommendation;
- 3. Comment, as appropriate, on the testimony presented at the hearings; and,
- 4. Incorporate supporting evidence of the recommendations of the committee.
- 5. Consent Calendar: The reference committee report will be presented as a Consent Calendar or waiver of debate list. At the time of presentation of the Consent Calendar, a request may be made for removal of any item for debate or individual action without the need for a vote on permission to separate it from the other items. Items not extracted from the Consent Calendar will be voted on as a block without further debate.

If an item is extracted from the reference committee report, the original report or resolution which has been accepted by the House as its business is the main motion before the House. Any amendments recommended by the reference committee will be accepted for discussion without the need for a second. In the event that a number of closely related items of business have been considered by the reference committee and a consolidation or substitution has been proposed by the committee, the reference committee substitute will be the matter before the House for discussion (as a main motion).

During debate in the House of Delegates, whenever a delegate proposes an amendment to a Reference Committee report, he/she shall immediately submit the proposal in writing to the Speaker. The Speaker shall not formally recognize the amendment until he/she receives it in written form.

D. <u>Form of action upon reports and resolutions</u>: There should be clear understanding of the precise effect of the language used in disposing of items of business.

In the interest of clarity the following recommendations are offered so that the House may accomplish its intent without misunderstanding:

 When the House wishes to acknowledge that a report has been received and considered, but that no action upon it is either necessary or desirable, the appropriate proposal for action is that the report be **FILED**. For example, a report, which explains a government program or regulations, or clarifies the issue in a controversial matter, may properly be filed for information. This does not have the effect of placing the Association on record as approving or accepting responsibility for any of the material in the report. When a report offers recommendations for action, these recommendations may be **ADOPTED**, **APPROVED** or **ACCEPTED** each of which has the effect of making the Association responsible for the matter.

- 2. When the House does not wish to assume responsibility for the recommendation of a report in its existing form, it may take action to refer back to committee, to refer elsewhere, to reject the report in entirety or in specific part, or to adopt as amended (**Amend and Adopt**).
- 3. The House of Delegates should take a definite action on resolutions and only if necessary reaffirm current policy. In the event that tabling a motion is the only appropriate posture for the Association with respect to a particular resolution, the chair of the reference committee after consultation with the Speakers, may place such resolution on the Consent Calendar in a category designated "table". Such a motion if adopted is the equivalent of a motion to postpone indefinitely and results in suppression of the resolution for the current meeting and in effect quashes it.
- 5. From time to time the Reference Committee will report on a resolution which calls for a policy position contrary to or at variance with existing policy. The committee may recommend reaffirmation of existing policy as an amendment by substitution in lieu of the original resolution. However, the committee should recommend rejection of such resolutions contrary to existing policy, particularly since the entire House of Delegates has not had the benefit of a thorough review of existing policy. It is the purpose of the Reference Committee to weigh existing policies, new information, standards of care, the will of the HOD, etc. to reach a consensus. The committee may recommend any of the options in Section V Item C. In the report to the HOD the recommendation will reference the current policy. The Speakers believe that reaffirmation is relatively indecisive since the previous policy has not been specifically reintroduced and debated. The appropriate recommendation therefore would be for a negative vote, so that previous policy will be reaffirmed.
- E. Parliamentary Procedure in the House:

A few comments on specific procedures may be helpful.

 The motion to REFER FOR REPORT BACK TO THE HOD: If it is desired that a matter be referred to the Board or through the Board to the appropriate Committee, it should be specifically indicated if a report back to the House of Delegates is desired at a definite time. Without such a directive, the matters of reporting back and its timing are up to the body receiving the referral. If the motion to REFER is adopted, all pending or adopted amendments as well as the subject are referred. All-Referral to specific committees are made through the Board.

The motion to REFER FOR DECISION: When the House of Delegates refers an item of business to the Board for decision, the House delegates to the Board the decision as to what action is appropriate. Once the Board determines the appropriate action, whether affirmative or negative or no action, it will inform the House via the Handbook prior to the next meeting, and may use other appropriate means such as MSV publications.

- 2. The motion to AMEND something already adopted: Not infrequently it becomes desirable on the basis of afterthought or further consideration to modify an action, which has already been taken. If the modification is a simple addition to the action taken, rather than a substantive change, it is not necessary to RECONSIDER. A motion to AMEND the previous action is in order and it becomes a main motion.
- F. The Motion to TABLE or POSTPONE TO A CERTAIN TIME of a question:

- 1. The motion to-postpone to a certain time is of higher rank than referral, and can be amended as to the definite time for consideration, with debate limited to brief discussion of the time or reason for postponement.
- 2. The motion to table is the highest ranking subsidiary motion to be applied to a main motion, requires a 2/3 majority vote, and has the effect to stop debate and remove the motion and any amendments to the motion from consideration on the floor.

VI. COMMITTEES OF THE HOUSE OF DELEGATES

To facilitate accomplishment of the business of the House of Delegates, the Speaker may appoint committees and their chairs from among the Delegates, Alternate Delegates, Student Members, and Affiliate members including but not limited to the following:

- A. Credentials Committee:
 - 1. To greet those attending the meeting;
 - 2. To direct those attending to appropriate areas of seating;
 - 3. To control the access to the floor of the House of Delegates and to monitor the doors so as to eliminate extraneous noise in the meeting;
 - 4. To record the attendance of delegates, developing the official Credentials Committee Report; and
 - 5. To deliver the Credentials Committee report to the House of Delegates.
- B. Rules Committee:
 - 1. To propose Rules of Procedure to the House of Delegates; and
 - 2. To make a determination and a report to the House of Delegates regarding late and deferred resolutions.
- C. Tellers Committee:
 - 1. To count and record votes at direction of the Speaker and according to Rules of Procedure.
 - 2. Affiliate members of the Society may serve as members on the Tellers Committee.

VII. NOMINATIONS

The House of Delegates, at its second session of the Annual Meeting, shall elect from its membership a committee on nominations, according to the applicable article of the Bylaws.

Members of the House of Delegates may make further nominations for each office at the Annual Meeting from the floor.

When applicable, one nominating speech for each candidate shall be limited to two minutes. A second to the nomination is required for acceptance.

MSV ANNUAL MEETING 2022 MAID / PAS Informational Packet

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Pros and Cons of Physician Aid in Dying

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The question of a physician's involvement in aid in dying (or "assisted suicide") is being debated across the country. This article adopts no one position because its authors hold contrasting views. It aims instead to articulate the strongest arguments in favor of aid in dying and the strongest arguments opposed. It also addresses relevant terminology and reviews the history of its legalization in the United States.

Physician aid in dying is a controversial subject raising issues central to the role of physicians. According to the American Medical Association, it occurs when a physician provides "the necessary means and/or information" to facilitate a patient's choice to end his or her life [1].

This essay's authors hold varying views on the ethics of aid in dying; thus, the essay explores the subject without taking a position. It addresses its terminology; history of legalization in the United States; arguments in favor of aid in dying; and arguments opposed.

TERMINOLOGY

Physician aid in dying goes by many names. Perhaps the best recognized is "physician-assisted suicide." Alternative terms include but are not limited to: death with dignity, doctor-prescribed death, right to die, and physician-assisted death. For simplicity's sake, we use aid in dying (AID†), although we recognize that there will be some who object, no matter the label.

A variety of factors have led to these various neologisms. Supplanting the word "physician" with "medical," for example, makes it possible for non-physician clinicians to prescribe the lethal medications. Some advocates of AID prefer not to use the term "suicide;" they contend that AID is a medical practice, distinct from the act of suicide for a depressed or hopeless person [2]. By contrast, opponents maintain that the process of prematurely and deliberately ending one's life is always suicide, regardless of motivation. Some insist that dissociating "physician-assisted suicide" from other types of suicide demeans those who die by suicide for other reasons, as if only medically-assisted suicides are legitimate [3]. People on both sides of the issue worry whether "aid in dying" or "assisted dying" might be confused with palliative, hospice, or other care of dying patients.

In the United States, physician-assisted suicide or aid in dying has always been carefully distinguished from euthanasia. Euthanasia, also called mercy killing, refers to the administration of a lethal medication to an incurably suffering patient. It may be voluntary (the patient requests it) or involuntary. Euthanasia is illegal in the United States, but voluntary euthanasia is legal in Belgium, Colombia, Luxembourg, and Canada. It is decriminalized in the Netherlands.

At risk of compounding terminology further, Canada legalized in June 2016 "medical assistance in dying" (MAiD), which includes both "voluntary euthanasia" and "medically-assisted suicide [4]."

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+Abbreviations: AID, aid in dying; MAiD, medical assistance in dying.

Keywords: Aid in dying, Physician-assisted suicide, End of life, Death, Dying, Ethics, Bioethics, Autonomy, Suicide

A BRIEF HISTORY OF LEGALIZATION IN THE UNITED STATES

In the early 1900s, advocates argued forcefully for legalizing euthanasia, which was already being secretly practiced in the US. According to Jacob Appel's work on this period, the eugenics movement strongly influenced discourse on euthanasia, and opponents of legalization tended to put forth practical rather than religious or moral arguments [5]. When efforts to legalize euthanasia failed, public discourse on the subject waned for many decades. In the 1980s, the pathologist Jacob "Jack" Kevorkian began advertising in Detroit area newspapers as a death counselor [6]. He had studied the technique of Dutch physicians in the Netherlands, and created his own device with which patients could self-administer lethal medications. His first patient ended her life in 1990 while lying on a bed inside Kevorkian's Volkswagen van. He went on to assist with some 130 deaths by suicide over the next eight years. In 1999, after Kevorkian publicly distributed a video of himself directly euthanizing a patient, he was convicted of second-degree murder and sent to prison. Although Kevorkian reignited national debate about dying, his off-putting approach and personal idiosyncrasies prevented his becoming a national leader on the issue.

Several of Kevorkian's physician contemporaries filed suit against New York's Attorney General, arguing that the State of New York's prohibition against physician-assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment. They argued, in effect, that the right to refuse treatment was effectively the same as the right to end one's life. The Supreme Court ruled in response in Vacco v. Quill (1997) that there is no constitutionally-protected right to die. It left such decisions to the states. The Court also ruled in Washington v. Glucksberg (1997) that a right to aid in dying was not protected by the Due Process Clause.

Oregon became the first to pass its death with dignity law that same year. More than a decade later, Washington legalized AID in 2008. Montana decriminalized the practice a year later. Vermont legalized it in 2013.

In 2014, a young Californian named Brittany Maynard was diagnosed with an astrocytoma and became a spokesperson for the legalization of AID. She was a newlywed facing terminal illness, and her story quickly captured the public imagination. Her well-publicized death by lethal ingestion in Oregon in 2014 influenced her home state of California to legalize AID in 2015. This was subsequently followed by Colorado in 2016, the District of Columbia in 2017, Hawai'i in 2018, and New Jersey and Maine in 2019.

PRO ARGUMENTS

The two most common arguments in favor of legalizing AID are respect for patient autonomy and relief of suffering. A third, related, argument is that AID is a safe medical practice, requiring a health care professional.

Respect for Patient Autonomy

Bioethics as a discipline gained significant traction in the 1970s, at a time when the concept of patient rights was pushing back against physician paternalism. The philosophers Tom Beauchamp and James Childress, in their well-known textbook Principles of Biomedical Ethics, advanced four fundamental principles as a framework for addressing ethically-complex cases: autonomy, beneficence, non-maleficence, and justice. Of these principles, autonomy undeniably exerts the most influence on current US medical practice [7].

Autonomy refers to governance over one's own actions. In the health care setting, this means a patient determines which medical interventions to elect or forgo. Patient autonomy serves as the justification for informed consent; only after a thorough explanation of risks and benefits can the patient have the agency to make a decision about treatments or participation in medical research. This logic, it is argued, naturally extends to AID; patients accustomed to making their own health care decisions throughout life should also be permitted to control the circumstances of their deaths.

Relief of Suffering

At its core, medicine has always aimed to relieve the suffering of patients from illness and disease. In the West, Hippocrates's ancient oath pledged to use treatments to help the sick, but not "administer a poison to anybody when asked to do so [8]." In contrast, advocates of AID argue that relief of suffering through lethal ingestion is humane and compassionate – if the patient is dying and suffering is refractory. Indeed, some of the most compelling arguments made in favor of AID come from patients, such as Maynard, who suffer from life-threatening illnesses.

A Safe Medical Practice

Aid in dying is lauded by advocates for being a safe medical practice – that is, doctors can ensure death in a way that suicide by other means cannot. Aid in dying thus becomes one option among many possibilities for care of the dying. Although individual state laws vary, most propose a number of safeguards to prevent abuses and to provide structure for an act that some people will do anyway, albeit more haphazardly or even dangerously. Safeguards include requiring that a patient electing AID be informed of all end-of-life options; that two witnesses confirm that the patient is requesting AID autonomously; and that patients are free of coercion and able to ingest the lethal medication themselves [9].

CON ARGUMENTS

Although opponents of AID offer many arguments ranging from pragmatic to philosophical, we focus here on concerns that the expansion of AID might cause additional, unintended harm through suicide contagion, slippery slope, and the deaths of patients suffering from depression.

Suicide Contagion

The sociologist David Phillips first described suicide contagion in the 1970s. He showed that after high profile suicides, society would witness a broad spike in suicides [10]. This was particularly true for individuals whose demographic profiles were similar to those of the person who died by suicide [11]. Although Phillips's work did not focus on AID, it has been corroborated recently by the spike in youth suicidality following the airing of Netflix's 13 Reasons Why [12].

The publicly-available data from Oregon, however, reveal that in the months surrounding Maynard's high-profile death in November 2014, the number of similarly situated individuals in Oregon who ended their lives by lethal ingestion more than doubled. Furthermore, from 1998 (when Oregon started recording data) to 2013, the number of lethal prescriptions written each year increased at an average of 12.1%. During 2014 and 2015, however, this increase doubled, suggesting that high-profile AID leads to more AID [13]. Although the data do not prove that an increase in AID causes more non-assisted suicide, a study by Jones and Paton found that the legalization of AID has been associated with "an increased rate of total suicides relative to other states and no decrease in non-assisted suicides [14]." They suggest that this means either AID does not inhibit non-assisted suicide or that AID makes non-assisted suicide more palatable for others.

Slippery Slope

Some opponents of AID express concern that once doctors are involved in the business of hastening patients' deaths; they have already slid down the slippery slope [15]. Others suggest that the slope is best exemplified by an expanding list of reasons for electing AID. Refractory physical pain is no longer the most compelling reason for ending one's life through lethal ingestion. Instead, cumulative Oregon data suggest that the vast majority of patients elect AID because they are concerned about "losing autonomy" (90.6%) or are "less able to engage in activities making life enjoyable" (89.1%). Some fear a "loss of dignity" (74.4%); being a "burden on family, friends/caregivers" (44.8%); or "losing control of bodily functions" (44.3%). Concern about inadequate pain control was the reason for pursuing a lethal ingestion in only 25.7% of cases [16].

Opponents also point to increasing calls in the US for euthanasia. In 2017, Senate Bill 893 was introduced to the Oregon State Legislature; it would have enabled patients to identify in a legal directive the person they wished to administer their lethal medications, effectively legalizing euthanasia [17]. Although this bill failed, the Oregon House passed HB2217 in 2019, which expanded the definition of "self-administer" to include options in addition to the oral ingestion of lethal drugs. The House also put forward HB2903, which seeks to expand the word "ingest" for lethal medication to "any means" and also proposes to expand the definition of "terminal disease" to include "a degenerative condition that at some point in the future" might cause death. It remains to be seen whether Oregon will become the first state to legalize euthanasia. Although Belgium and The Netherlands permit both AID and euthanasia, the latter dominates. Over the years there has been a steady increase in acceptable criteria. Currently, patients who suffer from depression, dementia, or being "tired of life" may be euthanized. In some cases, minors may also be euthanized [18]. Published data from the Flanders region of Belgium highlights that vulnerable populations are especially likely to be euthanized. From 2007 to 2013, the largest increases in rates of granting euthanasia requests were among women, those 80 years or older, those with lower educational achievement, and those who died in nursing homes [19].

Depression in Advanced Illness

Up to half of patients with cancer suffer from symptoms of depression [20]. The elderly also suffer from high rates of depression and suicide [21]. Because depression often manifests somatically [22], if patients are not screened, clinicians miss half of all cases of clinical depression [23-25]. Opponents of AID are concerned that in Oregon, greater than 70 percent of patients who elect AID are elderly and have cancer, but fewer than five percent are referred to a psychiatrist or psychologist to rule out clinical depression.

CONCLUSION

Physician AID remains a controversial subject relevant to the care of patients. The Hippocratic model dominated medical practice for thousands of years. With the rise of euthanasia in Europe during the second half of the twentieth century, many began to rethink this stance, but hastening the death of patients still sits uncomfortably with many physicians. Although a number of medical societies have begun to reconsider their positions, the American Medical Association's House of Delegates voted in June 2019 to maintain the organization's long-held opposition to physician-assisted suicide and euthanasia [26]. Strong arguments remain both in favor and in opposition to the practice, and physicians have an ethical responsibility to remain informed on this timely issue.

Additional Information: Co-author Daniel Callahan, PhD, died after the first submission of this article.

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Experiences with counselling to people who wish to be able to selfdetermine the timing and manner of one's own end of life: a qualitative in-depth interview study

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ABSTRACT

Background In the Netherlands, Foundation De Einder offers counselling to people who wish to be able to self- determine the timing and manner of their end of life.

Aim This study explores the experiences with counselling that counselees receive(d) from counsellors facilitated by Foundation De Einder.

Methods Open coding and inductive analysis of in- depth interviews with 17 counselees.

Results Counselling ranged from solely receiving information about lethal medication to combining this with psychological counselling about matters of life and death, and the effects for close ones. Counselees appreciated the availability of the counsellor, their careful and open attitude, feeling respected and being reminded about their own responsibility. Some counselees felt dependent on the counsellor, or questioned their competency. Most counselees collected lethal medication. This gave them peace of mind and increased their quality of life, but also led to new concerns. Few were inclined to use their self-collected medication. Counselling contributed to thinking about if, when and how counselees would like to end their life.

Conclusion Having obtained means to end their lives can offer people feelings of reassurance, which can increase their quality of life, but can also give rise to new concerns. Next to providing information on (collecting) lethal medication, counsellors can play an important role by having an open non-judgemental attitude, providing trustworthy information and being available. These positively valued aspects of counselling are also relevant for physicians taking care of patients who wish to self- determine the timing and manner of their end of life.

INTRODUCTION

In the Netherlands, people with a wish to end their life have the option to request for physician assistance in dying (PAD) under the Dutch Termination of Life on Request and Assisted Suicide Review Procedures Act.¹ Not everyone who requests PAD meets the criteria of due care laid out in this law which allows them to receive PAD, and physicians are not obliged to perform PAD.¹

A position paper of the Royal Dutch Medical Association about the role of the physician in a self-chosen death by the patient,² and a report from the Advisory Committee Completed Life state that physicians—or others like loved ones—can offer non-punishable demedicalised assistance in suicide (DAS).³ DAS consists of having conversations about the wish to end life, offering moral support and providing general information on ways to end your own life in a non-violent manner. This assistance is allowed under jurisprudence concerning Penal Code Article 294.⁴ It is referred to as demedicalised assistance to distinguish it from PAD, which is medicalised assistance that falls under the Dutch Termination of Life of Request and Assisted Suicide Review Procedures Act. Hagens et al offer a more detailed description on the differences between DAS and PAD.⁵

Several organisations in the Netherlands provide DAS, for example, Right-to-Die Netherlands, Foundation De Einder and Foundation End-of- Life Counselling, by counselling people who wish to self-determine the timing and manner of their end of life. These organisations provide information from publications about methods to end your life in a non-violent manner, also referred to as self-euthanasia.⁶⁻¹⁰ In practice, this usually entails ending your own life by self-ingesting self-collected lethal medication, or voluntarily stopping eating and drinking.

Research into Foundation De Einder—see table 1 for a description of history, aim and working method of Foundation De Einder has shown that people who seek DAS are not always currently suffering, often have not requested their physician for PAD, nor have an active wish to end their life (yet).¹¹ These findings are explained by distinguishing a group of people who are seeking reassurance to prevent possible future suffering. This is in line with an idea that Huib Drion had already expressed in 1991, 'without much doubt, I have the feeling that many older people would be greatly relieved by knowing that there is a means to end their life respectably at the moment suitable to them, based on what they can reasonably expect from that point on.'¹² By seeking DAS, people (know how to) obtain means to be able to self-determine the timing and manner of their end of life.

The idea of reassurance is supported by research conducted by Chabot.⁹ However, his study did not explore the experiences with the counselling people received. Our study aims to give insight into the experiences with the counselling provided by counsellors working in cooperation with Foundation De Einder by interviewing counselees about (1) what is discussed in the counselling (2) how they experienced the counselling, and (3) what happened afterwards, especially in relation to collecting medication and the manner and timing of their own end of life.

TABLE 1 HISTORY, AIM AND WORKING METHOD OF FOUNDATION DE EINDER²³

Торіс	
Foundation	Foundation De Einder was founded in 1995 as a result of dissatisfaction with the situation that people with a wish to end life were 'being left out in the cold'.
Aim	The goal of the foundation is 'to promote and—if deemed necessary—to offer professional counselling for people with a wish to end life who ask for help, with respect for the autonomy of the person asking for help [] ²³ Contrary to suicide prevention or crisis intervention organisations, Foundation De Einder regards suicide as a possible outcome and gives information about 'self-euthanasia. ¹⁰ Autonomy is regarded as an important value. Seen as an addition to the—since 2001 in the Netherlands legally regulated— medicalised approach of physician assistance in dying (PAD), Foundation De Einder works in cooperation with independent counsellors to offer counselling focused on demedicalised assistance in suicide (DAS).
Work method	Counsellors working in cooperation with Foundation De Einder offer non-directive counselling, which consists of having conversations, offering mental support and providing general information on 'self- euthanasia'. These three forms of assistance by lay persons are regarded as non-punishable assistance in suicide. ⁴ The counselling is not aimed at a certain choice or direction, but is aimed at attaining the highest possible quality of the choice and—if it comes to that—the highest possible quality of implementation of the wish to end one's own life. ²³ The counselling is aimed at creating an as large as possible clarity regarding the wish to end one's life and possible suicide. This covers the mental process of decision-making and might include matters like considering alternatives, timing of death and consideration of others. If the client decides to act on his or her desire to end their life, the counselling is aimed at realising the best possible preparations for 'self-euthanasia'. This covers the practical preparation and might include gathering means for and the effectuation of the suicide. ^{23 24}

METHODS DESIGN

A qualitative interview study was chosen because of the explorative nature of the research objectives.

Recruitment

A notice about this study was published in the magazine of Foundation De Einder, stating we were looking for people who were willing to be interviewed about their experiences with this counselling. This magazine was sent to people donating money to the Foundation, including—but not limited to—people seeking counselling. Also, counsellors were asked to notify people seeking their counselling, either in person, through postal letters or email.

Participants

Twenty-four potential participants enrolled themselves—20 through intermediation of the counsellor, and four through the notice in the magazine—by contacting the researcher (MH) by telephone or email. All potential participants were contacted by

telephone to ask five screening questions concerning gender, age, motivation to contact the counsellor, former request for PAD and personal consults with which counsellor. These screening questions, based on a previous quantitative study,11 were asked to ensure diversity in the participants. Some potential participants had not (yet) had a personal consult with a counsellor. These people were excluded from participation (n=3), because they often were still in an orientating phase where counselling does not entail providing information on ways to end their lives.¹¹

Three potential participants were not willing to participate in a personal interview (eg, due to emotional burden). Finally, one potential participant was not selected for participation due to similarity with already selected participants (data saturation). This resulted in 14 interviews with 17 people. Three interviews were conducted with couples who sought counselling together. Counselees from all seven counsellors facilitated by Foundation De Einder at the time of the interviews were included. The selected sample reflected the population of people seeking counselling from a counsellor facilitated by Foundation De Einder.¹⁰

Interviews

Between September and December 2012, in-depth qualitative interviews were held with people who were receiving or had received counselling from counsellors facilitated by Foundation De Einder. The interviewer (MH) has a background in training for professional and personal communication in psychology and had previously worked as a counsellor in cooperation with Foundation De Einder. This prior experience contributed to a considerable knowledge about DAS and experience with discussing the subject, but could also lead to a potential interviewer bias. The

Table 2 Personal characteristics of selected counseless

difference in position and the necessary skills as an interviewer compared with a counsellor have been addressed in the research team. All interviews took place at the residence of the respondent except for one, which—at the request of the interviewee—was held at a conference room at the VU University Medical Center. All respondents lived in the Netherlands. All were informed about the purpose of the study, and signed an informed consent form for participation in accordance with the procedure approved by the Ethical Committee of the VU University Medical Center. The interviews lasted between 1 and 2.5 hours.

One of the main aims of the interviews was to learn more about the experiences of the respondents with the counselling. Given the sensitive subject, it was decided to start with a general opening question such as 'how are you doing now?' However, it turned out the respondents were very eager to talk about the subject so later interviews were started with the question, 'What has been the motivation to contact foundation De Einder?' The consecutive questions were based on what the respondent said. A topic list was used as a reminder of the subjects that should be addressed in the interview. These topics included the content of the counselling, the experiences with the counselling and plans for the timing and manner of their own death. See online supplementary appendix 1 for the complete topic list of the interview.

Analysis

The interviews were recorded and fully transcribed. Field notes were made during and after the interview. For the purpose of this study, all interviews were analysed focusing on the research questions about the experiences with the counselling. Analysis

Table 2 Per	sonal characteris	Indie Z Personal characteristics of selected counselees									
Counselee	Primary Goal*	Gender	Age	Request for Pad	Relationship Status	Children Present	Health Problems				
1	PAD unable	F	<65	No request	No partner	No	Psychiatric				
2	PAD unable	F	<65	Denied†	Partner‡	No	Physical				
3	PAD unable	М	<65	Denied	No partner	No	Physical and psychiatric				
4	PAD unable	F	<65	No request	Widowed	Yes	Physical				
5	PAD unable	М	65-70	Denied	No partner	No	Psychiatric				
6§	Backup	F	65–70	No request	Partner	Yes	Healthy/old age (physical)				
7§	Backup	М	70-80	No request	Partner	Yes	Healthy/old age (physical)				
8	Backup	М	70-80	No request	Partner	Yes	Psychiatric/old age (physical)				
9§	Backup	М	70-80	No request	Partner	Yes	Healthy/old age (physical)				
10§	Backup	F	70-80	No request	Partner	Yes	Healthy/old age (physical)				
11	Backup	F	80-90	No request	Widowed	Yes	Healthy				
12§	Backup	М	80-90	No request	Partner	Yes	Old age (physical)				
13§	Backup	F	80-90	No request	Partner	Yes	Old age (physical)				
14	Autonomy	М	70-80	No request	No partner	No	Old age (physical)				
15	Autonomy	М	70-80	No request	Widowed	Yes	Old age (physical)				
16	Autonomy	М	70-80	No request	No partner	No	Old age (physical)				
17	Autonomy	F	90-99	No request	Partner	Yes	Old age (physical)				

*'PAD unable' refers to counselees who sought counselling as a result of current suffering and (thought they) were unable to obtain Physician Assistance in Dying (PAD). 'Backup' refers to counselees seeking demedicalised assistance in suicide (DAS) so self-euthanasia could form a backup in case they were unable to obtain PAD in a future situation. 'Autonomy' refers to counselees seeking DAS so self-euthanasia could be possible in a future situation, and preferring this over PAD (see Hagens et al11 for more detailed information). +Eventually granted by another physician.

#Partner present at interview to support with gaps in memory.

§Couple together.

followed the principles of sequential and thematic analysis.13 First, all interviews were thoroughly read to become familiar with the data, and case reports of every participant were made by the interviewer (MH), and discussed within the research team (BDOP, HRWP, MCS, KE). Consecutively, all interviews were analysed by the interviewer (MH) and one or two other coders (MCS, KE). Open, inductive coding was applied to identify recurring themes in the interviews. This was a constant movement between the data set, the coded extracts and the descriptive analysis in process. No prior theory or framework was used in the analysis.14 The code list extended as more interviews were analysed, and codes were grouped and regrouped in the process of analysis. Online supplementary appendix 2 shows an overview of the codes that were created in relation to the experiences with the counselling provided by a counsellor facilitated by Foundation De Einder. Writing of the article formed part of the analysis

because the writing process also pointed out which data, codes or interpretations were not clear yet, which led to new analysis cycles of the data. The writing process, the coding and descriptive analysis were discussed between all authors, and led to a clearer understanding and better representation of the data.

RESULTS

Characteristics of counselees and counselling

The majority of the counselees were over 70 years old. All counselees lived in independent housing, more than half together with their partner. About two-thirds described their health status as healthy or as experiencing problems of old age. Most counselees were hoping for a natural death. When having to self-determine death, most counselees preferred PAD, if this would be available to them, over a self-directed death that did not fall under

Box 1 Quotes about the characteristics of counselees, and content of and experiences with counselling

Quotes about preferred manner of passing away

Quote 1 'R1: I'd rather die from a heart attack, in a natural way. (Counselee 06)

R2: We expect to pass away from a natural cause, be it a traffic accident, be it a heart attack, be it something else. That we just die like that. But if that is not the case [...] then we like to take the decision to end our lives ourselves. [...] I would go to the physician [to request PAD—MH], because then your bereaved ones don't have that problem [being suspected of unlawful assistance in suicide—MH]. That's the main reason. (Counselee 07)

R1: And then at least you are completely sure dying goes well. (Counselee 06)

Quotes about the content of the counselling

Quote 2 'But okay, I thought I will go and talk to the counsellor how to obtain sleeping medication. So not at all because I was looking for psychological.... And that's what I like so much about the counsellor. The counsellor also thinks it's okay if you come to just talk about the pills.' (Counselee 08)

Quote 3 'Also, the awareness "what am I doing to society if I choose suicide?" Then you do make a statement. [...] So, I wanted some more counselling on that—on the moral aspect of suicide. Actually, it's abject, bad. Well, the society I'm part of...I ignore it, I contempt it when I choose for suicide [...] and then I thought: yes, I need a counsellor. Because I am an ambivalent person with a lot of contradictory wishes' (Counselee 11)

Quote 4 'And actually. Yes, how shall I put it. The counsellor looks at the whole situation from a completely different angle. So, what are your expectations and disappointments in life? What gives meaning in life? And yes, also, because that is the question you arrive with, questions and decisions about the end of life? (Counselee 01)

Quote 5 'The counsellor was so kind to honour my proposal to invite the children all together with the counsellor and me, so the counsellor could get an impression of each child. I liked that idea. In case the counselling would be for a longer period of time. The counsellor also thought that was very pleasant. So the counsellor acknowledged my situation and my position in the greater picture. I am very attached to my five children' (Counselee 11)

Quote 6 'I noticed the counsellor had thought things over a lot better than I had [...] because the counsellor is just a lot more careful in all the steps. And also towards the people surrounding you, for example about the enactment of the suicide and even about what happens after the suicide. I really thought that was very decent and considerate.' (Counselee 01)

Quotes about the experiences with the counselling

Quote 7 'Yes, because it also gives the counsellor a certain kind of power in deciding you can have the [information about the—MH] medication or

not. That's true. But the counsellor also has to take into account the politics, and cover for the police and the law and so on. And the counsellor has to manoeuvre carefully, so I understand that. And I think that is good in a way! (Counselee 06)

Quote 8 'What I think is still regrettable is the fact it [collecting lethal medication—MH] all goes through dubious routes [eg, through internet or abroad—MH]! (Counselee 01)

Quote 9 'The advantage is that something [your wish to self-determine your own end of life—MH] is being regarded from all possible angles—even separate from the practical side—like aren't you in a tunnel vision. Thoughts like "this is it" and "this situation I'm in is unsolvable and unbearable" and so on. The advantage of De Einder is [...] that someone listens seriously to your question. Without any taboo, they address your request, your question. Physicians often don't do that. People around you often don't do that, the Right to Die NL doesn't do that—well maybe, a few good ones. And here is someone who does do that, and who knows more about it. (Counselee 02)

Quote 10 'Well, the counsellor is someone who recognizes you for what you are and what you want. It's all about respect for life and someone's choice to want to die. That is important! (Counselee 05)

Quote 11 'At the first conversation, I was really surprised by the attitude of the counsellor and that gave me a lot of good energy, to say it like that, it was just very pleasant. [...] I had expected I would have had to defend myself the whole time [...] and then it turned out it was just a very open conversation [...] I felt—that was very good—my own responsibility. So yes, the counsellor's attitude has played a part in that, that I could do that. That was outstandingly good'. (Counselee 01)

Quote 12 'And that the counsellor gives me the full freedom...No force or stimulation from the counsellors side. That felt very pleasant. Not in any single matter. You have to process it all yourself' (Counselee 11)

Quote 13 'The counsellor did not help you, but he gave you the tools to do it yourself. And that...yes, gave a very sympathetic impression.' (Counselee 04)

Quote 14 'I call the counsellor sometimes. But I try to do this as sporadically as possible because I do not want to burden the counsellor too much in daily life. But I'm allowed to. The counsellor hasn't set any limits, and yes, I think that's special'. (Counselee 03)

Quote 15 'Well, I understand also, with those people [the physicians—MH] you have to be outside in six minutes. I don't feel like that. You don't feel real then. The counsellor "opens up all registers" and the consult may take one and a half hour. It never lasts that long. And now I notice I do need that [laughs].' (Counselee 08)

the Dutch Termination of Life on Request and Assisted Suicide Review Procedures Act. Some valued autonomy and their own responsibility and preferred ending their lives by self-ingesting self-collected lethal medication (see table 2) (see box 1, Quote 1).

The start of the current counselling ranged from as long as 10 years ago until as recently as 2 months ago. Counselees received between 1 and 24 personal counselling sessions. Almost half of the interviewed couples and individuals involved other people to their counselling. The majority of the counselees had already obtained lethal medication (see table 3).

Table 3 Setting and content of counselling and collection of lethal medication

Content of counselling

All counselees received information about ways to end their lives. While some received information about PAD, voluntarily stopping eating and drinking, and/or inhaling helium, all counselees received information about lethal medication (see table 3). For example, which (combination of) lethal medication to use, the availability of this medication, storing and testing medication, careful preparation and performance of a self-euthanasia by selfingesting lethal medication, and preparations for the situation after death. For some counselees this was the only reason they sought counselling (see box 1, Quote 2).

Counselee	Start of counselling (time ago)	Personal contacts, n	Involved others	Information about manners to end own life*	Collected lethal medicine	Counselling about mental aspects	Counselling about/of others
1	2 months	2	No	MED (which medication, obtaining, careful performance, consequences of law, after death)	No	Meaning and expectations life and death, hope, passion, ambivalence, responsibility	Current relationships, effect of self-euthanasia on others, saying goodbye, consequences of law on others
2†	3 years	6	Yes	VSED, MED (which medication, obtaining, careful preparation, performance)	No	Death wish, meaning life and death, preparing for suicide, emotions	Effect of self-euthanasia on others, preparing others for goodbye, consequences of law on others
3	3 months	6	Yes	PAD, Helium, MED (which medication, obtaining, after death)	Yes	Meaning completed life, death wish, fear of dying alone, emotions	Preparing others for goodbye
4	1 year‡	1	No	MED (which medication, obtaining, careful preparation (withdrawal), performance)	Yes	Not mentioned	Not mentioned
5	8 years§	24	Yes	MED (which medication, obtaining, storing, performance)	Yes	Meaning life and death	Current relationships, saying goodbye, presence of others
6/7 q	5 years	1	No	MED (which medication, obtaining)	Yes	Intake, screening death wish	Not mentioned
8	3–4 years	1	No	MED (which medication, obtaining, delivery)	Ordered	Not mentioned	Not mentioned
9/10 q	2 years	1	No	MED (which medication, obtaining, storing, testing)	No	Intake, screening death wish	Meaning relationship
11	1 year	3	Yes	MED (obtaining)	No	Righteousness to end own life	Counselling of others (system)
12/13 q	3 years	3	Yes	PAD, MED (which medication, obtaining, storing)	Yes	Not mentioned	Counselling of others (system)
14	10 years	3	No	PAD, VSED, Helium, MED (which medication, consequences of law, obtaining, careful performance, after death)	Yes	Meaning life (events), timing	Effect of self-euthanasia on others, consequences of law on others
15	1 year	1	No	VSED, Helium, MED(which medication, careful performance, consequences of law, after death)	Yes	Current life situation (grief)	Preventing harm to others, consequences of law for others
16	8–9 years	3-4	No	MED (which medication, obtaining)	Yes	Not mentioned	Not mentioned
17	1 year	1	Yes	MED (which medication, obtaining)	Yes	Not mentioned	Not mentioned

*PAD: Physician assistance in dying (as under Termination of Life on Request and Assisted Suicide Review Procedures Act); VSED: Self-euthanasia by voluntary stopping of eating and drinking; Helium: Self-euthanasia by helium method; MED: Self-euthanasia by self-ingesting self-collected lethal medication.

†Partner present at interview to support with gaps in memory. ‡10 years ago present at counselling as partner.

SReceived counselling 12 years ago from counsellor not active at time of interviews. QCouple together. A 'screening' of the counselees' wish to seek counselling was part of the counselling for most counselees. Some also specifically sought counselling to discuss psychological or mental aspects of the process to be able to self-determine the timing and manner of their end of life. For example, having conversations about the moral aspects of ending your own life and the meaning of life and death (see box 1, Quotes 3 and 4).

Besides having loved ones involved, discussing the subject of loved ones was part of the counselling for about half of the counselees. For example, the effects of ending your life on others, acting responsibly towards others and/or the counselling of loved ones (see box 1, Quotes 5 and 6).

Experiences with the counsellor and counselling

All participants were positive about the counselling and/ or counsellor, while some also expressed criticism. Criticism concerned feeling dependent on the counsellor who owned information that a counselee wished to obtain, secrecy around how to obtain medication and a counsellor being regarded as incompetent in psychological guidance due to a background in an unrelated work field (see box 1, Quotes 7 and 8).

The positive remarks focused on the trustful and careful attitude of the counsellor. The matter of preparing for a suicide could be openly discussed as a normal subject and was not treated as a taboo. It resulted in people experiencing being listened to, and feeling recognised and respected (see box 1, Quotes 9–11). They regarded the counsellor to be critical in an open respectful manner. The counsellor clearly reminded people about their own responsibility in preparing for self- euthanasia. They experienced not being stimulated, pushed or forced in a certain direction (see box 1, Quotes 11–13). Finally, people expressed being positive about the availability of the counsellor (see box 1, Quotes 14 and 15).

After counselling: self-collected lethal medication

Most counselees had already obtained lethal medication (see table 3). This lethal medication was ordered via internet from countries abroad or via the black market in the Netherlands. Some had not (yet) obtained medication because the idea that they could was satisfying enough for now, or felt they 'did not yet reach that stage! (Knowing how) to obtain medication brought reassurance, which was expressed by giving peace of mind, a safe feeling, reassurance to be able to decide for yourself and take your own responsibility (self-determination), and to be independent of healthcare professionals (see box 2, Quotes 16-18). This reassurance added to their guality of life because they experienced less uncertainty about the possibility of having to continue in a state of unwanted suffering, memory problems felt less threatening, a depression became easier to deal with and it offered energy to continue with life (see box 2, Quotes 16, 17, 19-21).

However, possessing lethal medication also offered new concerns and dilemmas to some counselees who had obtained them. For example, concerns about preserving medication and medication being taken away by the police or loved ones, and

Box 2 Quotes about what happens after counselling

Quotes about self-collected lethal medication

Quote 16 'So, it's peace of mind that I have. I have received the information from someone I trust. I have the means of which the counsellor has sworn they are adequate. So, that's all stored in a very good, airtight environment. Ready! [...] Now I can continue with daily living! (Counselee 14)

Quote 17 'It gives a very relieved feeling. Now, I have the feeling that I have something as insurance. And every time I panic, because I think I'm starting to have dementia, then at least I have a means as insurance. So it doesn't have to get that bad. And that gives me peace of mind [...] That I don't panic when I forget something.' (Counselee 15)

Quote 18 'The feeling that you have the medication in your own house and that you can decide for yourself. Maybe you will never use it. But just the feeling that when it is necessary, then I can use it: that is pleasant when you are older.' (Counselee 07)

Quote 19 'MH: Because you already have the medication at home for seven years, the possibility to end your life for seven years.

R: Yes, it gives a safe feeling.

MH: Can you tell me more about that safe feeling?

R: The feeling that you just—when you've reached your limits, when you really can't continue any longer—that there's a door you can enter and that will release you from life [...] that gives a good feeling. That gives a safe feeling [...] I also think only the fact you would have a legal possibility to end life in a humane way. If you know that, that knowledge is reason enough for people to live longer. That also counts for this medication. I have that medication at home. And it gives me peace. It sounds crazy, but that's how it works' (Counselee 05)

Quote 20 'To get the maximum out of life. Yes, I'm not depressed. So I do all these things that I think are important at such a last moment. Yes, many paradoxes [...] I will probably leave at the peak of the party. Yes, that's what it is. I grant myself to leave the party at its peak' (Counselee 03)

Quote 21 'And I sometimes have the urge to check if the medication is still there. Because if you take that away, then you take a piece of security away from me. And at the same time, the crazy thing, the ambivalence of that medication is that they maybe keep me living longer than when I would not have them. It also has...the whole procedure with taking anti-emetics beforehand, 24 hours before, there's a certain time frame. That also gives an inhibition. There are moments that I think that when the 24 hours would not be there, I would take them right away ...' (Counselee 05)

Quote 22 'But then, we do face a dilemma. Concerning our daughter. She also wants to end life by herself, but that will happen through the medical circuit [...] See, the dilemma is: we have the medication in the house for ourselves. But you can't give that to her, if she would want to' (Counselee 07)

Quotes 23 'To be able to make an end to my own life in a humane way. And I won't do that before I have had another conversation with the counsellor, also with the children present [...] That I will only do it if there really are no other possibilities to continue life in a dignified way anymore [...] That could be a topic to discuss. Yes, imagine I would be in so much pain, and after a conversation with the counsellor, who would say 'well, you could try this, think about it' I'm just saying as an example—then I could reconsider my choice.' (Counselee 15)

Quotes about the timing and manner of their end of life

Quote 24 'MH: If you have the medication in the house, do you have an image of when you would like to use it?

R: Not! We do not want to use it at all. We just want to keep on living. (Counselee 07)

Quote 25 'I can describe it as when I'm totally dependent.

Totally dependent on another. And that things happen I don't want to happen, and especially if I—that would be really important to me—if I foresee a moment in which I can't decide for myself. Then I would do it.' (Counselee 17)

Quote 26 'R: Then you think—yes, thank God we are not that far—but if at a certain moment you will say "I don't want anymore and now I will stop." [...] (Counselee 10)

R2: We don't know that. (Counselee 09) R: Of course we don't... (Counselee 10)

R2: That's the dilemma that you can't get away from, certainly not as an outsider. You can't foresee the experience of the moment. That is a well known fact...that people postpone! (Counselee 09)

a moral dilemma when a loved one wanted to self-determine their own end of life while the counselee owned the means to do so (see box 2, Quotes 21 and 22). Counselees did not worry about impulsivity. They possessed the medication for a long time already, and regarded the necessary 24 hours' period for taking antiemetics and the wish to have more counselling before acting on a wish to end their life as safeguards against impulsivity (see box 2, Quotes 19, 21, 23).

After counselling: the timing of their own end of life

The counselling and/or collecting the lethal medication contributed to a process in which counselees thought about if, when and how they would like to end their own life (see box 2, Quote 24). While one participant had an appointed date for PAD, and two persons mentioned a time frame ('the end of the year', 'within five years'), most counselees described future situations in which the option to end their lives would become more likely. These situations were overtreatment, memory problems, when life was not dignified anymore or would become unbearable or hopeless, when no other alternatives than a hospital or nursing home would be available, dependency of others and when the burden was greater than the capacity to carry it (see box 2, Quote 25). Often counselees made the side note that one cannot foresee the experience of a future situation, and the likelihood of postponing one's death due to a gradual acceptance of declining health conditions (see box 2, Quote 26).

DISCUSSION SUMMARY

People seeking counselling to be able to self-determine the timing and manner of their end of life have all received information about self-euthanasia through self-ingesting self-collected lethal medication. For half of the counselees, this has been accompanied by counselling about psychological aspects and/or the effect of self-determining your end of life on loved ones. All counselees are positive about the availability of the counsellor, the trustful, careful and critical attitude of the counsellor, being able to openly discuss the subject, the feeling of being respected, and being reminded about their own responsibility without being pushed or forced in a certain direction. Some counselees are critical about feeling dependent on the counsellor and mentioned incompetency of the counsellor. The majority have obtained lethal medication, which can give rise to new concerns, but also gives counselees peace of mind and reassurance. It adds to their quality of life because of less uncertainty about having to continue in a state of unwanted suffering. Collecting lethal medication does not imply people want to end their lives themselves, nor that they want to end their life soon.

Limitations

A limitation of this study is that only people receiving DAS from counsellors facilitated by Foundation De Einder have been selected. Conclusions therefore cannot be generalised to the whole population of people receiving DAS. Also, counselees have enrolled themselves in this study and most counselees were recruited through a counsellor, which can lead to a possible self-selection bias. This might result in the expression of mainly positive experiences. Furthermore, the subset of people who died shortly after receiving counselling is missing. Therefore, the data may be biased in reflecting that many counselees have no intention to use their collected lethal medication and regard it as a safeguard to prevent situations of future suffering.5 11 However, a previous study shows that the group who seeks counselling to prevent possible future suffering forms at least one-third of people receiving counselling.¹¹

Reassurance and quality of life

Drion published the idea that older people would find reassurance in knowing they would have means available to end their own life at a moment suitable to them.¹² This idea clearly resonates in the stories of the counselees, and forms a replication of other interview studies.^{9 15 16} Having obtained the means to be able to end their lives in a respectable manner (and for some just the knowledge how to obtain these means) does indeed give people reassurance to be able to self-determine the timing and manner of their end of life.

In addition to providing reassurance, it can have other positive effects like worrying less about current problems or about having to continue life in a state of unwanted (prospective) suffering. Some even experience a renewed energy to 'get the most out of the time left'. To have a wish (to be able) to end your life does not imply giving up on the life you are still living. Rurup et al described this by the existence of simultaneously having a wish to die and a wish to live.^{15 17} This latter might also be an explanation for findings by Van Wijngaarden where people who have a wish to die still 'exercise to keep fit and vital' or 'consider hip replacement to increase mobility and independence' while planning their death as well.^{16 18}

Owning lethal medication can lead to risks of impulsivity and misuse.^{3 19} Counselees do not share these concerns. However, a new finding is that owning lethal medication does give rise to other new concerns. For example, concerns about the due date of the collected medication, fear that people want to take that medication (and their peace of mind) away and a dilemma what to do with your lethal medication if loved ones seek a peaceful way to end their own life. This raises the question whether the obtained peace of mind outweighs the possible rise of new concerns, and whether the need for reassurance will ever be fully satisfied.

Counselling is more than just giving information about medication

While information about (obtaining) medication forms an important part of the counselling, it is not the only thing that is important. Also, the attitude of the counsellor which allows for an open conversation in which the wish to (be able to) end your life is not regarded as a taboo, is a positively valued aspect of the counselling as well. The importance of this openness in talking about and a non-judgemental attitude towards a wish to die is regarded as an essential aspect in providing care, and is also endorsed by a Dutch suicide prevention organisation,²⁰ and the multidisciplinary guideline for the diagnostics and treatment of suicidal behaviour.²¹ Also the guideline of the Royal Dutch Medical Association on the position of the physician in a self-chosen

death by the patient extends on the possibility of the physician to offer DAS, and focuses on having conversations with the patient about the wish to end their own life.² If patients feel unable to talk about these wishes, their quality of life may be diminished.²²

Concerns for counselling

Some negative experiences with the counselling or counsellor offer points of attention for the counselling itself. Counsellors should be aware that possible feelings of dependency might cause counselees to act in a socially desirable way to obtain information from the counsellor. Furthermore, the competence of the counsellor being questioned raises the discussion about when a person is regarded to be qualified and competent to counsel people in this delicate matter. Finally, concerns after having collected lethal medication may ask for specific care or counselling after having collected lethal medication.

Implications

As counselling can have positive effects for the counselee, one recommendation could be that a physician should have a more open attitude towards the role and importance of counsellors. Also, aspects of the counsellor and counselling valued by counselees can offer recommendations for physicians who want to offer DAS themselves to patients who wish to self-determine the timing and manner of their end of life. Although the counsellor might hold a different position than the physician, for example, because a patient might perceive the physician as a person more focused on treating (a wish to be able to end your own life) instead of understanding the patient. The guideline of the Royal Dutch Medical Association on the position of the physician in a selfchosen death by the patient explicates the judicial possibilities for the physician when it comes to providing DAS.² Our study can provide physicians with valuable recommendations in providing DAS, for example, the importance of an open non-judgemental attitude, experience with and knowledge about a self-chosen death, providing trustworthy information and being available.

CONCLUSION

This study confirms the idea that having the means available to be able to end your own life in a respectable manner can provide people with reassurance and can increase their quality of life. It can, however, also give rise to new concerns like worrying about the shelf-life of medication or not losing the medication. This study also makes clear that counselling entails more than just providing information on (collecting) medication. Counsellors can play an important role for people who wish to self-determine the timing and manner of their end of life, by having an open non-judgemental attitude, providing trustworthy information and being available. These positively valued aspects of DAS can provide recommendations for physicians taking care of patients who wish to self-determine the timing and manner of their end of life. **Contributors** MH had the initial idea for this study, wrote the research protocol, performed the interviews and the analysis, and drafted the manuscript. MCS and KE performed the analysis, and contributed to the drafts of the manuscript. HRWP and BDOP commented on and contributed to the design, the analysis of the data and the final draft of the manuscript. All authors had access to all the data, can take responsibility for the integrity of the data and the accuracy of the data analysis and approved the final manuscript.

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Physician-Assisted Suicide: Why Neutrality by Organized Medicine Is Neither Neutral Nor Appropriate

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It has been proposed that medical organizations adopt neutrality with respect to physician-assisted suicide (PAS), given that the practice is legal in some jurisdictions and that membership is divided. We review developments in end-of-life care and the role of medical organizations with respect to the legalization of PAS since the 1990s. We argue that moving from opposition to neutrality is not ethically neutral, but a substantive shift from prohibited to optional. We argue that medical organizations already oppose many practices that are legal in many jurisdictions, and that unanimity among membership has not been required for any other clinical or ethical policy positions. Moreover, on an issue so central to the meaning of medical professionalism, it seems important for organized medicine to take a stand. We subsequently review the arguments in favor of PAS (arguments from autonomy and mercy, and against the distinction between killing and allowing to die (K/ATD)) and the arguments against legalization (the limits of autonomy, effects on the patient-physician relationship, the meaning of healing, the validity of the K/ATD distinction, the social nature of suicide, the availability of alternatives, the propensity for incremental extension, and the meaning of control). We conclude that organized medicine should continue its opposition to PAS.

In 2015–2016, the medical societies of California, Colorado, and the District of Columbia adopted officially neutral stances regarding physician-assisted suicide (PAS), followed by the legalization of the practice in those jurisdictions.¹⁻⁶ Declarations of neutrality by state medical organizations in advance of legalization also occurred in Oregon⁷ and Vermont,⁸ but not Washington.⁹ The Massachusetts Medical Society adopted a neutral position in late 2017.¹⁰ Recently, both the American Medical Association and the World Medical Association have been asked by some members to consider revising their opposition to PAS.^{11,12} Some are now calling on official medical organizations to move beyond "neutrality" to "engaged neutrality" on the issue, providing advice to physicians who participate in the practice where it is legal.¹³

The US Supreme Court has ruled that PAS is not a constitutional right, but states may choose to legalize it.^{14,15} PAS is now legal in Oregon, Washington, Vermont, Montana, California, Colorado, and the District of Columbia. Over the last two decades, state referenda to legalize PAS have been defeated more often than they have passed. In 2017 alone, PAS bills were rejected in 27 US states.¹⁶ In 2016, the New Mexico Supreme Court overturned a lower court, ruling that there is no constitutional right to PAS in that state.¹⁷ New York also ruled there is no state constitutional right to PAS.¹⁸ The American Academy of Hospice and Palliative

Medicine is neutral,¹⁹ while the National Hospice and Palliative Care Organization is opposed.²⁰ The American Medical Association,²¹ the American College of Physicians,²² the American Academy of Pediatrics,²³ the American Nurses Association,²⁴ and the World Medical Association²⁵ all remain opposed. The British Medical Association is also opposed and has explicitly rejected calls for neutrality.²⁶ Informal online polls of US physicians have produced conflicting results, while a national, scientific, stratified poll has shown a majority opposed to PAS and euthanasia.²⁷⁻²⁹

WHY NEUTRALITY IS NOT NEUTRAL

In disagreements, a position of neutrality is sometimes proposed either as a compromise to accommodate diverse views or as an expression of uncertainty about an issue. This approach might seem reasonable were a position statement an internal document addressed exclusively to members. A position statement by a professional organization, however, is oriented externally, addressing the profession, state, and the public at large about an issue relevant to the practice of that profession.30 The stance of bodies representing the medical profession on issues of medical ethics has social and political consequences, especially in the case of PAS because doctors are the intended implementers, making the profession's views central to the political debate. Neutrality is not neutral. To change from opposition to neutrality represents a substantive shift in a professional, ethical, and political position, declaring a policy no longer morally unacceptable; the political effect is to give it a green light. Logically, neutrality implies, "We are not opposed."^{31,32} When the California Medical Society became neutral on PAS, the newspapers rightly reported, "California Physicians End Opposition to Aid-in-Dying Bill."³³

Some might argue that neutrality is necessary because there are jurisdictions in which members of medical organizations can prescribe PAS legally. But exceedingly few physicians engage in the practice even in jurisdictions where it is legal,³⁴ and the fact that some members do so does not require any professional body to be "neutral" with respect to that practice. As a logical counter-example (and not an analogy) to the thesis that professional neutrality is required if a medical practice is legal, consider the fact that physician participation in capital punishment is legal in 30 states. This fact does not affect the ethical opposition that the profession takes, nor has organized medicine felt compelled to give instructions on how to execute prisoners well for those few members who do this.

Disagreement among members does not require a position of neutrality. There certainly are members of medical organizations who are not opposed to physician participation in capital punishment even though their organizations oppose it. Similarly, there are members of medical organizations who disagree with their organizations' positions on mammogram screening and health care reform. Presumably, both sides have made their cases, but one side has prevailed.

Nor is an organization that opposes the legalization of PAS logically or ethically required to discipline members who participate in the practice in jurisdictions where it is legal. For example, a medical organization opposed to single-payer systems is not required to discipline physicians who practice in states that adopt it and participate in its billing system. Restraint in disciplining members who legally engage in a practice that an organization opposes does not logically require organizational neutrality.

Moreover, professions have a positive ethical responsibility to take public stances on issues that are central to the meaning of their work. Neutrality on PAS, in this light, seems an abdication of professional responsibility. Each profession has a duty to define the ethical parameters of its practice within the public sphere, subject to the political limits necessary to sustain and promote the common good.

WHAT ARE THE ARGUMENTS IN FAVOR OF LEGALIZATION?

There are three main arguments in favor of legalization. Proponents argue foremost that PAS is justified by respect for patient autonomy.³⁵ Some patients want to control how and when they die, and proponents argue that respect for patient self-determination requires that patients be given this option, since it is a private choice. Second, they argue that the primary duty of medicine is to relieve suffering, and that PAS is the ultimate, merciful medical means of ending suffering that patients deem intolerable.³⁶ Third, they argue that the distinction between

forgoing life-sustaining treatment and suicide is arbitrary and sophistical, denying patients who are not being maintained on life-sustaining treatments an equal opportunity to end their lives.³⁷ They supplement these arguments by suggesting that there has been no evidence of a "slippery slope" where PAS has been legalized.³⁸

WHAT ARE THE ARGUMENTS IN FAVOR OF CONTINUED OPPOSITION?

The arguments against a permissive stance towards PAS are based on the meaning of medical practice, the importance of the patient-physician relationship, and respect for the common good.

Respect for Autonomy Is Not a Sufficient Justification

Autonomy cannot be considered in isolation from the entire framework of ethical principles in medicine and in society.³⁹ Patient autonomy is not the isolated exercise of will.⁴⁰ Autonomy is relational—the way one person behaves affects others. One person's autonomy must not undermine another's; it does not mean "I want, therefore I must get." Autonomy must be weighed against other professional principles such as beneficence, nonmaleficence, the internal rationality of medicine, justice, and respect for the common good.⁴¹

Some claim that respect for autonomy in combination with the duty to relieve suffering jointly suffice to justify PAS.^{36,42} Yet this adds little to the argument that the duty to respect autonomy is what justifies PAS, since the suffering driving the demand for PAS is not occasioned by pain or other symptoms, but complaints such as loss of autonomy and fear of being a burden.^{43,44} This sort of suffering and its tolerability are subjective assessments by autonomous individuals. Thus, this argument becomes a restatement of the duty to respect autonomy, which, as we argue, is not sufficient to justify PAS. When patients report that their suffering is leading them to desire death, we suggest that physicians consider principles beyond autonomy and redouble their efforts to eliminate suffering, not the sufferer.

PHYSICIANS ARE NOT QUALIFIED TO MAKE THE JUDGMENTS THAT PAS LAWS REQUIRE

Many of the eligibility criteria in PAS laws are personal, interpersonal, and subjective rather than medical. Some suffering is amenable to direct medical intervention, but many experiences of suffering, such as loneliness and existential distress, are not. It is beyond the ken and expertise of the physician to judge whether such suffering is adequate to fulfill the criteria for the provision of lethal drugs. Among the legal requirements is that a request for PAS must be voluntary and free of undue pressures. Yet most doctors have limited knowledge of their patients' lives beyond the examination room-for example, what family dynamics are at work or what internal pressures may exist. This problem is particularly acute because the majority of doctors refuse to participate so that requests are often considered by doctors who have no prior relationship with the patient. PAS laws have a medical aspect-verifying the diagnosis and likely course of disease—but the most important criteria are subjective, personal, or interpersonal rather than medical and beyond a doctor's

sphere of professional competence. It is one thing to ask a doctor to provide a professional opinion on a requesting patient's medical state; quite another to load subjective, personal, and interpersonal judgments on the shoulders of doctors themselves.

THE FACILITATION OF SUICIDE IS NOT A HEALING ACT

Medicine's central task is to heal. Although healing is a much broader concept than curing, it makes no sense to claim that patients have been healed by having assisted them in ending their lives. Symptom relief heals, and forgoing treatment acknowledges the limits of healing, but PAS undermines the very meaning of medicine.^{22,45}

THE PATIENT-PHYSICIAN RELATIONSHIP

Since the time of Hippocrates, the pledge not to kill is one among the minimal conditions of commitment and trust within the patient-physician relationship. Modern medical knowledge has enabled a vast array of interventions, however, giving physicians far greater power over the patient's life than in the past. Patients, made vulnerable by disease, need to trust a physician upon whose skills they depend. Countertransference and physicians' own discomfort with death and the limits of medicine further complicate matters.^{46,47} When the doctor is licensed to provide lethal drugs, patients could be inadvertently steered towards assisted suicide, especially those with low self-esteem or who are viewed negatively as weak, dependent, unproductive, unattractive, costly, and unworthy of the efforts of others. Some press reports detail such transactions occurring.⁴⁸⁻⁵¹

THE DISTINCTION BETWEEN DELIBERATELY ENDING LIFE AND ACCEPTING THE END OF LIFE

Common sense suggests that there is a medical and ethical difference between forgoing a heart transplant and ingesting a poison. Yet, explaining the distinction requires simultaneous attention to logic, outcomes, intentions, and causes.⁵² Deliberately ending life means to create a new lethal pathophysiological state with the direct intention of making the patient dead. This is what the patient does to herself in PAS, with the aid and consent of her physician. Allowing to die means to forgo an intervention that is thwarting the progression of a preexisting lethal pathophysiological condition. It may be undertaken for good reasons, such as respect for a patient's judgment that the treatment is too burdensome or because the treatment has proven futile. Properly formulated, the distinction says that killing patients is never ethically justifiable, but allowing patients to die is often justifiable. A patient who requests cessation of life-prolonging treatment is not, either in law or medical ethics, expressing a suicide wish but an acceptance of death. The difference between forgoing treatment and PAS is the difference between accepting death and precipitating death.

Despite attacks on this commonsense distinction, US courts (including the Supreme Court) recognize the distinction between forgoing treatment and suicide.^{14,15,17,18}

SUICIDE IS NOT A PURELY SELF-REGARDING ACT

Suicide affects others. Assisted suicide can be traumatic for families.⁵³ Laws are more than mere regulatory instruments. They send social messages. A PAS law sends the message, however unintended, that if one is seriously ill, taking one's life is something to consider. Moreover, if it becomes socially acceptable for persons to commit suicide because they find loss of control and dependence on others intolerable, then the value of millions of other persons who are heavily dependent upon others is called into question. This is the chief reason that there is such widespread resistance to PAS in the disabled community^{54,55}—not that they will be disproportionately persuaded to undertake PAS, but that their dignity is deeply disrespected by the very fact that a society legally sanctions the notion that dependent persons like them can be considered better off dead. Those already undervalued by society understandably feel even more devalued.⁵⁶

Further, evidence suggests that publicity about PAS leads to suicide contagion,⁵⁷ and rates of suicide in the general population have increased faster in states that have legalized PAS relative to those that have not.⁵⁸

APPROACHING DEATH

The public sometimes falsely believes that, if terminally ill, they face a stark dilemma-either a gruesome death, strapped to machines, sickened by drugs, and stabbed with needles, or a peaceful death via a lethal prescription. Progress in symptom control, hospice, and palliative care belies this depiction of care at the end of life.59-⁶⁷ Moreover, progress in medical ethics has made it routine for patients to refuse life-sustaining therapies such as ventilators, dialysis, feeding tubes, and cardiopulmonary resuscitation that they judge to be more burdensome than beneficial, and then to be supported in dying. Acceptance of the principle of double effect makes it possible for patients to consent to be treated with sufficient doses of medication to control their symptoms even at the risk of unconsciousness or hastened death.68 There should be no need for PAS for uncontrolled symptoms; the response of medicine should be to ensure that physicians become skilled in providing good care at the end of life and assuring that all patients have access to that care.

THE DEMAND FOR PAS IS VERY SMALL UNTIL IT BECOMES NORMALIZED

Popular support for PAS seems based on the fear that doctors will not adequately relieve symptoms, particularly pain. Evidence is emerging, however, that those who actually seek assisted suicide and die by lethal ingestion where it is legal do so not because of unrelieved symptoms, but because of perceptions of diminished autonomy or dignity or the fear of being burdensome to others.^{43,44} Those who receive lethal prescriptions tend to have a distinct but uncommon personality type, fixated on issues of control.⁶⁹ Focusing on PAS distracts from efforts to empower the vast majority of patients to seek and obtain the improved care at the end of life that they need and deserve.^{70,71} Good care gives patients substantial control over their dying without the need for them to express that control by precipitating their own deaths.

THE INCREMENTAL EXTENSION OF PAS

Data from jurisdictions that have legalized PAS show year on year increases overall in the prescription of lethal drugs and in PAS deaths, suggesting a normalization of PAS as part of routine practice. Yet this is just the tip of the iceberg. Once PAS is legalized, on the strength of the argument that one must respect autonomy, it is a short step to say that those who are paralyzed and cannot self-administer drugs are being discriminated against on the basis of their handicaps, and that this requires a move from PAS to euthanasia.^{17/2-74} Moreover, since PAS can result in nausea and vomiting and the process can fail, legalizing PAS generates pressure to legalize euthanasia so that the process can be professionally controlled.

Similarly, those who are unable to speak for themselves (such as children, the demented, and severely retarded) would need to be eligible for euthanasia on the basis of surrogate judgments to avoid treating them unequally. Those suffering from refractory depression and autism, and others who are not terminally ill also become candidates for PAS in order not to discriminate against these classes of patients; the evidence from overseas shows how this happens.

In Belgium, 5% of all deaths (all causes) are now by euthanasia.⁷⁶ Quebec has witnessed a recent public outcry to permit euthanasia for those with dementia deemed ineligible for PAS.⁷⁶ A bill to allow surrogates to euthanize patients who have lost decisional capacity after receiving a PAS prescription was introduced in Oregon,⁷⁷ with proposals to extend the Death with Dignity Act to allow euthanasia for those incapacitated by dementia and those neurologically incapable of swallowing lethal drugs.⁷⁸ Opposition to these moves by pro-PAS groups appears tactical, not principled, inasmuch as proponents realize that it might hurt their cause in other states.⁷⁸

Laws prohibiting PAS rest on a clear and rational principle—that doctors ought not involve themselves in deliberately bringing about the deaths of their patients. Once this principle is diluted by introducing exceptions, like terminal illness or suffering, it becomes clear that this is just an arbitrary line, one that is easily crossed and hard to defend. If it is an act of compassion to help usher out of this world someone who is expected to die in the near future, why is it not an act of compassion to give similar assistance to a chronically ill person with many years of discomfort ahead or to someone suffering severe mental anguish?

CONTROL

Given that no one chooses to be ill, control can feel elusive to patients. Everyone who is dying wants some measure of control in the face of the overwhelming reality that no one can control—the fact of human mortality. They can exert substantial control over decisions such as whether to forgo life-sustaining treatments, how best to finalize their affairs in life, and how to maximize the time they have left. Dying nonetheless brings unavoidable uncertainties, such as the course of illness, response to interventions, and the response of others to one's illness. Doctors also face uncertainty. Prognostication, for instance, is fraught with error. PAS does not control these uncertainties at life's end.

Moreover, if it is argued that PAS is justified because respect for patient autonomy and control is the physician's ultimate duty, then professional judgment would be irrelevant and physicians mere functionaries. If autonomy always trumps other ethical considerations, there would be no principled way of withholding any requested treatments, including antibiotics for the common cold, or, ironically, requests for futile interventions at the end of life. Yet this seems absurd. Medical ethics requires the ability to decline some kinds of patient requests for the good of the individual or for the good of wider society.²²

CONCLUSION

There is more at stake in the debate over legalizing PAS than is at first apparent. Part of the concept of a profession is that it should define its ethics independently of the state, the market, and the vicissitudes of popular opinion.⁷⁹ Adopting a position of neutrality implies that organized medicine is avoiding taking responsibility for defining its fundamental ethical principles.

PAS is often presented to the medical community as "a matter for society," implying that doctors should stand back and be neutral. It is inconsistent, however, to ask doctors to stand back from the question of whether PAS should be legalized, yet to require them to be the gate keepers in any legalized system. Many of the factors behind a request for PAS are personal or interpersonal rather than medical and doctors are in no position to make knowledge-based judgements on them.

Medical organizations and the entire body politic must keep the bigger picture in focus. Doctors are not agents of the state and organized medicine cannot afford to be "neutral" on a topic that touches medicine at its very core.⁴⁵

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Compliance with Ethical Standards:

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Physician-Assisted Suicide and the Perils of Empirical Ethical Research

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Al Rabadi et al¹ compare statistics on physician-assisted suicide (PAS) available from public databases for the states of Washington and Oregon and find similar profiles and trends, which is unsurprising given the similarity of the laws and demographic characteristics of these states. Among the unanswered questions are what such a study can contribute to medical ethics (about PAS or any other ethical controversy) and what the limits are of such work.

CAUTIONS

First, it should be noted that the medical literature is, in general, favorably disposed toward the empirical and the new. Although this predilection is often advantageous for scientific progress, it introduces a problematic bias when applied to ethical questions. The appeal of the study by Al Rabadi et al1 is that it is empirical, and by comparing data from 2 states for the first time, it can be considered novel. Because there are new reports each year and the practice of PAS is legal in only a few states, descriptive reports about PAS are published frequently. This means, however, that articles defending the ethical status quo (ie, against PAS) tend to be shut out of the medical literature because they are not reporting anything new and, therefore, cannot have any data. The result is an impression of growing acceptance of PAS, but it really represents an artifact of a scientific bias.

The frequent publication of statistics on PAS and euthanasia also imparts another implicit ethical bias. Although conducting health services research about an ethically disputed question appears ethically neutral, one already presumes without argument that the service to be delivered is ethically good. Therefore, the standards for assessing good and bad within the framework assumed by the research are limited to questions of access, efficiency, effectiveness, implementation, safety, and regulation. This takes the central ethical question of whether the service ought to be delivered in the first place off the table, suppressing critical ethical debate. Frequent publication of studies like that by Al Rabadi et all have the effect of "normalizing" the practice, inuring readers to the practice and concealing ethical concerns.

Moreover, data cannot tell a society or a profession what ought to be done—a consequence of what philosophers call the fact-value distinction. Empirical reports alone cannot answer normative ethical questions. Whether just 1 person or 100 000 persons legally avail themselves of lethal prescriptions cannot tell us whether the practice is right or wrong.

Likewise, the language used by empirical investigators can obscure the ethical issues at stake. Language can shape people's

attitudes and approaches toward controversial questions. There is no scientific basis for deciding on terminology, except, perhaps, marketing science. The language around PAS includes such terms as "death with dignity," "assisted dying," "assisted death," and "hastened death." Al Rabadi et al¹ use the phrase "medical aid in dying." These terms are imprecise. Giving a dying person an aspirin might count as aid in dying every bit as much as 5 g of secobarbital. These terms obscure distinctions of both ethical and empirical importance but have been shown to improve public opinion polls in favor of the practice. Serious proponents of PAS, such as the philosopher Peter Singer,² prefer to describe it as a form of rational suicide and do not shy away from the most accurate description.

The public databases on which the study of Al Rabadi et al¹ relies are not designed for research. They rely on self-reported data supplied by clinicians, who are generally not present at the time of ingestion of the fatal dose of drug by the patient and have an incentive to make their own roles look good. These data have never been validated, to my knowledge. The information collected is purposefully thin to protect prescribers' confidentiality. There are no data on unreported cases. The health department is not permitted to investigate any allegations of abuse.³ Although these laws do suggest referral to psychiatrists if there are questions about the patient's decisional capacity, and it is known that large numbers of terminally ill patients, including those seeking PAS, are depressed, since 2003, only 0% to 4% of such patients have been sent for psychiatric referral.³ There are also data suggesting, for instance, that large numbers of patients who ingest these drugs are at least transiently awake and suffering, leading to calls for anesthesiologists to administer euthanasia using advanced medical monitoring techniques as the only way to ensure the sought-after peaceful death.⁴ Contrary to the characterization of Al Rabadi et al,¹ Sinmyee et al⁴ are advocates, not opponents, of PAS and euthanasia. These concerns make the conclusion of Al Rabadi et al¹ that PAS in Oregon and Washington is safe, reliable, and effective an invalid inference.

WHAT WE KNOW

At present, the number of reported cases, following the law, remains small but increasing steadily. Those who make use of the law tend to be white, wealthy, and educated.^{1,3} Despite public arguments that PAS is needed to avoid excruciating pain and other symptoms, the reasons attributed to patients who seek PAS are not uncontrolled symptoms but lost autonomy, independence, and control.^{1,3} About one-third of patients die without taking the drugs,³ which may suggest that patients only wanted the security of having a way out, but it could equally indicate that they died before using the drugs or changed their minds about using them. A small (but growing) number of physicians write the prescriptions.³ For example, one of the authors of the study by Al Rabadi et al¹ wrote 15% of all PAS prescriptions in Oregon in 2018.⁵

There is also much that we do not know. We have few direct, valid studies of the patients and practitioners. We do not know how many cases are unreported to the databanks. We do not know how many patients are pressured into obtaining prescriptions. We do not know how many patients engage in "doctor shopping," finding someone who will agree to their request if turned down by a given physician. We do not really know how often the process goes awry. We know little about the after-effects on practitioners and family, although there are reports of posttraumatic stress disorder.⁶ We also need more data on suicide contagion, because preliminary reports⁷ suggest increased rates of suicide in the general population of states that have legalized PAS.

SLIPPERY SLOPES?

Safeguards built into the law are coming to be seen as barriers. As already noted, few patients are ever referred to psychiatrists. A new law in Oregon (Oregon Senate Bill 579) now allows a patient to bypass the waiting period and take the pills within 2 days, and legislation has been passed by the Oregon House (Oregon House Bill 2217) to allow injection of lethal drugs, a hair's breadth away from euthanasia.5 There are increasing calls for permitting patients with dementia to be able to authorize their deaths through advance directives. In Belgium and the Netherlands, 5% of all deaths are by euthanasia and the indications have expanded to include psychiatric illness and life completion.89 Euthanized patients are now regular sources for organ donation.¹⁰ Although there is no empirical proof that the United States will follow these trends if PAS is more widely adopted, the logic that justifies PAS inexorably points in this direction. Studying these trends empirically will not prevent them from occurring. Are we willing to entertain a serious ethical debate, based on reasoned argument, or will we be content merely to file empirical reports on whatever fate befalls us?

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Statement on Physician-Assisted Dying

American Academy of Hospice and Palliative Medicine

BACKGROUND

Suffering near the end of life arises from many sources including loss of sense of self, loss of control, fear of the future, and/or fear of being a burden upon others, as well as refractory physical and non-physical symptoms. Excellent medical care, including stateof- the art palliative care, can address and help alleviate many sources of suffering. On occasion, however, patients seek the assistance of a physician to end their life.

Physician-Assisted Dying (PAD) is defined as a physician providing, at the patient's request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life. Although PAD has historically not been within the domain of standard medical practice, in recent years it has emerged as both an explicit and covert practice across various legal jurisdictions in the United States. PAD has become a legally sanctioned activity, subject to safeguards, first in Oregon in 1997 and, subsequently, in other states including Washington, Vermont, and California. As of the writing of this document, approximately one-sixth of the U.S. population resides in a jurisdiction where PAD is legally permitted, and its legal status continues to evolve at the state level.

A primary goal of the American Academy of Hospice and Palliative Medicine (AAHPM) is to promote the development, use, and availability of palliative care, including hospice, to relieve patient suffering and to enhance quality of life while upholding respect for patients' and families' values and goals. The ending of suffering by ending life has been held as distinct from palliative care, which relieves suffering without intentionally hastening death.

STATEMENT

Situations in which Physician-Assisted Dying (PAD) is requested are challenging for physicians and other healthcare practitioners because they raise significant clinical, ethical, and legal issues. A diversity of positions exists in society, in medicine, and among members of the American Academy of Hospice and Palliative Medicine (AAHPM). AAHPM acknowledges that morally conscientious individuals adhere to a broad range of positions on this issue.

AAHPM takes a position of studied neutrality on the subject of whether PAD should be legally permitted or prohibited. However, as a matter of social policy, the Academy has concerns about a shift to include physician-assisted dying in routine medical practice, including palliative care. Such a change risks unintended longrange consequences that may not yet be discernable, including effects on the relationship between medicine and society, the patient and physician, and the perceived or actual integrity of the medical profession. Any statutes legalizing PAD and related regulations must include safeguards to appropriately address these concerns, such as limiting eligibility to decisionally capable individuals with a limited life expectancy.

Social policy concerns notwithstanding, the Academy recognizes that in particular circumstances some physicians assist patients in ending their lives. Efforts to augment patients' psychosocial and spiritual resources so that they are better able to manage their suffering may make palliative treatments of physical symptoms more effective and may make these circumstances rarer.

Nevertheless, some patients will continue to desire PAD.

Physicians practicing in jurisdictions in which PAD is legally permitted should never be obligated to participate in PAD if they hold moral or professional objections, nor should they be prohibited from participating within parameters defined by relevant statutes and terms of employment. Physicians who affirmatively respond to requests for PAD are obligated to ensure their actions are consistent with best available practices that limit avoidable suffering through end of life.

When a request for PAD is made by a terminally ill patient, medical practitioners should carefully evaluate the patient's concerns precipitating the inquiry and address the sources. Requests originating from family should not be pursued without direct discussion with the patient. Requests for PAD from surrogates of incapacitated patients should not be considered due to the complexities of the ethics of surrogate decision-making. However, surrogates' concerns prompting the request should be fully explored.

EVALUATING REQUESTS FOR PAD

Access AAHPM's Advisory Brief "Guidance on Responding to Requests for Physician-Assisted Dying": http://aahpm.org/positions/padbrief

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PHYSICIAN-ASSISTED SUICIDE (RESOLUTION 15-A-16 AND RESOLUTION 14-A-17)

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTIONS 15-A-16 AND 14-A-17 REMAINDER OF REPORT FILED See Opinion E-5.7

At the 2016 Annual Meeting, the House of Delegates referred Resolution 15-A-16, "Study Aid-in-Dying as End-of- Life Option," presented by the Oregon Delegation, which asked:

That our American Medical Association (AMA) and its Council on Judicial and Ethical Affairs (CEJA), study the issue of medical aid-in-dying with consideration of (1) data collected from the states that currently authorize aid-in-dying, and (2) input from some of the physicians who have provided medical aid-in-dying to qualified patients, and report back to the HOD at the 2017 Annual Meeting with recommendation regarding the AMA taking a neutral stance on physician "aid-in-dying."

At the following Annual Meeting in June 2017, the House of Delegates similarly referred Resolution 14-A-17, "The Need to Distinguish between 'Physician-Assisted Suicide' and 'Aid in Dying'" (presented by M. Zuhdi Jasser, MD), which asked that our AMA:

(1) as a matter of organizational policy, when referring to what it currently defines as 'Physician Assisted Suicide' avoid any replacement with the phrase 'Aid in Dying' when describing what has long been understood by the AMA to specifically be 'Physician Assisted Suicide'; (2) develop definitions and a clear distinction between what is meant when the AMA uses the phrase 'Physician Assisted Suicide' and the phrase 'Aid in Dying'; and (3) fully utilize these definitions and distinctions in organizational policy, discussions, and position statements regarding both 'Physician Assisted Suicide' and 'Aid in Dying'.

This report by the Council on Ethical and Judicial Affairs addresses the concerns expressed in Resolutions 15-A-16 and 14-A-17. In carrying out its review of issues in this area, CEJA reviewed the philosophical and empirical literature, sought input from the House of Delegates through an I-16 educational program on physician-assisted suicide, an informal "open house" at A-17, and its I-17 Open Forum. The council wishes to express its sincere

appreciation for participants' contributions during these sessions and for additional written communications received from multiple stakeholders, which have enhanced its deliberations.

The council observes that the ethical arguments advanced today supporting and opposing "physician-assisted suicide" or "aid in dying" are fundamentally unchanged from those examined in CEJA's 1991 report on this topic [1]. The present report does not rehearse these arguments again as such. Rather, it considers the implications of the legalization of assisted suicide in the United States since the adoption of Opinion E-5.7, "Physician-Assisted Suicide," in 1994.

"ASSISTED SUICIDE," "AID IN DYING," OR "DEATH WITH DIGNITY"?

Not surprisingly, the terms stakeholders use to refer the practice of physicians prescribing lethal medication to be self- administered by patients in many ways reflect the different ethical perspectives that inform ongoing societal debate. Proponents of physician participation often use language that casts the practice in a positive light. "Death with dignity" foregrounds patients' values and goals, while "aid in dying" invokes physicians' commitment to succor and support. Such connotations are visible in the titles of relevant legislation in states that have legalized the practice: "Death with Dignity" (Oregon, Washington, District of Columbia), "Patient Choice and Control at the End of Life" (Vermont), "End of Life Options" (California, Colorado), "Our Care Our Choice Act" (Hawaii), and in Canada's "Medical Aid in Dying."

Correspondingly, those who oppose physician provision of lethal medications refer to the practice as "physician- assisted suicide," with its negative connotations regarding patients' psychological state and its suggestion that physicians are complicit in something that, in other contexts, they would seek to prevent. The language of dignity and aid, critics contend, are euphemisms [2]; their use obscures or sanitizes the activity. In their view such language characterizes physicians' role in a way that risks construing an act that is ethically unacceptable as good medical practice [3]. Still others, meanwhile, argue that the choice by terminally ill patients to take action to end their own lives with the assistance of their physician is distinct from what is traditionally understood as "suicide" [4].

The council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the council's view, despite its negative connotations [5], the term "physician assisted suicide" describes the practice with the greatest precision. Most importantly, it clearly distinguishes the practice from euthanasia [1]. The terms "aid in dying" or "death with dignity" could be used to describe either euthanasia or palliative/hospice care at the end of life and this degree of ambiguity is unacceptable for providing ethical guidance.

COMMON GROUND

Beneath the seemingly incommensurate perspectives that feature prominently in public and professional debate about writing a prescription to provide patients with the means to end life if they so choose, CEJA perceives a deeply and broadly shared vision of what matters at the end of life. A vision that is characterized by hope for a death that preserves dignity, a sense of the sacredness of ministering to a patient at the end of life, recognition of the relief of suffering as the deepest aim of medicine, and fully voluntary participation on the part of both patient and physician in decisions about how to approach the end of life.

Differences lie in the forms these deep commitments take in concrete decisions and actions. CEJA believes that thoughtful, morally admirable individuals hold diverging, yet equally deeply held, and well-considered perspectives about physicianassisted suicide that govern how these shared commitments are ultimately expressed. For one patient, dying "with dignity" may mean accepting the end of life however it comes as gracefully as one can; for another, it may mean being able to exercise some measure of control over the circumstances in which death occurs. For some physicians, the sacredness of ministering to a terminally ill or dying patient and the duty not to abandon the patient preclude the possibility of supporting patients in hastening their death. For others, not to provide a prescription for lethal medication in response to a patient's sincere request violates that same commitment and duty. Both groups of physicians base their view of ethical practice on the guidance of Principle I of the AMA Principles of Medical Ethics: "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights."

So too, how physicians understand and act on the goals of relieving suffering, respecting autonomy, and maintaining dignity at the end of life is directed by identity-conferring beliefs and values that may not be commensurate. Where one physician understands providing the means to hasten death to be an abrogation of the physician's fundamental role as healer that forecloses any possibility of offering care that respects dignity, another in equally good faith understands supporting a patient's request for aid in hastening a foreseen death to be an expression of care and compassion.

IRREDUCIBLE DIFFERENCES IN MORAL PERSPECTIVES ON PHYSICIAN-ASSISTED SUICIDE

How to respond when coherent, consistent, and deeply held beliefs yield irreducibly different judgments about what is an ethically permissible course of action is profoundly challenging. With respect to physician-assisted suicide, some professional organizations-for example, the American Academy of Hospice and Palliative Medicine [6]-have adopted a position of "studied neutrality." Positions of studied neutrality neither endorse nor oppose the contested practice, but instead are intended to respect that there are irreducible differences among the deeply held beliefs and values that inform public and professional perspectives [6,7], and to leave space open for ongoing discussion. Nonetheless, as a policy position, studied neutrality has been criticized as neither neutral or appropriate for organized medicine [8], and as being open to unintended consequences, including stifling the very debate it purports to encourage or being read as little more than acquiescence with the contested practice [9].

CEJA approaches the condition of irreducible difference from a different direction. In its 2014 report on exercise of conscience, the Council noted that "health care professionals may hold very different core beliefs and thus reach very different decisions based on those core beliefs, yet equally act according to the dictates of conscience. For example, a physician who chooses to provide abortions on the basis of a deeply held belief in protecting women's autonomy makes the same kind of moral claim to conscience as does a physician who refuses to provide abortion on the basis of respect for the sanctity of life of the fetus" [10].

Importantly, decisions taken in conscience are not simply idiosyncratic; they do not rest on intuition or emotion. Rather, such decisions are based on "substantive, coherent, and reasonably stable" values and principles [10]. Physicians must be able to articulate how those values and principles justify the action in question.

The ethical arguments offered for more than two decades by those who support and those who oppose physician participation in assisted suicide reflect the diverging "substantive, coherent, and reasonably stable" values and principles within the profession and the wider moral community. While supporters and opponents of physician- assisted suicide share a common commitment to "compassion and respect for human dignity and rights" (AMA Principles of Medical Ethics, I), they draw different moral conclusions from the underlying principle they share. As psychiatrist Harvey Chochinov observed with respect to the stakeholders interviewed by Canadian Supreme Court's advisory panel on physician-assisted death, "neither those who are strongly supportive nor those who are opposed hold a monopoly on integrity and a genuine concern for the well-being of people contemplating end of life. Equally true: neither side is immune from impulses shaped more by ideology than a deep and

nuanced understanding of how to best honor and address the needs of people who are suffering" [11].

THE RISK OF UNINTENDED CONSEQUENCES

From the earliest days of the debate, a prominent argument raised against permitting physician-assisted suicide has been that doing so will have adverse consequences for individual patients, the medical profession, and society at large. Scholars have cited the prospect that boundaries will be eroded and practice will be extended beyond competent, terminally ill adult patients; to patients with psychiatric disorders, children; or that criteria will be broadened beyond physical suffering to encompass existential suffering; or that stigmatized or socioeconomically disadvantaged patients will be coerced or encouraged to end their lives. Concerns have also been expressed that permitting the practice will compromise the integrity of the profession, undermine trust, and harm the physicians and other health care professionals who participate; and that forces outside medicine will unduly influence decisions.

The question whether safeguards—which in the U.S. jurisdictions that permit assisted suicide, restrict the practice to terminally ill adult patients who have decision-making capacity and who voluntarily request assisted suicide, along with procedural and reporting requirements—can actually protect patients and sustain the integrity of medicine remains deeply contested. Some studies have "found no evidence to justify the grave and important concern often expressed about the potential for abuse—namely, the fear that legalized physician-assisted dying will target the vulnerable or pose the greatest risk to people in vulnerable groups" [12], others question whether the available data can in fact support any such conclusions, finding the evidence cited variously flawed [13], inadequate [14], or distorted [15].

Although cross-cultural comparisons are problematic [16], current evidence from Europe does tell a cautionary tale. Recent findings from studies in Belgium and the Netherlands, both countries that permit euthanasia as well as physician-assisted suicide, mitigate some fears but underscore others [17]. For example, research in the Netherlands has found that "requests characterized by psychological as opposed to physical suffering were more likely to be rejected, as were requests by individuals who lived alone," mitigating fears that "solitary, depressed individuals with potentially reversible conditions might successfully end their lives." At the same time, however, among patients who obtained euthanasia or assisted suicide, nearly 4 percent "reported only psychological suffering." At the level of anecdote, a description of a case of euthanasia in Belgium elicited widespread concern about the emergence of a "slippery slope" [18].

Studies have also raised questions about how effective retrospective review of decisions to provide euthanasia/assisted suicide is in policing practice [19,20]. A qualitative analysis of cases that Dutch regional euthanasia committees determined had not met legal "due care criteria" found that such reviews focus on procedural considerations and do not "directly assess the actual eligibility" of the patients who obtained euthanasia [19]. A separate study of cases in which psychiatric patients obtained euthanasia found that physicians' reports "stated that psychosis

or depression did or did not affect capacity but provided little explanation regarding their judgments" and that review committees "generally accepted the judgment of the physician performing EAS [euthanasia or physician-assisted suicide]" [20]. It remains an open question whether reviews that are not able to assess physicians' reasoning truly offer the protection they are intended to provide. To the extent that reporting and data collection in states that permit physician-assisted suicide have similar limitations, oversight of practice may not be adequate.

Medicine must learn from this experience. Where physicianassisted suicide is legalized, safeguards can and should be improved-e.g., "[t]o increase safeguards, states could consider introducing multidisciplinary panels to support patients through the entire process, including verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all palliative and end-of-life options" [21]. Both the state and the medical profession have a responsibility to monitor ongoing practice in a meaningful way and to address promptly compromises in safeguards should any be discovered. It is equally important that strong practices be identified and encouraged across all jurisdictions that permit physicians to assist suicide. Health care organizations in California and Canada, for example, have shared richly descriptive reports of practices adopted in response to the recent legalization of "aid in dying" in those jurisdictions that seek to address concerns about quality of practice and data collection [22,23].

Medicine must also acknowledge, however, that evidence (no matter how robust) that there have not yet been adverse consequences cannot guarantee that such consequences would not occur in the future. As a recent commentary noted, "[p]art of the problem with the slippery slope is you never know when you are on it" [17].

SAFEGUARDING DECISIONS AT THE END OF LIFE

CEJA has found that just as there are shared commitments behind deep differences regarding physician-assisted suicide, there are also shared concerns about how to understand the available evidence. For example, in the council's recent Open Forum, both proponents and opponents of physician-assisted suicide observed that in the U.S., debate occurs against the backdrop of a health care system in which patients have uneven access to care, including access to high quality end-of-life care. They also noted that patients and physicians too often still do not have the conversations they should about death and dying, and that too few patients are aware of the range of options for end-of-life care, raising concern that many patients may be led to request assisted suicide because they don't understand the degree of relief of suffering state-of-the-art palliative care can offer. Participants who in other respects held very different views concurred as well that patients may be vulnerable to coercion, particularly patients who are in other ways disadvantaged; and expressed concern in common that forces external to medicine could adversely influence practice.

These are much the same concerns the Institute of Medicine identified in its 2015 report, Dying in America [24]. They are concerns echoed in a February 2018 workshop on physician-

assisted death convened by the National Academies of Science, Engineering and Medicine [25]. They underscore how important it is to understand why a patient requests assisted suicide as a starting point for care [26].

Patient requests for assisted suicide invite physicians to have the kind of difficult conversations that are too often avoided. They open opportunities to explore the patient's goals and concerns, to learn what about the situation the individual finds intolerable and to respond creatively to the patient's needs other than providing the means to end life-by such means as better managing symptoms, arranging for psychosocial or spiritual support, treating depression, and helping the patient to understand more clearly how the future is likely to unfold [5,27]. Medicine as a profession must ensure that physicians are skillful in engaging in these difficult conversations and knowledgeable about the options available to terminally ill patients [28]. The profession also has a responsibility to advocate for adequate resources for endof-life care [16,28], particularly for patients from disadvantaged groups. The availability of assisted suicide where it is legal must not be allowed to interfere with excellent care at the end of life.

CONCLUSION

At the core of public and professional debate, the council believes, is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs and in the presence of trusted companions, including where feasible and when the patient desires, the presence of a trusted physician. As Timothy Quill noted more than 20 years ago, "dying patients do not have the luxury of choosing not to undertake the journey, or of separating their person from their disease" [27]. Decisions about how to approach the end of life are among the most intimate that patients, families, and their physicians make. Respecting the intimacy and the authenticity of those relationships is essential if our common ideal is to be achieved.

While supporters and opponents of physician-assisted suicide share a common commitment to "compassion and respect for human dignity and rights" (AMA Principles of Medical Ethics, I), they draw different moral conclusions from the underlying principle they share. Where one physician understands providing the means to hasten death to be an abrogation of the physician's fundamental role as healer that forecloses any possibility of offering care that respects dignity, another in equally good faith understands supporting a patient's request for aid in hastening a foreseen death to be an expression of care and compassion.

RECOMMENDATION

The Council on Ethical and Judicial Affairs has reviewed the literature and received thoughtful input from numerous individuals and organizations to inform its deliberations, and is deeply grateful to all who shared their insights. CEJA engaged in extensive, often passionate discussion about how to interpret the Code of Medical Ethics in light of ongoing debate and the irreducible differences in moral perspectives identified above. The council recognized that supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity, but diverge in drawing different moral conclusions from those underlying values in equally good faith. The council further recognized that medicine must learn from experience of physician-assisted suicide, and must ensure that, where the practice is legal, safeguards are improved.

After careful consideration, CEJA concludes that in existing opinions on physician-assisted suicide and the exercise of conscience, the Code offers guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life in the intimacy of a patient- physician relationship.

Because Opinion E-5.7 powerfully expresses the perspective of those who oppose physician-assisted suicide, and Opinion E-1.1.7 articulates the thoughtful moral basis for those who support assisted suicide, the Council on Ethical and Judicial Affairs recommends that the Code of Medical Ethics not be amended, that Resolutions 15-A-16 and 14- A-17 not be adopted, and that the remainder of the report be filed.¹

¹CEJA plans to present E-5.7 and E-1.1.7 in online and print versions of the Code of Medical Ethics as suggested in the Appendix.

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APPENDIX

Thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self- defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith.

Guidance in the AMA Code of Medical Ethics encompasses the irreducible moral tension at stake for physicians with respect to participating in assisted suicide. Opinion E-5.7 powerfully expresses the perspective of those who oppose physicianassisted suicide. Opinion 1.1.7 articulates the thoughtful moral basis for those who support assisted suicide.

5.7 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I, IV

1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self- determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well- considered, deeply held beliefs that are central to their selfidentities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse lifesustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

- (a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
- (b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
- (c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.

- (d) Be mindful of the burden their actions may place on fellow professionals.
- (e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- (f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
- (g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

AMA Principles of Medical Ethics: I, II, IV, VI, VIII, IX

Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper

Lois Snyder Sulmasy, JD, and Paul S. Mueller, MD, MPH, for the Ethics, Professionalism and Human Rights Committee of the American College of Physicians*

Calls to legalize physician-assisted suicide have increased and public interest in the subject has grown in recent years despite ethical prohibitions. Many people have concerns about how they will die and the emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Some have advocated strongly, on the basis of autonomy, that physician-assisted suicide should be a legal option at the end of life. As a proponent of patient-centered care, the American College of Physicians (ACP) is attentive to all voices, including those who speak of the desire to control when and how life will end. However, the ACP believes that the ethical arguments against legalizing physician-assisted suicide remain the most compelling. On the basis of substantive ethics, clinical practice, policy, and other concerns articulated in this position paper, the ACP does not support legalization of physician-assisted suicide. It is problematic given the nature of the patient–physician relationship, affects trust in the relationship and in the profession, and fundamentally alters the medical profession's role in society. Furthermore, the principles at stake in this debate also underlie medicine's responsibilities regarding other issues and the physician's duties to provide care based on clinical judgment, evidence, and ethics. Society's focus at the end of life should be on efforts to address suffering and the needs of patients and families, including improving access to effective hospice and palliative care. The ACP remains committed to improving care for patients throughout and at the end of life.

How we die, live, and are cared for at the end of life is important, with implications for individuals, their families, and society. The 1997 report Approaching Death: Improving Care at the End of Life, by the Institute of Medicine (IOM), documented inadequate end- of-life care in the United States (1). The investigators of SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment; 2000) agreed (2, 3). The emphasis by medicine and society on intervention and cure has sometimes come at the expense of good end-of-life care. Inappropriate treatment at the end of life may be harmful and draining- physically, emotionally, and financially-for patients and their families. Many people have concerns about death. At the end of life, some patients receive unwanted care; others do not receive needed care (4 - 6). Some end-of-life concerns are outside of medicine's scope and should be addressed in other ways. Although medicine now has an unprecedented capacity to

treat illness and ease the dying process, the right care in the right place at the right time has not been achieved.

Medicine and society still struggle with getting it right for all patients. Although progress has been made, the principles and practices of hospice and palliative medicine have not been fully realized (4). Revisiting these issues in 2014, the IOM's Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life reported that challenges remain in delivering quality end-of-life care to a growing and diverse elderly population, especially with regard to access to care, communication barriers, time pressures, and care coordination (7). Inadequate reimbursement and other disincentives also are barriers to palliative and hospice care.

Hospice and palliative care may ease apprehension about the dying process. Such care requires improving access to, financing

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of, and training in palliative care; improving hospital, nursing home, and at-home capabilities in delivering care; and encouraging advance care planning and openness to discussions about dying. Of note, 90% of U.S. adults do not know what palliative care is; however, when told the definition, more than 90% say they would want it for themselves or family members if severely ill (4).

Within this context of challenges in providing palliative and hospice care, a few U.S. jurisdictions have legalized physicianassisted suicide. This paper presents the position of the American College of Physicians (ACP) on the topic. The ACP recognizes the range of views on, the depth of feeling about, and the complexity of this issue. This executive summary is a synopsis of the ACP's position. See the Glossary for definitions and the Appendix for the full position paper.

METHODS

This position paper was developed from September 2015 to March 2017 on behalf of the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP's conflict-of-interest policy and procedures (www. acponline.org/about-acp/who-we-are/acp-conflict-of-interestpolicy-and-procedures), and appointment to and procedures of the EPHRC are governed by the ACP's bylaws (www.acponline. org/about-acp/who-we-are/acp-bylaws). After an environmental assessment to determine the scope of issues and literature reviews, the EPHRC evaluated and discussed several drafts of the paper; the paper was then reviewed by members of the ACP Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, Council of Subspecialty Societies, Patient Partnership in Healthcare Center and Advisory Board, and other committees and experts. The paper was revised on the basis of comments from the aforementioned groups and individuals, reviewed again by the full leadership, and then revised further. Finally, the ACP Board of Regents reviewed the paper and approved it on 27 March 2017. Financial support for this project is exclusively from the ACP operating budget.

BACKGROUND AND BRIEF RATIONALE

In 2001, the ACP published a position paper opposing legalization of physician-assisted suicide (8). This issue also has been considered every few years in the American College of Physicians Ethics Manual, including the current edition (9). Given recent changes in the legal landscape, public interest in the topic, and continuing barriers to palliative and hospice care, an updated position paper is presented here. Within a framework that considers clinical practice, ethics, law, and policy, this paper provides background, discusses the role of palliative and hospice care, explores the nature of the patient-physician relationship and the distinction between refusal of life-sustaining treatment and physician-assisted suicide, and provides recommendations for responding to patient requests for physician-assisted suicide.

Medical ethics establishes the duties of physicians to patients and society, sometimes to a greater extent than the law (9). Physicians have duties to patients on the basis of the ethical principles of beneficence (that is, acting in the patient's best interest), nonmaleficence (avoiding or minimizing harm), respect for patient au tonomy, and promotion of fairness and social justice (9). Medical ethics and the law strongly support a patient's right to refuse treatment, including life-sustaining treatment. The intent is to avoid or withdraw treatment that the patient judges to be inconsistent with his or her goals and preferences. Death follows naturally, after the refusal, as a result of the underlying disease (9).

GLOSSARY

Suicide: The act of killing oneself intentionally.

Physician-assisted suicide: Physician participation in advising or providing, but not directly administering, the means or information enabling a person to intentionally end his or her life (e.g., ingesting a lethal dose of medication prescribed for that purpose).

Euthanasia: The act of intentionally ending a life to relieve pain or other suffering (e.g., lethal injection performed by a physician).

Ethical arguments in support of physician-assisted suicide highlight the principle of respect for patient autonomy and a broad interpretation of a physician's duty to relieve suffering (10). Proponents view physician-assisted suicide as an act of compassion that respects patient choice and fulfills an obligation of nonabandonment (11). Opponents maintain that the profession's most consistent ethical traditions emphasize care and comfort, that physicians should not participate in intentionally ending a person's life, and that physicianassisted suicide requires physicians to breach specific prohibitions as well as the general duties of beneficence and nonmaleficence. Such breaches are viewed as inconsistent with the physician's role as healer and comforter (12, 13).

Both sides agree that patient autonomy is critical and must be respected, but they also recognize that it is not absolute and must be balanced with other ethical principles (9, 14). To do otherwise jeopardizes the physician's ability to practice high-value care in the best interests of the patient, in a true patient-physician partnership. Only by this balancing of ethical principles can physicians fulfill their duties, including those in more everyday encounters, such as when a physician advises against tests requested by a patient that are not medically indicated, declines to write an illegal prescription, or breaches confidentiality to protect public health. It also undergirds the physician's duty not to engage in futile care (such as care based on requests for nonindicated cardiopulmonary resuscitation or end-of-life treatment of brain-dead patients under an expansive view of patient autonomy). Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of services (15).

The suffering of dying patients may be great and is caused by somatic symptoms, such as pain and nausea; psychological conditions, such as depression and anxiety; interpersonal suffering due to dependency or unresolved conflict; or existential suffering based in hopelessness, indignity, or the belief that one's life has ended in a biographical sense but has not yet ended biologically. For some patients, a sense of control over the manner and timing of death brings comfort. However, is it reasonable to ask medicine to relieve all human suffering? Just as medicine cannot eliminate death, medicine cannot relieve all human suffering. Both proponents and opponents of physicianassisted suicide wish to alleviate suffering of dying patients, and physicians have an ethical duty to provide competent palliative and hospice care (9). However, is physician-assisted suicide a type of control over suffering and the dying process that is within the goals and scope of medicine?

Balancing respect for patient autonomy against other principles reflects ethical arguments about the nature of the patient-physician relationship—a relationship that is inherently unequal because of power differentials and the vulnerability of illness—physicians' duties, and the role of the medical profession in society. A fuller consideration of this ethical balance, intent and causation in acts near the end of life, medicalization versus personalization of death, and the ethics and implications of physician-assisted suicide are presented in the Appendix (16–81).

POSITION STATEMENT

The ACP affirms a professional responsibility to improve the care of dying patients and their families.

The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all patients can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and management of pain and other symptoms, and support for families. Physicians and patients must continue to search together for answers to the challenges posed by living with serious illness before death (9).

CONCLUSION

Society's goal should be to make dying less, not more, medical. Physician-assisted suicide is neither a therapy nor a solution to difficult questions raised at the end of life. On the basis of substantive ethics, clinical practice, policy, and other concerns, the ACP does not support legalization of physician-assisted suicide. This practice is problematic given the nature of the patient-physician relationship, affects trust in that relationship as well as in the profession, and fundamentally alters the medical profession's role in society. Furthermore, the principles at stake in this debate also underlie medicine's responsibilities on other issues and the physician's duty to provide care based on clinical judgment, evidence, and ethics. Control over the manner and timing of a person's death has not been and should not be a goal of medicine. However, through high-quality care, effective communication, compassionate support, and the right resources, physicians can help patients control many aspects of how they live out life's last chapter.

From the American College of Physicians, Philadelphia, Pennsylvania.

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Clinical Criteria for Physician Aid in Dying

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ABSTRACT

More than 20 years ago, even before voters in Oregon had enacted the first aid in dying (AID) statute in the United States, Timothy Quill and colleagues proposed clinical criteria AID. Their proposal was carefully considered and temperate, but there were little data on the practice of AID at the time. (With AID, a physician writes a prescription for life-ending medication for a terminally ill, mentally capacitated adult.) With the passage of time, a substantial body of data on AID has developed from the states of Oregon and Washington. For more than 17 years, physicians in Oregon have been authorized to provide a prescription for AID. Accordingly, we have updated the clinical criteria of Quill, et al., based on the many years of experience with AID. With more jurisdictions authorizing AID, it is critical that physicians can turn to reliable clinical criteria. As with any medical practice, AID must be provided in a safe and effective manner. Physicians need to know (1) how to respond to a patient's inquiry about AID, (2) how to assess patient decision making capacity, and (3) how to address a range of other issues that may arise. To ensure that physicians have the guidance they need, Compassion & Choices convened the Physician Aid-in-Dying Clinical Criteria Committee, in July 2012, to create clinical criteria for physicians who are willing to provide AID to patients who request it. The committee includes experts in medicine, law, bioethics, hospice, nursing, social work, and pharmacy. Using an iterative consensus process, the Committee drafted the criteria over a one-year period.

INTRODUCTION

More than 20 years ago, even before voters in Oregon had enacted the first aid in dying (AID) statute in the United States, Timothy Quill and colleagues proposed clinical criteria for AID.¹ Their proposal was carefully considered and temperate, but there were little data on the practice of AID at the time. With AID, a physician writes a prescription for life-ending medication for a terminally ill, mentally capacitated adult. Consistent with the recommendation of the American Public Health Association, we use "aid in dying" rather than "physician-assisted suicide" to describe the practice.²

With the passage of time, a substantial body of data on AID has developed from the state of Oregon. For nearly two decades, physicians in Oregon have been authorized to provide a prescription for AID.³ Some data also come from Washington State, which enacted a statute in 2008 patterned after the Oregon law.⁴ Accordingly, for those physicians who are willing to provide AID, we have updated the clinical criteria of Quill, et al., based on these many years of experience.

To be sure, clinical criteria are included in the AID statutes in California, Oregon, Vermont, and Washington.³⁻⁶ But those criteria are incomplete. For example, while the states require

physicians to ensure that the patient is making an informed and voluntary decision, the statutes provide insufficient guidance for physicians in their assessment of the patient's decision-making process. Our clinical criteria discuss the ways in which physicians should respond to a request for AID, including (1) discussion of the patient's reasons for requesting AID, (2) evaluation of the patient's decisional capacity, and (3) assessment of the patient's understanding of palliative measures that might be used instead of or concurrent with AID. In addition, while the statutes authorize the writing of a prescription for AID, they say nothing about the kinds or doses of medication that should be used. In contrast, our criteria provide specific recommendations for the prescriptions that physicians should write and the steps that patients should take in preparing their medication for ingestion.

Not only are statutory criteria incomplete in the states that have them, but criteria are wholly absent in other states. AID has been recognized as legitimate by courts in Montana and New Mexico.⁷⁸ But, like the supreme courts of Colombia and Canada, those courts did so without issuing any guidelines, other than the requirement that patients be mentally capacitated adults who

^a David Orentlicher, et al., Published by Mary Ann Liebert, Inc. This Open Access article is distributed under the terms of the Creative Commons License (http:// creativecommons.org/licenses/by/4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly credited. are terminally ill and able to self- administer the medication.^{9,10} Courts in several other states also could decide that no state law prohibits AID (as the Montana Supreme Court did) or that the state constitution guarantees a right to the practice (as found by a New Mexico trial court). Several such lawsuits were filed in early 2015.11 While AID remains ethically controversial, the pace of legalization is accelerating. Between January and September 2015, more than 25 state legislatures considered bills to authorize AID.12

With more jurisdictions authorizing AID, it is critical that physicians can turn to reliable clinical criteria. As with any medical practice, AID must be provided in a safe and effective manner. Physicians need to know (1) how to respond to a patient's inquiry about AID, (2) how to assess patient decision making capacity, and (3) how to address a range of other issues that may arise.

To ensure that physicians have the guidance they need, Compassion & Choices (the nation's oldest and largest nonprofit organization working to improve care and expand choice at the end of life [EOL]) convened the Physician Aid-in-Dying Clinical Criteria Committee, in July 2012, to create clinical criteria for physicians who are willing to provide AID to patients who request it. The committee includes experts in medicine, law, bioethics, hospice, nursing, social work, and pharmacy. Using an iterative consensus process, the committee drafted the criteria over a oneyear period. The criteria draw upon over 25 combined years of extensive documentation and data collection from AID in Oregon and Washington, with the goal of supporting optimal patient care at EOL. Some statutory provisions impose requirements that are not necessary from a clinical perspective, so are not included. The full version of the clinical criteria can be found online. In the remainder of this article we provide a summary. (See online supplementary material at www.liebertpub.com/jpm.)

RESPONDING TO REQUESTS FOR AID

AID may be provided only to eligible patients—those with an incurable condition that will likely result in death within six months (or within a "relatively short time").¹³ The patient also must be an adult resident of the state and possess the capacity to make major medical decisions.

A patient's request for AID must receive prompt evaluation. Physicians should explore the physical, psychological, spiritual, financial, and social issues influencing the request.¹⁴ The criteria include examples of questions that the physician may use to do this. The goals are (1) to deter any premature action by the patient, (2) to establish whether a request reflects decisional capacity and freedom from external pressure, and (3) to ensure that the patient is considering alternatives to AID. It is important that the physician identify patient concerns that could be addressed without AID. AID must reflect a considered and voluntary choice by the patient.

If the physician is concerned that a mental health condition may be impairing the patient's judgment or decisional capacity, the physician should refer the patient to a licensed psychiatrist or clinical psychologist for evaluation. A number of mental health screening assessments are available for physicians to use in the office. For example, the Patient Health Questionnaire (PHQ-9) is a validated instrument for detecting and diagnosing depression.¹⁵

ENSURING INFORMED CONSENT

Studies show that few patients understand all their EOL options.16 Therefore, when a patient requests AID, the physician ought to explore with that patient the full range of EOL care available. First, patients should understand alternatives to hastening death: (1) hospice care and (2) aggressive management of symptoms, including deep sedation. Indeed, these two possibilities should be discussed with all patients in the terminal phase of disease. Patients who ask about AID should be referred for hospice care if they are not already enrolled. Furthermore, whenever feasible, the physician should obtain a second opinion from an experienced physician who ideally has palliative care experience. It is personally, professionally, and legally valuable for the physician to obtain this validation and confirmation. But in the exceptional cases in which it is infeasible to obtain a second opinion, that infeasibility should not preclude patient access to AID.17

Second, those patients who want to bring about a peaceful death at the time of their choosing should also understand that they may choose among several alternatives to AID: (1) discontinuing lifeprolonging treatment, (2) palliative sedation to unconsciousness when indicated, and (3) voluntarily ceasing to eat or drink.18 The physician must assure the patient that that care will be provided to relieve any associated distress.

Physicians ought to encourage the patient both (1) to include family members in the patient's discussions of EOL care with the physician and (2) to discuss EOL planning with close relatives and loved ones. If a terminally ill patient worries that informing a family member would be problematic, the reasons for not informing must be fully explored and understood. Not only must the family make sense of the patient's death (if it occurs), but also the family may have insights into the motivations underlying the AID decision that are not obvious to the physician. It is recommended that a mental health professional or the physician conduct a family meeting to resolve these issues.

Physicians must thoroughly document the elements of an informed request for AID in the patient's medical record. These elements include patient understanding of diagnosis, prognosis, and the alternatives to AID. Physicians should also document that the patient understands (1) the near certainty that ingesting the prescribed life-ending medication will cause death; (2) the possibility that ingesting the medication could cause nausea or vomiting or, rarely, could fail to cause death; (3) that the patient always retains the right to decide against AID; and (4) that the physician is willing to continue caring for the patient and to address subsequent palliative needs, whether or not the patient chooses to take the medication.

Physicians must also inform patients about the self-administration requirement for AID. Patients must be capable of taking the medication on their own, usually by drinking from a cup but also by pouring through a feeding tube. Family or others may assist the patient by mixing the medication into a drink.

PROVIDING A PRESCRIPTION

Oregon, Washington, and Vermont require a 15-day waiting period between the first request for AID and the writing of a prescription. When a waiting period is not required by state law, physicians may know the patient well enough to determine without difficulty that the request is voluntary, rational, and enduring. If physicians are uncertain about this, they should schedule a follow-up visit in 10 to 15 days to revisit the request. Putting a time buffer between requests and prescription writing generally will clear up any residual doubts. The attending physician also should encourage a meeting with the patient and family together to address any concerns about the patient's request.

Once physicians have written a prescription for life-ending medication, they must alert the patient's pharmacist. This allows the pharmacist to decide whether or not to participate and to have the appropriate medication available for pick-up. In many cases in which a patient has received a prescription— more than one-third in Oregon—the patient never ingests the medication and dies from progression of the terminal illness. But even for these patients, the option of AID is a valuable benefit. These and other AID patients realize an improvement in their quality of life from the sense of control that comes with mere receipt (not ingestion) of the prescription.¹⁹

END-OF-LIFE MEDICATION PROCEDURE

The medication protocol is a two-step procedure. First, the patient takes an antiemetic (e.g., metoclopramide or ondansetron). Fortyfive to sixty minutes later, the patient ingests 9 g of a short-acting barbiturate (e.g., secobarbital or pentobarbital). The powdered barbiturate is mixed with a half cup of water into a slurry and consumed. The barbiturate must be consumed quickly, within 30 to 120 seconds. Otherwise, the patient may fall asleep before ingesting an effective dose. The patient may then drink juice or other liquid as desired. The patient should not consume fatty foods within four to six hours prior to taking the medication.

Patients may wish to have their physicians present when they take their medication. This ought to remain a matter between patient and physician. It usually is a good idea for family members or friends to be with the patient at the time of ingestion to provide comfort. Indeed, a gathering of family and friends can be a rich experience for all.²⁰ When a physician is not present, family or friends can notify the patient's physician, hospice, or funeral home of the time of death. Those present should understand that it is not necessary to call 911 when the patient goes into a coma and subsequently dies.

To maintain confidentiality of the patient's EOL decisions, physicians in Oregon and Washington indicate on the death certificate either "respiratory failure" or the patient's underlying terminal illness as the immediate cause of death. The manner of death is recorded as "natural." This notation is similar to that used on death certificates following removal of a ventilator.²¹

CONCLUSION

Although AID has received legal recognition only since 1997 and only in a few states, the experience to date permits the drafting of clinical criteria to guide physicians when their patients request AID. For physicians who are willing to provide AID, it is important that they be medically knowledgeable doing so. These criteria are designed to provide that knowledge and guidance.

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What people close to death say about euthanasia and assisted suicide: a qualitative study

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Objective: To explore the experiences of people with a "terminal illness", focusing on the patients' perspective of euthanasia and assisted suicide.

Method: A qualitative study using narrative interviews was conducted throughout the UK. The views of the 18 people who discussed euthanasia and assisted suicide were explored. These were drawn from a maximum variation sample, who said that they had a "terminal" illness, malignant or non-malignant. Results: That UK law should be changed to allow assisted suicide or voluntary euthanasia was felt strongly by most people. Those who had seen others die were particularly convinced that this should be a right. Some had multiple reasons, including pain and anticipated pain, fear of indignity, loss of control and cognitive impairment. Those who did not want to be a burden also had other reasons for wanting euthanasia. Suicide was contemplated by a few, who would have preferred a change in the law to allow them to end their lives with medical help and in the company of family or friends. The few who opposed a change in UK law, or who felt ambivalent, focused on involuntary euthanasia, cited religious reasons or worried that new legislation might be open to abuse.

Conclusion: Qualitative research conducted on people who know they are nearing death is an important addition to the international debate on euthanasia and assisted suicide. Those who had seen others die were particularly convinced that the law should be changed to allow assisted death.

The Netherlands and Belgium permit euthanasia performed by a doctor, and define it as the act, undertaken by a third party, which intentionally ends a person's life at his or her request. Doctor-assisted suicide is legal in The Netherlands, Belgium and Oregon. Assisted suicide, with or without the involvement of a doctor, is legal in Switzerland. In Australia, the Northern Territory approved euthanasia in 1995, but in 1997 this bill was overturned by parliament.

In the UK, the issue of euthanasia has been widely debated since the 1870s,¹ and many argue that the question of the right to die has become one of the most important in contemporary ethics.² A House of Lords select committee recently produced a report on Joel Joffe's Assisted Dying for the Terminally III Bill, and recommended that, in future, assisted suicide and voluntary euthanasia be debated separately, allowing the possibility of a change in the law for one but not the other.³ Lord Joffe has since redrafted his bill, which had its formal first reading in November 2005.

Euthanasia in the UK is illegal, but the application of the law is not always clear. For example, although doctors in the UK are not allowed to give treatment that causes death, doctors can withhold artificial nutrition and hydration (defined by the British Medical Association as "life-prolonging treatments") if they believe that this would be in the patient's "best interests". In the absence of consensus, any decision must be authorised by a court, but the meaning of "best interests" can be controversial. Giving food and drink to the sick has long been used to symbolise "compassionate care",⁴ and some may regard the withdrawal of food and water, as in the Tony Bland case,ⁱ as a form of involuntary euthanasia or even murder.^{5 6} Thus, the law seems to be inconsistent.⁷ It forbids doctors to give a patient a lethal injection at his or her request, but permits a court to authorise death by starvation without such a request.

The UK law on assisted suicide has also been described as "contradictory, confusing and opaque".⁶ What counts as assistance in suicide in "mercy-killing cases" seems to be rather arbitrary. In 1989, a couple were convicted because they sat and watched their daughter (who had motor neurone disease) commit suicide and die of an overdose, but in 2005 Graham Lawson was not prosecuted after he comforted his sister, who had multiple sclerosis, during a 26-h suicide ordeal. She finally killed herself with a plastic bag. The Director of Public Prosecutions continues to consider cases individually. Under the Suicide Act 1961 section 2 (4), no prosecution for the offence of assisted suicide can take place without the consent of the Director of Public Prosecutions.

ⁱAiredale NHS Trust v Bland (1993) AC 789.

He will exercise his discretion only after a suicide has taken place; therefore, no prospective guidance can be given to people.⁹

Previously, attitudes to euthanasia and assisted suicide were examined mainly from the perspectives of politicians, ethicists, health professionals and the general public.¹⁰⁻¹² A few studies tried to capture the patients' perspective indirectly—for example, Seale and Addington-Hall¹³ found that a quarter of bereaved respondents would have preferred an earlier death, and examined the reasons, but they did not interview the people who were dying. Little is known about euthanasia or assisted suicide from the patients' point of view.¹⁴ We explore these issues from the perspectives of people who knew they were terminally ill.

METHOD

With the approval of the ethics committee, we invited people living in the UK to participate in a study on the experience of "living with a terminal illness". Interviews were contributed to the website, DIPEx (Personal Experiences of Health and Illness; www.dipex.org).¹⁵ We interviewed 41 people who said that they had a terminal illness. We aimed for a sample with maximum variation, including younger and older people from various social backgrounds, with malignant and non-malignant disease (table 1).16 The sample included people who had attended a hospice for day care and others who had spent a few weeks in a hospice or nursing home. Some people were recruited through general practitioners, hospice staff and Macmillan nurses. Long discussions (to explain the study) were held with health professionals, who then approached suitable patients with full information. Patients returned a reply slip to the research team if they wished to participate. Other people volunteered after reading about DIPEx in a national newspaper, through support groups or during a conference about palliative care that included patients.

THE INTERVIEWS

Most people were interviewed in their homes during 2003 and 2004 by a sociologist and asked to talk about their recent experience of illness. Some were interviewed twice, usually because of fatigue. All interviews were audiotaped and lasted 1-2 h. Rather than use a structured approach, we conducted narrative interviews, which were led by respondents. A few people themselves raised the subject of suicide, euthanasia or assisted suicide, which became a high profile issue in the media during the fieldwork. It was considered to be unethical to press respondents to talk about the subject, but in some cases the researchers judged that they could invite respondents to comment on the euthanasia debate. In some interviews the subject was initially raised during a break for rest or cup of tea (it is sometimes easier to raise a sensitive subject "off tape" in a more informal atmosphere) and then repeated as part of the taped interview. The subject was not always raised because it became apparent during the interviews that some respondents did not think they were dying (even though they had said they had a terminal illness and had volunteered for the study), and it did not seem appropriate at the time. Eighteen people discussed these topics, some briefly and others at some length.

ANALYSIS

Two members of the research team, both medical sociologists, read and re-read the data and constructed a coding frame. Data analysis included examining expected themes such as pain and emergent themes, including suicide and assisted death, across the whole dataset and in the context of each person's interview. The method of constant comparisons was used to ensure that all perspectives were included in the analysis.17 QSR N5 (a qualitative data-indexing package; QSR International Pty, Melbourne, Australia) facilitated the analysis.18 AC and SZ regularly discussed coding and interpretation of results (for more details on methods, see www.dipex.org/methodology. aspx).

Table 1 Characteristics of 18 people who discussed euthanasia or assisted suicide, drawn from a larger sample of 41 people interviewed about terminal illness

Characteristic	No of people
Age at interview (years)	
30-50	3 (5)
51–60	4 (11)
61–70	7 (16)
71–80	3 (7)
81–90	1 (2)
Ethnicity	
White	18 (39)
Indian	0 (1)
Black Caribbean	0 (1)
Main occupation before becoming ill	
Professional or higher managerial	13 (26)
Other non-manual	3 (9)
Skilled manual	2 (3)
Housewife	0 (3)
Type of disease	
Cancer	13 (32)
Non-malignant disease	5 (9)
Recruited through	
Hospice staff (nurses, social worker, consultants)	2 (14)
Article in national newspaper	7 (9)
Community palliative care nurse specialists	2 (4)
General practitioners	1 (4)
Conference on palliative care	2 (2)
Other—for example, via another participant, support group	4 (8
Numbers in parentheses indicate those in the e	ntire sample.

Numbers in parentheses indicate those in the entire sample.

RESULTS

Arguments supporting voluntary euthanasia or assisted suicide

Pool⁵ found that "control over the time and manner of death" was a central theme in requests for euthanasia in a Dutch hospital. Some people we interviewed also mentioned a need to control events, but had further reasons for wanting a change in the law. For example, a young woman with chronic obstructive lung disease said that without a change in the law she may commit suicide alone. She was in great pain, and could not find a place in a hospice. Throughout the interview she said she wanted to be in control and emphasised her right to choose:

R: I myself want to be in control as long as I can, I don't want doctors and nurses controlling me (...) I'm on morphine, I get a lot of breakthrough pain, when I get to the pitch where I really can't cope with anything any more, where my quality of life is totally gone, I will tell my husband I want a really good day out with the kids which is when he'll know that when I go to bed that night I won't wake up the next morning.

I: Because you're going to take control? R: Yes.

I: Have you talked to anyone else about that?

R: Yes, I've talked to my GP about it. He wishes I lived in another country because that decision would be helped. (...)

I: And if you were in control of legislation what would you say should happen?

R: (...) I think that you have to really look into it seriously, whether this is the right thing for the right person because I think there is the risk it might be abused. But with myself, if the legislation was there then it would be nicer for me, so I'm not on my own, which I know I will be because I don't want any of the family here when it happens.

I: Why don't you want anyone with you?

R: Because I don't want them involved, I don't want them to get in trouble. (...) In other countries, (...) I believe now, you're allowed to choose when you die so you've still got your dignity. This country we don't allow it; (...) if anybody helps us they lock them up, which is wrong. You've taken away that person's dignity and nobody should have the right to do that. We should all have the right to choose when we die and how we die (LD25).

She believes that without a change in UK law she would have to die alone to protect her family from prosecution for their involvement in assisted suicide. She also notes the difference made by personal involvement:

I think the government has got to seriously take it on board, and I realise that it's a very dangerous subject, and it's a very dangerous area, but in the right situation it's needed (...). I think if some of these ministers and politicians who are against euthanasia, I sometimes wonder, if it was their life or their wife or mother, how they'd feel then (LD25). One argument against euthanasia has been that good palliative care should control symptoms, including pain and depression, and therefore people who consider ending their lives may change their minds when symptoms are properly controlled. Although most patients do have a pain-free death, however, a few do not. Sometimes analgesia is insufficient without side effects such as sedation, nausea and confusion.19 Some respondents mentioned uncontrolled pain:

R: Sometimes I am in that much pain that all I want to do is put myself on my bed and go to sleep but I can't sleep because the pain keeps me awake (...). I feel sad and angry that at the dawn of the 21st century they're able to talk on television about taking photographs and soil samples of Mars but they can't give me something that will keep me awake, lucid and to be a useful member of society and kill the pain at the same time (LD09).

This man had searched the internet to find out how to commit suicide. He said that he would not do this without talking it through with his fiancée. He was against euthanasia but for assisted suicide:

R: The people that have motor neurone disease, the people that have MS and are in excruciating pain, a lot worse than the pain that I have, they should be able, in conjunction with their partner [our emphasis], to decide that enough is enough and that they should be able to take their own life (LD09).

The hospice movement exists to deliver outstanding care to dying patients and does so.20 But research suggests that hospice care does not stem the wishes of a notable minority for euthanasia. Seale and Addington-Hall²¹ interviewed relatives and acquaintances of those who had died and found that respondents for hospice patients were more likely than respondents for those who had not received hospice care to believe that an earlier death would have been better, even after controlling for levels of distress and dependency among those who were dying. The authors suggest that this may be either because hospice care is geared to helping patients express their fears and exercise choice or because people (and their relatives) who accept hospice care may be predisposed to consider the benefits of an earlier death. But other reasons may also contribute. One woman we interviewed said that she would welcome euthanasia or assisted suicide because of what she saw on a shared ward:

R: I spent a month in the hospice, (...) just unfortunately probably nine different ladies came into the ward and died (...). So I have seen what happens at the end and if I could avoid it happening to me I would, simple as that. (...). It was really bad luck because I've seen it first hand whereas in the past I could only guess at I suppose what it could be like at the end, and it's not a pleasant prospect and if I could just take enough of something to put myself to sleep for good, I would happily do it and [um]. If somebody wants, you know wanted to help me, if somebody was brave enough to help me, I'd be grateful to them. It's almost a nonsense we can't decide what to do with our life at the end, isn't it? Why should a judge be able to say, no, I can't kill myself if I want to? (LD02).

In the 1970s Murray Parkes²² interviewed surviving spouses, and asked how their husbands and wives had felt about other people's deaths in St Christopher's Hospice. Of these, 15 (44%) respondents said that their spouse had realised that a death had occurred but most were apparently not upset. More recently, however, Lawton²³ observed patients in a hospice who had unpleasant symptoms that could not be successfully treated or controlled, and who sometimes requested euthanasia or refused food and drink to hasten death. She noted that other patients in the ward, like the woman just quoted, were very distressed by what they saw and smelt.²³

Another woman with metastatic kidney cancer, whom we interviewed, had seen her mother die a painful, undignified death, and hoped that the law would be changed before she died. She too was worried by the possibility of an incontinent, "unbounded" body:²³

R: It would be a comfort to me to think that when I've come to a point where I'm clearly dying, you know there is no further treatment available for me and if I am in lots of discomfort, I would like to be able to say, "Can you get my kids to come and see me," and maybe, I don't know, my friend, that's a minister or whatever and say goodbye. And then [er] you know can you just do what has to be done, give me an overdose of morphine or whatever it is. Because actually my Mum was in hospital for about three months before she died. And she had sort of raging osteoporosis having taken lots of steroids for another condition. And she was in terrible pain and she had made a living will actually. [Um] And they had to give her so much morphine in the last few weeks, to be honest she was talking rubbish and coming up with ideas. She told us there was something she wanted to tell me and that she had murdered twelve children. And I said, "Oh Mum, you know that is your mind playing tricks because of the drugs. You haven't murdered anybody". But she still insisted that she had. And I just wish that she could have gone a month or two earlier before she went through all that indignity that is dying really. [um] And I would feel the same about myself (...). I just think that when you've come to that stage, only you know when that is, how bad that has to be, you don't need to go through the physical indignities of throwing up, being smelly, being incontinent, whatever it might be (LD17).

Others have noted that when death approaches, people still wish to remain physically independent.^{13 24} A man with progressive multiple sclerosis hated being dependent on his wife and wanted the option of euthanasia. He had run a nursing home and had seen others die in great pain. At times he suffered from excruciating pain himself, and he dreaded cognitive impairment:

R: I have a strong opinion about that [euthanasia]. First of all I believe that it is everybody's right to die as it is their right to live (...). Now I would like to think that if something happens to me [so] that I become completely incapable of enjoying life then I would want someone to do to me what they would do to any ordinary animal. They would if it was a dog and it was suffering and in pain and couldn't be a dog anymore, you would say, "Oh pity", and you would take the dog to the vet.

I would hope that I could be taken to a doctor or the doctor would come to me, or would be allowed to and would be able to just put me to sleep, because I think life is only tolerable if you're alive (...). What I am saying is for me if I have a stroke that leaves me paralysed, leaves me brain dead, then I don't want to live like that, I don't and why should I? (...) I've seen people who you could show a mirror and they would say, "Who's that?" and they don't know who it is, but the soul has gone as far as I'm concerned if that's what happens. I don't want to be like that (LD27).

That some people will feel undervalued and obliged to end their lives to reduce the cost to others is a concern. Two people we interviewed said that they did not want to be a burden to others, an important finding, but this was not the only reason they wanted the option of euthanasia. For example, one woman knew a man with dementia. Having seen his wife struggling to cope, she said she did not want to "lumber" herself with anyone or with any institution. But she was also concerned about pain:

If your usefulness has gone out of life I can't see the point in delaying things. And certainly if you are in a vegetative state there is none, I don't know how anyone can justify it (...). I know one lady who is determined to go on looking after her husband, and in the eleven years since he was diagnosed with Alzheimer's, he got to the stage where he was blind, dumb, and she thought deaf, and she was still pushing food in one end and collecting it the other. He wasn't alive he was existing (...) God forbid that I ever got to that (...). I don't want to lumber myself on anyone, or any institution for that matter (...) but if I ever get to the stage of having the pain which I'd had in the past without my husband and without my children really needing me, (...) I think the plastic bag might just come in use. Back to euthanasia, I would much prefer it if someone would say, "Well, we'll just do it for you calmly and quietly". I don't see any point in continuing when there is no purpose in life (LD 22).

A woman with motor neurone disease worried about the cost of care, but also strongly favoured euthanasia because she had seen her husband suffer:

R: I said the same when my lovely husband was ill, if I could have given him a tablet I would have done. But that isn't possible (...). If your GP or someone can't do it [assist with suicide or euthanasia] or wouldn't do it, I respect them but I think somewhere along the line someone should help you. What is the point? You're suffering unnecessarily and the cost is, you can end up with the cost, the costs are astronomical and there's no point because there's no end to it.

I: In some countries, I think in Scandinavia, it's different, isn't it?

R: Yes, and Holland there is. My grandson lives in Holland so I know.

I: Why do you think it's happened in those countries and not in ours?

R: Because we so drag our feet here, that's why. I mean it's all judgement by people who are able-bodied and they don't have a clue.

I: So if the people who are in your situation could be asked their opinion, do you think a lot of people would think like yourself?

R: I don't know, I really don't know. But I'm only speaking for me and I saw my own husband suffer unnecessarily for an end that was inevitable anyway. And to me that is evil or at least cruel (LD34).

Among these interviews with people who were themselves facing death, those who spoke most passionately about the need for a change in the law were those who had also seen others die.

Arguments against a change in UK law

A few people opposed a change in UK law (or were ambivalent), who represent negative cases in the analysis.25 Apart from three people who appeared to be discussing involuntary euthanasia, one said that people should trust God and that good could come out of suffering, and another was anxious that people might ask for assisted suicide to help carers rather than themselves. Others, who overall were in favour of euthanasia, feared that any new legislation may be misused. For example, a man with oesophageal cancer said that he would welcome euthanasia for himself, but hesitated to recommend it as national policy:

R: I would like an easy death and from that point of view I think I would welcome euthanasia. Having said that I see all the complications of it, and people who are at a stage of illness where they can't speak for themselves, a possibility of somebody wanting to get rid of their relatives, that makes me very nervous, so although on the one hand I would like to see it to help me, I'm very hesitant about it.

I: As a national policy.

R: As a national policy (...). Yet on the other hand there was um, Dianne [Dianne Pretty, who took her case to the European court] isn't it, with motor neurone disease, and that poor women obviously wanted to die and nobody would do anything about it. It's a conflict, I don't know, I can't deal with it, I don't know how you sort it out (LD21).

Others shared concerns about the potential for abuse, but concluded that each case should be judged on its own merit:

The thing that would concern me very much is the abuse of it [euthanasia]. It could be used in the wrong way, and therefore requires a lot of careful thought (...) I think you've got to judge each case on its own merit actually, and the people involved (LD31).

DISCUSSION

Our study is important because it draws on accounts of patients who knew that they would probably die soon of either cancer or non-malignant disease (table 1). Most previous qualitative research designed to understand the dying process has been based on the views of patients with cancer or those of patients dying of AIDS.14 26 When examining the views of those with HIV-1 or AIDS, Lavery et al²⁶ found that people desired euthanasia or assisted suicide because of disintegration or loss of community. Our participants did not mention loss of community as a reason for desiring euthanasia or assisted suicide, perhaps because they did not have diseases as highly stigmatised as AIDS. But they gave many other reasons for wanting the option of ending their lives. They often had multiple reasons for wanting a change in the law, including the right to choose when to end their own life, pain, anticipated pain, cognitive impairment, fear of indignity, fear of loss of control and concern that they may be a physical or financial burden on others. Some regretted that they may have to die alone if suicide became their only legal option.

Only a few people opposed a change in UK law, mainly it seems because they were discussing involuntary rather than voluntary euthanasia. Some were ambivalent about a change in the law that would allow voluntary euthanasia because they feared that a new law may be misused. It is important, however, to note that this was not a numerically representative sample and that interviews were led by the patient's story, not by a set of questions from the researcher. The appropriate emphasis for the findings is therefore the range of perspectives and the characteristics and experiences of people who held different views and not the numbers of people who were for or against euthanasia.

The method was appropriate to the aim of the study but it had some limitations. The interviewer did not define exactly what she meant by euthanasia when she introduced the subject herself, which led to confusion in some cases. One person, for example, mentioned Harold Shipman, and evidently thought that the interviewer was talking about involuntary euthanasia or murder. Also, some respondents may have had strong views but felt unable to introduce the topic themselves. Although we aimed for a maximum variation sample, we interviewed few manual workers and the two from minority ethnic groups did not discuss the subject. It is extremely hard to recruit patients who are dying for any type of research. Family members may resent precious time and energy being spent on work that will not give a chance of a cure.²⁷ Health professionals can also be very protective of their patients and may not facilitate recruitment.²⁸ Seale and Addington-Hall¹³ found that social class and religious denomination did not greatly influence people's views about euthanasia, but they interviewed few people of non-Christian faiths. If we had interviewed more people from minority groups with other religious views, we may have heard additional arguments. Numbers of people interviewed in qualitative studies are necessarily small; so entire studies may be needed to explore the subject of euthanasia and assisted suicide from the perspective of the various minority ethnic groups in the UK.29

Most people in our study were interviewed only once. Some of those who expressed strong views, either for or against the option of euthanasia or assisted death, may have changed their views as their illness progressed. Also, the comments some people made about euthanasia or assisted dying, or the lack of comment in other accounts, may have been influenced by a need to project a particular moral stance, by current media debates, or by the palliative care argument that better end of life care would reduce the need for euthanasia.

Of course it is important to provide more resources to help all patients die with dignity in a setting of their choice.²⁰ But, some reason that even with the best palliative care there may be a case for euthanasia or assisted suicide in certain situations,³⁰ and that without new legislation, euthanasia and assisted suicide will simply be driven underground.¹¹

In the UK, the law on euthanasia and assisted suicide certainly needs clarification, and perhaps even change. Our respondents spoke powerfully, some thinking about their own deaths, and others recalling the deaths of other people, which fuelled their criticism of the current UK law. In many parts of the world, the intense controversy about euthanasia and assisted suicide persists.³¹⁻³³ We believe that these accounts of ordinary people who are facing death should inform current debate in the UK and elsewhere, but there is still a need for more research that includes patients' views of these important issues.

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Delegate Handbook 2022 MSV Bylaws

AMENDED AND RESTATED BYLAWS OF THE MEDICAL SOCIETY OF VIRGINIA EFFECTIVE OCTOBER 21, 2018

ARTICLE I NAME AND PURPOSE

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

Section 2. <u>Purpose</u>. 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. <u>Use of Funds</u>. 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. <u>Classes of Membership</u>. 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. <u>Active Members</u>. 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. <u>Public Service Active Members.</u> A public service active member must be a doctor of medicine or osteopathic medicine licensed to practice that profession and practicing or stationed in Virginia and must be (1) a medical officer of the armed forces; (2) a member of the Public Health Service; or (3) employed or engaged by the U.S. Department of Veterans Affairs or Virginia Department of Veterans Services.

Any public service 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 public service active 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.

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Section 4. <u>Resident Physician Members</u>. 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 5. <u>Student Members</u>. 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 6. <u>Associate Members</u>. 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 6.1. <u>No Right to Vote</u>. Associate members shall have no right to vote, hold office or serve on committees, but shall be entitled to all other privileges of membership.

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Section 7. <u>Honorary Active Members; Honorary Associate Members</u>. 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 7.1. <u>No Right to Vote</u>. Honorary associate members shall not vote, hold office, or serve on committees, but shall be entitled to all other privileges of membership.

Section 8. <u>Affiliate Members</u>. 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.

89 Section 8.1. <u>No Right to Vote</u>. Affiliate members shall have no right to vote in the House of
 90 Delegates or hold office but shall be entitled to all other privileges of membership including serving on
 91 committees or task forces.

93 **Section 8.2.** <u>Physician Assistants</u>. Affiliate members who are physician assistants shall, as a 94 condition of membership, hold an active license as a physician assistant from the Virginia Board of 95 Medicine or, if such physician assistant is retired, hold an inactive license from the Virginia Board of 96 Medicine. 97

98 **Section 8.3**. <u>Physician Assistant Students</u>. Affiliate members who are physician assistant 99 students shall be a full-time student in a Virginia program accredited by the Accreditation Review 100 Commission on Education for the Physician Assistant (ARC-PA).

Section 9. <u>Funds</u>. 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 10. <u>Dues</u>. 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 111 than active members in full-time medical practice shall be determined by the Board of Directors and be 112 reviewed annually by the House of Delegates.

114 **Section 11.** <u>Fiscal Year</u>. The fiscal year of the Society for membership purposes shall correspond 115 with the calendar year.

116 117 Approval and Removal of Members. An applicant shall not be accepted as an active Section 12. 118 physician, affiliate or associate member of the Society until he/she has paid annual dues. Any member 119 may be censured, suspended or expelled by a majority vote of the House of Delegates for sufficient 120 cause, when such action has been recommended by an ad hoc committee, which will be appointed by the 121 Board of Directors specifically for the task of investigating complaints and providing recommendations for 122 action to the Board of Directors. Any member may be dropped from the membership rolls for non-123 payment of dues (or any other assessment) or for failure to satisfy any other requirement for membership 124 detailed in these Bylaws. 125

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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

131 Component Societies & Qualifications. A component society shall be comprised of Section 1. 132 physicians from one or more political subdivisions of the Commonwealth of Virginia. One component 133 society in a county or city shall be recognized by the Society. No component society will be recognized if 134 it is established in a territorial area included in the jurisdiction of another component society unless two 135 (2) or more political subdivisions have become a single political subdivision by merger, annexation, or 136 otherwise. In such case, any component societies in the said political subdivisions may be recognized as 137 separate component societies or unite to form a single component society. Component Societies deemed 138 active by the Board of Directors can be found in Appendix A. 139

140 A physician is eligible to join a component society in the political subdivision Section 1.1. 141 where he/she carries on the major portion of his/her practice. If a physician practices both in Virginia and 142 in an adjoining state or the District of Columbia, and the major portion of his/her practice is not in Virginia, 143 he/she may join a component society in the political subdivision in which he/she resides. Notwithstanding 144 the foregoing, a member may join a more convenient component society in the same or an adjoining 145 political subdivision if the component society, or societies, having jurisdiction in the county or city in which 146 the physician carries on the major portion of his/her practice consents. Any member may join a 147 component society in an adjoining political subdivision if there is no component society in the political 148 subdivision in which the physician carries on the major portion of his/her practice. 149

150Section 2.Specialty Sections, Qualifications and Guidelines.Each specialty section deemed active151by the Board of Directors can be found in Appendix A.

152 Section 2.1. The following guidelines must be satisfied in order for a specialty organization to
 153 be recognized as a specialty section of the Society:
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A. The specialty organization's constitution and bylaws must not be in conflict with
 the Articles of Incorporation and these Bylaws of the Society.

158 B. The specialty organization must not discriminate in membership on the basis of
 159 race, religion, national origin, gender, or handicap.
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161 C. The specialty organization must represent a field of medicine that has recognized
 162 scientific validity.
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164 **D.** The specialty organization must be stable and have been in existence for at least 165 five (5) years prior to submitting its application. 166

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167 **E.** Licensed Virginia physicians must comprise the majority of the voting 168 membership of the specialty organization. 169

F. 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.

174 G. The specialty organization must be active within its field of medicine and hold at
 175 least one (1) meeting of its members annually.
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177 H. The specialty organization must submit a resolution or other official statement to
 178 show that the request is approved by the governing body of the specialty organization.
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180 Section 2.2. The members of each specialty section shall adopt rules and regulations to 181 provide for the conduct of the meetings of the section and for the selection of the section's officers and its 182 delegate and alternate to the House of Delegates.

Section 3. <u>Component Student Societies, Qualifications and Guidelines</u>. 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.

190 Section 4. <u>Component Resident Physician Sections, Qualifications and Guidelines</u>. There shall be 191 one component resident physician section recognized by the Society. Any intern, resident or fellow in 192 good standing in an Accreditation Council for Graduate Medical Education (ACGME) approved training 193 program in the Commonwealth of Virginia shall be eligible for membership in the section.

Section 5. <u>Hospital Medical Staff Section, Qualifications and Guidelines</u>. 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. <u>Academic Medical Schools, Qualifications and Guidelines</u>. 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.

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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. <u>Health Systems, Qualifications and Guidelines</u>. 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. <u>Physician Assistant Section</u>. 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. <u>Attendance at Annual Meeting</u>. 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. <u>Member Rosters</u>. 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 student society and component resident physician section shall send a list of its members to the Executive Vice President and Chief Executive Officer 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 and Chief Executive Officer of the Society.

Section 11. <u>Component Meetings</u>. 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 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. 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. <u>Failure to Comply with Bylaws</u>. 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 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. <u>Annual Meeting</u>. There shall be an annual meeting of the Society, with the date and
 place to be determined by the Board of Directors.

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Section 3. <u>Voting</u>. 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.

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ARTICLE V HOUSE OF DELEGATES

283 Section 1. Composition. The House of Delegates shall be the policy making body of the Society. 284 The House of Delegates shall consist of delegates elected by the component societies, component 285 student societies, component resident physician sections, specialty sections, the hospital medical staff 286 section, health systems, academic medical schools and the following ex-officio members: The President, 287 President-Elect, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, Secretary-288 Treasurer, directors and associate directors, all Past Presidents of the Society, any general officer of the 289 American Medical Association who also is a member of the Society, and the delegates and alternate 290 delegates of the Society to the American Medical Association. Delegates elected by component societies, 291 specialty sections, component student societies, component resident physician sections, the hospital 292 medical staff section, health systems, and academic medical schools shall serve a one-year term. Ex-293 officio members of the House of Delegates, except for the Speaker, as provided in Article VII, Section 4, 294 shall have full voting rights and will not be included in the delegate allotment for each component society. 295 No voting by proxy shall be permitted in the House of Delegates. Each member of the House of 296 Delegates also must be a member of the Society.

Section 2. <u>Assembly</u>. 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.

302 Section 3. Election of Membership. Each component society shall annually elect to membership in 303 the House of Delegates, one delegate and one alternate for each thirty-five (35), or major fraction thereof, 304 of its members, or non-component society members that reside within the component's geographic 305 territory, who are members of the Society or, in its discretion, may elect one delegate and one alternate 306 from each county and each city in its territorial area. For purposes of determining the number of 307 delegates and alternates to which it is entitled, a component society may count (a) direct Society 308 members the major portion of whose practice is within the territorial jurisdiction of the component society 309 and (b) a resident physician only if he/she is a member of the component society, and an active member 310 of the Society. In any event, each component society is entitled to at least one delegate and one 311 alternate in the House of Delegates. In the event a delegate is not present at any meeting of the House 312 of Delegates, his/her alternate shall succeed to all of his/her privileges. Delegates and alternates shall be 313 active members, student active members or resident physician members of the Society. 314

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.

320 Section 3.2. The component resident physician section annually may elect to membership in 321 the House of Delegates one delegate and one alternate for each thirty-five (35), or major fraction thereof, 322 of its members who are members of the Society.

324 Each specialty section listed in Appendix A shall annually elect delegates, who Section 3.3. 325 are also members of the Medical Society of Virginia, to membership in the House of Delegates. The 326 apportionment of delegates from each specialty society shall be a minimum of one delegate and one 327 alternate. If at least forty (40) percent of its members are members of the Society the specialty society 328 shall be entitled to two delegates and two alternates; if at least sixty (60) percent of its members are 329 members of the Society the specialty society shall be entitled to three delegates and three alternates. 330 Prior to the annual meeting each specialty section shall submit the name(s) of its delegate(s) and 331 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.

335 Section 3.4. If the full number of delegates accredited to a component society, component 336 student society, component resident physician section, specialty section, the hospital medical staff 337 section, health system or academic medical school are not present at a meeting of the Society, those 338 members present from such component society, component student society, component resident 339 physician section, specialty section, the hospital medical staff section, health system or academic medical 340 school may, from members of that society, section, system or school present, who are voting members of 341 the Society, elect or appoint a sufficient number of delegates to complete its quota. 342

343 Section 3.5. The hospital medical staff section shall elect annually to membership in the 344 House of Delegates one delegate and one alternate. In the event the delegate for hospital medical staff 345 section is not present at any meeting of the House of Delegates, his/her alternate shall succeed to all 346 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.

362 Section 4. Quorum. Twenty-five (25) percent of the number of delegates allowed representing at
 363 least eight (8) districts shall constitute a quorum of the House of Delegates.
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365 Section 5. Election of Delegates and Alternates. The House of Delegates shall elect delegates and 366 alternates to the House of Delegates of the American Medical Association in accordance with the Bylaws 367 of that organization. Except where the number of nominees does not exceed the number of delegates to 368 be elected, such delegates shall be elected by ballot, and a majority vote shall be necessary for election. 369 The nominee receiving the fewest votes will be dropped on each ballot in succession until the requisite 370 number receives a majority. Following the election of delegates, the same method shall be used to elect 371 alternate delegates. 372

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

375 376 Section 7. Special Meetings. The Board of Directors may, by majority vote, call a special meeting of 377 the House of Delegates when in its opinion such a meeting is necessary. The President shall call such 378 meeting, upon petition of at least one-third (1/3) of the Delegates serving at the last regular meeting of the 379 House of Delegates. Written notice stating the date, place and time of the meeting, and the purpose for 380 which the meeting is called, shall be given not less than ten (10) nor more than fifty (50) days before the 381 date of the meeting, either personally or by mail, or at the direction of the President or Executive Vice 382 President and Chief Executive Officer, to each member of the House of Delegates serving, or who was 383 authorized to serve, at the last regular meeting of the House of Delegates. If any member is unable to 384 serve, then another member shall be elected or appointed by the Board of Directors to serve. The 385 transaction of business at any special meeting of the House of Delegates shall be limited to the purpose 386 in the notice for the meeting.

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ARTICLE VI ELECTIONS

Section 1. <u>Nominating Committee</u>. 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.

397 Section 1.1. The Nominating Committee is charged with the task of identifying, recruiting, 398 promoting and nominating those individuals that will best serve the needs of the Society, and to 399 encourage their decision to be active in Society leadership. 400

401 **A.** The Nominating Committee shall recommend to the House of Delegates one or 402 more members for each of the offices to be filled at the Annual Meeting, including Delegates and 403 Alternate Delegates to the Society's AMA Delegation. The Nominating Committee shall present its 404 recommendations to the membership in conjunction with the September Board meeting or within thirty 405 (30) days prior to the Annual Meeting.

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413 C. The two immediate former presidents of the Society, and the Chair of the 414 Society's AMA Delegation, shall be non-voting advisory members. If for any reason there is a vacancy on 415 the Nominating Committee, the District may nominate a replacement and recommend to the Board of 416 Directors for approval to fill that vacancy. If the District does not nominate a replacement for the vacant 417 Nominating Committee position, the President may recommend a replacement from that District for 418 approval by the Board. In the event of a vacancy of the medical student Nominating Committee member, 419 the student section may provide a nominee for appointment by the President for the remainder of the 420 term. Should a vacancy occur in the academic medical schools' representation to the committee, the 421 academic medical schools may provide a nominee for appointment by the President for the remainder of 422 the term. Any Nominating Committee member so elected to fill a vacant seat on the committee shall 423 serve until the next annual meeting unless earlier removed in accordance with these Bylaws and 424 applicable law. 425

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

431 **Section 2.** <u>Election of President-Elect</u>. At each annual meeting, the House of Delegates shall elect 432 a President-Elect for a term of one (1) year. At the end of this term, the President-Elect shall become 433 President for a term of one (1) year.

435 Section 3. <u>Election of Secretary-Treasurer, Speaker and Vice Speaker</u>. At each annual meeting,
436 the House of Delegates shall elect a Secretary-Treasurer. The House of Delegates also shall elect a
437 Speaker and Vice Speaker. The term of office for each of the officers described in this Article shall be
438 one (1) year except for the Secretary-Treasurer, whose term shall be three (3) years.

Section 4. <u>Board of Directors; Composition</u>. There shall be members of the Board of Directors consisting of one representative from Board Districts 1, 5, 6, 8, and 9, two (2) representatives from Board Districts 2, 3, 7, and 10, one representative from the academic medical schools, one (1) representative from the Medical Student Section, one (1) representative from the Resident and Fellow Section, one (1) 444 representative of the MSVF who is a member of the Society and who is a physician and the following ex-445 officio members: The President, the President-Elect, the immediate past President, the Speaker of the 446 House of Delegates and the Secretary-Treasurer. Ex-officio members of the Board of Directors shall have 447 full voting rights.

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449 Board of Directors, Election. Directors shall be elected by a majority vote of the House of Section 5. 450 Delegates at the annual meeting Directors shall be elected for a term of two (2) years; those from odd 451 numbered Districts are elected in odd-years, and those from even numbered Districts are elected in even 452 years. Any Director eligible for re-election shall not attend the meeting of his/her District during the time 453 the District is selecting its nominee for the Board of Directors. Any Director who has served three (3) 454 consecutive full two-year terms shall not be eligible for a fourth consecutive term, but may be re-elected 455 after being out of office for at least one (1) year. If at the time of the annual meeting there is a vacancy in 456 the membership of the Board of Directors and the District is not represented in the meeting, the House of 457 Delegates, on nomination by the Speaker, shall elect a Director for that District. If any representative 458 qualifies as a member of the Board of Directors as a result of his/her election or appointment to an office 459 in the Society, his/her membership on the Board of Directors as a representative of a District shall cease. 460

461 **Section 5.1.** A medical student from one of the recognized medical schools shall be elected 462 by the House of Delegates to the Board of Directors for a term of one (1) year. 463

464 **Section 5.2.** A resident, fellow, or intern shall be nominated by the Resident and Fellow 465 Section, and elected by the House of Delegates to the Board of Directors for a term of one (1) year. 466

467 An Associate Director from each District shall be elected by a majority vote of the Section 5.3. 468 House of Delegates at the annual meeting to assist the Director(s) for the District and to substitute when 469 a Director for the District is unable to perform his/her duties. Associate Directors shall be elected for a 470 term of two (2) years; those from odd numbered Districts are elected in odd-years, and those from even 471 numbered Districts are elected in even years. Any Associate Director who has served three (3) 472 consecutive full two (2) year terms shall not be eligible for a fourth consecutive term, but may be re-473 elected after being out of office for at least one (1) year. Associate Directors shall be requested to attend 474 all meetings. Any Associate Director may speak on behalf of his/her District, but shall not vote in Board 475 meetings. 476

477 Section 5.4. A medical student from one of the recognized medical schools shall be elected
478 by the House of Delegates as an Associate Director for a term of one (1) year.
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480 Section 5.5. A resident, fellow or intern from the Resident and Fellow Section shall be elected
481 by the House of Delegates as an Associate Director for a term of one (1) year.
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483 Section 5.6. A representative from the academic medical schools duly accredited or licensed 484 by the Commonwealth of Virginia shall be elected by the House of Delegates as a Director for a term of 485 two years provided all such schools annually achieve and maintain the established membership 486 equivalency requirements for their respective full time academic physicians as of the annual meeting of 487 the Society coincident with the election. Annual membership equivalency requirements shall be 488 determined by the Board of Directors and communicated by the President or his designee to all such 489 Such requirements are incorporated herein by reference. For subsequent elections, a schools. 490 representative shall only be elected by the House of Delegates provided all such schools have achieved 491 and continue to maintain annually the membership equivalency requirements established for their 492 respective full time academic physicians. In the event that the membership equivalency requirements are 493 not achieved or maintained annually for all such schools, the seat on the Board of Directors, seat on the 494 Associate Directors and seat on the Nominating Committee shall terminate until such time as the 495 membership equivalencies are achieved, as determined by the President of the Society. For regular term 496 elections, the nominee to serve as the representative shall be selected by such schools in a method 497 agreed upon by the schools. The name of the nominee shall be submitted to the Speaker of the House of 498 Delegates or his designee in advance of the annual meeting together with the number of full time 499 academic physicians for all such schools. The term limits in Section 5 shall apply to this section.

500 501 Section 5.7. An Associate Director representing the academic medical schools accredited or 502 licensed by the Commonwealth of Virginia shall be elected by majority vote of the House of Delegates at 503 the annual meeting to assist the Director and to substitute when the director is unable to perform his/her 504 duties. The Associate Director shall be elected for a term of two (2) years. Any Associate Director who 505 has served three (3) consecutive full two (2) year terms shall not be eligible for a fourth consecutive 506 terms, but may be re-elected after being out of office for at least one (1) year. Associate Directors shall 507 be requested to attend all meetings. Any Associate Director may speak on behalf of the academic 508 medical schools, but shall not vote in Board meetings. 509

Section 6. <u>Districts Described</u>. The Districts for the Society shall be composed of the component societies, component student societies and orphan <u>cities/</u>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.

515 Section 7. Vacancies. Each Director or Associate Director of the Society may resign at any time by 516 giving written notice to the Executive Vice President and Chief Executive Officer, who will inform the 517 President. The resignation will take effect on the date of the receipt of that notice or at a later date as 518 specified in the notice. Any resignation is without prejudice to the rights, if any, of the organization, as 519 long as the resigning party continues to abide by the bylaws and pays dues. At the time of a Board of 520 Directors meeting, if there is a vacancy in the membership of the Board of Directors, the Board of 521 Directors may fill the vacancy from nomination(s) by the President. If the vacancy is from a District with 522 an Associate Director, the Associate Director shall automatically be nominated to the Board of Directors 523 for approval to fill the vacancy of the Director seat and the District may nominate a new Associate Director 524 and may recommend to the Board of Directors for approval to fill the vacancy of the Associate Director 525 until the next annual meeting. If for any other reason there is a vacancy in the Director or Associate 526 Director position, the District may nominate a replacement and recommend to the Board of Directors for 527 approval to fill that vacancy. If the District does not nominate a replacement for the Director or Associate 528 Director position, the President may recommend a replacement from that District for approval by the 529 Board. In the event a vacancy of the medical student or resident Director occurs, the President may 530 contact the respective section to obtain a nomination to be submitted to the Board for approval. Any 531 Director so elected to fill a vacant Director's seat shall serve until the next annual meeting unless earlier 532 removed in accordance with these Bylaws and applicable law. Such Director shall be eligible to serve 533 three consecutive two (2) year terms in addition to the partial term for which the Director was elected to fill 534 the vacancy. Should a vacancy occur in the academic medical schools' representation to the Board, the 535 academic medical schools shall provide a nominee for appointment by the President for the remainder of 536 the term. 537

538 **Section 8.** <u>Term</u>. The officers shall begin service at the adjournment of the annual meeting of the 539 House of Delegates and continue until the end of the next meeting of the House of Delegates or until a 540 successor qualifies, except as provided for in Article VII, Section 6.3. 541

ARTICLE VII OFFICERS

544 545 **Section 1.** <u>President</u>. 546

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

548 549 **Section 1.2.** The President shall preside over meetings of the members of the Society, and 550 shall be a member of the House of Delegates, chair of the Board of Directors, and a voting, ex-officio 551 member of all committees. 552

553 **Section 1.3.** The President shall fill any vacancy in any committee or in the Society's 554 delegation to the House of Delegates of the American Medical Association occurring between annual

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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. <u>President-Elect</u>.

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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.

567 568 Section 2.2. In case there is a vacancy in the office of President-Elect and the House of 569 Delegates is not in session, the Board of Directors may appoint a President-Elect pro tempore. If at the 570 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 572 following term.

574 **Section 3.** <u>Executive Vice President and Chief Executive Officer</u>.

575 576 The Board of Directors, upon the recommendation of the Executive Committee of Section 3.1. 577 the Board of Directors, shall appoint the Executive Vice President and Chief Executive Officer. The 578 Executive Vice President and Chief Executive Officer need not be a member of the Society. The 579 Executive Vice President and Chief Executive Officer of the Society shall be the executive agent of the 580 Society, and shall assist the Secretary-Treasurer of the Society in developing minutes of general 581 meetings, the House of Delegates, the Board of Directors and the Executive Committee. In addition, the 582 Executive Vice President and Chief Executive Officer shall function as the Chief of the Society's staff and 583 shall be responsible for the allocation of resources towards the Society's strategic goals and program 584 portfolios across all entities. The Executive Vice President and Chief Executive Officer also shall serve as 585 the general manager of the official publications of the Society.

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

592 Section 3.3. The Executive Vice President and Chief Executive Officer shall collect all money
 593 due the Society and pay out these funds under the joint supervision of the President and Secretary 594 Treasurer, or upon their designated authority.

596 Section 3.4. The Executive Vice President and Chief Executive Officer shall make an annual
 597 report to the House of Delegates.
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599Section 4.Speaker and Vice Speaker of the House of Delegates.600

601 **Section 4.1.** The Speaker of the House of Delegates shall preside over all meetings of the 602 House of Delegates, but shall vote only in the case of a tie. The Speaker shall appoint all special 603 committees whose duties are concerned primarily with the operation and function of the House of 604 Delegates. 605

606 **Section 4.2.** The Speaker of the House of Delegates shall serve as an ex-officio voting 607 member of the Board of Directors and the Executive Committee. 608

609 **Section 4.3.** The Vice Speaker of the House of Delegates shall preside over the House of 610 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.

614 **Section 4.4.** In the event of a vacancy of the Vice Speaker of the House of Delegates, the 615 President shall appoint a successor to serve through the next annual meeting. 616

617 **Section 5.** <u>Secretary-Treasurer</u>. 618

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619 **Section 5.1.** The Secretary-Treasurer of the Society shall have the responsibility for 620 preparing, and maintaining custody of minutes of the meetings of the Board of Directors, its Executive 621 Committee, the House of Delegates and any other meeting of the Society's members, and for 622 authenticating records of the Society. The Secretary-Treasurer shall serve as the Chair of the Finance 623 Committee. 624

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.

628 Section 5.3. The term of office of the Secretary-Treasurer of the Society shall be three (3)
 629 years. In the event of a vacancy, the President shall appoint a successor to serve through the next annual
 630 meeting.
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632 Section 6. Officer resignations and vacancies633

634 **Section 6.1** Each officer of the Society may resign at any time by giving written notice to the 635 Executive Vice President and Chief Executive Officer, who will inform the President. The resignation will 636 take effect on the date of the receipt of that notice or at a later date as specified in the notice. Any 637 resignation is without prejudice to the rights, if any, of the organization, as long as the resigning party 638 continues to abide by the bylaws and pays dues.

640 Section 6.2 A vacancy in any office because of death, resignation, removal, disqualification 641 or any other cause shall be filled in a manner as prescribed in the Bylaws for regular appointment to the 642 office. In the event of a vacancy in any office other than the President, such vacancy shall be filled 643 temporarily by appointment by the President and shall remain in office until the next meeting of the House 644 of Delegates. 645

646 Section 7. Professional Conduct. Each officer will remain in compliance with the duties as
 647 described in Article IX Section 1 of these bylaws.
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ARTICLE VIII BOARD OF DIRECTORS

652 Section 1. <u>Duties</u>. The Board of Directors shall have charge of the affairs of the Society, when the
 653 House of Delegates is not in session.

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

659 **Section 3.** <u>Executive Committee</u>. There shall be a five (5) member Executive Committee of the 660 Board of Directors composed of the President, the President-Elect, the immediate Past-President, the 661 Speaker of the House of Delegates and the Secretary-Treasurer. The President may appoint non-voting 662 advisory members to the Executive Committee. The Executive Committee shall act in an advisory 663 capacity to the Board of Directors and to the President, who shall serve as its Chair.

665 **Section 4.** <u>Finance Committee</u>. There shall be a six (6) member Finance Committee of the Board of 666 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 and Chief Executive
 Officer. The Executive Vice President and Chief Executive Officer 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.

672 673 Section 5. Compensation Committee. There shall be an eight (8) member Compensation Committee of 674 the Board of Directors comprised of the President, President-Elect, Immediate Past President, the 675 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 676 677 President. The Immediate Past President shall serve as Chair of the Compensation Committee. The 678 Compensation Committee shall have responsibility for recommending to the Board of Directors 679 adjustments to the compensation and benefits package for the Executive Vice President and Chief 680 Executive Officer which shall be voted on by the Board of Directors in executive session. 681

Section 6. <u>Meetings.</u> Meetings of the Board of Directors shall be held upon call of the Executive
 Vice President and Chief Executive Officer 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.

687 **Section 7.** <u>Additional Duties</u>. The Executive Committee and the Board of Directors shall receive 688 reports at least semi-annually on the Society's budget. At each annual meeting, the Board of Directors 689 shall present to the House of Delegates for its action a budget for the next fiscal year. 690

Section 8. <u>Other Attendees</u>. 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 may be requested to attend all meetings of the Board of
 Directors.

696 Section 9. <u>Nominations for Virginia State Board of Medicine</u>. The Society shall submit nominations
 697 to the Governor of Virginia for membership on the Virginia State Board of Medicine.
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Section 10. <u>Quorum</u>. 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.

702Section 11.Professional Conduct.Each member of the Board of Directors will remain in compliance703with the duties as described in Article IX Section 1 of these bylaws.

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705 706 707	ARTICLE IX PROFESSIONAL CONDUCT
708 709 710 711 712 713	Section 1. <u>Professional Conduct.</u> 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 these bylaws and the Society's Code of Conduct contained within the Society's Board of Directors Handbook.
714 715 716 717	Each officer, Associate Director, or Director of the Society will utilize the Society's Conflict Resolution Processes, contained within the Society's Board of Directors Handbook, as the primary mechanism to resolve conflict and/or complaints, unless the act or conduct is consistent with Article IX Section 2.
718 719 720	Section 2. Removal Process and Proceedings
721 722 723	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:
724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745	 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 Actions that intentionally violate the bylaws Failure to comply with the proper direction given by the Board Failure or refusal to disclose necessary information on matters of organization business Unauthorized expenditures or misuse of organization funds Unwarranted attacks on any officer, member of the board of directors, board as a whole, or staff, on an ongoing basis Misrepresentation of the organization and its officers to outside persons Conviction for a felony 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 of an officer other than the Executive Vice President and Chief Executive Officer, an Associate Director, or a Director of this Society from office shall be commenced by the filing to the Executive Vice President and Chief Executive Officer of Directors. Proceedings for the removal of Directors. Proceedings for the removal and Chief Executive Officer of this Society shall be commenced by the filing with the General Counsel and 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.
746 747 748 749 750 751 752 753	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.
755 755 756	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.
757 758	The hearing rights under these bylaws do not apply if an individual voluntarily resigns in accordance with these bylaws.
759 760	ARTICLE X

INDEMNIFICATION

- 762 763 **Section 1.** <u>Definitions</u>. 764
- 765 "Applicant" means the person seeking, indemnification pursuant to this Article IX.
- 767 "Expenses" includes reasonable counsel fees.768

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"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 ina proceeding.

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

785 Right of Indemnification. The Society shall indemnify any person who was or is a party to Section 2. 786 any threatened, pending, or completed action, suit or proceeding, whether civil, criminal, administrative, 787 arbitrative or investigative by reason of the fact that he/she is or was a Director, officer or employee of the 788 Society, or a member of any committee of the Society or is or was serving at the request of the Society as 789 a director, trustee, partner or officer of another corporation, partnership, joint venture, trust, employee 790 benefit plan or other enterprise, against any liability incurred by him/her in connection with such 791 proceeding if (a) he/she believed, in the case of conduct in an official capacity, that his/her conduct was in 792 the best interests of the Society, and in all other cases that his/her conduct was at least not opposed to its 793 best interests, and, in the case of any criminal proceeding, had no reasonable cause to believe his/her 794 conduct was unlawful, (b) in connection with a proceeding by or in the right of the Society, he/she was not 795 adjudged liable to the Society, and (c) in connection with any, other proceeding charging improper benefit 796 to him/her, whether or not involving action in his/her official capacity, he/she was not adjudged liable on 797 the basis that personal benefit improperly was received. The termination of any action, suit or proceeding 798 by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, 799 of itself, create a presumption that the applicant did not act in good faith and in a manner which he/she 800 believed to be in, or not opposed to, the best interests of the Society, and, with respect to any criminal 801 proceeding or action, that the person had no reasonable cause to believe that her/his conduct was 802 unlawful. A person serves an employee benefit plan at the Society's request if his/her duties to the 803 Society also impose duties on, or otherwise involve services by, him/her to the plan or to participants in or 804 beneficiaries of the plan. A person's conduct with respect to an employee benefit plan for a purpose 805 believed to be in the interests of the participants and beneficiaries of the plan is conduct that satisfies the 806 requirements of this section.

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808 Section 3. Expenses of Successful Defense. To the extent that the applicant has been successful 809 on the merits or otherwise in the defense of any proceeding referred to in Section 2 of this Article, or in 810 the defense of any claim, issue or matter therein, he/she shall be indemnified against expenses (including 811 attorneys' fees) actually and reasonably incurred in connection therewith.

813 **Section 4.** Determination of Proprietary of Indemnification. Any indemnification under this Article 814 (unless ordered by a court) shall be made by the Society only as authorized in the specific case upon a 815 determination that indemnification of the applicant is proper in the circumstances because he/she has met 816 the applicable standard of conduct set forth in this Article. Such determination shall be made either: 817
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819 not at the time parties to the proceeding; or
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821 **B.** If a quorum cannot be obtained under subsection (A) of this section, by majority 822 vote of a committee duly designated by the Board of Directors (in which designation Directors who are 823 parties may participate), consisting of two (2) or more Directors not at the time parties to the proceeding; 824 or

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C. By special legal counsel in a written opinion:

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

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.

839 Section 5. Expenses of Counsel. Authorization of indemnification and evaluation of the 840 reasonableness of expenses shall be made in the same manner as the determination that indemnification 841 is permissible, except that if the determination is made by special legal counsel, authorization of 842 indemnification and evaluation of the reasonableness of expenses shall be made by those entitled under 843 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:

848 (i) The applicant furnishes the Society a written statement of his/her good
 849 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.

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 863 in the manner specified in Section 5.
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865 Authority to Indemnify. The Board of Directors is hereby authorized, by majority vote of a Section 6. 866 guorum of disinterested Directors, to cause the Society to indemnify, or contract in advance to indemnify, 867 any person not specified in Section 2 of this Article who was or is a party to any proceeding, by reason of 868 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 869 an employee or agent of another corporation, partnership, joint venture, trust, employee benefit plan or 870 other enterprise, to the same extent as if such person were specified as one to whom indemnification is 871 granted in Section 2. The provisions of Sections 3 through 5 of this Article shall be applicable to an 872 indemnification provided hereafter pursuant to this Section 6.

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- 874 Section 7. Insurance. The Society may purchase and maintain insurance to indemnify it against the 875 whole or any portion of the liability assumed by it in accordance with this Article and may also procure 876 insurance, in such amounts as the Board of Directors may determine, on behalf of any person who is or 877 was a Director, officer, employee or agent of the Society, or is or was serving at the request of the 878 Society, as a Director, officer, employee or agent of another corporation, partnership, joint venture, trust, 879 employee benefit plan or other enterprise, against any liability, asserted against or incurred in an such 880 capacity, whether or not the Society would have authority, to indemnify him/her against such liability 881 under the provisions of this Article. 882
- 883 Section 8. References Included. Every reference herein to Directors, officers, committee members, 884 employees or agents shall include former Directors, officers, committee members, employees and agents 885 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 886 887 right under policies of insurance that may be purchased and maintained by the Society or others, with 888 respect to claims, issues or matters in relation to which the Society would not have the power to 889 indemnify such person under the provisions of this Article, but no individual shall be entitled to be 890 indemnified more than once for the same claim and that credit will be given to the Society for any 891 collateral source reimbursement. 892
- **Section 9.** <u>Limitation of Liability of Officers and Directors</u>. 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
- 901 Section 1. <u>Power to Appoint</u>. The President shall appoint committees and subcommittees, as 902 he/she deems appropriate, as well as the chair of each committee or subcommittee. The chair of any 903 committee shall have the privilege of the floor when reporting to the House of Delegates or in any 904 incidental discussions. The President shall appoint one or more representative member(s) of the Virginia 905 Medical Group Management Association, or any of its successor organizations, as a voting member of 906 selected committees and subcommittees of the Society.
- 908 Section 2. Expenses. Actual expenses of members of any committee required to do official work 909 between annual meetings may be paid upon the recommendation of the chair of such committee and the 910 endorsement of the President, if presented within thirty (30) days after the meeting for which expenses 911 are sought, provided budget allowance be made for such purpose. All unexpended balances of any fund 912 authorized in the budget shall, on or before the end of each fiscal year, revert to the General Treasury.
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914 Section 3. <u>Authority</u>. Except as otherwise provided in these Bylaws, members of committees shall
 915 serve at the pleasure of the President.
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ARTICLE XII ETHICS

- 920 Section 1. <u>Removal and Guiding Principles</u>. The Principles of Medical Ethics governing the 921 members of the American Medical Association <u>or American Osteopathic Association Code of Ethics</u> shall 922 govern members of the Society. Any member whose license to practice medicine in Virginia has been 923 revoked <u>or suspended when such order becomes final by the Board of Medicine</u> shall be deleted from 924 membership in the Society.
 - ARTICLE XIII RULES OF ORDER

929 **Section 1.** <u>Rules of Order</u>. In all matters not covered by its bylaws, special rules of order, and 930 standing rules, this organization shall be governed by the current edition of the *American Institute of* 931 *Parliamentarians Standard Code of Parliamentary Procedure*.

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ARTICLE XIV AMENDMENTS

936 Section 1. Authority to Amend Bylaws. Bylaw amendments may be proposed by any member. 937 Proposed amendments shall be submitted in writing through the Executive Vice President and Chief 938 The Bylaws Committee shall consider and make written recommendations for Executive Officer. 939 disposition of all properly proposed amendments in its report to the House of Delegates. Amendments 940 made at the time of the annual meeting shall lay on the table at least twenty-four (24) hours before they 941 may be considered for adoption and shall be handled in accordance with rules established by the House 942 of Delegates in accordance with Article V, Section 2. All previous Bylaws of the Society are repealed 943 when these Bylaws are adopted and put into effect. 944

945 **Section 2.** <u>Vote to Amend Bylaws</u>. These Bylaws shall be amended only by a two-thirds majority 946 vote of the members of the House of Delegates present and shall be effective as of the vote or as 947 provided for in the Resolution of the House of Delegates.

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949	APPENDIX A
950	Approved September 25, 2018
951 952	First District:
953	Mid-Tidewater Medical Society
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955	Second District:
956	Chesapeake Medical Society; Norfolk Academy of Medicine; Tri-County Medical Society; Virginia Beach
957	Medical Society; Eastern Virginia Medical School Student Section
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959	Third District:
960	Richmond Academy of Medicine; Virginia Commonwealth University Medical School Student Section
961 962	Fourth District:
963	Reserved
964	
965	Fifth District:
966	Danville-Pittsylvania Academy of Medicine
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968	Sixth District:
969	Lynchburg Academy of Medicine; Roanoke Valley Academy of Medicine; Virginia Tech-Carillion Medical
970	School Student Section; Liberty University College of Osteopathic Medicine Student Section
971 972	Seventh District
972 973	Seventh District: Albemarle County Medical Society; Fauquier County Medical Society; University of Virginia Student
974	Medical Society, Fauquier County Medical Society, Oniversity of Virginia Student
975	
976	Eighth District:
977	Prince William County Medical Society
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979	Ninth District:
980	Tazewell County Medical Society; Edward Via College of Osteopathic Medicine Student Section
981	Tanth District
982 983	Tenth District: Arlington County Medical Society; Medical Society of Northern Virginia
905	Annigion County medical Society, Medical Society of Northern Virginia

 APPENDIX A (Continued)

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987 **Specialties:**

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- 989 Allergy 990
- Anesthesiology
- 991 Cardiology 992
- Dermatology
- 993 Emergency Medicine
- 994 Family Practice
- 995 Gastroenterology
- 996 Hematology/Oncology
- 997 Internal Medicine
- 998 **Neurological Surgery**
- 999 Neurology
- 1000 Obstetrics/Gynecology
- 1001 Occupational & Environmental Medicine
- 1002 Ophthalmology
- 1003 Orthopaedic Surgery
- 1004 Otolaryngology
- 1005 Pathology
- 1006 Pediatrics
- 1007 Physical Medicine & Rehabilitation
- 1008 Plastic Surgery
- 1009 Preventive Medicine
- 1010 Psychiatry
- 1011 Radiology
- 1012 Rheumatology
- 1013 Sleep Medicine
- 1014 Surgery
- 1015 Thoracic Surgery
- 1016 Urology



Delegate Handbook 2022 Minutes and Actions of the 2021 House of Delegates

1. Medical Society of Virginia 2021 House of Delegates Minutes

2. Final Actions of the 2021 Medical Society of Virginia House of Delegates

SATURDAY, OCTOBER 23, 2021 Medical Society of Virginia 2021 House of Delegates Minutes



First Session

Call to Order

Dr. Alan Wynn, Speaker, convened the virtual first session of House of Delegates at 8:00 am.

Invocation

The invocation was provided by fourth year medical student at Liberty University College of Osteopathic Medicine Anneke Bulthuis.

Commending Resolutions

The Speakers presented the following commending resolutions in honor of Dr. Lawrence Monahan, Roanoke, and to Dr. Randolph Gould, Norfolk, for their extraordinary leadership, dedication and many contributions made to the medical profession, and the Commonwealth of Virginia. Each physician and/or family member will receive a framed certificate of the Resolution.

Clarence A. Holland, MD Award

In pre-recorded videos, Dr. Lee Ouyang, Norfolk, Chair of the MSV Political Action Committee and Dr. William Reha, Vice-Chair of the Virginia Delegation to the American Medical Association (AMA) presented the Clarence A. Holland, MD Award to Mrs. David Monahan, Roanoke, in honor of her husband, Dr. Lawrence Monahan. This award is presented to Virginia physicians for their outstanding contributions promoting the art and science of medicine to the betterment of public health through their political service. Dr. Monahan is recognized for his many contributions to the medical profession and service to his community, the Commonwealth of Virginia, and his country.

Introduction of Guests

The following guests were acknowledged by the Speakers:

- Dr. Sharon Pryor President of MedChi, the Maryland State Medical Society
- Gene Ransom CEO of MedChi, the Maryland State Medical Society
- Dr. Shafic Sraj President of the West Virginia State Medical Society
- Dr. John Poole Chair of the AMA Southeastern Delegation
- Dr. Daniel Carey Virginia Secretary of Health and Human Resources
- Dr. Barbara Allison-Bryan Deputy Director of the Virginia Department of Health Professions
- Dr. Peter Francis Buckley Dean of the VCU School of Medicine
- Dr. Jan Wilcox Dean of the Edward Via College of Osteopathic Medicine
- Dr. Sterling Ransone President of the American Academy of Family Physicians
- Dr. Sandy Chung President-Elect of the American Academy of Pediatrics

In Memoriam

An "In Memoriam" PowerPoint slide of those MSV members who have passed in the last year was shared and Dr. Michele Nedelka offered In Memoriam remarks.

Member Recognitions

The Speakers recognized Former Presidents, new delegates, the robust MSV medical student section, 50-year medical school graduates, and MSV members who have been members of the Society for 20 years or longer.

MSV President Recognition

A pre-recorded message from Dr. David James from Sentara Healthcare, to thank and recognize our President, Dr. Art Vayer for his leadership and contributions to the Commonwealth was shared with the House.

Presidential Address

Dr. Art Vayer, President, shared pre-recorded remarks regarding his year as president.

MSV CEO/EVP Remarks

Ms. Melina Davis, Chief Executive Officer and Executive Vice President, (CEO and EVP), addressed the House via a prerecorded message.

Salute to Afghan Airlift Volunteers

More than one-hundred Virginia physicians volunteered their time and services this year to treating patients leaving Afghanistan following the U.S military withdrawal in late August and early September. Physician members staffed dozens of flights, and some volunteers took as many as three trips overseas to treat these patients. In a pre-recorded video, President, Dr. Art Vayer, and CEO and EVP Melina Davis to salute these invaluable volunteers.

Presenting Sponsor Presentation

A pre-recorded message from Dr. David Ellington, Lexington, on behalf of presenting sponsor, Professionals Advocate, was shared with the House.

Inaugural Ceremony

With the assistance of Dr. Claudette Dalton, member of the Virginia Delegation to the AMA, presented a Former President's Medallion, Crystal Gavel, and Pin to Dr. Art Vayer who served as an outstanding President of the Medical Society of Virginia (MSV) during a global pandemic.

Dr. Dalton administered the oath of office to incoming President, Dr. Mohit Nanda. A video was played of former presidents symbolizing their support to Dr. Nanda during his presidential year by passing the medallion to him in a video. Dr. Nanda's pre-recorded remarks of reflection of his inauguration were shared with the House.

Membership Appreciation

A pre-recorded membership appreciation video from the MSV Director of Membership Jenny Young was shared with the House.

2020 Salute to Service Winners Acknowledgement

Dr. Alan Wynn, Speaker, recognized our 2020 Salute to Service Award Winners. These award winners have gone above and beyond the call of duty in service to our profession, and to the patients that we serve. We thank them for their tireless efforts.

- Service to the uninsured and underserved Dr. Joan Ritter, Volunteer Medical Director of the Arlington Free Clinic.
- Service to the International Community Dr. Margarito Escario, Anesthesiologist of Danville, Virginia.
- Service to the Profession Dr. William Reha, Urologist of Woodbridge, Virginia.
- Service for Advancing Patient Safety and Quality Improvement Dr. Gonzalo Bearman, Chair of the Division of Infectious Diseases at VCU Healthcare's Infection Prevention Program.
- Service as a Medical Student or Resident Amanda Tosi, Fourth Year Medical Student at EVMS.
- Service to Healthcare during COVID-19 Dr. Carolyn Burns and the Richmond Academy of Medicine.

Remarks from Virginia Gubernatorial Candidate, Terry McAuliffe

In a pre-recorded video, the democratic candidate, Terry McAuliffe, addressed the House. MSV staff contacted both campaigns and both candidates had initially agreed to send along recorded remarks, however, at this time only remarks from democratic candidate were received.

Conclusion of 1st session

The first session of the House of Delegates recessed at 9:26 am.

Second Session

Call to Order

Dr. Alan Wynn, Speaker, reconvened the House of Delegates at 9:40 am.

Meditation Break

Dr. Daniel Carey, Virginia's Secretary of Health and Human Resources, lead the House in a 10-minute meditation break before the commencement of our Second House of Delegates session.

Technology Overview

Dr. Alan Wynn, Speaker, provided an overview and an explanation of the functions necessary to conduct the business of the House.

Credentialing of Delegates and Credential Report

Due to the virtual nature of the meeting, credentialing took place via a Zoom poll to determine if a quorum was met. The Credentialing process was as follows: The Delegate list was verified by MSV staff to ensure MSV membership status and registration for the Annual Meeting is complete. Societies, districts, sections, health systems, and academic medical schools, who can submit Delegates to represent them at MSV's House of Delegates were required to do so by October 21, 2021, to ensure verified credentialing.

Submission of the Delegates' names and emails via Zoom ensured only verified Delegates are voting and present. The credentialing process was completed by verification of today's Delegates login information by email and name through the previously conducted Credentialing Poll at the beginning of our programming.

The technical nature and support of MSV staff replaces the duties and responsibilities of a Credentials and Tellers committee.

Dr. Michele Nedelka, Vice-Speaker, reported that a quorum is present with more than twenty-five (25) percent of the number of delegates allowed representing at least eight (8) component districts.

Rules Committee Report

The Rules of Procedure have been amended to reflect the considerations of our virtual setting, and only govern the business conducted at the 2021 House of Delegates. This year, MSV's Board of Directors served the role of the Rules Committee.

Dr. Alan Wynn, Rules Committee Chair, recommended adoption of the proposed Rules of Procedure provided. The Rules of Procedure were adopted by unanimous vote.

Approval of the 2020 MSV House of Delegates Minutes

Dr. Larry Mitchell, Secretary-Treasurer, asked for comments on minutes from the 2020 meetings of the House of Delegates. Hearing none, the minutes were approved without objection.

Consent Calendar: Informational Reports

The following informational reports were presented as consent calendar items and filed.

- MSV Board of Directors Actions on the 2019 Resolutions Referred to the Board
- MSVPAC Report
- MSV Foundation Report
- AMA Virginia Delegation Report
- Medical Student Section Report
- Virginia Board of Medicine Annual Report
- Physician Assistant Section Report

New Business

No new business was brought forward to the House.

2021 STS Winners Acknowledgement

Dr. Alan Wynn, Speaker, recognized our 2021 Salute to Service Award Winners. These award winners have gone above and beyond the call of duty in service to our profession, and to the patients that we serve. We thank them for their tireless efforts.

- Service to the uninsured and underserved Dr. Kristina Johnson, physician from the UVA International Family Medicine Clinic.
- Service to the uninsured and underserved Dr. Robert Winn, Director and Lipman Chair in Oncology, VCU Massey Cancer Center.
- Service to the International Community Dr. Claude Louis, of Hampton, Virginia.
- Service to the Profession Dr. Hazle Konerding, of Richmond, Virginia.
- Service for Advancing Patient Safety and Quality Improvement Dr. Pavan Annamaraju of Abington, Virginia.
- Service as a Medical Student or Resident Matthew Van De Graf, Fourth Year Medical Student at EVMS.
- Service to Healthcare during COVID-19 Dr. Stephen Kates, of Richmond, Virginia.

Nominating Committee Report

As the Nominating Committee Report was displayed, Dr. Carol Shapiro, Chair of the Nominating Committee, opened the virtual floor for additional nominations and after hearing none, nominations were closed.

Election of the MSV Board of Directors and AMA Delegation

After the extraction of the vote for President-Elect, a motion was made to accept the nominations presented and the following were elected by unanimous vote:

OFFICERS (Elected for 1-year term)

Speaker Dr. Alan Wynn Vice Speaker Dr. Michelle Nedelka

OFFICER (Elected for 3-year Term) Secretary-Treasurer Larry Mitchell

DIRECTORS (Elected for 2-year term)

- District 1Dr. Timothy RainesDistrict 3Dr. Quinn LippmanDistrict 3Dr. Peter ZedlerDistrict 5Dr. Gary MillerDistrict 7Dr. Samuel CaughronDistrict 7Dr. Arturo SaavedraDistrict 9Dr. Jan Wilcox
- Foundation Dr. Varun Choudhary

DIRECTORS (Elected for 1-year term)

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Resident Director		Dr. Katie Marsh	
Medical Student Director		Anneke Bulthuis	

ASSOCIATE DIRECTORS (Elected for 2-year term)

- District 1 Dr. James Dudley
- District 3 Dr. Ikenna Ibe
- District 5 Dr. Jaqueline Fogarty
- District 7 Dr. Peter Netland
- District 9 Dr. Abraham Hardee

ASSOCIATE DIRECTORS (Elected for 1-year term)

Resident Associate DirectorDr. Lindsay GouldMedical Student Associate DirectorSalimah Gangji

- DELEGATES to the AMA (Elected for 2-year calendar term)
- Dr. Claudette Dalton Dr. Edward Koch Dr. Bushan Pandya Dr. Clifford Deal Dr. Alice Coombs Dr. Cynthia Romero

<u>ALTERNATE DELEGATES to the AMA (Elected for 2-year calendar term)</u> Dr. Joel Bundy

President Elect Election

Without objection, Dr. Harry Gewanter was elected as President-Elect of the MSV.

Installation of MSV Board Officers

Dr. Carol Shapiro, former President of MSV, conducted the installation of officers.

Election of the 2021-2022 Nominating Committee

The 2021-2022 Nominating Committee was presented for election and the following were elected by unanimous vote:

District 1	Timothy Raines, MD
District 2	Stuart Mackler, MD
District 3	Hazle Konerding, MD
District 5	Bhushan Pandya, MD
District 6	Cynda Johnson, MD
District 7	Claudette Dalton, MD
District 8	Carol Shapiro, MD
District 9	John Knarr, MD
District 10	Edward Koch, MD
Academic	Cynthia Romero, MD
AMA Advisor	William Reha, MD
2019-20 Former President Advisor	Clifford Deal, MD
20120-21 Former President Advisor	Arthur Vayer, MD

Reference Committee Reports

Reference Committee recommendations were presented for acceptance as consent calendar items. Extracted resolution submissions received by Oct. 19, 2021, were discussed at length by the House. Resolution extractions were not permitted during the virtual House of Delegates meeting.

Dr. Arturo Saavedra presented the consent calendar report of Reference Committee 1. Additional discussion occurred on the following extracted resolutions.

 21-108 Resolution on the Covid-19 Patient Protection Act for Mandatory Vaccinations for Healthcare Workers

Dr. Atul Marathe, presented the consent calendar report of Reference Committee 2. Additional discussion occurred on the following extracted resolution.

- 21-201 Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness
- 21-203 Truth in Advertising and Professional Credential Disclosure
- 21-206 Affirming the Health Needs of All Patient Populations
- 21-207 Amendment to the Non-Discrimination Policy

The final actions of the House of Delegates for all resolutions are attached to these minutes.

MSVPAC Fundraiser

A successful MSVPAC fundraiser was conducted by Senior Advocacy manager, Andrew Densmore, during both Sessions of the House.

MSV Foundation Raffle Drawings

The President of the MSV Foundation, Kathy Scarbalis and the Director of Development, Denise Kranich conducted live raffle drawings throughout the House of Delegates sessions.

Adjournment

The 2021 Annual Meeting of the House of Delegates of the Medical Society of Virginia adjourned at 12:30 pm.

SUMMARY OF ACTION

ADOPTED

- 21-101 Medical Society of Virginia Proposed 2022 Budget
- 21-102 2021 MSV Policy Compendium 10 Year Review
- 21-204 Resolution on the Interpretation of Radiological Images
- 21-205 Advancing Health Equity Through Implicit Bias Education Within Virginia's Academic Medical Centers

ADOPTED AS AMENDED OR SUBSTITUTED

- 21-104 Physician Representation: Cannabis Public Health Advisory Council
- 21-105 Opposing the Sale of Marijuana and THC-Infused Products to Individuals Under Age 21
- 21-106 Increasing HPV Vaccine Initiation and Accessibility Across the State of Virginia
- 21-107 HIV Post-Exposure Prophylaxis Recommendation 1
- 21-108 Resolution on the Covid-19 Patient Protection Act for Mandatory Vaccinations for Healthcare Workers
- 21-206 Affirming the Health Needs of All Patient Populations
- 21-208 Time Frame to Respond to Complaints to Virginia Board of Medicine

ADOPTED AS AMENDED IN LIEU OF

- Policy 35.4.02- Guidelines for Prescriptions
 - o In lieu of: 21-103 Pharmacy Responsibility to Providers and Patients
- Policy 05.4.01 Access Without Discrimination
 In lieu of: 21-207 A Resolution to Amend 05.4.01 Access Without Discrimination
 - Policy 05.6.02 Use of Title "Dr."
 - o In lieu of: 21-203 Truth in Advertising and Professional Credential Disclosure

REAFFIRMIRMATION OF EXISITING POLICY IN LIEU OF

- Policy 10.9.16- Reimbursement of Telemedicine and Disclosure of Ownership Interests in Telemedicine Companies
 - o In lieu of: 21-109 Resolution for Continuation of Telehealth, Including Audio Only

REFERRED TO THE BOARD OF DIRECTORS

- 21-107 HIV Post-Exposure Prophylaxis Recommendation 2 (Recommend Action)
- 21-201 Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness (Recommend report back to the House for Action)

NOT ADOPTED

• 21-202 Resolution to Properly Identify Healthcare Professionals by Title

21-101: Medical Society of Virginia 2020 Proposed Budget (ADOPTED)

RESOLVED, that the Medical Society of Virginia approve, as presented, the proposed budget for 2022.

21-102: 2019 MSV Policy Compendium 10 Year Review (ADOPTED)

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

19-103: 21-103 Pharmacy Responsibility to Providers and Patients (POLICY 35.4.02 AMENDED IN LIEU OF RESOLUTION 103)

RESOLVED, that Policy 35.4.02- Guidelines for Prescriptions be amended as follows:

35.4.02- Guidelines for Prescriptions

The Medical Society of Virginia adopts the following guidelines:

- All prescriptions must be initiated by the prescribing physician, or appropriately licensed prescribers.
- Authority to dispense may be provided by his signature on the prescription or by direct personal communication by the prescribing physician or an assistant under the physician's direct and immediate supervision to the pharmacist.
- When a prescription has been filled or refilled the maximum number of times as initially designated, it is an expired prescription. Authorization to refill an expired prescription must be obtained by the pharmacist by direct personal communication with the prescribing physician or an assistant under the physician's direct and immediate supervision, or by a new prescription.
- When a pharmacist has concern in his own mind about the timeliness of a prescription refill, patient's need, or and all other factors that <u>question</u> demonstrate the appropriateness of the <u>prescription</u> physician contact, he should contact the <u>prescribing</u> physician <u>and review the</u> <u>patient's medical record</u> for the purpose of obtaining authorization to fill or refill the prescription. <u>Failure to fill a prescription should be subject to Board of Pharmacy review."</u>
- Patient Profiles maintained by the pharmacist which document the patient's drug history are considered important documents that would be available to assist the pharmacist in familiarizing the physician with the patient and concurrent drugs prescribed by other physicians.
- Using the patient as an intermediary in communications between the physician and pharmacist is unacceptable; e.g., the physician should not tell the patient to inform the pharmacist that the physician approves additional refills of a prescription.

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- Use of the term "PRN" as a prescription refill authorization is discouraged.
- Physicians should be specific in designating 1) the frequency, 2) a maximum time limit, and 3) a maximum number of refills.
- The use of patient medication instruction forms and other patient education material by physicians is encouraged.

21-104: Physician Representation: Cannabis Public Health Advisory Council (ADOPTED AS AMENDED)

RESOLVED, The Medical Society of Virginia <u>supports</u> representative to the Advisory Council will first and foremost advocate protecting the health of vulnerable citizens <u>all persons</u> <u>when considering regulation of</u> <u>medical and recreational use of cannabis in Virginia</u>. <u>such as children</u>, pregnant women, and <u>breastfeeding babies</u>. <u>The Medical Society of Virginia believes regulatory consideration concerning</u> <u>cannabis</u>. <u>The Advisory Council recommendations to the Authority</u>-should be <u>Ee</u>vidence <u>Bb</u>ased and include <u>public health</u> data.-regarding emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, short- and long-term health effects of cannabis, prevalence of psychiatric and addictive disorders, including cannabis-use disorder.

21-105: Opposing the Sale of Marijuana and THC-Infused Products to Individuals Under Age 21 (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia opposes the sale of marijuana and THC delivery methods to individuals under the age of 21 and opposes the use of these products by individuals under the age of 21 in public places, including schools and school grounds, and be it further

RESOLVED, that MSV supports legislation <u>or regulation</u> to protect individuals under 21 from exposure to marijuana and all THC delivery methods <u>including secondhand exposure</u>.

21-106: Increasing HPV Vaccine Initiation and Accessibility Across the State of Virginia (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia support research offorts that aim to identify and reduce barriers to HPV vaccination in Virginia, and be it further

RESOLVED, that the Medical Society of Virginia support the efforts of the Virginia Department of Health to increase the vaccination rate affordability of the HPV vaccine for uninsured children and adults.

21-107: HIV Post-Exposure Prophylaxis (SPLIT QUESTION)

RECOMMENDATION 1: THE FIRST RESOLVED CLAUSE IS ADOPTED AS AMENDED.

RESOLVED, that the Medical Society of Virginia, acknowledges the need for and supports increased access to, and coverage for, physician-supervised initiated Post-Exposure Prophylaxis (PEP) for HIV, as well as enhanced public education on its effective use, and be it further,

RECOMMENDATION 2: THE SECOND RESOLVED CLAUSE IS REFERRED TO THE BOARD FOR DECISION AS AMENDED.

RESOLVED, that the Medical Society of Virginia acknowledges the need for a more streamlined process of obtaining nPEP and should consider dedication of staff resources toward determining potential <u>solutions</u>. -including encouraging local emergency departments, especially those in rural areas, to regularly stock nPEP starter packs for those presenting to the emergency department with a substantial exposure risk and exploring options to allow pharmacies to immediately dispense nPEP starter packs under the oversight of a licensed physician, nurse practitioner or physician assistant.

21-108: Resolution on the Covid-19 Patient Protection Act for Mandatory Vaccinations for Healthcare Workers (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia endorses mandatory Covid-19 vaccination(s) for all healthcare workers <u>unless a medical contraindication is present</u>. *in accordance with state and federal laws. in physician offices, outpatient facilities, hospitals, and long-term care facilities. This should be accomplished swiftly to prevent any further danger to patients entrusted with our care.*

21-109: Resolution for Continuation of Telehealth, Including Audio Only (POLICY 10.9.16 REAFFIRMED IN LIEU OF RESOLUTION 21-109)

RESOLVED, that the Medical Society of Virginia supports the entire continuation of telehealth, including audio only communications, as an effective and efficient method for the delivery of care to existing patients; and be it further

RESOLVED, that the Medical Society of Virginia supports appropriate reimbursement from insurers for audio only telehealth

21-201: Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness (*REFERRED TO BOARD FOR REPORT TO 2022 HOUSE OF DELEGATES*)

RESOLVED, the Medical Society of Virginia supports-*limiting* <u>removing</u> licensure and credentialing application questions in the state of Virginia to asking about <u>health</u> conditions that <u>do not</u> currently impair the physician's ability to practice medicine.

21-202: Resolution to Properly Identify Healthcare Professionals by Title (NOT ADOPTED)

RESOLVED, that the Medical Society of Virginia opposes the use of ambiguous and depersonalizing terms such as "provider" and "gatekeeper" when referring to healthcare professionals in regulatory language and statute.

21-203: Truth in Advertising and Professional Credential Disclosure (POLICY 05.6.02 AMENDED IN LIEU OF RESOLUTION 21-203)

RESOLVED, that MSV Policy 05.6.02 - Use of Title "Dr." be amended as follows:

Policy 05.6.02 - Use of Title "Dr." and Associated Specialty Credentials

The Medical Society of Virginia supports the enforcement by appropriate state agencies of the statutes requiring the disclosure of degree earned when using prefix "Dr." for advertising purposes.

Similarly, the Medical Society of Virginia supports protecting patients against false advertising of board certification or practitioners who falsely hold themselves out as a board-certified specialist.

21-204: Resolution on the Interpretation of Radiological Images (ADOPTED)

RESOLVED, The Medical Society of Virginia opposes any legislation permitting the formal interpretation of radiologic images by non-physicians.

21-205: Advancing Health Equity Through Implicit Bias Education Within Virginia's Academic Medical Centers (*ADOPTED*)

RESOLVED, The Medical Society of Virginia supports the necessary inclusion of implicit bias and health inequity education for students and faculty, throughout all the educational curricula and programs of the academic health centers incorporating such teachings in clinical and social courses as well as "in the field" settings; and

RESOLVED, The Medical Society of Virginia believes such coursework should be influenced by historical and evidence-based research; and

RESOLVED, The Medical Society of Virginia encourages the American Medical Association and the Association of American Medical Colleges to collaborate in the creation of health equity education criteria for academic health center programs and health professions education to follow and implement.

21-206: Affirming the Health Needs of All Patient Populations (SPLIT QUESTION)

RECOMMENDATION 1: RESOLUTION 21-206 IS ADOPTED AS AMENDED.

RESOLVED, the Medical Society of Virginia believes that non-judgmental impartial recognition of patient's sexual orientations, sexual behaviors, gender identities, and gender expressions is crucial for providing high-quality, equitable patient care., and be it further

RESOLVED, that the Medical Society supports adequate insurance coverage, equal access to healthcare providers and entities, and comprehensive health screenings for all populations regardless of a patient's sexual orientation, sexual behavior, gender identity, or gender expression.

RECOMMENDATION 2: MSV POLICY 05.4.01 ACCESS WITHOUT DISCRIMINATION IS AMENDED IN LIEU OF RESOLITION 21-207

RESOLVED, that MSV Policy 05.4.01- Access without Discrimination, be amended as follows,

The Medical Society of Virginia believes that <u>all persons in</u> citizens of Virginia should have access to medical services without discrimination based on race, religion, age, social status, income, sexual orientation, or perceived gender<u>identity or expression</u>, and be it further resolved that;

The MSV recognizes racial and ethnic health disparities as a major public health problem and that bias is a barrier to effective medical diagnosis and treatment. The Medical Society of Virginia will support policies and strategic interventions that decrease health disparities in medicine.

21-207: Resolution to Curtail Direct Consumer Advertising of Prescription Drugs (POLICY 05.4.01 AMENDED IN LIEU OF RESOLITION 21-207)

RESOLVED, The Medical Society of Virginia believes that <u>all persons</u> residents citizens of <u>in</u> Virginia should have access to medical services without discrimination based on race, religion, immigration status, age, social status, income, sexual orientation or perceived gender. The MSV recognizes racial and ethnic health disparities as a major public health problem and that bias is a barrier to effective medical diagnosis and treatment. The Medical Society of Virginia will support policies and strategic interventions that decrease health disparities in medicine.

21-208: Time Frame to Respond to Complaints to Virginia Board of Medicine (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia supports Virginia allowing providers <u>a reasonable</u> <u>timeframe</u> minimum of four (4) weeks to reply to complaints received by the Virginia Board of Medicine; and

RESOLVED, that the Medical Society of Virginia believes that such complaints be adjudicated and correspondence sent back to the provider in <u>a timely manner</u>. within a four (4) week period.



Delegate Handbook 2022 Nominating Committee Report

1. 2022 Nominating Committee Report

2022 MSV ANNUAL MEETING & HOUSE OF DELEGATES Nominating Committee Report



The Nominating Committee met on August 16, 2022, to consider all eligible candidates for the upcoming term of office. The committee recommends the following slate for consideration by the society membership.

MSV BOARD OF DIRECTORS

TERMS 2022-2023/2024

OFFICERS (Elected for 1-year term)

President-Elect	Alice Coombs, MD
Speaker	Alan Wynn, MD
Vice Speaker	Michele Nedelka, MD

DIRECTORS (Elected for 2-year term)

District 2	Lee Ouyang, MD	
District 2	Sharon Sheffield, MD	
District 6	Mark Kleiner, MD	
District 8	Atul Marathe, MD	
District 10	Tarek Abou-Ghazala	
District 10	Andrea Giacometti, MD	
Academic	Karen Rheuban, MD (UVA)	

DIRECTORS (Elected for 1-year term)

Resident	Lindsay Gould, MD (EVMS OBGYN)
Medical Student	Salimah Navaz Gangji (VCOM)

ASSOCIATE DIRECTORS (Elected for 2-year term)

District 2	John Sweeney, MD	
District 6	Joe Hutchison, MD	
District 8	Marc Alembik, MD	
District 10	Soheila Rostami, MD (MSNVA)	
Academic	Lindsay Robbins, MD (EVMS)	

ASSOCIATE DIRECTORS (Elected for 1-year term)

Resident	Pooja Gajulapalli, MD (VCU PEDS)
Medical Student	Shreya Mandava (UVA)

2022 MSV ANNUAL MEETING & HOUSE OF DELEGATES Nominating Committee Report



VIRGINIA DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION

TERM 2023-2024 Elected for a two-year calendar year term

DELEGATES

Thomas Eppes, MD Michele Nedelka, MD

ALTERNATE DELEGATES

Lee Ouyang, MD Josephine Nguyen, MD Josh Lesko, MD Mohit Nanda, MD

2022-2023 Nominating Committee

TERM 2022-2023 Elected for a one-year term

District 1 Sterling Ransone, MD District 2 Stuart Mackler, MD District 3 Hazle Konerding, MD District 5 Bhushan Pandya, MD District 6 District 7 Claudette Dalton, MD District 8 Carol Shapiro, MD District 9 District 10 Edward Koch, MD Academic Cynthia Romero, MD AMA Advisor Tom Eppes, MD 2020-2021 Former President Advisor Art Vaye 2021-2022 Former President Advisor Mohit Na

Art Vayer, MD Mohit Nanda, MD



Delegate Handbook 2022 Reference Committee One Index

The following section contains a list of the resolutions considered by Reference Committee One, and the staff analysis

Medical Society of Virginia Proposed 2023 Budget Submitted by: 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 2022 Policy Compendium Ten Year Review Submitted by: Dr. Alan Wynn, Speaker and Dr. Michele Nedelka , 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
- 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.

Recommendation Reaffirm

10.1.01 - Review Policies of Insurance Companies

Date: 10/31/1992

The Medical Society of Virginia supports legislation or regulation to impose the following minimum requirements upon insurance companies and managed care groups:

(1) That adequate authorizing or certifying personnel be available so that an immediate response to the physicians' offices can be obtained.

(2) If there is any question of a disagreement between the physician's office and the certifying personnel that a physician advisor be easily available to help resolve the conflict.

(3) In no instance should a letter written by a physician be required to obtain procedure or admission authorization when the treating physician feels that the care requested is emergent or semi-emergent in nature and that the delay would adversely affect the quality of patient care.

Reaffirmed 11/2/2012

10.7.01- Increased Reimbursement; Underserved Areas

Date: 11/9/1991

The Medical Society of Virginia advocates increased Medicare reimbursement levels which often are a major part of practice in an underserved area, and stress physician participation in the program.

Reaffirmed 11/2/2012

10.7.02- Extrapolation of Medicare Chart Audits and Post-Audit Refunds

Date: 10/31/1992

The Medical Society of Virginia supports legislation that limits or prevents extrapolation of denied claims to physicians on all Medicare payments for refunds. The Medical Society of Virginia urges the American Medical Association to request Federal legislation that prevents the required payment of refunds by physicians before their right of appeal process is completed.

Reaffirmed 11/2/2012

10.7.03- Medicare Carrier Advisory Committee

Date: 10/31/1992

The Medical Society of Virginia requests that the American Medical Association solicit the Centers for Medicare and Medicaid Services to mandate that each state carrier's professional advisory committee be made up of only physician representatives of the various affected specialties in each state that are approved by their respective state specialty societies as being designated as their representative.

Reaffirmed 11/2/2012

10.9.03- Reimbursement of Rural Practitioners

Date: 10/31/1992

The Medical Society of Virginia endorses the placement of family physicians on the advisory panels of all third party payers which are active in rural areas.

Reaffirmed 11/2/2012

15.4.01- Peer Review of Disputed Physician Fees

Date: 10/31/1992

The Medical Society of Virginia believes that the payer of a workers' compensation claim should submit disputed charges to a peer review committee for determination of the reasonableness of the challenged fee.

Reaffirmed 11/2/2012

25.1.02- Opposition to Criminalization of Reproductive Decision Making

Date: 11/2/2012

The Medical Society of Virginia will oppose any legislation or ballot measures that could criminalize in vitro fertilization, contraception, or the management of ectopic and molar pregnancies.

25.2.05- Advocacy for Physician Orders for Scope of Treatment

Date: 11/2/2012

The Medical Society of Virginia supports the Physician Orders for Scope of Treatment (POST) form as a uniform, portable and legal document in the Commonwealth of Virginia.

25.3.02- Legislation, Standards of Care and the Patient/Physician Relationship

Date: 11/2/2012

The Medical Society of Virginia will oppose or work to favorably amend legislation, regardless of its primary intent, that interferes with or jeopardizes the sanctity of the patient/physician relationship or is in conflict with or contrary to broadly accepted, evidence-based standards of care identified by credible medical organizations such as the American Medical Association or the specialties and sub-specialties recognized by the American Board of Medical Specialties.

30.2.02- Medical License Linkage with Medicare/ Medicaid Participants

Date: 11/4/2002

The Medical Society of Virginia opposes any linkage between physician licensure and Medicare/ Medicaid participation.

Reaffirmed 11/2/2012

30.6.05- Business, Professional and Occupational License (BPOL) Tax

Date: 1/21/2012

The Medical Society of Virginia supports reform of the Business, Professional and Occupational License (BPOL) tax.

40.1.01- Cooperation with Local Health Departments

Date: 11/3/1990

The Medical Society of Virginia encourages its local component societies to work cooperatively with local health departments to provide health care to all levels of the medically indigent in order to prevent the duplication of services and to conserve limited health care resources.

Reaffirmed 11/2/2012

40.1.02- Involvement of Local Businesses

Date: 11/3/1990

The Medical Society of Virginia encourages its local component societies to enlist the support of their local business communities in local plans to provide care to the medically indigent since the efficient delivery of care to this population would lessen cost shifting to insured patients.

Reaffirmed 11/2/2012

40.1.03- Local Plans

Date: 11/3/1990

The Medical Society of Virginia encourages local component societies to work with their local health departments and local hospitals to develop plans to provide medical care for the medically indigent in their localities.

Reaffirmed 11/2/2012

40.1.06- Tax Credits for Services to the Uninsured

Date: 10/31/1992

The Medical Society of Virginia supports the investigation of the feasibility of a tax credit for physicians who provide medical care to the uninsured indigent.

Reaffirmed 11/2/2012

40.2.02- Sales Tax Increase for Alcohol

Date: 10/31/1992

The Medical Society of Virginia supports legislation to raise the state tax on alcohol and to use the monies generated through this increase in tax to promote preventive medicine, public health and primary care.

Reaffirmed 11/2/2012

40.8.01- Repeal of EPA Requirements on Medical Waste

Date: 10/31/1992

The Medical Society of Virginia, in cooperation with the American Medical Association and other national health provider groups, shall work with Congress and the EPA to modify EPA requirements on medical waste, the goal of which would be to eliminate regulations that cannot be shown scientifically to protect the public health.

The Medical Society of Virginia, in cooperation with the American Medical Association and other national health provider groups, shall work with Congress and other governmental regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact.

Reaffirmed 11/2/2012

40.12.02- Health Literacy

Date: 11/4/2002

The Medical Society of Virginia supports health literacy programs and projects that increase the awareness of health literacy as well as educate patients and health care professionals on techniques to strengthen the patient/ physician relationship and improve health literacy.

Reaffirmed 11/2/2012

45.1.06- Regulations of the Board of Hearing Aid Specialists

Date: 11/4/2002

The Medical Society of Virginia supports otolaryngologists as the primary caregivers of children with hearing disorders, and vigorously opposes any efforts to remove the requirement in current regulations that a child must see an otolaryngologist prior to sale of a hearing aid by a hearing aid dealer.

Reaffirmed 11/2/2012

45.5.01- Chiropractic Licensure under the Board of Medicine

Date: 10/31/1992

The Medical Society of Virginia supports the principle that chiropractors and the public are best served by the current system of keeping the regulations of several health professions coordinated by a single board.

Reaffirmed 11/02/2012

55.1.09- Support of Northern Virginia Societies

Date: 11/4/2002

The Medical Society of Virginia supports the goals of the initiatives of the Northern Virginia medical societies as they relate to participation in the national effort to change the policies of managed care companies.

Reaffirmed 11/2/2012

Recommendation Reaffirm as Amended

40.20.01- Reallocation from General Fund for Preventive Health

Date: 10/31/1992

The Medical Society of Virginia supports treating the promotion of preventive medicine, public health, and primary care as a priority in the allocation of revenues from the General Fund.

Reaffirmed 11/2/2012

40.20.03- Legislation Restricting Nicotine Tobacco-Use

Date: 11/11/1989

The Medical Society of Virginia supports legislation in the General Assembly to restrict tobacco Nicotine use in Virginia.

Reaffirmed 11/2/2012

Recommendation to Archive

35.1.02 - Access to PMP Data for Law Enforcement

Date: 1/16/2012

The Medical Society of Virginia supports allowing law enforcement personnel access to Prescription Monitoring Program (PMP) data while involved in an active investigation.

Code of Virginia § 54.1-2523 allows trained law enforcement officers to access the PMP.

Amending MSV Bylaws to Grant the PA Members the Right to Vote and the Right to Delegate Representation

Submitted by the MSV Committee on Bylaws

WHEREAS, PAs currently can be members of the Medical Society of Virginia as associate members, with no right to vote, and

WHEREAS, the PA section has consistently and loyally supported the efforts of the Medical Society of Virginia, and

WHEREAS, the PA section has tirelessly joined the House of Medicine in our efforts to better patient care in the Commonwealth of Virginia, especially during our COVID 19 health crisis, and

WHEREAS, the PA section desire to have granted the right to vote and the right to delegate representation, therefore be it

RESOLVED, that the Medical Society of Virginia House of Delegates amend current bylaws as specified in the provided draft to grant the PA section the right to vote and the right to delegate representation by amending Affiliate Member rights reclassifying PAs as active members, and by reclassifying the PA section as a specialty section.

ARTICLE II MEMBERSHIP, VOTING, FUNDS, DUES

Section 7. <u>Honorary Active Members</u>; 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 7.1. <u>No Right to Vote</u>. Honorary associate members shall not vote, hold office, or serve on committees, but shall be entitled to all other privileges of membership.

Section 8. <u>Affiliate Members.</u> 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 8.1. 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 8.12. <u>Physician Assistants</u>. 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 8.2. Affiliate Member Rights. Affiliate members shall have the right to vote and serve on committees

Section 8.3. <u>Physician Assistant Students</u>. 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).

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 2. <u>Specialty Sections, Qualifications and Guidelines</u>. Each specialty section deemed active by the Board of Directors can be found in Appendix A.

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

E. Licensed Virginia physicians must comprise the majority of the voting membership of the specialty organization except the physician assistants specialty organization, the voting membership of which licensed Virginia physician assistants must comprise a majority of the voting membership.

APPENDIX A (Continued)

Specialties:

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

Resolution to amend the MSV Bylaws regarding the Compensation Committee

Submitted by the Bylaws Committee

- WHEREAS, the MSV is a nonprofit organization required to have a compensation committee, and
- WHEREAS, the Compensation Committee has expressed a desire to have more continuity in it's members, and
- WHEREAS, the composition of the Compensation Committee is dictated by the MSV Bylaws, therefore, be it
- RESOLVED, that the MSV Bylaws be amended as follows:

ARTICLE VIII BOARD OF DIRECTORS

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 a 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 appoint the Chair of the Compensation Committee. The Chair may serve multiple one-year terms. 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 and Chief Executive Officer which shall be voted on by the Board of Directors in executive session.

Resolution to amend the MSV Bylaws regarding meetings

Submitted by the Bylaws Committee

- WHEREAS, the MSV is a member based organization, and
- WHEREAS, the MSV is required to hold meetings to conduct business of the organization, and
- WHEREAS, circumstances may dictate that a virtual meeting may be necessary instead of an in person meeting, and
- WHEREAS, the MSV bylaws currently have no code regarding virtual meetings, therefore, be it
- RESOLVED, that the MSV Bylaws be amended as follows:

ARTICLE IV ANY MEETING<mark>S</mark> OF MEMBERS

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

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

Section 3. <u>Voting</u>. 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. <u>Virtual Meetings</u>. Any meeting of members described in these Bylaws may be held virtually at the discretion of the President and in consultation with the Executive Vice President and Chief Executive Officer.

MSV Support for Expanding AED Access in Public Spaces Around Virginia

22-106

Submitted by The MSV Medical Student Section

- WHEREAS. out-of-Hospital Cardiac Arrests (OHCAs) is one of the leading causes of death in the U.S., affecting more than 356,000 Americans annually, of which there is 9% survival to hospital discharge after EMS-treated cardiac arrest¹²³⁴, and
- WHEREAS, cardiac arrest outcomes are heavily determined by bystander intervention, however bystander CPR is provided in 40% of EMS-assessed OHCA cases, and only 9% of cases reported public use of an AED⁵, and
- WHEREAS, AED availability at public locations and early intervention with an AED improves patient morbidity, mortality and improves neurological outcomes for survivors⁶, and
- WHEREAS. the time to defibrillation of 3 minutes or less is correlated with OHCA survival rates greater than 70%⁷, and
- WHEREAS. AEDs are not widely available in public spaces where cardiac arrests are occurring with reported AED use at just 10.8% in public settings before emergency medical services arrive8, and
- WHEREAS, the location of OHCA largely occur in homes/residencies (70%) followed by public settings (18.8%) and nursing homes $(11.2\%)^9$, and
- WHEREAS. the current MSV policy supports funding for law enforcement agencies to buy AEDs, thus mandating the placement of AEDs in public parks, skilled nursing facilities, and long term care facilities would be a positive addition to MSV policies, therefore, be it
- RESOLVED. the MSV supports increased access to AEDs in public spaces, skilled nursing facilities and long term care facilities.

https://mycares.net/sitepages/uploads/2021/2020_flipbook/index.html?page=1

¹ Milan M, Perman SM. Out of Hospital Cardiac Arrest: A Current Review of the Literature that Informed the 2015 American Heart Association Guidelines Update. Curr Emerg Hosp Med Rep. 2016 Dec;4(4):164-171. doi: 10.1007/s40138-016-0118-x.

² 2020 CARES Annual Report. 2020 cares annual report. (n.d.). Retrieved September 7, 2022, from

³ Institute of Medicine, Strategies to Improve Cardiac Arrest Survival: A Time to Act, Washington, DC: The National Academies Press; 2015. https://www.nap.edu/read/21723/chapter/1#xiexternal icon.

⁴ Tsao, C. W., Aday, A. W., Almarzooq, Z. I., Alonso, A., Beaton, A. Z., Bittencourt, M. S., Boehme, A. K., Buxton, A. E., Carson, A. P., Commodore-Mensah, Y., Elkind, M. S. V., Evenson, K. R., Eze-Nliam, C., Ferguson, J. F., Generoso, G., Ho, J. E., Kalani, R., Khan, S. S., Kissela, B. M., ... Martin, S. S. (2022). Heart disease and stroke statistics—2022 update: A report from the American Heart Association. Circulation, 145(8). https://doi.org/10.1161/cir.000000000001052. ⁵ Brady, W. J., Mattu, A., & Slovis, C. M. (2019). Lay Responder Care for an Adult with Out-of-Hospital Cardiac Arrest. New England Journal of Medicine, 381(23), 2242-2251. https://doi.org/10.1056/NEJMra1802529

⁶ Mawani M, Kadir MM, Azam I, Mehmood A, McNally B, Stevens K, Nuruddin R, Ishaq M, Razzak JA. Epidemiology and outcomes of out-of-hospital cardiac arrest in a developing country-a multicenter cohort study. BMC Emerg Med. 2016 Jul 28;16(1):28. doi: 10.1186/s12873-016-0093-2

⁷ Valenzuela, T. D., Roe, D. J., Nichol, G., Clark, L. L., Spaite, D. W., & Hardman, R. G. (2000). Outcomes of rapid defibrillation by security officers after cardiac arrest in casinos. The New England journal of medicine, 343(17), 1206-1209. https://doi.org/10.1056/NEJM200010263431701.

⁸ Eckstein M. The Los Angeles public access defibrillator (PAD) program: ten years after. Resuscitation. 2012 Nov;83(11):1411-2. doi: 10.1016/j.resuscitation.2012.03.029

⁹ CPR Facts and stats. cpr.heart.org. (n.d.). Retrieved September 7, 2022, from https://cpr.heart.org/en/resources/cpr-facts-and-stats

Staff Analysis – 22-106: MSV Support for Expanding AED Access in Public Spaces Around Virginia

Submitted by: MSV Medical Student Section

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Support increased access to AED's in public spaces, skilled nursing facilities, and long-care facilities. Out-of-Hospital Cardiac Arrests (OHCAs) is one of the leading causes of death in the U.S., affecting more than 356,000 Americans annually, of which there is 9% survival to hospital discharge after EMS-treated cardiac arrest. AEDs are not widely available in public spaces where cardiac arrests are occurring with reported AED use at just 10.8% in public settings before emergency medical services arrive and the location of OHCA largely occur in homes/residencies (70%) followed by public settings (18.8%) and nursing homes (11.2%): 	40.3.01- AEDs for Police First Responders The Medical Society of Virginia supports funding for law enforcement agencies to buy AEDs and to equip and train their personnel as first responders to improve cardiac arrest survival.	 Patients in cardiac arrest outside of the hospital have an increased chance of survival and improves patient morbidity, mortality, and can improve neurological outcomes for survivors. Increased public access. Drawbacks AEDs are not under the oversight of VDH in Virginia. Some may argue it is unsafe for the untrained public to use AEDs on another person. 	Staff recommends adopting this policy by amending MSV policy 40.3.01 and amending the resolution. Staff recommends adding support for funding AEDs in skilled nursing facilities, and long-term care facilities. Staff recommends removing access to AED in public spaces. A 2019 JCHC study found that 7,750 AED units would be required in Richmond City to ensure bystander accessibility within 2 minutes, which would cost the city ~\$12million (too costly). The study also suggested that the general public would need to be trained on how to use an AED, similarly to naloxone training provided by the REVIVE! program. 40.3.01- AEDs for Police First Responders , <u>Skilled Nursing</u> <u>Facilities</u> , and Long-Term <u>Care Facilities</u> The Medical Society of Virginia supports funding <u>for skilled</u> <u>nursing facilities</u> , long-term care <u>facilities</u> , and law enforcement agencies to buy AEDs and to equip and train their personnel as first responders to improve cardiac arrest survival.

22-107 Striving for Adrenal crisis treatment by Virginia EMS responders (SAVE)

Submitted by the Richmond Academy of Medicine

- WHEREAS, the majority of EMS protocols in Virginia do not allow emergency medical response personnel to treat individuals with the patient's prescribed self-administered medication, and
- WHEREAS, patients with normal working adrenal can produce 5-10 times the normal amount of cortisol which helps maintain blood pressure, salt and sugar levels, and
- WHEREAS, in patients with adrenal deficiency, an immediate dose of hydrocortisone (a glucocorticoid) can avert the adrenal crisis. However, delay can lead to shock, heart failure and death, and
- WHEREAS, symptoms and signs of adrenal crisis, which may not be always quickly recognized, include dizziness, lethargy, nausea, vomiting, hypotension, shock and heart failure, and
- WHEREAS, these patients usually wear medical ID's that say "adrenal insufficiency" to indicate their condition, and
- WHEREAS, patients who are diagnosed with adrenal insufficiency (3% of population in US and UK) are prescribed patient-carried medication, typically hydrocortisone, to be administered to prevent and treat adrenal crisis. Prompt intervention can reduce mortality in these patients, and
- WHEREAS, there are many situations where the patient cannot self-administer the prescribed medication including patients in the care of someone who does not know how to give the medication or is not comfortable with giving this emergency injection (e.g. a child at a school without a nurse), an adult living alone too unwell to carry out the procedure themselves, or situations that are not intuitively connected with adrenal insufficiency such as an automobile accident or injury where the caregiver is not present or incapacitated, and
- WHEREAS, only 60% of patients who are appropriately instructed in self-management feel confident and secure in administering the medication, therefore be it
- RESOLVED, that the Medical Society of Virginia work with the Department of Health, all EMS Medical Directors, the Office of EMS, and all other appropriate stakeholders and organizations to educate them on the signs and symptoms of adrenal insufficiency as well allow authorized EMS staff to administer a patient's provided hydrocortisone injection when appropriate medical identification is available.

References:

- Hahner S, Spinnler C, Fassnacht M, Burger-Stritt S, Lang K, Milovanovic D, Beuschlein F, Willenberg HS, Quinkler M & Allolio B. High incidence of adrenal crisis in educated patients with chronic adrenal insufficiency: a prospective study. *Journal of Clinical Endocrinology and Metabolism* 2015 **100** 407–416. (https://doi.org/10.1210/jc.2014-3191).
- Thomas Goubar, David J Torpy, Shaun McGrath, R Louise Rushworth, Prehospital Management of Acute Addison Disease: Audit of Patients Attending a Referral Hospital in a Regional Area, *Journal of the Endocrine Society*, Volume 3, Issue 12, December 2019, Pages 2194–2203
- Miller, B. S., Spencer, S. P., Geffner, M. E., Gourgari, E., Lahoti, A., Kamboj, M. K., Stanley, T. L., Uli, N. K., Wicklow, B. A., & Sarafoglou, K. (2020). Emergency management of adrenal insufficiency in children: advocating for treatment options in outpatient and field settings. *Journal of investigative medicine : the official publication of the American Federation for Clinical Research*, 68(1), 16–25
- Karen Su, Dina Matos. EMS advisory letter for emergency hydrocortisone. Accessed March 15, 2020. <u>https://www.caresfoundation.org/wp-</u> content/uploads/2019/10/EMSAdvisoryLetterFinal4828.pdf

Submitted by: Richmond Academy of Medicine

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Collaborate with VDH, EMS Medical Directors, the office of EMS, and other supporting stakeholders to educate them on the signs and symptoms of adrenal insufficiency. Support permitting EMS staff to administer a patient's provided hydrocortisone injection when appropriate medical identification is available. Patients who are diagnosed with adrenal insufficiency (3% of population in US and UK) are prescribed patient-carried medication, typically hydrocortisone, to be administered to prevent and treat adrenal crisis. Prompt intervention can reduce mortality in these patients. Only 60% of patients who are appropriately instructed in self- management feel confident and secure in administering the medication. 	None	 Benefits MSV currently lacks a policy on adrenal crisis treatment, and this policy will promote greater education among state entities and emergency personnel to protect every patient's timely access to life-saving emergency medications. Drawbacks Possible patient safety concerns of insufficiently trained individuals injecting hydrocortisone in an emergency. 	Staff recommends ADOPTION AS AMENDED RESOLVED, that the Medical Society of Virginia work with Department of Health, all EMS Medical Directors, the Office of EMS, and all other appropriate stakeholders & organizations to educate them on the signs and symptoms of adrenal insufficiency as well allow authorized EMS staff to administer a patient's provided hydrocortisone injection when appropriate medical identification is availablesupports increased education and training among EMS Medical Directors and state government stakeholders on the signs and symptoms of adrenal insufficiency. The MSV supports authorized EMS staff to administer a patient's provided hydrocortisone injection when appropriate medical identification is availablesupports increased education and training among EMS Medical Directors and state government stakeholders on the signs and symptoms of adrenal insufficiency. The MSV supports authorized EMS staff to administer a patient's provided hydrocortisone injection when appropriate medical identification is available.

Maternity Leave

- WHEREAS, paid maternity leave, considered employment-protected time off for parental care, has been shown to decrease both maternal and infant re-hospitalization and mortality, risk of maternal mental illness, and intimate partner violence in the postpartum period^{1,2,3}, and
- WHEREAS, paid maternity leave has been shown to improve pediatric outcomes through increased breastfeeding duration, wellness visit attendance, and timely vaccine administration¹, and
- WHEREAS, the duration of paid maternity leave significantly predicts health outcomes, with mothers taking more than 12 weeks of paid leave in the critical postpartum period being associated with greater decreased odds of infant re-hospitalization and maternal distress compared to women who took either less than 12 weeks of paid leave or no paid leave^{2,4,5}, and
- WHEREAS, cross-national analyses of OECD nations shows that increasing the duration and benefit level of paid leave policies increased rates of women's labor force participation, showing long-term economic benefits of maternity leave⁵, and
- WHEREAS, the Commonwealth of Virginia currently does not have any mandatory statewide provisions for maternity leave following the birth or adoption of a child, with limited regulation in both public and private sectors, aside from The Family and Medical Leave Act (FMLA), and
- WHEREAS, the American Medical Association (AMA) has policy supportive of paid maternity leave, with H-405.954 stating that "Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.", therefore be it

¹ Van Niel MS, Bhatia R, Riano NS, et al. The Impact of Paid Maternity Leave on the Mental and Physical Health of Mothers and Children: A Review of the Literature and Policy Implications. *Harv Rev Psychiatry*. 2020;28(2):113-126. doi:10.1097/HRP.00000000000246

² Jou, J., Kozhimannil, K. B., Abraham, J. M., Blewett, L. A., & McGovern, P. M. (2017). Paid maternity leave in the United States: Associations with maternal and infant health. *Maternal and Child Health Journal*, 22(2), 216–225. https://doi.org/10.1007/s10995-017-2393-x

³ Hamad R, Modrek S, White JS. Paid Family Leave Effects on Breastfeeding: A Quasi-Experimental Study of US Policies. Am J Public Health. 2019 Jan;109(1):164-166. doi: 10.2105/AJPH.2018.304693. Epub 2018 Oct 25. PMID: 30359107; PMCID:

⁴ Weber A, Harrison TM, Steward D, Ludington-Hoe S. Paid Family Leave to Enhance the Health Outcomes of Preterm Infants. Policy Polit Nurs Pract. 2018 Feb-May;19(1-2):11-28. doi: 10.1177/1527154418791821. Epub 2018 Aug 22. PMID: 30134774; PMCID: PMC6532630.

⁵ Nandi A, Jahagirdar D, Dimitris MC, Labrecque JA, Strumpf EC, Kaufman JS, Vincent I, Atabay E, Harper S, Earle A, Heymann SJ. The Impact of Parental and Medical Leave Policies on Socioeconomic and Health Outcomes in OECD Countries: A Systematic Review of the Empirical Literature. Milbank Q. 2018 Sep;96(3):434-471. doi: 10.1111/1468-0009.12340. PMID: 30277601; PMCG131347. PMCG301394.

- RESOLVED, MSV recognizes the importance of the provision of at least 12 weeks of jobprotected paid maternity leave after delivery or adoption to further both the health of the parent and the child, and be it further
- RESOLVED, MSV supports the establishment of a maternity leave requirement, of at least 12 weeks following delivery or adoption, by legislation in the Commonwealth of Virginia.

Fiscal Impact: None Existing Policy: None

Staff Analysis 22-108: Maternity Leave

Submitted by: MSV Medical Student Section

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Recognize the importance of at least12 weeks of paid maternity leave after delivery or adoption. Support paid maternity leave for at least 12 weeks after delivery or adoption. Support paid maternity leave for at least 12 weeks after delivery or adoption. Research has demonstrated that the duration of paid maternity leave significantly predicts health outcomes, with mothers taking more than 12 weeks of paid leave in the critical postpartum period being associated with greater decreased odds of infant re-hospitalization and maternal distress compared to women who took either less than 12 weeks of paid leave. Research has also demonstrated that paid maternity leave, has been shown to decrease both maternal and infant re-hospitalization and mortality, risk of maternal mental illness, and intimate partner violence in the postpartum period. 	No MSV Policy. AMA Policy: Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other	 Physicians/Patients Benefits Studies show that paid maternity leave has decreased both maternal and infant re- hospitalization and mortality. Improves pediatric outcomes (mother has more time with newborn). Decreased odds of maternal distress. Drawbacks MSV traditionally opposes mandates on providers. Can increase cost for small practice employers. 	Staff recommends ADOPTING AS AMENDED. RESOLVED, MSV supports at least 12 weeks of job-protected paid maternity leave after delivery or adoption to further both the health of the parent and the child ₂₇ and be it further RESOLVED, MSV supports the establishment of a maternity leave requirement, of at least 12 weeks following delivery or adoption, by legislation in the Commonwealth of Virginia.
	factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.		

22-109

Gun Safety Resolution

Submitted by Dr. Michelle Whitehurst-Cook

WHEREAS,	the number of guns purchased by the American public is escalating, and
WHEREAS,	the number of suicides, homicides, and accidental injuries and deaths are rising, especially among young adults and children, and
WHEREAS,	the responsibility of medicine is to educate our patients to maintain health, and be it
RESOLVED,	that the MSV will develop or utilize existing patient education materials on the safe storage of guns in the home, and be it further
RESOLVED,	that this patient education material be shared with all members of the MSV, and be it further
RESOLVED,	that MSV physicians and health care providers be encouraged to share this with their patients who are gun owners or are considering purchasing a gun.

Submitted by: Dr. Michelle Whitehurst-Cook

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Develop or utilize existing patient education materials on the safe storage of guns in the home and share such resources with the membership of the MSV. Encourage MSV physicians and health care providers to share resources with patients who are gun owners and with those considering the purchase of a firearm. Research syntheses on child-access prevention laws, there is comparatively strong evidence that laws requiring safe storage practices can effectively reduce suicides and unintentional injuries and deaths. Furthermore, evidence in research suggests that clinicians that counsel their patients on safe storage practices can prove more effective than public awareness campaigns alone. 	 40.9.04- Child Firearm Injury Prevention The Medical Society of Virginia supports public education programs to reduce injuries to children from firearms as well as the dangers and legal liabilities of leaving loaded, unsecured firearms accessible to children. Such programs should use evidence-based, developmentally age- appropriate information. Further, the Society will the Medical Society of Virginia will cooperate and collaborate with interested advocacy groups regarding prevention of injury to children by firearms. The Medical Society of Virginia supports requiring safety devices to be sold or transferred with each gun sold or transferred in Virginia, either at a regulated gun store or through any other means such as gun shows 	 Benefits Having these materials available to patients in healthcare settings will bolster public awareness of such programs. Drawbacks Current policy can be interpreted to support safe storage of firearms already. Resolution would be more appropriate as an advocacy summit proposal for the dedication of MSV staff resources. 	Staff recommends AMENDING MSV POLICY 40.9.04 40.9.04- Child Firearm Injury Prevention The Medical Society of Virginia supports public education programs including safe storage initiatives, to reduce injuries to children from firearms as well as the dangers and legal liabilities of leaving loaded, unsecured firearms accessible to children. Such programs should use evidence-based, developmentally age- appropriate information. Further, the Society will the Medical Society of Virginia will cooperate and collaborate with interested advocacy groups regarding prevention of injury to children by firearms. The Medical Society of Virginia supports requiring safety devices to be sold or transferred with each gun sold or transferred in Virginia, either at a regulated gun store or through any other means such as gun shows

POSTPONED FROM 2021 FOR CONSIDERATION IN 2022

22-110

Resolution to Request the Virginia Legislature to Allow Virginia Physicians to Bear Financial Risk in Health Care Policies

Originally Submitted by Dr. Monroe Baldwin

- WHEREAS, the practice of medicine is carried out now in a free market economic arena, and
- WHEREAS, the supply-demand curve, taught in Economics 101, operates automatically in a free market guiding physicians and hospitals towards maximum profit thereby raising prices above what some working people can afford, and
- WHEREAS, presently approximately 15 % of the population earn too much for coverage by Medicaid and not enough to afford commercial insurance and are proud of not being on Medicaid, and
- WHEREAS, physician/doctors are the only members of society licensed to provide medical care and, therefore, are responsible for its delivery in all aspects, and
- WHEREAS, having health insurance is intrinsically part of healthcare because it releases daily stress by preventing bankruptcy from doctor/physician healthcare bills, and
- WHEREAS, the State Corporation Commission presently demands a financial reserve to stabilize healthcare policies and are unwilling to allow physician/doctors to provide the same stabilization by adjusting appropriately their charges month to month, and
- WHEREAS, the State Corporation Commission will agree to a doctor/physician risk bearing plan if the Virginia legislature will pass an "enabling law" that will allow it, therefore be it
- RESOLVED, that the Medical Society of Virginia ask the Virginia legislature to pass an "enabling Law" that allows Virginia doctors/physicians to control the solvency of a medical insurance plan covering their costs by adjusting their charges appropriately month to month.

Fiscal Impact: None

Existing Policy: None

Staff Analysis – Resolution 22-110: Resolution to Request the Virginia Legislature to Allow Virginia Physicians to Bear Financial Risk in Health Care Policies

Submitted by: Dr. Monroe Baldwin

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
This resolution asks the MSV to: ask the Virginia legislature to pass an "enabling Law" that allows Virginia doctors/physicians to control the solvency of a medical insurance plan covering their costs by adjusting their charges appropriately month to month. 	None	Benefits • None that don't exist under current operating practices. Physicians can already adjust their charges. Drawbacks • Further regulates the provision of health care by a state entity.	Staff recommends NOT ADOPTING

POSTPONERD FROM 2021 FOR CONSIDERATION IN 2022

22-111

Benefit for Patients at Virginia Physician Offices

Originally Submitted by: Dr. Larry Monahan

- WHEREAS, Patients had long been accustomed to receiving medical advice and care from their Virginia Physicians' *offices* (MDs, DOs, and now also from their NPs and PAs, hereafter in this resolution abbreviated as "VPs"), and to receiving prescription drugs and supplies from their *pharmacies*, and
- WHEREAS, this traditional professional contract has been beneficial to patients because of true patient-provider relationships based upon examinations, diagnosis, prescription of therapy at the VPs' offices, and because (among all of the potential providers of various PARTS of the health care services spectrum) the VPs have the most extensive clinical training and education for personal health care matters, and
- WHEREAS, many of the major pharmacies and health-care insurance companies are expanding their offerings to the public, often actually establishing "doctors' offices" within their own pharmacy buildings, to compete with VPs' offices, and
- WHEREAS, pharmacists and Pharmaceutical Companies recently supported legislation introduced in early 2020 (House Bill 1506, and Senate Bill S1026) which proposed to greatly expand their scope of practice to <u>diagnose</u>, treat, and prescribe drugs for several medical conditions such as Strep Throat, the Flu; and to <u>prescribe</u> Naloxone, Epinephrine, TB tests, and Contraceptives, and
- WHEREAS, VPs have recently experienced decreasing net income, partly because pharmacies have removed much medical care, prescriptions, immunizations, etc. from the VPs' offices, and
- WHEREAS, the above-mentioned pharmacies and pharmacists are administering medical care outside of their clinical training and education for profit, and
- WHEREAS, VPs are evaluating opportunities to address the increased overhead expenses associated with providing medical care in a practice setting, an
- WHEREAS, patients receiving a portion of their medicine prescriptions during their office visits with their VPs would be more efficient and cost effective, and
- WHEREAS, VPs should investigate prescribing and even delivering some traditional "pharmacy" benefits, to the financial and efficient benefit of the patients' care who visit their offices, and
- WHEREAS, the patients a one-stop visit at the VPs' offices for diagnosis and medication prescription, therefore be it
- RESOLVED, that the Medical Society of Virginia study and present to the MSV BOD and to next year's HOD a detailed and completely workable plan and process by which Virginia Physicians' Offices (VPs) can begin providing actual prescriptions (pills and capsules) to their office patients, for the patients' convenience, efficiency, and cost-savings, if such a

study does demonstrate that such plan and process would indeed be achievable and beneficial.

Fiscal Impact: None

Existing Policy: None

Staff Analysis – Resolution 22-111: Benefit for Patients at Virginia Physician Offices

Originally Submitted by: Dr. Larry Monahan

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: study and present to the MSV BOD and to next year's HOD a detailed and completely workable plan and process by which Virginia Physicians' Offices (VPs) can begin providing actual prescriptions (pills and capsules) to their office patients, for the patients' convenience, efficiency, and cost-savings, if such a study does demonstrate that such plan and process would indeed be achievable and beneficial. Current Board of Pharmacy regulations allow for physician offices to dispense controlled substances with a separate license and building permit. During the COVID 19 pandemic, physicians could also apply for a waiver to be able to deliver their patients' medications via the mail. This waiver has not yet been made permanent following the wind-down of the pandemic. 	35.2.03- Physician Dispensing The Medical Society of Virginia supports physician dispensing of prepackaged drugs for a fee or charge when it is in the best interest of the patient.	 Benefits Added convenience for patients. Potential additional revenue stream for physician offices. Direct physician to patient pipeline for receiving needed medications. Drawbacks Potential for high costs in order to meet regulatory guidelines for the storage and dispensing of medication from a physician office. Additional regulatory burden and oversight. 	Staff recommends AMENDING MSV POLICY 35.2.03 The Medical Society of Virginia supports physician dispensing of <u>prescribed</u> <u>medications at a physician's</u> <u>office or via the mail</u> prepackaged drugs for a fee or charge when it is in the best interest of the patient.

22-112

Hospital Medical Staff Self-Governance

Submitted by the Richmond Academy of Medicine

- WHEREAS, the increasing corporatization of medicine over the past decade has created a number of actual as well as more potential conflicts for physicians, both ethical and administrative. As more physicians are employed by hospitals and health care systems, the independence of the medical staffs and the differences in imperatives between the hospital staff physicians, administrators and boards can come into conflict. Physicians must be free to determine and carry out the responsibilities and functions of the medical staff without interference of the hospital administration or board, and
- WHEREAS, the core responsibilities of organized hospital medical staffs are the promotion of patient safety and the quality of patient care as well as to define and monitor the processes of physician credentialing, evaluation, peer review and discipline. To accomplish these tasks, the medical staff should be free to make and implement decisions as well as communicate these decisions with staff leaders, the administration and governing board regarding matters concerning the organization as well as the staff. Both Medicare and the Joint Commission (JCAHO) have many conditions and standards hospital medical staff are required to perform and maintain, and
- WHEREAS, hospital system board members are expected to be ethically, financially and legally responsible for the overall operations of the hospital, and
- WHEREAS, hospital administrators oversee the day-to-day management of the hospital and carrying out the directives of the board. Among these tasks are ensuring fiscal responsibility and maintaining good relations and communication with the medical staff as well as all other employees and report to the board, and
- WHEREAS, medical staff members, hospital boards and hospital administrators must work together to promote an environment of excellent and high-quality patient care. In order to accomplish this goal, there must be a sense of trust, good faith, fairness and open communication among all parties. This cannot be accomplished if there are hospital board or administration actions or polices enacted that thwart the ability of the medical staff to effectively carry out its duties or constitute threats to medical staff members' ability to speak freely regarding patient care quality issues. Any such actions not only erode the desired environment of trust, good faith and fairness among the principals, but they threaten patient care and can compromise the quality of physical performance, morale and mental health, and
- WHEREAS, optimal hospital medical and surgical patient care can only be accomplished when the hospital medical staff can preserve and maintain the ability to self-govern. The medical staffs should be able to maintain autonomy from hospital administrators and maintain the independent ability to at least the following actions:
 - 1. Initiate, develop and approve or disapprove medical staff bylaws, rules and regulations;
 - 2. Select and remove medical staff leaders;
 - 3. Control the use of medical staff funds;
 - 4. Be advised by independent attorneys to provide independent and unbiased legal counsel;

- 5. Establish and define, in accordance with applicable law, medical staff membership categories, including categories for non-physician; therefore, be it
- RESOLVED, that the Medical Society of Virginia create and adopt a hospital medical staff member bill of rights to better ensure that all members can more effectively and ethically carry out their professional responsibilities for their patients, and be it further
- RESOLVED, that the Medical Society of Virginia will expand their policy #30.4.05, Physician & Medical Staff Bill of Rights, to at least include the need for independent medical staff self-governance, and be it further
- RESOLVED, that the Medical Society of Virginia work with the Virginia Hospital Association and all other appropriate organizations to codify and enforce independent medical staff self-governance.

Originally Submitted by: Richmond Academy of Medicine

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Create and adopt a hospital medical staff member bill of right to better ensure that all members can more effectively and ethically carry out their professional responsibilities for their patients. Expand MSV policy 30.4.05 to include the need for independent medical staff self-governance. Work with VHHA to also codify and enforce independent medicals staff self-governance. Work with VHHA to also codify and enforce independent medicals staff self-governance. The AMA has an extensive Hospital Medical Staff Bill of Rights within its policy. That policy is based on the following foundation: The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated. The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This 	30.4.05- Physician & Medical Staff Bill of Rights Our Medical Society of Virginia adopts AMA policy H-225.942 "Physician and Medical Staff Bill of Rights" in the MSV Policy Compendium	 Benefits Increases physician autonomy in a hospital More physicians are seeking employment in hospital systems. This resolution can better define a physician's relationship with their administrators and patients alike in hospital settings Drawbacks The ask is large and would require significant use of financial and human capital to amend the Virginia Code related to hospital staff governance Codifying the practice of medicine can be detrimental to our membership 	Staff recommends REFERRAL TO THE MSV BOARD OF DIRECTORS Creating a MSV-specific bill of rights is a significant staff project, requiring several hours of outreach, research and member input. Historically, the Board has managed MSV staff yearly priorities.

accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.		

Acknowledging Climate Change as a Public Health Emergency

Submitted by Rose Dever, Lavinia Wainwright, and Vanessa Lin

- WHEREAS, The United Nations' Intergovernmental Panel on Climate Change (IPCC) states in its most recent report that climate change will significantly increase ill health and premature deaths; increase likelihood and frequency of severe droughts, floods, and heatwaves; increase food-borne, water-borne, and vector-borne disease; increase mental health challenges; and will significantly undermine food security and nutrition¹, and
- WHEREAS, the American Public Health Association in conjunction with 25 other leading medical groups including the American Lung Association, American Academy of Pediatrics, and American College of Physicians declared climate change a public health emergency which demands immediate action and which is already significantly impacting human health, with effects ranging from increased cardiovascular disease and premature death to expanding the geographic ranges for disease-carrying insects², and
- WHEREAS, the First Street Foundation–a non-profit environmental research and technology group using a peer-reviewed extreme heat model–predicts that the state of Virginia will be part of the "Extreme Heat Belt" by 2053, meaning the state will have at least one day greater than 125°F per year and will have more than double the number of days when the "feels like" temperature is greater than 105°F compared to 2022³, and
- WHEREAS, in 2019 United States healthcare accounted for 27% of global healthcare's carbon footprint, a larger proportion than any other country, and 17% of emissions worldwide from this sector emanate directly from healthcare facilities and transport vehicles⁴, and
- WHEREAS, the World Health Organization published 10 priorities for climate change and health in 2021, including urgent action to "train the health workforce to respond to climate change, take climate action in the healthcare sector, enable health professional advocacy on climate change and health, and protect the health of future generations"⁵, and
- WHEREAS, the American Medical Association declared climate change a public health crisis in June 2022, stating that "the global increase in temperature threatens the health of all people", and further supported efforts to decarbonize within the healthcare sector⁶, therefore be it

³ Amodeo M, Bauer M, Bryant K. First Street Foundation; Aug 15, 2022. https://firststreet.org/research-lab/published-research/article-highlights-from-hazardousheat/. Accessed August 18, 2022.

¹ IPCC, 2022: Summary for Policymakers [H.-O. Pörtner, D.C. Roberts, E.S. Poloczanska, K. Mintenbeck, M. Tignor, A. Alegría, M. Craig, S. Langsdorf, S. Löschke, V. Möller, A. Okem (eds.)]. In: *Climate Change 2022: Impacts, Adaptation, and Vulnerability*. Contribution of Working Group II to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change [H.-O. Pörtner, D.C. Roberts, M. Tignor, E.S. Poloczanska, K. Mintenbeck, A. Alegría, M. Craig, S. Langsdorf, S. Löschke, V. Möller, A. Okem, B. Rama (eds.)]. Cambridge University Press. In Press.
<u>https://report.ipcc.ch/ar6wg2/pdf/IPCC_AR6_WGII_SummaryForPolicymakers.pdf</u>

² A Declaration on Climate Change and Health 2021. January 6, 2021.

https://www.lung.org/getmedia/865bcc65-81a4-4f73-8207-74a9acd55c36/2021-declaration-on-climate-and-health.pdf

⁴ Health Care's Climate Footprint: How the Health Sector Contributes to the Global Climate Crisis and Opportunities for Action. Healthcare Without Harm. Published 2019.

https://noharm-global.org/sites/default/files/documents-files/5961/HealthCaresClimateFootprint_090619.pdf. Accessed August 2022. ⁵ COP26 Special Report on Climate Change and Health: The Health Argument for Climate Action. World Health Organization. Published 2021. https://www.who.int/publications/i/item/9789240036727. Accessed August 2022

⁶ Bansal, MD A. AMERICAN MEDICAL ASSOCIATION HOUSE of DELEGATES (A-22).; 2022:42 (36). Accessed August 30, 2022. https://www.ama-assn.org/system/files/a22-refcmte-d-report-annotated.pdf

RESOLVED, that the Medical Society of Virginia amend 40.8.03 – Protecting Human Health in a Changing Climate as follows:

40.8.03 - Protecting Human Health in a Changing Climate.

The Medical Society of Virginia notes the findings of leading U.S. and international scientific bodies that the Earth is undergoing adverse changes in the global climate, and recognizes climate change as a public health emergency that threatens the health and welfare of all people.

The Medical Society of Virginia supports educating the medical community on the adverse effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education and policymaking.

The Medical Society of Virginia encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the health effects of climate change can be anticipated and responded to more effectively.

Fiscal Impact: none

Existing Policy: 40.8.03 – Protecting Human Health in a Changing Climate. The Medical Society of Virginia notes the findings of leading U.S. and international scientific bodies that the Earth is undergoing adverse changes in the global climate. The Medical Society of Virginia supports educating the medical community on the adverse effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education and policymaking. The Medical Society of Virginia encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the health effects of climate change can be anticipated and responded to more effectively.

Staff Analysis – Resolution 22-113: Acknowledging Climate Change as a Public Health Emergency

Submitted by: Dr. Rose Dever, Dr. Lavinia Wainwright, and Dr. Vanessa Lin

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Amend Policy 40.8.03. Recognize climate change as a public health emergency that threatens the health and welfare of all people. The AMA passed similar policy in June 2022 at their Annual Meeting. As part of the new policy, the AMA will develop a strategic plan for how to enact its climate change policies, including advocacy priorities and strategies to decarbonize physician practices and the health sector with a report back to the House of Delegates at the 2023 Annual Meeting. The AMA's new policy also recognizes the health, safety, and climate risks of current methods of producing fossil fuel-derived hydrogen and the dangers of adding hydrogen to natural gas. 	40.8.03- Protecting Human Health in a Changing Climate The Medical Society of Virginia notes the findings of leading U.S. and international scientific bodies that the Earth is undergoing adverse changes in the global climate. The Medical Society of Virginia supports educating the medical community on the adverse effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education and policymaking. The Medical Society of Virginia encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the health effects of climate change can be anticipated and responded to more effectively.	 Benefits Current MSV policy on climate change does not recognize it as a public health emergency. By recognizing that fact, MSV positions itself to advocate for patients where appropriate at the local, state, and federal levels. Drawbacks Climate change is a politically divisive issue for some, and members may feel such policy falls outside of the scope of the MSV. 	Staff recommends ADOPTION.

Housing as Healthcare

Submitted by The MSV Medical Student Section

WHEREAS,	the lack of permanent, adequate housing in the US adversely affects health outcomes for many Americans, and
WHEREAS,	there were nearly 6,000 Virginians experiencing homelessness each day in 2020 ¹ , and
WHEREAS,	over 20,000 Virginia public school students experienced homelessness over the course of the 2018-2019 school year ² , and
WHEREAS,	the life expectancy and all-cause mortality risk for people without adequate housing is 27.3 years less than and 8.9 times greater than that of people with adequate housing, respectively ³ , and
WHEREAS,	people experiencing homelessness are at higher risk of contracting communicable disease like influenza, SARS-CoV-2, hepatitis, and HIV ⁴⁵⁶ , and
WHEREAS,	people with a history of homelessness experience a significantly greater prevalence of communicable and chronic health diseases, including cerebrovascular accident, dementia, epilepsy, head trauma, and chronic obstructive lung disease ⁷ , and
WHEREAS,	minoritized communities experience homelessness at disproportionately higher rates and have worse health outcomes ⁸ , and
WHEREAS,	multiple studies have demonstrated a significant return on economic investment through programs that address inadequate housing ⁹¹⁰ , therefore be it
RESOLVED,	the Medical Society of Virginia (MSV) recognizes long-term, adequate housing as a critical component and social determinant of health, and be it further
RESOLVED,	the MSV supports evidence-based state and national systems and legislation that expands supply of long-term, safe, and adequate housing.

¹ Homeless in Virginia Statistics 2019. Homeless Estimation by State | US Interagency Council on Homelessness. Accessed September 8, 2022. https://www.usich.gov/homelessness-statistics/va/

² Homeless in Virginia Statistics 2019. Homeless Estimation by State | US Interagency Council on Homelessness. Accessed September 8, 2022.

https://www.usich.gov/homelessness-statistics/va/ ³ Baggett TP, Hwang SW, O'Connell JJ, et al. Mortality Among Homeless Adults in Boston: Shifts in Causes of Death Over a 15-year Period. JAMA Intern Med. 2013;173(3):189-195. doi:10.1001/jamainternmed.2013.1604

⁴Perri M, Dosani N, Hwang SW. COVID-19 and people experiencing homelessness: challenges and mitigation strategies. CMAJ. 2020;192(26):E716-E719. doi:10.1503/cmaj.200834

⁵ Badiaga S, Raoult D, Brouqui P. Preventing and Controlling Emerging and Reemerging Transmissible Diseases in the Homeless. Emerg Infect Dis. 2008;14(9):1353-1359. doi:10.3201/eid1409.082042

 ⁶ Liu CY, Chai SJ, Watt JP. Communicable disease among people experiencing homelessness in California. Epidemiol Infect. 148:e85. doi:10.1017/S0950268820000722
 ⁷ Health Conditions Among Individuals with a History of Homelessness Research Brief. ASPE. Accessed September 8, 2022. https://aspe.hhs.gov/reports/health-conditions-among-individuals-bistory-homelessness-research-brief-0

 ⁸ Jones MM. Does Race Matter in Addressing Homelessness? A Review of the Literature. World Medical & Health Policy. 2016;8(2):139-156. doi:10.1002/wmh3.189

⁹ Hunter S, Harvey M, Briscombe B, Cefalu M. Evaluation of Housing for Health Permanent Supportive Housing Program. RAND Corporation; 2017. doi:10.7249/RR1694 ¹⁰ Frequent Users of Health Services Initiative: Final Evaluation Report. :77.

Staff Analysis – Resolution 22-114: Housing as Healthcare

Submitted by: MSV Medical Student Section

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Recognizes long-term, adequate housing as a critical component and social determinant of health. Support evidence-based state and national systems and legislation that expands supply of long-term, safe, and adequate housing. According to publicly available data, there were nearly 6,000 Virginians experiencing homelessness each day in 2020and over 20,000 Virginia public school students experienced homelessness over the course of the 2018-2019 school year. Research has indicated that the life expectancy and all-cause mortality risk for people without adequate housing is 27.3 years less than and 8.9 times greater than that of people with adequate housing, respectively. According to Health Affairs, 	None AMA Policy: Eradicating Homelessness H- 160.903 Our AMA: (1) supports improving the healthoutcomes and decreasing the healthcare costs of treating the chronicallyhomeless through clinically proven,high quality, and cost effectiveapproaches which recognize thepositive impact of stable and affordablehousing coupled with social services;(2) recognizes that stable, affordablehousing as a first priority, withoutmandated therapy or services compliance, is effective in improvinghousing stability and quality of lifeamong individuals who are chronically-homeless; (3) recognizes adaptive strategiesbased on regional variations,community characteristics and stateand local resources are necessary toaddress this societal problem on along-term basis; (4) recognizes the need for aneffective, evidence-based national planto eradicate homelessness; (5) encourages the National HealthCare for the Homeless Council to studythe funding, implementation, andstandardized evaluation of Medical	-	Staff Recommendation Staff recommends ADOPTION.
housing is one of the best- researched social determinants of health, and selected housing interventions for low-income			

people have been found to	Respite Care for homeless persons;(6) will	
improve health outcomes and	partner with relevantstakeholders to educate	
decrease health care costs.	physiciansabout the unique healthcare and	
	socialneeds of homeless patients and the	
The American Hospital	importance of holistic, cost-effective,	
Association recently published	evidence-based discharge planning, and	
"Housing and Health: A Roadmap	physicians' role therein, inaddressing these	
for the Future," which examines	needs;	
the impact of housing instability on	(7) encourages the development ofholistic,	
individuals' health and outlines	cost-effective, evidence-baseddischarge	
opportunities and avenues for	plans for homeless patientswho present to	
hospitals to reduce housing	the emergencydepartment but are not	
instability in their communities.	admitted to the hospital;	
This tool shares strategic	(8) encourages the collaborative effortsof	
considerations for how to tailor a	communities, physicians, hospitals, health	
housing strategy to meet	systems, insurers, social service	
community needs and case	organizations, government, and other	
examples of how hospitals are	stakeholders to developcomprehensive	
addressing housing instability	homelessness policiesand plans that	
during COVID-19.	address the healthcareand social needs of	
5	homeless patients;(9) (a) supports laws	
	protecting the civiland human rights of	
	individualsexperiencing homelessness , and	
	(b)opposes laws and policies thatcriminalize	
	individuals	
	experiencing homelessness forcarrying out	
	life-sustaining activitiesconducted in public	
	spaces that wouldotherwise be considered	
	non-criminalactivity (i.e., eating, sitting, or	
	sleeping)when there is no alternative private	
	space available;	
	(10) recognizes that stable, affordable	
	housing is essential to the health of	
	individuals, families, and communities, and	
	supports policies that preserve and expand	
	affordable housing across all	

neighborhoods; and (11) (a) supports training to understandthe needs of housing insecureindividuals for those who encounter thisvulnerable population through theirprofessional duties; (b) supports theestablishment of multidisciplinarymobile homeless outreach teamstrained in issues specific to housing insecure individuals; and (c) will make available existing educationalresources from federal agencies andother stakeholders related to the needsof housing-insecure individuals.	



Delegate Handbook 2022 Reference Committee Two Index

The following section contains a list of the resolutions considered by Reference Committee Two, and the staff analyses

Road Safety Resolution

Submitted by the Richmond Academy of Medicine

- WHEREAS, road accidents occur where there are not always immediate life-saving supplies, and
- WHEREAS, countries like Germany to Greece require specific safety items be kept in the car including a warning triangle, reflective safety jackets, first aid kit, beam deflectors, and a safety helmet (if riding a motorcycle), and
- WHEREAS, since Covid, these safety items must include 2 unused N95 masks or an equivalent, and
- WHEREAS, in Germany, if a driver is stopped at a traffic check and the required first-aid kit is either not available or it's out of date, he/she commits one misdemeanor whose offense is punishable by a fine, and
- WHEREAS, The United States does not require such equipment be available in our cars, therefore be it
- RESOLVED, that the Medical Society of Virginia work with all appropriate organizations and stakeholders to support legislation and/or regulatory actions requiring all licensed vehicles with four wheels or more in Virginia have emergency supplies in their car, and be it further
- RESOLVED, that the Medical Society of Virginia be involved in determining which safety items should be kept in an individual's car.

Financial impact to the state: None (car owner foots the bill)

Existing Policy:

None

Staff Analysis – Resolution 22-201: Road Safety Resolution

Submitted by: Richmond Academy of Medicine

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 Support legislative efforts and regulatory actions requiring owners of vehicles to maintain certain emergency supplies in their vehicles and ensuring MSV's involvement in the creation of such required supply list. Several national organizations, including the National Safety Council, the AARP, and AAA have been involved in recent public awareness campaigns stressing the utility of emergency car kits and their potential to save lives. 	40.21.08- Helmet Safety The Medical Society of Virginia encourages the use of safety helmets whenever appropriate, such as riding horses, bicycles, mopeds and "off road" vehicles. Further, the Medical Society of Virginia supports mandatory requirements for helmet use by minors when operating bicycles and by motorcycle operators and passengers. The Medical Society of Virginia is opposed to the repeal of mandatory helmet laws.	 Benefits Current MSV policy on vehicle safety does not include an emergency list of items for personal safety, and safety of emergency personnel providing medical assistance in emergency situations. Drawbacks Some may feel that this is outside of the scope of the MSV Writing policy supporting the regulation of industries outside of healthcare may set poor precedent. 	Staff recommends ADOPTION AS AMENDED RESOLVED, that the Medical Society of Virginia work with all appropriate organizations and stakeholders to supports legislation and/or regulatory actions requiring all licensed vehicles with four wheels or more in Virginia have being equipped with emergency supplies in their car, and be it further, RESOLVED,— that the Medical Society of Virginia be involved in determining which safety items should be kept in an individual's car.

22-202

Mental Health Questions on Credentialing Forms

Submitted by: Dr. Russ Libby and Dr. Joel Bundy

- WHEREAS, burnout and mental health issues are significant problems that impact the health, performance, and sustainability of the healthcare workforce, in particular, physicians, Advance Practice Providers, and nurses, and
- WHEREAS, the understanding and impact of burnout on physicians have been studied and elucidated over the past 10 years and has identified many and diverse causes, significant impact on patient care, safety and access to care, and an increased risk for mental health problems including physician suicide, all exacerbated by the Covid-19 pandemic, and
- WHEREAS, there is ample evidence that credentialing applications and job review procedures often ask intrusive questions that are broad and invasive of privacy, which may cause intrapersonal distress such as a fear of losing professional stature, workplace retribution, or other perceived negative consequences without evidence of improved patient outcomes, and
- WHEREAS, these types of questions and other workplace communications may increase worker susceptibility to misconceptions and confusion about their professional status, inhibiting their access to appropriate care and increasing the risk for adverse outcomes, such as burnout, diminished performance, reduced worker hours and/or career path, and self-harm or suicide, and
- WHEREAS, there is no evidence that asking questions beyond those that simply ask query if there are any conditions that may interfere or impair a worker's ability to perform their specific job requirements has any negative consequences for the employer, or the performance of their duties or patient safety, and
- WHEREAS, a recent survey conducted by the Physicians Foundation through Medscape (to be published 9/15/22) found that:
 - 80% of physicians agree that there is stigma surrounding mental health and the seeking of mental health care for physicians
 - 40% of physicians were either afraid or knew another physician fearful of seeking mental health care given these questions asked in medical licensure/credentialing/insurance applications
 - More than 30% believe that suicide prevention resources for physicians exist and are easy to access
 - More than 50% of physicians know of a physician who has ever considered, attempted, or died by suicide, and

WHEREAS, a survey of physicians published by Medscape in January 2022 reported:

"Why have you not sought help for burnout or depression?"

• 43% did not want to risk disclosure to medical board

- 32% were concerned it would be on their insurance record
- 25% were worried about their colleagues finding out
- 22% were concerned the medical profession will shun me, and
- WHEREAS, resolution 21-201 resolved that *the Medical Society of Virginia supports limiting licensure and credentialing application questions in the state of Virginia to asking about conditions that currently impair the physician's ability to practice medicine,"*, therefore, be it
- RESOLVED, that the MSV encourage all hospitals, health systems, malpractice insurers, licensing bodies, and health plans regularly review its (professional) healthcare workforce applications, credentialing and/or job review questionnaires, and worker communications to remove or reword questions that identify mental or physical health issues that do not have the potential to impair or interfere with performance expectations commensurate with their job and professional responsibilities, and be it further
- RESOLVED, these entities consider using the wording suggested by the Federation of State Medical Boards, American with Disabilities Act, American Medical Association, American Hospital Association, the Surgeon General's Advisory, and others.

Fiscal Impact: None

Existing Policy: None

Staff Analysis – Resolution 22-202: Mental Health Questions on Credentialing Forms

Originally Submitted by: Dr. Russ Libby and Dr. Joel Bundy

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: encourage all hospitals, health systems, malpractice insurers, licensing bodies, and health plans regularly review its (professional) healthcare workforce applications, credentialing and/or job review questionnaires, and worker communications to remove or reword questions that identify mental or physical health issues that do not have the potential to impair or interfere with performance expectations commensurate with their job and professional responsibilities. Encourage these entities consider using the wording suggested by the Federation of State Medical Boards, American with Disabilities Act, American Medical Association, American Hospital Association, the Surgeon General's Advisory, and others. The MSV Board of Directors has referred Resolution 21-201 back to the House of Delegates for reconsideration. Its resolved clause, as amended by the 2021 House of Delegates, reads: 	None	Benefits • Would help in removing stigma of health professionals seeking services for mental health and burnout. Drawbacks • Duplicative of Resolution 21-201, which has already been vetted by the House of Delegates and the Board of Directors.	Staff recommends ADOPTION OF RESOLUTION 21-201 IN LUEI OF. RESOLVED, the Medical Society of Virginia supports removing licensure and credentialing application questions in the state of Virginia about health conditions that do not currently impair the physician's ability to practice medicine.

RESOLVED, the Medical Society of Virginia supports removing licensure and credentialing application questions in the state of Virginia about health conditions that do not currently impair the physician's ability to practice medicine.		

Supporting Mental Health in Veterans and Families of Veterans

Submitted by Dr. Cynthia Romero on behalf of the 2nd District

- WHEREAS, 17 veterans commit suicide in the United States each day and approximately one-half (51.5%) of service members who died by suicide received some form of care via the Military Health Service in the 90 days prior to death, and
- WHEREAS, in 2017, 230 Virginia veterans who died of violent deaths had committed suicide, and
- WHEREAS, Virginia has the second largest active duty population (approximately 130,000 active duty personnel), and the second largest percentage of women veterans, and
- WHEREAS, military life can cause significant stressors on service members and their families due to frequent moves, separations due to deployments, financial burdens, and a limited support, and
- WHEREAS, combat may cause even more impactful stressors on service members and their families due to transition challenges, trauma exposure, impactful mental and physical injuries, and
- WHEREAS, service members and their families are at increased risk of social isolation and marginalization as well as post-traumatic stress disorder (PTSD), Traumatic Brian Injury (TBI), Military Sexual Trauma (MST), moral injury, anxiety, depression, and substance use disorder, and
- WHEREAS, cultural competency is a professional skill that enables individuals and organizations to serve their diverse population effectively and competently through equitable and personcentered care especially for individuals and populations that are socially isolated and marginalized, and
- WHEREAS, programs such as military cultural competency awareness and training can help clinical and non-clinical healthcare professionals to foster supportive environments for veterans and families of veterans, therefore be it
- RESOLVED, that the Medical Society of Virginia partner with the Virginia Department of Veteran Services to explore strategies that support mental health and prevent suicides in veterans and family members of veterans.

Staff Analysis – Resolution 22-203: Supporting Mental Health in Veterans and Families of Veterans

Submitted by: Dr. Cynthia Romero on behalf of the 2nd District

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Partner with the Virginia Department of Veterans Services to explore strategies that support mental health and prevent suicides in veterans and their family members. The Virginia Department for Behavioral Health and Developmental Services has developed a crisis line specifically for veterans. Their line specifies that family members can also call on behalf of veterans, but does not specifically state that the line is intended for family member use. The U.S Department of Health and Human Service, in coordination with the U.S Veterans Administration, has been expanding their efforts in providing for mental health services for veterans, active service members, and families. 	 40.18.04 - Optimizing Access of Mental Health Services by Veterans The Medical Society of Virginia supports initiatives in the Commonwealth that encourage and increase access to mental health services. The Medical Society of Virginia further supports targeted initiatives to improve access to mental health care for veterans and other high-risk populations. 	 Benefits Current MSV policy on veterans lacks targeted resources to prevent veteran suicide and does not include members of their families. Additionally, partnering with DVS will ensure MSV will have increased access to accurate data to better streamline the benefits process to the greater veteran community. Drawbacks None 	Staff recommends AMENDING POLICY 48.18.04 40.18.04 – Optimizing Access of Mental Health Services by Veterans and their Family <u>Members</u> The Medical Society of Virginia supports initiatives in the Commonwealth that encourage and increase access to mental health services. <u>The Medical Society of Virginia</u> supports research efforts to prevent suicides and support the mental health of veterans and their family members. The Medical Society of Virginia further supports targeted initiatives to improve access to mental health care for veterans, their family members, and other high-risk populations.

22-204

MSV Organizational Structure Proposal

Submitted by Dr. Monroe Baldwin, MD

- WHEREAS, the Medical Society of Virginia has been created by the physicians of the state to deal with all matters affecting the profession of medicine, and
- WHEREAS, the practice of medicine is a particular kind of utility economically; that is, they are a gal 'ere of professionals working for their overall mission of healthcare, and
- WHEREAS, doctors are the only ones licensed to practice medicine and derive the responsibility to make sure medical care is provided evenly and efficiently, and
- WHEREAS, by being relegated under an independent contractor law category, doctors could not create an entity to pay doctors a salary, place them where they are needed, or build clinics because of antitrust issues, and
- WHEREAS, the creation of a statewide entity having a utility structure would permit the negotiation with commercial insurance companies, the federal government, and the finance section of the state, therefore be it
- RESOLVED, the Medical Society of Virginia (MSV) supports amending the Virginia Constitution to create a state entity to deliver healthcare to its citizens. This is assuming that the entity is the Medical Society of Virginia which is a democratic organization with the ability to vote the way things are managed, and be it further
- RESOLVED, that the Medical Society of Virginia and the State of Virginia will collaboratively create the new entity which would be the Medical Society of Virginia.

Staff Analysis – Resolution 22-204: MSV Organizational Structure Proposal

Submitted by: Dr. Monroe Baldwin

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: amend the Virginia Constitution to create a state entity to deliver healthcare to its citizens. This is assuming that the entity is the Medical Society of Virginia which is a democratic organization with the ability to vote the way things are managed. Create the new entity which would be the Medical Society of Virginia. 	None	 Benefits Would grant the MSV overwhelming power to shape the healthcare sector in the Commonwealth. Drawbacks Would make the Medical Society of Virginia a state entity, and thus fully governed by state bureaucracy. Not politically feasibile 	Staff recommends NOT ADOPTING. While a broad and interesting idea, the policy is simply not possible or attainable.

POSTPONERD FROM 2021 FOR CONSIDERATION IN 2022

22-205

Improved Insurance Reimbursement for Hair Prostheses for Individuals with Cicatricial Alopecia

Originally Submitted by: Jennifer A. Wintringham

- WHEREAS, Primary cicatricial (scarring) alopecia is a group of inflammatory disorders of that scalp that result in irreversible hair loss¹, and
 WHEREAS, Scarring hair loss causes emotional suffering with a higher prevalence of psychiatric disorders such as major depression, anxiety, or social phobia², and
 WHEREAS, Hair prosthesis is a more specific term used to describe a wig worn to cover alopecia secondary to medical conditions³, and
 WHEREAS, Insurance coverage hair prostheses is inconsistent (partial or no coverage) and may be cost prohibitive for many patients as high quality wigs cost thousands of dollars⁴, and
 WHEREAS. Camouflaging hair loss with wigs or hairpieces has been shown to improve self-image and decrease the negative psychological impact of alopecia⁵, therefore be it
- RESOLVED, that the Medical Society of Virginia encourages State, local, and community entities to develop policies that expand insurance reimbursement and coverage of hair prostheses, thereby improving quality of life and reducing financial burden for those suffering from scarring alopecia.

Fiscal Impact: None

Existing Policy: None

¹Olsen EA, Bergfeld WF, Cotsarelis G, et al. Summary of North AMERICAN Hair Research Society (nahrs)-sponsored workshop On cicatricial Alopecia, Duke University Medical center, February 10 and 11, 2001. Journal of the American Academy of Dermatology. 2003;48(1):103-110. doi:10.1067/mjd.2003.68

² Shi Q, Duvic M, Osei JS, et al. Health-related quality of life (hrqol) in alopecia areata patients—a secondary analysis of the national alopecia areata registry data. Journal of Investigative Dermatology Symposium Proceedings. 2013;16(1). doi:10.1038/jidsymp.2013.18

³ Park J, Kim D-W, Park S-K, Yun S-K, Kim H-U. Role of hair prostheses (wigs) in patients with severe alopecia areata. Annals of Dermatology. 2018;30(4):505. doi:10.5021/ad.2018.30.4.505

⁴ Alopecia FAQ's. Headcovers.com. https://www.headcovers.com/resources/alopecia/alopecia/alopecia/faq/. Accessed August 24, 2021.

⁵ Saed S, Ibrahim O, Bergfeld WF. Hair camouflage: A comprehensive review. International Journal of Women's Dermatology. 2017;3(1). doi:10.1016/j.ijwd.2017.02.016

Staff Analysis – Resolution 22-205: Improved Insurance Reimbursement for Hair Prostheses for Individuals with Cicatricial Alopecia

Submitted by: Dr. Jennifer A. Wintringham

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Encourage state, local, and community entities to develop policies that expand insurance reimbursement and coverage of hair prostheses for those suffering from scarring alopecia. Coverage for cranial prosthesis for alopecia appears to be inconsistent across different insurance plans. Mandated coverage for such a benefit in Virginia would have to go through the vetting of the Health Insurance Reform Commission (HIRC). 	10.9.13- Assignment of Benefits The Medical Society of Virginia supports legislation in Virginia that physicians or other health care providers who file insurance claims for their patients and who have appropriately executed Assignment of Benefits directly receive insurance reimbursement for their medical services from the payer, whether or not they are participating providers with the insurance plan. The Medical Society of Virginia will continue to lobby our legislators educationally, and will introduce assignment of benefits legislation when the situation is appropriate.	 Benefits Individuals with scarring alopecia will be benefit from a higher quality of life and a reduced financial burden. Drawbacks More coverage mandates placed on health insurance plans could lead to an increase in premiums' 	Staff recommends ADOPTION AS AMENDED RESOLVED, that the Medical Society of Virginia <u>supports encourages</u> State, local, and community entities to_develop policies that expand insurance reimbursement and coverage of hair prostheses , thereby improving quality of life and reducing financial burden for those suffering from scarring alopecia

Amending Policy Compendium 25.1.02: Opposition to Criminalization of Reproductive Decision Making

Submitted by ACOG Virginia Section

- WHEREAS, policy compendium 25.1.02 states: The Medical Society of Virginia will oppose any legislation or ballot measures that could criminalize in vitro fertilization, contraception, or the management of ectopic and molar pregnancies, and
- WHEREAS, adding "obtaining and providing" after "criminalize" will strengthen opposition to criminalization on behalf of patients and providers, and
- WHEREAS, removing specific examples of reproductive health care defined in 25.1.02 as "in vitro fertilization, contraception, or the management of ectopic and molar pregnancies" and replacing this language with "evidence-based reproductive healthcare" will allow the medical society's preservation of the physician-patient relationship in all areas of reproductive healthcare including infertility, contraception, gender-affirming care, and pregnancy related care including abortion and pregnancy loss, and be it
- RESOLVED, that the MSV amends policy compendium 25.1.02 by addition and deletion as follows:

25.1.02- Opposition to Criminalization of Reproductive Decision Making

The Medical Society of Virginia will oppose any legislation or ballot measures that could criminalize <u>obtaining or providing evidence-based reproductive healthcare</u> in vitro fertilization, contraception, or the management of ectopic and molar pregnancies.

References:

Proceedings of the June 2022 Annual Meeting of the American Medical Association

https://www.acog.org/news/news-releases/2022/07/more-than-75-health-care-organizationsrelease-joint-statement-in-opposition-to-legislative-interference

https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/TSSenateJudiciaryCommitt ee-PostRoe-071222.pdf

Weinberger SE, Lawrence HC 3rd, Henley DE, Alden ER, Hoyt DB. Legislative interference with the patient-physician relationship. N Engl J Med 2012;367:1557-9.

Fiscal impact-no dollar amount requested.

Staff Analysis – Resolution 22-206: Amending Policy Compendium 25.1.02: Opposition to Criminalization of Reproductive Decision Making

Submitted by: ACOG Virginia Section

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Amend Policy 25.1.02. Oppose criminalization of evidence-based reproductive health care. 	25.1.02- Opposition to Criminalization of Reproductive Decision Making The Medical Society of Virginia will oppose any legislation or ballot measures that could criminalize in vitro fertilization, contraception, or the management of ectopic and molar pregnancies.	 Benefits Protects patients and providers from being criminalized or fined. Maintains patient-physician relationship. Physicians still have autonomy as to the services they provide. Drawbacks Not all physicians believe abortion to be considered healthcare. Not all patients believe abortion to be considered healthcare. Patients and providers that do not believe abortion is or should be considered healthcare have significant ethical concerns with the practice. 	Staff recommends FULL HOUSE CONSIDERATION AS AMENDED. RESOLVED, The Medical Society of Virginia will oppose any legislation or ballot measures that could <u>penalize</u> criminalizes <u>obtaining</u> <u>or providing reproductive</u> <u>healthcare, including abortion</u> <u>services.</u> invitro fertilization, contraception, or the management of ectopic and molar pregnancies.

Opposing Restriction of Medically Appropriate Care

Submitted by Dr. Stuart Henochowicz and Dr. Renee Carter

- WHEREAS, the Supreme Court overturned the Roe v. Wade decision, which mandated the federal right to abortion, and
- WHEREAS, the court stated that decisions regarding abortion be left to individual states, and
- WHEREAS, the American Medical Association(AMA) has stated, "The American Medical Association is deeply disturbed by the U.S. Supreme Court's decision to overturn nearly a half century of precedent protecting patients' right to critical reproductive health care representing an egregious allowance of government intrusion into the medical examination room, a direct attack on the practice of medicine and the patient-physician relationship, and a brazen violation of patients' rights to evidence-based reproductive health services.", and
- WHEREAS, the AMA has further stated, "In alignment with our long-held position that the early termination of a pregnancy is a medical matter between the patient and physician, subject only to the physician's clinical judgment and the patient's informed consent, the AMA condemns the high court's interpretation in this case. We will always have physicians' backs and defend the practice of medicine, we will fight to protect the patient-physician relationship, and we will oppose any law or regulation that compromises or criminalizes patient access to safe, evidence-based medical care, including abortion."¹, and
- WHEREAS, the American College of Physicians joined the American College of Obstetrics and Gynecology, American Academy of Pediatrics, the American Psychiatric Association and the American Association of Family Practice- to state: "Our organizations have consistently opposed any legislation or regulation that interferes in the confidential relationship between a patient and their physician and the provision of evidence-based patient care for any patient—and this decision will allow states to gravely interfere in that relationship by penalizing and even criminalizing the provision of evidence based medical care^{"2}, and
- WHEREAS, the Supreme Court, in the Casey decision, upheld Roe v. Wade and held that viability of the fetus be the measure of abortion restrictions, and
- WHEREAS, reproductive rights for women in Virginia is essential, no matter the partisan makeup of the state government, and

¹ https://www.ama-assn.org/press-center/press-releases/ruling-egregious-allowance-government-intrusion-medicine

² <u>https://medsocietiesforclimatehealth.org/latest-news/joint-statement-five-consortium-members-dobbs-case/</u>

WHEREAS, 35% of Virginians felt that abortion should be legal under any circumstances, 53% felt that it should be legal under certain circumstances, and only 11% felt that abortion should be completely illegal³, and therefore be it

RESOLVED, that the MSV amends policy compendium 25.1.04 as follows:

25.1.04 – Opposing Legislative Efforts to Restrict the Provision of Reproductive Healthcare

The Medical Society of Virginia opposes any government mandated efforts to restrict the provision of medically appropriate care, as decided by the physician and patient, in the management of reproductive health.

Comprehensive reproductive health care includes the provision of contraceptive and abortion services. Furthermore, the Medical Society of Virginia opposes the restriction of abortion services before the onset of fetal viability.

The Medical Society of Virginia further opposes efforts which <u>criminalize or</u> enforce medically unnecessary standards on providers <u>clinicians</u> and clinics that in turn make it economically or physically difficult for doctors and clinics to provide services.

³ Roanoke College Poll looks at war in Ukraine, abortion and more, Dr. Taylor, David, June 3, 2022, https://www.roanoke.edu.

Staff Analysis – Resolution 22-207: Opposing Restriction of Medically Appropriate Care

Submitted by: Dr. Stuart Henochowicz and Dr. Renee Carter

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: Amend Policy 25.1.04. Define "comprehensive reproductive healthcare." Oppose criminalization of providing comprehensive reproductive healthcare, as defined. 	 25.1.04 – Opposing Legislative Efforts to Restrict the Provision of Reproductive Healthcare The Medical Society of Virginia opposes any government mandated efforts to restrict the provision of medically appropriate care, as decided by the physician and patient, in the management of reproductive health. The Medical Society of Virginia further opposes efforts which enforce medically unnecessary standards on providers and clinics that in turn make it economically or physically difficult for doctors and clinics to provide services. 	 Benefits Protects providers from being criminalized or fined Maintains patient-physician relationship Physicians still have autonomy as to the services they provide Drawbacks Not all physicians believe abortion to be considered healthcare Not all patients believe abortion to be considered healthcare Patients and providers that do not believe abortion is or should be considered healthcare have significant ethical concerns with the practice 	Staff recommends FULL HOUSE CONSIDERATION OF 22-206 AS AMENDED IN LEUI OF.

22-208 Resolution to Protect Evidence Based Medicine and Safeguard Medical Speech

Submitted by Zubair Hassan, MD

- WHEREAS. disinformation and misinformation spread by physicians is rampant. Ever since the onset of COVID-19 SARS2 epidemic, COVID-19 misinformation and disinformation has flooded the public discourse. In an annual survey of state medical boards, 67% of respondents said they had seen an uptick in complaints about licensees spreading false or misleading COVID-19 information. Florida's Surgeon General and Head of the Florida Department of Health, an internist, has spread doubt about the safety and effectiveness of COVID-19 vaccines, promoted the use of unproven and possibly dangerous medications for treatment of COVID-19 and questioned the use of face masks in preventing the spread of the pandemic. Simone Gold MD is the founder of America's Frontline Doctors. She and her group vigorously oppose vaccination and mask mandates and instead have promoted ivermectin and hydroxychloroquine for prevention and early treatment of COVID-19. Several other physicians in authoritative positions, with media access or strong social standing have made similar claims. "These physicians often couch their claims in technical language that sounds convincing to non-scientists. Lay people don't have the skill to debunk a lot of medical jargon" (Rachel Moran PhD). Misinformation initiated by physicians is amplified by conspiracy theorists in the media and by politicians for their own advantage, and
- WHEREAS, disinformation spread by physicians is a serious problem affecting our national health and economy and is causing great harm. Millions of dollars were spent in stockpiling and dispensing of hydroxychloroquine, and thousands of patients were exposed to its toxic and potentially lethal effects. It is estimated that approximately 300,000 preventable deaths may have occurred in the last 6 months of year 2021 due to lack of vaccination alone, and
- WHEREAS, the majority of physicians, various medical societies and the lay public denounce disinformation by physicians and demand that it be stopped. In a poll of 200 US adults, 78% said physicians who intentionally spread COVID-19 misinformation should be disciplined. This year the AMA House of Delegates adopted a new policy to counteract disinformation by healthcare professionals. The American Board of Medical Specialists released a statement in September 2021: "The spread of misinformation and the misapplication of medical science by physicians and other medical professionals is especially harmful as it threatens the health and wellbeing of our communities and at the same time undermines public trust in the profession and established best practices in care." Neither the lay public nor the medical societies, however, have the power to take any effective action, and
- WHEREAS, only the state medical boards can suspend or revoke medical licenses, but they are encountering political hurdles and are hesitant to take action despite an uptick in complaints. Many politicians are using medical disinformation for personal political gain under the guise of free speech and legislating to protect the speech of physicians who spread false medical information. Physicians however are constrained in their speech by their oath to "first do no harm," and other restraints. In Florida, legislators are trying to take away their medical board's authority to discipline physicians for spreading false COVID-19 information (Fla SB 1184). In Tennessee, legislators have introduced at least

7 bills to eliminate the medical board's authority to discipline physicians for such behavior. The medical boards are asking for guidance and help. Dr. Chaudhry, the President and CEO of the Federation of State Medical Boards has said that some state boards have told the Federation "We need a little more guidance.", and

- WHEREAS, a proposal is under consideration by the Virginia Legislature to equate naturopaths and other unscientific practitioners with physicians practicing evidence-based medicine by bringing those practitioners under the aegis of the Virginia Board of Medicine. We, the members of the Medical Society of Virginia, have lobbied successfully against this proposal; if we are to maintain our credibility, we must police ourselves and keep our ranks from being polluted by those who spread demonstrably false information without scientific evidence, therefore be it
- RESOLVED, that the MSV support that the Virginia Board of Medicine shall have the authority to suspend or revoke the license of a physician or other medical licensee who demonstrates unprofessional conduct by propagating medical misinformation or disinformation.

Ref: Rubin R. When physicians spread unscientific information about COVID-19. JAMA 2022;327(10)904-906

Fiscal impact; none

Existing Policy; none

Staff Analysis – Resolution 22-208: Resolution to Protect Evidence Based Medicine and Safeguard Medical Speech

Submitted by: Dr. Zubair Hassan

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: support that the Virginia Board of Medicine shall have the authority to suspend or revoke the license of a physician or other medical licensee who demonstrates unprofessional conduct by propagating medical misinformation or disinformation. Under VA Code § 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action, the Virginia Board of Medicine is empowered to: "Refuse to issue a certificate or license to any applicant; reprimand any person; place any person on probation for such time as it may designate; impose a monetary penalty or terms as it may designate on any person; suspend any license for a stated period of time or indefinitely; or revoke any license for any of the following acts of unprofessional conduct: False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or deceit in the practice of any branch of the healing arts." VA Code utilizes "fraud and deceit" language that can be applied to the 	25.3.02- Legislation, Standards of Care and the Patient/Physician Relationship The Medical Society of Virginia will oppose or work to favorably amend legislation, regardless of its primary intent, that interferes with or jeopardizes the sanctity of the patient/physician relationship or is in conflict with or contrary to broadly accepted, evidence-based standards of care identified by credible medical organizations such as the American Medical Association or the specialties and sub-specialties recognized by the American Board of Medical Specialties.	 Benefits Protects patients from potentially harmful medical misinformation or disinformation Drawbacks Definitions of misinformation and disinformation can be subjective among patients and physicians Board of Medicine is already empowered to perform such action, making this policy appear moot. 	Staff recommends NOT ADOPTING. The Virginia Board of Medicine is already empowered to investigate licensees and potentially suspend or revoke their licenses under § 54.1- 2915. Unprofessional conduct; grounds for refusal or disciplinary action. The "knowing standard" utilized by the Board of Medicine is satisfactory to discipline licensees knowingly spreading fraudulent or deceitful information that may harm patients.

spread of medical misinformation or disinformation.		
The Board uses what is legally referred to as a "knowing standard;" meaning that grounds for discipline are appropriate if an individual is knowingly spreading fraudulent or deceitful information.		

Licensure and Discipline – Dissemination of Misinformation

Submitted by Dr. Thomas Eppes

- WHEREAS, recent shifts in public sentiment after the Dobbs v. Jackson decision have advanced efforts to change medical licensure, hospital privileges, and insurance panels, and
- WHEREAS, the "Physician exercise of conscience: Opinion E-1.1.7" is a well-founded standard in the AMA Code of Ethics; now, therefore, be it
- RESOLVED the Medical Society of Virginia believes that when a physician's board certification is revoked on accusations of alleged professional misconduct for the dissemination of misinformation or disinformation that may threaten public health, such revocation should be based on a clear and convincing evidentiary standard.

Staff Analysis – Resolution 22-209: Health Care Policy Should be Based Upon Peer-Reviewed Research and Evidence-Based Practices

Submitted by: Dr. Thomas Eppes

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: believe that when a physician's board certification is revoked on accusations of alleged professional misconduct for the dissemination of misinformation that may threaten public health, such revocation should be based on a clear and convincing evidentiary standard. Under VA Code § 54.1-2915. Unprofessional conduct; grounds for refusal or disciplinary action, the Virginia Board of Medicine is empowered to: "Refuse to issue a certificate or license to any applicant; reprimand any person; place any person on probation for such time as it may designate; impose a monetary penalty or terms as it may designate on any person; suspend any license for a stated period of time or indefinitely; or revoke any license for any of the following acts of unprofessional conduct: 1. False statements or representations or fraud or deceit in obtaining admission to the practice, or fraud or deceit in the practice of any branch of the healing arts." 	25.3.02- Legislation, Standards of Care and the Patient/Physician Relationship The Medical Society of Virginia will oppose or work to favorably amend legislation, regardless of its primary intent, that interferes with or jeopardizes the sanctity of the patient/physician relationship or is in conflict with or contrary to broadly accepted, evidence-based standards of care identified by credible medical organizations such as the American Medical Association or the specialties and sub-specialties recognized by the American Board of Medical Specialties.	 Benefits Protects patients from potentially harmful medical misinformation or disinformation when it is based on a clear and convincing evidentiary standards. Drawbacks Definitions of misinformation and disinformation can be subjective among patients and physicians. Board of Medicine is already empowered to perform such action, making this policy appear moot. 	Staff recommends NOT ADOPTING. The Virginia Board of Medicine is already empowered to investigate licensees and potentially suspend or revoke their licenses under § 54.1- 2915. Unprofessional conduct; grounds for refusal or disciplinary action. The "knowing standard" utilized by the Board of Medicine is satisfactory to discipline licensees knowingly spreading fraudulent or deceitful information that may harm patients. ABMS already conducts similar investigations regarding Board certifications.

VA Code utilizes "fraud and deceit"		
language that can be applied to the		
spread of medical misinformation or		
disinformation.		
disimormation.		
The Board uses what is legally		
referred to as a "knowing standard;"		
releffed to as a knowing standard,		
meaning that grounds for discipline		
are appropriate if an individual is		
knowingly spreading fraudulent or		
deceitful information.		
decentiul information.		
ABMS already conducts similar		
investigations regarding Board		
investigations regarding board		
certifications.		

Health Care Policy Should be Based Upon Peer-Reviewed Research and Evidence-Based Practices

Submitted by Dr. Bruce Silverman, MD

- WHEREAS, current MSV policy "opposes any legislation that would restrain the appropriate use of needed medical services"¹ and that the MSV "will oppose or work to favorably amend legislation, regardless of its primary intent, that interferes with or jeopardizes the sanctity of the patient-physician relationship or is in conflict with or contrary to broadly accepted, evidence-based standards of care identified by credible medical organizations such as the American Medical Association or the specialties and sub-specialties recognized by the American Board of Medical Specialties"², and
- WHEREAS, legislation regarding medical practice is infrequently based on peer-reviewed evidence^{3 4}, thereby hindering, or even preventing physicians to "uphold professional autonomy and clinical independence as well as advocate for the freedom to exercise professional judgment in the care and treatment of patients without undue influence by individuals, governments or third parties" as outlined by the AMA Medical Code of Ethics⁵, and
- WHEREAS, legislation passed in many states that limit, impair and hinder physicians' ability to provide high quality care to patients or require ordering or performing unnecessary medical interventions⁶, and
- WHEREAS, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American College of Surgeons have agreed that legislative interference in medicine weakens the patient-physician relationship and undermines patient autonomy⁷, therefore, be it
- RESOLVED, that MSV reaffirms that the patient-physician relationship is the bedrock upon which all safe and ethical medical care is provided and all joint decision-making between a physician and a patient must be private and specific to the patient's condition(s), and be it further
- RESOLVED, that MSV encourages the passage and implementation of laws, regulations, health codes, medical practice standards and institutional/corporate rules that are evidence-based, evidence informed or are based upon consensus advisory opinion by recognized health care organizations with significant efficacy and value, as demonstrated by the best available evidence, including, but not limited to peer-reviewed scientific literature, and be it further

¹ Medical Society of Virginia Policy Compendium, Updated 2021-2022, Policy # 25.3.01

² Medical Society of Virginia Compendium, Updated 2021-2022, Policy # 25.3.02

³ Crowley DM, Scott JT, Long EC, et al. Lawmakers' use of scientific evidence can be improved. *Proceedings of the National Academy of Sciences*. 2021;118(9). doi:10.1073/pnas.2012955118

⁴ Cairney P, Oliver K. Evidence-based policymaking is not like evidence-based medicine, so how far should you go to bridge the divide between evidence and policy? *Health Research Policy and Systems*. 2017;15(1). doi:10.1186/s12961-017- 0192-x

⁵ American Medical Association. AMA-Code of Ethics; 2016. 6.

⁶ Weinberger SE, Lawrence HC, Henley DE, Alden ER, Hoyt DB. Legislative interference with the patient–physician relationship. *New England Journal of Medicine*. 2012;367(16):1557-1559. doi:10.1056/nejmsb1209858

⁷ Weinberger SE, Lawrence HC, Henley DE, Alden ER, Hoyt DB. Legislative interference with the patient–physician relationship. *New England Journal of Medicine*. 2012;367(16):1557-1559. doi:10.1056/nejmsb1209858

RESOLVED, that MSV opposes all criminal sanctions against physicians and the other medical providers who deliver, and the patients who receive care that is evidence-based, evidence informed or are based upon consensus advisory opinion by recognized health care organizations and has significant efficacy and value as demonstrated by the best available evidence, including, but not limited to peer-reviewed scientific literature.

RELEVANT AMA AND AMA-MSS POLICY

Regulatory Standards Should be Evidence-Based H-220.930

Our AMA will work through its representatives on the Joint Commission and with other deeming authorities and the Centers for Medicare & Medicaid Services to: (1) ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence; and (2) require that appropriate citations(s) from the peer reviewed scientific literature be appended to the documentation for every clinical standard imposed on health care institutions

Staff Analysis – Resolution 22-210: Health Care Policy Should be Based Upon Peer-Reviewed Research and Evidence-Based Practices

Submitted by: Dr. Bruce Silverman

Background	MSV Policy	Impact on Physicians/Patients	Staff Recommendation
 This resolution asks the MSV to: reaffirm that the patient-physician relationship is the bedrock upon which all safe and ethical medical care is provided and all joint decision-making between a physician and a patient must be private and specific to the patient's condition(s). encourage the passage and implementation of laws, regulations, health codes, medical practice standards and institutional/corporate rules that are evidence-based, evidence informed or are based upon consensus advisory opinion by recognized health care organizations with significant efficacy and value, as demonstrated by the best available evidence, including, but not limited to peer-reviewed scientific literature. oppose all criminal sanctions against physicians and the other medical providers who deliver, and the patients who receive care that is evidence-based, evidence informed or are based upon consensus advisory opinion by recognized health care organizations and the other medical providers who deliver, and the patients who receive care that is evidence-based, evidence informed or are based upon consensus advisory opinion by recognized health care organizations and the other medical providers who deliver, and the patients who receive care that is evidence-based, evidence informed or are based upon consensus advisory opinion by recognized health care organizations and has significant efficacy and value 	25.3.02- Legislation, Standards of Care and the Patient/Physician Relationship The Medical Society of Virginia will oppose or work to favorably amend legislation, regardless of its primary intent, that interferes with or jeopardizes the sanctity of the patient/physician relationship or is in conflict with or contrary to broadly accepted, evidence-based standards of care identified by credible medical organizations such as the American Medical Association or the specialties and sub-specialties recognized by the American Board of Medical Specialties.	 Benefits Protects patient / provider relationship. Protects physicians delivering evidence-based care. Specifically defines some credible medical organizations, which provide a north star for staff and leadership when interpreting policy. Upholds standards currently represented in MSV Policy Compendium. Drawbacks Blanket opposing all criminal sanctions against providers could put the MSV in the middle of some hotly contested issues, potentially dividing the membership. "health care organizations with significant efficacy and value" may be subjective. Duplicative of current policy. 	Staff recommends AMENDING MSV POLICY 25.3.02 The Medical Society of Virginia will-opposes efforts to or work to favorably amend legislation, regardless of its primary intent, that-interferes with or jeopardizes the sanctity of the patient/physician relationship. <u>The MSV supports or is in</u> conflict with or contrary to broadly accepted, evidence- based standards of care identified by credible medical organizations such as the American Medical Association or the specialties recognized by the American Board of Medical Specialties.

as demonstrated by the best available evidence, including, but not limited to peer-reviewed scientific literature.		



Delegate Handbook 2022 Resolutions Referred Back to the HOD

The following section contains a list of the resolutions referred back to the HOD

REFERED TO HOD FOR ACTION

19-111

Medical Care for the Terminally III

Originally Submitted by: Dr. Latane Ware

RESOLVED, that the MSV adopt a position of engaged neutrality with regard to medical aid in dying and amends Policy Compendium 25.2.04 as follows:

Physician Assisted Suicide and Euthanasia Medical Care of the Terminally Ill

In dealing with the terminally ill, suffering patient, physicians may ethically:

1. Withdraw life-prolonging procedures or decline to initiate such treatment in situations in which a patient is terminally ill and has given informed consent for this to be done either personally or through an advance directive, or in instances in which the patient is unable to give such consent it is obtained from an authorized family member or a surrogate.

2. Prescribe medication to a patient even though the potential exists for inappropriate use by the patient that may result in death., provided the physician's intent in prescribing such medication is not to cause death or to assist the patient in committing suicide.

3. In situations where the distinction between relieving suffering and causing a terminally ill patient's death may be blurred, the physician should exercise his/her best medical judgment in caring for the patient.

4. Withhold or withdraw treatment from a terminally ill patient that the physician reasonably believes to be futile either in terms of promoting or improving the health of the patient or alleviating the patient's suffering, provided the physician's purpose in so doing is not actively to cause the patient's death, but rather to allow death to occur with minimal suffering.

In accordance with the above statements (which are consistent with and supplemented by the views of the Council on Ethical and Judicial Affairs of the American Medical Association 2.17, 2.20 and 2.21), the Medical Society of Virginia strongly opposes the practice of physician assisted suicide or euthanasia.

In accordance with the above statements, the Medical Society of Virginia adopts a position of engaged neutrality toward medical aid in dying, which is the process whereby adult terminally ill patients of sound mind ask for and receive prescription medication that they may self-administer to hasten death.

Fiscal Impact: None

REFERED TO HOD FOR ACTION

Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness

Originally Submitted by: The Virginia Chapter of the American College of Physicians

RESOLVED, the Medical Society of Virginia supports removing licensure and credentialing application questions in the state of Virginia about health conditions that do not currently impair the physician's ability to practice medicine.



Delegate Handbook 2022 Consent Calendar: Informational Reports

- 1. MSV Board of Directors Actions on the 2022 Resolutions Referred to the Board
- 2. MSVPAC Report
- 3. MSV Foundation Report
- 4. AMA Virginia Delegation Report
- 5. MSV Medical Student Section Report
- 6. Virginia Board of Medicine Annual Report
- 7. Physician Assistant Section Report



MSV Health Policy Staff Report

The 2021 HOD directed the Board of Directors to assess and recommend action on resolution 21-107 - HIV Post-Exposure Prophylaxis, Recommendation 2 as amended, which reads:

RESOLVED, that the Medical Society of Virginia acknowledges the need for a more streamlined process of obtaining nPEP and should consider dedication of staff resources toward determining potential solutions. -including encouraging local emergency departments, especially those in rural areas, to regularly stock nPEP starter packs for those presenting to the emergency department with a substantial exposure risk and exploring options to allow pharmacies to immediately dispense nPEP starter packs under the oversight of a licensed physician, nurse practitioner or physician assistant.

MSV staff dedicated resources researching the above request in order to help the Board make an informed decision. Staff's research shows that HIV Post-Exposure Prophylaxis is a treatment that, to be effective, must be taken within 72 hours of exposure to HIV, especially if exposure was through sexual intercourse or needle sharing. Often, exposed individuals need access to PEP after physician office hours or may live in geographic areas where clinics are difficult to access. Current statute does not require hospitals to be stocked with HIV PEP; however, some hospitals may voluntarily have the starter pack in case an individual shows to the emergency room after HIV exposure.

Several states' health departments suggest individuals seek support from their local health department before going to emergency room for PEP. Some states have extensive support for accessing and paying for PEP, and some have specific hotlines for all things HIV. The Virginia Department of Health (VDH) has some information online related to HIV, HIV PrEP, and HIV PEP. VDH does have a hotline active during regular business hours Monday-Friday if someone is exposed to HIV. Not all Virginia hospitals may have a starter kit of PEP in stock. Access to PEP was expanded through legislation in 2021 and as a result, Virginia pharmacists can now prescribe and dispense HIV PEP with some restrictions.

MSV continues to support education around HIV. In August, MSV promoted a CME opportunity on HIV prevention and treatment strategies to all MSV members.

Recommendations

Staff believes there are avenues in which HIV PEP can be more easily accessible to individuals exposed to HIV, particularly because PEP is an emergency treatment and must be taken within 72 hours of HIV exposure. Should there be interest from the membership to seek solutions to streamline PEP accessibility, staff can dedicate additional time to research. If the Board desires for staff to work on this, the resolution does not need to move forward—as such action is within the Board's discretion. The HOD did adopt the author's first resolved clause as policy at last year's annual meeting:

40.7.07- HIV Post-Exposure Prophylaxis

Date: 10/23/2021

The Medical Society of Virginia supports increased access to, and coverage for physician-supervised Post-Exposure Prophylaxis (PEP) for HIV, as well as enhanced public education on its effective use

Staff believes the above policy is sufficient for the needs of the author, and the Board may consider whether to make expanding access to PEP a staff priority for 2023.



MSV BOARD OF DIRECTORS

Report: 21-201: Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness

MSV Health Policy Staff Report

The 2021 HOD voted to request the Board of Directors recommend action on resolution 21-201 titled Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness, which reads:

RESOLVED, the Medical Society of Virginia supports limiting licensure and credentialing application questions in the state of Virginia to asking about conditions that currently impair the physician's ability to practice medicine.

Removing a question regarding physician mental health from the Virginia state medical license application was a priority recommendation of the 2021 MSV Advocacy Committee and was subsequently approved by the MSV Board of Directors in September 2021. As a direct result of this action, MSV composed a letter to Dr. William Harp, Executive Director of the Virginia Board of Medicine, expressing concern that the presence of such a question may discourage physicians from seeking treatment for their mental health.

The MSV Board of Directors discussed this resolution during its December Board 2021 meeting. At the time, the Board of Medicine was still considering the MSV's suggestion concerning the presence of the mental health question on the state licensing application but had indicated a willingness to working toward an appropriate solution. As a result, the MSV Board took no formal action on the issue at the meeting but did ask that MSV staff continue conversations with Board of Medicine leadership.

The Board of Medicine referred the issue to its Credentialing Committee for consideration. Dr. David Brown, Director of the Department of Health Professions, offered that while the questions currently asked by the Board on initial license applications have been deemed ADA-compliant by the Attorney General's office, the fact that MSV has reached out to the Board regarding this issue is indicative that the Board needs to ensure that it has language that serves its purpose of public protection and avoids language that might discourage physicians and other health care professionals from seeking needed treatment.¹ The committee ultimately made several recommendations to the full Board of Medicine, including amending the question, adding language on the application supportive of physicians seeking mental health treatment and care, and increasing physician education on the issue in conjunction with the MSV Foundation.

At the next full Board of Medicine meeting, Dr. Jacob Miller, Chair of the Credentials Committee, offered the recommendation that the Department of Health Professions counsel and policy staff review and amend the licensure questions based on the recommendations of the committee. Several members of the Board indicated interest in combining the mental health and physical health questions into one question, thus removing any stigma differentiating between physical or mental health conditions. While no formal action on the question was taken at the meeting, Department staff indicated they would, at the recommendation of the committee and the Board, dedicate resources into researching possible solutions.

¹ Virginia Board of Medicine Credential Committee Meeting from June 7th, 2022.

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On August 26, 2022, MSV staff spoke with Dr Brown regarding the mental health question issue. Dr Brown indicated the change was in process and he had every intention of completing the language change on all applicable DHP licensure applications. Dr Brown did share the DHP staff was overburdened, but he believed the change would be completed in the next few months.

Recommendations

Staff believes that the MSV Board's decision to allow collaboration between the MSV staff and the Board of Medicine to continue following the priority recommendation from the MSV Advocacy Committee has yielded a positive result as it relates to the mental health questions on state licensure application. The issue of these questions appearing on credentialing applications remains outstanding. Therefore, staff recommends the Board put forward the resolution as written to the 2022 HOD.



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www.msvpac.org

October 3, 2022

Dear MSV Colleagues,

I am pleased to provide you with a summary of the developments the MSVPAC has undertaken this year. Please note that we have several campaigns and events in development. Once they are completed, you will receive an updated report with those activities included.

New Prospectus and Year in Review Documents

The MSVPAC needed to have appropriate fundraising docs that show donors what they are funding and how their funds are used and recognized. The MSVPAC prospectus, the first of its kind for this PAC, shows sponsorship opportunities throughout the year so practices can align their dollars with their interests. The Year in Review document is a living document that shows, in simple terms, how the MSV Government Relations team wins on behalf of physicians and PAs as well as the looming threats to the practice of medicine in Virginia.

Studies show that people need at least 6 touches, contacts from a solicitor, to recognize the importance of an issue and decide whether or not to take action – in this case that means to donate, sign up for lobby day, or get involved. These documents help us reinforce the importance of the MSVPAC throughout the year.

Large Practice Outreach

Individual donors are important and show a measure of interest and support. However, the lions share of the MSVPAC funds come from large practices. Since 2015, 28 large practices have donated to the MSVPAC. Three donated in 2021. If the PAC will meet its disbursement goals, we must engage with leadership at large practices and get those donations back online.

Those 28 large practices have each received solicitations by post, email, phone call, and in person if located in the Richmond region. They have also been offered personal legislative updates in person or by zoom by Clark Barrineau.

The MSVPAC board is now reaching out to colleagues and contacts at those practices to follow up. Each practice will receive at least 6 contacts by the years end. And we'll continue to do the same next year.

Legislative Town Halls/ Legislative Updates

MSVPAC hosts legislative town halls not as a fundraiser – donations are not solicited during these calls – but to keep interested contacts in the know with recent policy developments affecting their business. This also provides the MSV government relations team a chance to hear what issues they are facing to see if we can fix them.



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To-date, we have hosted 4 town halls. This is up from zero last year. The goal is for each large practice to receive at least one personal legislative update and then join the pre session calls, and calls during the general assembly session.

Docs and Hops

Last year, the MSVPAC hosted a single Docs and Hops event in Richmond attended by 8 people. This year, we hosted three Docs and Hops events in Norfolk, Richmond, and Charlottesville. MSV and MSVPAC leadership hosted each event with a total of 42 attendees – 18 of which were students or residents.

Holland Award

The Holland Award recognizes MSV members who both leaders in the practice of medicine and dedicate their talents to promoting good-pro physician policies in Virginia. This honor is recognized at the Annual Meeting every year since 2000. Hancock, Daniel, & Johnson has decided to sponsor this award this year and in years to come. This is a huge boost to the award and the Political Action Committee.

Fundraising Update

The MSVPAC has received contributions from over 138 physicians, students, and practices in Virginia for over \$35,070. At this point last year 77 donors totaled \$46,000 raised. The PAC board voted to give a total of \$55,000 to incumbents who support our legislative efforts in the 2022-2023 legislative cycle.

The MSVPAC has \$209,224 in the reserve fund.

For reference:

2016: The MSV PAC contributed \$147,000
2016: The Virginia Trial Lawyers Association contributed \$232,683
2016: The Virginia Hospital and Healthcare Association contributed \$287,056
2020: MSV PAC contributed \$59,070
2020: The Virginia Trial Lawyers Association contributed \$266,104
2020: The Virginia Hospital and Healthcare Association contributed \$90,117

MSV PAC Board Recruitment

The PAC lost long time leader, Sterling Ransone in 2021 and Dr. Trish Anest in 2022. Those positions are being replaced by Dr. Richard Sparks of Williamsburg and Dr. Peter Kemp who is rejoining.



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Conclusion

We will be making a concentrated year end push to meet our PAC goal for 2022. If you can contribute or offer any ideas, please reach out to myself or Drew Densmore on the MSV staff.

Dr. Lee Ouyang

Chair, MSV PAC



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www.msvfoundation.org

Date: September 30, 2022

To: MSV Delegates

From: MSV Foundation Staff

Subject: MSV Foundation Update- Key Foundation Programs, Activities, Outcomes

Programs:	
	Program Description: The Virginia Mental Health Access Program (VMAP) is a statewide initiative that helps health care providers take better care of children and adolescents with mental health conditions through provider education and increasing access to child psychiatrists, psychologists, social workers, and care navigators.
	MSVF is the Contract Administrator for VMAP and collaborates with the Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Department of Health (VDH), and numerous other partners to expand the program statewide through the establishment of five regional hubs that will deliver key program goals.
Virginia Mental Health Access Program (VMAP)	In the 2019 General Assembly, VMAP was awarded \$1.2 million to build out regional hubs in the northern and eastern regions of the state. The 2020 General Assembly awarded VMAP an additional \$4.2 million dollars to implement hubs in the remaining regions of the state. This funding allowed VMAP to expand statewide, providing primary care providers (PCPs) who treat children and adolescents access to mental health training and education, regional child psychiatry/psychology consultation, and regional care navigation services. Additionally, VMAP is in the fourth year of a five-year HRSA grant providing \$445,000 a year to fund its education programming and other elements of the program.
	Over the last year, VMAP expanded statewide to implement regional hubs in the northern, eastern, central, western, and southwestern regions of the state. These hubs (7 contracted institutions) consist of regional teams available to consult with PCPs via the VMAP line. Teams include child and adolescent psychiatrists, licensed mental health professionals, and care navigators. To date, the VMAP line has received over 3,000 calls from PCPs treating children and adolescents throughout the state. VMAP has also expanded its pediatric mental health education and training opportunities for PCPs statewide, training over 700 health care providers.
	In the 2022 General Assembly, VMAP requested \$2.8 million in state funds to expand its services to provide additional supports for PCPs treating patients ages 0-5 and emergency room providers. VMAP received half of the requested amount (\$1.4 million) and is currently working to expand the program to these new focus areas.



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	Program Description: SafeHaven [™] is a program which supports the needs of clinicians struggling with stress, burnout and the effects of COVID-19. The program offers clinicians a comprehensive set of well-being resources they can use without risk to their medical license.
Safe Haven™	The SafeHaven [™] program has continued to expand throughout Virginia and the nation during 2022. To date, we have over 5,500 clinicians (physicians, PAs, residents, NPs, and nurses) enrolled in the program. SafeHaven's utilization rates continue to be viewed as the highest utilization rates for a physician focused wellness program in the country, with a current total utilization rate of 48%, and a 17% utilization rate for those seeking peer coaching or counseling.
	In addition to the increased number of enrollees, SafeHaven [™] has received significant national press during 2022. Press highlights include the program being featured in the September 2022 edition of Medical Economics, a second legislative issue brief published by AMA, and an article by AMA noting the value and importance of SafeHaven [™] featured on the AMA website homepage.
	As we look towards 2023, the SafeHaven [™] team will continue to focus on expansion of the program in Virginia with more groups and systems enrolling. The second focus will be expansion across the country by partnering with state medical societies to introduce and pass the SafeHaven [™] legislation and the SafeHaven [™] program resource set.
	To learn more about SafeHaven™, please visit <u>www.SafeHavenhealth.org</u>
Physician Leadership Institute	 Program Description: A program aimed at early-stage physician leaders focusing on building interpersonal skills, business/system literacy, and innovation/leading change. Participants are asked to complete a capstone project and assigned a physician mentor for continued development. 2-year, \$150,000 grant awarded from The Physicians Foundation to fund the 2021 and 2022 cohorts of the Physicians Leadership Institute. 2021: In-person weekend intensive program held in Williamsburg, VA in Nov with (12) early-stage physician leaders participating. Dr. Mark Townsend facilitated the weekend. 22 hours of CME provided Follow up activities have included pairing with "seasoned" physician mentor, participation in White Coats on Call, and an applied leadership capstone project to be presented at the MSV annual meeting. 2022: Thursday November 10th – Sunday November 13th for a weekend intensive program at MSV headquarters in Richmond, VA. Program will focus on soft skills, the business of healthcare, advocacy, innovation, and leading change. Register at: https://www.msv.org/pli-application/
Chronic Care	Ongoing collaboration with VA Pharmacists Assn and Health Quality Innovators
Management	offering turnkey support to implement a Chronic Care Management (CCM)
Initiative	Program. Aimed at independent physicians who are paired with pharmacy partner.
In partnership	Program is no cost and starts with 4-month trial. Support includes assembling
	Program is <u>no cost</u> and starts with 4-month trial. Support includes assembling team, workflow, EHR inclusion, and analysis. Open to <u>any</u> independent practice. Email <u>foundation@msv.org</u> for info and registration details.



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SYNC Interprofessional Leadership Program In partnership with VHHA, VNA, VDH, and VPhA	 Program Description: A healthcare <u>team-based</u> program teaching skills in interprofessional collaboration, creative problem solving, leadership, and wellness. Teams complete a self-selected <i>Capstone Project</i> to apply learned skills. Applicable to internal teams or clinical-community team 8th offering will be held October 2022 thru March 2023 (5) ½ day virtual sessions and (1) in person day comprise the program CME, Nursing and Pharmacy education credit offered Full tuition scholarships offered to teams that focus their project on initiatives in Diabetes, Hypertension/Stroke/High Blood Cholesterol/Heart Disease, Alzheimer's/Related Dementia, Cancer, Arthritis and share results with VDH Program is in collaboration with VHHA, VNA, VDH, VPhA
Vaccine Hesitancy (through CDC grant)	 Program Description: Through a CDC Foundation grant, MSVF has partnered with Dr. José Morey, Ad Astra Media and Eastern Virginia Medical School (EVMS) to create and provide a virtual reality (VR) experience to distract and engage children when getting a vaccine, with the goal of improving vaccination rates and protecting children and their families. Oculus units with the VR application and COVID-19 vaccines were available to two back-to-school events in the Hampton Roads region. Additional events in September and October are being identified to provide the VR experience alongside vaccines. The CDC Foundation highlighted the project through a September social media campaign.
Self-Measured Blood Pressure Monitoring Program (through VDH grant)	 Program Description: Through a VDH grant, MSVF provided self-measuring blood pressure (SMBP) monitors (no charge) to practices/clinics in priority areas with high hypertensive disease rates in exchange for data sharing on effectiveness. SMBP units were provided to St. Luke's Community Clinic, Johnson Health Center, EVMS Primary Care Internal Medicine, Institute for Advancement of Women's Health, Sheltering Arms, and Mother of Mercy Free Clinic Program resources set up: www.msv.org/smbp Free text messaging program was offered to patients where they receive reminders, motivation, and healthy tips (<i>heartBEAT Program</i>) Some Results: <u>EVMS Primary Care</u>: 18 patients participated for (6) months. Overall Ave: (-9) Systolic (-8) Diastolic; 67% - decrease in systolic 84% - decrease in diastolic Inst for Adv of Women's Health: 21 patients participated for (6) months. Overall Ave: (-7) Systolic and (-4) Diastolic; 76% had decrease in systolic and 71% had decrease in diastolic <u>St. Luke's Free Clinic</u>: 10 patients participated. Overall Ave (-12) Systolic and (-11) Diastolic. <u>Johnson Health Center (FQHC)</u>: part of extensive initiative across (9) locations



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Stroke Smart Initiative In partnership with Bon Secours (through VDH grant)	 Partnering with Bon Secours to develop and deliver a "Stroke Smart Medical Practice" campaign, building stroke awareness and literacy among patients and office staff to maximize positive outcomes. Areas targeted include Petersburg, Emporia, Chester & surrounding areas where there is a high prevalence of stroke. Program focus is: Patient education – providing self-serve wallet cards & magnets, displaying posters, creating a video to be shown (stroke signs and importance of calling 911 vs. going to primary care) Front Desk Staff Education (recognizing signs and when to triage a call) Intake - providing materials to high-risk patients Discussions with Inova in process; VCU is planning to initiate a program as part of a SYNC Program capstone project "Stroke Smart" Magnets and Wallet Cards <u>available</u> for <u>ANY</u> practice, hospital
CME Accreditation	 Program Description: The MSV is a Recognized Accreditor of the Accreditation Council for Continuing Medical Education (ACCME), which gives the MSV authority to accredit state-based providers of medical education. Accredited providers can then provide physician education that grants AMA PRA Category 1 CME credits. As a Recognized Accreditor, MSV adheres to ACCME's (5) Markers of Equivalency, showing equivalence in accreditation rules, processes, interpretation, outcomes, and process improvement. MSV currently has (5) accredited providers in Virginia: Carillion Clinic, Inova, Sentara Healthcare, SOVAH Danville, and Winchester Medical Center. Accreditation terms are for (4) years; if a provider achieves Accreditation with Commendation, the term is (6) years. Riverside Hospital allowed their accreditation to expire intentionally and voluntarily. As a very small program, they will provide their CME through joint providership with another health system. Sentara Healthcare's current accreditation term expires in December 2022. Their reaccreditation survey interview was conducted on September 14. The accreditation process is overseen by the MSV's Intrastate Accreditation Committee (IAC), chaired by Fred Parker MD. The process follows that of the ACCME, with providers completing a Self-study application and submitting 8-12 activity files for review by trained surveyors. Accreditation decisions are made by the full IAC. Current program improvement efforts include: Updating and revising MSVF's accreditation policies so that they more closely align with those of the ACCME; Ensuring IAC members have the knowledge, skills, and competence to perform reaccreditation surveys and to make accreditation decisions; and, Updating the MSV CME department webpages.



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Development:	
Grants Update	 \$287,500 grant with VDH as part of Living Well Grant Award from CDC (June 30, 2022 – June 29, 2023). Grant focuses on initiatives in chronic disease in high burden populations. Physicians Foundation - \$150,000 over 2 years for PLI (ends 2022) Awarded \$80,000 grant from CDC Foundation to study vaccine hesitancy in children. One of eight organizations that received an award.
Physicians Gala	Confirmed sponsor dollar amount: \$210,050 so far. We met our 2022 goal!
Salute to Service	• All STSA winners have been selected, and videos will be shown at Gala.
Awards	
Development	 2022 totals: \$244,442.19- money (sum of charges) 1820 - \$2,650 Medical Student sponsorship: \$1,147.99 Gala contributor: \$201,850 Corporate gift: \$6,073.20
Development	 Corporate match: \$1,500 Personal gifts: \$22,063 MSVF Pledge: \$250 Raffle Ticket: \$2,950 SafeHaven: \$3,121 VMAP: \$617
	 Recurring Gift: \$2,225 Wine tasting event: \$1,800 Trivia: \$110.00 MSVF Bingo card - \$70 MSVF Endowment - PA student fund - \$2,250 MSVF Endowment - Medical Student fund - \$150 Gala - Friend of the MSVF ticket - \$5,750 Gala - tickets - \$8,850
	 Development News 2022 Annual campaign – We are following up with all the members who donated in 2021, but not in 2022. We have \$100% board participation for MSVF and are lacking four members for 100% board participation for MSV. Endowment & planned giving campaigns – had a successful kickoff at Dr. Nanda's house in June. Members who have given to our endowment are Monroe G. Baldwin, Jr. MD; Arturo P. Saavedra, MD, PhD, FAAD, MBA; Kathleen Scarbalis, PA-C, MPAS; Anthony Miller, PA-C, and Thomas W. Eppes, Jr., MD. Trivia Night – postponed to January Virtual Cooking classes – postponed until March. MSVF BINGO starts May 6th and goes until early October. Members get blocks for participating in MSVF events, get a BINGO and win prizes.

MSV ANNUAL MEETING 2022 AMA Virginia Delegation Report



Your Virginia Delegation is proud to represent you in the AMA House of Delegates, which is the policymaking body of American medicine. The AMA House of Delegates has representation from state societies, specialty societies, public health organizations, military medicine, and academic medicine. We strive to work by consensus in a collegial fashion as we debate health policy and medical ethical issues. We strive to diligently support science and public health and promote excellence in academic medicine. We always try to advocate for policies which are in the best interest of our patients and promote the integrity of our profession.

For the first time since the beginning of the pandemic we were able to meet in person at the national meeting in Chicago. It was a blessing that our delegation was able to gather with their colleagues from other states to continue advancing our policymaking agenda. We have continued hybrid advocacy efforts as we represent you on Capitol Hill through in person and virtual lobbying. We maintain strong relationships with our Virginia congressional delegation and continue to advocate for our issues with national policymakers.

Your AMA Delegation elected new leadership earlier this year and Dr. Thomas Eppes was chosen to serve as the next chair of the Virginia delegation. Dr. Eppes, a long-time member of the AMA, brings with him a wealth of knowledge and years of advocacy experience – he will serve the delegation well in the years to come. Dr. Clifford Deal will continue serving as vice chairman of our delegation. Dr. Claudette Dalton, the most recent past chair of the Southeast Delegation of the AMA, and now serves as an SED board member. Dr. Dalton continues to provide exceptional leadership at the AMA at a senior level position. Dr. Alice Coombs continues to serve us with distinction as a member of the AMA Council on Medical Service. We would like to congratulate Dr. Cynthia Romero for she is now serving as delegate for Virginia. Dr. Joel Bundy graciously stepped up and served as delegate for the June Annual meeting. Dr. Pandya continues his work with the International Medical Graduates Section, offering his experiences as he is an IMG himself. Lastly, we'd like to thank Dr. Ed Koch for his years of service at the AMA and our Virginia Delegation. Dr. Koch has decided to retire as he and his Wife Kathy are building a house in Florida and will be moving within the near future.

Virginia representation at the AMA is continuing to show strong growth. Dr. Josh Lesko now serves as an alternate delegate or the American College of Emergency Physicians. Dr. Lee Ouyang, our MSV PAC Chair, also serves as a delegate of the Young Physicians Section and was a great mentor to our student representatives this past meeting. The AMA student section continues to grow. Lavinia Wainwright, 2nd year at EVMS, serves as a Regional 6 delegate to the AMA HOD and Shaylyn Fahey, 2nd year at VTC, serves as the alternate delegate for Region 6. We are currently preparing for the interim AMA House of Delegates meeting this November in Honolulu, Hawaii. We have participated with other states and specialty societies deliberating several resolutions which are being proposed at this upcoming meeting and we look forward to convening in just over two weeks.

We continue to benefit from strong health policy support provided by Scott Castro, Chris Fleury and Valentina Vega from our health policy team. Jenny Young continues to be invaluable to our leadership development initiatives and promotes Delegation involvement with our young physicians, residents, and medical students. Melina Davis has represented us admirably at the AMA House of Delegates and is well respected by other state executives.

These are certainly challenging times in American medicine. Your MSV AMA Delegation looks at these challenges as opportunities for sound policy development. We encourage you to consider AMA membership and AMPAC political contributions. We feel very privileged to represent you at the AMA, and we appreciate your ongoing support of the important work of the Delegation.

Respectfully submitted,

Thomas Eppes, MD Chair, Virginia Delegation to the AMA

MSV	MEDICAL SOCIETY OF VIRGINIA
Date	October 1, 2022
To:	MSV House of Delegates
From:	Caitlin <i>Hodges</i> Blaukovitch, MSV Medical Student Section Chair Liberty University College of Osteopathic Medicine
Re:	Medical Student Section Annual Report, 2021-2022

On behalf of the Medical Student Section (MSS) of the Medical Society of Virginia (MSV), I would like to thank the House of Delegates for their continued support of the section and our chapters at Eastern Virginia Medical School (EVMS), Liberty College of Osteopathic Medicine (LUCOM), University of Virginia (UVA), Virginia Commonwealth University (VCU) Edward Via College of Osteopathic Medicine (VCOM), and Virginia Tech Carilion (VTC).

I am honored and proud to write to the House of Delegates on behalf of our MSS. The opportunity to take part in this organization has proven vital to our section's efforts in developing essential skills to become strong advocates for our future patients and profession. It has always been a privilege to work alongside the students and staff of the MSV.

While our in-person events were halted in 2021 due to the COVID-19 pandemic, MSV is still making a tremendous impact for its medical student members. We are excited to have been able to begin in-person events beginning in the 2022-2023 academic year. Any opportunity to network with physician leaders of MSV is always an impactful experience for our peers.

AMA + MSV Medical Student Retreat – Distinguish Yourself Series

My peers and I are honored to partner with AMA to pilot the first ever joint medical student retreat between AMA and a state medical society. The event took place in Charlottesville on Saturday, October 1st with over 80 medical students representing Virginia's 6 medical schools in attendance. We sincerely appreciate the physician leaders who took time out of their weekend to share wisdom, guidance and insight as we enter the profession. We are especially grateful for Dr. Clifford Deal, Dr. Cynthia Romero, and Dr. Sandy Chung who served as keynote speakers for the retreat. I know my peers and I will remember the wisom shared for years to come.

I speak on behalf of my peers in saying that the conversations and interactions with MSV's physicians have made our experiences with MSV both significant and effective. I am honored to be a part of an organization where the leadership has embraced our section, a sentiment that our students will engender in their roles as future physician leaders. In interacting with many of my counterparts across the country at national AMA MSS meetings, I have seen first-hand how fortunate we are to be members of the

MSV. We have been given many opportunities and much support that is not always available in other states.

It is with sincere gratitude that I thank the leadership and staff of the Medical Society of Virginia for its continued support. We would like to extend a special thank you to Jenny Young, whose guidance, support, and leadership remains essential to our continued success.

The relationships we build in the MSS, both with one another and with the physicians in the MSV, are indispensable. They have proven to be an integral part of not only my medical school experience, but that of many of our members as well. Thank you, once again, for your support - it has allowed us to establish Virginia medical students as a robust and capable section, an envy at both state and national levels.

Respectfully, Caitlin *Hodges* Blaukovitch

Board of Medicine Report to the Medical Society of Virginia September 28, 2022

- The Virginia Board of Medicine is comprised of 18 members appointed by the Governor. There is 1 MD from each of the 11 Congressional Districts plus 1 DO, 1 DPM and 1 DC at large. Additionally there are 4 citizen members.
- 2. This year, the Board bid a fond farewell to Jim Arnold, DPM, Amanda Barner, MD, Milly Rambhia, MD, Brenda Stokes, MD, and Khalique Zahir, MD. Their successors are Randy Clements, DPM of Roanoke, Peter Apel, MD of Roanoke (6th Congressional District), Hazem Elariny, MD of McLean (8th Congressional District), William Hutchens, MD of Great Falls (11th Congressional District), and Krishna Madiraju, MD of Ashburn (10th Congressional District).
- 3. The officers of the Board for 2022-2023 are President Blanton Marchese, citizen member of Chesterfield, Vice-President David Archer, MD, OB-GYN of Norfolk, and Secretary-Treasurer Alvin Edwards, MDiv/PhD of Charlottesville.
- 4. The Board of Medicine has 11 Advisory Boards to assist with matters of the professions that do not have representation on the Board of Medicine. The Advisory Boards are Acupuncture, Athletic Training, Behavior Analysis, Genetic Counseling, Midwifery, Occupational Therapy, Physician Assistants, Polysomnographic Technology, Radiological Technology, Respiratory Therapy, and Surgical Assisting.
- 5. Since the end of the declared emergency in Virginia on June 10, 2021, Board meetings, Advisory Board meetings, Committee meetings and Work Groups have all been held in-person at the Perimeter Center.
- 6. The Board of Medicine issues licenses for 19 professions and certification for 1 profession, Surgical Technology. Additionally, it jointly licenses and regulates Nurse Practitioners and Licensed Certified Midwives with the Board of Nursing.
- 7. In December 2018, the Board of Medicine introduced licensure by endorsement. Endorsement is an abbreviated and more expeditious pathway to licensure for experienced physicians with no adverse information. To date, 1,662 licenses have been issued by endorsement, which represents approximately 12% of physician licenses in the last 3 years.

- 8. In the fall of 2021, the Credentials Committee of the Board leveraged the experience gained from expedited licensing that was implemented during the declared emergency for MD's, DO's, DPM's, PA's and Respiratory Therapists. The principles learned have been applied to all the Board's professions, thereby streamlining the application process while still providing protection for the public.
- 9. The Board worked with the Medical Society of Virginia to review the Board's mental health questions on its initial applications, as well as the broader issue of physicians and other healthcare professionals being reluctant to seek mental health treatment for fear of an action on their license. The Credentials Committee reviewed the mental health questions and made recommendations to the full Board and to the Director of the Department. An article was placed in the Board Briefs, and then again emailed to all licensees to clarify that the Board was in full support of licensees seeking necessary mental health treatment.
- 10. On July 1, 2020, law required that all prescriptions containing an opioid are to be transmitted to a pharmacy by electronic means. This does not include telephone or fax. The law does provide for a one-time waiver of 1 year for demonstrated economic hardship, technological limitations beyond the licensee's control, or other exceptional circumstances. COVID-19 affected the economics of physicians' practices and in some instances, pushed the horizon for getting technological support to comply with the law much further out. To date, there have been 2,106 waivers granted.
- 11. Since last year's report to the Medical Society of Virginia, 1,912 complaints have been lodged against Board of Medicine licensees. In the past year, the Board has taken 157 disciplinary actions, including 8 summary suspensions, and 22 mandatory suspensions. Summary suspensions are urgent Orders that immediately remove a licensee from practice. Mandatory suspensions occur when a licensee has been convicted of a felony or suspended by another state board.
- 12. The 2022 Session of the General Assembly passed a number of bills impacting licensees of the Board including: the sunset of the requirement to obtain 2 hours of Continuing Education on opioids each biennium for renewal; expansion of the number of Behavioral Health Nurse Practitioners per Patient Care Team Physician from 6 to 10; Physician Assistants serving as medical examiners not needing to have a practice agreement with a Patient Care Team Physician to serve in that capacity; an extension for Surgical Technologists "grandfathering" into certification until the end of 2022; authorization for out-of-state practitioners to provide telemedicine services to Virginia patients with whom a physician-patient relationship has already been established; authorization for a Virginia hospital to employ for 90 days an out-of-state healthcare provider who does not hold a Virginia license; and for the Board to develop Statewide Pharmacy Protocols for pharmacists to initiate or administer treatment for Tobacco Cessation therapies, COVID-19 vaccines, and COVID-19 testing.
- 13. This year, the General Assembly designated the Board of Medicine the lead for the Statewide Pharmacy Protocols Work Group. On the Work Group were 3 Board of Medicine members, 3 Board of Pharmacy members, a physician and a pharmacist from the Virginia Department of Health. With the help of Board of Pharmacy staff and the Senior Policy Analyst for the Department

of Health Professions, protocols were derived to implement the law, guide pharmacists, and protect the public. There are now 13 protocols authorizing pharmacists to initiate treatment.

- 14. Ophthalmology participated with the Board of Optometry's Therapeutic Pharmaceutical Agents Committee to address the use of pilocarpine ophthalmic solution and varenicline nasal spray by optometrists.
- 15. Ophthalmology participated with the Board of Optometry's Regulatory Advisory Panel to develop criteria for the certification of optometrists to perform laser surgery, specifically peripheral iridotomy, selective trabeculoplasty, and YAG capsulotomy.
- 16. The Board has been in discussion with the District of Columbia Board of Medicine and the Maryland Board of Physicians about establishing reciprocal licensing for physicians amongst the 3 jurisdictions. Reciprocal licensing would be an expedited pathway for physicians that have offices and patients in more than one jurisdiction. The process is at the Memorandum of Agreement stage. The earliest that reciprocal licensing can begin is January 1, 2023.
- 17. The Joint Commission on Health Care conducted a review of the Interstate Medical Licensure Compact and included Board of Medicine staff, the Board President, Department of Health Professions staff and others. Sections of the report included: current licensing by the Board; how the Compact would affect physicians and the workforce; legal concerns; and other strategies to accomplish the same goals as the Compact. Virginia's pursuit of reciprocal licensing with the District of Columbia and Maryland was mentioned.
- 18. The Office of the Chief Medical Examiner has reported that: 1) There has not been a significant increase or decrease in fatal prescription (Rx) opioid overdoses over the 15-year time span from 2007 to 2021 and 2) fentanyl (prescription, illicit, and/or analogs) caused or contributed to death in 76.4% of all fatal overdoses in 2021.
- 19. Every 4 years, the Board of Medicine must review its regulations and guidance documents to see if revisions, additions, or deletions are required. The Youngkin Administration seeks a 25% reduction in regulations, especially those which are not mandated by law. The review process has begun for the Board of Medicine and its Advisory Boards.
- 20. The Department of Health Professions is moving towards paperless licensing. Your last paper license was issued in the 2020 renewal cycle. With your renewal notice in 2022, there will be information indicating that paper licenses will no longer be issued along with instructions that the current status of a license can be found real-time on <u>License Lookup</u>. All hospitals, health care organizations, and others can be directed to License Lookup for the real-time status of a license. Going forward, renewal notifications will also be paperless. So be sure that the Board of Medicine has your correct email address to send the e-notification. Only those that do not have an email address will be sent a paper notification.
- 21. The Department of Health Professions held 2 meetings with representatives from the 3 groups of midwives Certified Nurse Midwives, Licensed Midwives, and Licensed Certified Midwives to

discuss the optimal regulatory approach. Ideas included a Board of Midwifery and an Advisory Board on Midwifery under the Board of Nursing. Licensed Midwives are currently regulated by the Board of Medicine and indicated they would prefer to stay with the Board of Medicine.

- 22. The Office of the Secretary of Health and Human Resources held a meeting of various stakeholders to review the progress of electronic submission of opioid prescriptions to pharmacies. Data showed that 97.7% of Virginia pharmacies were able to accept e-prescriptions, which was slightly higher than the national percentage. For prescribers, Virginia was at 84.5%, which is well behind the national rate of 95.1%.
- 23. The following tables show the Board of Medicine professions and their current numbers.

Board	Occupation	State	License Status	License Cou
Medicin				
Medicin	Assistant Behavior Analyst			
		\//l-l-	Oursel Author	044
	Assistant Behavior Analyst Assistant Behavior Analyst	Virginia Virginia	Current Active Current Inactive	214 2
	Assistant Behavior Analyst	Out of state	Current Active	31
	Total for Assistant Behavior Analyst			247
	Athletic Trainer			=
	Athletic Trainer	Virginia	Current Active	1,483
	Athletic Trainer	Virginia	Current Inactive	5
	Athletic Trainer	Out of state	Current Active	310
	Athletic Trainer	Out of state	Current Inactive	6
	Total for Athletic Trainer			1,804
	Behavior Analyst			
	Behavior Analyst	Virginia	Current Active	1,552
	Behavior Analyst	Virginia	Current Inactive	1
	Behavior Analyst	Out of state	Current Active	744
	Behavior Analyst	Out of state	Current Inactive	3
	Total for Behavior Analyst			2,300
	Chiropractor			
	Chiropractor	Virginia	Current Active	1,424
	Chiropractor	Virginia	Current Inactive	18
	Chiropractor Chiropractor	Out of state Out of state	Current Active Current Inactive	254 74
	Total for Chiropractor	Out of state	Guitent inactive	
	Genetic Counselor			1,770
	Genetic Counselor	Virginia	Current Active	124
	Genetic Counselor	Out of state	Current Active	418
	Genetic Counselor	Out of state	Current Inactive	1
	Total for Genetic Counselor			543
	Genetic Counselor-Temporary			
	Genetic Counselor-Temporary	Virginia	Current Active	6
	Genetic Counselor-Temporary	Out of state	Current Active	1
	Total for Genetic Counselor-Temporary			7
	Interns & Residents			
	Interns & Residents Interns & Residents	Virginia Out of state	Current Active Current Active	2,659 874
	Total for Interns & Residents			3,533
	Licensed Acupuncturist			100
	Licensed Acupuncturist	Virginia	Current Active	449
	Licensed Acupuncturist	Virginia	Current Inactive	1
	Licensed Acupuncturist	Out of state	Current Active	135
	Licensed Acupuncturist	Out of state	Current Inactive	4
	Total for Licensed Acupuncturist			589

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Board	Occupation	State	License Status	License Cou
Medicir	10			
	Licensed Midwife			
	Licensed Midwife	Virginia	Current Active	79
	Licensed Midwife	Out of state	Current Active	29
	Licensed Midwife	Out of state	Current Inactive	1
	Total for Licensed Midwife			109
	Licensed Surgical Assistant			
	Licensed Surgical Assistant	Virginia	Current Active	513
	Licensed Surgical Assistant	Out of state	Current Active	108
	Total for Licensed Surgical Assistant			621
	Limited Radiologic Technologist			
	Limited Radiologic Technologist	Virginia	Current Active	484
	Limited Radiologic Technologist	Virginia	Current Inactive	19
	Limited Radiologic Technologist	Out of state	Current Active	23
	Limited Radiologic Technologist	Out of state	Current Inactive	1
	Total for Limited Radiologic Technologist			527
	Medicine			
	Medicine	Virginia	Current Active	22,720
	Medicine	Virginia	Current Inactive	489
	Medicine	Virginia	Probation - Curre	1
	Medicine	Out of state	Current Active	17,622
	Medicine Medicine	Out of state Out of state	Current Inactive Probation - Curre	1,064 1
	Total for Medicine	Out of state	FIODAUOII - CUITE	41,897
	Occupational Therapist			
	Occupational Therapist	Virginia	Current Active	3,832
	Occupational Therapist	Virginia	Current Inactive	61
	Occupational Therapist	Virginia	Probation - Curre	1
	Occupational Therapist	Out of state	Current Active	976
	Occupational Therapist	Out of state	Current Inactive	70
	Total for Occupational Therapist			4,940
	Occupational Therapy Assistant			
	Occupational Therapy Assistant	Virginia	Current Active	1,560
	Occupational Therapy Assistant	Virginia	Current Inactive	25
	Occupational Therapy Assistant	Out of state	Current Active	205
	Occupational Therapy Assistant	Out of state	Current Inactive	11
	Total for Occupational Therapy Assistant			1,801
	Osteopathic Medicine	10-1-1-		0.000
	Osteopathic Medicine	Virginia	Current Active	2,330
	Osteopathic Medicine Osteopathic Medicine	Virginia Out of state	Current Inactive Current Active	15
	Osteopathic Medicine	Out of state Out of state	Current Inactive	2,410 67
	Total for Osteopathic Medicine	Out of state	Odifelit Indetve	4,822
	Physician Assistant			-1955
	Physician Assistant	Virginia	Current Active	4,054
	Physician Assistant	Virginia	Current Inactive	4,034
	Physician Assistant	Out of state	Current Active	1,621
	Physician Assistant	Out of state	Current Inactive	38

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Board	Occupation	State	License Status	License Cou
Medicin	10			
	Total for Physician Assistant			5,732
	Podiatry			
	Podiatry	Virginia	Current Active	406
	Podiatry	Virginia	Current Inactive	10
	Podiatry	Out of state	Current Active	132
	Podiatry	Out of state	Current Inactive	20
	Total for Podiatry			568
	Polysomnographic Technologist			
	Polysomnographic Technologist	Virginia	Current Active	352
	Polysomnographic Technologist	Virginia	Current Inactive	5
	Polysomnographic Technologist	Out of state	Current Active	136
	Total for Polysomnographic Technologist			493
	Radiologic Technologist			
	Radiologic Technologist	Virginia	Current Active	3,564
	Radiologic Technologist	Virginia	Current Inactive	28
	Radiologic Technologist	Out of state	Current Active	1,193
	Radiologic Technologist	Out of state	Current Inactive	15
	Total for Radiologic Technologist			4,800
	Radiologist Assistant			
	Radiologist Assistant	Virginia	Current Active	12
	Radiologist Assistant	Out of state	Current Active	4
	Total for Radiologist Assistant			16
	Respiratory Therapist			
	Respiratory Therapist	Virginia	Current Active	3,051
	Respiratory Therapist	Virginia	Current Inactive	83
	Respiratory Therapist	Virginia	Probation - Curre	1
	Respiratory Therapist	Out of state	Current Active	1,268
	Respiratory Therapist	Out of state	Current Inactive	25
	Total for Respiratory Therapist			4,428
	Restricted Volunteer			
	Restricted Volunteer	Virginia	Current Active	55
	Restricted Volunteer	Out of state	Current Active	12
	Total for Restricted Volunteer			67
	Surgical Technologist	V for a la la	0	4 4 7 4
	Surgical Technologist Surgical Technologist	Virginia Out of state	Current Active Current Active	1,173 310
	Total for Surgical Technologist			1,483
	University Limited License			
	University Limited License	Virginia	Current Active	7
	University Limited License	Out of state	Current Active	2
	Total for University Limited License			
	Total for Onlyersity Linned License			9

Total for Medicine

83,106

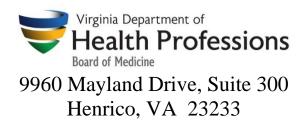
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Blanton Marchese, President President

William L. Harp, MD

Executive Director



Date	August 26, 2022
То:	MSV House of Delegates
From:	Sara Nicely, VAPA President
Re:	Physician Assistant Update

The Virginia Academy of PAs has been enjoying a busy and productive year. Our 2022 legislative efforts to remove the Practice Agreement requirement for PAs working as Medical Examiners, add use of fluoroscopy to code for PAs working in Orthopedics, and the specific addition of PAs to code as hospice providers were a success. We appreciate the support of MSV in moving this legislation forward, and we look forward to continued collaboration in the coming year.

VAPA held a successful, fully in-person Summer CME Conference in Virginia Beach, VA in July 2022. We enjoyed hosting this conference at a new venue, and the participants seemed excited for this change. The Fall VAPA CME Conference will also be offered in-person this year in November 2022. This one-day conference will be jam packed with CME. The evening of the conference will include a reception and the presentation of VAPA awards to deserving nominees. And, finally, the PA students in the Commonwealth will be facing off again in the annual VAPA Student Challenge Bowl, sponsored again by ROSH Review.

VAPA held a successful virtual Fireside Chat in 2021, and we plan to do so again during PA Week in October this year. This will be a time to share legislative updates and collaborate with our professional colleagues in the Commonwealth.

As always, we appreciate the support of legislative actions and inclusion of PAs by MSV.

Respectfully, Sara Nicely, DHEd, PA-C, DFAAPA, VAPA President