MSV℠ MEDICAL SOCIETY OF VIRGINIA

2023 ANNUAL MEETING
Delegates Handbook

MSV℠ MEDICAL SOCIETY OF VIRGINIA

2023 Annual Meeting Delegates Handbook
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F. Virginia Board of Medicine Annual Report
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MEDICAL SOCIETY OF VIRGINIA

MEMORANDUM

Date: **July 28, 2023**

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
2023 Annual Meeting of the Medical Society of Virginia House of Delegates

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Resolutions should be submitted online by August 29th, 2023, to the MSV House of Delegates to be considered as regular business.

- Visit http://www.msv.org/submit-resolution to submit a resolution and for additional materials.
- Late resolutions, submitted after August 29, 2023 will be subject to consideration under the Rules of Procedure.
- If your society has a scheduled meeting that occurs after August 29, 2023, 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 12, 2023. Please email healthpolicy@msv.org 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 healthpolicy@msv.org.

OCTOBER 15, 2023 @ 8:00AM

House of Delegates-Second Session

Call to Order
The Speakers

Pledge of Allegiance
Lavinia Wainwright

Invocation
Kurtis Elward, MD

Speaker Acknowledgements
The Speakers

- Welcome Guests
- In Memoriam
- MSV Past Presidents
- Recognize New Delegates
- Recognize 20+ year MSV members
- Recognize Second Century Circle members

Presidential Address
Harry Gewanter, MD

Secretary of Health and Human Resources Update
John Littel

Virginia Delegation to the American Medical Association Update
Thomas Eppes, MD

MSV Foundation Raffle Drawing
The Speakers

MSVPAC Update & Awards
Lee Ouyang, MD

Credentials Committee Report
Soheila Rostami, MD

Rules Committee Report
Arthur Vayer, MD

Request for approval of the 2022 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 2022 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 15, 2023

OCTOBER 13, 2023 @ 10:00AM

House of Delegates-First Session

Call to Order
The Speakers

Speakers Remarks
The Speakers

MSV Chief Executive Officer & EVP Remarks
Melina Davis

Credentials Committee Report
Soheila Rostami, MD

Nominating Committee Report
Edward Koch, MD

Election of Officers and Directors
The Speakers

Election of President-Elect
The Speakers

Installation of MSV Board of Directors Officers
TBD

Incoming President's Remarks
Alice Coombs, MD

Election of the 2023-2024 Nominating Committee
The Speakers

Reference Committee Reports
Reference Committee 1: Dr. Andrea Giacometti
Reference Committee 2: Dr. Atul Marathe

Announcements
The Speakers

Adjournment
The Speakers

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2023

Delegate References

1. New Delegate Orientation PowerPoint
2. Quick Guide to Parliamentary Procedure
3. Rules of Procedure 2023

MSV℠ MEDICAL SOCIETY OF VIRGINIA

New Delegate Orientation

2023 MSV Annual Meeting

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, Physician Assistants, 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 13th

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

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2019 Annual 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 Ill
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 Policy Compendium
- The Policy Compendium governs MSV's legislative positions and actions

Questions?

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

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

MM = Main Motion

[1]Motions are in order only if no motion higher on the list is pending.
[2]Restricted
[3]Not debatable when applied to undebatable motion
[4]Member may interrupt proceedings, but not a speaker
[5]Withdraw may be applied to all motions
[6]Renewable at discretion of presiding officer (chair)
[7]Tie or majority vote sustains the ruling of the presiding officer; majority vote in negative reverses the ruling
[8]If decided by assembly (by motion), requires a majority vote to adopt

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MSV℠ MEDICAL SOCIETY OF VIRGINIA

Rules of Procedure

of the

Medical Society of Virginia

House of Delegates

2023 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, Oct. 2022.

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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.

All proceedings of the House of Delegates and Reference Committees are for the purpose of establishing the policies and actions of the Medical Society of Virginia. Such proceedings shall not be recorded and shall not be disseminated on any platform. Recordings and transcriptions by staff for the operational purposes necessitated by these Rules in furtherance of the purpose of the House of Delegates' function are permitted.

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 **PURPOSE** 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 in Section V.

B. **WHO** 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. **WHEN** 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.

LATE RESOLUTIONS 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.

Courtesy Resolutions: 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.

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

Memorial Resolutions: 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", precisely 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 "How to Write a Resolution" as well as a "Sample Resolution."

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 suggested 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. REVIEW 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, ***or would otherwise subject the Society to adverse publicity,*** 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. A two thirds-majority of the MSV Board of Directors makes any proposed resolution a "Deferred Resolution." If the Board determines the resolution constitutes a "Deferred Resolution," 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. PRESENTATION 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

1. 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. Amending of Existing Policy

      (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 underlining the proposed additions and by ~~striking out the proposed deletions or changes.~~

   c. Substitution of a Proposed Policy Statement for Existing Policy, 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. Rescission 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. Reaffirmation 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. Directives 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 re-emphasis 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. Organization: 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 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. Conduct of the Reference Committee Hearings: Reference Committee hearings are open to all members of the Association, guests, and official observers. 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 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. Reference Committee Reports: 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. Form of action upon reports and resolutions: 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:

1. 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. 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.

E. Parliamentary Procedure in the House:

A few comments on specific procedures may be helpful.

1. 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. 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.

AMENDED AND RESTATED BYLAWS OF
THE MEDICAL SOCIETY OF VIRGINIA
EFFECTIVE OCTOBER 30, 2022

ARTICLE I
NAME AND PURPOSE

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

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

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

ARTICLE II
MEMBERSHIP, VOTING, FUNDS, DUES

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

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

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

Section 3. Public Service Active Members. 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.

Section 4. Resident Physician Members. A resident physician member must be an intern, resident or fellow in an approved training program in Virginia. Any resident physician member may hold any office and serve on any committee of the Society.

Section 5. Student Members. A student member must be a member in good standing of a component student society (as defined in Article III below). Any student membership shall terminate automatically when the member graduates from medical school or when he/she no longer is enrolled in a medical school at which there is a component student society. Any student member may hold any office and serve on any committee of the Society.

Section 6. Associate Members. An Associate member must be: (1) a non-resident of Virginia, not currently practicing medicine in Virginia and who holds or has held an active license as a physician by the Virginia Board of Medicine; (2) a medical officer of the armed forces; (3) a member of the Public Health Service; or (4) a doctor of medicine or osteopathy attached to a veterans' hospital. Associate members, other than honorary associate members, shall pay dues unless at the time of payment they have been active members in good standing for more than ten (10) years and are retired.

Section 6.1. No Right to Vote. Associate members shall have no right to vote, hold office or serve on committees, but shall be entitled to all other privileges of membership.

Section 7. Honorary Active Members; Honorary Associate Members. Honorary active or honorary associate membership may be granted by a majority vote of the House of Delegates at its annual meeting to no more than two (2) Virginia residents and one non-resident as an acknowledgement of long, faithful and distinguished service. Honorary active members shall not pay dues, but otherwise shall have the same rights as active members.

Section 7.1. No Right to Vote. Honorary associate members shall not vote, hold office, or serve on committees, but shall be entitled to all other privileges of membership.

Section 8. Affiliate Members. An Affiliate member shall be a healthcare provider or person in good standing with their profession, their community and the Medical Society of Virginia and who has an interest in supporting physicians and healthcare in Virginia. Affiliate membership is restricted to those persons specified in this section. Affiliate members shall pay dues.

Section 8.1. Physician Assistants. Affiliate members who are physician assistants shall, as a condition of membership, hold an active license as a physician assistant from the Virginia Board of Medicine or, if such physician assistant is retired, hold an inactive license from the Virginia Board of Medicine.

Section 8.2. Affiliate Member Rights. Affiliate members shall have the right to vote and serve on committees.

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

Section 9. Funds. In addition to annual dues, funds for the Society may be raised by a per capita assessment approved by the House of Delegates or by the Board of Directors subject to ratification by the House of Delegates, voluntary contributions and other business activities. The funds shall be expended to carry out the general purposes of the Society.

Section 10. Dues. The amount of membership dues for active members in full-time medical practice shall be determined by the House of Delegates for each fiscal year. At each annual meeting for which a change in the dues structure is recommended, such recommendation shall be presented by the Board of Directors to the House of Delegates for action. Membership dues for all classes of membership other

than active members in full-time medical practice shall be determined by the Board of Directors and be reviewed annually by the House of Delegates.

Section 11. Fiscal Year. The fiscal year of the Society for membership purposes shall correspond with the calendar year.

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

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

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

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

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

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.

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.

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

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

Section 2.2. The members of each specialty section shall adopt rules and regulations to provide for the conduct of the meetings of the section and for the selection of the section's officers and its delegate and alternate to the House of Delegates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 10. Member Rosters. The secretary of each component society, component student society and component resident physician section shall keep a roster of its members. Once a year, not later than July 1, the secretary of each component 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. Component Meetings. The component societies, component student societies and component resident physician sections shall cooperate with the officers of the Society to carry out the plans and objectives of the Society and to this end shall meet at least 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. Failure to Comply with Bylaws. If a component society, component student society, component resident physician section, or physician assistant section fails to comply with the provisions of these Bylaws, the Board of Directors shall request a report of the 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
ANY MEETINGS OF MEMBERS

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

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

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

Section 4. Virtual Meetings. 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.

ARTICLE V
HOUSE OF DELEGATES

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

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

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

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

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

Section 3.3. Each specialty section listed in Appendix A shall annually elect delegates, who are also members of the Medical Society of Virginia, to membership in the House of Delegates. The apportionment of delegates from each specialty society shall be a minimum of one delegate and one

alternate. If at least forty (40) percent of its members are members of the Society the specialty society shall be entitled to two delegates and two alternates; if at least sixty (60) percent of its members are members of the Society the specialty society shall be entitled to three delegates and three alternates. Prior to the annual meeting each specialty section shall submit the name(s) of its delegate(s) and alternate delegate(s) to the Speaker of the House of Delegates or his designee. In the event a delegate for a specialty section is not present at any meeting of the House of Delegates, his/her alternate shall succeed to all privileges.

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

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

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

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

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

Section 4. Quorum. Twenty-five (25) percent of the number of delegates allowed representing at least eight (8) districts shall constitute a quorum of the House of Delegates.

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

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

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

authorized to serve, at the last regular meeting of the House of Delegates. If any member is unable to serve, then another member shall be elected or appointed by the Board of Directors to serve. The transaction of business at any special meeting of the House of Delegates shall be limited to the purpose in the notice for the meeting.

ARTICLE VI
ELECTIONS

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

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

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

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

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

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.

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

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

Section 4. Board of Directors; Composition. 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) representative of the MSVF who is a member of the Society and who is a physician and the following ex-officio members: The President, the President-Elect, the immediate past President, the Speaker of the House of Delegates and the Secretary-Treasurer. Ex-officio members of the Board of Directors shall have full voting rights.

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

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

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

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

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

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

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

membership equivalencies are achieved, as determined by the President of the Society. For regular term elections, the nominee to serve as the representative shall be selected by such schools in a method agreed upon by the schools. The name of the nominee shall be submitted to the Speaker of the House of Delegates or his designee in advance of the annual meeting together with the number of full time academic physicians for all such schools. The term limits in Section 5 shall apply to this section.

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

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

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

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

ARTICLE VII
OFFICERS

Section 1. President.

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

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

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

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

Section 2. President-Elect.

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

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

Section 3. Executive Vice President and Chief Executive Officer.

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

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

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

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

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

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

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

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

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

Section 5. Secretary-Treasurer.

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

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

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

Section 6. Officer resignations and vacancies

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

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

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

ARTICLE VIII
BOARD OF DIRECTORS

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

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

Section 3. Executive Committee. There shall be a five (5) member Executive Committee of the Board of Directors composed of the President, the President-Elect, the immediate Past-President, the

Speaker of the House of Delegates and the Secretary-Treasurer. The President may appoint non-voting advisory members to the Executive Committee. The Executive Committee shall act in an advisory capacity to the Board of Directors and to the President, who shall serve as its Chair.

Section 4. Finance Committee. There shall be a six (6) member Finance Committee of the Board of Directors composed of the President, the President-Elect, the immediate Past-President, the Speaker of the House of Delegates, the Secretary-Treasurer and the Executive Vice President 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.

Section 5. Compensation Committee. There shall be an eight (8) member Compensation Committee of the Board of Directors comprised of the President, President-Elect, 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 President shall 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.

Section 6. Meetings. 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.

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

Section 8. Other Attendees. The Secretary of Health and Human Resources, State Health Commissioner, the Executive Director of the Virginia Board of Medicine and the Dean of each allopathic or osteopathic medical school in Virginia may be requested to attend all meetings of the Board of Directors.

Section 9. Nominations for Virginia State Board of Medicine. The Society shall submit nominations to the Governor of Virginia for membership on the Virginia State Board of Medicine.

Section 10. Quorum. One-third of the Directors representing at least one-third of the districts, and either the President or President-Elect, shall constitute a quorum of the Board of Directors.

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

ARTICLE IX
PROFESSIONAL CONDUCT

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

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.

Section 2. Removal Process and Proceedings

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

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

Proceedings for the removal 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 a written complaint signed by not less than one-third of the Board of Directors. Proceedings for the removal of the Executive Vice President 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.

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

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

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

ARTICLE X
INDEMNIFICATION

Section 1. Definitions.

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

"Expenses" includes reasonable counsel fees.

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

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

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

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

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

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

Section 4. Determination of Proprietary of Indemnification. Any indemnification under this Article (unless ordered by a court) shall be made by the Society only as authorized in the specific case upon a

determination that indemnification of the applicant is proper in the circumstances because he/she has met the applicable standard of conduct set forth in this Article. Such determination shall be made either:

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

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

C. By special legal counsel in a written opinion:

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

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

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

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

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

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

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

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

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

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

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

granted in Section 2. The provisions of Sections 3 through 5 of this Article shall be applicable to an indemnification provided hereafter pursuant to this Section 6.

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

Section 8. References Included. Every reference herein to Directors, officers, committee members, employees or agents shall include former Directors, officers, committee members, employees and agents and their respective heirs, personal representatives, executors and administrators. The indemnification provided shall not be exclusive or any other rights to which any person may be entitled, including any right under policies of insurance that may be purchased and maintained by the Society or others, with respect to claims, issues or matters in relation to which the Society would not have the power to indemnify such person under the provisions of this Article, but no individual shall be entitled to be indemnified more than once for the same claim and that credit will be given to the Society for any collateral source reimbursement.

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

ARTICLE XI
COMMITTEES

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

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

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

ARTICLE XII
ETHICS

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

ARTICLE XIII
RULES OF ORDER

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

ARTICLE XIV
AMENDMENTS

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

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

APPENDIX A
Approved September 25, 2018

First District:
Mid-Tidewater Medical Society

Second District:
Chesapeake Medical Society; Norfolk Academy of Medicine; Tri-County Medical Society; Virginia Beach Medical Society; Eastern Virginia Medical School Student Section

Third District:
Richmond Academy of Medicine; Virginia Commonwealth University Medical School Student Section

Fourth District:
Reserved

Fifth District:
Danville-Pittsylvania Academy of Medicine

Sixth District:
Lynchburg Academy of Medicine; Virginia Tech-Carillion Medical School Student Section; Liberty University College of Osteopathic Medicine Student Section

Seventh District:
Albemarle County Medical Society; Fauquier County Medical Society; University of Virginia Student Medical Society

Eighth District:
Prince William County Medical Society

Ninth District:
Tazewell County Medical Society; Edward Via College of Osteopathic Medicine Student Section

Tenth District:
Arlington County Medical Society; Medical Society of Northern Virginia

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

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2023

Minutes and Actions of the 2022 House of Delegates

1. Medical Society of Virginia 2022 House of Delegates Minutes
2. Final Actions of the 2022 Medical Society of Virginia House of Delegates

First Session

Call to Order
Dr. Alan Wynn, Speaker, convened the virtual first session of House of Delegates at 10:00 am.

Pledge of Allegiance
The Pledge of Allegiance was led by Dr. Michele Nedelka, Vice Speaker.

Invocation
The invocation was provided by MSV Board of Directors District 8 Director Dr. Atul Marathe of Woodbridge.

Introduction of Guests
The following guests were acknowledged by the Speakers:

- Dr. Arthur Apolinario, President of the NC State Medical Society
- Dr. Susanne Bathgate, President of the Medical Society of DC
- Dr. Edward Capparelli, President of the Tennessee Medical Association
- Dr. Loralie Ma, President of MedChi
- Dr. Shafic Sraj, Former President of the West Virginia Medical Association
- Dr. Alvin Harris, Vice President of the Old Dominion Medical Society
- Dr. John Poole, Chair of the AMA Southeast Delegation
- Sean Connaughton, President and CEO of the Virginia Hospital and Health Care Association
- Gene Ransome, CEO of MedChi
- Abraham Segres, Vice President of Quality and Patient Safety at the Virginia Hospital and Healthcare Association

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, MSV members who have been members of the Society for 20 years or longer, and Second Century Circle members (MSV Endowment).

Presidential Address
Dr. Mohit Nanda, President, shared remarks regarding his year as president.

Clarence A. Holland, MD Award
Dr. Lee Ouyang, Norfolk, Chair of the MSV Political Action Committee provided an update on the Society's Political Action Committee and presented the Clarence A. Holland, MD Award to Dr. Russell Libby. This award is for MSV member physicians with high personal integrity who have demonstrated outstanding leadership in their fields. Dr. Libby is recognized for his lifelong commitment to advancing medical policy at the local, state and national levels.

Meditation Break
Dr. Tiffany Niide, Medical Director, Physician Wellness and Engagement of Centra Health, lead the House in a 10-minute meditation break.

Credential Committee Report
Dr. Quinn Lippman, Chair of the Credentials Committee, 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
Dr. Sam Bartle, Rules Committee Chair, recommended adoption of the proposed Rules of Procedure provided. The Rules of Procedure were adopted by unanimous vote.

Approval of the 2021 MSV House of Delegates Minutes
Dr. Larry Mitchell, Secretary-Treasurer, asked for comments on minutes from the 2021 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 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

Resolutions Referred to the Board
The following resolutions will receive House consideration on Sunday, prior to this year's Reference Committee reports.

- Resolution 19-111 Medical Care for the Terminally Ill
- Resolution 21-201 Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness

MSV Foundation Raffle Drawings
The Speakers conducted live raffle drawings throughout the House of Delegates session.

Conclusion of 1st session
The first session of the House of Delegates recessed at 10:45 am.

Second Session

Call to Order
Dr. Alan Wynn, Speaker, reconvened the House of Delegates at 8:00 am.

MSV CEO/EVP Remarks
Ms. Melina Davis, Chief Executive Officer and Executive Vice President, (CEO and EVP), addressed the House.

Credential Committee Report
Dr. Quinn Lippman, Chair of the Credentials Committee, 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.

Nominating Committee Report
As the Nominating Committee Report was displayed, Dr. Edward Koch, Chair of the Nominating Committee, opened the floor for additional nominations. After nominations were received from the floor for District 10 for the MSV Board of Directors and Districts 6 and 9 for Nominating Committee the 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)

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	Andrea Giacometti, MD
District 10	Soheila Rostami 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	Shashi Ranganath, MD
Academic	Lindsay Robbins, MD (EVMS)

ASSOCIATE DIRECTORS (Elected for 1-year term)

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

DELEGATES to the AMA (Elected for 2-year calendar term)

Thomas Eppes, MD
Michele Nedelka, MD

ALTERNATE DELEGATES to the AMA (Elected for 2-year calendar term)

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

President Elect Election
Without objection, Dr. Alice Coombs was elected as President Elect of the MSV.

Installation of MSV Board Officers
Dr. Hazle Konerding, former President of MSV, conducted the installation of officers.

Incoming President's Remarks
Dr. Harry Gewanter, Incoming President, addressed the House.

Election of the 2022-2023 Nominating Committee
The 2022-2023 Nominating Committee was presented for election and the following were elected by unanimous vote:

District 1 Sterling Ransone, 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 Tom Eppes, MD
2020-2021 Former President Advisor Art Vayer, MD
2021-2022 Former President Advisor Mohit Nanda, MD

Meditation Break
Dr. Tiffany Niide, Medical Director, Physician Wellness and Engagement of Centra Health, lead the House in a 10-minute meditation break.

Resolution Referred from MSV Board
Dr. Wynn opened the floor for discussion and consideration on Resolution 19-111: Medical Care for the Terminally Ill. The House approved the proposed amendment to the MSV policy 25.4 0.02.

Reference Committee Reports
Reference Committee recommendations were presented for acceptance as consent calendar items. Extracted resolution submissions were discussed at length by the House. The final actions of the House of Delegates for all resolutions are attached to these minutes.

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

- 22-103 Amending MSV Bylaws to Grant the PA Members the Right to Vote and the Right to Delegates Representation
- 22-104 Resolution to Amend the MSV Bylaws Regarding the Compensation Committee
- 22-105 Resolution to Amend the MSV Bylaws Regarding Meetings
- 22-108 Maternity Leave
- 22-111 Benefit for Patients at Virginia Physician Offices
- 22-113 Acknowledge Climate Change as a Public Health Emergency
- 22-114 Housing as Healthcare

Dr. Art Saavedra presented the consent calendar report of Reference Committee 2. Additional discussion occurred on the following extracted resolutions.

- 22-201 Road Safety Resolution
- 22-206 Amending Policy Compendium 25.1.02: Opposition to Criminalization of Reproductive Decision Making
- 22-207 Opposing Restriction of Medically Appropriate Care
- 22-208 Resolution to Protect Evidence Based Medicine and Safeguard Medical Speech
- 22-209 Licensure and Discipline- Dissemination of Misinformation

Resolution Referred from MSV Board
The speakers excised privilege and the House voted on resolution 21-201: Removing Health Questions on Licensure and Credentialing Forms to Promote Physician Wellness based on the language of the resolve clause in resolution 22-202 Mental Health Questions on Credentialing Forms. Resolution 22-202 addresses the same issue with MSV policy and thus rendered resolution 21-201 moot. The House approved the Speakers recommendation in an effort not to create duplicative MSV policy within our compendium, that resolution 21-201 not be adopted.

Adjournment
The 2022 Annual Meeting of the House of Delegates of the Medical Society of Virginia adjourned at 11:25 am.

SUMMARY OF ACTION

ADOPTED

- 19-111 Medical Care for the Terminally Ill
- 22-101 Medical Society of Virginia Proposed 2023 Budget
- 22-103 A Proposed Bylaws Change Concerning PA Membership
- 22-104 A Proposed Bylaws Change Concerning the Compensation Committee
- 22-105 A Proposed Bylaws Change Concerning Meetings
- 22-202 Mental Health Questions on Credentialing Forms
- 22-203 Supporting Mental Health in Veterans and Veteran's Families

ADOPTED AS AMENDED OR SUBSTITUTED

- 22-102 2022 MSV Policy Compendium 10 Year Review
- 22-107 Striving for Adrenal crisis treatment by Virginia EMS responders (SAVE)
- 22-108 Resolution Supporting Maternity Leave
- 22-113 Acknowledging Climate Change as a Public Health Emergency
- 22-205 Improved Reimbursement for Hair Prostheses for Individuals with Cicatricial Alopecia
- 22-206 Amending Policy Compendium 25.1.02: Opposition to Criminalization of Reproductive Decision-Making
- 22-207 Opposing Restriction of Medically Appropriate Care
- 22-208 Resolution to Protect Evidence Based Medicine and Safeguard Medical Speech

ADOPTED AS AMENDED IN LIEU OF

- Policy 40.3.01- AEDs for Police First Responders
    - (in lieu of Resolution 22-106: MSV Support for Expanding AED Access in Public Spaces Around Virginia).
- Policy 40.9.04- Child Firearm Injury Prevention
    - (in lieu of Resolution 22-109: Gun Safety Resolution).
- Policy 35.2.03- Physician Dispensing
    - (in lieu of Resolution 22-111: Benefit for Patients at Virginia Physicians' Offices)
- Policy 25.3.02 Legislation, Standards of Care and the Patient/Physician Relationship
    - (in Lieu of Resolution 22-210: Health Care Policy Should Be Based Upon Peer Reviewed Research and Evidence-Based Practices

REFERRED TO THE BOARD OF DIRECTORS FOR REPORT

- 22-112 Hospital Medical Staff Self-Governance
- 22-114 Housing as Healthcare

NOT ADOPTED

- 21-201 Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness
- 22-110 Resolution to Request the Virginia Legislature to Allow Virginia Physicians to Bear Financial Risk in Health Care Policies
- 22-201 Road Safety Resolution
- 22-204 MSV Organizational Structure Proposal

- 22-209 Licensure and Discipline: Dissemination of Misinformation

19-111: Medical Care for the Terminally Ill (ADOPTED)

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.

21-201: Removing Health Questions on Licensure and Credentialing Applications to Promote Physician Wellness (NOT ADOPTED)

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.

22-101: Medical Society of Virginia 2023 Proposed Budget *(ADOPTED)*

RESOLVED, that the Medical Society of Virginia approve, as presented, the proposed budget for 2023.

22-102: 2022 MSV Policy Compendium 10 Year Review *(ADOPTED AS AMENDED)*

RESOLVED, that the Medical Society of Virginia adopt the recommendations in the enclosed report as amended to archive MSV Policy 55.1.09*. – Support for Northern Virginia Medical Societies*

22-103: A Proposed Bylaws Change Concerning PA Membership (ADOPTED)

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 and by reclassifying the PA section as a specialty section.

22-104: A Proposed Bylaws Change Concerning the Compensation Committee (ADOPTED)

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.*

22-105: A Proposed Bylaws Change Concerning Meetings (ADOPTED)

RESOLVED, that the MSV Bylaws be amended as follows:

ARTICLE IV

ANY MEETINGS OF MEMBERS

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

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

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

Section 4. Virtual Meetings. 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.

22-106: MSV Support for Expanding AED Access in Public Spaces Around Virginia (ADOPTED AS AMENDED IN LIEU OF)

RESOLVED, that MSV Policy 40.3.01- AEDs for Police First Responders be adopted as amended in lieu of Resolution 22-106 MSV Support for Expanding AED Access in Public Spaces Around Virginia.

40.3.01- AEDs for Police First Responders, Skilled Nursing Facilities, and Long-Term Care Facilities

The Medical Society of Virginia supports increasing access to AEDs, including funding for skilled nursing facilities, long-term care facilities, 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) (ADOPTED AS AMENDED)

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.~~ supports

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 information is available.

22-108: Resolution Supporting Maternity Leave (ADOPED AS AMENDED)

RESOLVED, the MSV (a) encourage employers to offer or expand paid parental leave policies with job protection following the birth, adoption, foster placement, or newly appointed legal guardianship of a child younger than age 18; ~~for birthing and non-birthing parents~~; (b) work with the state legislature to establish and promote paid parental leave policies; (c) advocate for improved social and economic support for paid family leave to care for newborns or new adoptees; and (d) encourage key stakeholders to implement policies and programs that help protect against parental discrimination.

22-109: Gun Safety Resolution (ADOPTED AS AMENDED IN LIEU OF)

RESOLVED, that MSV Policy 40.9.04- Child Firearm Injury Prevention be adopted as amended in lieu of Resolution 22-109: Gun Safety Resolution.

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.

22-110: Resolution to Request the Virginia Legislature to Allow Virginia Physicians to Bear Financial Risk in Health Care Policies (NOT ADOPTED)

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.

22-111: *Benefit for Patients at Virginia Physicians Offices (ADOPTED AS AMENDED IN LIEU OF)*

RESOLVED, that Policy 35.2.03: Physician Dispensing be adopted as amended in lieu of Resolution 22-111: Benefit for Patients at Virginia Physicians Offices.

35.2.03: Physician Dispensing

The Medical Society of Virginia supports physician dispensing of prescribed medications at a physician's office or via the mail ~~prepackaged drugs for a fee or charge~~ when it is in the best interest of the patient.

22-112: Hospital Medical Staff Self-Governance (REFERRED TO BOARD OF DIRECTORS FOR REPORT)

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.

22-113: Acknowledging Climate Change as a Public Health Emergency (ADOPTED AS AMENDED)

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 an urgent public health threat ~~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.

RESOLVED, that our MSV provide information on the MSV website about governmental and non-governmental resources on climate change available for members to work within the Commonwealth.

21-114: Housing as Healthcare (REFERRED TO BOARD OF DIRECTORS FOR REPORT)

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.

22-201: Road Safety Resolution (NOT ADOPTED)

RESOLVED, that the Medical Society of Virginia ~~work with all appropriate organizations and stakeholders to~~ supports ~~legislation and/or regulatory actions requiring~~ all ~~licensed~~ registered motor 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 (ADOPTED)

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.

22-203: Support Mental Health for Veterans and Families of Veterans (ADOPTED)

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.

22-204: MSV Organizational Structure Proposal (NOT ADOPTED)

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.

22-205: Improved Reimbursement for Hair Prostheses for Individuals with Cicatricial Alopecia (ADOPTED AS AMENDED)

RESOLVED, that the Medical Society of Virginia supports ~~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.

22-206: Amending Policy Compendium 25.1.02: Opposition to Criminalization of Reproductive Decision-Making (ADOPTED BY SUBSTITUTION)

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 or impose civil penalty for obtaining or providing evidence-based reproductive health services.~~healthcare in vitro fertilization, contraception, or the management of ectopic and molar pregnancies.~~

22-207: Opposing Restriction of Medically Appropriate Care (ADOPTED BY SUBSTITUTION)

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~~ Health Services

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 services ~~care~~ includes the provision of contraception ~~contraceptive and~~ or abortion. ~~services. Furthermore, the Medical Society of Virginia opposes the restriction of abortion services.~~

The Medical Society of Virginia further opposes efforts which criminalize or impose civil penalties for obtaining or providing evidence-based reproductive health services, or enforce medically unnecessary standards on healthcare providers ~~providers~~ ~~clinicians~~ and clinics that in turn make it economically or physically difficult for healthcare providers ~~doctors~~ and clinics to provide services.

22-208: Resolution to Protect Evidence Based Medicine and Safeguard Medical Speech (ADOPTED AS AMENDED)

RESOLVED, that the MSV supports ~~that~~ the Virginia Board of Medicine ~~shall have the authority~~ in the Board's authority to take appropriate disciplinary action against ~~suspend or revoke the license of~~ a physician or other medical licensee who demonstrates unprofessional conduct by propagating medical misinformation or disinformation.

22-209: Licensure and Discipline: Dissemination of Misinformation (NOT ADOPTED)

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.

22-210: Health Care Policy Should Be Based Upon Peer Reviewed Research and Evidence-Based Practices (ADOPTED AS AMENDED IN LIEU OF)

RESOLVED, that Policy 25.3.02 Legislation, Standards of Care and the Patient/Physician Relationship be amended as follows in Lieu of Resolution 22-210: Health Care Policy Should Be Based Upon Peer Reviewed Research and Evidence-Based Practices.

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

The Medical Society of Virginia ~~will~~ oppose efforts to ~~or work to favorably amend legislation, regardless of its primary intent, that~~ interfere with or jeopardize the sanctity of the patient/physician relationship.

The MSV supports ~~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.

RESOLVED, that MSV further opposes all criminal penalties against physicians and the other healthcare providers who deliver, and the patients who receive, care that is evidence-based.

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2023

Nominating Committee Report

1. 2023 Nominating Committee Report

Nominating Committee Report

The Nominating Committee met on July 31st 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

TERM 2023-2024/2025

OFFICERS (Elected for 1-year term)

President-Elect	Joel Bundy, MD
Speaker	Michele Nedelka, MD
Vice Speaker	Atul Marathe, MD

DIRECTORS (Elected for 2-year term)

District 1	Bobbie Sperry, MD
District 3	Carolyn Burns, MD
District 3	Mark Townsend, MD
District 5	Gary Miller, MD
District 7	Peter Netland, MD
District 7	Karen Rheuban, MD
District 9	Jan Willcox, DO
MSV Foundation	Jose Morey, MD
Academic	Arturo Saavedra, MD (VCU)

DIRECTORS (Elected for 1-year term)

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

ASSOCIATE DIRECTORS (Elected for 2-year term)

District 1	Andreya Risser, MD
District 3	Sidney Jones, MD
District 5	Jacqueline Fogarty, MD
District 7	John Mason, MD
District 9	Stephen Combs, MD
Academic	Lindsay Robbins, MD (EVMS)

ASSOCIATE DIRECTORS (Elected for 1-year term)

Resident	Matthew Adsit, MD (VCU Ortho)
Medical Student	Elizabeth Ransone (VCU)

VIRGINIA DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION

TERM 2024-2025

Elected for a two-year calendar year term

DELEGATES

Alice Coombs, MD
Claudette Dalton, MD
Cliff Deal, III, MD
Bhushan Pandya, MD
Cynthia Romero, MD
Sterling Ransone, MD

ALTERNATE DELEGATES

Sandy Chung, MD
Mark Townsend, MD
Jan Willcox, DO

2023-2024 Nominating Committee

TERM 2023-2024

Elected for a 1-year term.

District 1	Sterling Ransone, 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	William Hutchens, MD
Academic	Cynthia Romero, MD (EVMS) (Chair)
AMA Advisor (Chair of the Delegation)	Tom Eppes, MD
2021-2022 Former President Advisor	Mohit Nanda, MD
2022-2023 Former President Advisor	Harry Gewanter, MD

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2023

Reference Committee One Index

The following section contains a list of the resolutions considered by Reference Committee One

23-101

Medical Society of Virginia Proposed 2024 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.

23-102

MSV 2023 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

05.5.01- Dissemination of Inflammatory Information

Date: 10/30/1993

The Medical Society of Virginia supports legislation to amend the Code of Virginia to make it a criminal offense to endanger physicians and other health care providers by disseminating inflammatory information to advance a political agenda.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

10.4.01- Managed Care and Patient Choice

Date: 10/30/1993

The Medical Society of Virginia supports legislation that mandates that any insurance company or managed care health delivery system functioning in the Commonwealth of Virginia provide a provision which allows a patient enrollee an option to seek health care outside the managed care network with a reasonable (not punitive) financial voucher.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

10.7.04- Inequitable Reimbursement of Primary Care Physicians under RBRVS

Date: 10/30/1993

The Medical Society of Virginia believes that the application of grossly inaccurate practice overhead RVU's in the calculation of RBRVS payment schedules to primary care medical practice seriously undermines the fiscal viability of such practices and fosters the denial of care to tens of millions of America's elderly and disadvantaged populations and supports recalculation of practice overhead RVU's based on current available data.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

15.2.01- Confidentiality in Legal Proceedings

Date: 10/30/1993

The Medical Society of Virginia supports legislation which will amend the Code of Virginia to strengthen features relating to confidentiality in the areas of discovery, admission as evidence, forced testimony, and protection only for suits concerning the pending subject.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

20.2.01- Graduate Medical Education Funding and Residency Slots

Date: 5/31/2014

The Medical Society of Virginia (MSV) encourages and advocates for private and alternative sources of funding for Virginia-specific graduate medical education (GME) opportunities.

MSV will support when appropriate and encourage the American Medical Association to advocate for additional sources of funding direct and indirect costs of GME; to explore funding for additional residency slots; and to encourage state and specialty societies to seek private and alternative sources of funding for state-specific GME opportunities.

Further, the MSV supports that revenue generated through the Affordable Care Act's excise tax on indoor tanning services, the annual fee on health insurance providers, and the annual fee on branded prescription pharmaceutical manufacturers and importers be

directed toward increasing GME funding with the intention of expanding the number of available residency positions and maintaining the positions offered now.

30.1.01 - Right of Physicians to Negotiate Medical Cost and Utilization

Date: 10/30/1993

The Medical Society of Virginia, in order to advance health care system reform, believes that modification of antitrust regulations is needed to allow appropriate collective negotiations by physicians.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

30.3.02- Federal Regulations

Date: 10/30/1993

The Medical Society of Virginia supports the efforts of the American Medical Association to seek the repeal of CLIA 88 and OSHA rules that are of unproven value and place onerous financial and time burdens on medical offices and laboratories.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

35.2.01- Questionable Activities of Certain Pharmaceutical Manufacturers

Date: 10/30/1993

The Medical Society of Virginia opposes pharmaceutical manufacturers paying pharmacists incentives that reward pharmacists for substituting their brand preference for the physician’s choice in the prescribing of patient medications based solely on personal financial incentives.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.1.07- Providing Better Access to Primary Care in Federally Designated Health Professional Shortage Areas

Date: 10/30/1993

The Medical Society of Virginia supports changing federal legislation to reinstate the private practice repayment option for indebted physician providers by the National Health Service Corps., so that the National Health Service Corps Loan Repayment Program would apply to all primary care physicians wishing to locate in private practice or in not-for-profit primary health care facilities and practice in a health professional shortage area as designated.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.4.01- Nonclinical Antibiotic Usage in Livestock

Date: 5/31/2014

The Medical Society of Virginia (MSV) opposes the routine use of antibiotics in livestock for nonclinical reasons and supports legislative and other measures that phase out the use of antibiotics in livestock for nonclinical use.

40.6.06- School Start Times and Adolescent Sleep

Date: 5/31/2014

The Medical Society of Virginia supports legislative and other efforts to encourage public school systems in Virginia to implement a strategy to improve student sleep health to include but not be limited to later school start times.

40.20.05- Smoking Education

Date: 10/30/1993

The Medical Society of Virginia shall work actively to disseminate relevant medical information about the health hazards and health costs of smoking.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.20.08- Electronic Nicotine Delivery Devices

Date: 5/31/2014

The Medical Society of Virginia (MSV) supports legislation and Food and Drug Administration action to tax, label and regulate electronic nicotine delivery devices (ENDS) as tobacco products and drug delivery devices. Further, the MSV supports state and federal legislation that restricts the minimum age, locations of permissible use, advertising, promotion, and sponsorship of ENDS to the same restrictions as that of tobacco products. The MSV supports local, state and national efforts to require transparency and disclosure concerning the design, content and emissions of ENDS; to require secure, child-proof, tamper-proof packaging and design of ENDS; and to require enhanced labelling that warns of the potential consequences of ENDS use, restriction of ENDS marketing as tobacco cessation tools, and restriction of the use of characterizing flavors in ENDS. The MSV encourages basic, clinical, and epidemiological research concerning ENDS.

40.21.01- Passengers in the Beds of Pickup Trucks
Date: 10/30/1993

The Medical Society of Virginia supports prohibiting the transportation of passengers in the bed of a pickup truck.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

55.1.01 - Endorsement of the Commission on Office Laboratory Accreditation (COLA) Program
Date: 10/30/1993

The Medical Society of Virginia endorses the accreditation program for office laboratories of the Commission on Office Laboratory Accreditation.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

55.1.08- Virginia Health Quality Center
Date: 4/7/2000

The Medical Society of Virginia supports the Virginia Health Quality Center in its pursuit of health care quality improvement.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

Recommendation Reaffirm as Amended

40.6.01- Anabolic Steroids
Date: 10/30/1993

The Medical Society of Virginia believes that the Virginia Department of Education (VDOE) ~~state department of education~~ should develop and implement a program of drug testing for all Virginia State District Champions in all varsity sports proceeding to that level, and be it further

The Medical Society of Virginia believes that any program should include 1) mandatory urine testing of each individual champion athlete for illicit drugs; 2) suspension from all Virginia State High School varsity competition for the subsequent calendar year if positive, and 3) elimination of the positive member's varsity team from the State Tournament (gymnastics, swimming, tennis, ~~and~~ track teams, and any other sport, excepted because of the individual nature of the sports), and be it further

The Medical Society of Virginia believes that an athlete's or team's refusal to comply with mandatory testing serve to eliminate the varsity team from the state tournament; vacate all team titles earned in that varsity sport in that school year; and suspend the non-complying athlete from sports activities during the subsequent calendar year.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

40.22.01- State Funding For Childhood Vaccines

Date: 10/30/1993

The Medical Society of Virginia supports the Virginia Department of Health ~~State Health Department~~ in seeking funding to purchase vaccines to be administered in physicians' offices to all children.

Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

Recommendation to Archive

23-103

Requirement for Doctors to Practice in Low-Income Communities

Submitted by Dr. Monroe Baldwin

WHEREAS, it is an established fact that there is considerably more illness in low-income communities, and

WHEREAS, the primary mission of the profession of medicine is diagnosis and treatment of illness, and

WHEREAS, doctors do not have a good reputation in low-income communities, and

WHEREAS, Brazil provides helpers for doctors to aid in making house calls in follow-up of office visits and making sure patients are taking their medicines, therefore be it

RESOLVED, the profession of medicine make a maximum effort to provide health care in low-income communities care being taken to build positive relationships and hopefully adding helpers to make house calls, etc, thereby making healthcare more thorough.

Fiscal Impact: None
Existing Policy: None

23-104

The Practice of Medicine is a Utility Economic Structure

Submitted by Dr. Monroe Baldwin

WHEREAS, doctors' offices and clinics are now in a free-market economy making them subject to antitrust laws. These laws prevent doctors combining to prevent monopolies which squash and prevent competition. The laws work to keep doctors in competition, thereby forcing prices down; and carried across the entire free market economy, the public has concluded that this is the best way to establish proper prices for all things, and

WHEREAS, doctors go out every day accomplishing healthcare similar to electrical, gas, and water personnel accomplishing their jobs and, therefore, can be considered similar to them which are utilities governed by the state or local government, and

WHEREAS, utilities negotiate their fees with their payors who are local, state, and federal government as well as insurance companies, and

WHEREAS, professions generally establish offices in sections of the economy that contain more affluent populations who are able to pay; while the profession of medicine has heavy responsibilities in communities that are unable to pay, and

WHEREAS, utilities must provide data to explain their costs in negotiating funding requests, and

WHEREAS, in a free market there is no central office or entity that can explain why America consumes 18% of the gross natural product and other civilized countries accomplish the same thing with 10-11% with better statistical results in many cases, and

WHEREAS, every doctor must have a license in the state where he/she practices which serves, by withdrawal, as a check on practice behavior should it not adhere to negotiated agreement, therefore be it

RESOLVED, the Medical Society of Virginia Supports the concept that the profession of medicine be considered a large utility for each state with a state office negotiating with state and federal governments as well as insurance companies for funds.

Fiscal Impact: None
Existing Policy: None

23-105

Insurance Coverage of Fertility Care

Submitted by The MSV Medical Student Section

WHEREAS, the Centers for Disease Control (CDC) and Prevention define infertility as the inability to conceive after one year (or longer) of unprotected sex[1], and

WHEREAS, 13.4% of all women age 15-49 have impaired fecundity and 40-50% of all cases of infertility are caused by male factor infertility[2,3], and

WHEREAS, studies show that the average cost of an in vitro fertilization (IVF) cycle is $12,400 and a successful IVF pregnancy costs upwards of $112,799[4,5,6], and

WHEREAS, since 2017, 11 states (California, Colorado, Connecticut, Delaware, Illinois, Maryland, New Hampshire, New Jersey, New York, Rhode Island, and Utah) passed benefit mandates for insurance coverage of FP (fertility preservation) services[7], and

WHEREAS, the policy of the American Medical Association states in Infertility and Fertility Preservation Insurance Coverage H-185.990 that, "Our AMA advocates for third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.", therefore be it

RESOLVED, that the Medical Society of Virginia supports the provision of coverage for diagnosis and treatment of male and female factor infertility within all insurance policies in the state of Virginia.

[1] Infertility FAQs. cdc.gov. https://www.cdc.gov/reproductivehealth/infertility/index.htm. Published 2022. Accessed September 22, 2022

[2] "NSFG - Listing I - Key Statistics from the National Survey of Family Growth." *Www.cdc.gov*, 16 Dec. 2022, www.cdc.gov/nchs/nsfg/key_statistics/i-keystat.htm. Accessed 20 Aug. 2023.

[3] Kumar N, Singh AK. Trends of male factor infertility, an important cause of infertility: A review of literature. *J Hum Reprod Sci*. 2015;8(4):191-196. doi:10.4103/0974-1208.170370

[4] American Society of Reproductive Medicine. (n.d.). Is in vitro fertilization expensive? In Vitro Fertilization (IVF). Retrieved November 28, 2022, from https://www.reproductivefacts.org/faqs/frequently-asked-questions-about-infertility/q06-is-in-vitro-fertilization-expensive/

[5] Katz P, Showstack J, Smith JF, et al. Costs of infertility treatment: results from an 18-month prospective cohort study. Fertil Steril. 2011;95(3):915-921. doi:10.1016/j.fertnstert.2010.11.026

[6] Klitzman R. How much is a child worth? Providers' and patients' views and responses concerning ethical and policy challenges in paying for ART. Linkov I, ed. PLoS ONE. 2017;12(2):e0171939. doi:10.1371/journal.pone.0171939

[7] Flores Ortega RE, Yoeun SW, Mesina O, Kaiser BN, McMenamin SB, Su HI. Assessment of Health Insurance Benefit Mandates for Fertility Preservation Among 11 US States. *JAMA Health Forum.* 2021;2(12):e214309. doi:10.1001/jamahealthforum.2021.4309

23-106

Hospital OR Time Set Aside

Submitted by The Medical Society of Northern Virginia

WHEREAS, most independent physicians have admitting privileges at hospitals located across the Commonwealth, and

WHEREAS, hospitals benefit from substantial funding from State and local governments, and

WHEREAS, independent physicians are experiencing extended waiting periods of up to 90 days to block operating room time to perform routine clinical surgeries on their patients, therefore be it

RESOLVED, that the Medical Society of Virginia supports the Medical Society of Northern Virginia's advocacy efforts to secure legislative patrons to introduce a bill in the Virginia 2024 General Assembly to mandate that any hospital that receives State or local government funding, set aside 40% of OR time for non-employed community physicians who have admission privileges.

Fiscal Impact: None
Existing Policy: None

23-107

Skilled Nursing Facility (SNF) Medical Director Listing

Submitted by The Richmond Academy of Medicine

WHEREAS, throughout the COVID-19 pandemic, congregate care settings, including nursing homes, disproportionately experienced large COVID-19 outbreaks, and

WHEREAS, in the early part of the pandemic, the facilities would often turn to the medical director of the facility for the latest guidance which created various adoptions of clinical practice and infection control, and

WHEREAS, in the later part of the pandemic when guidance was available from the state health department and CDC, the facilities would again turn to medical directors for interpretation guidance and case discussions. As such, medical directors for Skilled Nursing Facilities (SNFs) became important in guiding clinical guidelines and treatment of SNF patients, and

WHEREAS, the state health department and CDC often lacked the means necessary to communicate directly with SNF medical directors, and

WHEREAS, the information was largely coordinated with local health departments and SNF ownership, and

WHEREAS, information was changing rapidly and there was a need for the state health department to communicate directly with medical directors, and

WHEREAS, to build back a better support system for the next pandemic and emergency preparedness, the Commonwealth of Virginia needs to establish ongoing communication channels with nursing home medical directors, therefore be it

RESOLVED, that the Medical Society of Virginia work with the Department of Health, Office of Licensure and Certification (OLC) who regularly survey nursing homes for regulatory compliance to produce and make publicly available a list of all current medical directors whose contact information must be on record with the Virginia Department of Health.

Fiscal Impact: None
Existing Policy: None

23-108

CRNA Scope of Practice

Submitted by The Richmond Academy of Medicine

WHEREAS, that §§ 54.1-2900[1] and 54.1-2957[2] of the Code of Virginia requires a Certified Registered Nurse Anesthetists (CRNA) who is jointly licensed by the Boards of Medicine and Nursing to practice "under the supervision of a doctor of medicine, osteopathy, podiatry, or dentistry", and

WHEREAS, the Virginia General Assembly considered a bill in the 2023 session to extend independent practice to CRNA, (HB 2287, CRNA; practice, William C. Wampler, III)[3], and

WHEREAS, the American Association of Nurse Anesthesiology (AANA) nationally advocating for independent practice citing "…CRNAs are not extenders of physicians, nor are they dependent on physicians to provide anesthesia services. CRNAs practice both autonomously and in collaboration with other healthcare professionals on the inter-professional team to deliver high-quality, holistic, patient-centered, evidence-based anesthesia and pain care services,"[4], and

WHEREAS, the American Society of Anesthesiologists states, "Physician anesthesiologists are highly trained medical specialists. They evaluate, monitor, and supervise patient care before, during, and after surgery. Additionally, they diagnose and treat any complications that may occur – from cardiac arrest to excessive bleeding. In recent years, a growing number of state nurse anesthetist associations have promoted legislation or regulation to diminish or eliminate laws requiring nurse anesthetists to work within the relationship of a physician. To ensure optimal patient safety, it is critical that states maintain requirements for physician involvement when non-physician anesthetists such as nurse anesthetists administer anesthesia."[5] , and

WHEREAS, a 2018 World Health Organization-World Federation of Societies of Anesthesiologists (WHO-WFSA) article stating anesthesia is complex and hazardous and its administration "requires a high level of expertise in medical diagnosis, pharmacology, physiology, and anatomy…therefore, the WFSA views anesthesiology as a medical practice." Anesthesia should always be "provided, led, or overseen by an anesthesiologist." The article also states that when anesthesia is administered by someone other than a physician anesthesiologist, those providers should be "directed and supervised by anesthesiologists…"[6], and

WHEREAS, the American Psychiatric Association's 2017 A Consensus Statement on the Use of Ketamine in the Treatment of Mood Disorders states, "We suggest that a licensed clinician who can administer a Drug Enforcement Administration Schedule III medication (in most states this is an [sic] MD or DO with appropriate licensing with Advanced Cardiac Life Support Certification should provide the

treatments."[7] CRNAs have little, if any, formal training to evaluate and treat psychiatric conditions, and

WHEREAS, Patient safety and quality of care are of paramount importance, therefore be it

RESOLVED, that the Medical Society of Virginia supports the requirement of physician supervision of certified registered nurse anesthetists (CRNA) in all practice settings including telehealth, and be it further

RESOLVED, that the Medical Society of Virginia actively oppose all legislation or regulation permitting independent practice by CRNA in the Commonwealth of Virginia.

Fiscal Impact: None

Existing Policy: None

References:

1. https://law.lis.virginia.gov/vacode/54.1-2900/
2. https://law.lis.virginia.gov/vacode/54.1-2957/
3. https://lis.virginia.gov/cgi-bin/legp604.exe?231+sum+HB2287
4. https://www.aana.com/docs/default-source/practice-aana-com-web-documents-(all)/professional-practice-manual/crna-advanced-practice-registered-nurses.pdf?sfvrsn=da0049b1_16
5. https://www.asahq.org/advocacy-and-asapac/advocacy-topics/supervision-of-nurse-anesthetists
6. file:///C:/Users/jbeckner/Downloads/WHO%20Excerpt_FINAL%20(4).pdf
7. https://vailmed.com/PDF/Consenus%20Statement%20on%20the%20Use%20of%20Ketamine%20in%20the%20Treatment%20of%20Mood%20Disorders%20JAMA%20Psychiatry.pdf

23-109

Post-Acute and Long-Term Care (PALTC) Physician Workforce Shortage

Submitted by The Richmond Academy of Medicine

WHEREAS, primary care physician shortages are well reported and studied in the literature, and

WHEREAS, according to one study, the Association of American Medical Colleges (AAMC) projects a shortage of 21,000 to 55,000 primary care physicians by 2033, and

WHEREAS, other organizations like the US Health Resources and Services Administration (HRSA) have predicted a shortage of more than 23,000 primary care physicians by 2025, and

WHEREAS, what is less known is the shortage of physicians and advance practice practitioners (APPs - NPs/PAs) practicing in post-acute and long-term care medicine (PALTC), therefore be it

RESOLVED, that the Medical Society of Virginia ask the General Assembly to commission a study through the Joint Commission on Healthcare (JCHC) looking at the supply and demand of medical directors, physicians and NP/PA workforce in post-acute and long-term care medicine in the Commonwealth of Virginia.

Fiscal Impact: None
Existing Policy: None

Resources:

1. White, Ryan MS, MPH, PA-C; Keahey, David PA-C, MSPH; Luck, Morgan MS, PA-C; Dehn, Richard W. MPA, PA-C, DFAAPA. Primary care workforce paradox: A physician shortage and a PA and NP surplus. Journal of the American Academy of Physician Assistants 34(10):p 39-42, October 2021. | DOI: 10.1097/01.JAA.0000791476.25727.d9
2. Association of American Medical Colleges. The Complexities of Physician Supply and Demand: Projections from 2018-2033. www.aamc.org/media/45976/download. Accessed April 25, 2023.
3. US Health Resources and Services Administration, National Center for Health Workforce Analysis. National and regional projections of supply and demand for primary care practitioners: 2013-2025. November 2016. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/primary-care-national-projections-2013-2025.pdf. Accessed April 25, 2023.

JCHC Related Studies:

1. 2010: RD90 - Final Report: Analysis of Virginia's Health Workforce Pipelines. https://rga.lis.virginia.gov/Published/2010/RD90/PDF
2. 2014: HD2 - Update on the Virginia Physician Workforce Shortage (HJR 689, 2013). https://rga.lis.virginia.gov/Published/2014/HD2/PDF

23-110

Support Single-Payer Health Care

Submitted by Edward Si

WHEREAS, people in the United States (U.S.) experience the worst health outcomes overall of any high-income nation[1], and

WHEREAS, health care spending, both per person and as a share of gross domestic product (GDP), is twice as much per capita relative to other nations of similar size and wealth, and more than any nation that provides universal coverage[2], and

WHEREAS, the U.S. has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates of any high-income nation[2], and

WHEREAS, Americans see physicians less often than people in most other countries and have among the lowest rate of practicing physicians and hospital beds per 1,000 population[2], and

WHEREAS, forty-three percent of working-age adults were inadequately insured in 2022. Of this population, 9% were uninsured, 11% had a gap coverage over the past year, and 23% were underinsured, meaning that their coverage did not provide them with affordable access to health care[3], and

WHEREAS, lack of health insurance is associated with higher morbidity and mortality rates, and when compared to ten other high-income countries, the U.S. ranks last in healthcare affordability, and has the highest rate of infant mortality and mortality amenable to health care[4-7], and

WHEREAS, the shrinking number of employer-sponsored health plans are increasingly unaffordable for workers since 85% of these plans include an annual deductible averaging $1,931[8], and

WHEREAS, illness and medical bills contribute to 66.5% of all bankruptcies, a figure that is virtually unchanged since the passage of the Affordable Care Act (ACA)[9], and

WHEREAS, COVID-19 has exposed the fragility of job-connected health insurance for people and employers as evidenced by millions of Americans losing employer sponsored health insurance[10], and

WHEREAS, a single-payer system could control costs through proven-effective mechanisms such as global budgets for hospitals and negotiated drug prices, thereby making healthcare financing sustainable[11], and

WHEREAS, total administrative costs make up 34.2% of U.S. health spending, while the administrative costs of fee-for-service Medicare is less than 2%[12-13], and

WHEREAS, the U.S. could save over $500 billion annually on administrative costs with a single-payer system[11,14], and

WHEREAS, the savings from reduced administrative costs would be enough to cover all of the uninsured and eliminate cost sharing for everyone else[15], and

WHEREAS, US physicians spend an average 20.6 hours per week interacting with health plans—nearly ten times that of Canadian counterparts[16], and

WHEREAS, billing-driven documentation that contributes to physician burnout would be greatly reduced under a single-payer reform, freeing up roughly 5% of doctors' work hours[17,18], and

WHEREAS, the Medical Society of Virginia (MSV) supports efforts to address the mental health of physicians including the issue or burnout (05.5.04), and

WHEREAS, prominent economic analyses of single-payer reform, such as those from the Congressional Budget Office, have projected that net increases in physicians' revenue could rise by between $39,816 and $157,412 annually[18], and

WHEREAS, a single-payer reform will dramatically reduce, although not eliminate, health disparities. The passage of Medicare in 1965 led to the rapid desegregation of 99.6% of U.S. hospitals[19], and

WHEREAS, the MSV recognizes health disparities as a major public health problem and will support policies and strategic interventions that decrease health disparities in medicine (05.4.01)- and as leaders of the healthcare field, we must remain open to engaging in productive conversations to create a healthcare system that mutually benefits patients and physicians, and

WHEREAS, the MSV supports policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase (35.3.06), and

WHEREAS, under a single-payer system it is estimated that savings on prescription drugs would be between $200 billion and $300 billion a year, if we paid about the same price as other wealthy countries pay for their drugs[15], and

WHEREAS, the MSV opposes any legislative program which would prevent free choice of physician by patient or patient by physician, and opposes efforts to interfere with or jeopardize the sanctity of the patient/physician relationship (10.3.06, 25.3.02), and

WHEREAS, a single-payer system will allow patients to freely choose their doctors, in contrast to our current health insurance system of narrow provider networks and employer-based private health insurance, which restricts patients from having full freedom to choose their insurance plan and disrupts the physician-patient relationship[20-23], and

WHEREAS, a single-payer system could allow private practice to once again become a viable practice setting; for example, in Canada most physicians are self-employed in private practice[24], and

WHEREAS, single-payer could improve the viability of the private practice of medicine by reducing administrative expenses, allowing more time for actual patient care, and establishing site-neutral payment policies[11,14], and

WHEREAS, the MSV seeks legislation that would implement a cost effective alternative to address malpractice cases involving substantial medical expenses (15.3.01), and

WHEREAS, a single-payer reform will reduce malpractice lawsuits and insurance costs because injured patients would not have to sue for coverage of future medical expenses[25], and

WHEREAS, the MSV believes all persons in Virginia should have access to medical services without discrimination based on race, religion, age, social status, income, sexual orientation or gender identity or expression (05.4.01), and

WHEREAS, meta studies have concluded that single-payer systems are the best health care systems in terms of risk pooling, administrative costs, health care equity, and negotiation—all of which is in the direct interest of the LGBTQ community[26], and

WHEREAS, the MSV supports policies and strategic interventions that decrease health disparities in medicine and supports efforts in pursuing a low cost insurance product to be available for uninsured Virginians and low-income workers. (05.4.01, 10.3.15), and

WHEREAS, a single-payer system would address access and affordability issues for all Virginians by covering all U.S. residents for all medically necessary services and patients would no longer face financial barriers to care such as copays or deductibles, and would regain free choice of doctor and hospital[27], and

WHEREAS, the MSV supports the promotion of preventive medicine, public health, and primary care as a priority in the allocation of revenues from the General Fund and strongly supports legislation to strengthen the infrastructure of the Public Health System in Virginia, and to provide an equitable, stable and adequate source of funding to accomplish this (40.15.03, 40.20.01), and

WHEREAS, given that a single-payer system would be financially responsible for healthcare throughout the lifespan of all Americans, it becomes efficient to incur a small cost in the present with the purpose of avoiding more serious and costly health conditions in the future[28], and

WHEREAS, by contrast, private insurance companies, within which patients are most often transiently enrolled, maximize profit by minimizing short-term costs[28], and

WHEREAS, the American Medical Association (AMA) and World Health Organization both recognize health care as a basic human right and its provision as an ethical obligation of a civil society[29-31], and

WHEREAS, other physician groups such as the American College of Physicians, American Medical Student Association, Vermont Medical Society, Hawaii Medical Society, New Hampshire Medical Society, and Washington State Medical Association endorse single-payer health care reform[32], therefore be it

RESOLVED, that the Medical Society of Virginia expresses its support for universal access to comprehensive, affordable, high-quality health care through a single-payer national health insurance program, as well as for single-payer legislation at the state level.

Existing Policy:

05.4.01- Access without Discrimination Date:
11/5/1994
The Medical Society of Virginia believes that all persons in Virginia should have access to medical services without discrimination based on race, religion, age, social status, income,
sexual orientation or gender identity or expression. The MSV recognizes 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.

05.5.04- Burnout and Suicide Prevention Date:
10/16/2016
The Medical Society of Virginia supports efforts to address the mental health of medical
students, residents, and physicians. The Medical Society of Virginia will work cooperatively with state and national stakeholders to develop and promote strategies for comprehensive education,
screening and treatment of mental health issues including burnout and suicide prevention.

10.3.06- Freedom of Choice - Patients and Physicians Date:
11/5/1994
The Medical Society of Virginia opposes any legislative program which would prevent free choice of physician by patient or patient by physician.

10.3.15- Low Cost Insurance Product
Date: 11/8/1997
The Medical Society of Virginia supports the concept of a low cost health insurance product and continued efforts in pursuing a low cost insurance product to be available for uninsured Virginians, low income workers, and small businesses.

15.3.01- Medical Malpractice Cap on Damages
Date: 11/9/1991
The Medical Society of Virginia supports maintaining the cap on professional medical liability awards at a level consistent with the Code of the Commonwealth § 8.01-581.15 and seeks legislation that would implement a cost effective alternative to address cases involving
substantial medical expenses. Furthermore, the Medical Society of Virginia opposes efforts to extend the cap or attempts to increase, stack, or repeal the cap, including any attempt to add on an inflation factor.

25.3.02- Legislation, Standards of Care, and the Patient/Physician Relationship Date:
11/2/2012
The Medical Society of Virginia opposes efforts to interfere with or jeopardize the sanctity of the patient/physician relationship.
The MSV supports 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.
The MSV further opposes all criminal penalties against physicians and the other healthcare providers who deliver, and the patients who receive care that is evidence-based.

35.3.06- Reasonable Price Control for Prescription Medications Date:
10/20/2019
The Medical Society of Virginia supports policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

40.15.03 – Public Health
Date: 11/5/1994
The Medical Society of Virginia strongly supports legislation to strengthen the infrastructure of the Public Health System in Virginia, and to provide an equitable, stable and adequate source of funding to accomplish this.

40.20.01- Reallocation from General Fund for Preventive Health Date:
10/31/1992
The Medical Society of Virginia supports the promotion of preventive medicine, public health, and primary care as a priority in the allocation of revenues from the General Fund.

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23-111

Resolution to Direct the MSV AMA Delegation to Expand the AMA's Position on Healthcare Reform Options

Submitted by Edward Si

WHEREAS, AMA policy states that "health care is a basic human right" and that "the provision of health care services… is an ethical obligation of a civil society." (H-65.960), and

WHEREAS, AMA Principles of Medical Ethics states that "physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means" (11.1.4 Financial Barriers to Health Care Access), and

WHEREAS, AMA policy establishes "a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans" (H-165.904), and

WHEREAS, AMA policy supports health insurance coverage for all Americans (H-165.838), and

WHEREAS, AMA policy calls for improved health insurance affordability (H-165.824, H-165.828), and

WHEREAS, AMA policy supports the curtailment of surprise out-of-network billing (H-285.904), and

WHEREAS, AMA policy recognizes that systemic bias in healthcare financing has been one of many factors leading to rural health disparities and will advocate for elimination of these biases through payment policy reform to help reduce the shortage of rural physicians and eliminate health inequities in rural America (H-390.898), and

WHEREAS, advancing health equity is a stated goal of the AMA (H-140.824, H-180.944), and

WHEREAS, AMA policy opposes excessive regulatory costs (H-155.974), and

WHEREAS, AMA policy supports reducing non-clinical health system costs that do not contribute value to patient care (H-155.960), and

WHEREAS, AMA policy supports programs whose purpose is to contain the rising costs of prescription drugs (H-110.997), and

WHEREAS, AMA policy supports federal medical liability reform and the inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform (H-435.978, D-435.974), and

WHEREAS, AMA policy supports streamlining the prior authorization process and reducing the overall volume of prior authorizations for physician practices (D-320.978), and

WHEREAS, AMA policy supports comprehensive reforms to reduce the administrative inefficiencies, costs, and burdens (H-155.976), and

WHEREAS, AMA policy states that "Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians" (H-373.998), and

WHEREAS, evidence suggests that a single-payer health insurance system has the potential to address the above AMA policies via: elimination of uninsurance and underinsurance through universal coverage[1-3]; improved health insurance affordability and elimination of surprise bills through no out-of-pocket payments[1,4]; improved financing for physicians in rural areas through removal of systemic biases[5,6]; improved health equity through reduced disparities in health insurance coverage and health care access, with greatest relief to lower-income households[7-9]; improved prescription drug costs through drug price negotiations[10]; reduced tort claims because medical expenses would no longer be a major concern[11]; reduced prior authorization burden[12]; reduced administrative expenses[1-3,13]; expanded patient choice to choose any physician[3], and

WHEREAS, evidence suggests that a single-payer health insurance system has potential added benefits such as saving over 68,000 lives and 1.73 million life-years every year,[8] saving the health system billions annually,[14,15] having positive effects on the economy,[16] lowering the cost burden for lower- and middle-income households,[17] and even leading to increased physician wages[18], and

WHEREAS, single-payer health insurance is not a monolith, and the effects on the economy and individuals would depend on key features of the design of the program, such as how it paid clinicians and what services were covered[19], and

WHEREAS, our AMA is limited in its ability to meaningfully contribute to the design and implementation of any potential single-payer proposals due to its blanket opposition to single-payer financing mechanisms, and

WHEREAS, other physician groups part of the AMA, such as the American College of Physicians,[20] American Medical Women's Association,[21] Hawaii Medical Society,[22] New Hampshire Medical Society,[23] Vermont Medical Society,[24] and

Washington State Medical Association,[25] endorse a single-payer financing approach as an option to achieve universal coverage, and

WHEREAS, evidence suggests that our AMA's stance against single-payer does not currently represent the majority of physicians, with surveys by Merritt Hawkins (56% either strongly support or somewhat support a single-payer system),[26] The Physicians Foundation (67% rate a two-tiered system featuring a single payer option plus private pay insurance as the best or next-best direction for the U.S. health care system),[27] and the Chicago Medical Society (66.8% have a "generally favorable" view of a single-payer financing health care system),[28] demonstrating broad support for single-payer health insurance, therefore be it

RESOLVED, that our AMA adopts a neutral stance on single payer healthcare reform, and instead will evaluate single payer proposals by the extent to which they align with the AMA's policy on healthcare reform, and be it further

RESOLVED, that the MSV AMA delegation is directed to introduce this resolution by the next AMA Annual Meeting.

Fiscal Impact: Minimal – less than $1,000.

Existing Policy:

05.4.01- Access without Discrimination

Date: 11/5/1994

The Medical Society of Virginia believes that all persons in Virginia should have access to medical services without discrimination based on race, religion, age, social status, income, sexual orientation or gender identity or expression. The MSV recognizes 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.

10.3.02- Single Payer System

Date: 10/31/1992

The Medical Society of Virginia will support discussion of a national system of providing and financing a Single Payer System of health insurance.

10.3.04- Fair Market Competition/Systems Date:

11/5/1994

The Medical Society of Virginia supports the concept of neutral public policy and fair market competition among all systems of health care delivery. The potential growth of HMOs should not be determined by federal subsidy, preferential federal regulation, or federal advertising promotion, but by the number of consumers who prefer this mode of delivery. Further, public policy should not exempt HMOs from fair market competition and applicable laws.

10.3.05- Federal Regulation of Private System

Date: 11/5/1994

The Medical Society of Virginia opposes any legislation which would increase federal regulation of or control over the private health care system.

10.3.08- Free-Market
Date: 11/5/1994
The Medical Society of Virginia endorses a plurality of health care delivery and financing systems in a free market setting.

10.3.09- Opposition to Preferential Treatment Date:
11/5/1994
The Medical Society of Virginia opposes any program which would create or perpetuate preferential treatment of any one system or plan of health care over another.

10.3.12- Use of Medicine/Business Coalitions/Reform Date:
11/5/1994

The Medical Society of Virginia endorses the use of medicine/business coalitions to discuss problems of mutual concern and to work together to seek health system reform in the Commonwealth.

10.3.15- Low Cost Insurance Product Date:
11/8/1997
The Medical Society of Virginia supports the concept of a low cost health insurance product and continued efforts in pursuing a low cost insurance product to be available for uninsured Virginians, low income workers, and small businesses.

10.3.17- Guidelines for Health Care System Reform Date:
2/5/2011
The Medical Society of Virginia adopts the following guidelines for health care system reform:

1. Every individual should be required to have an insurance policy that meets individual and family needs. The health care system should be structured so as to encourage the individual purchase of insurance, which may include public, private and/or employer-based incentives.
2. All Virginians should be granted access to essential health care through a defined minimum benefit package.
3. Universal health care should be provided that encourages and emphasizes the responsibility of the individual.
4. Government programs should provide assistance to those unable to provide coverage for themselves or their families. Public financial support for the indigent should be provided through appropriate patient vouchers, incentives and tax credits for the purchase of health insurance.
5. All reform should include Medicare, Medicaid and federal employee health benefits programs. The Medicaid program should be reformed and/or replaced with an alternative system designed to provide benefits to persons at or below the poverty level.
6. The health insurance market should be reformed to increase availability of affordable health insurance options. These reforms should include:
   - community based rating
   - creation of state risk pools
   - elimination of waiting periods and pre-existing condition clauses
   - approved health benefit insurance options
   - greater emphasis on providing coverage for catastrophic, long term and preventive care
   - portability of coverage
7. The health care system should place increased emphasis upon the patient's responsibility for his/her health and insurance premiums should be structured to encourage healthy lifestyles and preventive care. Individuals should be encouraged and rewarded for healthy behaviors (e.g., reduced consumption of alcohol and tobacco,

use of seat belts, healthy eating habits and body weight, consistent exercise).

8. Costs and quality should be controlled in part by ensuring that appropriate medical procedures are delivered in a cost effective manner. This can be accomplished through:

1. the development and appropriate use of professionally developed practice parameters
2. enactment of meaningful tort reform to reduce costs associated with the defensive practice of medicine
3. providing immunity to physicians who withdraw or withhold care appropriately deemed to be medically futile by an interdisciplinary ethics committee
4. administrative efficiencies
5. regulatory reform

9. Quality of care is paramount in the doctor/patient relationship and should be promoted by: •appropriate initial and continuing physician education programs

- credentialing of physicians subject to any willing provider provisions
- encouraging the ethical practice of medicine
- eliminating economic disincentives to provide appropriate care
- appropriate quality assurance mechanisms

10. The patient should be encouraged to base health care decisions on value considerations. Value competition in the health care marketplace should be enhanced by:

- creating easily accessible sources (public and/or private) of information regarding the fees and qualifications of physicians and other health care providers
- requiring physicians and other health care providers to release price information upon request prior to treatment
- encouraging the voluntary release of fee information when feasible

11. Administrative costs should be reduced, and the fairness and appropriateness of coverage decisions should be improved by:

- requiring all third-party payers to use a uniform claims form
- requiring professional development and universal use of one set of medical necessity and utilization review screening criteria by all third-party payers
- eliminating unnecessary regulation and/or streamlining cumbersome regulation of physicians and other health care providers

35.3.06- Reasonable Price Control for Prescription Medications Date: 10/20/2019

The Medical Society of Virginia supports policies that prohibit price gouging

40.15.03- Public Health
Date: 11/5/1994

The Medical Society of Virginia strongly supports legislation to strengthen the infrastructure of the Public Health System in Virginia, and to provide an equitable, stable and adequate source of funding to accomplish this.

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23-112

Increased Oversight of Medicare Advantage Plans

Submitted by Edward Si

WHEREAS, the Tax Equity and Fiscal Responsibility Act of 1982 authorized Medicare to contract with private health plans creating Medicare Part C, now known as Medicare Advantage (MA), with the intended goals of increasing beneficiaries' benefits and lowering the cost to taxpayers[1], and

WHEREAS, in 2019 taxpayers paid $9 billion more to MA plans than if the enrollees of these MA plans were instead on fee-for-service Traditional Medicare (TM)[2], and

WHEREAS, this increase in costs to taxpayers compared to TM is due in part to MA plans' financial incentive to inflate their enrollees' risk scores, via increased diagnostic coding intensity, in order to increase payment[2], and

WHEREAS, the Medical Society of Virginia (MSV) supports strong and continued evaluation of capitated health plans and suggests requiring the plan to disclose to the plan member the exposure to the incentive risks and insurance risks imposed upon the physician (10.9.08), and

WHEREAS, multiple MA plans have allegedly submitted false and invalid diagnosis codes to the government and have or are currently facing lawsuits by the U.S. Department of Justice[3], and

WHEREAS, MA plans restrict their enrollees' access to providers by putting them into networks such that 35% of MA beneficiaries were in networks that had less than 30% of their counties' physicians, whereas TM beneficiaries can access 98% of physicians in America[4], and

WHEREAS, the MSV opposes any legislative program which would prevent free choice of physician by patient or patient by physician (10.3.06), and

WHEREAS, MA plans denied 13% of prior authorization requests considered "medically necessary;" the three most prominent services rejected were advanced diagnostic imaging, transfers to post-acute care facilities, and injections[5], and

WHEREAS, 18% of payment requests by providers rejected by MA plans should have actually been approved[5], and

WHEREAS, the MSV opposes any health plan mechanism that interferes in the timely delivery of medically necessary care and supports the timely payment of claims (10.10.04, 10.9.06), and

WHEREAS, the MSV believes that "all health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former" (10.5.03), and

WHEREAS, MA plans use aggressive marketing tactics as well as false and misleading information to advertise their plans to vulnerable seniors and/or people with disabilities[6], and

WHEREAS, high-need enrollees in MA plans are more likely than non-high-need enrollees to disenroll from MA plans into TM, even in the highest rated MA plans[7], and

WHEREAS, MA plans have increased the burden on taxpayers while performing little in difference compared to TM[8], and in light of the litany of aforementioned problems such as risk-score inflation, perverse incentives for physicians to manipulate diagnosis codes, criminal fraud, restricted provider networks, denial of medically necessary prior authorization requests, burden for physicians in denial of payment requests, and deceptive marketing tactics targeting the senior and disabled population, therefore be it

RESOLVED, the MSV will oppose the perpetuation of MA plans for problems inherent to their operations including but not limited to risk-score manipulation, perverse incentives for physicians to participate in increased diagnosis code intensity, and fraud. The MSV will do so by supporting legislation for increased oversight and investigation of Medicare Advantage plans and other risk-based capitation models. In addition, the MSV will support efforts to educate seniors and the general public on the implications of participating in programs offered under Medicare Advantage (e.g. narrow provider networks, denial of prior authorization requests) and support efforts to protect seniors and people of disability from misleading marketing tactics.

Fiscal Impact: None

Existing Policy:

10.3.06- Freedom of Choice - Patients and Physicians Date:
11/5/1994
The Medical Society of Virginia opposes any legislative program which would prevent free choice of physician by patient or patient by physician.

10.5.03- Principles of Managed Care (Part D) Date:
11/5/1994
D. Disclosure
All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

10.9.06- Timely Insurance Claims Payment Date:
11/4/1995
The Medical Society of Virginia supports the timely payment of claims and supports efforts to require all health plans to pay interest on claims unpaid thirty days after submission.

Resources:

1. Meyers, D. J., Belanger, E., Joyce, N., McHugh, J., Rahman, M., & Mor, V.(2019). Analysis of drivers of disenrollment and plan switching among Medicare Advantage Beneficiaries. *JAMA Internal Medicine*, *179*(4), 524–532. https://doi.org/10.1001/jamainternmed.2018.763X
2. Ochieng, N., & Biniek, J. F. (2033). *Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature*. KFF. Retrieved August 26, 2023, from https://www.kff.org/medicare/report/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/.
3. UNITED STATES OF AMERICA v. CIGNA CORPORATION, et al. (District Court for the Middle District of Tennessee Nashville Division October 14, 2022).
4. Jacobsen, G., Rae, M., Neuman, T., Orgera, K., & Boccuti, C. (2017). Medicare Advantage: October 2017 How Robust Are Plans' Physician Networks? Kaiser Family Foundation.
5. Grimm, C. A., Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. Office of Inspector General.
6. Wyden, R., Deceptive Marketing Practices Flourish in Medicare Advantage (2022). US Senate Committee on Finance.
7. Meyers, D. J., Belanger, E., Joyce, N., McHugh, J., Rahman, M., & Mor, V. (2019). Analysis of drivers of disenrollment and plan switching among Medicare Advantage Beneficiaries. JAMA Internal Medicine, 179(4), 524–532. https://doi.org/10.1001/jamainternmed.2018.7639
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23-113

Prescription and Administration of mRNA Vaccines

Submitted by James C. LaRocque, MD

WHEREAS, mRNA vaccines for COVID-19 are licensed and administered by the federal and state governments only under an Emergency Use Authorization, and have not been proven by any long-term study to be safe for human use[1], and

WHEREAS, substantial bodies of evidence exist which demonstrate major harm can accrue to those to whom the vaccine is administered[2], and

WHEREAS, according to the principles of the Nuremberg Code enshrined in International Law, voluntary consent is absolutely essential before an experimental agent is administered to a human subject[3], and

WHEREAS, the State of Emergency declared by the federal government concerning the coronavirus COVID-19 pandemic as of 11 May 2023 is no longer is in effect, and

WHEREAS, the present prevalence of coronavirus COVID-19 no longer constitutes an epidemic, and has been transformed by mutation and herd immunity to an endemic prevalence similar to other coronaviruses[4], therefore be it

RESOLVED, that the MSV does not support, and in fact decries the use of "vaccine mandates" and any and all other forms of coercion, whether by the state itself or by private employers, schools, universities or other bodies that would in any way constrain individuals to accept administration of an mRNA vaccine, and be it further

RESOLVED, that the MSV hereby enjoins physicians and all other health care providers in prescribing mRNA vaccines to their patients to meticulously follow all provisions of the Nuremberg Code for protection of experimental subjects. It specifically asserts that voluntary unconstrained consent is an essential and absolute requirement for vaccine administration. Such consent must include provision of full disclosure of all benefits and all known and possible risks, to the patient's full comprehension.

References:

1. U.S. Food and Drug Administration (www.fda.gov) https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-changes-simplify-use-bivalent-mrna-covid-19-vaccines#:~:text=Today%2C%20the%20U.S.%20Food%20and,4%2FBA.
2. Center for Disease Control and Prevention (www.cdc.gov) https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/myocarditis.html#:~:text=Pericarditis%20is%20inflammation%20of%20the%20outer%20lining%20of%20the%20heart.&text=Myocarditis%20and%20pericarditis%20have%20rarely,Pfizer%2DBioNTech%20or%20Moderna).
3. *The Nuremberg Code 75th Anniversary Edition,* Brasscheck Press, Tivoli NY, 2022

4. Virginia Department of Health (www.vdh.virginia.gov) https://www.vdh.virginia.gov/news/statement-from-virginia-state-health-commissioner-colin-m-greene-md-mph-on-updates-to-virginia-department-of-health-covid-19-quarantine-and-isolation-guidance/

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2023

Reference Committee Two Index

The following section contains a list of the resolutions considered by Reference Committee Two

23-201

Protecting Physicians from Health Plan Credit Card Fees

Submitted by The Richmond Academy of Medicine

WHEREAS, section 1104 of the Affordable Care Act expanded efforts to standardize health care business practices, electronic funds transfer (EFTs) and electronic remittance advice (ERA). The CMS ERA and EFT rule was published in 2012 and took effect in 2014. The standards apply to all insurers, not just Medicare and Medicaid[1], and

WHEREAS, not all private insurers followed the letter or spirit of the regulations. Some insisted on making payments with so-called virtual credit cards (VCCs), a 16-digit number emailed, faxed or mailed to a provider in order to make a one-time payment[1], and

WHEREAS, VCCs often receive cash back (up to 1.75 percent) or other incentives for these transactions. The bank or credit card company issuing the VCC is also paid for use of their card network. In other words, unknown to many physicians and their staff responsible for claims and billing, insurers and credit card companies are indirectly charging up to 5 percent of a claim for processing the transfer of money via VCC[2], and

WHEREAS, an August 2014 letter from the AMA to the Health and Human Services Secretary states, "Providers are unexpectedly losing income through these card fees, which essentially reduce the contracted fee rate that has been negotiated with the health plan for a particular service or services. Many providers are understandably opposed to incurring these fees, especially when they did not choose to use this payment method and when they are faced with a manual, burdensome opt-out process that further delays payment."[1], and

WHEREAS, CMS states on its FAQ page, "A health plan cannot require a provider to accept virtual credit card payments," the CMS states. "A provider has the right to request that a health plan use the electronic funds transfer (EFT) transaction. If a provider makes the request, the health plan must comply."[1], and

WHEREAS, not only do individual practices benefit from adherence to the ACH (Automated Clearing House) EFT, the health system as a whole could save billions if more transactions are done electronically rather than manually, according to the "2016 CAQH Index," a report on health care adoption of electronic business processes published by the Council for Affordable Quality Healthcare[1], therefore be it

RESOLVED, that the Medical Society of Virginia fully support the advocacy efforts of the AMA to require all insurers fully adhere to the ACH EFT, and be it further

RESOLVED, that the Medical Society of Virginia proactively sponsor and/or support legislation to ensure (A) physicians are notified by all insurers in their contracts and in separate written notice annually of their right to be paid with ACH EFT payments over VCCs; (B) that all insurer contracts contain specific language that the health insurer cannot delay or deny a transaction because of the choice of electronic funds transfer; (C) That physicians and practices must specifically "opt in" in writing to be paid by VCCs; (D) that any "value added fees must be individually itemized and declared in writing annually to each participating physician; (E) and require specific written agreement by any participating physician prior to being charged such fees.

Fiscal Impact: None
Existing Policy: None

Citations:

1. Physicians protected from health plan credit card fees; American Medical Association, https://www.ama-assn.org/practice-management/claims-processing/physicians-protected-health-plan-credit-card-fees
2. CMS Issues More Protections to Physicians from Health Plan Credit Card Fees; Medical Association of the State of Alabama, https://alabamamedicine.org/?p=2174

Additional Resources:

1. https://www.propublica.org/article/the-hidden-fee-costing-doctors-millions-every-year
2. https://www.medscape.com/viewarticle/lobbying-allowed-insurers-charge-docs-receive-payments-2023a1000jdl?ecd=WNL_trdalrt_pos1_230822_etid5777901&uac=282294BY&impID=5777901

23-202

SafeHaven for Medical and Physician Assistant Students

Submitted by The MSV Medical Student Section

WHEREAS, increased rates of burnout and depression have been reported in health care workers since the start of the COVID-19 pandemic and are risk factors for physician suicide, medical errors, patient safety issues, teamwork deterioration, and patient mortality[1,2], and

WHEREAS, it is estimated that almost half of medical students will experience emotional exhaustion, depersonalization, and reduced sense of personal accomplishment during their time in medical school, with a current reported prevalence of 37.23%[2,3,4], and

WHEREAS, Physician Assistant students are at an increased risk of developing major depression during didactic years[5], and

WHEREAS, in 2020, the Virginia General Assembly Session passed legislation enabling the creation of the SafeHaven program to address confidential access to mental health services among clinicians and trainees, and

WHEREAS, there is no standardized mental health programing among medical students and physician assistant students across the Commonwealth of Virginia, and therefore be it

RESOLVED, the Medical Society of Virginia supports the adoption of SafeHaven programs at all medical schools and physician assistant programs in the state because it is imperative for improving the health and wellness of the future healthcare workforce.

[1] Burrowes SAB, Casey SM, Pierre-Joseph N, et al. COVID-19 pandemic impacts on mental health, burnout, and longevity in the workplace among healthcare workers: A mixed methods study. *J Interprof Educ Pract*. 2023;32:100661. doi:10.1016/j.xjep.2023.100661

[2] Muaddi MA, El-Setouhy M, Alharbi AA, et al. Assessment of Medical Students Burnout during COVID-19 Pandemic. Int J Environ Res Public Health. 2023;20(4):3560. doi:10.3390/ijerph20043560

[3] Prevalence of burnout in medical students: A systematic review and meta-analysis - Hessah Almutairi, Abeer Alsubaiei, Sara Abduljawad, Amna Alshatti, Feten Fekih-Romdhane, Mariwan Husni, Haitham Jahrami, 2022. Accessed August 20, 2023. https://journals.sagepub.com/doi/10.1177/00207640221106691?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

[4] Jezzini-Martinez S, Martinez-Garza JH, Quiroga-Garza A, et al. Assessment of burnout syndrome and associated factors among medical students during the COVID-19 pandemic. Journal of Affective Disorders Reports. 2023;14:100616. doi:10.1016/j.jadr.2023.100616

[5] Neary S, Ruggeri M, Roman C. Assessing Trends in Physician Assistant Student Depression Risk, Suicidal Ideation, and Mental Health Help-Seeking Behavior. J Physician Assist Educ. 2021 Sep 1;32(3):138-142. doi: 10.1097/JPA.0000000000000369. PMID: 34293797.

Resources:
MSV Policy Compendium

- 40.18.05 - Supporting Standardization
- 05.5.03 - House Staff Depression
- 05.5.04 - Burnout and Suicide Prevention

Health care providers, certain; program to address career fatigue and wellness, civil immunity, HB 115/SB 120, 161st Virginia General Assembly (2020).
https://lis.virginia.gov/cgi-bin/legp604.exe?201+sum+HB115
https://lis.virginia.gov/cgi-bin/legp604.exe?201+sum+SB120

Career fatigue and wellness in certain health care providers; programs to address, civil immunity, HB 1913/SB 1205, 162nd Virginia General Assembly, Special Session I (2021).
https://lis.virginia.gov/cgi-bin/legp604.exe?212+sum+HB1913
https://lis.virginia.gov/cgi-bin/legp604.exe?212+sum+SB1205

23-203

Advancing Health Equity Through Implicit Bias and Health Literacy Education Within Virginia's Academic Medical Centers

Submitted by The MSV Medical Student Section

WHEREAS, policy 20.4.05 of the MSV Policy Compendium states, "that 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. The Medical Society of Virginia believes such coursework should be influenced by historical and evidence-based research. 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,", and

WHEREAS, patient-provider communication is a cornerstone of patient-centered care with important implications for health outcomes[1,3], and

WHEREAS, health literacy, especially organizational health literacy characteristics, serves as a backbone for effective patient-provider communication[1,2], and

WHEREAS, peer-reviewed prospective studies and established health literacy initiatives throughout the Commonwealth have demonstrated the benefits of increasing health literacy among patients and communities of color[1,4,5], therefore be it

RESOLVED, that the MSV supports amending Policy 20.4.05 to read:

"... the Medical Society of Virginia supports the necessary inclusion of implicit bias, and health inequity education, and structured health literacy curricula for students, trainees, 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. The Medical Society of Virginia believes such coursework should be influenced by historical and evidence-based research. The Medical Society of Virginia encourages the American Medical Association and the Association of American Medical Colleges to collaborate in the creation of creating health equity and health literacy education criteria for academic health center programs and health professions education to follow and implement."

Existing Policy: MSV Policy 20.4.05

Research, Citations, and Supplemental Information:

1. Allenbaugh et al. Health Literacy and Clear Bedside Communication: A Curricular Intervention for Internal Medicine Physicians and Medicine Nurses. MedEdPORTAL. 2019; 15:10795. https://doi.org/10.15766/mep_2374-8265.10795S
2. Kružliaková et al. Understanding and Advancing Organizational Health Literacy Within a Public Health Setting. Health Lit Res Pract. 2021 Feb 11;5(1):e35-e48. doi: 10.3928/24748307- 20210114-01. PMID: 33577691; PMCID: PMC7880626.
3. NORC Walsh Center for Rural Health Analysis, 2022. Rural Health Literacy Toolkit [online] Rural Health Information Hub. https://www.ruralhealthinfo.org/toolkits/health-literacy
4. Fairfax County Health Department Stronger2 Initiative
5. The HEAL Program

23-204

GME Parity for Osteopathic Medical Students

Submitted by Carl Hoegerl, DO, MSc

WHEREAS, osteopathic medicine is the fastest growing medical field in the US, representing more than 11% of US physicians, and Colleges of Osteopathic Medicine currently educate more than 35,000 physicians, 25% of all US medical students[1], and

WHEREAS, the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) is the licensing exam series required by the Commission on Osteopathic College Accreditation (COCA) to be taken by all osteopathic (DO) medical students in order to graduate from COCA-accredited medical schools[2], and

WHEREAS, the United States Medical Licensing Examination (USMLE) is the licensing exam series taken by all allopathic (MD) medical students[3], and

WHEREAS, the COMLEX-USA and USMLE are equivalent medical licensing exams, supported by published predictive validity and score concordance studies[4], and

WHEREAS, from 2015 to 2020, residency training was consolidated under a single accreditor, the Accreditation Council for Graduate Medical Education (ACGME) for all US residency and fellowship programs[5], and

WHEREAS, the percentage of DOs matching to their preferred surgical specialties has declined since consolidation[6], and

WHEREAS, according to the 2022 National Residency Matching Program survey, 32% of Residency Program Directors reported never (7%) or seldom (25%) interviewing DO seniors[7], and

WHEREAS, for residency programs that do interview DOs, many require the USMLE[7], and

WHEREAS, ACGME does not specify the licensing exams that residency applicants must take to be eligible for appointment in ACGME-accredited residency programs[8], and

WHEREAS, in 2020 it was reported that approximately 60% of osteopathic medical students took at least one portion of the USMLE[9], and

WHEREAS, DO students who take the USMLE spend an additional $2,235 in exam fees and 32 hours of exam time per student[10], and

WHEREAS, licensing examinations increase rates of stress, anxiety and depression among medical students, placing significant hardships on DO students who complete both the COMLEX-USA and USMLE[11], and

WHEREAS, these exclusionary and burdensome requirements on DOs impact specialty choices of osteopathic medical students and exacerbate physician workforce shortages, particularly in rural and underserved communities, and

WHEREAS, Medicare accounts for 71% of Graduate Medical Education (GME) funding totaling over $10 billion annually[12], therefore be it

RESOLVED, that the MSV supports non-legislative, properly vetted legislative and regulatory and other public policy solutions that assure GME equity for osteopathic medical students and also assure universal acceptance of applications from qualified osteopathic medical students and universal acceptance of COMLEX when a test score is required by a GME program.

References

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3. Scope and Purpose of Accreditation. LCME. https://lcme.org/about/. Published December 30, 2015. Accessed May 5, 2023.
4. Barnum S, Craig B, Wang X, et al. A Concordance Study of COMLEX-USA and USMLE Scores. Journal of Graduate Medical Education. 2022;14(1):53-9.
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12. Office USGA. Physician Workforce: HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding | U.S. GAO. https://www.gao.gov/products/gao-18-240. Published May 12, 2020. Accessed May 5, 2023.Rich EC, Liebow M, Srinivasan M, et al. Medicare financing of graduate medical education. J Gen Intern Med. 2002;17(4):283-292. doi:10.1046/j.1525-1497.2002.10804.x

23-205

Addressing Unique Health Needs of Youth in Foster Care

Submitted by The MSV Medical Student Section

WHEREAS, there are over 5,071 youth in foster care in Virginia as of July 2023, with national and state-level evidence indicating at least 2.5 times more overrepresentation of Black, American Indian, Alaska Native, and LGBTQ youth, among other marginalized and intersectional identities [1-12], and

WHEREAS, youth in foster care experience a multitude of poor physical health and psychosocial outcomes relative to youth not in the foster care system due to the effects of historical trauma, structural violence, and adverse childhood experiences that often manifest as abuse, neglect, loss, uncertainty, and frequent transitions [13-17], and

WHEREAS, negative health outcomes of youth in foster care often include, but are not limited to, increased rates of teen pregnancy, homelessness, suicidal ideation, prolonged or recurrent hospital admissions, and at least one chronic medical condition [18-21], and

WHEREAS, current AMA advocacy efforts recognize disparities in the healthcare presentation of this population and policy H-60.910 “advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care,”, and

WHEREAS, both the American Academy of Pediatrics and The American Academy of Child and Adolescent Psychiatry have released policy statements that acknowledge the significant unmet healthcare needs of youth in foster care [22-23], therefore be it

RESOLVED, that our MSV acknowledges the distinct health care needs of children in foster care and supports increased funding to improve health outcomes for this population, and be it further

RESOLVED, that our MSV recognizes that youth with marginalized minority identities – including, but not limited to, race, religion, age, social status, income, sexual orientation and gender identity or expression – are disproportionately represented in foster care and have unique, intersectional health needs.

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23-206

COPN Approval of Certified Surgical Suites located in Independent Physicians' Offices

Submitted by The Medical Society of Northern Virginia

WHEREAS, hospital systems own most surgical facilities throughout the Commonwealth, and

WHEREAS, hospitals charge inflated facility fees per procedure that add to the out-of-pocket cost co-payments and deductibles for patients, and

WHEREAS, patients lack access to lower out-of-pocket cost facilities for their surgical needs, therefore be it

RESOLVED, that the Medical Society of Virginia supports the Medical Society of Northern Virginia's advocacy efforts to secure legislative patrons to introduce a bill in the Virginia 2024 General Assembly to extend a blanket COPN approval for all AAAHC O.R.'s with up to 3 surgical suites located within independent physicians' offices across the Commonwealth.

Fiscal Impact: None
Existing Policy: None

23-207

Opposition to Criminalization of Transgender Health Providers and Others

Submitted by The Richmond Academy of Medicine; Co-Authorship by the Virginia Chapters/Sections of the following organizations: American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), Pediatric Endocrine Society (PES), Society for Adolescent Health Medicine (SAHM), and Virginia Academy of Family Physicians (VAFP)

WHEREAS, Policy compendium 25.01.04 states: 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, this does not speak directly to gender-affirming care, and

WHEREAS, Organizations comprising over 600,000 members oppose any laws and regulations that discriminate against transgender and gender-diverse individuals or interfere in the confidential relationship between a patient and their physician[1], and

WHEREAS, Growing evidence suggests improved physical and mental health outcomes when individuals with gender incongruence receive gender-affirming treatment.[2-6] Stress and uncertainty created by threats to gender-affirming care and the adverse effects of anti-transgender legislation have deleterious impacts on mental health, increased stigma, decreased safety, and potential legal risks.[7,8] Restrictive legislation and targeted harassment only further stigmatize transgender and gender-diverse adolescents and their families, leading to poorer access to care and worse health outcomes, disproportionality impacting already minoritized populations.[9,10], therefore be it

RESOLVED, that the MSV adds a new compendium policy stating: The Medical Society of Virginia will oppose discriminatory legislation prohibiting transgender and gender-diverse individuals and their families, from receiving needed care, and condemns harassment and criminalization of clinicians, patients and families, programs, and institutions.

Fiscal Impact: None

Existing Policy: None

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23-208

Protection of Minors from Sex Change Treatments, Therapies, and Procedures

Submitted by Kenneth Lipstock, M.D.

WHEREAS, the scientific evidence base for the risks versus benefits of the treatment of minors for gender dysphoria is very much lacking because the quality of the studies by several systematic reviews including those in England, Sweden, Finland, France and Australia and New Zealand report that the quality of the evidence is of low or very low quality, and

WHEREAS, in June 2023 21 mostly European gender dysphoria leading subspecialists wrote an open letter in the Wall Street Journal stating "As experienced professionals involved in direct care for the rapidly growing numbers of gender-diverse youth, the evaluation of medical evidence or both, we were surprised by the Endocrine Society's claims about the state of evidence for gender-affirming care for youth (Letters, July 5). Stephen Hammes, president of the Endocrine Society, writes, "More than 2,000 studies published since 1975 form a clear picture: Gender-affirming care improves the well-being of transgender and gender-diverse people and reduces the risk of suicide." This claim is not supported by the best available evidence. Every systematic review of evidence to date, including one published in the Journal of the Endocrine Society, has found the evidence for mental-health benefits of hormonal interventions for minors to be of low or very low certainty. By contrast, the risks are significant and include sterility, lifelong dependence on medication and the anguish of regret. For this reason, more and more European countries and international professional organizations now recommend psychotherapy rather than hormones and surgeries as the first line of treatment for gender-dysphoric youth. Dr. Hammes's claim that gender transition reduces suicides is contradicted by every systematic review, including the review published by the Endocrine Society, which states, "We could not draw any conclusions about death by suicide." There is no reliable evidence to suggest that hormonal transition is an effective suicide-prevention measure. The politicization of transgender healthcare in the U.S. is unfortunate. The way to combat it is for medical societies to align their recommendations with the best available evidence—rather than exaggerating the benefits and minimizing the risks.", and

WHEREAS, the National Health Service of England`s 2020 review stated for puberty blockers: "The results of the studies that reported impact on the critical outcomes of gender dysphoria and mental health (depression, anger and anxiety), and the important outcomes of body image and psychosocial impact (global and psychosocial functioning), in children and adolescents with gender dysphoria are of very low certainty using modified GRADE. They suggest little change with GnRH analogues from baseline to follow….. This evidence review found limited evidence for the effectiveness and safety of genderaffirming hormones in children and adolescents with gender dysphoria, with all studies being uncontrolled,

observational studies, and all outcomes of very low certainty. Any potential benefits of treatment must be weighed against the largely unknown long-term safety profile of these treatments.", and

WHEREAS, the Swedish National Health System (NBHW) stated in 2022, "Following a comprehensive review of evidence, the NBHW concluded that the evidence base for hormonal interventions for gender-dysphoric youth is of low quality, and that hormonal treatments may carry risks….there is a need to treat gender dysphoric youth with dignity and respect", and

WHEREAS, the NBHW stated "identity formation in youth is an evolving process, and that the experience of natural puberty is a vital step in the development of the overall identity, as well as gender identity", and

WHEREAS, the NBHW stated "In light of above limitations in the evidence base, the ongoing identity formation in youth, and in view of the fact that gender transition has pervasive and lifelong consequences, the NBHW has concluded that, at present, the risks of hormonal interventions for gender dysphoric youth outweigh the potential benefits. As a result of this determination, the eligibility for pediatric gender transition with puberty blockers and cross-sex hormones in Sweden will be sharply curtailed.", and

WHEREAS, the English NHS review stated that in many cases "gender incongruence does not persist into adolescence" and that "it is important to view social transition as an active intervention when it forms part of a managed individual care plan because it may have significant effects on the child or young person in terms of their social and psychological functioning. While there are different views on the benefits versus the harms of early social transition, it is important to acknowledge that it is not a neutral act - and that better information is needed about outcomes. Decisions will be individual, and the agency to make the decision will ultimately rest with the young person, along with their family", and

WHEREAS, there is a poorly understood marked change in demographics: The sharp rise in the numbers of youth seeking to transition and the change in sex ratio toward a preponderance of females is not well-understood, and

WHEREAS, there is a growing visibility of detransition/regret: New knowledge about detransition in young adults challenges prior assumption of low regret, and the fact that most do not tell practitioners about their detransition could indicate that detransition rates have been underestimated, and

WHEREAS, there is a disproportionate number of youth with autism are presenting with gender dysphoria, and

WHEREAS, the reduction of psychiatric symptoms cannot be achieved with hormonal and surgical interventions and that it is not a valid justification for gender

reassignment and that the presence of psychiatric diagnosis must be stable first so that the young person can genuinely face and discuss their gender dysphoria, therefore be it

RESOLVED, that the Medical Society of Virginia reexamine the way gender dysphoria in minors in Virginia is approached by the medical community with an understanding that it is important to make sure that the minor <18 understands the realistic potential of gender reassignment treatments to alter secondary sex characteristics, the reality of a lifelong commitment to medical therapy, the permanence of the effects, and the possible physical and mental adverse effects of the treatments and that although patients may experience regret, after reassignment treatments, there is no going back to the non-reassigned body and its normal functions and that brain development continues until early adulthood – about age 25, which also affects young people's ability to assess the consequences of their decisions on their own future selves for the rest of their lives, and be it further

RESOLVED, that the Medical Society of Virginia recommends that psychological and psychiatric care become the first line of treatment for all gender dysphoric minors (<18) and that a focus will be placed on gender exploration that does not privilege any given outcome, and be it further

RESOLVED, that the Medical Society of Virginia will recommend the presence of psychiatric diagnosis be addressed with prolonged evaluation to ensure that these conditions are under control and that the diagnosis of autism spectrum disorder will warrant additional evaluation, and be it further

RESOLVED, that the Medical Society of Virginia will recommend that access to hormonal interventions for youth <18 must be tightly restricted and that the goal is to administer these interventions in tertiary care multidisciplinary research settings only, and to restrict eligibility criteria to mirror those in the "Dutch protocol" that is defined by the prepubertal onset of gender dysphoria persisting for at least 5 years and persists into adolescence and causes severe suffering and that some exceptions could apply for puberty blockade in extreme cases of post pubertal onset of gender dysphoria, and be it further

RESOLVED, that the Medical Society of Virginia will recommend that social transitioning be recommended only after considerable time is spent under therapy and that this decision should be made with the youth and family in accordance with the 2023 Virginia Dept. of Education guidelines and that it must be made clear to them that not only medical transitioning but social transitioning as well may alter the course of gender identity development i.e., it may consolidate a gender identity that would have otherwise changed in a still maturing minor, and be it further

RESOLVED, that the Medical Society of Virginia will recommend that no surgical transitioning should be allowed in the State of Virginia.

Fiscal Impact: None
Existing Policy:

05.4.06-Affirming the Health Needs of All Patient Population
Date: 10/23/21

25.5.01 Prohibiting Conversion Therapy in Those Under Age 18
Date 10/21/2018

References:

1. WSJ. Youth Gender Transition Is Pushed Without Evidence. 2023. https://www.wsj.com/articles/trans-gender-affirming-care-transition-hormone-surgery-evidence-c1961e27
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4. Society For Evidence Based Gender Medicine. Summary of Key Recommendations From The Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW) 2022. https://segm.org/segm-summary-sweden-prioritizes-therapy-curbs-hormones-for-gender-dysphoric-youth
5. Council For Choices In Health Care in Finland. Medical treatment methods for gender related to gender variance in minors. 2020. https://segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf

23-209

Sudden Unexpected Death in Epilepsy: investigation, understanding, and awareness

Submitted by Adam Gibson

WHEREAS, sudden Unexpected Death in Epilepsy (SUDEP) represents the sudden and unexplained death of a healthy individual with epilepsy that is not by drowning, injury, or other known causes, and

WHEREAS, over 84,000 Virginians have active epilepsy, which carries a 12% cumulative risk of SUDEP by age 40 without long-term remission or successful management, or a 35% cumulative lifetime risk of SUDEP overall[1-3], and

WHEREAS, the Virginia General Assembly has proposed a bill to amend the Code of Virginia by adding a section numbered 32.1-283.9, relating to SUDEP, which includes provisions for the standardization of documentation of deaths in Virginia involving SUDEP, protocols, information, and training, and

WHEREAS, the Virginia bill mandates the Office of the Chief Medical Examiner to indicate SUDEP when appropriate as the cause of death on the decedent's death certificate, and shall provide information to the decedent's next of kin regarding the benefits of and process for submitting the deceased's medical information, including information about the deceased's history of epilepsy and seizures, to the North American SUDEP Registry, and

WHEREAS, the Chief Medical Examiner and all assistant medical examiners shall complete one hour of virtual training in the investigation of SUDEP per triennium, with the medical examiner's office conducting these trainings and investigations up to the amount funded by public and private institutions, including the Epilepsy Foundation of Virginia, and

WHEREAS, the proposed bill aligns with the broader goals of enhancing understanding, awareness, and management of epilepsy, and improving the care and support for individuals affected by SUDEP, therefore be it

RESOLVED, that our MSV supports legislative efforts advancing the investigation, understanding, and awareness of SUDEP, and be it further

RESOLVED, that our MSV encourages collaboration with the Epilepsy Foundation of Virginia and other relevant stakeholders to promote education and support for individuals and families affected by epilepsy and SUDEP.

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1. Zack MM, Kobau R. National and State Estimates of the Numbers of Adults and Children with Active Epilepsy — United States, 2015. MMWR Morb Mortal Wkly Rep 2017;66:821–825. DOI: http://dx.doi.org/10.15585/mmwr.mm6631a1
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23-210

Increasing the Number of Collection Sites for Donated Drugs

Submitted by Betty Ma

WHEREAS, there are about only 14 pharmacies registered in Virginia to be a collection site for donated drugs on the Virginia Department of Health Professions website[1], and

WHEREAS, based on volunteer experience, there is at least 1 clinic on Native American reservation in Virginia with medication shortages, and there are potentially many more clinics with similar medication shortage problems, and

WHEREAS, patients sometimes do not finish all of the medications they were prescribed, leading to medications being wasted, therefore be it

RESOLVED, that the Medical Society of Virginia support increasing the number of collection sites for donated drugs

Fiscal Impact: None
Existing Policy: None

[1] https://www.dhp.virginia.gov/pharmacy/donationsites.asp

23-211

Curbing Green House Gas Emissions

Submitted by The Richmond Academy of Medicine

WHEREAS, the US healthcare sector is responsible for 8.5% of all US greenhouse gas emissions and 27% of worldwide healthcare emissions despite serving less than 5% of the world's population, and

WHEREAS, climate change resulting from GHG emissions adversely affects the US and global populations, therefore be it

RESOLVED, that MSV encourages all Virginia Hospitals and health systems to track and report their environmental impacts by using, for example, the HEALTH CARE EMISSIONS IMPACT CALCULATOR (Health Care Emissions Impact Calculator | Practice Greenhealth), and be it further

RESOLVED, that MSV encourage Virginia Hospitals and health systems to take steps toward achieving net zero emissions related to health care.

Fiscal Impact: None
Existing Policy: None

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Delegate Handbook 2023

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

Workgroup Membership

Joel Bundy, MD; Alice Coombs, MD; Cliff Deal, MD; Art Vayer, MD; Michele Nedelka, MD; Gary Miller, MD; Mark Townsend, MD; Steven Combs, MD

Workgroup Meetings

07/17/2023, 08/09/2023

Workgroup Report

During the April Executive Board meeting, the Board approved action on 2022 MSV HOD, resolution *22-112: Hospital Medical Staff Self-Governance*. MSV Policy staff worked with President Dr. Harry Gewanter to establish a member-led workgroup to review this issue before the next House of Delegates Meeting and to produce a report with recommendations.

The first meeting of the workgroup explored MSV resolution 22-112, which proposed an edit to existing MSV policy 30.4.05. The discussion touched on the recent trend of standardization of medical staff bylaws and the differences between self-governance and staff independence. The workgroup also discussed a case involving an anesthesiologist who was removed from his position as chief of staff and trustee position at a medical facility in Tennessee due to allegations of sharing confidential information and breaking his fiduciary duty. Discussion was had about the issue of summarily suspending physicians and the need for an enforceable due process and appeals system. Education emerged as a key theme, with participants highlighting the need for comprehensive education on medical staff bylaws and governance for physicians and providers on the medical staff. Additionally, the workgroup discussed the conflicts that the multiple accrediting organizations will ultimately have with some aspects of medical staff self-governance. The importance of educating the broader medical community about the issues and policies related to medical staff governance was emphasized.

At the second meeting, the workgroup reviewed current MSV policy 30.4.05 and its associated AMA Policy H-225.942. After reviewing the policies, the workgroup members indicated that changes to AMA policy have addressed some of the concerns the authors of resolution 22-112 had with the underlying policy. The workgroup also discussed the need for independent legal counsel and decision-making separate from the hospital administration's interests. There was an additional review of AMA Policy 235.980, but ultimately the policy was found to be outdated and requires multiple amendments before a deeper exploration of the policy for inclusion into the MSV policy compendium. The workgroup agreed to recommend that the current MSV policy 30.4.05 be reaffirmed without revision.

Additionally, the workgroup discussed the importance of educating physicians about their rights and responsibilities regarding medical staff bylaws and related documents. There was a conversation about the possible dissemination of this information at the Virginia Chief Medical Officer meeting. Ultimately, the workgroup came to an agreement that the MSV Board of Directors should consider allocating resources for member education about medical staff bylaws.

Workgroup Recommendations

The workgroup recommends the following actions:

- The MSV reaffirm MSV Policy 30.4.05: Physician & Medical Staff Bill of Rights that aligns with an updated AMA Policy H-225.942: Physician and Medical Staff Bill of Rights.
- The MSV House of Delegates should defer codifying AMA Policy H-235.980: Hospital Medical Staff Self-Governance in the MSV policy compendium until the AMA has made necessary amendments to update outdated references.
- The MSV Board of Directors should consider allocating resources for member education about medical staff bylaws and advocacy.

Housing As Healthcare: A MSV Perspective

Housing plays a vital role in human existence, fulfilling our fundamental psychological and safety requirements, such as shelter and security, as per Maslow's hierarchy of needs. Housing also significantly impacts healthcare, including physical and mental well-being, chronic disease management, and overall health outcomes. Although housing's relationship to health has long been acknowledged, "housing as healthcare" is a more modern construction highlighting its role in maintaining individual and community wellness. This report seeks to explore the link between housing conditions and health outcomes while exploring how treating housing as a healthcare intervention could be approached by the Medical Society of Virginia (MSV).

Substandard housing conditions can have an immense effect on physical health.[1] For example, damp and moldy environments can cause dwellings to become contaminated with microorganisms, which might cause adverse health effects.[2] Multiple meta-analyses find a significant and consistent link between dampness and adverse health effects. According to Fisk's research, buildings with moisture and mold have been linked to a 30-50% increase in respiratory and asthma-related health outcomes.[3] Mendell finds evidence of an association between indoor dampness-related factors and a wide range of respiratory or allergic health effects, including asthma development, asthma exacerbation, current asthma, ever asthma, dyspnea, wheeze, cough, respiratory infections, bronchitis, allergic rhinitis, eczema, and upper respiratory tract symptoms.[4] Additionally, housing conditions can expose young children to environmental hazards, such as poisonous lead paint in older homes. A nationally represented study found that an estimated 25% of the nation’s housing, equal to 24 million housing units, had significant lead-based paint hazards in the form of deteriorated paint, dust lead, or bare soil lead.[5] These examples emphasize how essential adequate and safe housing is in maintaining the physical well-being of an individual.

Substandard housing conditions can likewise influence mental health by exacerbating stress levels and impacting overall well-being. Rautio’s study suggests that poor housing quality, lack of green space, noise, and air pollution correlate to depressive mood.[6] Mothers of young children experiencing housing

[1] Krieger, J., & Higgins, D. L. (2002). Housing and Health: Time Again for Public Health Action. *American Journal of Public Health*, *92*(5), 758-768. https://doi.org/10.2105/ajph.92.5.758
[2] Institute of Medicine (US) Committee on Damp Indoor Spaces and Health. Damp Indoor Spaces and Health. Washington (DC): National Academies Press (US); 2004. Available from: https://www.ncbi.nlm.nih.gov/books/NBK215643/ doi: 10.17226/11011
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[5] Jacobs, D. E., Clickner, R. P., Zhou, J. Y., Viet, S. M., Marker, D. A., Rogers, J. W., Zeldin, D. C., Broene, P., & Friedman, W. (2002). The prevalence of lead-based paint hazards in U.S. housing. *Environmental Health Perspectives*, *110*(10), A599. https://doi.org/10.1289/ehp.021100599
[6] Rautio, N., Filatova, S., Lehtiniemi, H., & Miettunen, J. (2018). Living environment and its relationship to depressive mood: A systematic review. *The International journal of social psychiatry*, *64*(1), 92–103. https://doi.org/10.1177/0020764017744582

instability will likely develop depression and generalized anxiety disorder.[7] Additional research suggests a strong, long-term impact of poor housing and persistent poor housing on mental health. Housing problems have a lasting effect on mental health for up to 5 years, particularly for individuals who move from poor housing to poor housing. Additionally, worsening housing conditions are associated with a decline in mental health.[8] Evans demonstrates that assessing housing quality can predict psychological distress. Furthermore, he provides strong evidence that housing quality can benefit mental health and that the degree of housing improvement can indicate a change in psychological distress.[9] Stable housing supports mental well-being and access to mental health services. Homelessness likewise affects mental health, and the Lancet Commission's most recent report on global mental health mentions it is both a cause and consequence of poor mental health.[10] Mental health and substance misuse disorders such as depression, post-traumatic stress disorder, and personality disorder increase the risk of and exacerbate homelessness.[11] Supportive housing programs combine affordable housing with wraparound services like mental health treatment, case administration, and substance abuse support recovery efforts. These programs decrease emergency department use and hospital stays while improving unhoused individuals' housing status and well-being.[12] Aubry's meta-analysis found that permanent supportive housing interventions increased long-term (6-year) housing stability for participants with moderate and high support needs compared to usual care.[13]

Housing supports chronic disease management, providing an ideal setting to adopt and practice healthy behaviors such as engaging in regular physical activity, eating nutritious foods, and prioritizing health-related activities. Individuals with chronic diseases living in stable housing environments have improved access to healthcare services, medication adherence, and follow-up care, resulting in better outcomes.[14] Conversely, housing-insecure individuals are less likely to maintain healthy practices, thus exacerbating chronic disease risks. Martin finds that housing insecurity is associated with poor health, chronic disease, and inefficiently delivered care. Her study found that housing-insecure individuals had

[7] Suglia, S. F., Duarte, C. S., & Sandel, M. T. (2011). Housing Quality, Housing Instability, and Maternal Mental Health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, *88*(6), 1105-1116. https://doi.org/10.1007/s11524-011-9587-0

[8] Pevalin, D. J., Reeves, A., Baker, E., & Bentley, R. (2017). The impact of persistent poor housing conditions on mental health: A longitudinal population-based study. *Preventive medicine*, *105*, 304–310. https://doi.org/10.1016/j.ypmed.2017.09.020

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[10] Fazel, P. S., R Geddes, P. J., & Kushel, P. M. (2014). The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet (London, England)*, *384*(9953), 1529. https://doi.org/10.1016/S0140-6736(14)61132-6

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[12] National Academies of Sciences, Engineering, and Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, Policy and Global Affairs, Science and Technology for Sustainability Program, & Committee on an Evaluation of Permanent Supportive Housing Programs for Homeless Individuals. (2018). *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*. National Academies Press (US).

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[14] Aidala, A. A., Wilson, M. G., Shubert, V., Gogolishvili, D., Globerman, J., Rueda, S., Bozack, A. K., Caban, M., & Rourke, S. B. (2016). Housing Status, Medical Care, and Health Outcomes Among People Living With HIV/AIDS: A Systematic Review. *American Journal of Public Health*, *106*(1), e1. https://doi.org/10.2105/AJPH.2015.302905

three times higher odds of delaying care due to cost, 4.7 more days in poor physical health, 6.9 more days in poor mental health, 4.7 more days in poor overall health, and one or more chronic conditions compared to those with secure housing.[15] Another study finds that housing-insecure individuals were more likely to delay doctor's visits, report poor or fair health, and experience poor physical or mental health, limiting their daily activities by 14 or more days in the past month.[16] Wilder's meta-analysis proposes that when basic needs compete with health problems, people may prioritize their basic needs over their health, which correlates with poor medication adherence.[17] Energy insecurity can lead to lower-income households spending too much of their income on utility expenses, worsening chronic health disparities related to housing affordability.[18] Financial burdens restrict resources available for healthcare, medications, and healthy living, leading to health inequities and poorer chronic disease outcomes.[19] Enhancing housing stability may lower chronic disease risks by encouraging healthy behaviors and providing safe living environments.

Pediatric health and housing conditions are inextricably linked. Mold, dust mites, and secondhand smoke increase childhood asthma prevalence and exacerbations.[20] Allergens and irritants found in substandard housing can also increase the risk of developing early childhood asthma for those genetically predisposed.[21] Lead exposure, predominantly through lead-based paint in older housing units, poses a considerable threat to pediatric health and neurodevelopment. Lead exposure at even low levels can result in cognitive impairments, learning difficulties, and behavioral issues in children. Canfield's study observed an IQ loss in children of 4.6 points for each increase in blood lead concentration of 10 µg per deciliter.[22] Therefore, identifying and eliminating lead hazards from housing environments is imperative in protecting children's health. Stable and secure housing environments provide essential support for healthy childhood development. Conversely, substandard housing conditions adversely impact a child's educational outcomes. Childhood well-being can be negatively affected by experiencing housing instability characterized by frequent moves, overcrowding, or homelessness. Goux's study finds that residential overcrowding increases adolescents' likelihood of not moving up a grade. About 37% of the

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normal-age adolescents living in the more overcrowded housing do not move up to the next grade, against only about 21% of those living in the less overcrowded housing.[23] Additional research finds that elementary school-aged children from more crowded homes perform more poorly on standardized reading tests and perceive themselves as lower in scholastic competency. The study also observes that children exposed to traffic noise manifest significant delays in reading and have poorer attention spans.[24] Children experiencing housing instability were found to have poorer health, lower weight, and increased likelihood of developmental risk.[25] Furthermore, increased housing instability in adolescents accounts for significant elevations in rates of depression, arrest, and smoking.[26] Adolescents' academic achievement and educational attainment are impeded in these environments. Additionally, children living in unstable housing environments who experience homelessness face further adverse outcomes. The proportion of homeless school-aged children with mental health problems was 2-4 times higher than that of stably housed poor children.[27] Many of these children also suffer adverse childhood events such as trauma, victimization, neglect, and toxic stress that contribute to chronic health conditions and chronic homelessness as adults.[28]

Affordable housing and home remediation efforts are essential strategies for improving health outcomes that alleviate financial pressure, decrease homelessness risk, and allow individuals and families to allocate more resources toward healthcare needs. The increased cost of rent and utilities forces most poor renting families to spend at least half their income on housing costs.[29] By offering access to secure housing and comprehensive support services, supportive housing can improve well-being and reduce housing costs, stress, and health issues.[30] Remediation and maintenance programs can reduce environmental exposures linked to housing while enhancing housing quality standards and lowering health risks.[31] Housing instability was independently associated with not having a usual source of primary care, postponing medications, increased emergency department use, and increased hospitalization rates.[32] Supportive housing programs that combine affordable housing with tailored supportive services have

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[32] Kushel, M. B., Gupta, R., Gee, L., & Haas, J. S. (2006). Housing instability and food insecurity as barriers to health care among low-income Americans. *Journal of General Internal Medicine*, *21*(1), 71–77. https://doi.org/10.1111/j.1525-1497.2005.00278.x

proven effective in improving health outcomes among vulnerable populations suffering from severe mental illness.[33] One 3-year study of previously unhoused individuals found that having priority access to a permanent housing subsidy reduced psychological distress, relative to usual care, by about one-tenth of a standard deviation and intimate partner violence by one-third.[34]

Integrating health considerations into housing policies and vice versa is necessary for housing to become a part of healthcare. Adopting a "Health in All Policies" framework[35] can ensure that housing policies and practices align with public health goals. This approach involves collaboration among housing agencies, healthcare providers, public health departments, and community organizations to develop coordinated strategies that address social determinants of health. This collaboration is critical for finding innovative solutions, leveraging resources, and developing sustainable approaches that improve housing conditions and health outcomes. The voice of physicians within the MSV can undoubtedly advocate for housing-related bills when appropriate and when directly linked to health outcomes. This strategy will provide the most significant latitude to the MSV, allowing physicians to take a stance on housing-related issues that impact patients while also maintaining its laser-focused lobbying efforts on legislation that directly impacts the profession of medicine. In Virginia, the MSV can collaborate with well-established organizations such as the Virginia Poverty Law Center, American Civil Liberties Union of Virginia, Virginia Legal Aid Justice Center, Virginia Supportive Housing, Habitat for Humanity, Voices for Virginia's Children, New Virginia Majority, and Virginia Housing Alliance that all work towards affordable housing solutions and eliminating homelessness.[36]

Recognizing housing as healthcare is essential to understanding the broader determinants of health and designing effective interventions to improve outcomes. Housing conditions have an immense influence over multiple aspects of health, from physical to mental well-being to chronic disease management and children's well-being. By prioritizing safe, affordable, and stable housing conditions, policymakers, healthcare providers, communities, and organizations can contribute to creating healthier societies while working towards attaining health equity for all.

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September 27, 2023

Dear MSV Colleagues,

I am pleased to provide you with a summary of the developments of the MSVPAC for the first nine months of 2023. On June 28th, Clark Barrineau issued a challenge for the MSV Board of Directors to raise at least $5,000 each either through direct contributions or through collecting donations from practices and colleagues. The unprecedented changeup in the Virginia General Assembly creates an uncertain future and the MSVPAC must be prepared now financially to raise the voice of medicine.

MSVPAC at-a-glance since the last update:

Number of donations since January 1:	240	Goal: 250 individual donations
Amount raised since January 1:	$99,323.31	Goal: $120,000
Disbursements to Candidates:	$54,500	Committed: $27,500 Senate; $27,000 House

PAC Campaigns/ Events:

- Donor Legislative Call February
- Donor Legislative Call June
- Donor Legislative Call September
- Docs and Hops Richmond
- Docs and Hops Charlottesville
- Docs and Hops Norfolk
- Legislative Update VA Cardio
- Legislative Update Carilion Pediatrics
- Chairman's Crossover Challenge
- MSV Board Challenge

Large Practice Outreach

The MSVPAC offers practices, regardless of membership status, legislative updates in person or by zoom. These are not fundraising pitches but intended to help develop relationships with practices so when we ask for money, we are more likely to get a response.

This works. Just a few months after Dr. Quinn Lippman helped set up a legislative update with Virginia Urology, that practice donated $10,000 to the MSVPAC. For reference, VA Urology gave $0 to the PAC in 2022 and $1,000 to the Foundation in 2022.

This list will grow and the MSVPAC wants help from the leadership in expanding that list and reaching out. One email from Quinn Lippman resulted in a $10,000 donation. Each member of MSV leadership can assist with this effort.

The MSVPAC would like to thank Dr. Harry Gewanter, Dr. John Paul Verderese, Dr. Atul Marathe, Dr. Bobbie Sperry, Dr. Dr. Bruce Silverman, Dr. Ryan Fulton, Dr. Hazle Konerding, Dr. Carolyn Burns, Dr. Michelle Nedelka, Dr. Jo Hutchison, Dr. Alice Coombs, Dr. Pat Pletke, Dr Sterling Ransone, Dr. Lee Ouyang, Dr. Gary Miller, and Dr. Lindsay Robbins for your assistance in setting up meetings.

Docs and Hops

The 2021 Docs and Hops event in Richmond had seven attendees. 42 attendees attended three Docs and Hops events in 2022. In 2023, 101 attendees came to three Docs and Hops events. The increase is largely due to sponsorship packages providing free tickets for residents and students.

Richmond Docs and Hops 8/17/23
Location: Hardywood Brewery 2410 Ownby Ln, Richmond, VA 23220
Hosts: Dr. Harry Gewanter, Dr. Art Saavedra, Dr. Sterling Ransone, Dr. Pooja Gajulapalli, Dr. Bruce Silverman, Kathy Scarbalis, PA-C

Charlottesville Docs and Hops 8/23/23
Location: Kardinal Hall
Hosts: Dr. Mohit Nanda, Kathy Scarbalis, PA-C, Dr. Samuel Caughron, Dr. Peter Netland, Dr. Karen Rheuban, Shreya Mandava

Norfolk Docs and Hops 8/24/23
Location: Smartmouth Brewery 1309 Raleigh Ave, Norfolk, VA 23507
Hosts: Dr. Lee Ouyang, Dr. Peter Kemp, Dr. Lauren Forbes, Dr. Michele Nedelka, Dr. Lindsay Gould, Dr. Randy Gould, Dr. Cyn Romero, Kathy Scarbalis, PA-C

Annual Meeting

The MSVPAC will host two concurrent fundraisers during the Annual Meeting on Saturday October 14th from 1:30 -4:00PM.

Sail-ebrate the MSVPAC: We currently have 22 tickets sold to this event which includes brief sailing instructions on 20ft sailboats followed by a series of mini regattas right in Norfolk Harbor. Tickets are $200 or 2 tickets for $300.

Chug-a-long with the MSVPAC Beer Trolley: We currently have 20 tickets sold to this event which includes peddling a local beer trolley to a few breweries and a restaurant. Tickets are $50 per person.

Fundraising Update

The MSVPAC received contributions from 240 physicians, students, and practices in Virginia for $99,323.31 to date in 2023. We include sponsored student and residents who attend Docs and Hops as donors as their tickets are purchased through sponsorships.

The MSVPAC has disbursed or allocated $54,500 to incumbents as of September 27th, 2023.

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

Conclusion

We rely on personal and professional connections in reaching out to large practices. We have asked most of MSV leadership to assist and will continue to do so. 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

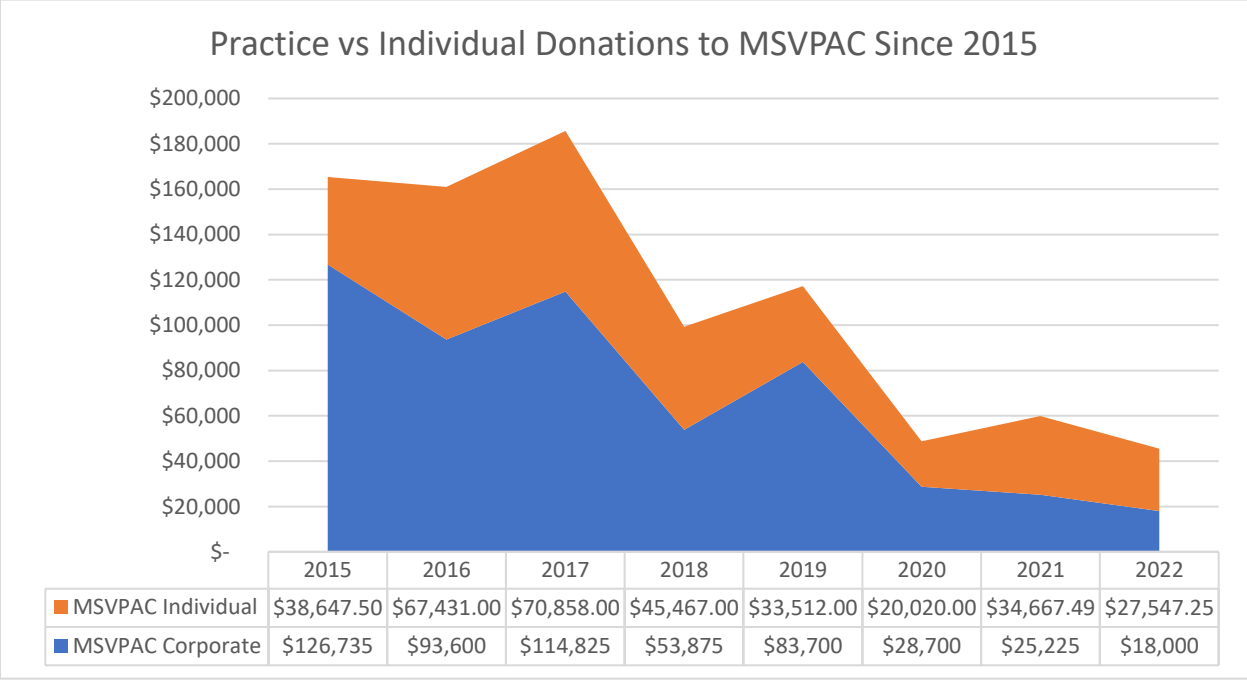
Andrew Densmore

Political Advocacy Manager, MSV

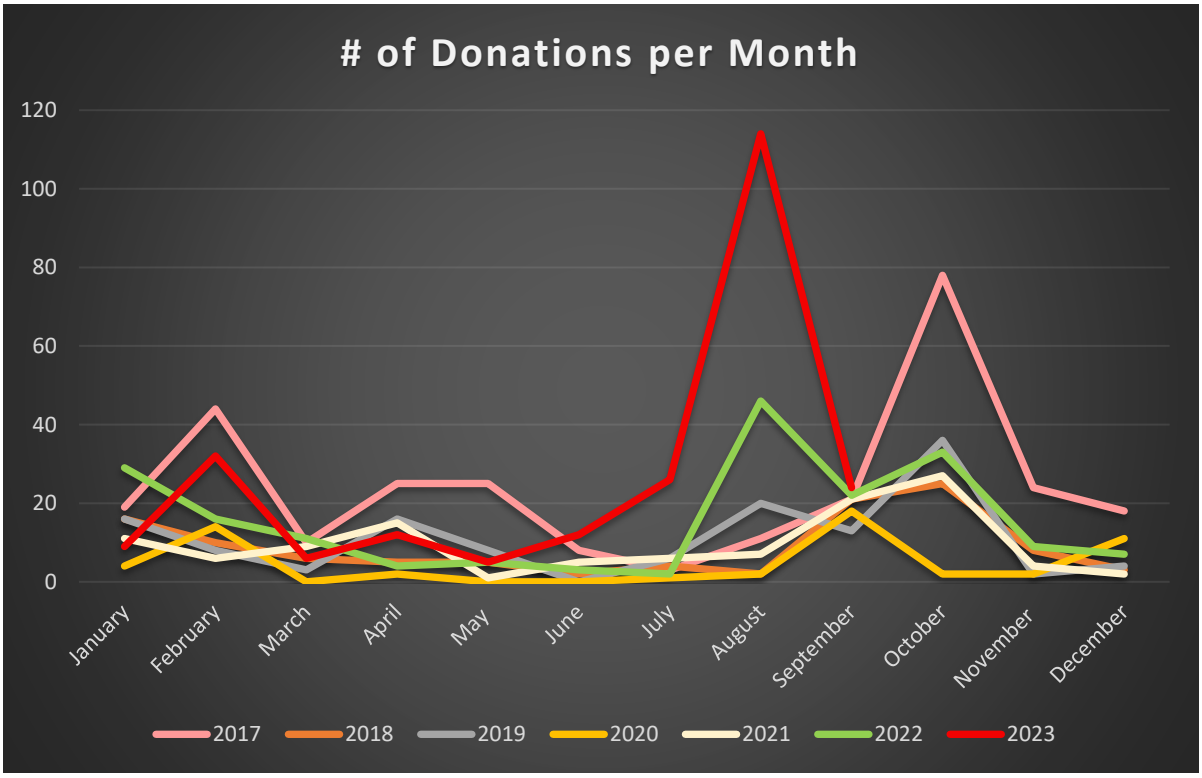
Member	Term Beg.	Term End	Term Count	District
Atul Marathe	1/1/22	12/31/23	1	8
Robert Glasgow	1/1/22	12/31/23	1	PA
Bruce Silverman	1/1/22	12/31/23	2	3
Peter Kemp	10/29/22	10/28/24	1	2
Barbara Boardman	10/15/22	10/16/24	2	10
John Whyte	10/29/22	10/28/24	1	10
Jacqueline Fogarty	10/29/22	10/28/24	2	5
Lauren Forbes	12/20/21	12/19/23	NA	Resident
Kenneth Young	12/20/21	12/19/23	NA	Student
Lee Ouyang	10/23/21	10/22/23	2	Chair

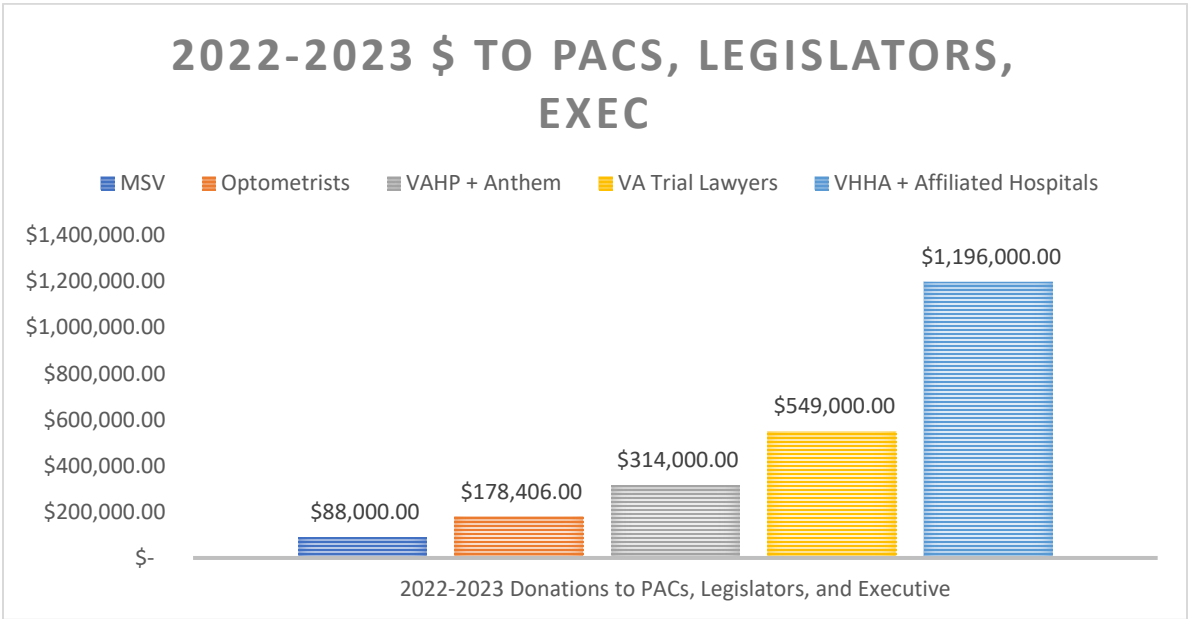
Candidate Contributions as of 9/27/23			
Senator George Barker	$2000	Senator Ghazala Hashmi	$1500
Senator Emily Brewer	$1000	Senator Scott Surovell	$2000
Senator Creigh Deeds	$2000	Senator Barbara Favola	$1000
Senator Siobhan Dunnavant	$3000	Senator Jennifer Boysko	$1000
Senator Monty Mason	$1000	Senator Mark Peake	$1000
*Senator Todd Pillion	$1500	Senator Louise Lucas	$3000
(2022 check re-issue)		Senator Frank Ruff	$1000
Senator Todd Pillion	$1500	Senator Mamie Locke	$2500
(2023 check)		Senator Jeremy McPike	$1000
Chris Head for Senate	$2000	Senator Scott Surovell	$2000

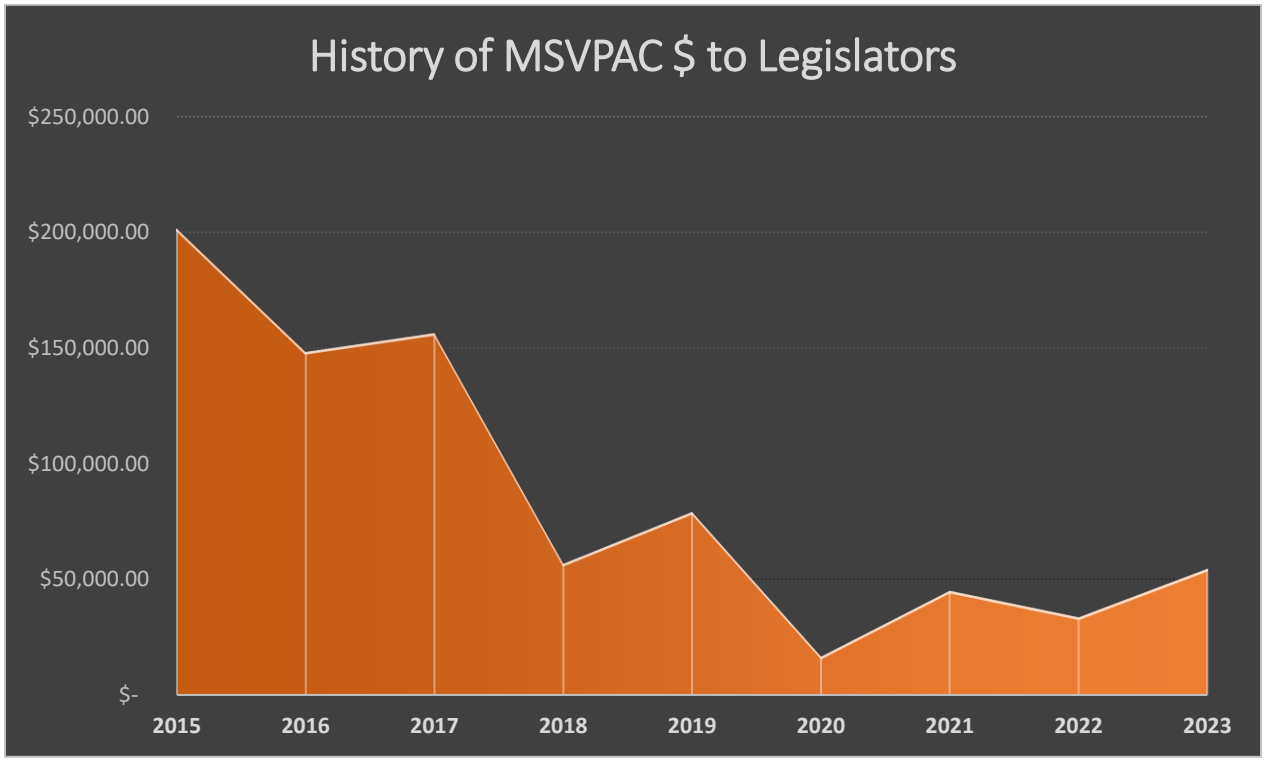
Delegate Terry Kilgore	$1000	Delegate Keith Hodges	$1000
Delegate Patrick Hope	$1000	Delegate Mike Cherry	$1000
Delegate Karrie Delaney	$1000	Delegate Otto Wachsmann	$1000
Delegate Mark Sickles	$2000	Delegate Cia Price	$1000
Speaker Todd Gilbert	$5000	Delegate Don Scott	$2000
Delegate Jason Ballard	$1000	Delegate Cliff Hayes	$1000
Delegate Wendell Walker	$1000	Delegate Bobby Knight	$2500
Delegate Rodney Willett	$1000	Delegate Luke Torian	$1500
Delegate Bobby Orrock	$3000		



	2015	2016	2017	2018	2019	2020	2021	2022
MSVPAC Individual	$38,647.50	$67,431.00	$70,858.00	$45,467.00	$33,512.00	$20,020.00	$34,667.49	$27,547.25
MSVPAC Corporate	$126,735	$93,600	$114,825	$53,875	$83,700	$28,700	$25,225	$18,000


# of Donations per Month
120
100
80
60
40
20
0
January
February
March
April
May
June
July
August
September
October
November
December
2017
2018
2019
2020
2021
2022
2023


2022-2023 $ TO PACS, LEGISLATORS, EXEC
MSV
Optometrists
VAHP + Anthem
VA Trial Lawyers
VHHA + Affiliated Hospitals
$1,400,000.00
$1,200,000.00
$1,000,000.00
$800,000.00
$600,000.00
$400,000.00
$200,000.00
$-
$88,000.00
$178,406.00
$314,000.00
$549,000.00
$1,196,000.00
2022-2023 Donations to PACs, Legislators, and Executive


History of MSVPAC $ to Legislators
$250,000.00
$200,000.00
$150,000.00
$100,000.00
$50,000.00
$-
2015
2016
2017
2018
2019
2020
2021
2022
2023

Date: September 27, 2023
To: MSV Delegate Handbook
From: MSV Foundation Staff
Subject: MSV Foundation Update– Governance, Key Foundation Programs, Activities, Outcomes

Board Updates:	
Governance	The Medical Society of Virginia Foundation Board met on August 28th to consider eligible candidates for the upcoming term of office. The Foundation Board recommended the following slate for consideration by the society membership, which was approved by the Medical Society of Virginia Board on September 9th. 2023-2024 Officers: • President-Elect: José Morey, MD • Vice President: Mark Townsend, MD • Secretary: Steven Lewis, MD New Directors: • Taylan Bozkurt, MBA • Samuel Caughron, MD • Steven Lewis, MD As part of its regularly scheduled review of the Foundation Board bylaws, the Directors reviewed and submitted minor changes to the Society Board which were approved at the Society Board Meeting on September 9th.

Programs:	
Virginia Mental Health Access Program (VMAP)	**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. 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 final year of a five-year HRSA grant providing $445,000 a year to fund its education programming and other elements of the program, and recently received $700,000 continuation of these funds for three additional years. Over the last three years, VMAP expanded statewide to implement regional hubs supporting all areas 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 5,500 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 800 health care providers. In the 2022 General Assembly, VMAP received an additional $1.4 million in state funds to expand its services to provide additional supports for PCPs treating patients ages 5 and under. Implementation of VMAP's early childhood program is currently in progress: In 2023, VMAP added early childhood physicians (developmental pediatricians and/or early childhood child psychiatrists) to the VMAP line available to consult with PCPs statewide on early childhood issues. VMAP also launched two new early childhood trainings for PCPs. In the coming months, VMAP will be adding additional early childhood services to the VMAP line and piloting a new early childhood training program for PCPs. In the 2023 General Assembly, the MSVF General Assembly team advocated for additional funding for VMAP to expand in two key areas: 1. Complete implementation of early childhood (0-5 years old) intervention and prevention in primary care through training, consultation, and resource support. 2. Expand VMAP to include pregnant and postpartum moms. Delegate Brewer and Senator Deeds filed budget amendments for $7.9 million to achieve these goals. The Senate included the full amount for expansion in their budget. The House budget did not include any additional funding. After a delay, the General Assembly approved $3.9 million in new funding for FY 23-24.
SafeHaven™	**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. SafeHaven has continued to expand throughout Virginia and the nation during 2022. To date, we have over 8,000 clinicians (physicians, PAs, residents, NPs, and nurses) enrolled in the program. SafeHaven's utilization rates continue to be viewed as the highest in the country for a physician focused wellness

	program, with a current total utilization rate of 48%, and a 17% utilization rate for those seeking peer coaching or counseling. 2023 goal updates: • The Physicians Foundation has awarded SafeHaven with a cohort grant program. In the grant, MSV will create a toolkit for other state medical societies to aid in passing of the legislation and implementation of resources. The Physicians Foundation has selected 5 state medical societies as part of the cohort, and MSV has committed to supporting another 2 states. Those in the cohort will receive additional consultative support from MSV and financial support from The Physicians Foundation to cover staff time. MSV will receive $125,000 to cover staff time and expenses. • SafeHaven has partnered with Georgetown University to create a SafeHaven focused physician peer coaching certification training program. Physicians who complete the program will have the opportunity to receive an International Coaching Federation (ICF) coaching certification and will join SafeHaven's physician peer coaching network. The team intends to launch the first cohort in 2024. To support this new initiative, Quality Insights has awarded SafeHaven with a $19,000 grant. For more information on the program contact Carolyn McCrea (cmccrea@msv.org). • SafeHaven has also partnered with Nav.it to offer financial wellness resources and access to Accredited Financial Counselors to interns, residents and fellows in Virginia. This pilot program will run September 2023-July 2024 to measure interest in the resource, utilization rates among clinicians in training, and to secure feedback from the pilot pool. MSV will gather quantitative and qualitative data to build a robust financial wellness service offering as the first major expansion of SafeHaven resources. • The SafeHaven team is continuing to have robust discussions with health systems, practices, specialty organizations, and foundations regarding enrolling clinicians in SafeHaven™. To learn more about SafeHaven™, please visit www.SafeHavenhealth.org or contact Jenny Young (jyoung@msv.org)
Physician Leadership Institute (PLI)	**Program Description**: A program aimed at early-stage physician leaders focusing on building interpersonal skills, business/system literacy, and innovation/leading change. The 2023 program will be held Thursday November 30th – Sunday December 3rd for a weekend intensive session at MSV headquarters in Richmond, VA. PLI will focus on soft skills, the business of healthcare, advocacy, innovation, and leading change. Nominations for the cohort are requested and may be emailed to Carolyn McCrea. Applications are available and, for the first

	time, MSV is offering an Early Bird rate for applicants through September 30. Applications are available now. Staff contact: Carolyn McCrea (cmccrea@msv.org)
Stroke Smart *In partnership with Stroke Smart Virginia*	**Program Description:** *Stroke Smart Virginia* is an initiative aimed at reducing pre-hospital delay for strokes. MSVF partnered with VDH and Kwikpoint to define *Stroke Smart Medical Practice (SSMP)*, a subset aimed at medical practices. Studies suggest that 1/3 of people experiencing a stroke will call their family doctor 1st for an appointment. SSMP consists of (5) criteria aimed at educating patients and office staff on stroke signs and actions to take. • We have partnered with health systems for implementation in practices: VCU (largest Richmond clinic), Bon Secours (25 teams/40 clinics in Richmond and Portsmouth), Augusta (12 primary care practices), Mary Washington (system wide), Inova (5 practices), Riverside (interested) along with distributing materials to (15) additional practices • A collaboration has been formed with VHHA, VDH, Stroke Smart Virginia, and MSV to create a "toolkit" of resources to use for staff training, patient training, and SSMP implementation guidance • *Stroke Smart* Magnets and Wallet Cards **available for ANY practice, hospital** free of charge through MSV or VDH websites or by emailing Foundation@msv.org Staff contact: Amy Swierczewski (aswierczewski@msv.org)
Chronic Care Management	**Program Description:** We are collaborating with the Virginia Department of Health to implement a Chronic Care Management (CCM) Program in practices in areas of high chronic disease prevalence. The model would incorporate a Community Health Worker (CHW) into the care team. • We have engaged practices in Danville, Franklin, Colonial Heights/Petersburg, Portsmouth and Norfolk. • We are looking to engage a practice in Roanoke • Currently assessing practice operations and workflows for understanding and to identify how to effectively integrate a Community Health Worker and build up CCM practice. • Looking for additional grant funding to support practices as they implement a CHW into their workflows
CME Accreditation	**Program Description:** The MSV is a Recognized Accreditor of the Accreditation Council for Continuing Medical Education (ACCME), and currently accredits six healthcare organizations to provide physician education that grants AMA PRA Category 1 CME credits. Five of the organizations are from Virginia: Carillion Clinic, Inova Healthcare, Sentara Healthcare, SOVAH Danville, and Winchester Medical Center. **Program Update:**

	• The West Virginia State Medical Society recently withdrew as a Recognized Accreditor from the ACCME system. When this happens, the ACCME encourages accredited providers to transition their accreditation to an adjacent state's medical society. One of the WV providers, West Virginia University-Berkeley Medical Center (WVU-BMC) elected to transfer their accreditation to MSV, and they were transitioned on June 1. WVU-BMC will undergo reaccreditation in 2024. • SOVAH Danville is currently in the reaccreditation process. Their materials will be reviewed after Labor Day, and they will undergo a survey interview in October. The MSV Intrastate Accreditation Committee will decide on their reaccreditation status in November. • MSV is in late discussion with the state medical societies of North Carolina and Mississippi regarding the formation of a CME Collaborative that will merge and share some of the administrative and committee work and result in a stronger accreditation enterprise. MSV has taken the lead in developing an operational framework, and a formal collaboration agreement is under review by the leadership of each of the SMS. The ACCME was the catalyst for this collaboration by first requiring and now encouraging smaller SMS accreditor programs to form regional collaborations to allow for more experience with decision-making and enable better quality accreditation outcomes. The MSV CME program is managed by Dr. Marc Jackson (mjackson@msv.org) with assistance from Amy Swierczewski (aswierczewski@msv.org).

Development:	
Physicians Gala	Still getting more sponsorships. So far, we have raised $230,800 in sponsorships for 2023 (as of September 22, 2023). This is the most money we have ever raised for our sponsorships. Our theme is: The Golden Age of Hollywood. The Gala will be held at the Hilton, the Main in Norfolk, October 14, 2023.
Salute to Service Awards	Our five Salute to Service Award winners have been chosen, and the videos of all five will be shown at the 2023 Gala.
Development	2023 totals - $268,170 development dollars collected only • 1820 Society - $1,450 • PLI - $600 • Medical Student Sponsorship - $1,099 • Medical Student sponsorship –endowment, $16,550 • MSVF endowment, PA student sponsorship - $2,250 • MSVF Foundation endowment, Advocacy/Policy - $5 • MSVF Innovation Fund, Center for Poly Trauma - $10,050

	• MSVF Gala contribution or sponsor- $230,800 • Personal donation - $22,789 • Corporate donation - $1,577.00 • Endowment pledge paid for PA, (long and short-term) - $750 • Raffle Ticket - $3,600 • Wine is my Valentine - $2,400 • MSVF recurring gift - $2,025 • SafeHaven - $3,635 • VMAP Support - $385 • Friend of MSVF – Gala ticket - $9,500 • Gala General admission ticket - $10,995 Development News • 2023 Annual campaign – Theme is “Empowering people who help people.” • Endowment & planned giving campaigns – working on Presidents’ Wall for endowment. • The development committee is considering a whisky tasting for the fall. Development Staff Contact: Denise Kranich (dkranich@msv.org)

Your Virginia Delegation is proud to represent you in the AMA House of Delegates, 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 collegially 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 advocate for policies in our patient's best interest and promote our profession's integrity.

For the second time since the beginning of the pandemic, we met in person at the national meeting in Chicago. It was a blessing that our delegation gathered with their colleagues from other states to continue advancing our policymaking agenda. During that meeting, Dr. Cynthia Romero had the privilege to serve as Chair of the Public Health Reference Committee. While running the committee meeting and delivering her report, she did a fantastic job on the dais and in front of the entire House of Delegates. Dr. Alice Coombs continues to serve the Delegation with distinction after her successful re-election to the AMA Council on Medical Service. Dr. Sterling Ransone and Jenny Young did a tremendous job presenting SafeHaven and showcasing the video before the OSMAP section meeting. The AMA maintains its focus on prior authorization reform, scope of practice defense, physician well-being, and efforts to reform Medicare. 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 has strong leadership, with Dr. Thomas Eppes serving as Chairman and Dr. Clifford Deal serving as Vice Chairman. Dr. Claudette Dalton now serves as the Chair of the SED's Board of Trustees Compensation Committee, and she continues to provide exceptional leadership at the AMA in a senior-level position. Dr. Pandya continues his work with the International Medical Graduates Section, offering his experiences as an IMG. Dr. Lee Ouyang graciously stepped up and served as a delegate for the June Annual meeting, covering multiple committees for the Delegation. Dr. Michelle Nedelka took the lead for Virginia during the AMA candidate interview process. Lastly, we'd like to thank Dr. Joel Bundy for his years of service at the AMA and our Virginia Delegation. Dr. Bundy will be leaving the Delegation as he assumes his new role as President-Elect of the MSV this year. We wish him the best during his term.

Virginia's representation at the AMA continues to show strong growth, bolstering its ranks with many new and returning members and alternates who bring a wealth of knowledge to the Delegation. Dr. Sterling Ransone will rejoin the Delegation after serving as the president of the American Academy of Family Physicians and subsequently as the Chair of their Board of Directors. Dr. Sandy Chung will join the Delegation after serving as the American Academy of Pediatrics president. Dr. Mark Townsend, an Executive in Residence at Bon Secures Mercy Health, and Dr. Jan Willcox, a family medicine osteopathic physician and immediate past dean of the Edward Via College of Osteopathic Medicine (VCOM) Virginia campus, will also join the Delegation. We are truly grateful for their willingness to serve and look forward to working with them this next year. The AMA student section continues to grow. Lavinia Wainwright, 4th year at EVMS, and Shaylyn Fahey, 3rd year at VTC SOM, serve as Regional 6 delegates to the AMA HOD, and Sneha Krish, 4th year at VTC SOM, serves as the alternate delegate for Region 6. We are preparing for the interim AMA House of Delegates meeting at National Harbor, Maryland, this November. We have participated with other states and specialty societies, deliberating several resolutions proposed at this upcoming meeting, and look forward to convening in just over a month.

We continue to benefit from solid health policy support provided by Scott Castro and Chris Fleury 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 undoubtedly challenging times in American medicine. Your MSV AMA Delegation sees 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 vital work of the Delegation.

Respectfully submitted,

Thomas Eppes, MD
Chair, Virginia Delegation to the AMA

MSV℠ MEDICAL SOCIETY OF VIRGINIA

Date September 20, 2023

To: MSV House of Delegates

From: Seth Weir, MSV Medical Student Section Chair
Edward Via College of Osteopathic Medicine – Virginia Campus

Re: Medical Student Section Annual Report, 2023 - 2024

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.

Following several years of limited in person events due to the COVID-19 pandemic, I'm pleased to report the student section has returned to pre-pandemic engagement levels. We began the year with more than 90 medical students representing all 6 of Virginia's medical schools joining MSV at the General Assembly. We lobbied for key MSV issues such as increased VMAP funding, Medicaid reimbursement rate increases, protecting our healthcare workers against violent verbal threats, scope of practice, and revising mental health related questions on Virginia's physician licensure applications. Joining MSV in advocating for the profession and our patients is an impactful and inspiring experience.

Virginia had 19 medical students join the Virginia Delegation at AMA's Annual Meeting in June. Our students had great success with 3 of my peers winning prestigious leadership elections on AMA's Medical Student Region 6 Board. Region 6 represents AMA medical student members in Virginia, DC, Maryland, Pennsylvania, and New Jersey. Shreya Mandava (UVA) was elected as Region 6 Chair, Shaylyn Fahey (VTC) was elected as Region 6 Advocacy Chair, and Brianna Baldwin (UVA) was elected as Diversity, Equity, Inclusion, & Accessibility (DEIA) Chair. Virginia's medical student delegation continues to be a very respected voice in the MSS Assembly.

In August, 35 medical student leaders attended our medical student leadership retreat held at MSV's Headquarters. The retreat served as a planning and goal setting meeting for our team and was our first in-person retreat post pandemic. It was exceptional to see

how passionate our MSS leaders are in engaging Virginia's medical students to advance MSV's goals and initiatives.

Since the start of the 2023-2024 academic year, MSV has hosted more than a dozen events on our medical school campuses. The events have ranged from lunch lectures, networking events, study sessions, and MSVPAC's Docs n Hops events. During these events, we have recruited over 100 new MSV medical student members. Each chapter has a robust event schedule for the rest of the year and ambitious membership recruitment goals.

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 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,
Seth Weir

Board of Medicine
Report to the Medical Society of Virginia
September 26, 2023

1. 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 appointed to the Board.

2. The officers of the Board for 2023-2024 are President John R. Clements, DPM, of Roanoke, Vice-President Peter Apel, MD, of Roanoke, and Secretary-Treasurer Karen Ransone, MD, of Deltaville.

3. 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.

4. The Board of Medicine issues licenses for 19 professions and certification for 1 profession, Surgical Technology. Additionally, it jointly licenses and regulates Advanced Practice Registered Nurses* and Licensed Certified Midwives with the Board of Nursing.
   *Note, SB 975 amended the Code of Virginia to change all references to "nurse practitioner" to "advanced practice registered nurse" to align the Code with the professional designations established by the National Council of State Boards of Nursing.

5. For nearly two years, the medical boards of Virginia, Maryland and the District of Columbia have worked toward creating a Licensing by Reciprocity pathway for physicians who wish to practice in all three jurisdictions. On March 13, 2023, reciprocal licensing became an option for applicants. Under this expedited pathway, if a physician is licensed in one of the three jurisdictions; that license will be accepted by the other two jurisdictions. However, each board has different basic requirements for licensure, so each has its own application questions and specific documentation to be submitted. To date, 297 licenses have been issued by reciprocity in Virginia to applicants from the District of Columbia and Maryland. Virginia has submitted 74 license verifications to the District of Columbia and 61 to Maryland, for a total of 135 Virginia physicians applying for a reciprocal license in the District of Columbia and Maryland.

6. Since last year's report to the Medical Society of Virginia, 2,155 complaints have been lodged against Board of Medicine licensees. In the past year, the Board has taken 138 disciplinary actions, including 10 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 suspended/revoked or surrendered a license in lieu of discipline in another jurisdiction, or has been convicted of a felony.

7. Through HB 1573/SB 970 the General Assembly directed each health regulatory board within the Department of Health Professions to amend its licensure, certification and registration applications to remove any existing questions pertaining to mental health conditions and impairment and to include the following questions: *1) Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? And 2) Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodations?* The bill contained an emergency clause, and the Board of Medicine began making the changes to its applications in March 2023 and all paper and online applications have been updated with the new questions.

8. On July 1, 2023, the law prohibiting licensed midwives from possession or administration of drugs was amended to permit licensed midwives to obtain, possess and administer drugs and devices within the scope of their practice. Through HB 1511/SB 1275 the General Assembly also directed the Board to develop and publish best practices and standards of care guidance for all such drugs. On July 20, 2023, the Ad hoc Committee on Medications for Midwives, consisting of Board of Medicine members, midwifery advisory board members, and outside experts, convened to draft a medication formulary and best practices/standard of care protocol. The formulary and protocol were approved by the Executive Committee of the Board on August 4.

9. At the direction of the General Assembly through SB 948/HB 2274, members of the Board of Medicine and Board staff participated in August of 2023 on the Board of Pharmacy Statewide Protocol Work Group, to recommend statewide protocols for pharmacists to initiate treatment with controlled substances or devices for the treatment of diseases or conditions for which the clinical decision-making can be guided by a clinical test that is classified as waived under the federal Clinical Laboratory Improvement Amendments of 1968. The covered diseases or conditions are: Group A streptococcus bacteria infection; influenza virus infection; COVID-19 virus infection; urinary tract infection.

10. 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 sought a 25% reduction in regulations, especially for those regulations which are not mandated by law. The Board of Medicine has identified a significant number of regulations for deletion or revision. The Board recommended actions are currently under review by the Secretary of Health and Human Resources and/or the Office of the Attorney General.

11. Effective July 1, 2023, SB 1539 was enacted, authorizing a dentist to possess and administer botulinum toxin injections for cosmetic purposes, provided the dentist has completed training and continuing education in the administration of botulinum toxin injections for cosmetic purposes. The bill requires the Board of Dentistry, in consultation with the Board of Medicine, to amend its regulations regarding training and continuing education requirements for dentists related to the administration of botulinum toxin injections for cosmetic purposes. The Board of Dentistry Regulatory Committee is scheduled to meet on October 27, 2023 to begin work on regulations.

12. The following tables show the Board of Medicine professions and their current numbers.

License Count Report for Medicine

Board	Occupation	State	License Status	License Count
Medicine				
	Assistant Behavior Analyst			
	Assistant Behavior Analyst	Virginia	Current Active	210
	Assistant Behavior Analyst	Out of state	Current Active	33
	Total for Assistant Behavior Analyst			243
	Athletic Trainer			
	Athletic Trainer	Virginia	Current Active	1,442
	Athletic Trainer	Virginia	Current Inactive	3
	Athletic Trainer	Out of state	Current Active	303
	Athletic Trainer	Out of state	Current Inactive	3
	Total for Athletic Trainer			1,751
	Behavior Analyst			
	Behavior Analyst	Virginia	Current Active	1,704
	Behavior Analyst	Virginia	Current Inactive	2
	Behavior Analyst	Out of state	Current Active	895
	Behavior Analyst	Out of state	Current Inactive	3
	Total for Behavior Analyst			2,604
	Chiropractor			
	Chiropractor	Virginia	Current Active	1,447
	Chiropractor	Virginia	Current Inactive	16
	Chiropractor	Out of state	Current Active	274
	Chiropractor	Out of state	Current Inactive	68
	Total for Chiropractor			1,805
	Genetic Counselor			
	Genetic Counselor	Virginia	Current Active	127
	Genetic Counselor	Out of state	Current Active	436
	Genetic Counselor	Out of state	Current Inactive	3
	Total for Genetic Counselor			566
	Genetic Counselor-Temporary			
	Genetic Counselor-Temporary	Virginia	Current Active	9
	Genetic Counselor-Temporary	Out of state	Current Active	5
	Total for Genetic Counselor-Temporary			14
	Interns & Residents			
	Interns & Residents	Virginia	Current Active	2,657
	Interns & Residents	Out of state	Current Active	882
	Total for Interns & Residents			3,539
	Licensed Acupuncturist			
	Licensed Acupuncturist	Virginia	Current Active	474
	Licensed Acupuncturist	Virginia	Current Inactive	3
	Licensed Acupuncturist	Out of state	Current Active	123
	Licensed Acupuncturist	Out of state	Current Inactive	5
	Total for Licensed Acupuncturist			605

License Count Report for Medicine

Board	Occupation	State	License Status	License Count
Medicine				
	Licensed Midwife			
	Licensed Midwife	Virginia	Current Active	78
	Licensed Midwife	Virginia	Probation - Currei	1
	Licensed Midwife	Out of state	Current Active	34
	Licensed Midwife	Out of state	Current Inactive	2
	Total for Licensed Midwife			115
	Licensed Surgical Assistant			
	Licensed Surgical Assistant	Virginia	Current Active	587
	Licensed Surgical Assistant	Out of state	Current Active	160
	Total for Licensed Surgical Assistant			747
	Limited Radiologic Technologist			
	Limited Radiologic Technologist	Virginia	Current Active	401
	Limited Radiologic Technologist	Virginia	Current Inactive	16
	Limited Radiologic Technologist	Out of state	Current Active	24
	Limited Radiologic Technologist	Out of state	Current Inactive	1
	Total for Limited Radiologic Technologist			442
	Medicine			
	Medicine	Virginia	Current Active	23,204
	Medicine	Virginia	Current Inactive	455
	Medicine	Virginia	Probation - Currei	2
	Medicine	Out of state	Current Active	19,422
	Medicine	Out of state	Current Inactive	1,007
	Medicine	Out of state	Probation - Currei	2
	Total for Medicine			44,092
	Occupational Therapist			
	Occupational Therapist	Virginia	Current Active	4,004
	Occupational Therapist	Virginia	Current Inactive	64
	Occupational Therapist	Virginia	Probation - Currei	1
	Occupational Therapist	Out of state	Current Active	1,142
	Occupational Therapist	Out of state	Current Inactive	58
	Total for Occupational Therapist			5,269
	Occupational Therapy Assistant			
	Occupational Therapy Assistant	Virginia	Current Active	1,599
	Occupational Therapy Assistant	Virginia	Current Inactive	24
	Occupational Therapy Assistant	Out of state	Current Active	238
	Occupational Therapy Assistant	Out of state	Current Inactive	11
	Total for Occupational Therapy Assistant			1,872
	Osteopathic Medicine			
	Osteopathic Medicine	Virginia	Current Active	2,567
	Osteopathic Medicine	Virginia	Current Inactive	13
	Osteopathic Medicine	Out of state	Current Active	2,717
	Osteopathic Medicine	Out of state	Current Inactive	68
	Total for Osteopathic Medicine			5,365
	Physician Assistant			
	Physician Assistant	Virginia	Current Active	4,280
	Physician Assistant	Virginia	Current Inactive	16
	Physician Assistant	Out of state	Current Active	1,748
	Physician Assistant	Out of state	Current Inactive	46

License Count Report for Medicine

Board	Occupation	State	License Status	License Count
Medicine				
	Total for Physician Assistant			6,090
	Podiatry			
	Podiatry	Virginia	Current Active	412
	Podiatry	Virginia	Current Inactive	9
	Podiatry	Out of state	Current Active	148
	Podiatry	Out of state	Current Inactive	19
	Total for Podiatry			588
	Polysomnographic Technologist			
	Polysomnographic Technologist	Virginia	Current Active	332
	Polysomnographic Technologist	Virginia	Current Inactive	4
	Polysomnographic Technologist	Out of state	Current Active	130
	Total for Polysomnographic Technologist			466
	Radiologic Technologist			
	Radiologic Technologist	Virginia	Current Active	3,517
	Radiologic Technologist	Virginia	Current Inactive	30
	Radiologic Technologist	Out of state	Current Active	1,519
	Radiologic Technologist	Out of state	Current Inactive	15
	Total for Radiologic Technologist			5,081
	Radiologist Assistant			
	Radiologist Assistant	Virginia	Current Active	11
	Radiologist Assistant	Out of state	Current Active	3
	Total for Radiologist Assistant			14
	Respiratory Therapist			
	Respiratory Therapist	Virginia	Current Active	3,001
	Respiratory Therapist	Virginia	Current Inactive	99
	Respiratory Therapist	Out of state	Current Active	1,582
	Respiratory Therapist	Out of state	Current Inactive	32
	Total for Respiratory Therapist			4,714
	Restricted Volunteer			
	Restricted Volunteer	Virginia	Current Active	52
	Restricted Volunteer	Out of state	Current Active	12
	Total for Restricted Volunteer			64
	Surgical Technologist			
	Surgical Technologist	Virginia	Current Active	1,580
	Surgical Technologist	Out of state	Current Active	769
	Total for Surgical Technologist			2,349
	University Limited License			
	University Limited License	Virginia	Current Active	7
	University Limited License	Out of state	Current Active	3
	Total for University Limited License			10
Total for Medicine				88,405

J. Randolph Clements, DPM
President

William L. Harp, MD
Executive Director

Virginia Department of Health Professions
Board of Medicine
9960 Mayland Drive, Suite 300
Henrico, VA 23233

Date September 27, 2023

To: 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 legislative efforts were stalled due to internal General Assembly politics, but we plan on introducing our 2023 legislation again in 2024. It would permit PAs to practice as part of a patient care team without a practice agreement in specific institutional settings governed by credentialing and/or privileging. We also have two pending regulatory actions before the Board of Medicine. We appreciate the support of MSV in moving our legislative and regulatory initiatives forward, and we look forward to continued collaboration in 2024.

VAPA hosted our 41st Annual Summer CME conference in Virginia Beach in July. The week-long conference was filled with general sessions, workshops, networking opportunities, and the presentation of the 2023 VAPA Awards. Our Fall CME Conference is scheduled for November 4th in Richmond. This one-day event offers 7 hours of CME, as well as a separate track for our student attendees. That evening, we will host the annual VAPA Student Challenge Bowl, where PA students from across the Commonwealth compete for this year's trophy!

VAPA will kick-off PA Week by hosting our annual Fireside Chat via Zoom on October 5th. 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